MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

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

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About the *Medicare A Bulletin*

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

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

Who receives the *Bulletin*?

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

Distribution of the *Medicare Part A Bulletin* in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us*.

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

We use the same mailing address for *all* correspondence, and we cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. **Please remember that address changes must be done using CMS-855A.**

What is in the *Bulletin*?

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

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

The Medicare A Bulletin represents formal notice of coverage policies

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

Quarterly provider update

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

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

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

Providers may access the QPU by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU. ❖

GENERAL INFORMATION

Point of origin codes update to the UB-04 (CMS-1450) manual code list

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

Provider types affected

All hospitals and other providers who submit UB-04s or their electronic equivalent to Medicare fiscal intermediaries (FI) and Medicare administrative contractors (MAC) for services provided to Medicare beneficiaries.

Provider action needed

This article explains the addition of two new valid point of origin codes to the valid list of acceptable UB-04 codes. The new codes are E, transfer from ambulatory surgical center; and F, transfer from hospice and is under a hospice plan of care or enrolled in a hospice program. These codes must be used to complete Form CMS-1450 data set, described in the *Medicare Claims Processing Manual,* Chapter 25 (Completing and Processing the Form CMS-1450 Data Set). Providers should inform their claims staff of the new codes.

Background

The following point of origin (formerly source of admission) codes, created by the National Uniform Billing Committee (NUBC), should be used, when appropriate in FL 15 of the UB-04 and its electronic equivalent and these codes will be accepted by Medicare's claims processing systems as of January 4, 2010:

E – Transfer from ambulatory surgical center:

- Inpatient: This patient was admitted to this facility as a transfer from an ambulatory surgery center.
- Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services from an ambulatory surgery center.

F – Transfer from hospice and is under a hospice plan of care or enrolled in a hospice program:

- Inpatient: The patient was admitted to this facility as a transfer from hospice.
- Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services from a hospice.

Additional information

The official instruction, CR 6478, issued to your Medicare FI and/or MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1775CP.pdf*.

If you have questions, please contact your Medicare FI and/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: MM6478
Related Change Request (CR) Number: 6478
Related CR Release Date: July 24, 2009
Related CR Transmittal Number: R1775CP
Effective Date: October 1, 2007
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1775, CR 6478

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October 2009 quarterly average sales price Medicare Part B drug pricing files and revisions to prior quarterly pricing files

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6585 and instructs Medicare contractors to download and implement the October 2009 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2009, April 2009, January 2009, and October 2008, files. Medicare will use the October 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2009 with dates of service October 1, 2009, through December 31, 2009. See the *Background* and *Additional information* Sections of this article for further details regarding these changes.

October 2009 quarterly average sales price Medicare Part B drug pricing files and revisions to prior files (continued)

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

ASP methodology

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

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

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP plus five percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP plus four percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly. There are exceptions to this general rule and they are stated in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3 and may be reviewed on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf*.

Drugs furnished during filling or refilling an implantable pump or reservoir

Physicians (or a practitioner described in Section 1842(b) (18) (C) of the Social Security Act) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

Use of Quarterly Payment Files

The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and ASP NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008

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

Additional information

The official instruction (CR 6585) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1795CP.pdf*.

CMS would like providers to be aware that the following MLN products are available through the MLN Catalogue:

1. The guide at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf* describes topics such as: types of remittance advice (RA), the purpose of the RA and types of codes that appear on the RA.
2. A fact sheet at *http://www.cms.hhs.gov/PQRI/Downloads/PQRIEPrescribingFactSheet.pdf* introduces the E-Prescribing Incentive Program as authorized by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).
3. The brochure at *http://www.cms.hhs.gov/MLNProducts/downloads/Protectingpracbroch508-09.pdf* highlights some the steps providers can employ to protect their practices from inappropriate Medicare business interactions.

October 2009 quarterly average sales price Medicare Part B drug pricing files and revisions to prior files (continued)

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: MM6585
Related Change Request (CR) Number: 6585
Related CR Release Date: August 14, 2009
Related CR Transmittal Number: R1795CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal1795, CR 6585

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Reporting non-tax withholding due to federal payment levy program

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

Provider types affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), and Medicare administrative contractors (MAC) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6228, from which this article is taken, notifies providers that (effective October 1, 2009) in addition to collecting for overdue taxes (effective October 1, 2008), the Centers for Medicare & Medicaid Services (CMS) will also levy non-tax debt offsets against Medicare providers to repay unpaid debts owed to other federal agencies, such as educational loans.

Make sure that your billing staffs are aware that both tax and non-tax debt, subject to federal payment levy program FPLP, will be withheld from Medicare payments.

If you have a question about the non-tax payment reduction, call the Treasury Department Financial Management Service (FMS) at 1-800-304-3107.

Background

The Taxpayer Relief Act of 1997 authorized the FPLP, which the Internal Revenue Service (IRS) and the Treasury Department's Financial Management Service implemented in July 2000. This program gives CMS the authority to collect overdue taxes through a levy on certain federal payments; including those made to providers, contractors, and vendors doing business with the government.

The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to fully implement the FPLP for Medicare payments for overdue taxes, and extends it to also include a levy for non-tax debt.

CR 6125 (Reporting Withholding Due to IRS Federal Payment Levy Program (FPLP) on the Remittance Advice) issued on August 15, 2008, covers the implementation of the debt levy for overdue taxes, effective October 2008. (A related MLN Matters article is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf*.), CR 6228, from which this article is taken, notifies providers that (effective October 1, 2009) non-tax debt offsets will also be levied against Medicare providers to repay unpaid debts owed to other federal agencies, such as from educational loans.

Should you owe such taxes and/or debt, and your payments are reduced:

- For tax levy (effective October 1, 2008), your Medicare remittance advice will reflect the provider level adjustment code (PLB) of "WU" in the PLB03-1 data field (however, in the HIPAA 835, PLB reason code "LE" will replace currently used WU for: Third party payment (TPP) – garnishments, including attorneys, child support, alimony, secondary corporation, and change of ownership). In addition, the toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field.
- For non-tax debt levy (effective October 1, 2009), your Medicare remittance advice will reflect the PLB code of "ZZ" in the PLB03-1 data field, and the amount of the withholding can be found in the PLB04 field. In addition, the toll-free FMS number will appear in the PLB03-2 data field.

Notes:

1) Due to current privacy rules and regulations, the IRS is the only agency that can discuss the tax-related debt question with you, and FMS/Treasury is the only agency that can discuss the non-tax debt issue with you. Thus, if you have questions, contact them at the toll-free numbers just mentioned, instead of contacting your Medicare contractor.
2) Please observe that the toll-free IRS telephone number for questions regarding tax-related withholding is not the same as the toll-free FMS/Treasury toll-free telephone number for non-tax withholding questions.

You may find the following details about non-tax FPLP withholding of interest:

- CMS may reduce federal payments subject to the non-tax levy by 100 percent, (or the exact amount of the non-tax debt owed if it is less than 100 percent of the payment); and this levy is continuous until the non-tax debt is paid in full, or other arrangements are made to satisfy the debt.

Reporting non-tax withholding due to federal payment levy program (continued)

- The Medicare provider payment offset priority order is
  1. Medicare accounts receivable (AR) debt
  2. FPLP offsets for federal tax debt at 15 percent maximum of the payable amount
  3. Administrative offsets for federal non-tax debt at 100 percent of the payable amount
  4. Third-party payments (TPP).
- Within each payment offset priority category, CMS will collect the oldest debts first, namely the FPLP offsets for federal tax debt and the administrative offsets for federal non-tax debt.
- CMS will implement a minimum $25 threshold for tax and non-tax debt offsets.
- The Treasury Department will process refunds to providers from CMS over-collections of FPLP federal tax debt or administrative offsets for federal non-tax debt.

Additional information

You may find the official instruction, CR 6228, issued to your carrier, FI, or MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R503OTN.pdf*.

You may also want to review the article related to CR 6125 (Reporting Withholding Due to IRS Federal Payment Levy Program (FPLP) on the Remittance Advice), which you can find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.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: MM6228
Related Change Request (CR) Number: 6228
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Related CR Transmittal Number: R503OTN
Effective Date: January 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-20, Transmittal 380, CR 6228

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Medicare travel allowance fees for collection of specimens under the clinical laboratory fee schedule

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6524 which updates the Medicare travel allowance fees for collection of specimens for calendar year (CY) 2009. Subsequent updated travel allowance amounts will be issued by the Centers for Medicare & Medicaid Services (CMS) on an annual basis via a recurring update CR.

Background

CR 6524 clarifies payment of travel allowances, either on a per mileage basis (Healthcare Common Procedure Coding System (HCPCS) code P9603) or on a flat rate basis (HCPCS code P9604) for calendar year (CY) 2009.

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under the Social Security Act (Section 1833(h)(3); see the Internet a *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*), and payment is made based on the clinical laboratory fee schedule.

Travel allowance for 2009

The travel codes allow for payment either on a per mileage basis (HCPCS code P9603) or on a flat rate per trip basis (HCPCS code P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Medicare allows contractor discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor.

Per mile travel allowance (HCPCS code P9603)

The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

CR 6524 instructs that Medicare contractors will pay for HCPCS code P9603, where the average trip to the patients' homes exceeds 20 miles round trip, at a total of $1.00 per mile. This includes:

Medicare travel allowance fees for collection of specimens under the clinical laboratory fee schedule (continued)

- The federal mileage rate of $0.55 per mile plus
- An additional $0.45 per mile to cover the technician's time and travel costs.

Contractors shall have the option of establishing a higher per mile rate for HCPCS code P9603, in excess of the minimum $1.00 per mile, if local conditions warrant it.

The minimum mileage rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule (CLFS) as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles that are not actually traveled by the laboratory technician.

Per flat-rate trip basis travel allowance (HCPCS code P9604)

CR 6524 also instructs that Medicare contractors shall pay for HCPCS code P9604 on a flat-rate trip basis travel allowance of $10.00 per trip.

