MEDICARE A Bulletin

A NEWSLETTER FOR MAC J9 PROVIDERS

# In This Issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS



## Features



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:

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

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***Medicare A Bulletin***

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

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:

- Sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities are included in the first part of the publucation.
- 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

## Initial enrollment assignment for federally qualified health centers, end-stage renal disease facilities, and rural health clinics

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

### Provider types affected

Federally qualified health centers (FQHCs), end-stage renal disease (ESRD) facilities, and rural health clinics (RHCs) that are currently enrolled with a fiscal intermediary (FI) or a Medicare administrative contractor (MAC), and FQHCs, RHCs, and ESRD facilities that are planning to submit a CMS-855 initial enrollment application.

### Provider action needed

#### STOP – impact to you

This article is based on change request (CR) 6207, which describes initial enrollment policy for assignment of FQHCs, ESRD facilities, and RHCs.

#### CAUTION – what you need to know

As FQHCs, ESRD facilities, and RHCs seek to enroll in the Medicare program, they should file their enrollment applications with the legacy FI or MAC that covers the state where they are located. Exceptions to the geographic assignment rule are set forth in MM5979, which may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5979.pdf*.

This represents a shift from legacy-world assignment policy where there existed regional and national FIs for these distinct provider types.

#### GO – what you need to do

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

### Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 911) amended the Social Security Act (the Act; Title XVIII) to add Section 1874A (Contracts with Medicare Administrative Contractors (MACs)) which replaces the prior Medicare intermediary and carrier contracting authorities formerly found in Sections 1816 and 1842 of the Act. CMS procured the first Part A/B MAC in 2006 and continues to award the fifteen A/B MAC contracts. The process of moving workload from legacy contractors to the MACs continues.

The MMA also repealed the provider nomination provision of the Social Security Act and replaced it with the geographic assignment rule. Generally, a provider or supplier will be assigned to the MAC that covers the state where the provider or supplier is located. Exceptions to the geographic assignment rule are described in *MLN Matters* article MM5979, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5979.pdf*.

In the legacy FI environment, FQHCs, RHCs, and ESRD facilities were concentrated within the workloads of several regional and national FIs.

Most of the providers that were assigned to regional or national FIs represent "out-of-jurisdiction providers" (OJPs). An OJP is defined as a provider that is not currently serviced by the FI or MAC that covers the state where the provider is located. Regional and national Medicare contractors for FQHCs, RHCs, and ESRD facilities will not exist in the MAC environment.

#### Federally qualified health centers

Most FQHCs are currently within the workload serviced by National Government Services (NGS) Wisconsin. The jurisdiction 6 MAC will absorb this workload. FQHCs in the NGS workload will be transferred to their destination MACs during the OJP migration. The destination MAC will not always be the geographic MAC.

Indian health service (IHS) facilities will be assigned to the Jurisdiction 4 MAC. For purposes of CR 6207, "tribal FQHC" means a Medicare FQHC operated by a tribe or tribal organization under the Indian Self-Determination Act (25 USCS 40(b)) or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (25 USCS 13). All other freestanding FQHCs, not meeting that tribal description, will be assigned to the MAC that covers the state where the facility is located.

CMS is implementing the geographic assignment rule for initial enrollment FQHCs now to avoid creating additional OJPs. An initial enrollment for an IHS FQHC will be submitted to the Jurisdiction 4 MAC. A new, non-tribal FQHC will submit its initial CMS-855A application to the FI or MAC that covers the state where the facility is located.

Some classes of FQHCs may present latent challenges for the geographic assignment rule. However, CMS will make accommodations for these providers. For example, if an initial enrollment FQHC satellite is located in the jurisdiction of a MAC other than the audit MAC, then the geographic MAC will service the claims, and the audit MAC will service the cost report.

#### Rural health clinics and end-stage renal disease facilities

RHCs and many ESRD facilities have been serviced by a limited set of regional FIs in the legacy environment. Those legacy FI workloads will be absorbed by incoming MACs. Out-of-jurisdiction RHCs and ESRD facilities will be transferred to their destination MACs during the OJP migration. An initial enrollment for a RHC or ESRD facility will be submitted to the MAC or FI that serves the state where the RHC or ESRD facility is located.

***Initial enrollment assignment for FQHCs, ESRD facilities, and rural health clinics (continued)***

**Note:** If the FQHC, RHC or ESRD facility is provider-based, it will be assigned to the FI or MAC that covers the state where the main provider is located.

### Misfiled CMS 855-A Applications

If a FQHC, RHC or ESRD facility submits a CMS-855A initial application to an incorrect Medicare contractor, the receiving contractor will mail the application to the appropriate contractor and notify the provider that its application has been sent to the new contractor and that all future questions regarding the application should be directed to the new contractor.

### Internet-based PECOS

FQHCs, RHCs, and ESRD facilities will not be able to use Internet-based PECOS for the filing of CMS-855A initial applications, changes of ownership, or changes of information. Only paper forms will be accepted for these transactions.

The following is a table that summarizes the changes of CR 6207:

| Facility | New Enrollment Applications |
|---|---|
| FQHC | FI/MAC covering the state where they are located |
| RHC | FI/MAC covering the state where they are located |
| ESRD | FI/MAC covering the state where they are located |
| IHS FQHC | J4 MAC |
| Provider-based FQHC | FI/MAC servicing the main provider |

### Additional information

The official instruction (CR 6207) issued to your Medicare contractor, regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1707CP.pdf*.

A listing of contractor addresses can be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

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

*MLN Matters*® Number: MM6207
Related Change Request (CR) Number: 6207
Related CR Release Date: March 27, 2009
Related CR Transmittal Number: R1707CP
Effective Date: April 27, 2009
Implementation Date: April 27, 2009

Source: CMS Pub. 100-04, Transmittal 1707, CR 6207



## Incorporation of regulatory changes related to provider enrollment

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

### Provider types affected

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

### Provider action needed

All Medicare physicians, providers, and suppliers, as well as those who are considering applying to participate in the program should be aware of the new rule and of upcoming changes to the Medicare enrollment process.

### Background

Change request (CR) 6310 implements regulatory changes found in the calendar year (CY) 2009 Medicare physician fee schedule final rule with comment (CMS-1403-FC). Significant changes are summarized below.

### Effective date of Medicare billing for physicians, certain nonphysician practitioners, and physician and nonphysician practitioner organizations

- Carriers and Part A and Part B MACs will establish the effective date of Medicare billing privileges (see 42 CFR 424.520(d)) for physicians, nonphysician practitioners, and physician or nonphysician practitioner organizations. Physicians, nonphysician practitioners and physician and nonphysician practitioner organizations will no longer be allowed to establish retrospective Medicare effective billing dates.

***Incorporation of regulatory changes related to provider enrollment (continued)***

- Carriers and A/B MACs will establish an effective date of Medicare billing privileges for the following individuals and organizations: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and physician and nonphysician practitioner organizations (e.g., clinics/group practices).
- The effective date of Medicare billing privileges for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location.

  **Note:** The date of filing for Internet-based provider enrollment, chain and ownership system (PECOS) applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement that were both processed to completion.
- The individuals and organizations identified above may, however, retrospectively bill for services when:
  - The supplier has met all program requirements, including state licensure requirements, and
  - The services were provided at the enrolled practice location for up to—
    - **Thirty days prior** to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
    - **Ninety days prior** to their effective date if a presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

### Timeframes for reporting changes of information

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph; the following changes must be reported within 30 days:
  - A change of ownership
  - A final adverse action, or
  - A change in practice location.
- If an individual or organization identified above does not comply with the reporting requirements relating to, respectively, final adverse actions and practice location changes, the supplier may be assessed an overpayment back to the date of the final adverse action or change in practice location.

### Application rejections and denials for physician and certain non-physician practitioner applications

- Carriers and A/B MACs will deny, rather than reject, incomplete applications submitted by physicians, nonphysician practitioners, and physician or nonphysician practitioner organizations.
- This change will allow the individuals and organizations identified above to preserve their effective date of filing by submitting a corrective action plan or an appeal and submitting the missing information/ documentation to allow the carrier or A/B MAC to adjudicate the enrollment application to completion.

### Revocation effective dates

- A revocation based on a: (1) federal exclusion or debarment, (2) felony conviction, (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that the Centers for Medicare & Medicaid Services (CMS) or its contractor determined that the provider or supplier is no longer operational.
- Any physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., clinic/group practices) consisting of the individuals previously identified, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

### Requirements for maintaining ordering and referring documentation

- Carriers or A/B MACs may revoke the billing privileges of any provider or supplier that fails to comply with Medicare's ordering and referring documentation requirements as specified in 42 CFR 424.5216 (f).
- Such revocation is also possible in cases where the physician or nonphysician practitioner fails to maintain written ordering and referring documentation for seven (7) years from the date of service.
- Off-site or electronic storage of the ordering and referring documentation described in 42 CFR Section 424.516(f) is not precluded, as long as these records are readily accessible and retrievable.

### Other changes

- Final adverse action is defined.

## Additional information

The official instruction, CR 6310, issued to your carrier, FI, or A/B MAC regarding this change may be view on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R289PI.pdf*.

***Incorporation of regulatory changes related to provider enrollment (continued)***

If you have any questions, please contact your RHHI, 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: MM6310
Related Change Request (CR) Number: 6310
Related CR Release Date: April 15, 2009
Related CR Transmittal Number: R289PI
Effective Date: January 1, 2009
Implementation Date: April 1, 2009

Source: CMS Pub. 100-08, Transmittal 289, CR 6310



# Internet-based enrollment available in all states and the District of Columbia

## It's fast, secure, and easy to use

Now there is a better way for provider and supplier organizations to enroll in Medicare or make a change to their Medicare enrollment information. The Centers for Medicare & Medicaid Services (CMS) announces the availability of Internet-based provider enrollment, chain and ownership system (PECOS) to provider and supplier organizations. They may use Internet-based PECOS to enroll in Medicare, make a change in their Medicare enrollment information, view their existing Medicare enrollment information, voluntarily withdraw from the Medicare program, or check on the status of an Internet-submitted Medicare enrollment application.

Internet-based PECOS is already available to physicians and nonphysician practitioners in all 50 states and the District of Columbia. CMS expects to make Internet-based PECOS available to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in the future.

### Fast

By submitting an initial Medicare enrollment application through Internet-based PECOS, a provider or supplier organization's enrollment application can be processed as much as 50 percent faster than by paper. This means that it will take less time to enroll or make a change in an existing enrollment record.

For information about the types of changes that enrolled Medicare provider and supplier organizations must report, go to the *Downloads* section of the Medicare provider/supplier enrollment page at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

### Secure

Internet-based PECOS meets all required government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only individuals whose identities have been verified by CMS and who have been approved by a provider or supplier organization's authorized official may use Internet-based PECOS on behalf of that provider or supplier organization. The PECOS user IDs and passwords that these individuals establish will protect the access to the given provider or supplier organization's Medicare enrollment information. PECOS users should change their passwords frequently (at least once a year). By safeguarding their user IDs and passwords, PECOS users will be taking an important step in protecting the provider or supplier organization's Medicare enrollment information. CMS does not disclose Medicare provider or supplier enrollment information to anyone except when authorized or required to do so by law.

### Easy to use

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process ensures that provider and supplier organizations complete and submit only the information necessary to facilitate the action they wish to take. The CMS external user services (EUS) help desk (1-866-484-8049) is available and staffed to respond to questions about using Internet-based PECOS, such as navigating through the screens, and to receive reports of systems problems as noted by users.

### Obtaining approval to use Internet-based PECOS for a provider or supplier organization

There are several steps that must be completed before a provider or supplier organization can use Internet-based PECOS. These steps are described in detail in the document entitled, "Getting Started with Internet-based Provider Enrollment, Chain and Ownership System (PECOS) – Information for Provider and Supplier Organizations," which will soon be available in the *Downloads* section on the Medicare provider/supplier enrollment page at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Below is an overview of the process.

1. The first step is taken by the authorized official (AO) of the provider or supplier organization. This is done only one time. He or she will register in the Internet-based PECOS identification and authentication system (PECOS I&A) by going to *https://pecos.cms.hhs.gov*.

   CMS will verify the information provided and the CMS EUS help desk will notify the AO of the verification.

