MEDICARE A Bulletin

A NEWSLETTER FOR MAC J9 PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

FCSO welcomes our Part A providers in the U.S. Virgin Islands

First Coast Service Options Inc. (FCSO) is pleased to extend a special welcome to the newest members of our provider community. Now more than ever, it is essential for providers to be aware of changes to the Medicare program and to have immediate access to accurate and current information. To ensure providers throughout jurisdiction 9 (J9) remain informed, FCSO electronically publishes a new, comprehensive issue each month and offers both English and Spanish editions to serve the jurisdiction's diverse provider community more effectively.

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

[ ] Medicare Manager
[ ] Reimbursement Director
[ ] Chief Financial Officer
[ ] Compliance Officer
[ ] DRG Coordinator
[ ] _____
[ ] _____
[ ] _____

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Publication Staff

Millie C. Pérez
Terri Drury
Mark Willett
Robert Petty

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.

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

Medicare Publications
1-904-361-0723

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://medicare.fcso.com*.

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy (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

April 2009 update and previous revisions to the quarterly ASP Medicare Part B drug pricing file updates

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], 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) 6380 which informs Medicare contractors that on or after December 16, 2008, the January 2009 average sales price (ASP) file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. In addition, on or after March 16, 2009, the April 2009 ASP not otherwise classified (NOC) files will be available for retrieval from the Centers for Medicare & Medicaid Services (CMS) ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary.

Background

The Medicare Modernization Act of 2003 (Section 303(c); see the CMS Web site at *http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf*) revised the payment methodology for Part B-covered drugs and biologicals that are not paid on a cost or prospective payment basis. The vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology. Pricing for compounded drugs is performed by your local Medicare contractor.

CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by the Social Security Act (Section 1847A; see *http://www.ssa.gov/OP_Home/ssact/title18/1847.htm* on the Internet). As part of this effort, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. Specifically, CMS considers:

- The Food and Drug Administration (FDA) approval
- Therapeutic equivalents as determined by the FDA
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA biologic license application or other relevant FDA approval) first sold in the United States after October 1, 2003, or
- A single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003.

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of NOC HCPCS codes.

Average sales price methodology

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. Note that payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the integrated outpatient code editor (I/OCE) through separate instructions.

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for:

- End-stage renal disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP plus five percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP plus four percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update these payment allowance limits quarterly.

Exceptions to this general rule are summarized below.

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood

April 2009 update and previous revisions to the quarterly ASP Medicare Part B drug pricing file updates (continued)

products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.

- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. The payment allowance limits were not updated in 2008. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- Payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2009, the blood clotting furnishing factor of $0.164 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

  Note: At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS Web site.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005. Your Medicare contractor, at their discretion, may contact CMS to obtain payment limits for new drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors will determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

Quarterly payment files

On or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR 6380 (April 1, 2009) for the dates of service noted in the table that follows.

Please be aware that your Medicare contractor will not search and adjust claims that have already been processed unless you bring them to their attention.

April 2009 update and previous revisions to the quarterly ASP Medicare Part B drug pricing file updates (continued)

Payment allowance limit revision date	Applicable dates of service
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Drugs furnished during filling or refilling an implantable pump or reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm* on the Internet) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Additional information

The official instruction, CR 6380, issued to your carrier, FI, or 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/R1685CP.pdf*.

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

MLN Matters Number: MM6380
Related Change Request (CR) Number: 6380
Related CR Release Date: February 20, 2009
Related CR Transmittal Number: R1685CP
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 1685, CR 6380

Centers for Disease Control and Prevention updates and health advisory

The Centers for Medicare & Medicaid Services has released the following information from the Centers for Disease Control and Prevention (CDC):

- Updates to the CDC information and guidance from March 9 to 16, 2009: *http://emergency.cdc.gov/coca/updates/2009/2009mar16.asp*.

Health advisory related to invasive haemophilus influenzae type B disease in young children and the importance of receiving the primary series of the Hib vaccine: *http://www2a.cdc.gov/HAN/ArchiveSys/ViewMsgV.asp?AlertNum=00281*. ❖

Source: CMS PERL 200903-27

April update to the 2009 Medicare physician fee schedule database

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

Provider types affected

Physicians, nonphysician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors (A/B MACs) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 6397 which amends payment files that were issued to contractors based upon the 2009 Medicare physician fee schedule (MPFS) final rule. Physical therapists should pay particular attention to the "Background" section regarding the billing of canalith repositioning procedures.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

Canalith repositioning

In the 2009 MPFS final rule, the Centers for Medicare & Medicaid Services (CMS) discussed a newly created CPT code, 95992, describing canalith repositioning procedures. CMS indicated that, prior to the new CPT code, this service was billed by physicians as part of an evaluation and management service, and by other practitioners, primarily therapists, using existing codes. CMS assigned the code a status indicator of B (bundled), and stated that bundling this code is most appropriate because this service is currently being paid for as part of an evaluation and management (E and M) service. However, since therapists also provide this service and they cannot bill for E and M services, they should continue to bill *CPT* code *97112* for this service.

2009 physician quality reporting initiative (PQRI) program

CMS identified a technical problem affecting twenty quality-data codes (QDCs) used for reporting thirteen quality measures through the claims-based method for the 2009 physician quality reporting initiative (PQRI). These twenty QDCs are new codes for the 2009 PQRI. The *CPT II* codes and the 2009 PQRI measures affected are listed below.

CPT II code	Measure number	Measure
3250F	99	*Breast cancer resection pathology reporting: pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade*
3250F	100	*Colorectal cancer resection pathology reporting: pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade*
3570F	147	*Nuclear medicine: correlation with existing imaging studies for all patients undergoing bone scintigraphy*
3016F	173	*Preventive care and screening: unhealthy alcohol use – screening*
3455F	176	*Rheumatoid arthritis (RA): tuberculosis screening*
4195F	176	*Rheumatoid arthritis (RA): tuberculosis screening*
4196F	176	*Rheumatoid arthritis (RA): tuberculosis screening*
3470F	177	*Rheumatoid arthritis (RA): periodic assessment of disease activity*
3471F	177	*Rheumatoid arthritis (RA): periodic assessment of disease activity*
3472F	177	*Rheumatoid arthritis (RA): periodic assessment of disease activity*
1170F	178	*Rheumatoid arthritis (RA): functional status assessment*
3475F	179	*Rheumatoid arthritis (RA): assessment and classification of disease prognosis*
3476F	179	*Rheumatoid arthritis (RA): assessment and classification of disease prognosis*
0540F	180	*Rheumatoid arthritis (RA): glucocorticoid management*
4192F	180	*Rheumatoid arthritis (RA): glucocorticoid management*
4193F	180	*Rheumatoid arthritis (RA): glucocorticoid management*
4194F	180	*Rheumatoid arthritis (RA): glucocorticoid management*
4148F	183	*Hepatitis C: hepatitis A vaccination in patients with HCV*
4149F	184	*Hepatitis C: hepatitis B vaccination in patients with HCV*

April update to the 2009 Medicare physician fee schedule database (continued)

CPT II code	Measure number	Measure
0529F	185	*Endoscopy & polyp surveillance: colonoscopy interval for patients with a history of adenomatous polyps – avoidance of inappropriate use*
4267F	186	*Wound care: use of compression system in patients with venous ulcers*

In most instances, the technical problem has caused line items containing any of the QDCs listed above to reject/return as unprocessable. In those circumstances, the eligible professional (EP) received a message other than N365 indicating that the procedure code was not accepted for reporting proposes. Since this is an issue that affects claims-based PQRI reporting only, the reporting of quality measures through registries is not affected.

CMS is actively working with the carriers and A/B MACs to address this issue. All carriers and A/B MACs will be able to accept the affected codes within the next three weeks. Once this has been accomplished, submission of the affected *CPT II* codes will result in the normal N365 message on the remittance advice indicating that the code has been accepted for reporting purposes.

In order to minimize any adverse impact on EPs for determination of satisfactory reporting for affected measures, CMS will exclude from the reporting denominator all cases for dates before which the carriers and A/B MACs could accept the affected *CPT II* codes, unless inclusion of cases for such dates is more favorable to the EP. In view of this, EPs have the option to seek correction of first quarter (i.e., January 1, 2009 – March 31, 2009) QDC submissions which were returned as unprocessed if desired, but EPs would not be required to seek correction for the affected codes. The two basic options for EPs are:

A. Do not seek correction of the submitted codes which were returned unprocessed.
As indicated above, CMS will exclude from the determination of satisfactory reporting cases for dates prior to the date the carriers and A/B MACs can process the relevant codes. Thus, EPs are not required to seek correction of claims. On the other hand, EPs who have begun to submit codes for the affected measures should continue to submit such codes. The beginning of acceptance of the codes will be apparent when the N365 message is noted on the remittance advice. The 2009 reporting period will not be changed and the EP who qualifies for the incentive based on the listed or affected measures will receive the two percent incentive payment with respect to the entire reporting period.

B. Seek correction of the submitted codes that were returned unprocessed.
In certain circumstances, EPs may desire to seek correction of the unprocessed claims. To accomplish this, EPs who have already billed and included any of the listed QDCs for dates of service January 1, 2009 and after and received a message other than N365 on their remittance advice, can call their carrier or A/B MAC and request a correction beginning April 1, 2009. In this case the EP should be prepared to give specific claim information to the carrier or A/B MAC, such as, the internal control number (ICN), the beneficiary's health insurance claim number (HIC), dates of service and the QDCs. EPs who began reporting the affected measures using the measures group consecutive method during the first three months of 2009 may find that it is worthwhile to pursue correction.

Note: PQRI reporting and performance rate analysis for only the affected measures will initially be performed after excluding cases for the first three months of 2009. If an EP does not qualify based on this calculation, then the EP's claims without excluding claims for the first three months of 2009 will be evaluated. Thus, the determination of satisfactory reporting will be evaluated both ways for all EPs who report on the relevant measures.

Other specific changes included in the April update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6397. That CR is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1691CP.pdf*.

Key changes, however, are summarized as follows:

These *Current Procedural Terminology* /Healthcare Common Procedure Coding System (*CPT*/HCPCS) codes are assigned a procedure status = M as follows:

0529F *0540F* *1170F* *3016F* *3250F* *3455F* *3470F* *3471F* *3472F* *3475F* *3476F* *3570F* *4148F*
4149F *4192F* *4193F* *4194F* *4195F* *4196F* *4267F* G8489 G8490 G8491 G8492 G8493 G8494.

These *CPT*/HCPCS codes are assigned a procedure status = I as follows:

0575F, 4270F, 4271F, 4279F, 4280F.

Physicians/providers should also note the following:

***CPT*/HCPCS**	**ACTION**
93351 Global	*Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision* Short Descriptor: Stress tte complete

April update to the 2009 Medicare physician fee schedule database (continued)

93351 TC *Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision*
Short Descriptor: Stress tte complete

93351 26 *Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision*
Short Descriptor: Stress tte complete

Descriptor Changes

The long descriptor has been revised for the following codes:

CPT Code	Revised Long Descriptor	Revised Short Descriptor
G0248	Demonstration, prior to initiation of home INR monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient's ability to perform testing and report results	N/A
G0249	Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests	N/A
G0250	Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include four tests	N/A

Change in procedure status for *CPT* code *0085T*

Effective for claims with dates of service on and after December 8, 2008, the heartsbreath test used to predict heart transplant rejection is nationally noncovered. *CPT* code *0085T*, breath test for heart transplant rejection, is assigned procedure status of N and is no longer payable by Medicare.

Additional information

The official instruction, CR 6397, 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/R1691CP.pdf*.

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

MLN Matters Number: MM6397
Related Change Request (CR) Number: 6397
Related CR Release Date: March 4, 2009
Related CR Transmittal Number: R1691CP
Effective Date: January 1, 2009
Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 1691, CR 6397

Implementation of the Internet-based provider enrollment, chain, and ownership system

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

Provider types affected

All physicians, providers, and suppliers who submit CMS-855 applications into the provider enrollment, chain and ownership system (PECOS) via the Internet to Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], carriers or regional home health intermediaries [RHHIs]).

Provider action needed

This article is based on change request (CR) 6231 and alerts providers to the fact that the information about Internet-based PECOS applications provided in previously issued CR 5954 is now incorporated into Centers for Medicare & Medicaid Services (CMS) *Medicare Program Integrity Manual* Chapter 10─Medicare Provider/Supplier Enrollment, which is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf*.

CMS emphasizes that none of the material in CR 5954 is changing in any way; the material is simply being shifted to chapter 10.

Background

This article is based on change request (CR) 6231 and alerts providers to the fact that the information about Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications provided in previously issued CR 5954 is now incorporated into Centers for Medicare & Medicaid Services (CMS) *Medicare Program Integrity Manual* Chapter 10─Medicare Provider/Supplier Enrollment, which is available at *http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf* on the CMS Web site. CMS emphasizes that none of the material in CR 5954 is changing in any way; the material is simply being shifted to chapter 10.

Key points of change request 6231

Effective immediately CMS has incorporated the instructions regarding PECOS applications into the *Medicare Program Integrity Manual* Chapter 10. The instructions are as follows:

- If the provider fails to submit a signed and dated certification statement to the Medicare contractor within 15 calendar days of the date on which it submitted its Internet-based PECOS CMS-855 to the contractor, the contractor may reject the application.
- For initial CMS-855 applications sent via the Internet-based PECOS, it is only necessary that the dated signature of at least one of the provider's authorized officials be on the certification statement that must be sent in by the 15th day. The signatures of the other authorized and delegated officials will be collected through the normal application development process.
- If the provider submits an undated certification statement or a certification statement on which the Web tracking ID does not match that in PECOS, the Medicare contractor will treat it as a non-submission.
- If your contractor determines that additional or clarifying information is needed, the contractor will send an e-mail to the provider: (1) requesting said data along with, as necessary, a signed and dated certification statement; and (2) listing a date(s) by which the information and certification statement, respectively, must be submitted to the contractor.
- Note that your contractor may, at its discretion, initiate a follow-up contact with you after sending the e-mail, but is not required to do so.
- If the provider fails to submit the requested additional/clarifying information and the accompanying certification statement within 30 calendar days from the date the contractor sent the e-mail, the contractor may reject the provider's application.
- If the contractor receives the additional/clarifying information from the provider, the contractor will not recommence its processing of the application until the accompanying certification statement is received in the contractor's provider enrollment department.

The provider must submit all applicable supporting documentation (e.g., licenses, CMS-588) with its Internet-based PECOS application. (It is not necessary, however, for the provider to submit the supporting documentation: (1) in the same package as the certification statement, or (2) prior to its submission of the certification statement.).

Additional information

For complete details regarding this CR please see the official instruction (CR 6231) issued to your Medicare A/B MAC, FI, carrier or RHHI. That instruction may be viewed by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R271PI.pdf*.

If you have any questions, please contact your Medicare A/B MAC, FI, 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*.

MLN Matters Number: MM6231
Related Change Request (CR) Number: 6231
Related CR Release Date: October 24, 2008
Related CR Transmittal Number: R271PI
Effective Date: November 24, 2008
Implementation Date: November 24, 2008

Source: CMS Pub. 100-08, Transmittal 271, CR 6231

Implementation of provider authentication requirements for contacting Medicare

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) revised this article to reflect the revised change request (CR) 6139, which CMS re-issued on March 4, 2009. The effective and implementation dates for providers have been changed to April 6, 2009, by Transmittal R23COM on February 10. In this revision of the article, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same. The previously revised *MLN Matters* article MM6139 was published in the February 2009 *Medicare A Bulletin* (pages 5-6).

Provider types affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], or durable medical equipment Medicare administrative contractors [DME MACs]). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to interactive voice response (IVR) systems.

What you need to know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a customer service representative (CSR).