Additional information

The official instruction, CR 6524, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1790CP.pdf*.

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

MLN Matters® Number: MM6524
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Related CR Release Date: August 7, 2009
Related CR Transmittal Number: R1790CP
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Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1790, CR 6524

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Use of the CR modifier and DR condition code on disaster/emergency-related claims

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 (MACs)) for disaster/emergency-related services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6451, which updates and amends claim processing requirements for the use of condition codes and modifiers on Medicare fee-for-service claims when the furnishing of an item or service to a Medicare beneficiary was affected by a disaster or other general public emergency. CR 6451 also establishes a new chapter in the *Medicare Claims Processing Manual* dedicated to standing policies and procedures applicable to disasters and other public emergencies. Please make sure your billing staff is familiar with these changes, especially if they submit claims affected by emergencies to Medicare.

Background

As part of its response to the 2005 Katrina hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency. The DR condition code and CR modifier were also authorized for use on claims for items and services affected by subsequent emergencies. Based on that experience, the Medicare fee-for-service program is refining the uses of both the code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/suppliers in emergency situations without adding undue administrative burden associated with claim submission. The use of the "CR" modifier and "DR" condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.

Key points of change request 6451

DR condition code: The title of the DR condition code is "disaster related" and its definition requires it to be "used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster." The DR condition code is used only for

Use of the CR modifier and DR condition code on disaster/emergency-related claims (continued)

institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. In previous emergencies, use of the DR condition code was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. **Effective August 31, 2009,** use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned directly or indirectly on the presence of a "formal waiver."

CR modifier: Both the short and long descriptors of the CR modifier are "catastrophe/disaster related." The CR modifier is used in relation to Part B items and services for both institutional and non-institutional billing. Non-institutional billing, i.e., claims submitted by "physicians and other suppliers," are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format. In previous emergencies, use of the CR modifier was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. **Effective August 31, 2009,** use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned directly or indirectly on the presence of a "formal waiver."

Formal waivers: A "formal waiver" is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers. One type is a waiver of a requirement specified in Section 1135(b) of the Social Security Act (Act). Although Medicare payment rules themselves are not "waivable" under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred. The second type of formal waiver is a waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the "three-day qualifying hospital stay" requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Social Security Act.

Further instructions in the event of a disaster or emergency: In the event of a disaster or emergency, CMS will issue specific guidance to Medicare contractors that will contain a summary of the Secretary's declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.

Additional information

The official instruction, CR 6451, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1784CP.pdf*.

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

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Source: CMS Pub. 100-04, Transmittal 1784, CR 6451

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Telehealth services in Indian Health Service or tribal providers

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

Provider types affected

Indian Health Service (HIS) and tribal providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MAC) for providing telehealth services to Medicare beneficiaries.

What you need to know

CR 6493, from which this article is taken, expands the instructions for telehealth services (effective January 1, 2009) to include Indian Health Service (IHS) and tribal providers as eligible to receive the telehealth originating site facility fee. The CR also clarifies the payment basis to the distant site physician or practitioner. You should make sure that your billing staffs are aware of this new information.

Background

Change request (CR) 6493, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is expanding the instructions for telehealth services to include Indian Health Service (IHS) and tribal providers.

Effective January 1, 2009, IHS and tribal providers are included in the telehealth service polices (presented below) and eligible to receive:

Telehealth services in Indian Health Service or tribal providers (continued)

- The originating site facility fee (generated from an originating site facility service in which the beneficiary is presented to the distant site practitioner).
- The payment to the distant site physician or practitioner (usually a professional consultation).

Telehealth Policies

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) – Revision of Medicare Reimbursement for Telehealth Services amended Section 1834 of the Social Security Act (the Act) to provide for an expansion of Medicare payment for telehealth services. With this amendment, effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a federal telemedicine demonstration program in Alaska or Hawaii. In addition, BIPA does not require that a practitioner present the patient for interactive telehealth services.

Originating Site Facility and Distant Site Practitioner Services

The originating site facility fee is equal to $23.72 for the period January 1, 2009 through December 31, 2009. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI). For CY 2009, the payment amount is 80 percent of the lesser of the actual charge or $23.72. (No clinic visit is to be billed if this is the only service received.)

The following facility types are authorized by law to be eligible for payment of the telehealth originating site facility fee when a beneficiary is presented to a distant site practitioner:

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)
- A critical access hospital (CAH)
- A rural health clinic (RHC)
- A federally qualified health center (FQHC).

Note: Except for the federal telemedicine demonstration in Alaska and Hawaii, eligibility of originating sites is limited to rural health professional shortage areas (HPSAs) and counties not classified as a metropolitan statistical area (MSA).

IHS/tribal facilities should submit claims for the originating site facility fee on types of bills (TOB) 12x, 13x, 71x, 73x, or 85x, using HCPCS code Q3014 and revenue code 0780.

Distant site practitioners include only physicians and selected medical practitioners, specifically physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse-midwives, clinical social workers (CSW), clinical psychologists (CP), or registered dietician or nutrition professionals.

Distant site practitioners services are payable as if they were provided face-to-face, using the Medicare physician fee schedule (MPFS); and are based on 80 percent of the Medicare physician fee schedule (MPFS) payment amount for a physician, and the appropriate step down percentages for other practitioners. The usual Part B coinsurance and deductible apply, but are waived for IHS/tribal facilities.

Billing providers should use the following Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology (CPT)* codes on claims for distant site practitioner services:

- Consultations (*CPT* codes *99241-99255*)
- Office or other outpatient visits (*CPT* codes *99201-99215*)
- Individual psychotherapy (*CPT* codes *90804-90809*)
- Pharmacologic management (*CPT* code *90862*)
- Psychiatric diagnostic interview examination (*CPT* code *90801*)
- Individual medical nutrition therapy (HCPCS codes G0270, 97802, and 97803)
- Neurobehavioral status exam (*CPT* code *96116*)
- Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408).

You must include either the GT modifier (for interactive telecommunications) on your claims, or the GQ modifier (for the store and forward communication) if used in the Federal Telemedicine Demonstration in Alaska or Hawaii.

Additional information

Your Medicare contractor will not search their files to find and adjust claims with dates of service on or after January 1, 2009 that were processed prior to the January 4, 2010 implementation date of CR 6493. However, they will adjust such claims that you bring to their attention.

You can find more information about the provision of telehealth services by IHS or tribal providers by going to CR 6493, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1776CP.pdf*.

You will find the updated *Medicare Claims Processing Manual,* Chapter 19 (Indian Health Services), Sections 100.16 (Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners), 100.16.1 (FI – Payment for Telehealth Services to Indian Health Service/ Tribal Facilities and Practitioners), 100.16.2 (FI – Telehealth Originating Site Facility Fee – Medicare Part B – Payment Policy) and (FI – Telehealth Originating Site Facility Fee – Medicare Part B – Claims Processing) as an attachment to that CR.

You might also want to review Medicare Claims Processing Manual Chapter 12 (Physicians/Nonphysician Practitioners), Section 190 (Medicare Payment for Telehealth Services); and *Medicare Benefit Policy Manual*

Telehealth services in Indian Health Service or tribal providers (continued)

Chapter 15 (Covered Medical and Other Health Services), Section 270 (Telehealth Services) for more information on telehealth services. This manual is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/IOM/list.asp*.

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

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Fact sheet on telehealth services now available

The *Telehealth Services* fact sheet (July 2009), which provides information about originating sites, distant site practitioners, telehealth services, and billing and payment for professional services furnished via telehealth and for the originating site facility fee, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf*. ❖

Source: CMS PERL 200907-32

Medicare demonstrations show paying for quality health care pays off

Demonstrations being conducted by the Centers for Medicare & Medicaid Services (CMS) continue to provide strong evidence that offering financial incentives for improving or delivering high quality care increases quality and can reduce the growth in Medicare expenditures. CMS is announcing new results from three of these demonstrations, one for large physician practices, one for small and solo physician practices, and one for hospitals. CMS is also announcing the start of three additional value based purchasing demonstrations.

> "We continue to be encouraged by the progress of our ongoing programs that test value based-purchasing across a variety of health care services," said Charlene Frizzera, Acting Administrator of CMS; "Building on those efforts, we are pleased to announce the start of our Nursing Home Value-Based Purchasing Demonstration and two gain-sharing demonstrations."

> "What we learn from the various Medicare demonstrations help to achieve the Administration's goals of paying for high quality and efficient health care in America," said Jonathan Blum, director of the CMS' Center for Medicare Management and acting director of the Center for Health Plan Choices. "Building on these findings, we will aggressively test new demonstration concepts to continue to meet these goals."

The CMS value-based purchasing (VBP) initiative is designed to tie Medicare payments to performance on quality and efficiency and is part of CMS' effort to transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care.

Entering its fifth year, the Hospital Quality Incentive Demonstration (HQID) shows continued quality improvement among participating hospitals. In addition, physician practices participating in the Physician Group Practice (PGP) Demonstration continue to improve quality for patients with chronic illnesses or requiring preventive care.

And more than 560 small and solo physician practices participating in the Medicare Care Management Performance (MCMP) Demonstration are being rewarded for providing high quality care in the delivery of preventive care and care for patients with chronic illnesses.

New demonstration programs include the Nursing Home Value-Based Purchasing Demonstration, the Medicare Hospital Gain-sharing Demonstration, and the Physician Hospital Collaboration Demonstration. The nursing home demonstration program will reward facilities that can improve or deliver high quality care in four specific areas: staffing, resident outcomes, avoidable hospitalizations and reductions in deficiency citations. The gain-sharing and physician hospital collaboration programs will evaluate whether gain-sharing leads to improvements in quality and efficiency. The demonstrations provide a promising opportunity for hospitals and physicians to join forces to improve quality and efficiency of care, establish effective means to govern use of inpatient resources, reduce costs, and share the rewards. Overall, demonstrations give CMS the opportunity to work closely with providers to improve quality and efficiency and serve as a vehicle to test various VBP methodologies.