***Internet-based enrollment available in all states and the District of Columbia (continued)***

2. An individual who will use Internet-based PECOS to submit enrollment applications for the provider or supplier organization will also register in PECOS I&A. This individual may be an employee of the provider or supplier organization, or an employee of a separate organization. CMS will verify the information provided and the permission of the AO for that individual to use Internet-based PECOS on behalf of the provider or supplier organization. The individual will complete the security consent form and have it signed by an official of his or her employer and by the AO of the provider or supplier organization. The individual will mail the signed and dated security consent form to the CMS EUS help desk. The AO will need to periodically log onto Internet-based PECOS to see if there is a pending request for permission to access Internet-based PECOS on behalf of the provider or supplier organization. More than one person may be approved to use Internet-based PECOS on behalf of a given provider or supplier organization, but the security consent form is completed only one time.
3. Once the registration and verification processes are completed, the CMS EUS help desk will notify the AO of the establishment of the relationship between the provider or supplier organization and the organization that will be using Internet-based PECOS on its behalf.

It may take several weeks for the registration and verification processes to be completed. Therefore, we encourage the AO of a provider or supplier organization to begin the registration process now; before the provider or supplier organization has the need to use Internet-based PECOS to submit a Medicare enrollment application or enrollment update.

If a provider or supplier organization has an immediate need to submit a Medicare enrollment application to enroll or to report a change in enrollment information and the steps above have not been successfully completed, the provider or supplier organization should complete and submit the paper version of the Medicare enrollment application (CMS-855).

### Submitting an enrollment application using Internet-based PECOS

After the steps above are successfully completed, the individual who will be using Internet-based PECOS is considered a PECOS user. If a PECOS user has not already done so, he or she should visit the Medicare provider enrollment Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* to download and read the documents relating to Internet-based PECOS. CMS advises PECOS users to review this information before logging onto Internet-based PECOS.

After reading the informational documents referenced above, a PECOS user will log onto Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*. He or she will complete, review, and submit the Medicare enrollment application over the Internet to the designated Medicare contractor. Internet-based PECOS will guide the user through each of these processes.

Internet-based PECOS enables the user to print a copy of the enrollment application, if desired. We recommend this be done so the provider or supplier organization has a copy for its records.

As part of the enrollment application submittal process, the AO of the provider or supplier organization must sign and date the two-page certification statement that the user will print from Internet-based PECOS. The user must mail the signed and dated certification statement, along with any required supporting paper documentation, to the designated Medicare contractor. The Medicare contractor will not begin processing the application that was submitted over the Internet until it has received the signed and dated certification statement.

### Limitations of Internet-based PECOS

At this time, Internet-based PECOS is unable to handle changes of ownership applications from provider and supplier organizations. Therefore, changes of ownership must be submitted using the paper Medicare enrollment application (CMS-855) process. Internet-based PECOS will be able to accommodate changes of ownership at a future date.

### Additional information

Several documents about Internet-based PECOS for provider and supplier organizations will soon be available in the *Downloads* section of the Medicare provider/supplier enrollment Web page at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*. ❖

Source: CMS PERL 200904-01

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

## Healthcare common procedure coding system update

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

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

Source: CMS PERL 200904-06

# Billing routine costs of clinical trials

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

## Provider types affected

Physicians and nonphysician practitioners submitting claims to Medicare administrative contractors (MACs) and carriers for clinical trials.

## Provider action needed

This article is based on change request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. **It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.**

## Background

CR 6431 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 69.6 (Requirements for Billing Routine Costs of Clinical Trails). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the **modifier QV or Q1** is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor **will not** consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed 90 days after issuance of CR 6431 with dates of service on or after January 1, 2008, claims submitted with either the **modifier QV or the modifier Q1** will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.
- Providers will see the following messages from their Medicare contractor with the returned claim:

  **Claim adjustment reason code 16** – Claim/service lacks information which is needed for adjudication, and

  As least **one remark code,** which may be comprised of either:

  - The remittance advice code (M76, Missing/ incomplete/invalid diagnosis or condition) or
  - National council for prescription drug programs reject reason code.

**Note:** Healthcare Common Procedure Coding System (HCPCS) codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30
- Report a secondary diagnosis code of V70.7, and
- Identify all lines that contain an investigational item/ service with a HCPCS modifier of:
  - **QA/QR** for dates of service before January 1, 2008, or
  - **Q0** for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
  - **QV** for dates of service before January 1, 2008, or
  - **Q1** for dates of service on or after January 1, 2008.

## Additional information

The official instruction (CR 6431) issued to your Medicare MAC, or carrier is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1721CP.pdf*.

If you have questions, please contact your Medicare MAC and/or carrier 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: MM6431
Related Change Request (CR) Number: 6431
Related CR Release Date: April 29, 2009
Related CR Transmittal Number: R1721CP
Effective Date: For claims with dates of service on or after January 1, 2008
Implementation Date: July 10, 2009

Source: CMS Pub. 100-04, Transmittal 1721, CR 6431,

## Medicare announces funding for state health insurance counseling programs for 2009

### Funding designed to help people with Medicare

Nearly $36 million in funding is being distributed to the 54 state health insurance assistance programs (SHIPs) to help people with Medicare get more information about their health care choices.

The $35.8 million in funding is the first installment of federal grant funds provided to SHIPs by the Centers for Medicare & Medicaid Services (CMS) for the grant year beginning April 1, 2009, and ending March 31, 2010.

An additional $1.5 million in performance-based funding will be awarded in September 2009. SHIPs are state-based programs that use community-based networks to provide Medicare beneficiaries with local, personalized assistance on a wide variety of Medicare and health insurance topics.

"State health insurance assistance programs serve an important role in providing information and support to people with Medicare where they live," said CMS acting administrator Charlene Frizzera. "These funds help ensure SHIPs continue their work with state and local governments, community-based organizations and others to meet the needs, beyond health care, of our Medicare beneficiaries."

CMS expects the SHIPs to use the 2009 funding to conduct targeted community-based outreach to people with Medicare who may be unable to access other sources of information. SHIPs will also provide outreach and assistance to current and newly eligible Medicare beneficiaries and their caregivers, with a special emphasis on reaching people who will most likely be eligible for Medicare's low-income subsidy if they enroll in Medicare prescription drug coverage.

CMS will continue to support the quality of services provided by SHIPs through training, technical assistance, the SHIP resource center, and the online tools at *http://www.medicare.gov* to help people with Medicare. ❖

Source: CMS PERL 200904-11

## Registration now open for national conference call regarding ICD-10-CM/PCS

Providers may now register for the Centers for Medicare & Medicaid Services ICD-10-CM/PCS implementation and general equivalence mappings (crosswalks) national provider conference call that will be conducted on May 19, 2009, from 1:00 p.m.-2:30 p.m. ET. This conference call will include a discussion of the following topics:

- An overview of the ICD-10 final rule, which requires the implementation of ICD-10-CM/PCS **on October 1, 2013.**
- The differences between ICD-9-CM and ICD-10-CM/PCS codes
- The use of the general equivalence mappings that have been created to assist in converting policies, edits, and trend data from ICD-9-CM to ICD-10-CM/PCS.
- Available resources to assist in planning with transitioning from ICD-9-CM to ICD-10-CM/PCS.

Conference call discussion materials and registration information may be accessed at *http://www.cms.hhs.gov/ICD10/07a_2009_CMS_Sponsored_Calls.asp*. ❖

Source: CMS PERL 200904-17, and PERL 200904-21

## Tools conversion for the international classification of diseases codes

*The General Equivalence Mappings – ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet* (March 2009) that provides information and resources regarding the general equivalence mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, Tenth Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* (*MLN*) at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10_GEM_factsheet.pdf*.

The general equivalence mappings information discussed in this fact sheet has also been posted in the CMS frequently asked questions database at *https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=l2s5Zouj*.

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

Source: CMS PERL 200904-08

## ICD-10-CM/PCS conference call transcripts

The audio transcripts of the following International Classification of Diseases, Tenth Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/PCS) conference calls, sponsored by the Centers for Medicare & Medicaid Services in 2008, are now available and may be accessed in the *Downloads* section of the 2008 CMS Sponsored Calls Web page, located at *http://www.cms.hhs.gov/ICD10/07_Sponsored_Calls.asp*.

- Hospital staff (October 14)
- Other Part A and Part B providers (November 12)
- Physicians (November 17). ❖

Source: CMS PERL 200903-36

## Hospice Cap Calculations Letters and Administrative Appeals

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

### Provider Types Affected

Hospice providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on change request (CR) 6400 which requires Medicare contractors to send each of their providers a letter which serves as a determination of program reimbursement, regardless of whether or not they have exceeded a cap. The letter you receive will include the inpatient and aggregate cap calculation results. Additionally, it will include appeals language in every determination of program reimbursement letter. If you have exceeded the cap, the letter will include a demand for repayment.

### Background

The law governing payment for hospice care subjects hospice payments to two statutory caps:

- A cap on payments for inpatient days, described in Section 1861(dd)(2)(A)(iii) of the Social Security Act.
- An aggregate cap on total payments, described in Section 1814(i)(2)(A)-(C).

These statutory caps limit total hospice payments during a cap year. Payments in excess of either cap must be refunded. Currently, after the end of the cap year, the applicable contractor (RHHI, FI, or A/B MAC) computes both cap amounts, and determines the amount of program reimbursement for each hospice provider they serve.

### Important information

The latest hospice cap amount for the cap year ending October 31, 2008 is $22,386.15. The hospice cap is discussed further in the *Medicare Claims Processing Manual* (Chapter 11 – Processing Hospice Claims, Section 80.2) which is available on the Centers for Medicare & Medicaid Services Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf*.

Your contractor (RHHI, FI, or AB MAC) will issue a letter to notify you of the results of the contractor's cap calculations and to serve as your determination of program reimbursement. If there is a cap overpayment, there will be an accompanying demand for repayment.

### Administrative appeals

As indicated in Section 418.311 of 42 CFR, if you believe that your payments have not been properly determined, you may request a review from the applicable contractor if the amount in controversy is $1,000 or more, but less than $10,000, or from the Provider Reimbursement Review Board (PRRB) if the amount in controversy is $10,000 or more. Appeal requests must be in writing and be filed within 180 days from the date of the determination. Your appeal rights are discussed further in the *Medicare Claims Processing Manual* (Chapter 11 – Processing Hospice Claims, Section 80.3), which is attached to CR 6400.

### Additional Information

The official instruction, CR 6400, issued to your RHHI, FI, or A/B MAC regarding this change may be view on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1708CP.pdf*.

If you have any questions, please contact your RHHI, 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: MM6400
Related Change Request (CR) Number: 6400
Related CR Release Date: April 3, 2009
Related CR Transmittal Number: R1708CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1708, CR 6400,

# CMS proposes Medicare hospice fiscal year 2010 wage index 2008

**Proposal includes physician narrative for certification of illness**

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule to update the Medicare hospice wage index for fiscal year (FY) 2010.

Payments to Medicare participating hospices are estimated to decrease by approximately 1.1 percent in FY 2010. The decrease in the hospice payments is the net result of a 3.2 percent reduction in payments due to the phase-out of a temporary adjustment used in calculating the wage index, partially offset by an estimated 2.1 percent increase in the hospital market basket indicator of costs.

The elimination of this adjustment with a two-year phase-out would result in more accurate payments and saves Medicare $2.9 billion over five years. The phase-out would include a 75 percent reduction for FY 2010 and ultimately eliminate it in FY 2011. As such, hospice expenditures are estimated to be about $13 billion in 2010 for more than 3,000 for-profit and not-for-profit hospices across the country.

The Medicare Payment Advisory Commission (MedPAC) reports that through 2015, hospice expenditures are projected to grow at a rate that outpaces those projected for hospitals, skilled nursing facilities, physician services or home health care.

In the Medicare hospice-wage index FY 2009 final rule, CMS laid out a plan to phase-out the budget neutrality adjustment factor (BNAF) over a three year period, with the first BNAF reduction of 25 percent in the fiscal year 2009 wage index. With the passage of the American Recovery and Reinvestment Act, Congress suspended the BNAF reduction set for 2009. However, the legislation did not affect FYs 2010 and 2011. CMS plans to reduce the BNAF by 75 percent in FY 2010 and ultimately eliminate it in FY 2011.

The BNAF was implemented in 1997 as part of an effort to change from an outdated wage index to a more current and accurate method for determining hospice payments. In order to minimize disruption to services this special adjustment was applied.