Effective April 6, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication:

1. Your national provider identifier (NPI)
2. Your provider transaction access number (PTAN)
3. The last five-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last five-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor system will verify that the NPI, PTAN, and last five-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last five-digits of your TIN.

As a result of CR 6139, the *Disclosure Desk Reference* for provider contact centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

Authentication of providers with no NPI

Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

Beneficiary authentication

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

1. Last name
2. First name or initial
3. Health Insurance Claim Number (HICN)
4. Either date of birth (eligibility, next eligible date, durable medical equipment Medicare administrative contractor information form [DIF] [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Implementation of provider authentication requirements for contacting Medicare (continued)

Written Inquiries

In general, three data elements (NPI, PTAN, and last five digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on remittance advice (RAs) or Medicare summary notices (MSNs),

The exception to this requirement is written inquiries received on the provider's official letterhead including emails with an attachment on letterhead. In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either the NPI, the PTAN, or last five-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last five-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

Overlapping Claims

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last five-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional information

You may find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R25COM.pdf*.

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

MLN Matters Number: MM6139 – Revised
Related Change Request (CR) Number: 6139
Related CR Release Date: March 4, 2009
Related CR Transmittal Number: R25COM
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Source: CMS Pub. 100-09, Transmittal 25, CR 6139

Enhancements to the national plan and provider enumeration system

The national plan and provider enumeration system (NPPES) underwent system maintenance. The following enhancements will be incorporated into NPPES:

- The NPPES application help page text will be revised to ensure consistency with the instructions found on the revised National Provider Identifier (NPI) Application/Update Form, CMS-10114 (11/08).
- NPPES Web users will be required to change their passwords after the enumerator has reset them. When the enumerator resets a user's password, the user will be redirected to the password reset page to change the reset password to a password of his/her choice. NPPES will also enforce a minimum password length of eight characters.

The following enhancements will be incorporated into the NPI registry:

- The "doing business as" (DBA) search feature will be restored.
- The NPI registry will be updated daily.
- The NPI registry will display all results in all capital letters. This change will not affect the way information is displayed in a health care provider's NPPES record.

Electronic file interchange

The electronic file interchange (EFI) user manual and technical companion guide have been revised. The upcoming changes will not impact the EFI XML schema.

Additional information

Health care providers may apply for an NPI online at *https://nppes.cms.hhs.gov*.

Health care providers needing assistance with applying for an NPI or updating their data in NPPES records may contact the NPI enumerator at 1-800-465-3203 or e-mail the request to the NPI enumerator at *CustomerService@NPIEnumerator.com*. ❖

Source: CMS PERL 200902-37

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

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this *MLN Matters* article SE0837 to add definitions of an outgoing and incoming contractor and the article is re-issued to remind affected providers of upcoming Medicare contractor transitions. The *MLN Matters* article SE0837 was published in the November 2008 *Medicare A Bulletin* (pages 18-22).

Provider types affected

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

Impact on providers

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

Background

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

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

MAC implementation milestones definitions

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

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

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

Outgoing contractor – a Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare contracting reform and whose work will transition to a MAC.

Incoming MAC – the entity that has won a contract under Medicare contracting reform and which will assume the workload that was performed by a carrier or FI.

Pre-award

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

Post-award

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

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

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

Two month prior to cutover

- **Complete and return your electronic funds transfer (EFT) agreements**. CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC. (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and get it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. Contact your MAC with any questions concerning the agreement.
    - The CMS-588 form may be found on the CMS Web site at *http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf*.
    - You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's Web site. Your contractor may also provide instructions on its Web site on accurately completing the form.
- Your new MAC may also request you to execute a new **electronic data interchange (EDI) trading partner agreement** as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available on the CMS Web site at *http://www.cms.hhs.gov/EducationMaterials/downloads/TradingPartner-8.pdf*.

  Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their Web site for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these Submitter IDs and passwords to you in hardcopy or electronically. You don't need to do anything to get the new IDs, however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.
- **Contact your claims processing vendor and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?" "Have you tested with the MAC?"
- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.
- Be aware that some MACs may offer participation in an "early boarding" process for electronic claims submission and/or electronic remittance advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password – watch for and document them for use after cutover to the MAC.

Cutover weekend

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

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

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

Post cutover

The first one-two weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.

- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll free number for use.
- Be prepared that you may experience longer than normal wait times for customer service representatives and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Learn how to use the MAC's IVR**. The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the contact center representative (CSR) line, the result is a spike in volume of calls to (CSRs) that are difficult to accommodate.

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

- Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's Web sites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.
- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that you may experience changes in remittance advice (RA) coding. While the combination of codes used on the remittance advice (RA) is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS post-cutover monitoring

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

Additional assistance

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

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

Additional information

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

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

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

MLN Matters Number: SE0837 – 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 SE0837

Attachment A

Timeline and checklist for preparing for MAC implementation

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

90 days before cutover

1. Visit MAC Web site and bookmark for future use
2. Join the MAC listserv
3. **Monitor:**
   - LCDs published by the new MAC; compare current LCD's that affect your practice's services.

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

4. **Review:**
   - Provider enrollment status for all providers, update as needed.
   - Pay-to address information for practice/providers, update as needed.
5. **Contact:**
   1. Your practice management/billing software vendor to determine if your system will be able to send and receive data to/from the new MAC.
   2. Claims Clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.

75 days before cutover

1. Continue to check the MAC's Web site and/or listserv for outreach programs, educational and informational events, and conference calls.
2. Check your state's Medical Society or local provider organization Web site for MAC transition information, MAC Coordinators.

60 days before cutover

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

45 days before cutover

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

30 days before cutover

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of e-mail from the MAC listserv.

15 days before cutover

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

10 days before cutover

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

5-10 days after cutover

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

30 days after cutover

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

Attachment B

Schedule of MAC contractor training classes

Scheduled date	Title of class	Attendee(s)

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

Schedule of MAC conferences

Scheduled date	Conference subject	Attendee(s)

Attachment C

Important MAC implementation dates

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

Update on ICD-10 code sets and standards governing electronic transactions

On January 15, the U.S. Department of Health & Human Services released two final rules that will facilitate the United States ongoing transition to an electronic health care environment through adoption of an updated set of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.

In accordance with the White House Chief of Staff's memorandum of January 20, 2009, titled "Regulatory Review," a determination has been made that the effective date will not be extended and the comment period will not be reopened for either of these rules.

- The first rule finalizes new code sets to be used for reporting diagnoses and procedures on health care transactions. This final rule replaces the ICD-9-CM code sets, developed nearly 30 years ago, with greatly expanded ICD-10 code sets.
- The second final rule adopts updated versions of the standards governing electronic transactions under the authority of the Health Insurance Portability and Accountability Act of 1996. The updated versions replace the current standards and will promote greater use of electronic transactions.

In response to public comments suggesting that more time would be needed for effective industry implementation, the final rules include later compliance dates. More specifically, the final rules provide compliance dates of Jan. 1, 2012, for the transaction standards and Oct. 1, 2013, for the ICD-10 code sets. ❖

Source: CMS PERL 200903-18

Advance notice of 2010 methodological changes for Medicare Part C and Part D plans

The Centers for Medicare & Medicaid Services (CMS) issued the advance notice of changes in methods used to calculate capitation rates for payments to Medicare Advantage organizations for 2010. The advance notice also announced policy and technical changes to the payment methodology for Medicare Advantage and Medicare prescription drug plans. The advance notice is issued annually 45 days before the final rates are announced, in accordance with statute.

The technical adjustments announced included a preliminary estimate of a 0.5 percent increase in the national per capita Medicare advantage growth percentage. For 2010, Part C capitation rates will be based on the 2009 county capitation rates updated by the Medicare Advantage growth percentage. The growth percentage is the estimated growth in per capita expenditures for all Medicare beneficiaries whether they are receiving their coverage through Medicare Advantage or Medicare prescription drug plans.

The final capitation rates for each county are scheduled to be announced on April 6, 2009. The county capitation rates define the upper limit for CMS payments to Medicare Advantage plans.

The advance notice also described changes in risk adjustment of payments to Medicare Advantage and to Medicare prescription drug plans. Under risk adjustment, higher payments are directed to plans enrolling beneficiaries with greater health care costs. The notice announced preliminary estimates of the normalization factors used to maintain average Part C and Part D risk scores at 1.0 in the payment year. The preliminary estimate of the normalization factor applied to Part C risk scores for aged and disabled beneficiaries is 1.041.

The advance notice may be viewed at *http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2010.pdf*.

Comments

In order to receive consideration prior to the April 6, 2009 release of the announcement of calendar year (CY) 2010 Medicare Advantage capitation rates and Medicare Advantage and Part D payment policies, comments were required to be received by 6:00 p.m. ET on March 6, 2009. ❖

Source: CMS PERL 200902-39

Information to include in communications to your membership

Help your association members stay up-to-date on the latest Medicare-related information! Below is a brief news item that we encourage you to put in your next newsletter, bulletin, or whatever vehicle you use to provide your members with news they need to know:

> Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare administrative contractor [MAC]) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor Web site and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for "listserv" or "e-mail list" to find the registration page. If you do not know the Web address of your contractor's homepage, it is available at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

Through their electronic mailing lists, Medicare contractors serve as a valuable source of news and information regarding Medicare business in specific provider practice locations, including local coverage determinations and local provider education events.

So do your members a favor and help us spread the word! ❖

Source: CMS PERL 200902-38

It's not too late to give and get the flu shot

In the United States, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one-time pneumococcal vaccination. Protect yourself, your patients, your family, and friends by getting and giving the flu shot.

Don't get the fly. Don't give the flu

Remember: Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are not Part D covered drugs.

Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing special edition *MLN Matters* article SE0838 located on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf*. ❖

Source: CMS PERL 200903-03

Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier accreditation

CMS has issued the following MLN Matters article. Information for Medicare fee-for-service health care professionals.

Provider types affected

All providers and suppliers that furnish Medicare Part B durable medical equipment (DME), prosthetic devices, prosthetic or orthotic items, and medical supplies to Medicare beneficiaries.

Provider action needed

Stop – impact to you

DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) providers and suppliers enrolled in the Medicare Part B program are required to obtain accreditation by September 30, 2009.

Caution – what you need to know

In order to retain or obtain a Medicare Part B billing number, all DMEPOS providers and suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health & Human Services as noted below in this article) must comply with the Medicare program's supplier standards and quality standards and become accredited. A DMEPOS supplier's Medicare Part B billing privileges will be revoked on October 1, 2009, if the DMEPOS supplier fails to obtain accreditation by September 30, 2009.

Go – what you need to do

DMEPOS providers and suppliers that have not yet done so should contact an accreditation organization (AO) right away to obtain information about the accreditation process and submit an accreditation application to the AO of their choosing. Suppliers can find a list of the deemed accrediting organizations on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf*.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a)(20) to the Social Security Act (the Act) that required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to receive or retain a provider or supplier number.

Covered items and services

Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834 (a) (13), Section 1834 (h) (4) and Section 1842 (s) (2) of the Act. The covered items and services include:

- Durable medical equipment (DME)
- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral and enteral nutrient, equipment and supplies
- Blood products
- Transfusion medicine, and
- Prosthetic devices, prosthetics, and orthotics.

Noncovered items

- Medical supplies furnished by home health agencies
- Drugs used with DME (inhalation drugs and drugs infused with a DME pump)
- Implantable items, and
- Other Part B drugs:
- Immunosuppressive drugs
- Anti-emetic drugs.

DMEPOS quality standards

The quality standards, published at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationStandards.pdf* on the CMS Web site, are separated into two sections and have three appendices as follows:

- Section I includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management, product safety and information management.
- Section II contains service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver and follow-up service.
- Appendix A addresses respiratory equipment, supplies and services.
- Appendix B addresses manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- Appendix C addresses custom fabricated and custom fitted orthoses, prosthetic devices, external breast prostheses, therapeutic shoes and inserts and their accessories and supplies, and custom-made somatic, ocular and facial prostheses.

Accreditation deadline for DMEPOS suppliers

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required all DMEPOS suppliers to meet quality standards for Medicare accreditation by September 30, 2009.

Who needs accreditation?

The September 30, 2009, accreditation deadline applies to all Medicare Part B enrolled providers and suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics. The accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier accreditation (continued)

As of March 1, 2008, new DMEPOS providers and suppliers submitting an enrollment application to the national supplier clearinghouse (NSC), except those eligible professionals and other persons mentioned below, must be accredited prior to submitting the application. The NSC shall reject the enrollment application unless the DMEPOS supplier demonstrates an approved accreditation.

Who is exempt?

MIPPA stated that certain eligible professionals and other persons do not have to be accredited by September 30, 2009, unless the Secretary determines that the quality standards are specifically designed to apply to such professionals and persons. In addition, those providers that were accredited prior to the enactment of MIPPA (July 15, 2008) will not have to undergo a re-accreditation process.

The eligible professionals that are exempt from the September 30, 2009, accreditation deadline include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act)
- Physical therapists
- Occupational therapists
- Qualified speech-language pathologists
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Certified nurse-midwive
- Clinical social workers
- Clinical psychologists
- Registered dietitians, and
- Nutritional professionals.

Additionally MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the September 30, 2009, accreditation deadline unless the Secretary determines that the quality standards are specifically designed to apply to such other persons. At this time, these "other persons" are only defined as the following practitioners:

- Orthotists
- Prosthetists
- Opticians
- Audiologists.

Accreditation process

The accreditation process takes an average of six to seven months but may take up to nine months to complete for a Medicare enrolled or new DMEPOS supplier that submits a complete application to an accrediting organization (AO) and has no deficiencies to correct post onsite-survey.

Pre-application process

- A DMEPOS supplier that wishes to become accredited should contact the AOs and obtain information about each organization's accreditation process.
- The supplier should review the information and choose the organization to which it will apply.
- The AO will assist the supplier to determine what changes will be required to meet the accreditation standards (e.g., modify existing services, practices, developing appropriate policies and procedures, develop an implementation plan, timeline, and training employees).
- The supplier should apply for accreditation after the changes are in place or during implementation.

Application review and on-site survey

- The supplier submits a completed application to the AO with all the supporting documentation.
- The AO reviews the application and documentation (verify licensures, organizational chart, etc.).
- The on-site surveys are conducted minimally every three years and are unannounced.
- The AO will determine whether to accredit the supplier based on the submitted data and the results of the on-site survey.

Key points

All Medicare Part B enrolled DMEPOS providers and suppliers are required to obtain accreditation by September 30, 2009.

DMEPOS suppliers who submitted a completed application to an accrediting organization on or before January 31, 2009, **will have their accreditation decision** (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.

DMEPOS suppliers submitting applications to an accrediting organization after January 31, 2009, **may or may not have their accreditation decision** by the September 30, 2009, deadline.

It takes an average of six to seven months but could take as long as nine months for a DMEPOS supplier to complete the accreditation process. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

A DMEPOS supplier's Medicare Part B billing privileges will be revoked on October 1, 2009, if the DMEPOS supplier fails to obtain accreditation by September 30, 2009.

Note: The current delay in the DMEPOS competitive bidding program has no impact on the September 30, 2009, accreditation deadline.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier accreditation (continued)

Accreditation frequently asked questions (FAQs)

1. **Do the accrediting organizations have enough capacity to get everyone who applies at least nine months before September 30, 2009 accredited by the deadline?**

   Yes. The AO's have increased surveyor staffing anticipating the additional workload. A DMEPOS supplier should choose an AO based upon their deemed status, policies, procedures and the philosophy of the organization. CMS encourages suppliers to ask the AO's questions, such as, how long it takes to become accredited from application to accreditation decision. The time to become accredited can take up to nine months for some organizations.

2. **Who are the approved DMEPOS accrediting organizations?**

   In November 2006, CMS approved (deemed) 10 national accreditation organizations that will accredit providers and suppliers of DMEPOS as meeting new quality standards under Medicare Part B. Most of the accreditation organizations are authorized to accredit all major supplier types, and most will be able to accredit both national and local suppliers, as well as mail order companies. A list of the CMS-approved deemed accreditation organizations and information about the types of suppliers each accrediting organization is approved to accredit and how to contact a deemed accrediting organization is posted on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf*.