Medicare demonstrations show paying for quality health care pays off (continued)

Hospitals continue to improve quality

The HQID is sponsored by Medicare in partnership with Premier, Inc., a national hospital quality measurement organization. The demonstration, which began in 2003 with hospitals in 38 states, was designed to test payment incentives under Medicare to see if they would improve the safety, quality, and efficiency of inpatient services by linking incentives to improved quality.

Participants raised overall quality by an average of 17 percentage points over four years, based on their performance on more than 30 nationally standardized and widely accepted care measures for patients in five clinical areas – heart attack, coronary bypass graft, heart failure, pneumonia, and hip and knee replacements.

CMS is awarding incentive payments totaling $12 million in year four to 225 hospitals for top performance, top improvements and overall attainment in the five clinical areas. Through the first four years, CMS awarded more than $36.6 million to top performers. After the initial three years of the demonstration, CMS extended the project for three additional years to test new incentive models, and ways to improve patient care.

Physician groups improve quality and share savings

All ten of the physician groups participating in the PGP demonstration achieved benchmark performance on at least 28 of the 32 measures reported in year three of the demonstration. Two groups – Geisinger Clinic in Danville, Penn. and Park Nicollet Health Services in St. Louis Park, Minn. – achieved benchmark performance on all 32 performance measures.

Over the first three years of the demonstration, the physician groups increased their quality scores an average of 10 percentage points on ten diabetes measures, 11 points on ten congestive heart failure (CHF) measures, six points on seven coronary artery disease (CAD) measures, 10 points on two cancer screening measures, and one percentage point on three hypertension measures.

Under the PGP demonstration, physician groups earn incentive payments based on the quality of care they provide and the estimated savings they generate in Medicare expenditures for the patient population they serve. As a result of their efforts to reduce the growth rate in Medicare expenditures, five physician groups will receive performance payments totaling $25.3 million as part of their share of $32.3 million of savings generated for the Medicare Trust Funds in performance year three.

Over 560 small physician practices earn incentive payments for quality performance

In the first year of the MCMP demonstration, almost all of the 610 participating small and solo physician practices are being rewarded for performance on 26 quality measures. CMS is awarding approximately $7.5 million dollars in incentive payments to over 560 practices in California, Arkansas, Massachusetts, and Utah. The average payment per practice is $14,000 but some practices earned as much as $62,500. Last year, CMS paid out over $1.5 million in incentives for reporting baseline quality measures.

The goal of the MCMP demonstration is to promote the use of health information technology to improve the quality of care for beneficiaries with chronic conditions.

Doctors in small to medium sized practices who meet clinical performance standards on each measure are eligible to receive financial rewards under the MCMP demonstration. The demonstration also provides an additional bonus to practices that report the data using an electronic health record (EHR) certified by the Certification Commission for Health Information Technology. Twenty-three percent of practices were able to submit at least some of the measures from a certified EHR.

Nearly 200 nursing homes in three states testing value-based purchasing

Nearly 200 nursing homes in three states will participate in a Medicare demonstration to determine if financial incentives will improve the quality of the care they provide.

The Nursing Home Value-Based Purchasing Demonstration will reward those facilities that improve or deliver quality care in four areas: nurse staffing, resident outcomes, avoidable hospitalizations, and reduction of the scope and severity of deficiency citations the home may have received during inspections. Nursing homes will be awarded points in each of these areas; homes with the highest scores or greatest improvement will become eligible for a performance payment. Savings that result from improved quality and efficiency will be used to fund incentive pools in each state.

CMS will conduct the demonstration in 79 homes in New York, 62 in Wisconsin, and 41 in Arizona. Each of these states assisted in the recruitment process by encouraging facilities to apply to CMS. Participating homes were then selected from the applicant pool.

The demonstration will run from July 2009 through June 2012, at which time its effectiveness will be evaluated to inform Medicare value-based purchasing policies.

Fourteen hospitals collaborating with over 1,000 physicians in gain-sharing demonstrations

CMS also announced today it will operate two demonstrations to evaluate gain-sharing as a means of aligning incentives between hospitals and physicians to improve quality of care and overall hospital efficiency. Gain-sharing occurs when a hospital pays incentives to a physician who assists in saving internal hospital costs while improving quality and efficiency and is normally restricted in Medicare's fee-for-service program.

The Medicare Hospital Gain-sharing Demonstration began in October 2008. This demonstration consists currently of two sites, Beth Israel Medical Center in New York City and Charleston Area Medical Center in West Virginia. Under this demonstration, CMS will evaluate whether gain-sharing leads to short-term improvements in quality and efficiency during the inpatient stay and immediately following discharge.

Medicare demonstrations show paying for quality health care pays off (continued)

The Physician Hospital Collaboration Demonstration, comprised of a consortium of twelve hospitals administered by the New Jersey Hospital Association, began in July. This demonstration is designed to track patients beyond a hospital episode to determine the impact of hospital-physician collaborations on preventing short- and longer-term complications and duplication of services.

These demonstrations will allow physicians to share in the savings generated by the adoption of structural and procedural changes made to improve the quality of inpatient hospital care.

For additional information on VBP demonstrations, visit the demonstrations Web page at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp*. ❖

Source: CMS PERL 200908-27

Provider enrollment reminder for physicians, nonphysicians, and group practices

The Centers for Medicare & Medicaid Services (CMS) reminds physicians, nonphysician practitioners, and group practices that they are required to notify their designated Medicare contractor regarding (1) a change in ownership, (2) a change in practice location, including a change in reassignment of benefits, or (3) any final adverse action (e.g., license suspension/revocation or felony conviction) within 30 days of the reportable event. By reporting changes as soon as possible, but within 30 days of the reportable event, will help to ensure that claims are processed correctly.

They are also encouraged to update their Medicare enrollment information on file with the Medicare contractor if not done so since November 2003.

They can use CMS' electronic enrollment process, known as Internet-based provider enrollment, chain and ownership system (PECOS), to enroll or make a change in an existing enrollment record.

Information in regard to reporting responsibility and other informational material regarding provider enrollment may be found on the Medicare Provider/Supplier Enrollment section of the CMS Web site, *http://www.cms.hhs.gov/MedicareProviderSupEnroll*, and in the documents available for downloading in the Downloads section of each Web page.

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

Source: CMS PERL 200908-11

Guidance on using Internet-based provider enrollment, chain and ownership system

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

Provider types affected

This article is for physicians, nonphysician practitioners, and organization providers and suppliers who are enrolled or wish to enroll in the Medicare program.

Note: Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) do not, at this time, have the option of using Internet-based provider enrollment, chain and ownership system (PECOS). The availability of Internet-based PECOS to DMEPOS suppliers will be announced at a future date.

Provider action needed

This special edition (SE) 0914 article alerts physicians, nonphysician practitioners, providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is reaching out to assist those providers and suppliers who wish to use Internet-based PECOS for enrollment in Medicare and/or to maintain the currency of the enrollment data they have on file with Medicare. Internet-based PECOS offers physicians, nonphysician practitioners, and organization providers and suppliers a means of applying for enrollment and updating their enrollment information faster than the paper enrollment process that required the use of the paper CMS-855 series of forms. The documents that describe Internet-based PECOS are available on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage*.

Background

Internet-based PECOS has been available to physicians and nonphysician practitioners since December 2008, and to organization providers and suppliers since April 1, 2009. (As noted above, DMEPOS suppliers may not use the system at this time, but will be able to do so at a future date.) There are certain pre-requisites that must be met before one can use Internet-based PECOS. In addition, the processes for physicians and nonphysician practitioners differ somewhat from those used by provider and supplier organizations. This article will present a high-level overview of these processes and will direct physicians, nonphysician practitioners, providers, and organization providers and suppliers to other sources available via the *Medicare Learning Network (MLN)* that will enable them to learn more.

An important benefit for all physicians, nonphysician practitioners, and organization providers and suppliers is that Internet-based PECOS speeds up the completion of their initial Medicare enrollment application as well as the

Guidance on using Internet-based provider enrollment, chain and ownership system (continued)

update of their enrollment information when changes occur. CMS timelines for Medicare contractors to process Internet-submitted enrollment applications are more stringent than those for paper:

- Contractors must process 90 percent of web-based applications (e.g., initial enrollments and changes of information) within 45 days of receipt of the signed and dated certification statement and supporting documentation.
- Contractors must process 80 percent of initial paper applications within 60 days, and 80 percent of paper changes of information within 45 days.

With the temporary exception of the DMEPOS suppliers, physicians, nonphysician practitioners, and organization providers and suppliers can use the Internet to enroll in Medicare, to update their existing enrollment information, to view their existing enrollment information, or to voluntarily terminate their Medicare enrollment. Once a provider or supplier submits an application via the web, the provider or supplier can view the status of that application beginning 15 days after the submission. (The 15-day time frame allows sufficient time for the Medicare enrollment contractor to have received the signed and dated certification statement and begin action on the application. More information about the certification statement will be supplied later in this article.)

One crucial point that physicians, nonphysician practitioners, and organization providers and suppliers should understand is that, if they want to use Internet-based PECOS to update or view their Medicare enrollment information, or to terminate their enrollment in Medicare, they must first have an enrollment record in PECOS. If a physician, nonphysician practitioner, or organization provider or supplier enrolled in Medicare more than five years ago and has not submitted any updates or changes to their enrollment record over the past five years, it is very likely that the provider or supplier is not in PECOS. If one of these providers or suppliers accesses Internet-based PECOS attempts to view or update the enrollment record, there will be nothing there to view or update. Providers and suppliers who find themselves in this situation will have to revalidate their enrollment with Medicare. In order to revalidate, the provider or supplier has to furnish all the information necessary to initially enroll in Medicare. This will get the provider or supplier into PECOS and will ensure that their enrollment information, which may have changed over the years, is current. **If they never submitted the CMS-588 Electronic Funds Transfer Agreement, they will have to do so as part of the revalidation.** Providers and suppliers can revalidate their enrollment via Internet-based PECOS or they can fill out the appropriate paper CMS-855 Medicare provider enrollment forms and mail them to the appropriate enrollment contractor.