This proposed regulation would bring the Medicare hospice wage index more in line with that used for home health agencies, while maintaining the fiscal integrity of Medicare and allowing continued access to services for its beneficiaries. Both hospices and home health agencies are home-based benefits, which compete in the same labor markets.

The rule also proposes to adopt a MedPAC recommendation that would increase accountability in the physician hospice certification and recertification process. MedPAC found an increasing proportion of hospice patients with stays exceeding 180 days and significant variation in hospice length of stay. Therefore, CMS is proposing that hospice physicians who certify or recertify a beneficiary as terminally ill write a short narrative on the certification form. The narrative would briefly describe the clinical evidence supporting a life expectancy of six months or less.

## Background

The Medicare hospice benefit is intended to assist terminally ill patients, with a prognosis of six months or less if the disease runs its normal course, to remain in their homes. The focus of care shifts from curative to palliative care for relief of pain and symptom management. The law requires that hospice physicians certify that the patient is terminally ill, with a life expectancy of six months or less, and periodically recertify that the patient continues to be terminally ill.

Payment is made to a hospice for each day that an individual elects the benefit. Payment rates are adjusted to reflect local differences in area wage levels using a hospice-specific wage index, which is based on hospital wage data. Overall aggregate payments to a hospice are subject to a statutorily prescribed aggregate cap amount.

The number of Medicare-certified hospices has increased significantly since 1997, up by over 70 percent. The number of Medicare beneficiaries in hospice care has also grown rapidly from just over 400,000 in 1998 to close to one million in 2007.

## Proposed Rule Details

This proposed rule also solicits comments on a number of potential policy changes for the future. In order to increase accountability in the recertification process, the rule seeks comment on requiring a physician or nurse practitioner to visit every hospice patient after 180 days on the benefit, and every benefit period thereafter.

This proposed rule also solicits comments on broader payment reform, such as alternate methods to calculate the hospice aggregate cap.

This proposed rule will be published at the *Federal Register* on April 24, 2009. Comments are due 60 days after publication by June 22, 2009. A link to the proposed rule is available at *http://www.federalregister.gov/OFRUpload/OFRData/2009-09417_PI.pdf*. ❖

Source: CMS PERL 200904-25

# New common working file Medicare secondary payer type for workers' compensation Medicare set-aside arrangements to stop conditional payments

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

**Note:** CMS has revised *MLN Matters* article MM5371 to reflect a revised transmittal related to change request (CR) 5371. The CR was changed to clarify some of the business requirements. The CR release date, transmittal numbers, and the Web address for accessing the transmittal were changed. All other information remains the same. The *MLN Matters* article MM5371 was published in the January 2009 *Medicare A Bulletin* (page 114).

## Provider types affected

Physician, providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services related to workers' compensation liability claims

## What you need to know

In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), CR 5371, from which this article is taken, provides your Medicare contractors with instructions on the creation of a new Medicare secondary payer (MSP) code in Medicare's claim processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) will have the capability to discontinue conditional payments for diagnosis codes related to such settlements.

## Background

A workers' compensation Medicare set-aside arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare. CMS has a review process for proposed WCMSA amounts and updates its common working file (CWF) system in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit the CMS Web site at *http://www.cms.hhs.gov/WorkersCompAgencyServices*.

CMS has determined that establishing a new MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist Medicare contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

When denying a claim because of these edits, your Medicare contractor will notify the beneficiary using Medicare summary notice (MSN) message 29.33 – *Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury (ies).*

In addition, Medicare will use reason code 201, group code PR, and remark code MA01, on outbound claims and/or remittance advice transactions when Medicare denies claims based on the WCMSA presence. Also, on 271 inquiry reply transactions, Medicare will reflect the WCMSA on the 271 response with "EB" followed by the qualifier WC.

## Additional information

You may find the official instruction, CR 5371, issued to your Medicare contractor on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1703CP.pdf*, and *http://www.cms.hhs.gov/Transmittals/downloads/R65MSP.pdf*.

Finally, if you have any 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: MM5371 – Revised
Related Change Request (CR) #: 5371
Related CR Release Date: March 20, 2009
Related CR Transmittal #: R1703CP, R65MSP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1703, CR 5371

## CMS statement on the DMEPOS competitive bidding program

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the competitive bidding program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), including a requirement that the Secretary of Health & Human Services conduct a second competition to select suppliers for round 1 in 2009. The Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period (IFC) on January 16, 2009. The rule incorporates into existing regulations specific statutory requirements contained in MIPPA related to the competitive bidding program.

The Administration delayed the effective date for the IFC to allow CMS officials the opportunity for further review of the issues of law and policy raised by the rule. Based upon its review and on the need to ensure that CMS is able to meet the statutory deadlines contained in MIPPA, the Administration has concluded that the effective date should not be further delayed. The rule became effective April 18, 2009. However, there will be no immediate effect on the Medicare DMEPOS benefit, and Medicare beneficiaries may continue to use their current DMEPOS suppliers at this time.

During the comment period, CMS received many suggestions from a range of stakeholders, to make further improvements to the competitive bidding program, such as ensuring that CMS's processes for collecting and evaluating bids are fair and transparent. In the upcoming weeks, CMS will be issuing further guidance on the timeline for and bidding requirements related to the round one re-bid. In finalizing these guidelines, CMS will continue to seek input from all affected stakeholders to ensure program implementation consistent with the legislative requirements. ❖

Source: CMS PERL 200904-26

## 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 to complete, 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/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 200904-05, PERL 200904-23, PERL 200904-29

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# GENERAL COVERAGE

## Surgery for diabetes national coverage determination

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

### Provider Types Affected

All hospitals and physicians who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (MACs) for bariatric surgery procedures.

### Provider Action Needed

Providers are advised that the Centers for Medicare & Medicaid Services (CMS) has developed the following national coverage determination (NCD) entitled Surgery for Diabetes:

- Effective for services performed on and after February 12, 2009, CMS determines that open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS) in Medicare beneficiaries who have type 2 diabetes mellitus (T2DM) and a body mass index (BMI) <35 are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act, and therefore are not covered by Medicare.
- Effective for services performed on and after February 12, 2009, CMS determines that open and laparoscopic RYGBP, open and laparoscopic BPD/DS, and LAGB are covered for Medicare beneficiaries who have T2DM and a BMI ≥ 35. Additionally, CMS determines that T2DM is a comorbidity related to obesity as defined in Publication 100-03, *National Coverage Determinations (NCD) Manual,* Section 100.1. In addition, the procedure must be performed at an approved facility. A list of approved facilities may be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage*.

Ensure that your billing staffs are informed of these changes for preparing claims for covered or noncovered bariatric surgery.

### Background

CMS has a specific NCD at Section 100.1 (attached to CR 6419), Bariatric Surgery for Treatment of Morbid Obesity, effective February 21. 2006. That NCD covers open and laparoscopic RYGBP, open and laparoscopic BPD/DS, and LAGB for persons with a BMI ≥35 having one or more comorbidities associated with obesity, and have been previously unsuccessful with medical treatments for obesity. The only change to this NCD is the clarification that effective February 12, 2009, T2DM is considered a comorbidity for purposes of bariatric surgery for the treatment of morbid obesity.

**Note:** This NCD does not change related NCDs in the *National Coverage Determinations (NCD) Manual,* at Sections 40.5 (Obesity), 100.8 (Intestinal Bypass Surgery), or 100.11 (Gastric Balloon for Treatment of Obesity). In addition, treatments for obesity alone remain noncovered, as does use of the open or laparoscopic sleeve gastrectomy, open adjustable gastric banding, and open and laparoscopic vertical banded gastroplasty procedures, regardless of the patient's BMI or comorbidity status.

The covered ICD-9-CM procedure and HCPCS procedure codes are listed in Attachment 1 of the transmittal of CR 6419 containing the *Medicare Claims Processing Manual* revisions. The ICD-9-CM diagnosis codes reflecting the requisite BMI indexes are also part of that attachment. The ICD-9-CM diagnosis codes indicating T2DM are listed in Attachment 2 of that same transmittal.

The remittance advice for claims for bariatric surgery that are denied or rejected by Medicare because the patient's BMI was <35 will contain a claim adjustment reason code of 167 (This (these) diagnosis(es) is (are) not covered.), a remittance advice remark code of N372 (Only reasonable and necessary maintenance/service charges are covered.), and a group code of OA (Other adjustments).

### Additional Information

The official instruction, CR 6419, issued to your carrier, FI, or MAC via two transmittals. The first modifies the *Medicare Claims Processing Manual* and it is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1728CP.pdf*.

The second transmittal modifies the *National Coverage Determinations (NCD) Manual,* and it is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R100NCD.pdf*.

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

*MLN Matters*® Number: MM6419
Related Change Request (CR) Number: 6419
Related CR Release Date: May 4, 2009
Related CR Transmittal Number: R100 NCD and R1728CP
Effective Date: February 12, 2009
Implementation Date: May 18 2009

Source: CMS Pub. 100-04, Transmittal 1728, CR 6419

## Medicare expands coverage of PET scans as cancer diagnostic tool

The Centers for Medicare & Medicaid Services' (CMS) coverage with evidence development (CED) project shows positron emission tomography (PET) scans as "reasonable and necessary" for initial treatment decisions of most solid tumor cancers.

CMS issued a final national coverage determination (NCD) to expand coverage for initial testing with PET scans for Medicare beneficiaries who are diagnosed with and treated for most solid tumor cancers.

This NCD removes a clinical study requirement for PET scan use in these patients.

Since 2005, Medicare coverage of PET scans for diagnosing some forms of cancer and guiding treatment has been tied to a requirement that providers collect clinical information about how the scans have affected doctors' treatment decisions. This information was gathered through the national oncologic PET registry (NOPR) observational study. Today's decision removes the requirement to report data to the NOPR when the PET scan is used to support initial treatment (or diagnosis and "staging") of most solid tumor cancers.

Medicare collects data from the NOPR under CMS' CED program. CED allows Medicare to develop evidence about how a medical technology is used in clinical practice so that Medicare may do the following:

- Clarify the impact of these items and services on the health of Medicare beneficiaries.
- Consider future changes in coverage for the technology.
- Generate clinical information that will improve the evidence base upon which providers base their recommendations to Medicare beneficiaries regarding the technology.

This decision is based, in part, on the information generated as a result of CMS' 2005 decision to require NOPR reporting for many cancer PET scans. As a result of this evidence from NOPR, CMS reconsidered its 2005 coverage policy.

This decision is the first time that CMS has reconsidered a coverage policy based on new evidence developed under the CED program.

"This expansion in coverage for PET scans shows that the Coverage with Evidence Development program is a success," said CMS Acting Administrator Charlene Frizzera. CED allowed us to cover an emerging technology, learn more about its usage in clinical practice, and adjust our coverage policies accordingly. Thanks to CED, Medicare beneficiaries have greater access to cutting edge medical technologies and treatments."

This decision applies to PET scans used to support initial diagnosis and treatment for most types of solid tumor cancers. It also expands coverage of PET scans for subsequent follow up testing in beneficiaries who have cervical or ovarian cancer, or who are being treated for myeloma, a cancer that affects white blood cells. For these cancers, NOPR data collection will no longer be required.

It is important to note that today's decision still requires clinicians to report data to the NOPR when using PET scans to monitor the progress of treatment or remission of cancer in some cases. Although the evidence generated by the NOPR study helped CMS determine that PET scans are useful in helping guide treatment when cancer is first diagnosed, scientific evidence is not as strong in showing that PET scans are as useful in making subsequent treatment decisions for some types of cancer.

A minimally invasive diagnostic imaging procedure, PET uses a radioactive tracer to evaluate glucose metabolism in tumors and in normal tissue. The test may provide important clinical information to guide the initial treatment approach (e.g., diagnosis and "staging") for many cancers.

This additional information may help physicians to distinguish benign from cancerous lesions and better determine the extent of a tumor's growth or metastasis. PET scans have also been used in subsequent testing for cancer patients, e.g., to monitor cancer progression or remission after cancer treatment has begun.

More information about the types of cancer covered by this new policy is available in CMS' final decision memorandum. Read the final decision on the CMS Web site at *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=218*. ❖

Source: CMS PERL 200904-12

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# 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

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

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### 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.**

# NEW LCD IMPLEMENTATION

## A75722 Renal angiography – new LCD

**LCD ID Number: L29893 (Florida)**
**LCD ID Number: L29895 (Puerto Rico/U.S. Virgin Islands)**

Diagnostic arteriography is an invasive method of evaluating vascular disease. It involves percutaneous passage of a needle and/or catheter into an artery under fluoroscopic guidance, followed by injection of contrast material and imaging of the vascular distribution in question using serial film or digital imaging systems, under conscious sedation.