3. **Is accreditation transferable upon merger, acquisition or sale of a supplier?**

   Accreditation cannot be transferred upon merger, acquisition or sale of a supplier. As specified in 42 CFR 424.57 (c) (3), CMS, the NSC and the accrediting organization must be notified when a new DMEPOS location is opened.

4. **If I have just recently received a survey by an accreditor, will I be subject to a site visit by a representative of the national supplier clearinghouse (NSC)?**

   These actions are independent of one another. The accreditor checks quality standards. The NSC site visit concerns enforcing supplier standards. In many cases a new supplier will receive a site survey by the AO and a site visit by the NSC.

5. **Is information transferred between the accreditor and NSC?**

   Transfer of information between these two entities concerning their findings does occur. The NSC needs to know if a supplier is accredited prior to issuing an enrollment number, thus they will need to verify the accreditation status.

6. **Will the accreditation survey efforts be coordinated with reenrollment efforts?**

   Not at the present time. A supplier must meet both the NSC supplier standards and the accreditation requirements on a continuous basis. We are not changing reenrollment dates and timeframes to match survey timeframes.

Additional information

There is additional information on the accreditation process on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp#TopOfPage*.

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

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Related Change Request (CR) Number: N/A
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Source: CMS Special Edition *MLN Matters* Article SE0903

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DMEPOS supplier accreditation – get it now

Deadline is September 30, 2009

CMS wants to remind suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B that they must obtain accreditation by September 30, 2009. In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary) must comply with Medicare's supplier and quality standards and become accredited. DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

DMEPOS suppliers who submitted a completed application to an accrediting organization, on or before January 31, 2009, will have an accreditation decision (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.

DMEPOS suppliers submitting applications to an accrediting organization, on or after February 1, 2009, may or may not have their accreditation decision by the September 30, 2009 deadline.

The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics. Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers must also meet the September 30, 2009, deadline for DMEPOS accreditation.

Certain eligible professionals and other persons as specified by the Secretary are exempt from the accreditation requirement.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at *http://www.cms.hhs.gov/medicareprovidersupenroll*. ❖

Source: CMS PERL 200903-11

DMEPOS supplier accreditation – time is running out

Deadline is September 30, 2009

Time is running out for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. While the accreditation process takes on average six to seven months, the process could take as long as nine months to complete. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary of Health & Human Services) must comply with the Medicare program's supplier standards and quality standards to become accredited. The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, and prosthetics and orthotics.

Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers must also meet the September 30, 2009, deadline for DMEPOS accreditation. Certain eligible professionals and other persons as specified by the Secretary are exempt from the accreditation requirement.

Further information on the DMEPOS accreditation requirements, along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation, may be found at the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp*. ❖

Source: CMS PERL 200903-25, PERL 200903-33

New Web page for e-Prescribing incentive program

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the new e-Prescribing incentive program Web page on the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive*. All information about the e-Prescribing incentive program has been moved from the CMS Physician Quality Reporting Initiative (PQRI) Web page at *http://www.cms.hhs.gov/PQRI* to *http://www.cms.hhs.gov/ERXIncentive*.

This new Web page provides information about the new e-Prescribing incentive program that was authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Please note that many new resources have also been added to the e-Prescribing incentive Web page as part of the migration to the new URL.

Included on this page in the *Downloads* section is:

- A 2009 e-Prescribing incentive program made simple fact sheet
- A Spanish version of the Introduction to e-Prescribing Incentive fact sheet
- A sample electronic prescribing claim
- Information on how to access the audiotapes and slides from the national e-Prescribing conference that was held in October 2008 for continuing education credit.

New and updated information will be added frequently, so please visit the e-Prescribing incentive program Web page at *http://www.cms.hhs.gov/ERXIncentive*. ❖

Source: CMS PERL 200903-14

AMBULANCE SERVICES

Updates to the *Medicare Bene t Policy Manual* for 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.

Provider action needed

This article is based on change request (CR) 6318 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR6318 to highlight the revisions to the *Medicare Benefit Policy Manua*l, Chapter 10 – Ambulance Services. The article is informational in nature, since CR 6318 revises that manual to incorporate information previously released via Transmittal AB-02-130 and updates to the *Medicare Claims Processing Manual*, Chapter 15, which is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf*.

Background

Key points

The key updates made to Chapter 10 of the *Medicare Benefit Policy Manual* are as follows:

- **Chapter 10/Section 10.4**. Medically appropriate air ambulance transportation is a covered service regardless of the state or region in which it is rendered. However, Medicare contractors approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

  1. **Fixed Wing Air Ambulance (FW)**: Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.
  2. **Rotary Wing Air Ambulance (RW)**: Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

- **Chapter 10/Section 10.4.2**. Medical reasonableness is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health. A list of examples of cases for which air ambulance could be justified is available in section 10.4.2, which is attached to CR 6318. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.

- **Chapter 10/Section 20/20.1.2 – Beneficiary Signature Requirements**. Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

  1. The beneficiary's legal guardian;
  2. A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary;
  3. A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs;
  4. A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary;
  5. A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1 – 4); and/or
  6. A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least four years from the date of service.

Updates to the Medicare Benefit Policy Manual for ambulance services (continued)

Note: A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

- **Chapter 10/Section 30.1.1**. This section is revised to add information regarding advanced life support (ALS) assessments. The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Additional information

The official instruction (CR 6318) issued to your Medicare FI, carrier, or MAC, is available at on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R103BP.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*.

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Source: CMS Pub. 100-02, Transmittal 103, CR 6318

Updates to the *Medicare Claims Processing Manual* for ambulance services

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6347 which implements significant changes to the Internet only Manual Publication 100-04, Chapter 15. Most of the changes in CR 6347 have already been communicated via prior change requests and related *MLN Matters* articles. The key purpose of CR 6347 is to eliminate references to the reasonable charge payment methodology and the transition to the ambulance fee schedule, which took place from April 2002 until December 2006, in the actual Medicare manual. Please make sure your staff is familiar with these changes.

Background

Medicare has revised the *Medicare Claims Processing Manual*, Chapter 15 – Ambulance section. Some sections have been added and other sections have been renumbered. Most of the added information has been conveyed in prior *MLN Matters* articles related to ambulance services.

Key points

The most important changes for providers of ambulance services are listed as follows:

References to statues and regulations have been updated as follows:

Section 1861(s) (7) of the Social Security Act (Act) establishes an ambulance service as a Medicare Part B service. Payment for ambulance services is addressed at Section 1834(l) of the Act. Coverage rules are addressed at 42 *Code of Federal Regulations* (CFR), Section 410.40. Additional rules, including rules regarding vehicular and staffing requirements, are specified at 42 CFR 410.41. Payment rules under the fee schedule established in 2002 are specified at 42 CFR Part 414, Subpart H (414.601 et seq.). Payment rules for ambulance services furnished by a critical access hospital (CAH) or by an entity owned and operated by a CAH are specified at 42 CFR 413.70(b)(5). Other general Medicare provisions apply to ambulance services. See Title XVIII of the Act and 42 CFR Parts 400 to 429 to determine applicability.

References to Centers for Medicare & Medicaid Services (CMS) manual instructions for ambulance providers have been updated as follows:

Coverage: Manual instructions regarding coverage of ambulance services, including specifications for vehicular and staffing requirements, are specified in the *Medicare Benefit Policy Manual,* Chapter 10, which is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/bp102c10.pdf*.

Medical Review: Manual instructions regarding medical review for ambulance services are specified in the *Medicare Program Integrity Manual,* Chapter 6 on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/pim83c06.pdf*.

Updates to the Medicare Claims Processing Manual for ambulance services (continued)

A summary of the ambulance services benefit has been provided in the revised manual as follows:

Ambulance services are covered under Medicare Part B. However, a Part B payment for an ambulance service furnished to a Medicare beneficiary is available only if the following, fundamental conditions are met:

- Actual transportation of the beneficiary occurs.
- The beneficiary is transported to an appropriate destination.
- The transportation by ambulance must be medically necessary, i.e., the beneficiary's medical condition is such that other forms of transportation are medically contraindicated.
- The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements.
- The transportation is not part of a Part A service.

Other requirements specified in CR 6347 or in the above-cited CMS manuals may also apply to the provider/supplier or to a particular transport or billing.

New and revised definitions related to ambulance claims processing have been added as follows:

A/MAC – For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term refers to those Medicare contractors that process claims for institutionally-based ambulance providers billed on CMS-1450 Form (UB-04) and/or a Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant ANSI X12N 837I electronic transaction.

B/MAC – For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term refers to those Medicare contractors that process claims for ambulance suppliers billed on a CMS-1500 Form and/or a HIPAA compliant ANSI X12N 837P electronic transaction.

Date of Service – The date of service (DOS) of an ambulance service is the date that the loaded ambulance vehicle departs the point of pickup (POP). In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the DOS is the date of the vehicle's dispatch. In the case of an air transport, if the beneficiary is pronounced dead after the aircraft takes off to pick up the beneficiary, the DOS is the date of the vehicle's takeoff.

Provider – For the purposes of this Chapter 15 of the *Medicare Claims Processing Manual* only, the term "provider" is used to reference a hospital-based ambulance provider which is owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e) of the Act, a fund.

Supplier – For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term supplier is defined as any ambulance service that is not institutionally based. A supplier may be an independently owned and operated ambulance service company, a volunteer fire and/or ambulance company, a local government run firehouse based ambulance, etc., that provides Part B Medicare covered ambulance services and is enrolled as an independent ambulance supplier.

Claim jurisdiction

Claims jurisdiction for suppliers is considered to be where the ambulance vehicle is garaged or hangared. Claims jurisdiction for institutional based providers is based on the primary location of the institution.

Payment is based on the level of service provided, not on the vehicle used. Occasionally, local jurisdictions require the dispatch of an ambulance that is above the level of service that ends up being provided to the Medicare beneficiary. In this, as in most instances, Medicare pays only for the level of service provided, and then only when the service provided is medically necessary.

Adjustments for fee schedule payment rates for ground ambulance transports

The payment rates under the fee schedule (FS) for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006 as well as July 1, 2008 through December 31, 2009. For ground ambulance transport services furnished where the POP is urban, the rates are increased by 1 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 2 percent for claims with dates of service July 1, 2008 through December 31, 2009 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. For ground ambulance transport services furnished where the POP is rural, the rates are increased by 2 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 3 percent for claims with dates of service July 1, 2008 through December 31, 2009 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors.

Billing instruction reminder information

Independent ambulance suppliers may bill on CMS-1500 Form or the ANSI X12N 837P data set. These claims are processed using the multi-carrier system (MCS).

Institution based ambulance providers may bill on CMS-1450 Form or the ANSI X12N 837I. These claims are processed using the fiscal intermediary shared system (FISS).

Updates to the Medicare Claims Processing Manual for ambulance services (continued)

Institutional providers and suppliers must report an origin and destination modifier for each ambulance trip provided in Healthcare Common Procedure Coding System (HCPCS)/rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes

E = Residential, domiciliary, custodial facility (other than 1819 facility)

G = Hospital based end stage renal disease (ESRD) facility

H = Hospital

I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport

J = Freestanding ESRD facility

N = Skilled nursing facility

P = Physician's office

R = Residence

S = Scene of accident or acute event

X = Intermediate stop at physician's office on way to hospital (destination code only)

In addition, institutional providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM – Ambulance service provided under arrangement by a provider of services; or

QN – Ambulance service furnished directly by a provider of services.

While combinations of these items may duplicate other HCPCS modifiers, when billed with an ambulance transportation code, the reported modifiers can only indicate origin/destination.

Additional information

The official instruction, CR 6347, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1696CP.pdf*.

The revised portions of Chapter 15 of the *Medicare Claims Processing Manual* are attached to CR 6347.

A version of the ambulance fee schedule is also posted to the CMS Web site for public consumption at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp*.

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*.

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Source: CMS Pub. 100-04, Transmittal 1696, CR 6347.

ACCESS TO CMS COMPUTER SERVICES

Individuals authorized access to CMS computer services – provider/ supplier community

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

The first in a series

Note: The Center for Medicare & Medicaid Services (CMS) has revised this *MLN Matters* article on February 20, 2009, to reflect current terminology and processes as reflected on the IACS Web site. Please note that CMS will notify providers as CMS applications integrated with the CMS security system known as the Individuals Authorized Access (IACS) become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example**,** *MLN Matters* articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This special edition *MLN Matters* article SE0747 was published in the September 2008 *Medicare A Bulletin* (pages 30-33)**.**

These articles will help providers to register for future access to CMS online computer services when directed to do so by CMS. This article contains:

- Eleven questions and answers to get you started
- Overview of the registration process for IACS defined provider/supplier organization users.

Provider types affected

Medicare physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS at this time. DMEPOS suppliers may want to review question number 11 below.

What providers need to know

The Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC-supplied Internet applications. Details of these provider applications that are integrated with IACS will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access in the IACS. The IACS Web page is on the CMS Web site at *http://www.cms.hhs.gov/IACS*.

The specific community for providers may be accessed by clicking on the "Provider/Supplier Community" in the left margin of the aforementioned Web site. Or, you can go directly to the "Provider/Supplier Community" page on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp*.

Provider action needed

CMS will notify providers as internet applications integrated with IACS become available, and provide clear instructions that specify which providers should register in IACS. **Do not register until you are informed to do so by CMS or one of its contractors and only if you meet the criteria in the notice.** This article and other articles in the IACS series will help you navigate this process when directed to do so by CMS. The other articles available to help with general navigation are:

- SE0753 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf* on the CMS Web site
- SE0754 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf* on the CMS Web site.

Eleven questions and answers to get you started

1. **What is IACS?**
   IACS is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS, provider organizations, as defined by IACS (see question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Through IACS, provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

   Note: IACS is not applicable to FI/carrier/MAC-sponsored internet applications**.**

2. **Who can use this system?**
   Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the software used for DMEPOS Competitive Bidding has a dedicated version of IACS. (See question # 11 below.)

3. **When should I register?**
   CMS will notify providers as Web-based applications become available and provide clear instructions that specify which providers should register in IACS. **Do not register unless you fit the criteria in the CMS notice.** For example, DMEPOS suppliers interested

Individuals authorized access to CMS computer services – provider/supplier community (continued)

in becoming a contract supplier under the Medicare Competitive Bidding Program will receive explicit instructions on how and when to register for access to bid software.

4. **How long is my password valid?**
Passwords expire in 60 days. After that point, when you log into IACS, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS to keep your current password active.

5. **How do I register as an IACS user?**
IACS uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS user you selec. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

Note: User guides for the IACS community may be found on the CMS Web site a**t** *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage***.**

The External User Services (EUS) Help Desk will support this process for IACS. It may be reached by e-mail at ***EUSSupport@cgi.com*** or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. **When would I register as an individual practitioner?**
An individual practitioner (IP) is defined by IACS as a solo physician or nonphysician practitioner (NPP); who has not reassigned Medicare payments to a group practice. This designation is intended for practitioners who will be conducting transactions with online applications personally **and who have no staff that will be accessing the applications on their behalf.** If you will have staff or other practitioners who will need to access CMS applications, you should register as a provider organization (not as an individual practitioner). (Please see #7.)
CMS will match your IACS registration with Medicare enrollment data before allowing you to access a CMS application. Those registering as individual practitioners who have not submitted a Medicare enrollment application (CMS-855) since November 2003 will need to update their CMS-855.

Note: See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* **f**or more information about the Medicare enrollment process. To facilitate your enrollment into the Medicare program or updating your enrollment with Medicare, you should review the following downloadable file at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollmenttips.pdf* before submitting an enrollment application to a Medicare contractor.