The remainder of this article provides the overviews of the processes for using Internet-based PECOS and identifies other sources of information.

Physicians and nonphysician practitioners

Before a physician or nonphysician practitioner initiates a Medicare enrollment action using Internet-based PECOS, he or she will need the following:

- An active national provider identifier (NPI)
- A national plan and provider enumeration system (NPPES) user ID and password
- Personal identifying information, which includes the physician's or nonphysician practitioner's legal name on file with the Social Security Administration, date of birth, and social security number
- Professional license and certification information, which includes information regarding the physician's or nonphysician practitioner's professional license, professional school degrees or certificates
- Practice location information, which includes information regarding the physician's or nonphysician practitioner's medical practice location
- The legal business name of a solely-owned professional association (PA), professional corporation (PC), or limited liability company (LLC) on file with the Internal Revenue Service and appearing on the IRS CP575 form
- A photocopy of the CP-575 form
- The NPI of the PA, PC, or LLC
- Any federal, state, and/or local (city/county) business licenses, certifications and/or registrations specifically required by that business to operate as a health care facility
- If applicable, information about any final adverse action that impacts the physician or nonphysician practitioner.

Internet based PECOS can be accessed with the same User ID and password that a physician or nonphysician practitioner uses for NPPES. If the physician or nonphysician practitioner does not have an NPPES User ID and password and needs help in obtaining one, he or she may contact the NPI Enumerator at 1-800-465-3203 or send an e-mail to *customerservice@npienumerator.com* on the Internet.

Note: CMS recommends that a physician or nonphysician practitioner change his/her NPPES password before accessing Internet based PECOS for the first time and at least once a year thereafter. Although the user ID cannot be changed, the password should be changed periodically – at least once a year. If you need help in changing your password, contact the NPI enumerator at 1-800-465-3203 or send an e-mail to *customerservice@npienumerator.com* on the Internet.

For physicians and nonphysician practitioners, there are three basic steps to completing an enrollment action using Internet-based PECOS.

Guidance on using Internet-based provider enrollment, chain and ownership system (continued)

- Use your NPPES user ID and password to log on to Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*.
- Complete, review, and submit the electronic enrollment application via Internet-based PECOS.
- Print, sign and date the certification statement and mail the certification statement and all supporting paper documentation to the designated Medicare contractor within seven days of electronic submission.

Note: A Medicare contractor will not process an Internet-enrollment application without receipt of the signed and dated certification statement. In addition, the effective date of filing an enrollment application is the date the Medicare contractor receives the signed certification statement that is associated with the Internet-submitted application.

The certification statement must be signed by the physician or nonphysician practitioner enrolling or making changes to enrollment information. Signatures must be original and in ink (blue ink recommended). Copied or stamped signatures or dates will not be accepted.

The physician or nonphysician practitioner assumes full and complete liability for new and updated Medicare enrollment information that is transmitted to the enrollment contractor via Internet-based PECOS once the enrollment contractor receives the signed and dated certification statement.

While CMS encourages physicians and nonphysician practitioners to print and retain a copy of the Internet-submitted enrollment application for their records, physicians and nonphysician practitioners should **only mail the Certification Statement and supporting documentation to the designated Medicare contractor. Do not mail the copy of the enrollment application to the designated Medicare contractor; to do so may delay the processing of the application.**

For more information about Internet-based PECOS, along with questions and answers (Q&As), go to the Downloads section on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage*.

Provider and supplier organizations

Before a provider or supplier organization can use Internet based PECOS, the organization's authorized official must take the first step. Below is the process that occurs for an organization provider or supplier to gain access to Internet-based PECOS:

1. The organization provider/supplier's authorized official (AO) goes into PECOS I&A and registers. As part of this process, the AO must mail a photocopy of the CP-575 to the CMS EUS Help Desk so that the Help Desk can verify the organization provider/supplier.
2. The Help Desk verifies both the organization provider/supplier and the AO, and approves the AO's registration. The AO receives a system-generated e-mail indicating that the registration has been approved.
3. Once the AO receives this notification, the AO can let the end-user know that he/she can register in PECOS.
4. The end-user goes into PECOS I&A and registers. The registration request will be directed to the AO of the provider/supplier organization.
5. The AO must approve or reject the end-user in PECOS I&A.
6. Once the end-user has been approved in PECOS I&A by the AO for access on behalf of the organization provider/supplier, the end-user will receive a system-generated e-mail indicating that he/she has been approved.
7. The end-user then logs into PECOS and downloads the security consent form. He or she fills it out, obtains the signature/date of signature of the AO, and mails the completed security consent form to the CMS EUS Help Desk at P.O. Box 792750, San Antonio, TX 78216.
8. The Help Desk verifies the information on the security consent form and also calls the AO to verify that the AO did, in fact, sign the security consent form.
9. Once the information on the security consent form has been confirmed, the Help Desk approves the security consent form in PECOS and an e-mail is sent to the AO notifying the AO that the end user's organization has been approved to use Internet-based PECOS on behalf of the organization provider/supplier.
10. It is the AO's responsibility to notify the end-user's organization that the end-user can now use Internet-based PECOS. An e-mail is sent to the AO (step 9) because the AO is ultimately responsible for the enrollment information and who has access to that enrollment information. It is the AO's responsibility to inform the end-user that the security consent form has been approved.

Note: The security consent form is completed only one time to establish the relationship between the provider or supplier organization and the employer organization whose employee(s) would submit enrollment applications on behalf of the provider or supplier organization. More than one individual may request access to Internet-based PECOS for a given provider or supplier organization, but the security consent form is generated and completed by the first (if more than one) approved user who logs on to Internet-based PECOS to submit an enrollment application for the given provider or supplier organization. A security consent form must be completed, signed and dated, and mailed to the CMS EUS Help Desk even if the employer organization is the provider or supplier organization.

More detail about obtaining access to Internet-based PECOS for providers and suppliers can be found in the document entitled, "Getting Started with Internet-based Provider Enrollment, Chain and Ownership System (PECOS) – Information for Provider and Supplier Organizations," along with Q&As is available on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf*.

Guidance on using Internet-based provider enrollment, chain and ownership system (continued)

Limitations of Internet-based PECOS for provider and supplier organizations

There are some scenarios that Internet-based PECOS cannot accommodate at this time; they will be available at a future date. These scenarios are:

- Changes in taxpayer identification number (TIN). These must be done using the paper enrollment application (CMS-855).
- Changes in legal business name (LBN). These must be done using the paper enrollment application (CMS-855).
- An enrolled Medicare Part A provider or supplier organization wants to enroll with a Medicare carrier or A/B Medicare administrative contractor (MAC) to bill for Part B services. This must be done using the paper enrollment application (CMS-855).

These scenarios are listed in the document entitled, "Overview of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) – Information for Provider and Supplier Organizations," available on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/OrganizationOverview.pdf*.

Additional information

The CMS External User Services (EUS) Help Desk contact information for providers and suppliers using Internet-based PECOS may be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/ContactInformation.pdf*.

The Help Desk hours of operation are Monday – Friday, from 6 a.m. to 6 p.m. Central Standard Time. The Help Desk toll-free number is 1-866-484-8049 and their e-mail address is *eussupport@cgi.com*. Questions about accessing and using Internet-based PECOS should be directed to the CMS EUS Help Desk.

The overall CMS site regarding provider and supplier enrollment can be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on the CMS Web site. From there, click on "Internet-based PECOS" on the left-hand side to go to information specific to Internet-based PECOS.

If you have Medicare enrollment policy 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*.

Remember that for security reasons, passwords should be periodically, at least once a year. Physicians and nonphysician practitioners should read and fully understand the document entitled, "Medicare Physician and Nonphysician Practitioners – Protecting Your Privacy, Protecting Your Medicare Enrollment Record" which is available on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/MedPhysPrivacy.pdf*.

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Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0914

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Update to the payment rates, cap, wage index, and the hospice PRICER for fiscal year 2010

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.

What you need to know

This article is based on change request (CR) 6606 which provides the annual update to the hospice payment rates for fiscal year (FY) 2010, the hospice aggregate cap amount for the cap period ending October 31, 2009, and the hospice wage index and PRICER for FY 2010. Be sure your billing staffs are aware of these changes, which are described in the *Background* section, below.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the payment for hospice care, the hospice aggregate cap amount, and the hospice wage index annually.

- The Social Security Act (Section 1814(i)(1)(C)(ii)) (the Act) stipulates that the payments for hospice care for fiscal years after 2002 will increase by the market basket percentage increase for that fiscal year, and this payment methodology has been codified in the *Code of Federal Regulations* (Title 42, Section 418.306 (a)&(b)).

Update to the payment rates, cap, wage index, and the hospice PRICER for fiscal year 2010 (continued)

You may review the Social Security Act, Section 1814(i)(1)(C)(ii) on the Internet at *http://www.ssa.gov/OP_Home/ssact/title18/1814.htm*, and 42CFR418.306(a)&(b) at *http://edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr418.306.pdf*.

- The hospice aggregate cap amount is updated annually. Specifically, the cap amount is increased or decreased for accounting years after 1984 by the same percentage as the percentage increase or decrease (respectively) in the medical care expenditure category of the consumer price index for all urban consumers.
- The hospice wage index, used to adjust payment rates to reflect local differences in wages according to the revised wage index, is updated annually in accordance with recommendations made by a negotiated rulemaking advisory committee as published in the *Federal Register* on August 8, 1997 (see on the Internet *http://bulk.resource.org/gpo.gov/register/1997/1997_42883.pdf*) and on August 8, 2008 (see on the Internet *http://edocket.access.gpo.gov/2008/pdf/E8-17795.pdf*); and the *Code of Federal Regulations* (42 CFR 418.306(c)) requires that the updated hospice wage index be published annually in the *Federal Register* (see on the Internet at *http://edocket.access.gpo.gov/cfr_2006/octqtr/pdf/42cfr418.306.pdf*.)