With modern noninvasive imaging techniques (e.g., duplex ultrasonography, gadolinium enhanced magnetic resonance angiography (MRA), computed tomographic angiography [CTA]), the need for renal arteriography has been significantly reduced. Currently, renal arteriography is mainly used in conjunction with lesions that can potentially be treated or to analyze renal vasculature preoperatively.

Recent data analysis demonstrated the need for the development of a local coverage determination (LCD) to outline indications and limitations of coverage for the following *CPT*/HCPCS codes:

*75722* *Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation*

75724 *Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation*

G0275 Renal angiography, nonselective, one or both kidneys, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of any catheter in the abdominal aorta or near the origins (ostia) of the renal arteries, injection of dye, flush aortogram, production of permanent imaging, and radiologic supervision and interpretation (list separately in addition to primary procedure)

This new LCD outlines the indications and limitations of coverage, documentation requirements and utilization guidelines and contains a coding guideline attachment for the above listed procedure codes. In addition, the ICD-9-CM codes that support medical necessity are listed out accordingly.

For *CPT* codes *75722* and *75724* the following ICD-9-CM codes are medically necessary:

| | | | | |
|---|---|---|---|---|
| 189.0 | 189.1 | 198.0 | 223.0 | 223.1 |
| 233.9 | 401.0 | 405.01 | 405.11 | 405.91 |
| 440.1 | 441.00 | 441.01 | 441.02 | 441.03 |
| 441.1 | 441.2 | 441.3 | 441.4 | 441.5 |
| 441.6 | 441.7 | 441.9 | 442.1 | 442.2 |
| 442.83 | 442.84 | 443.22 | 443.23 | 444.0 |
| 444.81 | 445.02 | 445.81 | 447.3 | 447.6 |
| 557.0 | 557.1 | 557.9 | 593.81 | 593.9 |
| 599.70 | 747.62 | 794.4 | 902.40 | 959.12 |
| 959.8 | 996.1 | V42.0 | V58.44. | |

For HCPCS code G0275 the following ICD-9-CM codes are medically reasonable and necessary:

| | | | |
|---|---|---|---|
| 401.0 | 402.00 | 402.01 | 403.00 |
| 403.01 | 404.00-404.03 | 404.10-404.13 | 405.01 |
| 405.11 | 440.1 | 442.1 | 445.81 |
| 447.3. | | | |

### Effective date

This newLCD is effective for services provided **on or after June 30, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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



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## A93015 Cardiovascular stress testing – new LCD

**LCD ID Number: L29901 (Florida)**
**LCD ID Number: L29903 (Puerto Rico/U.S. Virgin Islands)**

Cardiovascular stress testing or exercise stress test (EST) consists of the continuous monitoring of an electrocardiogram (generally a 12-lead system) with frequent 3-lead or 12-lead recordings taken according to clinical circumstances, frequent blood pressure determinations and continuous patient observation before, during and after exercise of progressively increasing intensity (usually with a treadmill or cycle ergometer) to any of a number of test end points.

First Coast Service Options Inc. (FCSO) Medicare will consider a cardiovascular stress test medically reasonable and necessary for the following conditions:

- To evaluate the prognosis and functional capacity of patients with Coronary Artery Disease (CAD) soon after a myocardial infarction (before discharge or early after discharge and again 6-8 weeks after uncomplicated MI).
- To assess for the presence or absence of coronary disease, appropriate heart rate and/or blood pressure response for cardiac transplant patients. For optimal management of these patients, annual testing is recommended.
- Evaluation of patients before and after coronary artery revascularization by the following methods:
  - Coronary Artery Bypass Grafting (CABGs). Testing is recommended in patients with suspected incomplete revascularization, technical difficulties during or after the operation, initial difficulties in being disconnected from the extra corporeal support system, enzymatic or electrocardiographic evidence of intraoperative MI, or other evidence of perioperative complications.
  - Percutaneous Coronary Intervention (PCI). Testing is performed prior to discharge (1-3 days after procedure) and again at 3 to 6 months (helps identify the 20-30 percent of patients who restenose in the first six months after the procedure).
- To evaluate functional capacity serially in the course of an exercise cardiac rehabilitation program (prior to starting rehab and at 12 weeks).
- Initial evaluation of patients with symptoms consistent with recurrent, exercise-induced cardiac arrthymias (e.g., shortness of breath (SOB) on exertion, syncope, palpitations, etc.).
- Initial evaluation of exercise capacity of selected patients with valvular heart disease with related symptomatology.
- Initial diagnostic workup for a patient that presents with abnormal signs and symptoms such as chest pain, palpitations, dyspnea, etc., which may suggest a cardiac origin. (Including those with RBBB or less than 1 mm ST depression, with an intermediate pre-test probability of CAD).
- Initial evaluation of patients with new onset of arrhythmias.
- Initial evaluation of a patient with an old Myocardial Infarction in which a workup has not been previously performed.
- Evaluation of a patient presenting with recent changes in an ECG.
- Evaluation of a patient with known CAD that presents with new symptoms such as increasing SOB, palpitations, change in EKG, etc.
- Evaluate patient's response to a newly established therapy for angina, palpitations, arrhythmias, SOB or any other cardiopulmonary disease process.
- Evaluation of other symptomatology which may indicate a cardiac origin especially in those patients who have a history of a MI, CABG surgery or PCI or patients who are being treated medically after a positive stress test or cardiac catheterization.
- This local coverage determination (LCD) was developed to outline the "Indications and Limitations of Coverage and/or Medical Necessity", "ICD-9 codes that Support Medical Necessity", "Documentation Requirements", "Utilization Guidelines", and "Sources of Information" sections of the LCD.

### Effective date

This new LCD is effective for services provided **on or after June 30, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## A95805 Polysomnography and sleep testing – new LCD

**LCD ID Number: L29905 (Florida)**
**LCD ID Number: L29907 (Puerto Rico/U.S. Virgin Islands)**

Sleep studies and polysomnography (PSG) refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation and report. Normally, sleep studies and PSG for sleep disorders are performed in sleep centers or laboratories. However, the diagnosis of obstructive sleep apnea (OSA) for coverage of continuous positive airway pressure (CPAP) may also be established by home sleep testing (HST).

Effective for claims with dates of service on and after March 13, 2008, the Centers for Medicare & Medicaid Services (CMS) determined that CPAP therapy, when used in adult patients with OSA, is considered reasonable and necessary under specified criteria which are listed in the *Medicare National Coverage Determinations (NCD) Manual*, Pub 100-03, Chapter 1, Section 270.4. Medicare will allow for coverage of CPAP therapy based upon a diagnosis of OSA by unattended HST.

Based on the above CMS decision and criteria for specified medical conditions outlined by CMS for sleep disorder clinics, this local coverage determination (LCD) is being developed to include polysomnography and sleep testing *CPT* codes as well as the 2009 HCPCS codes (G0398, G0399, and G0400) for HST devices.

Indications and limitations of coverage criteria for specific medical conditions performed in sleep disorder clinics are included, as well as indications and limitations of coverage for unattended HST for OSA with the types of allowed devices defined. In addition, ICD-9-CM codes, documentation/credentialing requirements, utilization guidelines, and coding guidelines were included.

### Effective date

This new LCD is effective for services provided **on or after June 30, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## AA0425 Non-emergency ground ambulance services – new LCD

**LCD ID Number: L29916 (Florida)**
**LCD ID Number: L29920 (Puerto Rico/U.S. Virgin Islands)**

A new LCD that addresses non-emergency ground ambulance services has been developed. The LCD clarifies indications and limitations according to Medicare national guidelines. The "ICD-9 Codes that Support Medical Necessity" section of the LCD includes the following ICD-9-CM codes:

- V49.84 (Bed confinement status)
- V49.89 (Other specified conditions influencing health status)

In addition, coding guidelines were developed to provide information regarding crew, vehicle, destination, and physician certification statement (PCS) requirements.

### Effective date

This new LCD is effective for services provided **on or after June 30, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## Intravitreal bevacizumab (Avastin®) – new LCD

**LCD ID Number: L29933 (Florida)**
**LCD ID Number: L29935 (Puerto Rico/U.S. Virgin Islands)**

Prior to the development of this new local coverage determination (LCD), First Coast Service Options Inc. (FCSO) gave consideration for intravitreal bevacizumab (Avastin®) on an individual case-by-case basis for the treatment of age-related macular degeneration (AMD). This information was published in an article (article ID number A41456), updated on August 1, 2008. After numerous requests for FCSO to provide the coverage requirements for intravitreal bevacizumab (Avastin®), FCSO has developed this new LCD.

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).

***Intravitreal bevacizumab (Avastin®) – new LCD (continued)***

Based on published reports and widespread clinical use, there is compelling evidence of bevacizumab's safety and efficacy for CNV in AMD and also in proliferative diabetic retinopathy, neovascular glaucoma, macular edema, retinal and iris neovascularizations and branch and central retinal vein occlusions, due to common VEGF-induced pathogenic pathways. The ophthalmology community is increasingly using intravitreal bevacizumab in the treatment of these conditions that have not responded to other accepted therapies.

FCSO Medicare will consider bevacizumab (Avastin®) given by intravitreal injection medically reasonable and necessary for patients who are deemed by their treating ophthalmologist to have failed U.S. Food & Drug Administration (FDA) approved therapies, or in the judgment of the treating ophthalmologist, based on his/her experience, are likely to have a therapeutic response from the use of intravitreal bevacizumab which is comparable to results from other approved treatments for conditions outlined in this LCD.

The LCD outlines indications and limitations of coverage and/or medical necessity, documentation requirements and coding guidelines for the off-label use of intravitreal bevacizumab (Avastin®). HCPCS code J3490, unclassified drug, should be billed for intravitreal bevacizumab, along with *CPT* code *67028, intravitreal injection of a pharmacologic agent*. In addition, the following ICD-9-CM codes are considered medically reasonable and necessary for the off-label uses described in this LCD: 362.02, 362.07, 362.16, 362.35, 362.36, 362.52, 362.53, 362.83, 364.42 and 365.63.

Bevacizumab (Avastin®; Genentech) is FDA approved for treatment of select cancers as a systemic drug. However, this LCD only addresses the use of bevacizumab for ophthalmic off-label indications (not approved by the FDA). HCPCS codes J9035, injection, bevacizumab, 10 mg does not apply to the intravitreal administration since the agent has been processed by compounding pharmacies.

### Effective date

This new LCD is effective for services provided **on or after June 30, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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



# ADDITIONS/REVISIONS TO EXISTING LCDS

## A70210 Radiologic examination, sinuses, paranasal – revision to the LCD

**LCD ID Number: L29046 (Florida)**
**LCD ID Number: L29047 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for radiologic examination, sinuses, paranasal was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the following sections of the LCD have been revised to update the language:

- Type of Bill Code
- Revenue Codes
- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Sources of Information and Basis for Decision
- In addition, the ICD-9-CM code range for acute sinusitis (461.0 – 461.9) was deleted from the LCD and the descriptors for all of the other ICD-9-CM codes were updated. The LCD title was changed to "Sinus X-ray(s)" and the contractor's determination number was changed to A70210.

### Effective date

This LCD revision is effective for services provided **on or after June 30, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## A77055 Breast imaging: mammography/breast echography (sonography) – revision to the LCD

**LCD ID Number: L29048 (Florida)**
**LCD ID Number: L29049 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for breast imaging: mammography/breast echography (sonography) was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD title was changed to reflect coverage guidelines for screening and diagnostic mammography procedures only. All coverage guidelines for other diagnostic breast procedures were deleted. Additionally, the indications for screening and diagnostic mammography procedures have been clarified, and new technology codes have been added to the "*CPT*/HCPCS Codes" section of the LCD.