If you enrolled in Medicare after November 2003, or have updated your enrollment since then, register as an individual practitioner following the steps in the Individual Practitioner Registration – Quick Reference Guide, which may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

7. **When would I register as an IACS provider organization?**
The term "organization," as defined by IACS, should not be confused with the term organization as it applies to provider enrollment or the national provider identifier (NPI).
For IACS registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers **and physician group practices.**
It also includes individual physicians and nonphysician practitioners who want to delegate staff to conduct transactions on their behalf (office staff, administration support, etc.). In this case, for IACS registration purposes, registration must be as an organization.
IACS provider organizations require security officials (see question # 9 below) that establish the provider organization in IACS. All users will then be grouped together within IACS under the provider organization security official.

8. **What should I have in hand before I register as an individual practitioner?**
An individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) will need to know his or her:

- Social security number
- Correspondence information.

9. What should I have in hand before I register as a security official of a provider organization?

For an IACS provider organization, the SO of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- taxpayer identification number (TIN)
- legal business name
- corporate address
- Internal Revenue Service (IRS) issued CP-575 hard copy form.

If the SO does not have the CP-575, a copy of other official IRS documentation may be submitted. An official IRS document should have the following information:

Required:
- IRS letterhead
- legal business name (not handwritten)
- TIN/employee identification number (EIN) (not handwritten)

Examples of acceptable IRS documents include, but are not limited to:

Individuals authorized access to CMS computer services – provider/supplier community (continued)

- copy of IRS CP-575
- copy of IRS 147C letter
- copy of federal tax deposit coupon
- **All documents received must be legible**

10. How do I register my provider organization in IACS?

IACS is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS and then be accountable for users in the organization. Using information supplied via the IACS registration as well as a mailed-in copy of the organization's IRS documentation, CMS will verify the SO's role in the organization, the TIN and the legal business name of the organization. This may take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the *Overview* section, which follows question number 11.

Once you understand IACS user roles, and have designated an SO, the SO should register using the instructions in the Security Official Registration - Quick Reference Guide, which is available on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

The next *MLN Matters* article in this series of articles provides instructions for additional users to register in IACS.

11. Why is registration not available at this time for DMEPOS suppliers in IACS?

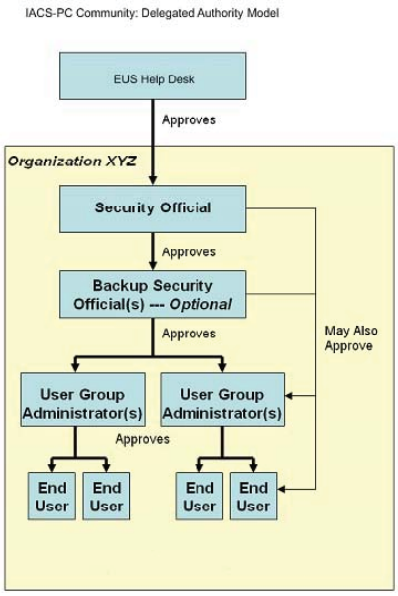
DMEPOS suppliers should not register in IACS because CMS does not have new online applications at this time. DMEPOS suppliers interested in DMEPOS competitive bidding should follow CMS DMEPOS competitive bid instructions which would be released closer to the bid window.

Overview: Registering in IACS as a provider organization or a provider organization user

For IACS registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and nonphysician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The registration process

IACS is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. **At this time, a provider organization must have at least two users, one of whom will be able to access IACS applications.** The "delegated authority model" previously described is below. The EUS help desk will be responsible for approving the organization's security official. Then the security official may approve the backup security official(s) etc.



Individuals authorized access to CMS computer services – provider/supplier community (continued)

II. Registration roles

1. The first person to register must be the SOl

The security official is the person who registers their organization in IACS and updates the organization profile information in IACS. There may be only one security official for an organization. The security official is trusted to approve the access request of backup security official(s) and can approve the access requests of user group administrators. The security official will be approved by CMS through its EUS help desk. The security official is held accountable by CMS for the behavior of those approved in the organization, including the end users.

The IACS SO – *Quick Reference Guide* may be found on the CMS Web site at: *http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf*.

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS help desk.

2. An organization may choose to have one or more backup security officials (optional)

This is an optional role. **You need not have a backup security official.** The security official approves the backup security official. A backup security official performs the same functions as a security official in an organization, with the exception of approving other backup security officials. There may be one or more backup security officials in an organization. The backup security official can approve the access requests of user group administrators and end users and may aid the security official with the administration of user groups and user group administrators' accounts.

3. The next registrant must be a user group administrator

The UGA is approved by the SO or BSO. The UGA is trusted to approve the access requests of end users for that user group.

A UGA registers the user group within an organization in IACS and updates the user group profile information in IACS. There can be multiple UGAs for the same user group within an organization.

If the UGA is a surrogate user (not part of the organization but rather a contractor company working on behalf of the organization), they should select the option to create a "surrogate user group." See Section III. Note that surrogates will not have access to the provider statistical and reimbursement (PS & R) system.

4. The next registrants are end users

An end user is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An end user is part of a user group within the provider organization. An end user may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An end user may belong to multiple groups in one or more organizations. The end user is approved by the UGA.

Note: End user requests cannot be register in user groups until after the UGA has been approved.

III. Surrogate user groups

This applies to provider organizations that want to delegate online work to individuals or a company **outside of the provider organization.** Under this scenario, those working on behalf of the provider organization register as a **surrogate user group**. Examples include clearinghouses, credentialing departments, independent contractors. A surrogate user group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A surrogate user group may be associated with multiple provider organizations. As noted above, surrogates will not have access to the PS & R system.

1. The first contractor employee to register in a surrogate user group must be the UGA

If there will be only one user in a surrogate group, that user must register as a UGA. The UGA for the surrogate user group will register the surrogate user group and update the user group profile information in IACS. There may be multiple UGAs within the same surrogate user group. The UGA is trusted to approve the access requests of end users for their user group. The UGA of the surrogate user group must be approved by the security official or backup security official in the provider organization on whose behalf it performs work. Once approved, the UGA of a surrogate group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an end user

An end user is approved to perform Medicare business for a surrogate or provider user group by their UGA. An end user may belong to multiple groups in one or more organizations.

Additional help

The EUS help desk will support this process for IACS. It may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

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Source: CMS Special Edition *MLN Matters* Article SE0747

Individuals authorized access to CMS computer services – provider/ supplier community

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

The second in a series

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this *MLN Matters* article on February 20, 2009, to reflect current terminology and processes as reflected on the Individuals Authorized Access to CMS Computer Services (IACS) Web site. Please note that CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example, *MLN Matters* articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This special edition *MLN Matters* article SE0753 was published in the September 2008 *Medicare A Bulletin* (pages 34-35).

This article contains:

- three questions and answers about the registration process for provider organizations
- links to the quick reference guides for completing the registration process for provider organizations.

Provider types affected

Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in this new series on IACS, which may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Provider action needed

CMS will inform providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS. **Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice.** This article and other articles in the IACS series will help you navigate this process when directed to do so by CMS.

What providers need to know

The CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications that are hosted/managed by those entities. Details of these provider applications will be announced as they become available.

Registering in IACS

IACS protects and allows access to CMS enterprise applications. Communities (e.g., the IACS provider/ supplier community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (for example, providers need access to provider-related CMS applications). The next community, which will become available is the FI/carrier/MAC community. It will be comprised of users who work within Medicare fee-for-service contracting organizations (FIs, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, Medicare providers should select the "Provider/Supplier Community".

The first *MLN Matters* article in this series provided an overview of the IACS registration process as well as registration instructions for security officials (SOs) of provider organizations and individual practitioners using IACS personally. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Three questions and answers about the provider organization registration process

1. How can I get registered in IACS? Can I just figure it out by myself?

We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS, go to *https://applications.cms.hhs.gov* and then click on **Enter CMS Applications Portal**.

2. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?

No, only register once. Each user will receive only one IACS User ID and password. Once you receive approval and your user ID and password, you can add additional roles to your account.

Instructions for modifying your IACS profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the *Additional Help* section at the end of this article.

3. My organization is too small to fill all these roles. What should I do?

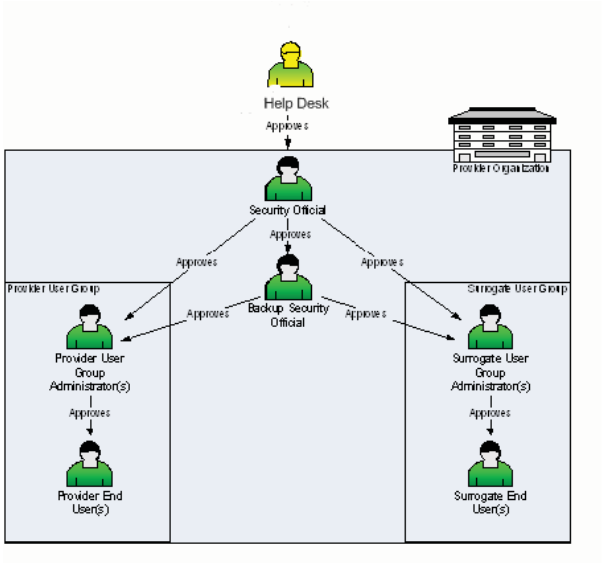
As few as two staff may be registered in IACS for a provider organization to access CMS enterprise applications. The first person must register as a SO, the second registers as a user group administrator (UGA). The UGA may access CMS applications as approved by the SO.

Individuals authorized access to CMS computer services – provider/supplier community (continued)

The backup security official (BSO) is an optional role. End users are only required for provider organizations with 10 or more IACS users.

If you are an individual professional who will be using IACS personally, you may register for the single role of individual practitioner. Please refer to the first *MLN Matter* article, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Quick reference guides for completing the provider organization registration process



IACS registration approval process

1. Backup Security Official Guide

Backup security officials (BSOs) will request access to an organization using the BSO *Registration Quick Reference Guide* on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

2. User group administration guide

User group administrators (UGAs) are the first user type able to request access to CMS Web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which he or she is responsible, for this reason they should know everyone in their user group.

The IACS UGA Registration Quick Reference Guide may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

Special note for UGAs of surrogate user groups

A surrogate user group is established by individuals or a company outside of the provider organization that performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: Surrogate-billing company ABC will work on behalf of provider organization XYZ. Once the provider organization XYZ is approved in IACS, the surrogate-billing company ABC can register in IACS and request to create a surrogate user group under the provider organization XYZ. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of three different provider organizations, the UGA for the surrogate user group will need to make three different requests to create three different surrogate user groups, one for each provider organization with which the UGA needs to associate. If a provider organization does not appear in IACS, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider organization appears in IACS.

If the provider organization does appear in IACS, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS.

Individuals authorized access to CMS computer services – provider/supplier community (continued)

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS.

3. An IACS end user registration quick reference guide

An end user registration quick reference guide may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

4. IACS user guide for approvers

The IACS user guide for approvers provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS. The IACS user guide for approvers can be found by going to the *Downloads* section on the CMS Web site of *http://www.cms.hhs.gov/IACS/03_General_User_Guides_and_Resources.asp*.

Next steps in accessing a CMS enterprise application

A third *MLN Matters* article discussing the final steps for using IACS to access CMS enterprise applications may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf*.

Additional help

CMS has established an external user services (EUS) help desk to assist with your access to IACS. The EUS help desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you may find an informative reference chart outlining the steps for accessing CMS enterprise applications on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*.

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This article describes the three steps providers must take to access a CMS enterprise provider application including how to request a provider application role in IACS (see step 2).

Provider types affected

Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in a new series on IACS which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Individuals authorized access to CMS computer services – provider/supplier community (continued)

Provider action needed

CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS). Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice.

What providers need to know

The CMS will announce new online enterprise applications that will allow Medicare fee-for-service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include Internet applications offered by FIs/carriers/MACs. Details of these provider applications will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access through the CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS).

The first article in this series provided an overview of the IACS registration process as well as registration instructions for security officials (SOs) and individual practitioners. This may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Note: Individual practitioners must use a different registration process depending on whether they will have employees use IACS and/or the CMS application on their behalf. Those using employees must register in IACS as an "Organization". See the MLN Matters SE 0747 for more information.

The second article in this series addressed common questions and gave follow-up instructions for registering provider organizations including registration as backup security officials (BSOs), user group administrators (UGAs), and end users (EUs). It also provided instructions SOs, BSOs, and UGAs can use to approve user registration requests. This article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf*.

The three steps to access a CMS enterprise provider application

Provider IACS users must take three steps to access a CMS enterprise application:

Step 1 Be approved for an IACS role.

The first two *MLN Matters Articles* in this series discussed how to register in IACS.

The purpose of the IACS registration process is to:

- Confirm the identity of the person requesting registration.
- Assure registrants have a legitimate business need to access CMS provider systems.
- Provide the registrant an IACS role (e.g., SO, BSO, UGA, or EU) that defines their responsibilities (if any) for approving the registration requests of others in their organization.
- Provide the registrant a user ID and password for IACS.

Step 2 Be approved for an application role.

After receiving approval for an IACS role, and obtaining an IACS user ID and password, the registered user in a provider organization may then request access to CMS provider applications. This requires specifying a role for specific applications. For example, the role may be an "application approver" or an "application user." (**Note**: Because individual practitioners do work in the application themselves, they do not require "application approver" roles).

This application role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization.
- What CMS enterprise applications (if any) to which they have a legitimate need to access.
- The appropriate level of access to each application for their job function (which application "role" they require).

Users who received approval in IACS in Step 1 can then request access to specific CMS enterprise applications using their IACS account.

This requires requesting either an "application approver" or an "application user" role for each application needed to perform Medicare-related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example, some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS.

Note: Each user must request a specific application role in IACS for each CMS enterprise provider application they wish to use. Roles will be specific to each application.

The "IACS Request Access to CMS Application Quick Reference Guide" provides instructions for requesting an application role. It may be found on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

Application approvers

Organizations must have designated persons that approve each user's request for an application role. The person who performs this task is an "application approver" and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate person who should have this role, organizations have discretion in how they designate the application approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an EU may be approved for this role by the SO or BSO for the user group with which they are associated.

Individuals authorized access to CMS computer services – provider/supplier community (continued)

Note: If a user group does not have an application approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.

Application approver key points

- An application approver must be a member of the user group(s) for which they serve as an application approver (this does not apply if the SOs/BSOs is the application approver).
- Providers have flexibility in assigning the application approver role.
- The UGA does not have to be the application approver within the user group.
- An end user within a user group may serve in the role of the application approver.
- A different person may serve as an application approver in a user group for each application.
- The same person can be the application approver for multiple applications in a user group.
- The same person can be the application approver for multiple user groups (though they must be a member of each group).
- There may be multiple application approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an application approver for one application, and an application user for a different application, just not for the same one.
- If an application approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
- Organizations with a large number of IACS users are encouraged to have application approvers in each user group for each application (can be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

Note: System security requires a "separation of duties" – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in application approver roles will not have access to the application for which they are an approver. SOs and BSOs, by definition, can never access any applications as they serve as the default application approvers as noted above.

Instructions for approving application role requests are the same as for approving IACS registration requests. The IACS User Guide for Approvers may be found by selecting General User Guides and Resources in the left column of the page on the CMS Web site at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage*.

Step 3: Enter the application when it becomes available.

You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications in accordance with approved application specific roles via the CMS or application Web site.

Additional CMS partner and customer communities will use IACS

IACS protects and allows access to CMS enterprise applications. IACS communities (e.g., the IACS – Provider/Supplier Community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications. For example, the next community will be the FI/carrier/MAC community. It will be comprised of users who work within Medicare fee-for-service contracting organizations (FIs, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider/Supplier Community."

Additional help

CMS has established the external user services (EUS) help desk to support providers and Medicare contractors in their access to IACS. The EUS help desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you may find an informative reference chart outlining the steps for organizations to access CMS enterprise applications on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf*.