The annual hospice payment updates will be implemented through the hospice PRICER software. The new PRICER module will not contain any new calculation logic, but will simply apply the existing calculation to the updated payment rates shown below. An updated table will be installed in the module, to reflect the FY 2010 hospice wage index.

Fiscal year 2010 hospice payment rates

The FY 2010 payment rates will be the FY 2009 payment rates, increased by 2.1 percentage points, which is the total hospital market basket percentage increase forecasted for FY 2010. The FY 2010 hospice payment rates are shown in the following table and are effective for care and services furnished on or after October 1, 2009, through September 30, 2010.

Code	Description	Rate	Wage component subject to index	Non-weighted amount
651	Routine home care	$142.91	$ 98.19	$ 44.72
652	Continuous home care full rate = 24 hours of care $34.75= hourly rate	$834.10	$573.11	$260.99
655	Inpatient respite care	$147.83	$ 80.02	$ 67.81
656	General inpatient care	$635.74	$406.94	$228.80

Reference to the hospice payment rate is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 30.2 (Payment Rates); see the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf*.

Hospice cap

The latest hospice cap amount for the cap year ending October 31, 2009 is $23,014.50. In computing the cap, CMS used the medical care expenditure category of the March 2009 consumer price index for all urban consumers, published by the Bureau of Labor Statistics (*http://www.bls.gov/cpi/home.htm*), which was 373.189. The hospice cap is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 80.2 (Cap on Overall Hospice Reimbursement); see on the CMS Web site *http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf*.

Hospice wage index

The hospice wage index final rule will be effective October 1, 2009, and the final rule for the 2010 hospice wage index is available at *http://edocket.access.gpo.gov/2009/pdf/E9-18553.pdf* on the Internet. The revised wage index and payment rates will be incorporated in the hospice Pricer and forwarded to the intermediaries following publication of the wage index final rule.

Reminder: Hospice providers are encouraged to split claims when the dates of service span separate fiscal years, e.g., claims with September and October services. This allows Medicare systems to price the September services at the FY 2009 rates and the October services at the FY 2010 rates. If you do not split such claims, all the services will be paid using the FY 2009 rates and your Medicare contractor will not perform subsequent adjustments for such claims paid totally at the 2009 rates.

Additional information

You may find the official instruction, CR 6606, issued to your FI, A/B MAC, or RHHI by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1796CP.pdf*.

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

Update to the payment rates, cap, wage index, and the hospice PRICER for fiscal year 2010 (continued)

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Related CR Release Dte: August 14, 2009
Related CR Transmittal Number: R1796CP
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Source: CMS Pub. 100-04, Transmittal 1796, CR 6606

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Compliance standards for consignment closets and stock and bill arrangements

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

Provider types affected

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that maintain inventory at a practice location owned by a physician or nonphysician practitioner for the purpose of DMEPOS distribution and which submit claims to the national supplier clearinghouse Medicare administrative contractor (NSC-MAC) are affected. In addition, physicians and nonphysician practitioners who maintain DMEPOS inventory at the physician or non-physician practitioner's practice location for the purpose of DMEPOS distribution should be aware of this issue.

Provider action needed

DMEPOS suppliers, physicians and non-physician practitioners who maintain consignment closets and stock and bill arrangements for DMEPOS must comply with current standards, which may be verified by the NSC-MAC. Providers should assure that their billing staff are advised of these billing and compliance standards.

Background

This article is based on CR 6528, which defines and prohibits certain arrangements where an enrolled DMEPOS supplier maintains inventory at a practice location that is not owned by the enrolled DMEPOS supplier, but rather, owned by a physician or nonphysician practitioner for the purpose of DMEPOS distribution, commonly referred to as a consignment closet and/or stock and bill arrangement. A common practice example is that of an enrolled physician practice that allows DMEPOS owned by a separately enrolled DMEPOS supplier to be kept at the physician's practice location.

CR 6528 instructs the NSC-MAC that use of consignment closets and/or stock and bill arrangements, as defined in the background above, must be in compliance with current standards. In addition, the CR defines additional specific compliance standards for NSC-MAC validation for consignment closets and stock and bill arrangements added to the *Medicare Program Integrity Manual (PIM)*, Chapter 10, Section 21.8, and viewable as an attachment to CR 6528 on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R297PI.pdf*.

Medicare allows Medicare-enrolled DMEPOS suppliers to maintain inventory at a practice location owned by a physician or nonphysician practitioner for the purpose of DMEPOS distribution when the following conditions are met by the DMEPOS supplier and verified by the NSC-MAC:

- The title to the DMEPOS shall be transferred to the enrolled physician or nonphysician practitioner's practice at the time the DMEPOS is furnished to the beneficiary.
- The physician or nonphysician practitioner's practice shall bill for the DMEPOS supplies and services using their own enrolled DMEPOS billing number.
- All services provided to a Medicare beneficiary concerning fitting or use of the DMEPOS shall be performed by individuals being paid by the physician or non-physician practitioner's practice, not by any other DMEPOS supplier.
- The beneficiary shall be advised that, if they have a problem or questions with the DMEPOS, they should contact the physician or non-physician practitioner's practice, not the DMEPOS supplier who placed the DMEPOS at the physician or nonphysician practitioner's practice.

The NSC-MAC shall verify that no more than one enrolled DMEPOS supplier shall be enrolled and/or located at the same practice location. (Note: This prohibition does not exist for one or more physicians enrolled as DMEPOS suppliers at the same physical location.) A practice location shall have a separate entrance and separate post office address, recognized by the United States Postal Service.

The NSC-MAC customer service personnel shall respond to direct provider and/or supplier questions concerning compliance with this policy. The responsibility for determining compliance with these provisions is the responsibility of the DMEPOS supplier, physician, or nonphysician practitioner.

Compliance standards for consignment closets and stock and bill arrangements (continued)

Additional information

The official instruction, CR 6528, issued to the Medicare NSC-MAC regarding this change, may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R300PI.pdf*.

If you have questions, please contact the Medicare NSC-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: MM6528
Related Change Request (CR) Number: 6528
Related CR Release Date: September 1, 2009
Related CR Transmittal Number: R300PI
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Implementation Date: March 1, 2010

Source: CMS Pub. 100-08, Transmittal 297, CR 6528

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Areas and product categories included in the DMEPOS competitive bidding program round one rebid in calendar year 2009

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

Provider types affected

Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers that bill DME Medicare administrative contractors (DME MACs) as well as providers that bill Medicare regional home health intermediaries (RHHIs) or Part A/B Medicare administrative contractors (A/B MACs) whom refer or order DMEPOS for Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6571 in order to identify the nine metropolitan statistical areas (MSAs) as well as product categories in which the DMEPOS competitive bidding round one re-bid will occur in calendar year (CY) 2009 under section 1847 of the Social Security Act.

Key points of change request 6571

As mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the DMEPOS competitive bidding round one rebid in 2009 will occur in the following nine MSAs:

- Cincinnati—Middletown (Ohio, Kentucky and Indiana)
- Cleveland—Elyria—Mentor (Ohio)
- Charlotte—Gastonia—Concord (North Carolina and South Carolina)
- Dallas—Fort Worth—Arlington (Texas)
- Kansas City (Missouri and Kansas)
- Miami—Fort Lauderdale—Miami Beach (Florida)
- Orlando (Florida)
- Pittsburgh (Pennsylvania)
- Riverside—San Bernardino—Ontario (California).

Further information on the boundaries and list of ZIP codes for each competitive bid area (CBA) and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp* on the CMS Web site and following the link to competitive bidding implementation contractor (CBIC).

The DMEPOS competitive bidding round one rebid in 2009 will include the following nine product categories:

- Oxygen supplies and equipment
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (group 2)
- Mail-order diabetic supplies
- Enteral nutrients, equipment and supplies
- Continuous positive airway pressure (CPAP), respiratory assist devices (RADs), and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Support surfaces (group 2 mattresses and overlays) in Miami.

The MSAs and product categories that are included in the DMEPOS competitive bidding round I rebid in 2009 may also be found on the CMS Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp*.

Suppliers and providers may call the Provider Contact Centers with competitive bidding inquiries at the CBIC Competitive Bidding Program Helpdesk at 1-877-577-5331 or go to the "Contact Us" feature on the CBIC Competitive Bidding Program Web site at *http://www.dmecompetitivebid.com/* on the Internet to submit competitive bidding specific questions.

Areas and product categories included in the DMEPOS competitive bidding program round one rebid... (continued)

Background

The Medicare payment for most DMEPOS is currently based on fee schedules. However, section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which amended section 1847 of the Social Security Act (the Act), mandates a competitive bidding program to replace the current DMEPOS fee schedule payment amounts for selected items in selected areas.

The statute provides that competitive bidding will apply to DME meeting the definition of a "covered item" as specified in section 1834(a) (13) of the Act, including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with DME, but excluding class III devices under the Federal Food, Drug and Cosmetic Act. Competitive bidding will also apply to enteral nutrients, equipment, and supplies. Further, competitive bidding will apply to off-the-shelf orthotics described in section 1861(s)(9) for which payment would otherwise be made under Section 1834(h) which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

The statute, as amended by the MMA, also provided for phasing in competitive bidding beginning in 10 of the largest MSAs. Areas that may be exempt from the DMEPOS competitive bidding program include rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service.

Round one of the DMEPOS competitive bidding program was implemented on July 1, 2008, in ten competitive bidding areas, as mandated by the MMA. However, as part of MIPPA, Congress enacted a temporary delay in the competitive bidding program for round one competitive bidding areas. The law required CMS to terminate the existing contracts that were awarded in round one and conduct a second round one competition (the "round one rebid") in 2009. The MIPPA also excluded certain round one DMEPOS items and areas from the competitive bidding program. Section 154(a) of the MIPPA exempted group three complex rehabilitative power wheelchairs and related accessories when furnished in connection with such wheelchairs for the round one rebid and subsequent rounds of the program, as well as, negative pressure wound therapy (NPWT) items and services from the round one rebid competition. The MIPPA also excluded Puerto Rico as an area so that the round one rebid competition covers nine, instead of ten of the largest MSAs. Except for the aforementioned exceptions, section 154(a) of the MIPPA requires that the round one rebid occur in 2009 with the same items and services and the same areas as in round one.