### Effective date

This LCD revision is effective for services provided **on or after June 30, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## A92135 Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the LCD

**LCD ID Number: L28982 (Florida)**
**LCD ID Number: L29015 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. First Coast Service Options Inc. (FCSO) evaluated coverage for *CPT* code *0187T, scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report*, and determined coverage would be reasonable and necessary to add to the LCD for SCODI. This LCD was presented for notice and comment from February 20, 2009, to April 6, 2009.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to include language pertaining to anterior segment SCODI. The "*CPT*/HCPCS Codes" section of the LCD has been revised to add *CPT* code *0187T* as medically reasonable and necessary. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to include appropriate ICD-9-CM codes for *CPT* code *0187T*. The "Documentation Requirements" section of the LCD has been revised to add language regarding *CPT* code *0187T*. The "Sources of Information and Basis for Decision" section of the LCD has also been revised accordingly. In addition, type of bill (TOB) code 85x was added to the LCD and TOB 14x was removed.

### Effective date

This LCD revision is effective for services provided **on or after June 30, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖



## A93798 Cardiac rehabilitation programs – revision to the LCD

**LCD ID Number: L28794 (Florida)**
**LCD ID Number: L28799 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for cardiac rehabilitation programs was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised to add ICD-9-CM code V15.1 (Surgery to heart and great vessels) to the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

### Effective date

This revision is effective for services provided **on or after May 15, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## ABOTULINUMTOXINS: Botulinum toxins – revision to the LCD

**LCD ID Number: L28788 (Florida)**
**LCD ID Number: L28790 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for botulinum toxins was effective for services rendered on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD has been revised under "Off-label indications for Botox" to add language regarding coverage for neurogenic urinary incontinence and neurogenic detrusor overactivity in patients when documented oral therapy of this condition has failed. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has also been revised to add ICD-9-CM codes 596.54, 596.55 and 596.59 for HCPCS code J0585. The "Sources of Information and Basis for Decision" section of the LCD has also been updated.

### Effective date

This revision is effective for services provided **on or after April 16, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## AJ0881 Erythropoiesis stimulating agents – revision to the LCD

**LCD ID Number: L28836 (Florida)**
**LCD ID Number: L28869 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for erythropoiesis stimulating agents was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. Since the implementation of the national coverage decision (NCD) 110.21 for non-ESRD (end-stage renal disease) use of erythropoiesis stimulating agents (ESAs) in cancer and related conditions, First Coast Service Options Inc. (FCSO) has encountered various issues surrounding the coding of the covered and noncovered indications outlined in the LCD. Although FCSO has handled these coding issues on a case by case basis as they were brought to our attention, it was determined that the coding rules as outlined needed to be streamlined in order to make it easier for providers to submit claims accurately. To address this, FCSO posted the LCD for ESAs for notice and comment from February 20, 2009-April 6, 2009. The language opened up for comment was limited to the ICD-9-CM codes that support medical necessity and the second set of ICD-9-CM codes bulleted out in the coding guidelines. This article serves to outline the final decisions made by FCSO, which take into account all comments received. This article will also serve to summarize all the rules for billing non-ESRD ESAs (HCPCS codes J0881 and J0885) implemented since April 7, 2008, and how they apply to this newly revised LCD. Any questions on this LCD should be submitted to the medical policy department at *medical.policy@fcso.com*.

The lists of "ICD-9 codes that support medical necessity" for J0881 and J0885 have been revised to now include two lists of ICD-9-CM codes for each HCPCS code. The two lists for J0881 and J0885 now outline which ESA modifier (EA or EC) must be billed with the ICD-9-CM codes and any dual diagnosis requirement for the ICD-9-CM codes. These modifier designation and dual diagnosis rules are found at the beginning of each list for J0881 and J0885. ICD-9-CM codes that require a dual diagnosis are designated with an *. In addition, the coding guidelines attachment for the LCD has been revised to instruct providers how to bill for certain noncovered indications outlined in NCD 110.21. This change is outlined in more detail below. All other language and coding have not changed due to this revision.

### Coding changes

**J0881** (This list does not require a dual diagnosis.)
The following ICD-9-CM codes require **modifier EA:**

| | | |
|---|---|---|
| 140.0-149.9 | 150.0-159.9 | 160.0-165.9 |
| 170.0-176.9 | 179-189.9 | 190.0-199.2 |
| 200.00-200.88 | 201.00-201.98 | 202.00-202.98 |
| 203.00-203.82 | 204.00-204.92 | 209.00-209.03 |
| 209.10-209.17 | 209.20-209.29 | 209.30 |
| 230.0-234.9 | 235.0-235.9 | 236.0-236.99 |
| 237.0-237.9 | 238.0 | 238.1 |
| 238.2 | 238.3 | 238.4 |
| 238.5 | 238.6 | 238.8 |
| 238.9 | 239.0-239.9 | |

**J0881** (This list does not require a dual diagnosis.)
The following ICD-9-CM codes require **modifier EC**:

| | | | |
|---|---|---|---|
| 238.71 | 238.72 | 238.73 | 238.74 |
| 238.75 | 238.76 | or 273.3. | |

**J0881**
The following ICD-9-CM codes require **modifier EC and a dual diagnosis** (*): 285.21* and one of the following must be billed together:

| | | | |
|---|---|---|---|
| 403.01* | 403.11* | 403.91* | 404.02* |
| 404.03* | 404.12* | 404.13* | 404.92* |
| 404.93* | 585.1* | 585.2* | 585.3* |
| 585.4* | 585.5* | or 585.9*. | |

**J0885** (This list does not require a dual diagnosis.)
The following ICD-9-CM codes require **modifier EA:**

| | | |
|---|---|---|
| 140.0-149.9 | 150.0-159.9 | 160.0-165.9 |
| 170.0-176.9 | 179-189.9 | 190.0-199.2 |
| 200.00-200.88 | 201.00-201.98 | 202.00-202.98 |
| 203.00-203.82 | 204.00-204.92 | 209.00-209.03 |
| 209.10-209.17 | 209.20-209.29 | 209.30 |
| 230.0-234.9 | 235.0-235.9 | 236.0-236.99 |
| 237.0-237.9 | 238.0 | 238.1 |
| 238.2 | 238.3 | 238.4 |

***AJ0881 Erythropoiesis stimulating agents – revision to the LCD (continued)***

238.5 238.6 238.8
238.9 or 239.0-239.9

**J0885** (This list does **not** require a dual diagnosis.)
The following ICD-9-CM codes require **modifier EC**:

238.71 238.72 238.73 238.74
238.75 238.76 or 273.3.

**J0885**
The following ICD-9-CM codes require **modifier EC and a dual diagnosis** (*):285.21* and one of the following must be billed together:

403.01* 403.11* 403.91* 404.02*
404.03* 404.12* 404.13* 404.92*
404.93* 585.1* 585.2* 585.3*
585.4* 585.5* or 585.9*.

285.29* **or** 285.9* **and** one of the following must be billed together:

042* 070.54* 070.70* 714.0* or V07.8*.

### Coding guideline changes made as a result of LCD revision:

As of January 1, 2008, the following are nationally non-covered indications for non-ESRD ESAs that report ESA modifier EC. These are not to be reported with any other ESA modifier. Because no specific ICD-9-CM code exists for these indications listed, FCSO will identify these non-covered conditions with ICD-9-CM code V49.89. This will indicate the ESA was given for a nationally noncovered condition as identified in business requirement 5818.1.1 of change request (CR) 5818.

- Any anemia in cancer or cancer treatments patients due to bone marrow fibrosis
- Anemia of cancer not related to cancer treatment
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatments if patients have uncontrolled hypertension

Please see end of article for additional list of nationally non-covered indications identified in the NCD for non-ESRD ESA use.

### Summary of non-ESRD ESA coverage based on CR 5818 and CR 5699 implemented on April 7, 2008

Effective January 1, 2008 all claims reporting non-ESRD ESAs (HCPCS codes J0881 and J0885) are required to report one of the following modifiers: (based on CR 5699)

- EA: ESA, anemia, chemo induced
- EB: ESA anemia, radio-induced
- EC: ESA anemia, non-chemo/radio

**Modifier EA** should only be reported when the ESA is being given for anemia resulting from myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia that is not related to the administration of chemotherapy for one of the listed covered cancer conditions is noncovered per the NCD. Therefore it is inappropriate to append **modifier EA** to those ESA claims. These ESA administrations should be identified with ICD-9-CM code V49.89 (as instructed in the coding guideline of the LCD) and **modifier EC** should be appended.

**Modifier EC** should only be reported for those covered indications outlined in the LCD under "ICD-9 codes that support medical necessity" for HCPCS codes J0881 and J0885 where the anemia being treated is non-chemo/radio induced. The provider must also append **modifier EC** for those nationally non-covered conditions outlined in the NCD and the coding guideline of the LCD. The noncovered ICD-9-CM codes that correspond to the nationally noncovered indications are noted in the coding guideline. If one of the noncovered ICD-9-CM codes and modifier EC are billed with J0881 or J0885, the ESA will be denied.

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

Effective January 1, 2008, all claims reporting ESAs J0881, J0882, J0885, J0886 or Q4081 must report the most recent hemoglobin or hematocrit readings. For non-ESRD ESAs J0881 and J0885 reporting **modifier EA** (anemia that is related chemotherapy), the hemoglobin or hematocrit are required to be below a certain level in order for the service to be medically necessary. Contractors are instructed, per CR 5818 to deny ESA services that report J0881 or J0885 with and **modifier EA** when Hgb is > 10.0g/L or the Hct is > 30 percent. There is no exception to this requirement, and there is no 4-week window at initiation where providers can report a level above 10.0 g/L or 30 percent and have the service paid. The entire discussion surrounding ESA administration for cancer conditions is outlined in the LCD and NCD 110.21.

Additional noncovered indications as identified in NCD 110.21 for non-ESRD ESA use are listed below. The ESA services for J0881 and J0885 when reported with an EC modifier will be denied when the following ICD-9-CM codes are reported:

- Any anemia in cancer or cancer treatment patients due to folate deficiency 281.2
- B-12 deficiency 281.1, 281.3
- Iron deficiency 280.0-280.9
- Hemolysis 282.0, 282.2, 282.9, 283.0, 283.10, 283.19, 283.2, 283.9
- Bleeding 280.0, 285.1
- Aanemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) 205.00-205.21, 205.80-205.91
- Erythroid cancers (207.00-207.81)

***AJ0881 Erythropoiesis stimulating agents – revision to the LCD (continued)***

### Resources for information on ESA coverage:

The complete NCD may be accessed in section 110.21 of Publication (Pub.) 100-03, *Medicare National Coverage Determinations (NCD) Manual*, and claim processing instructions may be accessed in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 17, sections 80.8-80.12 and through the following link:

*http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=110.21&ncd_version=1&basket=ncd%3A110%2E21%3A1%3AErythropoiesis+Stimulating+Agents+%28ESAs%29+in+Cancer+and+Related+Neoplastic+Conditions*

CR 5818, transmittal 80 and 1413, dated January 14, 2008 may be accessed through the following links:

*http://www.cms.hhs.gov/transmittals/downloads/R1413CP.pdf*

*http://www.cms.hhs.gov/transmittals/downloads/R80NCD.pdf*

CR 5699, transmittal 1412, dated January 11, 2008 may be accessed through the following link:

*http://www.cms.hhs.gov/transmittals/downloads/R1412CP.pdf*

### Effective date

This LCD revision is effective for services provided **on or after June 30, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

## 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 last revised on March 12, 2009. Since that time, the LCD has been revised. First Coast Service Options Inc. (FCSO) presented this LCD for notice and comment from February 20, 2009-April 6, 2009. This LCD is being revised to add the ICD-9-CM codes that support medical necessity for HCPCS codes J3487, injection zoledronic acid (Zometa®), 1mg and J3488, injection, zoledronic acid (Reclast®), 1 mg. The coding guidelines attachment has also been revised to include an outline of appropriate coding for each indication.

The following ICD-9-CM codes are medically necessary for HCPCS code J3487:

198.5 203.00-203.02 275.42 733.90.

The following ICD-9-CM codes are medically necessary for HCPCS code J3488:

731.0 733.01.

The Food and Drug Administration (FDA)-approved indications for the use of Zometa and Reclast should be billed as follows:

- Hypercalcemia of malignancy: ICD-9-CM code 275.42 Hypercalcemia (associated with malignancy)
- Multiple myeloma: ICD-9-CM 203.00-203.02 Multiple myeloma
- Documented bone metastases from solid tumors in conjunction with standard neoplastic therapy, including bone metastases from multiple myeloma, breast carcinoma, prostate carcinoma, and other solid tumors:

  ICD-9-CM 198.5 Secondary malignant neoplasm of bone or bone marrow
- Paget's disease: ICD-9-CM code 731.0 osteitis deformans without mention of bone tumor
- Post menopausal osteoporosis: ICD-9-CM code 733.01 senile osteoporosis
- Treatment to increase bone mass in men with osteoporosis: ICD-9-CM code 733.01 senile osteoporosis.