Information on the steps needed to register to access Physician Quality Reporting Initiative (PQRI) feedback reports is available in *MLN Matters* articles SE0830 and SE0831. These articles are available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf*, respectively.

Coming soon

- CMS enterprise applications to be made available via the Web include those related to the Physician Quality Reporting Initiative (PQRI) and the Provider Statistical and Reimbursement Report (PS&R).
- Instructions for modifying your user profile.
- What to do if you forget your user ID or password.
- Tools for SOs, BSOs and UGAs to manage user accounts.

MLN Matters Number: SE0754 – 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 SE0754

GENERAL COVERAGE

Changes to the laboratory national coverage determination for April 2009

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6383 which announces the changes that will be included in the April 2009 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in January 2009. See the *Background* section of this article for further details regarding these changes.

Background

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

CR 6383 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for April 2009 as described below. These changes become effective for services furnished on or after April 1, 2009 and are as follows:

For blood counts

- Add ICD-9-CM codes 525.71, 525.72 and 525.73 to the list of ICD-9-CM codes that do not support medical necessity for blood counts (190.15) NCD.

For partial thromboplastin time (PTT)

- Add ICD-9-CM codes 535.70 and 535.71 to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.

For prothrombin time (PT)

- Add ICD-9-CM codes 414.3, 535.70, and 535.71 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.

For serum iron studies

- Add ICD-9-CM codes 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 535.70, and 535.71 o the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.

For blood glucose testing

- Add ICD-9-CM code 414.3 to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD.

For lipid testing

- Add ICD-9-CM code 414.3 to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD.

For gamma glutamyl transferase

- Add ICD-9-CM codes 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, and 208.92 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

For fecal occult blood test (FOBT)

- Add ICD-9-CM codes 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 535.70 and 535.71 to the list of ICD-9-CM codes covered by Medicare for the FOBT (190.34) NCD.

Additional information

The official instruction (CR 6383) issued to your Medicare MAC, carrier, or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1684CP.pdf*.

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

MLN Matters Number: MM6383
Related Change Request (CR) Number: 6383
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R1684CP
Effective Date: April 1, 2008
Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 1684, CR 6383

Heartsbreath test for heart transplant rejection

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 MM6366 to reflect the revised transmittal number related to change request (CR) 6366. The CR release date, transmittal number, and the Web address for accessing that transmittal were changed. All other information remains the same. The *MLN Matters* article MM6366 was published in the February 2009 *Medicare A Bulletin* (page 14).

Provider types affected

Providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for Heartsbreath testing services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6366 and alerts providers that CMS determined that the Heartsbreath test is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act, and is noncovered for dates of service on or after December 8, 2008. See the *Background* and *Additional* information sections of this article for further details regarding this issue.

Background

On December 8, 2008, CMS issued a decision memorandum in response to a formal request for Menssana Research, Inc., to consider national coverage of the Heartsbreath test as an adjunct to the heart biopsy to detect grade 3 heart transplant rejection in patients who have had a heart transplant within the last year and an endomyocardial biopsy in the prior month. CMS determined that the evidence does not adequately define the technical characteristics of the test nor demonstrate that Heartsbreath testing to predict heart transplant rejection improves health outcomes in Medicare beneficiaries.

Key points

- Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath test used to predict heart transplant rejection is nationally noncovered. This coverage change to *Current Procedural Terminology (CPT)* code *0085T*, *breath test for heart transplant rejection*, will be effective with the April 1, 2009, quarterly update of the Medicare physician fee schedule database.
- Effective with the April 1, 2009, quarterly update of the integrated outpatient code editor, *CPT* code *0085T*, *breath test for heart transplant rejection*, is no longer payable by Medicare.
- When denying claims for *CPT* code *0085T*, Medicare contractors will use:

  Medicare summary notice (MSN) message 16.10: Medicare does not pay for this item or service

  Claim adjustment reason code 50: These are noncovered services because this is not deemed a medical necessity by the payer

  Claim adjustment remark code MA 51: Missing/incomplete/invalid procedure code(s)

  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* on the CMS Web site. (If you do not have Web access, contact your Medicare contractor to request a copy of the NCD.)

- For beneficiaries who choose to have this procedure anyway, providers shall issue an advance beneficiary notice (ABN) indicating that Medicare issued an NCD at section 260.10 of the *NCD Manual* stating that the Heartsbreath test is not reasonable and necessary for Medicare beneficiaries. Medicare never pays for this test and the beneficiary would be held financially liable. (Beginning March 1, 2009, the ABN-G will no longer be valid and providers must issue the revised ABN (CMS-R-131.)
  - Medicare contractors will include the group code CO (contractor obligation) or PR (provider responsibility) depending on liability.
- For claims already processed with dates of service between December 8, 2008, and April 1, 2009, contractors will not search their files, but may go back and adjust claims that are brought to their attention.

Additional information

The official instruction (CR 6366) was issued to your Medicare FI, carrier or MAC via two transmittals. The first conveys the revised claims processing instructions and is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1697CP.pdf*.

The second transmittal conveys the change to the *National Coverage Determinations Manual* and that transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R99NCD.pdf*.

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

MLN Matters Number: MM6366 – Revised
Related Change Request (CR) Number: 6366
Related CR Release Date: March 12, 2009
Related CR Transmittal Number: R1697CP and R99NCD
Effective Date: December 8, 2008
Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 1697, CR 6366

LOCAL COVERAGE DETERMINATIONS

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

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

This section of the *Medicare A Bulletin* features summaries of new and revised LCDs developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the fiscal intermediary's LCDs and review guidelines are consistent with accepted standards of medical practice.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the provider education Web site is considered the notice date.

Electronic notification

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

More information

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

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

Local Coverage Determination Table of Contents

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

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

ADDITIONS/REVISIONS TO EXISTING LCDS

A77078: Bone mineral density studies – revision to the LCD

LCD ID Number: L28766 (Florida)
LCD ID Number: L28767 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was effective for services provided on **or after February 16, 2009,** for Florida and **on or after March 2, 2009,** for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Frequency Standards" and "Utilization Guidelines" sections of the LCD have been revised to add zoledronic acid (Reclast®) injection to the list of agents approved by the U.S. Food and Drug Administration (FDA) for osteoporosis prevention and/or treatment.

Effective date

This revision is effective for services provided **on or after March 19, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database.

Florida Part A active LCD list sorted by LCD Title.

Puerto Rico and U.S. Virgin Islands Part A active LCD list. ❖

AJ2505: Pegfilgrastim (Neulasta®) – revision to the LCD

LCD ID Number: L28946 (Florida)
LCD ID Number: L28967 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim (Neulasta®) was effective for services provided **on or after February 16, 2009,** for Florida and **on or after March 2, 2009,** for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCDs have been revised. First Coast Service Options Inc. (FCSO) published an article on December 2, 2008, outlining the correct administration of Neulasta® per the instructions found in the LCD and Food and Drug Administration (FDA)-approved labeling. FCSO encountered claims data that demonstrated providers were administering this drug outside of the established parameters. Neulasta® should not be administered 14 days before or 24 hours after the administration of cytotoxic chemotherapy.

It was brought to FCSO's attention, through the LCD reconsideration processed, that patients receiving dose dense chemotherapy schedules should be allowed an exception to the 14 day before/ 24 hour after rule since these patients would need to receive the Neulasta®, typically on the second day of the chemotherapy cycle. FCSO has reviewed the evidence submitted to support this exception and has revised the LCDs to include language allowing for this off-label administration only if the physician can document that the patient is on a dose dense chemotherapy cycle. For those patients that are not on a dose dense chemotherapy cycle, this off-label administration would not be acceptable.

Effective date

This revision is effective for services provided **on or after March 12, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database.

Florida Part A active LCD list sorted by LCD Title.

Puerto Rico and U.S. Virgin Islands Part A active LCD list. ❖

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 Medicare administrative contractor. 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://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

AJ3487: Zoledronic acid – revision to the LCD

LCD ID Number: L29009 (Florida)
LCD ID Number: L29041 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for zoledronic acid was effective for services provided **on or after February 16, 2009,** for Florida and **on or after March 2, 2009,** for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised. On December 19, 2008, the Food and Drug Administration (FDA) approved a new indication for zoledronic acid (Reclast®) (J3488). Reclast is now indicated for the treatment to increase bone mass in men with osteoporosis. First Coast Service Options Inc. (FCSO) has revised the LCD for zoledronic acid to allow for this new indication for Reclast®. Language has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Utilization Guidelines" sections of the LCD outlining coverage criteria. In addition, the coding guidelines attachment has been revised to include this new indication.

Effective date

This revision is effective for claims processed **on or after March 12, 2009,** for services provided **on or after December 19, 2008.** FCSO LCDs are available through the CMS Medicare Coverage Database.

Florida Part A active LCD list sorted by LCD Title.

Puerto Rico and U.S. Virgin Islands Part A active LCD list. ❖

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

LCD ID Number: L28791 (Florida)
LCD ID Number: L28796 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin®, Paraplatin-AQ®) was effective for services provided **on or after February 16, 2009,** for Florida and **on or after March 2, 2009,** for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made based on a request for a reconsideration to add an additional indication and ICD-9-CM code to the LCD.

After review of the submitted literature and other documentation, a revision was made to add the following indication and ICD-9-CM code range to the LCD:

- Non-melanoma skin cancers (Merkel cell carcinoma)
- 173.0 - 173.9 -- Other malignant neoplasm of skin

In addition, references under the "Sources of Information and Basis for Decision" section of the LCD were updated.

Effective date

This revision is effective for services provided **on or after April 2, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database.

Florida Part A active LCD list sorted by LCD Title.

Puerto Rico and U.S. Virgin Islands Part A active LCD list. ❖

AJ9263: Oxaliplatin (Eloxatin®) – revision to the LCD

LCD ID Number: L28942 (Florida)
LCD ID Number: L28963 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for oxaliplatin (Eloxatin®) was effective for services provided **on or after February 16, 2009**, for Florida and **on or after March 2, 2009**, for Puerto Rico and the U.S. Virgin Islands billed as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made based on a request for a reconsideration to add an additional indication and ICD-9-CM code range to the LCD.

After review of the submitted literature and other documentation, a revision was made to add the following off-label indication and ICD-9-CM code range to the LCD:

- In combination with other Food and Drug Administration (FDA)-approved or Centers for Medicare & Medicaid Services (CMS) approved compendia supported chemotherapy regimens for the treatment of esophageal cancer.
- 150.0 - 150.9 - Malignant neoplasm of esophagus

In addition, verbiage was updated under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, and references were updated under the "Sources of Information and Basis for Decision" section of the LCD.

AJ9263: Oxaliplatin (Eloxatin®) – revision to the LCD (continued)

Effective date

This revision is effective for services provided **on or after March 19, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database.

Florida Part A active LCD list sorted by LCD Title.

Puerto Rico and U.S. Virgin Islands Part A active LCD list. ❖

ATHERSVCS: Therapy and rehabilitation services – revision to the coding guidelines

LCD ID Number: L28992 (Florida)
LCD ID Number: L29024 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was effective for services provided **on or after February 16, 2009,** for Florida and **on or after March 2, 2009,** for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD coding guideline attachment has been revised. Change request 6254, dated October 31, 2008, updated Medicare's therapy code list with two "sometimes therapy codes", *CPT* codes *0183T (Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day)* and *CPT* code *95992 (Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day)*. Language was added to the coding guidelines attachment stating that *CPT* code *0183T* is considered a "sometimes therapy" service, however this code is listed in First Coast Service Options Inc. (FCSOs) noncovered services LCD, the service will be denied when billed. Change request 6254 also listed *CPT* code *95992* as a "sometimes therapy" code. However, the Centers for Medicare & Medicaid Services (CMS) issued JSM/TDL 09132 on January 21, 2009, which stated that the bundled status indicator was inadvertently left off this code. CMS installed a fix for this error, which was implemented on March 2, 2009. Language was added to the coding guidelines attachment, which states that separate payment will not be made when this service is billed.

Effective date

For *CPT* code *0183T*, this revision is effective for claims processed **on or after January 5, 2009,** for services provided **on or after January 1, 2009.** For *CPT* code *95992*, this revision is effective for claims processed **on or after March 2, 2009,** for services provided **on or after January 1, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

Florida Part A active LCD list sorted by LCD Title.

Puerto Rico and U.S. Virgin Islands Part A active LCD list. ❖

ADDITIONAL MEDICAL INFORMATION

0176T and 0177T: Transluminal dilation of aqueous outflow canal

0176T Transluminal dilation of aqueous outflow canal; without retention of device or stent
0177T with retention of device or stent

Transluminal dilation of the aqueous outflow canal or transluminal canaloplasty is a form of non-penetrating glaucoma surgery that serves as an alternative to trabeculectomy in patients requiring surgical treatment of primary open-angle glaucoma (POAG). Patients requiring surgery for POAG are those in whom medical management is no longer providing adequate results. Transluminal canaloplasty has been shown to lower the intra-ocular pressure and may be associated with fewer short- and long-term complications than trabeculectomy. The procedure involves placement of a catheter into Schlemm's canal and dilation of the canal by injection of sodium hyaluronate. The device or stent may or may not be retained in Schlemm's canal.

The ICD-9-CM diagnosis code supporting the medical necessity of the procedure is 365.11, primary open angle glaucoma, **effective for services provided on or after March 2, 2009**. ❖

Intravitreal bevacizumab (Avastin®) for neovascular age-related macular degeneration – coding and billing update

Neovascular age-related macular degeneration (AMD), when untreated or refractory to usual therapies, almost always leads to permanent blindness. Neovascular (wet) AMD is characterized by choroidal neovascularization (CNV) beneath the retina. The neovascular tissue often leaks blood and fluid, and when untreated, eventually progresses to scarring with destruction of the macula and loss of vision. As such, additional therapeutic interventions have been pursued in order to try and salvage the vision of AMD patients who have failed to respond to the usual therapies.

One of these options is the use of bevacizumab (Avastin®), a recombinant humanized monoclonal IgG1 antibody that binds to and inhibits the biologic activity of vascular endothelial growth factor (VEGF, also known as vascular permeability factor [VPF] or VEGF-A) with receptors on the surface of endothelial cells, thereby preventing cell proliferation and new blood vessel formation (i.e., angiogenesis).

Bevacizumab (Avastin®; Genentech) is approved by the Food and Drug Administration (FDA) for treatment of select cancers as a systemic drug. However, based on published reports and widespread clinical use, there is compelling evidence of bevacizumab's safety and efficacy for CNV in AMD. Ophthalmologists have been using intravitreal bevacizumab increasingly in the treatment of wet AMD.

First Coast Service Options Inc. (FCSO) will consider bevacizumab (Avastin®) given by intravitreal injection medically reasonable and necessary for patients diagnosed with neovascular (wet) AMD.

HCPCS code J9035 (Injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent. Providers billing for intravitreal bevacizumab should use *CPT* code *67028* for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab.

For Medicare Part A providers, "Intravitreal bevacizumab and the dosage" should be entered in item FL 80 of the Centers for Medicare & Medicaid Services (CMS) Form UB-04 or its electronic equivalent. The administration of the intravitreal injection of bevacizumab (Avastin®) must be billed on the same claim as the drug.

For Medicare Part B providers, "Intravitreal bevacizumab and the dosage" should be entered in item 19 of CMS Form 1500 or its electronic equivalent. The administration of the intravitreal injection of bevacizumab (Avastin®) must be billed on the same claim as the drug.

When performing an injection on both eyes, modifier 50 should be used and modifier RT or LT should be used for unilateral services.

Medical record documentation maintained by the performing ophthalmologist must include the following:

- The diagnosis of wet AMD (ICD-9-CM code 362.52) with leakage/fluid in the macula has been confirmed by optical coherence tomography (OCT) or fluorescein angiography.
- Actual dose administered in milligrams.
- Indication that the patient has been provided appropriate informed consent regarding the benefits and risks of this therapy and off-label use of this drug.