Additional information

The official instruction (CR 6571) issued to your Medicare DME/MAC, RHHI or A/B MAC is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R527OTN.pdf*.

For clarification of the initial delay in the DMEPOS competitive bidding program you may review MM6203 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6203.pdf*.

If you have questions, please contact your Medicare DME/MAC, RHHI 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: MM6571
Related Change Request (CR) Number: 6571
Related CR Release Date: August 3, 2009
Related CR Transmittal Number: R527OTN
Effective Date: August 3, 2009
Implementation Date: September 3, 2009

Source: CMS Pub. 100-20, Transmittal 527, CR 6571

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Medicare provider enrollment reminder for DMEPOS suppliers

With the implementation of the surety bond requirements for certain suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in October 2009, the Centers for Medicare & Medicaid Services (CMS) reminds DMEPOS suppliers that each practice location of a DMEPOS supplier must be enrolled in the Medicare program. Each practice location of a DMEPOS supplier is required by Medicare regulations to be uniquely identified. As a result, each practice location must have its own unique national provider identifier (NPI) and its own Medicare-assigned provider transaction access number (PTAN). With the exception described in the "Important note" below, there should be a one-to-one relationship between a DMEPOS supplier's NPI and its PTAN. The PTAN is assigned to a DMEPOS supplier by the national supplier clearinghouse (NSC) upon enrollment in the Medicare program. (The PTAN has previously been referred to as the NSC number.)

Note: DMEPOS suppliers who are sole proprietorship business structures with more than one practice location must ensure that each location is enrolled in Medicare. Each practice location would be assigned a PTAN upon its enrollment. However, as a sole proprietorship, the business is legally one and the same as the person who is the sole proprietor and, therefore, like any individual, is eligible for only a single NPI. ❖

Source: CMS PERL 200908-12

Reminders for getting ready for the durable medical equipment, prosthetics, orthotics, and supplies competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 1 rebid is coming soon.

Summer 2009

- CMS announces bidding schedule/schedule of education events
- CMS begins bidder education campaign
- Bidder registration period to obtain user ID and passwords begins

Fall 2009

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait.

Update your national supplier clearinghouse (NSC) files: DMEPOS supplier standard # 2 requires all suppliers to notify the NSC of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update:

- The list of products and services found in Section 2.D
- The authorized official(s) information in Sections 6A and 15
- The correspondence address in Section 2A2 of the CMS-855S.

This is especially important for suppliers who will be involved in the Medicare DMEPOS competitive bidding program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC Web site (*http://www.palmettogba.com/nsc*) by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get licensed: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. As part of the bid evaluation we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

Get accredited: CMS would like to remind DMEPOS suppliers that time is running out to obtain accreditation by the September 30, 2009 deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of six months to complete. DMEPOS suppliers should contact a CMS deemed accreditation organization to obtain information about the accreditation process and the application process. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Get bonded: CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009 deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of sureties from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies;" located at *http://www.fms.treas.gov/c570/c570_a-z.html*.

Visit *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/* for the latest information on the DMEPOS competitive bidding program.

DMEPOS supplier accreditation and surety bond requirement deadlines coming in October

Suppliers may choose to voluntarily terminate enrollment if they do not plan to comply.

Medicare suppliers DMEPOS, unless exempt, must be accredited and obtain a surety bond by October 1, 2009, and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntary terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page 4 of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the NSC. By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier. For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Reminders for getting ready for the DMEPOS competitive bidding (continued)

Frequently asked questions (FAQs) on the surety bond requirement may be found on the NSC's FAQ page at *http://www.palmettogba.com/nsc*.

Take action now to prepare for the Medicare DMEPOS Competitive Bidding Program

A special edition MLN Matters education article identifying steps suppliers should take in preparation for the DMEPOS Competitive Bidding Program to ensure successful bidder registration is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0915.pdf*. ❖

Source: CMS PERL 200908-13

Registration is open for suppliers interested in durable medical equipment, prosthetics, orthotics, and supplies competitive bidding

Registration is now open and available to all suppliers interested in participating in the round 1 rebid of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding Program. Interested suppliers may submit their bids using an online application. To help ensure bid security and privacy, suppliers must first register to obtain a user ID and password. Only suppliers that have a user ID and password will be able to use the online bidding system; suppliers that do not register will not be able to bid.

If you are a supplier interested in bidding, register now – don't wait. Designate one authorized official (AO) listed on the CMS-855S enrollment form to act as your AO for registration purposes. The AO must register first and must approve other supplier employee requests to register. The AO's user ID and password will be sent by mail and should be delivered within 10 days after successful registration. After an AO successfully registers, the AO may designate other supplier employees to serve as backup authorized officials (BAO) and/or end users (EU). BAOs and EUs must also register in order to be able to use the online bidding system. Legal names, dates of birth, and social security numbers (SSNs) of all users must match the information on file with the Social Security Administration. Legal names, dates of birth, and SSNs of all users must match what is on file with the Social Security Administration.

We strongly urge all AOs to register no later than September 14, 2009, to ensure that BAOs and EUs have time to register before bidding begins. We recommend that BAOs register no later than October 9, 2009, so that they will be able to assist AOs with approving EU registration. Registration will close on November 4, 2009, at 9:00 p.m. (ET); no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) Web site at *http://www.dmecompetitivebid.com*.

Please review the IACS Reference Guide for step-by-step instructions on registration. The CBIC Web site also has the following useful tools: A registration checklist, quick step guides, and frequently asked questions. All suppliers interested in bidding are urged to sign up for e-mail updates on the homepage of the CBIC Web site.

We would like to remind all suppliers interested in bidding that we will be holding the first in a series of eight special open door forum (ODF) bidders' conferences for the round 1 rebid of the DMEPOS Competitive Bidding Program on August 19, 2009, from 2:00-3:00 p.m. (ET). This special ODF will provide an overview of what to expect during the bidder education period and provide suppliers with a step-by-step explanation of the registration process. In addition, common registration issues will be identified from the original round 1 of the DMEPOS Competitive Bidding Program, and refinements to the bidding system will be discussed.

The PowerPoint presentation for the conference, along with information on how to participate, may be found on the CBIC Web site.

If you have any questions about the registration process, please contact the CBIC Customer Service Center at 1-877-577-5331. For information about the competitive bidding areas and product categories included in the round 1 rebid, as well as bidder education materials, please visit the CBIC Web site at http://www.dmecompetitivebid.com.

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

Source: CMS PERL 200908-19

Calendar year 2009 home health prospective payment system PC PRICER update

The calendar year 2009 home health PPS (HH PPS) PC PRICER is needed to revert back to the previous release level. However, the provider data distributed with the HH PPS PC PRICER has been updated as of August 2009. This is available on the Web page, *http://www.cms.hhs.gov/PCPricer/05_HH.asp*, under the Downloads section.

If you use the HH PPS PC PRICER, go to this page and download the latest version (which is the previous version) of the PC PRICER.

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

Source: CMS PERL 200908-24

Revised processing of osteoporosis drugs under the home health benefit

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

Provider types affected

Home health agencies (HHA) submitting claims to Medicare contractors (regional home health intermediaries (RHHI), fiscal intermediaries (FI) and Medicare administrative contractors (MAC)) for injectable osteoporosis drugs provided to Medicare beneficiaries are affected.

Provider action needed

HHAs are reminded that the current criteria for coverage of injectable osteoporosis drugs must be met when submitting claims for these drugs. There is no change in these criteria. However, this article explains that the date of service on claims submitted for covered osteoporosis drugs must fall within the start and end dates of an existing home health prospective payment system (PPS) episode. Please inform your billing staffs of this requirement.

Background

Medicare covers injectable osteoporosis drugs if certain criteria are met. These criteria include:

- Eligibility for coverage of home health services
- Physician certification that the individual sustained a bone fracture related to post-menopausal osteoporosis
- Physician certification that the female patient is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

Currently, the second and third criteria are enforced to the extent possible through Medicare systems by edits that require that the beneficiary is female and that the diagnosis code 733.01 (post-menopausal osteoporosis) is present. However, the first criterion that the beneficiary must be covered under the home health benefit is only partially enforced. If an osteoporosis claim is received and a home health episode of care is on file, Medicare requires that the provider number of the HHA submitting the osteoporosis claim must be the same as the provider number on the episode record. Change request 6512 revises the Medicare systems to fully enforce this criterion by requiring that the date of service for an injectable osteoporosis drug on a home health claim falls within the start and end dates of an existing home health episode if the claim contains:

- Type of bill 34x
- Healthcare Common Procedure Coding Systems (HCPCS) codes J0630, J3110 or J3490
- Covered charges corresponding to these HCPCS codes.

Claims not meeting the criteria for coverage will be rejected with the following messages: MSN message 6.5, “Medicare cannot pay for this injection because one or more requirements for coverage were not met,” and claim adjustment reason code 177, “Patient has not met the required eligibility requirements.”

Additional information

The official instruction, CR 6512, issued to your Medicare RHHI, FI, and/or MAC regarding this change, may be viewed at on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1773CP.pdf*.

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

MLN Matters® Number: MM6512
Related Change Request (CR) Number: 6512
Related CR Release Date: July 24, 2009
Effective Date: January 1, 2010
Related CR Transmittal Number: R1773CP
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1773, CR 6512

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Electronic Health Records

Electronic health records and the 21st century health care system

A message from Dr. David Blumenthal, National Coordinator for Health Information Technology

In my role as national coordinator for Health IT, I have the privilege to be part of a transformative change in health care that will help to extend the benefits of health information technology (HIT) to all Americans. With the passage earlier this year of the Health Information Technology for Economic and Clinical Health (HITECH) Act, we have the tools to begin a major transformation in American health care made possible through the creation of a secure, interoperable nationwide health information network.