The off-labeled indication for the use of Zometa should be billed as follows:

- Drug induced osteopenia, secondary to androgen-depravation therapy in prostate cancer patients (prophylaxis) ICD-9-CM code 733.90 Disorder of bone and cartilage, unspecified.

### Effective date

This LCD revision is effective for services provided **on or after June 30, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

## AJ9305 Pemetrexed – revision to the LCD

**LCD ID Number: L28947 (Florida)**
**LCD ID Number: L28968 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for pemetrexed was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to update the Food and Drug Administration (FDA)-approved indications.

### Effective date

This revision to the LCD is effective for claims processed **on or after April 2, 2009,** for services provided **on or after September 26, 2008.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## ANCSVCS The list of Medicare noncovered services – revision to the LCD

**LCD ID Number: L28991 (Florida)**
**LCD ID Number: L29023 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for the list of Medicare noncovered 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. Since that time, the LCD has been revised.

The following "Laboratory Procedures" section and *CPT* codes have been added to the "Local Noncoverage Decisions" section of the LCD:

| | | | |
|---|---|---|---|
| *0103T** | *0111T** | *82016** | *82017** |
| *82172* | *83090GY* | *84134* | *86316** |
| *86343** | *86618* | *86628* | *86631* |
| *87084* | *87270* | *87320* | *87470* |
| *87471* | *87472* | *87475* | *87477* |
| *87482* | *87485* | *87487* | *87492* |
| *87511* | | | |

The "Local Noncoverage Decisions – Procedures" section of the LCD has been revised as follows:

- Added *CPT* codes *0144T**, *0184T**, *45999** *Unlisted procedure, rectum (Stapled transanal rectal resection [STARR]), 95806, 97799** *Unlisted physical medicine/rehabilitation service or procedure* (Vertebral axial decompression/Intervertebral differential dynamics) and similar devices that would fall under this category of a noncovered benefit for this service, and *99199 Unlisted special service, procedure or report* (pulsatile intravenous insulin therapy [PIVIT])
- Deleted *CPT* code *0187T** *(Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral).*

The "National Noncoverage Decisions- Procedures" section of the coding guidelines attachment has been revised to align the descriptor of vertebral axial decompression (VAX-D) (*CPT* code *97799**) with the Centers for Medicare & Medicaid Services (CMS) Manual System, Pub 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2, Section 160.16.

*Services which are noncovered due to their being investigational/experimental.

### Effective date

This revision to the LCD is effective for services provided **on or after June 30, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖



## ASKINSUB Skin substitutes – revision to the LCD

**LCD ID Number: L28985 (Florida)**
**LCD ID Number: L29327 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for skin substitutes was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a major revision was made based on new replacement skin substitute codes and descriptors issued by the Centers for Medicare & Medicaid Services (CMS) with the 2009 HCPCS update.

Language was updated/revised under the following sections of the LCD:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Sources of Information and Basis for Decision

***ASKINSUB Skin substitutes – revision to the LCD (continued)***

The allowable HCPCS codes were listed, as well as the HCPCS codes that are not covered under this LCD. A statement regarding reconsideration requests for noncovered services with supporting literature was included. The ICD-9-CM codes were also updated based on the indications of the allowable HCPCS codes. In addition, the "Coding Guidelines" attachment was revised.

### Effective date

This revision to the LCD is effective for services provided **on or after June 30, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

## ATHERSVCS Therapy and rehabilitation services – revision to the LCD

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

The local coverage determination (LCD) for therapy and rehabilitation services was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD has been revised under "Neuromuscular Reeducation (*CPT* code *97112*)" to add language from change request (CR) 6397 regarding the Canalith repositioning procedure(s). In addition, the "coding guidelines" attachment was revised to include the changes from CR 6397, as well as language changes from CR 6321 regarding the notice of exclusion from Medicare benefits (NEMB) form, the advance beneficiary notice (ABN) form, the access to accrued amount information, and the therapy cap dollar amount change for 2009.

### Effective date

This LCD revision is effective for services for claims processed **on or after April 6, 2009,** for services provided **on or after January 1, 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖



## AVISCO Viscosupplementation therapy for knee – revision to the LCD

**LCD ID Number: L29005 (Florida)**
**LCD ID Number: L29037 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for viscosupplementation therapy for knee was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised.
In the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD under "Limitations" the third bullet was revised to clarify that there are no limitations for the number of courses of treatment for viscosupplementation. HCPCS code J3490 was added to the "*CPT*/HCPCS Codes," "ICD-9 Codes that Support Medical Necessity," and "Utilization Guidelines" sections of the LCD for use when billing Synvisc-one.

### Effective date

This revision is effective for claims processed **on or after May 15, 2009,** for services provided **on or after February 26. 2009.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

# ADDITIONAL MEDICAL INFORMATION

## Updated Medicare coverage for off-label use of anti-cancer drugs

An off-label use of a drug is a use that is not included as an approved indication by the Food and Drug Administration (FDA) on the drug's label. For drugs used in an anti-cancer chemotherapeutic regimen, off-label indications may be covered under certain conditions. This article defines the criteria that must be met before coverage of an off-label indication of an anti-cancer drug is made. Currently, Medicare does not provide pre-authorization for drugs and biologicals. Denials may be appealed by means of the prescribed process.

In order for a Medicare administrative contractor (MAC) to support payment for an off-label indication of an anti-cancer chemotherapeutic drug, two criteria must be met:

***Updated Medicare coverage for off-label use of anti-cancer drugs (continued)***

1. Benefit category qualification as noted by the indication listed in a compendium (see below) or if no current positive compendium listing, support in the current scientific or peer-reviewed literature. (Trial studies submitted should definitively demonstrate safety and effectiveness supporting the request and must have been published in one of the Centers for Medicare & Medicaid Services (CMS)-approved journals [see list in the CMS *Medicare Benefit Policy Manual,* Pub. 100-02, Chapter 15, Section 50.4.5. C.]. Abstracts or summary materials are not sufficient.)
2. If the indication is listed in one or more of the current CMS recognized compendia, the MAC confirms that the listed indication is medically reasonable and necessary after review of a copy of the complete compendium listing of the drug and review of the copies of current scientific or peer reviewed literature submitted by a J9 physician or appropriate stakeholder.
    - If the indication is not listed in one or more of the current CMS recognized compendia, the MAC will be limited to the review of the copies of current scientific or peer reviewed literature submitted by a J9 physician or appropriate stakeholder.
    - Also, suggested ICD-9-CM diagnosis code(s) that apply to the proposed indication should be submitted with the documentation, as well as specific information on proposed dosage schedules for the indication, if different than the FDA approved product information on dosage and administration.

CMS current compendia instruction accepts the use of compendia as the initial tool to determine whether an anti-cancer drug should be covered under Medicare Part B for an off-label indication. MAC consideration of payment for an off-label, medically accepted indication, will require that the indication be supported in either one or more of the compendia (listed below).

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

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

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

This article is subordinate to any national coverage determination (NCD) or local coverage determination (LCD) of this MAC.

Under the above provisions, this MAC will consider coverage of an unlabeled indication after receipt and review of supporting documentation outlined above. Since this contractor does not have access to all the above listed compendia, providers should submit the **complete** compendia listing for each drug request. If there is an existing LCD for the drug in question, the reconsideration process will be followed. If there is no current LCD, an evaluation of the request will be made after review of the submitted literature to determine if an LCD needs to be developed.

In this article, unlabeled uses of anti-cancer drugs are limited to the treatment of malignant neoplastic conditions. Other drugs and biologicals and/or the use of anti-cancer drugs for non-cancerous conditions are outside the scope of this publication. ❖

## 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.

Insulin for administration through durable medical equipment (DME) (i.e., insulin pump) per 50 units (HCPCS code J1817) has been added to the Part A list of excluded self-administered injectable drugs incident to a physician's service (SAD list).

### Effective date

This revision is effective for claims provided **on or after April 30, 2009.** The SAD list in its entirety is available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

# HOSPITAL SERVICES

## New Medicare pilot program helps eliminate unnecessary hospital re-admissions

### Fourteen communities funded to reduce rates of hospital re-admissions and fragmentation of care

The Centers for Medicare & Medicaid Services (CMS) announced the 14 communities around the nation that have been chosen for the agency's Care Transitions Project, seeking to eliminate unnecessary hospital readmissions.

"Our data show that nearly one in five patients who leave the hospital today will be readmitted within the next month, and that more than three-quarters of these re-admissions are potentially preventable," said CMS acting administrator Charlene Frizzera. "This situation can be changed by approaching health care quality from a community-wide perspective, and focusing on how all of the members of an area's health care team can better work together in the best interests of their shared patient population."

The goal of the project is to improve health care processes so that patients, their caregivers, and their entire team of providers have what they need to keep patients from returning to the hospital for ongoing care needs. By promoting seamless transitions from the hospital to home, skilled nursing care, or home health care, this community-wide approach seeks not only to reduce hospital readmissions but also to yield sustainable and replicable strategies that achieve high-value health care for Medicare beneficiaries.

"The Care Transitions Project is a new approach for CMS," said Barry M. Straube, M.D., chief medical officer for CMS and its Office of Clinical Standards & Quality director. "Rather than focusing on one global problem and trying to apply a one-size-fits-all solution across the country, care transitions experts will look in their own backyards to learn why hospital readmissions occur locally and how patients transition between health care settings. Based on this community-level knowledge, care transitions teams will design customized solutions that address the underlying local drivers of re-admissions."

Communities in the following regions have been selected to participate in the project: Providence, R.I.; Upper Capitol Region, N.Y.; western Pennsylvania; southwestern New Jersey; metro Atlanta east, Ga.; Miami, Fla.; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing Area, Mich.; Omaha, Neb.; Baton Rouge, La.; northwest Denver, Colo.; Harlingen, Texas; and Whatcom County, Wash. The work of the project will respond to the unique needs of each of the 14 communities. Each of the care transitions communities is led by a state quality improvement organization (QIO). QIOs work throughout the country as part of CMS's quality program to help health care providers, consumers, and stakeholder groups to refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high-value health care they deserve.

Each QIO in the project is required to work with partners to implement the following:

a) hospital and community system-wide interventions

b) interventions that target specific diseases or conditions, and

c) interventions that target specific reasons for admission.

The following QIOs serve as care transitions leaders throughout the country: Quality Partners of Rhode Island, IPRO Inc. (New York), Quality Insights of Pennsylvania, Healthcare Quality Strategies Inc. (New Jersey), Georgia Medical Care Foundation Inc., FMQAI (Florida), AQAF (Alabama), Health Care Excel (Indiana), MPRO (Michigan), CIMRO of Nebraska, Louisiana Health Care Review, Colorado Foundation for Medical Care, TMF Health Quality Institute (Texas), and Qualis Health (Washington).

CMS will monitor the success of this project by watching the rates at which patients in these communities return to the hospital. Re-admission rates for hospitals have been tracked by CMS for some time and will be available to consumers later this year through the Hospital Compare Web site at *http://www.hospitalcompare.hhs.gov*.

The Care Transitions Project will continue in all 14 communities through summer 2011. For more information about the Care Transitions Project, visit *http://www.cfmc.org/caretransitions/*.

To learn more about the work that QIOs are doing across the country, visit *http://www.cms.hhs.gov/qualityimprovementorgs*. ❖

Source: CMS PERL 200904-19

# Implementation of phase-out capital for indirect medical education and long-term care hospital provisions

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

## Provider types affected

Inpatient acute care hospitals and long-term care hospitals (LTCHs) that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

This article discusses provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 that impact capital inpatient prospective payment system (IPPS) payments to hospitals for indirect medical education (IME) and changes to certain LTCH PPS policies. Please note that FIs and MACs will reprocess any claims with discharge dates on or after October 1, 2008, that were previously processed with an incorrect payment amount for IME and/or short-stay outlier claims of LTCHs with a teaching program. You need take no action to initiate the reprocessing of the claims. You should notify your billing office staff that adjustments to payments will be made within six months of PRICER software installation at your contractor. That installation is scheduled to occur on or before April 6, 2009.