Providers should not submit this information with the claim. FCSO may request it separately with an additional documentation request (ADR) letter.

- The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration of retina).

Anytime there is a question whether Medicare's medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS/CPT codes. If and when a denial should be received, providers may collect from the beneficiary based on the fee schedule. The GA modifier should be billed with 67028 and J3490. For further details about CMS' beneficiary notice initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*. ❖

Addition to the self-administered injectable drug (SAD) list

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare incident to a physician's service. Providers may read the instructions in their entirety in the Medicare benefit policy manual, Pub 100-02, Chapter 15, Section 50.2.

Relistor® (methylnatrexone bromide) HCPCS code C9399/J3490 has been added to the list of excluded self-administered injectable drugs incident to a physician's service (SAD list).

Effective date

This revision is effective for services provided **on or after April 20, 2009.** To view the SAD list in its entirety please click on one of the links below:

Florida Part A list of excluded SAD incident to a physician's service.

Puerto Rico and U.S. Virgin Islands Part A list of excluded SAD incident to a physician's service. ❖

HOSPITAL SERVICES

Information for hospice providers, teaching and long-term care hospitals

The American Recovery and Reinvestment Act (ARRA) of 2009 was signed into law on February 17, 2009.

Indirect medical education

In the fiscal year (FY) 2008 inpatient prospective payment system (IPPS) final rule, CMS adopted a policy to phase-out the capital IPPS teaching adjustment. The ARRA changes the final rule 50 percent adjustment that would apply in FY 2009 to 100 percent effective for discharges occurring on or after October 1, 2008, through September 30, 2009.

Providers are not required to take any actions and should continue to submit claims. Medicare contractors will automatically reprocess affected claims and make adjusted payments within six months following the installation of the revised payment systems.

Hospice

In the FY 2009 hospice wage index final rule, CMS adopted a policy in which the budget neutrality adjustment factor, which is applied to the hospice wage index, was reduced by 25 percent. This was to be the first year of a three-year phase-out. The ARRA delays the phase-out of the Medicare hospice budget neutrality adjustment factor by one year, essentially removing the 25 percent reduction in FY 2009.

Providers are not required to take any actions and should continue to submit claims. Medicare contractors will automatically reprocess affected claims and make adjusted payments within six months following the installation of the revised payment systems.

Long term care hospitals

ARRA makes one additional exception to the moratorium on the expansion of existing Long term care hospitals (LTCHs) and expands the categories of LTCHs that would be subject to the delay or change in application of the 25 percent payment provision. CMS will issue further instructions and educational materials on the LTCH provision and other ARRA provisions in the near future. ❖

Source: CMS PERL 200902-35

Medicare Advantage information for fiscal year 2006 for supplemental security income

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

Provider types affected

Inpatient prospective payment system (IPPS) hospitals that received disproportionate share hospital (DSH) and inpatient rehabilitation facilities (IRF)) that received low income patients (LIP) payments and which provided care to Medicare Advantage (MA) beneficiaries during fiscal year (FY) 2006. IPPS hospitals that did not receive DSH payments and IRFs that did not receive LIP payments may also want to review this article.

What you need to know

Change request (CR) 6329, from which this article was taken, advises hospitals that received DSH payments and IRFs that received LIP payments are required to submit informational only bills to your Medicare contractor (fiscal intermediary [FI] or Medicare administrative contractor [MAC]) for the MA beneficiaries that you treated on or after October 1, 2005, through September 30, 2006 (FY 2006). IPPS hospitals and IRFs that did not receive such payments have the option of submitting FY 2006 informational claims for MA patients, but they are not required to do so. These claims are needed to ensure that the supplemental security income (SSI) data for FY 2006 accurately reflects MA patient days for purposes of DSH or LIP calculations. Hospitals must submit their FY 06 claims between July 1, 2009, and November 30, 2009.

Teaching hospitals should have already submitted their MA claims with condition codes 04 and 69 in order to be reimbursed for their indirect medical education (IME) and direct graduate medical education (DGME) payment. Therefore, teaching hospitals must not re-submit MA claims and are not affected by CR 6329.

Background

Part of the calculation that Medicare uses to determine whether a hospital is eligible for DSH/LIP add-on payments is based on the percentage of days for which the Medicare Part A entitled beneficiary received SSI payments from the Social Security Administration (SSA).

Effective July 1, 2009, IPPS hospitals and IRFs must submit informational only bills to your Medicare contractor for the MA beneficiaries that you treated on or after October 1, 2005, through September 30, 2006 (FY 2006).

Specifically, hospitals and IRFs need to submit informational only claims (covered 11x type of bill (TOB), not 110), showing Medicare fee-for-service (FFS) as the primary payer, no Medicare secondary payer (MSP), condition code 04, the beneficiary's Medicare health insurance claim (HIC) number, and all other required Medicare fee-for-service claim data elements needed for the inpatient claim for MA beneficiary discharges on or after October 1, 2005, through September 30, 2006. In addition, IRFs will also need to append case mix group (CMG) A9999 to the revenue code 0024 line and include the discharge date in the 'service date' field.

You should be aware that:

1. Teaching hospitals should have already submitted their MA claims with condition codes 04 and 69 in order to be reimbursed for their indirect medical education

Medicare Advantage information for fiscal year 2006 for supplemental security income (continued)

(IME) payment. Therefore, teaching hospitals must not re-submit MA claims and are not covered under this instruction.

2. IPPS hospitals and IRFs that did not qualify for DSH/LIP payments in FY 2006 have the option to submit FY 2006 MA claims, but are not required to do so.

Also please note that your Medicare contractors will override timely filing for covered TOB 11x, will suppress the Medicare summery notice (MSN) on covered TOB 11x when condition code 04 is present, remove deductible, and will reject claims that contain condition code 04 and no MA record exists in Medicare's files for the beneficiary.

Additional information

You may find more information about capturing MA days in SSI information for DSH or LIP calculations during FY 2006 by going to CR 6329, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1695CP.pdf*.

You will find the updated *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing), Sections 20.3 (Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients) and 140.2.4.3(Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)) as an attachment to that CR.

Also, the IPPS regulations on DSH are located in 42 CFR 412.106, which you can read at *http://edocket.access.gpo.gov/cfr_2003/octqtr/pdf/42cfr412.106.pdf* and the Inpatient Rehabilitation Facility (IRF) PPS regulations on Low-Income Patients (LIP) are located in 42 CFR 412.624(e)(2), which is on the Internet at *http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr412.624.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*.

MLN Matters Number: MM6329
Related Change Request (CR) Number: 6329
Related CR Release Date: March 6, 2009
Related CR Transmittal Number: R1695CP
Effective Date: Discharges on or after October 1, 2005 through September 30, 2006
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1695, CR 6329

Disclosure of physician ownership in hospitals

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

Provider types affected

Physician-owned hospitals and physicians with hospital ownership interests who bill Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (MAC) for services provided to Medicare beneficiaries in those physician-owned hospitals.

What you need to know

Change request (CR) 6306, from which this article is taken, announces that:

- Physician-owned hospitals are required to disclose to their patients the names of the physician owners and the names of immediate family members of the physician who have an ownership or investment interest in the hospital.
- Physicians are required to disclose to their patients at the time of referral if they (or their immediate family members) have an ownership or investment interest in the hospitals to which they refer patients for treatment.

Hospitals that fail to disclose this information to patients may lose their provider agreements to participate in the Medicare program, and physicians who fail to disclose this information to patients may lose their hospital medical staff memberships.

You should make sure that you have appropriate hospital physician-ownership disclosure procedures in place and that you are providing appropriate disclosures to your patients.

Background

The *Code of Federal Regulations* Title 42, Volume 3,Section 489.3 defines a physician-owned hospital as any participating hospital (as defined in section 489.24) in which a physician, or their immediate family member, has an ownership or investment interest. Pursuant to Section 489.3, hospitals that do not have any physician owners who refer patients to the hospital are exempt from these disclosure requirements.

Section 5006 of the Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, required the Secretary of Health & Human Services (HHS) to develop a "strategic and implementing plan" to address certain issues related to physician investment in specialty hospitals. Accordingly (in order to allow patients to make informed decisions regarding their treatment and to decide if the existence of a hospital-related financial relationship suggests a conflict of interest that may not be in their best interest), in the August 8, 2006 final report to Congress on this requirement, the Centers for Medicare & Medicaid Services (CMS) stated the

Disclosure of physician ownership in hospitals (continued)

adoption of a disclosure requirement that would require both hospitals and physicians to disclose to patients whether the hospital is physician-owned and if the referring physician is a physician owner of the hospital.

Specifically, the fiscal year (FY) 2008 and FY 2009 inpatient prospective payment system (IPPS) regulations require hospitals to disclose to patients whether they are physician-owned, and if so, to disclose the physician owners' names. This ownership or investment interest may be through equity, debt, or other means (including an interest in the entity that holds an ownership or investment interest in the hospital.) In disclosing this ownership relationship, hospitals must furnish written notice to each patient at the beginning of their hospital stay, or outpatient visit, that the hospital is physician-owned. The notice must disclose the fact that the hospital meets the Federal definition of a physician-owned hospital, and that the list of physician owners or their immediate family members (who have an ownership or investment interest in the hospital) is available upon request and must be provided to the patient at the time of the request.

These regulations also require each physician who is a member of the hospital's medical staff to agree (as a condition of continued medical staff membership or admitting privileges), to disclose to all patients that he or she refers to the hospital (in writing at the time of the referral), any ownership or investment interest that he/she, or an immediate family member, holds in the hospital.

You should be aware that if a physician-owned hospital fails to disclose physician ownership information as required, it may lose its provider agreement to participate in the Medicare program. Similarly, if a physician fails to disclose his/her hospital ownership or investment information, he or she may lose hospital medical staff membership.

Additional information

The official instruction issued to your Medicare carrier, FI, or MAC, CR 6306, is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R58GI.pdf*.

If you are interested in reading about physician hospital ownership disclosure in the *Code of Federal Regulations* Title 42, Volume 3, Section 489.3, you may find it on the Internet at *http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr489.3.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*.

MLN Matters Number: MM6306
Related Change Request (CR) Number: 6306
Related CR Release Date: March 6, 2009
Related CR Transmittal Number: R58GI
Effective Date: June 8, 2009
Implementation Date: June 8, 2009

Source: CMS Pub. 100-01, Transmittal 58, CR 6306

FY 2007 inpatient prospective payment system personal computer PRICER release

To correct pricing issues, the inpatient prospective payment system (IPPS) personal computer (PC) PRICER for fiscal year (FY) 2007 has been updated with the January 2008 provider data. If you use the IPPS PC PRICERS, please go to the "Inpatient PPS PC PPRICER" Web page (*http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*), under the "Downloads" section and download the FY 2007 version of the PC PRICER (posted March 5, 2009). ❖

Source: CMS PERL 200903-12

Revised Acute Inpatient Prospective Payment System fact sheet

The revised *Acute Inpatient Prospective Payment System* fact sheet (January 2009), which provides general information about the acute inpatient prospective payment system (IPPS) including IPPS payment rates and how IPPS payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf*. ❖

Source: CMS PERL 200903-06

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SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Spell of Illness Quick Reference Chart

The revised *Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart* (January 2009), which provides Medicare claims processing information related to SNF spells of illness, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/SNFSpellIllnesschrt.pdf*. ❖

Source: CMS PERL 200902-31

Five-star provider preview reports now available

The five-star provider preview reports were available beginning Wednesday, March 18, 2009. Providers can access the report from the minimum data set (MDS) state welcome pages available on the state servers for submission of minimum data set data.

Provider preview access information

Visit the MDS state welcome page (available on the state servers where you submit MDS data) to review your results. To access the five-star provider preview reports, select the "Certification and Survey Provider Enhanced Reports" (CASPER) reporting link (located at the bottom of the login page). Once in the CASPER reporting system, click on the "Folders" button and access the five-star report in your "st LTC facid" folder."

Note: "st" is the 2-digit postal code of the state in which your facility is located, and "facid" refers to the state-assigned facility identifier for your facility.

Nursing Home Compare updated March's five-star data on Thursday, March 26, 2009. ❖

Source: CMS PERL 200903-21

Sign up to our *eNews* electronic mailing list

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ESRD Services

Billing for HCPCS code A4755 on a type of bill 72x

First Coast Service Option Inc. (FCSO) Medical Review department has identified an increase in billing for HCPCS code A4755 (blood tubing, arterial and venous combines for hemodialysis, each) as a line item on type of bill 72x.

FCSO is reminding providers that HCPCS code A4755 is a bundled procedure included in the end-stage renal disease (ESRD) composite rate allowance. Services included in the ESRD-composite rate cannot be unbundled. Submitting items included in the ESRD-composite rate as a separate line item will cause an overpayment if additional payment is issued for the bundled service. ❖

Revised Outpatient Maintenance Dialysis – End-Stage Renal Disease fact sheet

The revised *Outpatient Maintenance Dialysis – End-Stage Renal Disease* fact sheet (February 2009), which provides general information about outpatient maintenance dialysis for end-stage renal disease, the composite payment rate system, and separately billable items and services, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymtfctsht508-09.pdf. ❖

Source: CMS PERL 200903-09

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CORF/ORF SERVICES

Outpatient therapy caps with exceptions in calendar year 2009

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Medicare administrative contractors [MACs], fiscal intermediaries [FIs], and/or regional home health intermediaries [RHHIs]) for therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6321 which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy cap exceptions for 2009 and updates the dollar amount of the therapy caps for 2009. Be sure billing staff is aware of the updates

Background

The Balanced Budget Act of 1997 established limits on outpatient therapy services. These limits change annually. The Deficit Reduction Act of 2005 allowed CMS to establish an exceptions process, which began January 1, 2006, and was extended by later legislation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) **extended the exceptions process for therapy caps through December 31, 2009. CR 6321 makes no change to the exceptions process.**

CR 6321 revises the *Medicare Claims Processing Manual* Chapter 5, Section 10.2 (The Financial Limitation) to include the outpatient therapy cap exceptions for 2009. The revised manual chapter is included as attachment to CR 6321, and the following is extracted from that attachment:

Financial limitations on outpatient therapy services, as described in the *Medicare Claims Processing Manual* (Chapter 5, Section 10.2 [The Financial Limitation]) were $1,740 in 2006, $1,780 in 2007, and $1,810 for 2008.

For 2009, the financial limitations are:

- **The annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1,840**
- **The separate limit for occupational therapy is $1,840**

An **advance beneficiary notice (ABN) of noncoverage** is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements before the cap is reached. The ABN informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights. **Since therapy that exceeds the cap is statutorily excluded from Medicare coverage, the ABN is not required.** However, the ABN may be used on a voluntary basis to inform the beneficiary of potential liability for therapy that exceeds the cap.

Note: The ABN-G is no longer effective as of March 1, 2009. The revised ABN (CMS-R-131) must now be used and the revised ABN is available for download on the CMS Web site at *http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip*.

Additional information

The official instruction, CR 6321, issued to your carrier, FI, MAC, and RHHI regarding this change may be view on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1678CP.pdf*.

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

MLN Matters Number: MM6321
Related Change Request (CR) Number: 6321
Related CR Release Date: February 13, 200[9]
Related CR Transmittal Number: R1678CP
Effective Date: January 1, 2009
Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 10678, CR 6321

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

April 2009 integrated outpatient code editor specifications version 10.1

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

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6413, which describes changes to the integrated outpatient code editor (I/OCE). Be sure billing staffs are aware of these changes.

Background

CR 6413 describes changes to the April 2009 I/OCE. Attached to CR 6413 are lengthy specifications for the I/OCE (Attachment A) and the summary of data changes (Attachment B).

Note: A summary of the changes for April 2009 is within Appendix M of Attachment A of CR 6413 and that summary is captured in the following key points.