Of course, this system is not an end in itself. Rather, it will enable countless other improvements in the quality and efficiency of health care that will make Americans healthier and their economy stronger.

My personal belief in this transformation is not based on theory or conjecture. As a primary care physician for over 30 years, I spent the first twenty shuffling papers in search of missing studies and frequently hoping, during middle-of-the-night emergencies, that I knew enough about patients' medical histories to make good decisions. All that changed when I began to have access to patients' electronic medical records. It made me a much better doctor. I would never go back, and neither would the vast majority of American physicians who have made the leap into the electronic age.

In fact, it would be hard for any health professional today to escape the conclusion that the antiquated, paper-dominated system we now have in place isn't working well for patients, creates added costs and inefficiencies, and isn't sustainable. As we look at our nation's annual health care expenditures of approximately $2.5 trillion, there are many ways our current system fails both patients and providers. It is clear that change is necessary.

But how and why is nationwide electronic health information exchange so critical to achieving such change? Most importantly, because it provides the best opportunity for each patient to receive optimal care. The technology will make patients' complete medical information securely and reliably available to health care providers where and when it is needed – when clinician and patient are together facing medical decisions that can make a lasting difference.

Better, faster, more reliable and efficient care also ultimately reduces system-wide costs by delivering results that help to avoid expensive or prolonged hospitalization from delayed or ineffective treatment, avert costly and sometimes fatal adverse events and unnecessary procedures, and can help to eliminate the onset of disease by better informed management of each patient's health.

The goal of assuring an electronic health record for every American is daunting. We at the Office of the National Coordinator for Health Information Technology (ONC) do not pretend otherwise. We know this will be hard for some clinicians and hospitals, and we stand ready to help with resources provided by the Congress and the Administration.

We also recognize that we cannot achieve the benefits of a nationwide health information system unless we can assure all Americans that their personal health information will remain private and secure when this system exists. Putting into place safeguards for the privacy and security of this information, when it is in electronic form, will be an ongoing priority that influences and guides all of our efforts.

In the days, weeks, and months ahead, we will be rolling out a number of pivotal initiatives called for under the HITECH Act. I urge you to join and support us as we lay the foundation for every American to benefit from an electronic health record, as part of a modernized, interconnected, and vastly improved system of care delivery. We at ONC will be making every effort to keep you updated and fully engaged in all the steps of this national journey.

Sincerely,
David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health & Human Services

This letter is the first in a series of ongoing updates from the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology.
For more information and to receive regular updates from the Office of the National Coordinator for Health Information Technology, please subscribe to the Health IT News list.
If you have difficulty viewing this message, please view it online at *http://healthit.hhs.gov/portal/server.pt?open=512&objID=1327&parentname=CommunityPage&parentid=4&mode=2&in_hi_userid=11113&cached=true*.

To ensure that you receive future correspondence, please add this e-mail address to your list of secure addresses *https://service.govdelivery.com/service/subscribe.html?code=USHHS_188*. ❖

Source: CMS PERL 200908-26

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Available grants to help hospitals and doctors use electronic health records

Vice President Joe Biden announced the availability of grants worth nearly $1.2 billion to help hospitals and health care providers implement and use electronic health records. The grants will be funded by the American Recovery and Reinvestment Act of 2009 (ARRA) and will help health-care providers qualify for new incentives that will be made available in 2010 to doctors and hospitals that meaningfully use electronic health records.

> "With electronic health records, we are making health care safer; we're making it more efficient; we're making you healthier; and we're saving money along the way," said Vice President Biden. "These are four necessities we need for health care in the 21st-century." "Expanding the use of electronic health records is fundamental to reforming our health care system," said HHS Secretary Sebelius. "Electronic health records can help reduce medical errors, make health care more efficient and improve the quality of medical care for all Americans. These grants will help ensure more doctors and hospitals have the tools they need to use this critical technology."

The grants made available include:

- Grants totaling $598 million to establish approximately 70 health information technology regional extension centers, which will provide hospitals and clinicians with hands-on technical assistance in the selection, acquisition, implementation, and meaningful use of certified electronic health record systems.
- Grants totaling $564 million to states and qualified state designated entities (SDEs) to support the development of mechanisms for information sharing within an emerging nationwide system of networks.

The extension center grants will be awarded on a rolling basis, with the first awards being issued in fiscal year 2010. Grants to states will be made in fiscal year 2010. Those interested in applying for these grants may visit *http://healthit.hhs.gov/portal/server.pt* for more information.

> "With these programs, we begin the process of creating a national, private and secure electronic health information system. The grants are designed to help doctors and hospitals acquire electronic health records and use them in meaningful ways to improve the health of patients and reduce waste and inefficiency," said Dr. David Blumenthal, National Coordinator for Health Information Technology. "They will also help states lead the way in creating the infrastructure for health information exchange, which enables information to follow patients within and across communities, wherever the information is needed to help doctors and patients make the best decisions about medical care."

The Department of Health & Human Services (HHS) will also provide additional assistance to health care providers through the Health Information Technology Research Center (HITRC). The HITRC will gather relevant information on effective practices from a wide variety of sources across the country and help the regional extension centers collaborate with one another and with relevant stakeholders to identify and share best practices in EHR adoption, effective use, and provider support.

The following two fact sheets are available:

Health Information Technology Extension Program Facts-At-A-Glance – *http://www.hhs.gov/recovery/programs/hitech/factsheet.html*

State Health Information Exchange Grant Programs Facts-At-A-Glance – *http://www.hhs.gov/recovery/programs/hitech/stateinfoexch.html*

The activities described in this release are being funded through the American Recovery and Reinvestment Act (ARRA). To track the progress of HHS activities funded through the ARRA, visit *http://www.hhs.gov/recovery*.

To track all federal funds provided through the ARRA, visit *http://www.recovery.gov*. ❖

Source: CMS PERL 200908-28

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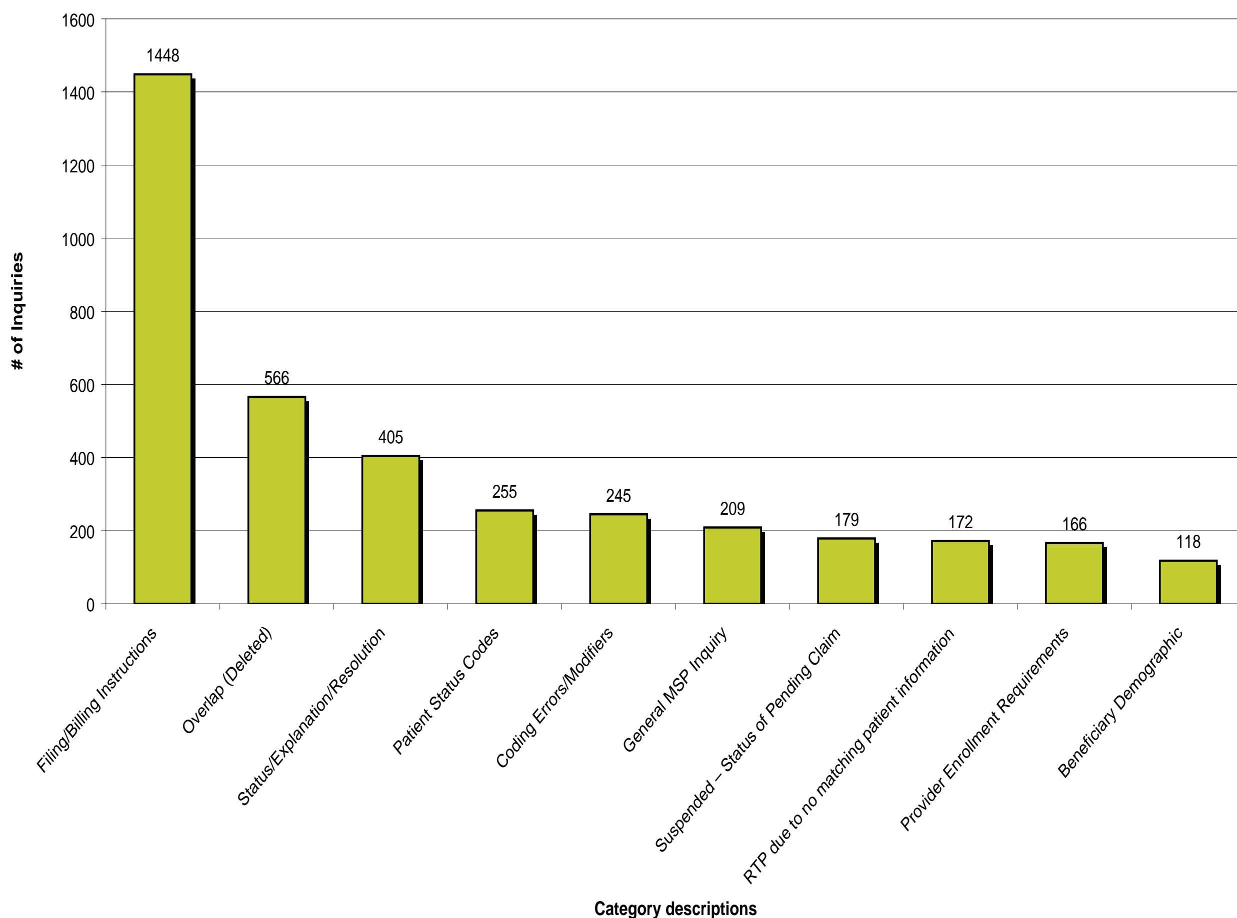
Claim and Inquiry Summary Data

Top inquiries, return to provider, and reject claims for July 2009

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

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

Florida Part A top inquiries for July 2009



Frequent asked question related to overlapping services

Q: What steps can be taken to identify claims that overlap with another provider?