## Background

The ARRA was signed into law on February 17, 2009. Change request (CR) 6444 provides a summary of the legislation as well as implementation instructions on certain provisions that affect the Medicare fee-for-service program.

The first key point of the legislation affects capital IPPS indirect medical education (IME) payments for fiscal year (FY) 2009. Beginning in FY 2009, hospitals were to receive 50 percent of the capital IME adjustment provided under the current formula. Section 4301(b)(1) of the ARRA removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full capital IME amount for discharges occurring on or after October 1, 2008, through September 30, 2009. The ARRA also explicitly specifies that the elimination of the capital IME adjustment in FY 2010 and subsequent years is not to be affected. Therefore, beginning in FY 2010 and after, under current law, hospitals will no longer receive a teaching adjustment under the capital IPPS. This provision also affects LTCH PPS payments as part of the short stay outlier (SSO) calculation. The revision to the capital IPPS IME adjustment for FY 2009 provided for by section 4301(b)(1) of the ARRA also affects the payments for some SSO cases from LTCHs with teaching programs since the calculation of the "IPPS comparable amount" component of the SSO "blend" option must also be revised to reflect the change to the capital IME adjustment for FY 2009 provided for in the ARRA. In the same way as with the SSO calculation, changes to the capital IME payments specified by the ARRA of 2009 affect LTCH PPS payments governed by the "25 percent" threshold payment adjustments. Under these policies, those cases in excess of the applicable thresholds are paid an amount based on an amount equivalent to what would be paid under the IPPS. Therefore, the revision to the capital IPPS IME adjustment for FY 2009 provided for in section 4301(b) would apply to those LTCHs with teaching programs.

A second key point of the legislation affects LTCHs. The Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 placed a moratorium on new LTCHs or new LTCH satellites and expansions in the number of beds in existing LTCHs, effective December 29, 2007. MMSEA allowed for limited exceptions to the moratorium. The ARRA makes one additional exception to the moratorium that will allow existing LTCHs to expand the number of beds in the LTCH or its satellite if the hospital obtained a certificate of need for an increase in beds in a state for which such certificate of need is required that was issued on or after April 1, 2005, and before December 29, 2007.

A third key point of the legislation also affects LTCHs. As noted above, CMS regulations create special payment provisions for LTCHs or LTCH satellites that receive more than 25 percent of their admissions from a single referral source. The ARRA amended the MMSEA changes to the 25 percent threshold policy by adding another category of LTCHs that would be subject to the 3-year delay in application of the 25 percent payment provision, i.e., LTCHs or LTCH satellites that were co-located with provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located. The ARRA also extended the increase in percentages under the 25 percent threshold policy to include "grandfathered" LTCH satellites, i.e., those in existence prior to October 1, 1999, and changed the implementation date of all changes to the 25 percent threshold payment adjustment from the date of enactment of the MMSEA (December 29, 2007), to either July 1, 2007, or October 1, 2007, as appropriate for the specific provision.

## Additional information

The official instruction (CR 6444) issued to your Medicare MAC and/or FI is available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/transmittals/downloads/R466OTN.pdf*.

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

*MLN Matters* Number: MM6444
Related Change Request (CR) Number: 6444
Related CR Release Date: March 27, 2009
Related CR Transmittal Number: R466OTN
Effective Date: February 17, 2009
Implementation Date: April 6, 2009

Source: CMS Pub. 100-20, Transmittal 466, CR 6444

## Funding available to support hospitals serving uninsured vulnerable Americans

Building on President Barack Obama's efforts to ensure access to health care for millions of uninsured Americans, the U.S. Department of Health & Human Services (HHS) announced that states can access an additional $268 million authorized by the American Recovery and Reinvestment Act to help pay hospitals to treat their most vulnerable patients.

"Millions of people rely on the care provided by their community hospitals," said Acting Health & Human Services (HHS) Secretary Charles E. Johnson. "Through the help provided by the Recovery Act, we can make sure they continue to get the care they need in those hospitals."

Eligible hospitals are those that serve a disproportionate share of low-income or uninsured individuals and are known as disproportionate share hospitals (DSH). States receive an annual allotment to make payments to DSH hospitals to account for higher costs associated with treating uninsured and low income patients. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to hospitals are not higher than the actual costs incurred by the hospital to provide the uncompensated care. The recovery act increases the amount of allotments available to states from approximately $11.06 billion to $11.33 billion for 2009.

The Centers for Medicare & Medicaid Services (CMS) will notify states about the availability of the increased portion of allotments for hospitals. Not all states spend their full DSH allotments. Therefore, before this new funding may be accessed, states must demonstrate they have used all of their existing fiscal year 2009 DSH allotments. States must request the additional funds from CMS as part of their quarterly Medicaid budget request and the funds will be distributed as separate Recovery Act DSH grants.

"Thousands of hospitals around the country are the first place many families take their sick children for care or the only place where some of the more than 45 million uninsured Americans can receive some form of health care," said Acting HHS Secretary Johnson. "The funding from the Recovery Act will help ensure hospitals can keep their doors open to the people who need care most."

To see a complete list of the revised DSH allotments that include additional funding provided through the recovery act, please visit *http://www.hhs.gov/recovery/cms/dshstates.html*.

To track the progress of HHS activities funded through the recovery act, visit *http://www.hhs.gov/recovery*. To track all federal funds provided through the recovery act, visit *http://www.recovery.gov*. ❖

Source: CMS PERL 200903-29

## Fiscal year 2008 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) 2008 has been updated with the January 2009 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 2008.6 version of the PC PRICER (posted March 20, 2009). ❖

Source: CMS PERL 200903-30

## Fiscal Year 2009 inpatient prospective payment system personal computer PRICER updated

The American Recovery and Reinvestment Act (ARRA) of 2009 was signed into law on February 27, 2009. The ARRA removed the 50 percent reduction in capital indirect medical education (IME) and hospitals will receive the full capital IME retroactive to October 1, 2008. To comply with the ARRA, the IPPS PC PRICER for fiscal year (FY) 2009 has been updated. If you use the inpatient prospective payment system (IPPS) personal computer (PC) PRICERs, please go to *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp* under the Downloads section, and download the FY 2009.5 version of the PC PRICER software updated April 9, 2009. ❖

Source: CMS PERL 200904-18

### 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.

## Revised national correct coding initiative edits for the hospital outpatient prospective payment system

Incorrect files were posted for the national correct coding initiative (NCCI) edits for the hospital outpatient prospective payment system (OPPS). The correct version number is 15.0, effective April 1, 2009, through June 30, 2009. The version number and files have been corrected and may be found on the CMS Web site at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp*.

Please be advised that the NCCI hospital OPPS edit files are always one version and one quarter behind the NCCI physicians edit files. ❖

Source: CMS PERL 200904-04

## Order information for the expanded modified MedPAR data

The Centers for Medicare & Medicaid Services (CMS) expanded modified Medicare provider analysis and review (MedPAR) data that will be used in simulating the policies proposed in the fiscal year (FY) 2010 inpatient prospective payment system (IPPS) proposed rule, is available for purchase. To assist analyzing the transition from the CMS-DRGs (diagnosis related group) to the MS-DRG (Medicare severity-diagnosis related group), the FY 2008 MedPAR released in support of the FY 2010 notice of proposed rule making (NPRM) will include the FY 2007, FY 2008, FY 2009, and the proposed FY 2010 DRG assignments. If you are interested in receiving this file, you are encouraged to order the data as soon as possible by following the directions below. Requests will be processed in the order they are received.

### Ordering information

For information on how to order the expanded modified MedPAR, go to the following Web site *http://www.cms.hhs.gov/LimitedDataSets/* and click on MedPAR Limited Data Set (LDS) – Hospital (National).

This Web page will describe the file and provide directions to further detailed ordering instructions.

Persons placing an order must send the following:

Letter of request

LDS Data Use Agreement and Research Protocol (see Web site for further instructions)

LDS form

Check for $3,655 to:

**For U.S. Postal Service**

Centers for Medicare & Medicaid Services
RDDC Account
Accounting Division
P.O. Box 7520
Baltimore, Maryland 21207-0520

**For express mail (Federal Express, Airborne, etc.)**

Centers for Medicare & Medicaid Services
OFM/Division of Accounting-RDDC
7500 Security Boulevard, C3-07-11
Baltimore, Maryland 21244-1850

Source: CMS PERL 200903-31

# SKILLED NURSING FACILITY SERVICES

## Clarifications for skilled nursing facility and therapy billing

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

### Provider types affected

Skilled nursing facilities and other providers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for skilled nursing facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

### Background

CR 6407 provides clarifications and updates to the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS Coding Requirements). These clarifications indicate that effective January 1, 2009, the new *Current Procedural Terminology* (*CPT*) code *95992* (*Canalith repositioning procedure(s) (eg Epley maneuver, Semont maneuver), per Day*) is bundled under the Medicare physician fee schedule (MPFS).

Regardless of whether *CPT* code *95992* is billed alone or in conjunction with another therapy code, separate Medicare payment is never made for this code. If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 ("Payment is included in the allowance for another service/procedure."). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

In addition, CR 6407 provides clarifications and updates to the *Medicare Claims Processing Manual* (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that both full and partial benefits exhaust claims must be submitted by SNFs monthly. For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim.

2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

**Note:** Type of bill 22x (SNF inpatient Part B) must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a type of bill 22x (SNF inpatient part B).

**Note:** Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 (SNF no-payment bill type).

### Additional information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1706CP.pdf*.

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

*MLN Matters* Number: MM6407
Related Change Request (CR) Number: 6407
Related CR Release Date: March 27, 2009
Related CR Transmittal Number: R1706CP
Effective Date: October 1, 2006
Implementation Date: April 27, 2009

Source: CMS Pub. 100-04, Transmittal 1706, CR 6407

## Five-star provider preview reports now available

Providers may access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of MDS 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 two-digit postal code of the state in which your facility is located, and "facid" refers to the state-assigned facility identifier for your facility.

The five-star helpline will be open for through Friday, May 1, 2009, to address any April's data concerns.

There will be no helpline access for the months of May and June to coincide with the release of each month's preview data. You may e-mail five-star provider preview questions during these months, to *BetterCare@cms.hhs.gov*.

The helpline will begin quarterly operation beginning in July.

Nursing home compare will update with April's five-star data on Thursday, April 23, 2009. ❖

Source: CMS PERL 200904-22

## New version of the minimum data sets available for download

The minimum data sets, version 3.0 (MDS 3.0) timeline has been posted. Please go to the Downloads section on the MDS 3.0 for Nursing Home Web page at *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*. ❖

Source: CMS PERL 200904-27

### 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.

# ELECTRONIC DATA INTERCHANGE

## Instructions on using ANSI X12 837 institutional segments for Medicare secondary payer Part A claims

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has rescinded change request (CR) 6275 and replaced it with CR 6426. As a result, *MLN Matters* article MM6275 is replaced by *MLN Matters* article MM6426, which is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6426.pdf*.

The *MLN Matters* article MM6275 was published in the January 2009 *Medicare A Bulletin* (page 73).

*MLN Matters* Number: MM6275 – Rescinded
Related Change Request (CR) Number: 6275
Related CR Release Date: December 19, 2008
Related CR Transmittal Number: R63MSP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-05, Transmittal 63, CR 6275



## Instructions on using ANSI X12 837 institutional segments for Medicare secondary payer Part A claims

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

### Provider types affected

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

### What you need to know

Change request (CR) 6426, from which this article is taken, alerts your Medicare Part A contractors (FIs, MACs, and RHHIs) and their associated systems to the changes they will need to follow when calculating MSP payment amounts from incoming American National Standards Institute (ANSI) ASC X12N 837 4010-A1 claims transactions. It specifically addresses their use of data reported in ANSI ASC X12N 837 institutional claim adjustment segments (CAS) for MSP Part A claims.

CR 6426 only affects providers submitting Part A claims. It is important for such providers to code the CAS segments of their claims accurately so that Medicare will make the correct MSP payments. See the *Background* and *Additional Information* sections of this article for further details regarding these changes.

### Background

The Medicare Secondary Payer (MSP) provisions apply to situations where Medicare is not the beneficiary's primary insurance. Medicare's secondary payment for Part A MSP claims is based on:

- Medicare-covered charges, or the amount the physician (or other supplier) is obligated to accept as payment in full (OTAF), whichever is lower.
- What Medicare would have paid as the primary payer.
- The primary payer(s) payment.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health & Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions and the implementation guides for each transaction are available on the Internet at *http://www.wpc-edi.com*.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6426 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements.