Key points of CR 6413 based on preliminary summary of data changes and appendix M of the I/OCE specifications

Medicare has made the following I/OCE logic changes for April (note: **All** of the logic changes are detailed in the specifications in CR 6413):

- Status indicator U (to SI =H) was added to the criteria for edit 38
- The program was modified to ignore procedures that had SI changed from Q(#) to N - in subsequent logic for purposes of assigning composite APC
- The program was modified to apply edit 80 to type of bill (TOB) 76x
- The program was modified to remove TOB 14x from mental health (MH) processing

Medicare has made the following Healthcare Common Procedure Coding System/ambulatory payment class/status indicator (HCPCS/APC/SI) changes:

Added APCs (for providers paid under OPPS)

- APC 01253 (triamcinolone A inj PRS-free), with a status indicator (SI) = K has been added effective January 1, 2009.
- APC 09247 (Inj, iobenguane, I-123, dx) and 09249 (Inj, certolizumab pegol) with a SI = G have been added effective April 1, 2009.

APC SI changes

- APC 01236 and 01238 previously had SIs = K and now both have new SIs of G.

New HCPCS

- HCPCS code C9249, with a SI = G has been added effective April 1, 2009, with an APC of 09249.
- HCPCS codes K0739 and K0740 with SI = Y have been added effective April 1, 2009.
- HCPCS codes S3865, S3866, S3870 with SI = E have been added effective April 1, 2009.

Deleted HCPCS/*Current Procedural Terminology (CPT)* procedure codes

- HCPCS codes S8190 has been deleted effective April 1, 2009.

HCPCS changes to APC and/or SI

- 18 E-codes from E0250 to E0310 were changed from SI=E to Si=Y effective July 1, 2006 (see Attachment B for the full list)
- HCPCS codes 0085T had an old APC of 00340 but was changed to APC 00000 with a new SI = E effective January 1, 2009.
- HCPCS codes 0529F, 0540F, 1170F, 3016F, 3455F, 3470F, 3471F, 3472F, 3475F, 3476F, 3570F, 4148F, 4149F, 4192F, 4193F, 4194F, 4195F, 4196F, 4267F were changed from SI= E to SI = M effective January 1, 2009.
- HCPCS codes 0575F, 4270F, 4271F, 4279F, 4280F were changed from SI= M to SI = E effective January 1, 2009.
- HCPCS code J3300 had an old APC of 00000 but was changed to APC 01253 with a new SI = K effective January 1, 2009.
- HCPCS code 90649 and 90716 were changed from SI= B to SI = M effective April 1, 2009.
- HCPCS code C9247 had an old APC of 00000 but was changed to APC 09247 with a new SI = G effective April 1, 2009.
- HCPCS code E0315 was changed from SI= E to SI = Y effective April 1, 2009.
- HCPCS code E1340 was changed from SI= Y to SI = E effective April 1, 2009.
- HCPCS codes J0641 and J8705 were changed from SI= K to SI = G effective April 1, 2009.

April 2009 integrated outpatient code editor specifications version 10.1 (continued)

HCPCS Edit Changes

- HCPCS code 0193T was added to the list of female procedures effective January 1, 2009.

HCPCS Termination Date Changes

- HCPCS code 0085T has a new termination date of December 7, 2008)

Edit Assignments

- HCPCS codes 27027, 27057, 35535, 35570, 35632, 35633, 35634, 49652, 49653, 49654, 49655, 49656, 49657, 50546, 64455, 64632, 65756 were added to the conditional bilateral list effective January 1, 2009.

Modifier Additions

- Modifier K8 is a valid modifier effective April 1, 2009.

Revenue code additions

- Revenue codes 0951 and 0952 are valid and have SI = E effective October 1, 2000.
- Revenue code 0392 is valid and has SI = E effective April 1, 2007.

CCI Edit Information

- Version 15.0 of the national correct coding initiatives has been implemented effective with this April 2009 version of the I/OCE.
- The following language was added to the specs: "In some instances, both codes in a CCI code pair may be allowed if an appropriate modifier is used that describes the circumstances when both services may be allowed. The code pairs that may be allowed with a modifier are identified with a modifier indicator of "1"; code pairs that are never allowed, whether or not a modifier is present, are identified with a modifier indicator of "0". (Modifiers that are recognized/used to describe allowable circumstances are: 25, 27, 58, 59, 78, 79, 91, E1-E4, F1-F9, FA, LC, LD, RC, RT, T1-T9, and TA).

Additional information

The official instruction (CR 6413) issued to your Medicare MAC, RHHI, or FI is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1700CP.pdf*.

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

MLN Matters Number: MM6413
Related Change Request (CR) Number: 6413
Related CR Release Date: March 13, 2009
Related CR Transmittal Number: R1700CP
Effective Date: April 1, 2009
Implementation Date: April 6, 2009
Source: CMS Pub. 100-04, Transmittal 1700, CR 6413

April 2009 update of the hospital outpatient prospective payment system

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

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 6416 which describes changes to the OPPS to be implemented in the April 2009 OPPS update. Be sure your billing staff are aware of these changes.

Background

Change request (CR) 6416 describes changes to and billing instructions for payment policies implemented in the April 2009 OPPS update. The April 2009 integrated outpatient code editor (I/OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in this change request.

April 2009 revisions to I/OCE data files, instructions, and specifications are provided in CR 6413, April 2009 I/OCE specifications version 10.1." Upon release of CR 6413, a related *MLN Matters* article will be available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6413.pdf*.

Key OPPS Updates for April 2009

1. Pass-through devices and non pass-through devices included in kits

Manufacturers frequently package a number of individual items used with a device in a particular procedure in a kit. Generally, to avoid complicating the device pass-through category list unnecessarily and to avoid the possibility of double coding, CMS has not established HCPCS codes for such kits. However, hospitals may purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items should be separately billed using applicable HCPCS codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits. This information can also be found in the revised *Medicare Claims Processing Manual*, Chapter 4, Section 60.4 (General Coding and Billing Instructions and Explanations) which is included as an attachment to CR 6416.

April 2009 update of the hospital outpatient prospective payment system (continued)

In cases of devices that are described by 1) device category HCPCS codes whose pass-through status has expired or 2) device category HCPCS codes that describe devices without pass-through status and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their line-item charge for the associated device/device category HCPCS code that is assigned status indicator "N" for packaged payment. That is, hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these codes are assigned status indicator "N." In the case of a device kit, should a hospital choose to report the device charge alone under a device/ device category HCPCS code with status indicator "N," the hospital should report charges for other items that may be included in the kit on a separate line on the claim. Hospitals may use the same revenue code to report all components of the kit. This information can also be found in the *Medicare Claims Processing Manual*, Chapter 4, Section 61.1 (Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures) which is included as an attachment to CR 6416.

Hospitals are advised to continue to report all HCPCS codes that describe packaged items and services that were provided, unless *CPT* instructions or CMS provide other guidance. Further, hospitals should include charges for packaged items or services described and reported by those HCPCS codes with status indicator "N" on their claims when those codes can be appropriately reported, so that the costs associated with the packaged items or services can then be added to the costs of separately payable procedures on the same claims when establishing the annual payment rates for the separately payable services under the OPPS.

2. Further clarification related to billing for medical and surgical supplies

When medical and surgical supplies (other than prosthetic and orthotic devices as described in the *Medicare Benefit Policy Manual*, Chapter 15, Sections 120 and 130 and take-home surgical dressings; see *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site) described by HCPCS codes with status indicators other than "H" or "N," are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in rate setting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4) (see *http://www.gpoaccess.gov/cfr/retrieve.html* on the Internet).

For example, if the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPPS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim.

In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPPS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient's use of the item, the hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment.

3. Billing for inherently bilateral procedures

Inherently bilateral procedures represent services that are performed bilaterally. Often, the word "bilateral" appears in the HCPCS code long descriptor. Since the implementation of the OPPS on August 1, 2000, inherently bilateral procedure codes have been included in the I/OCE as a table that is used in applying edit 17 (inappropriate specification of bilateral procedure). I/OCE edit 17 occurs when a bilateral procedure code appears on the claim form more than once per day on the same date for the same patient. Recently, CMS received reports of a clinical scenario where a bilateral procedure may be performed more than once per day on the same date for the same patient. For only those instances that involve more than one bilateral procedure and are medically necessary and appropriate, hospitals are advised to report the procedure code with a modifier 76 (repeat procedure or service by same physician) in order for the claim to process correctly. Appending

April 2009 update of the hospital outpatient prospective payment system (continued)

modifier 76 to one of the reported bilateral HCPCS code indicates that the bilateral procedure or service was repeated on the same day for the same patient. CMS expects these types of claims to be uncommon and will be monitoring claims to ensure that this is the case.

4. Billing for processing and storage of blood and blood products

CMS updated (and included as an attachment to CR 6416) the *Medicare Claims Processing Manual*, Chapter 4, Section 231.1 and Section 231.2) to include revenue code 0392 (Blood processing/storage; processing and storage) as an acceptable revenue code for billing blood processing and storage charges. Most OPPS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself. These hospitals should follow the instructions outlined in Section 231.1, which require using revenue code 0390 (blood processing/storage), 0392 (blood processing/storage; processing and storage), or 0399 (blood processing / storage; other processing and storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service (LIDOS). OPPS providers that incur a charge for the blood or blood product itself in addition to the charge for processing and storage should follow the coding requirements outlined in Section 231.2, which instructs hospitals to report charges for the blood or blood product itself using revenue code series 038x (excluding 0380) with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPPS provider also should report charges for processing and storage services on a separate line using revenue code 0390, 0392, or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on both lines.

5. Billing for autologous stem cell transplant procedures

CMS updated (and included as an attachment to CR 6416) the Medicare Claims Processing Manual, Chapter 3, Section 90.3.3) to clarify billing for allogeneic stem cell transplant acquisition services, which are billed and payable under Part A, and to clarify billing for autologous stem cell transplant procedures, which may be billed and payable under either Part A or Part B. CMS also revised (and included as an attachment to CR 6416) Chapter 4, Section 231.10 on billing for autologous stem cell transplant procedures.

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in revenue center code 0362 or another appropriate cost center.

CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the OPPS when provided in the hospital outpatient setting of care. CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

Payment for stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

6. Billing for drugs, biologicals, and radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

a. Drugs and biologicals with payments based on average sales price – effective April 1, 2009

For calendar year (CY) 2009, payment for nonpass-through drugs and biologicals is made at a single rate of ASP plus four percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In CY 2009, a single payment of ASP plus six percent for pass-through drugs and biologicals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the second quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B drug competitive acquisition program (CAP) rate, as the CAP program was suspended

April 2009 update of the hospital outpatient prospective payment system (continued)

beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2009, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2009 release of the OPPS PRICER.

Note: The updated payment rates, effective April 1 2009, will be included in the April 2009 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp*.

b. Drugs and biologicals with OPPS pass-through status – effective April 1, 2009

Three drugs and one diagnostic radiopharmaceutical have been granted OPPS pass-through status effective April 1, 2009. These items, along with their descriptors and APC assignments, are identified in Table 1 below.

Table 1 – Drugs and biologicals with OPPS pass-through status effective April 1, 2009

HCPCS code	Long descriptor	APC	Status indicator effective 4/1/09
C9247	Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries	9247	G
C9249*	Injection, certolizumab pegol, 1 mg	9249	G
J0641	Injection, levoleucovorin calcium, 0.5 mg	1236	G
J8705	Topotecan, oral, 0.25 mg	1238	G

Note: The HCPCS code identified with an "*" indicates that this is a new code effective April 1, 2009.

c. Adjustment to status indicator for HCPCS code J3300 for calendar year 2009

As stated in the CY 2009 OPPS/ASC correction notice, CMS erroneously assigned a packaged status indicator (SI = "N") to HCPCS code J3300, Injection,triamcinolone acetonide, preservative free, 1 mg, for CY 2009. To correct this error, CMS is updating the payment rate in the OPPS PRICER retroactively to January 1, 2009 to reflect the updated separately payable status of HCPCS code J3300 (SI = "K") for CY 2009. HCPCS code J3300 is assigned to APC 1253 (Triamcinolone A inj PRS-free) with a payment rate of $3.18 for the first quarter of CY 2009. If this payment rate changes for the second quarter of CY 2009, CMS will include the pricing update for HCPCS code J3300 in the corresponding update for other separately payable drugs and biologicals for the April 2009 OPPS PRICER.

d. Recognition of multiple HCPCS codes for drugs

Prior to January 1, 2008, the OPPS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPPS assigned a status indicator "B" indicating that another code existed for OPPS purposes. For example, if drug x has two HCPCS codes, one for a 1 ml dose and another for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and status indicator "B" to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPPS. However, beginning January 1, 2008, the OPPS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

e. Correct reporting of drugs and biologicals when used as implantable devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure. When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

April 2009 update of the hospital outpatient prospective payment system (continued)

f. Correct reporting of units for drugs
Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

g. Introduction of payment offset for pass-through diagnostic radiopharmaceuticals

Effective April 1, 2009, diagnostic radiopharmaceutical HCPCS code C9247, Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries, has been granted pass-through status under the OPPS and will be assigned status indicator "G." As finalized in the CY 2009 OPPS/ASC final rule with comment period, payment for diagnostic radiopharmaceuticals with pass-through status during CY 2009 will be made according to the established ASP methodology. Therefore, beginning April 1, 2009, payment for HCPCS code C9247 will be made at 106 percent of ASP if ASP data are submitted by the manufacturer. Otherwise, payment will be made based on the product's wholesale acquisition cost (WAC). Further, if WAC data are not available, payment will be made at 95 percent of the average wholesale price (AWP). Effective for nuclear medicine services furnished on and after April 1, 2009, when HCPCS code C9247 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 by the corresponding nuclear medicine procedure's portion of its APC payment associated with "policy packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made. The "policy packaged" portions of the CY 2009 APC payments may be found on the CMS website at *http://www.cms.hhs.gov/HospitalOutpatientPPS/06_Annual_Policy_File.asp#TopOfPage* in the download file labeled "2009 OPPS Offset Amounts by APC." Pass-through payment for the diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used. Effective for services furnished on and after April 1, 2009, but before the date that HCPCS code C9247 expires from pass-through status, CMS will reduce the payment for HCPCS code C9247 by the estimated amount of payment that is attributable to the predecessor radiopharmaceutical that is packaged into payment for the associated nuclear medicine procedure reported on the same claim as HCPCS code C9247.

When HCPCS code C9247 is billed on a claim with one or more nuclear medicine procedures, the OPPS PRICER will identify the offset amount or amounts that apply to the nuclear medicine procedures that are reported on the claim. Where there is a single nuclear medicine procedure reported on the claim with a single occurrence of C9247, the OPPS PRICER will identify a single offset amount for the procedure billed and adjust the offset by the wage index that applies to the hospital submitting the bill. Where there are multiple nuclear medicine procedures on the claim with a single occurrence of the pass-through radiopharmaceutical, the OPPS PRICER will select the nuclear medicine procedure with the single highest offset amount and will adjust the selected offset amount by the wage index of the hospital submitting the claim. When a claim has more than one occurrence of C9247, the OPPS PRICER will rank potential offset amounts associated with the units of nuclear medicine procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through radiopharmaceutical on the claim and adjust the total offset amount by the wage index of the hospital submitting the claim. The adjusted offset will be subtracted from the APC payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

7. OPPS PRICER changes

New pass-through diagnostic radiopharmaceutical offset logic will be added (see section "6.g". above) along with the April average sales price (ASP) APC updates.

8. Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure,

April 2009 update of the hospital outpatient prospective payment system (continued)

or service may be paid if covered by the program. FIs/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 6416, issued to your FI, A/B MAC, and RHHI regarding this change is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1702CP.pdf.*

If you have any questions, please contact your FI, MAC, 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*.