***Instructions on using ANSI X12 837 institutional segments for Medicare secondary payer Part A claims (continued)***

- Providers code for the CAS segments claims to reflect any adjustments made by primary payers.
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 Institutional claim.

Adjustments made by the payer are reported in the CAS segment on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

**Note:** If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer (a.k.a. your contractual obligation), you must identify this amount as value code 44 in the 2300 HI value information. This amount is also known as the obligated to accept as payment in full amount (OTAF). Details of the MSP payment provisions may be found in the CMS *Medicare Secondary Payer Manual* and in the federal regulations at 42 CFR 411.32 and 411.33.

## Additional Information

You may find the official instruction (CR 6426) issued to your FI, RHHI, or MAC by visiting the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/transmittals/downloads/R66MSP.pdf*.

You will find the updated *Medicare Secondary Payer (MSP) Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.3.2 (Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format) as an attachment to that CR.

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

*MLN Matters* Number: MM6426
Related Change Request (CR) Number: 6426
Related CR Release Date: March 27, 2009
Related CR Transmittal Number: R66MSP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-05, Transmittal 66, CR 6426



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# FRAUD AND ABUSE

## An open letter from the Office of the Inspector General

This open letter refines the Office of the Inspector General (OIG)'s self-disclosure protocol (SDP) to build upon the initiative announced in my April 24, 2006, open letter. The 2006 open letter promoted the use of the SDP to resolve matters giving rise to civil monetary penalty (CMP) liability under both the anti-kickback statute and the physician self-referral ("Stark") law. As part of our ongoing efforts to evaluate and prioritize our work, these refinements aim to focus our resources on kickbacks intended to induce or reward a physician's referrals. Kickbacks pose a serious risk to the integrity of the health care system, and deterring kickbacks remains a high priority for OIG.

To more effectively fulfill our mission and allocate our resources, we are narrowing the SDP's scope regarding the physician self-referral law. OIG will no longer accept disclosure of a matter that involves only liability under the physician self-referral law in the absence of a colorable anti-kickback statute violation. We will continue to accept providers into the SDP when the disclosed conduct involves colorable violations of the anti-kickback statute, whether or not it also involves colorable violations of the physician self-referral law. Although we are narrowing the scope of the SDP for resources purposes, we urge providers not to draw any inferences about the government's approach to enforcement of the physician self-referral law.

To better allocate provider and OIG resources in addressing kickback issues through the SDP, we are also establishing a minimum settlement amount. For kickback-related submissions accepted into the SDP following the date of this letter, we will require a minimum $50,000 settlement amount to resolve the matter. This minimum settlement amount is consistent with OIG's statutory authority to impose a penalty of up to $50,000 for each kickback and an assessment of up to three times the total remuneration. See 42 U.S.C. Section 1320a-7a(a)(7). We will continue to analyze the facts and circumstances of each disclosure to determine the appropriate settlement amount consistent with our practice, stated in the 2006 open letter, of generally resolving the matter near the lower end of the damages continuum, i.e., a multiplier of the value of the financial benefit conferred.

These refinements to the OIG's SDP are part of our ongoing efforts to develop the SDP as an efficient and fair mechanism for providers to work with OIG collaboratively. Further information about our SDP may be found at *http://oig.hhs.gov/fraud/selfdisclosure.asp*.

I look forward to continuing our joint efforts to promote compliance and protect the federal health care programs and their beneficiaries.

Sincerely,

Daniel R. Levinson Inspector General

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

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# EDUCATIONAL EVENTS

## Upcoming provider outreach and educational events
### May 2009 – June 2009

**Hot topics – Medicare 2009 updates and changes**

When: Wednesday, May 13, 2009

Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida and U.S. Virgin Islands

**Topic: Skilled nursing facility (SNF) demand bills**

When: Tuesday, May 19, 2009

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida and U.S. Virgin Islands

**Topics –Medicare 2009 updates and changes**

When: Tuesday, May 19, 2009

Time: 2:00 p.m. – 3:30 p.m. ET **Delivery language:** Spanish (Español)

Type of Event: Webcast **Focus:** Puerto Rico providers

**Topic – Non-emergency ambulance transportation**

When: Thursday, May 28, 2009

Time: 4:00 a.m. – 5:30 p.m. ET **Delivery language:** Spanish (Español)

Type of Event: Webcast **Focus:** Puerto Rico providers

### 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. ❖

## Fee schedule resources webcast

**Topic: Learn how to find fee information for most Medicare-covered procedure codes**

**When:** Wednesday, May 21

11:30 a.m.-12:30 p.m. **Delivery language:** English

4:00 p.m.-5:00 p.m. **Delivery language:** Spanish (Español)

First Coast Service Options Inc. (FCSO) understands providers need to have fast and easy access to the resources required to submit Medicare claims successfully – the first time. That's why FCSO offers an extensive selection of Medicare resources, from informative articles and helpful tools on its provider Web sites to online training and live educational events to help providers learn how to use these valuable resources to their best advantage.
This webcast will offer providers an introduction to the fee schedule information resources available on the FCSO provider Web sites -- including an interactive fee lookup tool – and to powerful database tools offered on the Centers for Medicare & Medicaid Services (CMS) Web site.
Participants will learn how to:

- Find location-specific fee information for most Medicare-covered procedure codes with FCSO's easy-to-use, interactive look-up tool.
- Find printable portable document format (PDF) fee schedules and text-only fee schedule data files that can be imported into a spreadsheet or database.
- Research fee schedules and fee schedule-related information from previous payment years in FCSO's comprehensive archive.
- Use CMS' national physician fee schedule database tool to find fee information based upon a single, list, or a range of Healthcare Common Procedure Coding System (HCPCS) criteria.

**Note: An open question-and-answer period will follow the presentation.**

**To participate in this webcast, please register by May 20.**

Please join us for this live Medicare educational event, and take advantage of this opportunity to learn about the resources you can use to find the information you need the most. ❖

# OTHER EDUCATIONAL RESOURCES

## Update to the quick reference immunization billing chart

The revised Medicare preventive services quick reference information: Medicare Part B immunization billing chart (revised March 2009), which provides billing and coding information related to adult immunizations, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

Printed copies will be available at a later date. ❖

Source: CMS PERL 200904-28

## Medicare payment policy publications are now available in print format

The following Medicare payment policy publications are now available in print format from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll own to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

**Outpatient maintenance dialysis – end-stage renal disease fact sheet (revised February 2009) –** provides general information about outpatient maintenance dialysis for end-stage renal disease, the composite payment rate system, and separately billable items and services.

**Medicare physician fee schedule fact sheet (revised January 2009)** – provides general information about the Medicare physician fee schedule.

**Hospital outpatient prospective payment system fact sheet (revised January 2009) –** provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set.

**Hospice payment system fact sheet (revised January 2009) –** provides general information about the Medicare hospice benefit including coverage of hospice services, certification requirements, election periods, and how payment rates are set.

**Clinical laboratory fee schedule fact sheet (revised February 2009) –** provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set.

**Acute inpatient prospective payment system fact sheet (revised January 2009) –** provides general information about the acute inpatient prospective payment system (IPPS) including IPPS payment rates and how IPPS payment rates are set.

**Home health prospective payment system fact sheet (revised December 2008) –** provides information about coverage of home health services and elements of the home health prospective payment system.

**Ambulance fee schedule fact sheet (revised January 2009) –** provides general information about the ambulance fee schedule.

**Ambulatory surgical center fee schedule fact sheet (revised January 2009) –-** which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined. ❖

Source: CMS PERL 200904-03

## Two new electronic prescribing pages now available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that two new pages have been created on the 2009 Electronic Prescribing (e-Prescribing) Incentive Program Web page on the CMS Web site.

- e-Prescribing Measure – this page contains several resources including: measure specifications, new claims-based reporting principles and a sample e-Prescribing claim. To access these resources, visit *http://www.cms.hhs.gov/ERxIncentive/06_E-Prescribing_Measure.asp*.
- Educational Resources – this page contains *MLN Matters* articles, e-Prescribing Incentive Program fact sheets, a link to *Medicare's Practical Guide to the e-Prescribing Incentive Program*, and information on how to receive continuing education credits related to the e-Prescribing Incentive Program. To access these resources and information, visit *http://www.cms.hhs.gov/ERxIncentive/09_Educational_Resources.asp*.

New and updated information will continually be added, so please visit the e-Prescribing Incentive Program Web page on a frequent basis at *http://www.cms.hhs.gov/ERXIncentive*. ❖

Source: CMS PERL 200904-27

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# Order form for Medicare Part A materials

The following materials are available for purchase. To order these items, please complete and submit this form along with your check/money order payable to FCSO Account # (use appropriate account number)

| ITEM | ACCOUNT NUMBER | COST PER ITEM | QUANTITY | TOTAL |
|---|---|---|---|---|
| **Part A subscription** – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Non-provider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2008 through September 2009. | 40-500-150 | Hardcopy $33 | | |
| | | CD-ROM $55 | | |
| Language preference for subscription:<br>**English [ ] Español [ ]** | | | | |

| | | |
|---|---|---|
| ***Please write legibly*** | Subtotal | **$** |
| | Tax (***add % for your area***) | **$** |
| | Total | **$** |

**Mail this form with payment to:**

**First Coast Service Options Inc.**
**Medicare Publications**
**P.O. Box 406443**
**Atlanta, GA 30384-6443**

Contact Name:
_____

Provider/Office Name:
_____

Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
_____

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

## Addresses

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

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

***MEDICARE SECONDARY PAYER***
**Information on Hospital Protocols**
**Admission Questionnaires, Audits**
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

**General MSP Information**
**Completion of UB-04 (MSP Related)**
**Conditional Payment**
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

**MSPRC DPP Debt Recovery**
**Automobile Accident Cases**
**Settlements/Lawsuits**
**Other Liabilities**
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

***ELECTRONIC CLAIM FILING***
**"DDE Startup"**
Direct Data Entry (DDE)
P. O. Box 44071
Jacksonville, FL 32231-4071

***FRAUD AND ABUSE***
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

***POST-PAY MEDICAL REVIEW***
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

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

**Freedom of Information Act Requests (relative to cost reports and audits)**
Provider Audit and Reimbursement Department (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

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

***PROVIDER ENROLLMENT***
**American Diabetes Association Certificates**
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

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

## Other Important Addresses

***REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY***
**Home Health Agency Claims**
**Hospice Claims**
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

***RAILROAD MEDICARE***
**Railroad Retiree Medical Claims**
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

***DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)***
**Durable Medical Equipment Claims**
**Orthotic and Prosthetic Device Claims**
**Take Home Supplies**
**Oral Anti-Cancer Drugs**
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

## Telephone Numbers

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

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

**Speech and Hearing Impaired**
1-877-660-1759

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

***ELECTRONIC DATA INTERCHANGE***
***1-888-670-0940***

**Option 1**
**Transaction Support**

**Option 2**
**PC-ACE Support**

**Option 3**
**Direct Data Entry (DDE) Support**

**Option 4**
**Enrollment Support**

**Option 5**
**Electronic Funds**
**(check return assistance only)**

**Option 6**
**Automated Response Line**

***PROVIDER EDUCATION & OUTREACH***
**Seminar Registration Hotline**
1-904-791-8103

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

***PROVIDER ENROLLMENT***
1-877-602-8816

***CREDIT BALANCE REPORT***
***Debt Recovery***
1-904-791-6281
**Fax**
1-9043610359

## Medicare Web sites

***PROVIDERS***
**Florida Medicare Contractor**
***medicare.fcso.com***
**Centers for Medicare & Medicaid Services**
***www.cms.hhs.gov***

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

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***DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)***
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1-800-633-4227
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**Option 6**
**Automated Response Line**

***PROVIDER EDUCATION & OUTREACH***
**Seminar Registration Hotline**
1-904-791-8103

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

***PROVIDER ENROLLMENT***
1-877-602-8816

***CREDIT BALANCE REPORT***
***Debt Recovery***
1-904-791-6281
**Fax**
1-9043610359

## Medicare Web sites

***PROVIDERS***
**Florida Medicare Contractor**
***medicare.fcso.com***
**Centers for Medicare & Medicaid Services**
***www.cms.hhs.gov***

***BENEFICIARIES***
**Centers for Medicare & Medicaid Services**
***www.medicare.gov***