MLN Matters Number: MM6416
Related Change Request (CR) Number: 6416
Related CR Release Date: March 13, 2009
Related CR Transmittal Number: R1702
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 1702, CR 6416

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ELECTRONIC DATA INTERCHANGE

Healthcare provider taxonomy code update effective April 1, 2009

Effective April 1 2009, the healthcare provider taxonomy codes (HPTC) were updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of the HPTC is available from the *Washington Publishing Company Web site* at *http://www.wpc-edi.com/codes/taxonomy*.

If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level rejection may occur.

To ensure you do not receive a claim or file level rejection, it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system please contact your software support vendor. ❖

Source: CMS Pub. 100-04, Transmittal 1692, CR 6382

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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 who submit claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 6336, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective April 1, 2009, for Medicare. Be sure billing staff are aware of these changes.

Background

Two code sets (the group and the reason and remark code sets) must be used to report payment adjustments in remittance advice transactions. For Medicare, remark codes must also be used when appropriate to report additional explanation for any adjustment or to provide general policy information. The reason codes are also used in some coordination of benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. RARC list is updated three times a year (early March, July, and November), although the committee meets every month.

The CARC list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated at the same time and posted *at http://www.wpc-edi.com/Codes* on the Internet. The lists summarizing the latest changes may be found at the end of the *Additional information* section.

CMS has also developed a tool to help you search for a specific category of remark code and that tool is available at *http://www.cmsremarkcodes.info* on the Internet. Note that this Web site does not replace the Washington Publishing Company (WPC) site. That site is *http://www.wpc-edi.com/Codes* and should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional information

To see the official instruction (CR 6336) issued to your Medicare contractor refer to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1674CP.pdf*.

For additional information about remittance advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

If you use the Medicare Remit Easy Print software from your Medicare contractor, you may need to download the updated version when it is available on April 6, 2009.

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

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

New codes – CARC

Code	Current Narrative	Effective Date
226	Information requested from the billing/rendering provider was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	9/21/2008
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	9/21/2008
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008

Modified codes – CARC

Code	Current Modified Narrative	Effective Date
148	Information requested from the billing/rendering provider was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	7/1/2009

Deactivated codes – CARC

Code	Current Narrative	Effective Date
17	Requested information was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	7/1/2009
B18	This procedure code and modifier were invalid on the date of service.	3/1/2009

New codes – RARC

Code	Current Narrative	Medicare Initiated?
N505	**Alert**: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.	No
N506	**Alert**: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.	No
N507	Plan distance requirements have not been met.	No
N508	**Alert**: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an explanation of benefits electronically or in the mail. Contact the insurer if there are any questions.	No
N509	**Alert**: A current inquiry shows the member's consumer spending account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the consumer spending account will depend on the availability of funds and determination of eligible services at the time of payment processing.	No
N510	**Alert**: A current inquiry shows the member's consumer spending account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the consumer spending account will depend on the availability of funds and determination of eligible services at the time of payment processing.	No
N511	**Alert**: Information on the availability of consumer spending account funds to cover the member liability on this claim/service is not available at this time.	No
N512	**Alert**: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	No
N513	**Alert**: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.	No

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

Code	Current Narrative	Medicare Initiated?
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Yes
N515	**Alert**: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

Modified or deactivated codes – RARC

There are no modified or deactivated RARC codes in CR 6336.

MLN Matters Number: MM6336
Related Change Request (CR) Number: 6336
Related CR Release Date: January 30, 2009
Related CR Transmittal Number: R1674CP
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Source: CMS Pub. 100-04, Transmittal 1674, CR 6336

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
April 2009 – May 2009

Topic: Lifetime reserve (LTR) days and duplicate reject reason codes

When: Wednesday, April 15, 2009

Time: 11:30 a.m. – 1:00 p.m. ET

Type of Event: Webcast

Topic – Community Mental Health Center – Psychiatric Partial Hospitalization Program

When: Thursday, April 23, 2009

Time: 11:30 a.m. – 1:00 p.m. ET

Type of Event: Webcast

Hot topics – Medicare 2009 updates and changes

When: Wednesday, May 13, 2009

Time: 11:30 a.m. – 12:30 p.m. ET

Type of Event: Webcast

Topics –Medicare 2009 updates and changes (Puerto Rico providers)

When: Tuesday, May 19, 2009

Time: 2:00 p.m. – 3:30 p.m. ET

Type of Event: Webcast

Two easy ways to register

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

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

Tips for using the FCSO provider training Web site

To search and register for events on *www.fcsomedicaretraining.com* click on the following links:

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

Select **Register** in the Options column located next to the specific course listed on the Instructor-Led Training (ILT) schedule page. For further assistance, contact FCSO Medicare training help desk at 1-866-756-9160 or send an e-mail to *fcsohelp@geolearning.com*.

Please Note:

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

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

Keep checking our Web site, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers. ❖

PREVENTIVE SERVICES

March is National Colorectal Cancer Awareness Month

In conjunction with National Colorectal Cancer Awareness Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for certain colorectal cancer screenings. Colorectal cancer affects both men and women of all racial and ethnic groups, is most often found in people age 50 and older, and the risk increases with age. Screening can help prevent and detect colorectal cancer in its earliest stages when outcomes are most favorable.

Medicare covered colorectal cancer screenings

Medicare provides coverage of colorectal cancer screenings for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered in place of the screening colonoscopy. An individual is considered to be at high risk for colorectal cancer if he or she has had colorectal cancer before or has a history of polyps, has a family member who has had colorectal cancer or a history of polyps, or has a personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Medicare provides coverage for the following colorectal cancer screenings subject to certain coverage, frequency, and payment limitations:

- fecal occult blood test (FOBT)
- colonoscopy
- sigmoidoscopy
- barium enema (as an alternative to a covered screening flexible sigmoidoscopy or screening colonoscopy)

Prevention is key

Colorectal cancer is the second leading cause of death from cancer in the United States; however, it doesn't have to be. Colorectal cancer is largely preventable through screening. The United States Preventive Services Task Force (USPSTF) found convincing evidence that certain screenings for colorectal cancer can detect early-stage cancer and adenomatous polyps and reduce colorectal cancer mortality (see the USPSTF link below for more information). CMS needs your help to ensure that all eligible people with Medicare get screened for colorectal cancer. Talk with your Medicare patients and their caregivers about the importance of getting screened. Patients who were screened before becoming Medicare beneficiaries should be encouraged to continue with screening at clinically appropriate intervals.

Additional information

- CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

  The *MLN* Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

  Cancer Screenings Brochure – this tri-fold brochure provides health care professionals with an overview of cancer screenings covered by Medicare, including colorectal cancer screening services. *http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf*.

To order copies of the brochure, go to the MLN Product Ordering Page located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

- For information to share with your Medicare patients, visit *http://www.medicare.gov*.
- The United State Preventive Services Task Force (USPSTF) recently revised its colorectal cancer screening recommendations: *http://www.ahrq.gov/clinic/uspstf/uspscolo.htm*.
- The Carolinas Center for Excellence Web site is a great resource for examining screening rates at a local level: *http://www2.thecarolinascenter.org/crc/crc.aspx?tabid=229*.
- The American Cancer Society offers free materials to help clinicians continue encouraging colorectal cancer screening among patients 50 and older: *http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp*.
- The National Colorectal Cancer Roundtable, which is convened by the Centers for Disease Control and Prevention (CDC) and the American Cancer Society, provides resources for providers, including a guide for primary care physicians: *http://www.nccrt.org/*.

For more information about National Colorectal Cancer Awareness Month, please visit *http://www.preventcancer.org/colorectal3c.aspx?id=1036*.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened. It could save their lives. ❖

Source: CMS PERL 200903-03

March Is National Nutrition Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. More than 13.7 million Americans at least 60 years or older are diagnosed with diabetes or chronic kidney disease[1]. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management as well as other health outcomes and may also help delay disease progression.

Medicare coverage

Medicare provides coverage of MNT for beneficiaries diagnosed with diabetes and/or renal disease (except for those receiving dialysis) and post renal transplant when provided by a registered dietitian or nutrition professional who meets the provider qualifications requirement. A referral by the beneficiary's treating physician indicating a diagnosis of diabetes or renal disease is required. Medicare provides coverage for three hours of MNT in the first year, two hours in subsequent years, and additional hours in certain situations.

Note: For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular filtration rate (GFR) 13-50 ml/min/1.73m2].

What can you do?

As a trusted source of health care information, your patients rely on their physician's or other health care professional's recommendations. CMS requests your help to ensure that all eligible people with Medicare take full advantage of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- **The MLN Preventive Services Educational Products Web Page** – provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- **Diabetes-Related Services Brochure** – this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*. To order copies of the brochure, go to the MLN Product Ordering System located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.*
- The CMS Web site provides additional information about the MNT benefit at *http://www.cms.hhs.gov/MedicalNutritionTherapy/.*

For information to share with your Medicare patients, visit *http://www.medicare.gov*.

For more information about National Nutrition Month® or to "Find a Nutrition Professional," please visit *http://www.eatright.org*. ❖

Source: CMS PERL 200903-05

[1]Department of Health & Human Services. Centers for Disease Control and Prevention, "2007 National Diabetes Fact Sheet," accessed at *http://apps.nccd.cdc.gov/ddtstrs/FactSheet.aspx*. The United States Renal Data System, "2008 USRDS Annual Data Report (ADR) Atlas," accessed at *http://www.usrds.org/2008/pdf/V1_Precis_2008.pdf*.

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March 12 is World Kidney Day

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of the diabetes-related services that are covered by Medicare.

More than 13.7 million Americans at least 60 years or older are diagnosed with diabetes or chronic kidney disease (CKD)[1]. Detection and proper treatment of kidney disease is crucial to helping Medicare beneficiaries to avoid complications and lead healthier, longer lives.

Medicare covers a range of dialysis-related services to eligible Medicare beneficiaries, including dialysis and transplant services.

Medicare's efforts to improve kidney disease detection

Tens of millions of Americans who have diabetes or high blood pressure are at risk for kidney disease and many do not know it. People with diabetes and high blood pressure, the leading risk factors for the disease, should check their kidney function with:

- an annual urine screening (micro-albumin test)
- a blood pressure check, and
- a blood test to determine eGFR (estimated glomerular filtration rate).

Throughout National Kidney Month, CMS' quality improvement organizations (QIOs) are working in eleven states throughout the country to urge high-risk patients to ask their doctors for this life-saving screening.

QIOs are partnering with primary care physicians, nephrologists, and vascular surgeons to improve care for patients with CKD to prevent or slow the progression of the disease. QIOs work throughout the country with healthcare providers, consumers, and stakeholder groups to refine care delivery systems to make sure all patients, particularly patients from underserved populations, get the right care at the right time.

For more information

- CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for kidney dialysis and transplant-related services.
  - *http://cms.hhs.gov/MLNProducts/downloads/Book_Kidney_Dialysis-Final.pdf*.
  - **Outpatient Maintenance Dialysis End Stage Renal Disease Fact Sheet** – this fact sheet provides information on the composite rate system Medicare uses to pay for outpatient dialysis, including separately billable items and services. This fact sheet is available at *http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymtfctsht508-09.pdf*.
- For information to share with your Medicare patients, visit: *http://www.medicare.gov*.
- For more information about World Kidney Day, please visit the National Kidney Foundation's World Kidney Day Web site at: *http://www.kidney.org/news/wkd/*.

To learn more about how QIOs are working to increase kidney disease screening rates, visit *http://www.qualitynet.org/medqic*. ❖

Source: CMS PERL 200903-15

[1]Department of Health and Human Services. Centers for Disease Control and Prevention, "2007 National Diabetes Fact Sheet," accessed at *http://apps.nccd.cdc.gov/ddtstrs/FactSheet.aspx*. The United States Renal Data System, "2008 USRDS Annual Data Report (ADR) Atlas," accessed at *http://www.usrds.org/2008/pdf/V1_Precis_2008.pdf*.

National Patient Safety Awareness Week

March 8-14, 2009, is national patient safety awareness week. The Centers for Medicare & Medicaid Services (CMS) reminds beneficiaries and health care professionals what patients and their local healthcare providers can do to improve the safety of care. CMS is also working to make health care safer through its quality improvement organization (QIO) program.

What can patients/consumers do to make health care safer?

According to the National Patient Safety Foundation, consumers can help bring patient safety to the forefront of healthcare providers' agendas:

- Ask your hospital or health care professional about patient safety and how communication and partnership between you and your providers can be improved.
- Ask your hospital or health care organization what they are doing for Patient Safety Awareness Week, and attend events to learn more about patient safety.
- Communicate with your provider about your health care safety concerns.
- Let your health care provider know who they should talk with in the case that you are unable to speak for yourself.

Consumers can also work with the Quality Improvement Organization (QIO) in their state to raise concerns about the quality or safety of care they or a loved one have received under the Medicare program. QIOs will work to find the reason why things happened to cause the concern and to determine the likelihood that it will happen again. The purpose of a quality of care review is not to punish the doctor but to help improve care delivery for future patients. In cases where chances are

National patient safety awareness week (continued)

high that the scenario will happen again, the QIO will help health care providers make changes in procedures to prevent future problems.

CMS has published two guides for consumers about working with QIOs about quality/safety of care problems.

- *Quality of Care Concerns: What Can Your Quality Improvement Organization Address? (Publication CMS-11362)*, available at *http://www.medicare.gov/Publications/Pubs/pdf/11362.pdf*.
- *Frequently Asked Questions: What to Do If You Have a Quality of Care Concern (Publication CMS-11348)*, available at *http://www.medicare.gov/Publications/Pubs/pdf/11348.pdf*.

Consumers can learn more about how the QIO works with them in their state by visiting the directory of QIOs at *http://www.medicare.gov/Contacts*.

What is CMS doing to make health care safer?

In addition to working with consumers on quality of care problems, QIOs are working nationwide with select hospitals and nursing homes to improve patient safety by:

- Improving surgical safety/infection rates
- Reducing rates of certain infections in hospitals
- Intensively working with "nursing homes in need"
- Improving care for patients with heart failure
- Preventing pressure ulcers (bed sores) in patients from nursing homes and hospitals
- Eliminating physical restraints in nursing homes
- Combating drug-drug interactions and potentially inappropriate medication errors.

Health care professionals can learn more about how QIOs are making care safer at *http://www.qualitynet.org/medqic*.

CMS Web site contains more information about each of these tasks as well as tools designed to help providers improve quality in each of these areas. Professionals can also contact the Patient Safety QIO Support Center at *psqiosc@okqio.sdps.org*. ❖

Source: CMS PERL 200903-19

March 24 is Diabetes Alert Day

Diabetes is the sixth leading cause of death in the United States. However, early detection and treatment of diabetes may prevent or delay many of the complications associated with the disease.

In conjunction with Diabetes Alert Day, the Centers for Medicare & Medicaid Services (CMS) would like to remind health care professionals that Medicare provides coverage for several diabetes-related services, including:

- diabetes screening tests
- diabetes self-management training
- medical nutrition therapy
- certain other diabetes supplies and services.

CMS offers several educational products related to Medicare-covered preventive services, including diabetes services. Please visit the *Medicare Learning Network* for more information, including the following diabetes-related pages:

- **The *MLN* Preventive Services Educational Products Web Page** – provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- **Diabetes-Related Services Brochure** – this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.

  To order copies of the brochure, go to the MLN Product Ordering System located at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The CMS Web site provides additional information about the medical nutrition therapy benefit at *http://www.cms.hhs.gov/MedicalNutritionTherapy/*.

For more information diabetes, please visit the National Diabetes Education Program Web site at *http://www.ndep.nih.gov/*. This site contains several publications to help you educate your patients about diabetes prevention, including The Road to Health toolkit, which contains resources specifically tailored for community health workers in Hispanic/Latino and African-American communities, who are at a higher risk for type 2 diabetes. ❖

Source: CMS PERL 200903-20

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