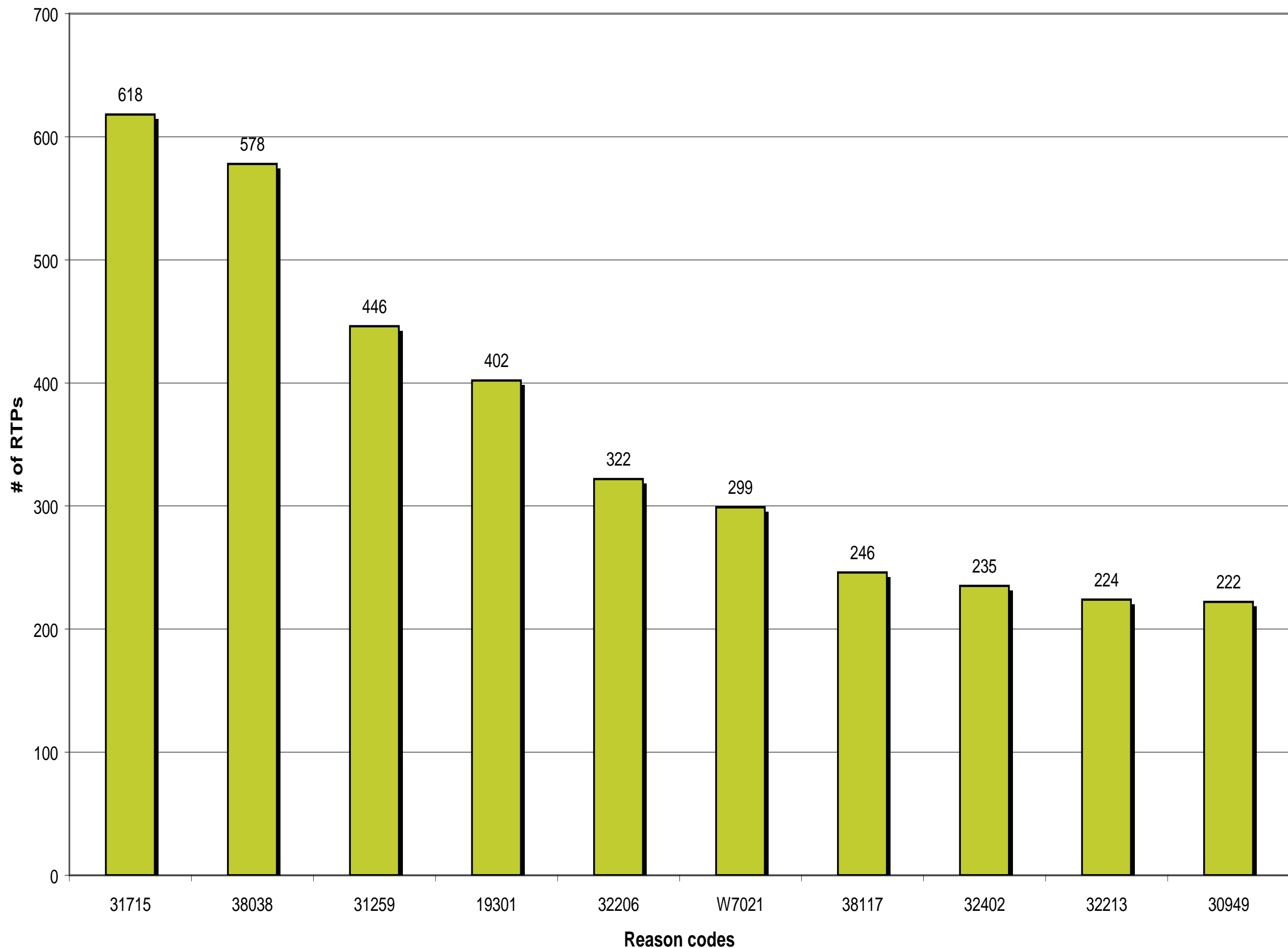
A: If you receive an overlap reason code, you can do one of the following:

- Verify claims submitted through direct data entry (DDE): Use option 1 (inquiry menu), choose option 12 (claims summary), and key in the beneficiary's health insurance claim (HIC) number, your provider number, and press enter. This will give you a list of claims you have submitted for this beneficiary. Review the list to identify those claims with identical dates of service and open them to ensure that they have been submitted correctly.
- Review the CMS Internet-only manual, publication 100-04, Chapter 25, Completing and Processing the Form CMS-1450 Data Set, for a listing of appropriate codes to use on the claim(s). You may view the manual at *http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf*.
- Review the remittance advice notice, which lists the claims processed to final adjudication. ❖

Source: CMS Pub. 100-04, Chapter 25

Top inquiries, return to provider, and reject claims for July 2009 (continued)

Florida Part A top RTPs for July 2009



Frequent asked question related to reason code 31715

Q: What steps can we take to validate if the units of service are in excess of the medically reasonable daily allowable frequency and avoid RTP reason code 31715 on our claims?

A: CMS established units of service edits, referred to as medically unlikely edits (MUEs), to lower the Medicare fee-for-service paid claims error rate. Reason code 31715 will set when your claim fails these edits. Verify the information you submitted on your claim, correct any error(s), and resubmit your claim.

You may review change request (CR) 5402 and/or MLN Matters® article MM5402 to become familiar with the MUEs and the process. We have provided the links to these documents below:

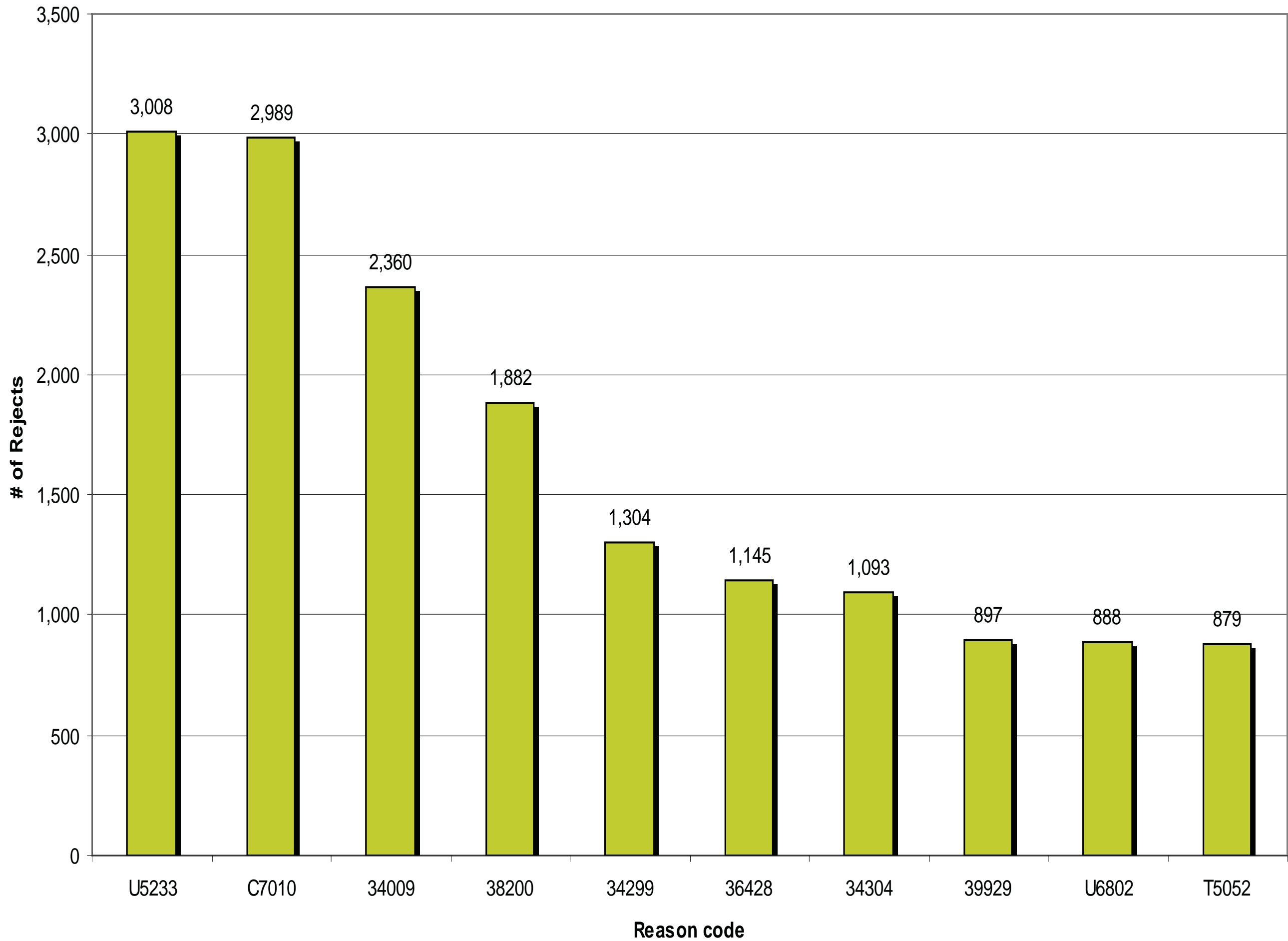
- CR5402 – *http://www.cms.hhs.gov/transmittals/downloads/R178PI.pdf*
- MM5402 – *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5402.pdf*

CMS also released an article concerning MUEs, as well as some of the codes. You can find the information on the following link: *http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp*. ❖

Source: CMS Pub. 100-08, Transmittal 178, CR 5402

Top inquiries, return to provider, and reject claims for July 2009 (continued)

Florida Part A top rejects for July 2009



Frequent asked question related to reason code U5233

Q: We are receiving reject reason code U5233 on some of the claims that we submit, indicating the admission date falls within a risk Group Health Organization (GHO) paid period. What steps should we take to determine if a beneficiary is in a GHO?

A: To avoid this reject reason code, verify the beneficiary eligibility prior to submitting the claims. There are two ways to obtain this information:

1. Direct data entry (DDE), or
2. You can contact the interactive voice response (IVR) unit by calling 1-877-602-8816. For instructions, refer to the Part A IVR operating guide.

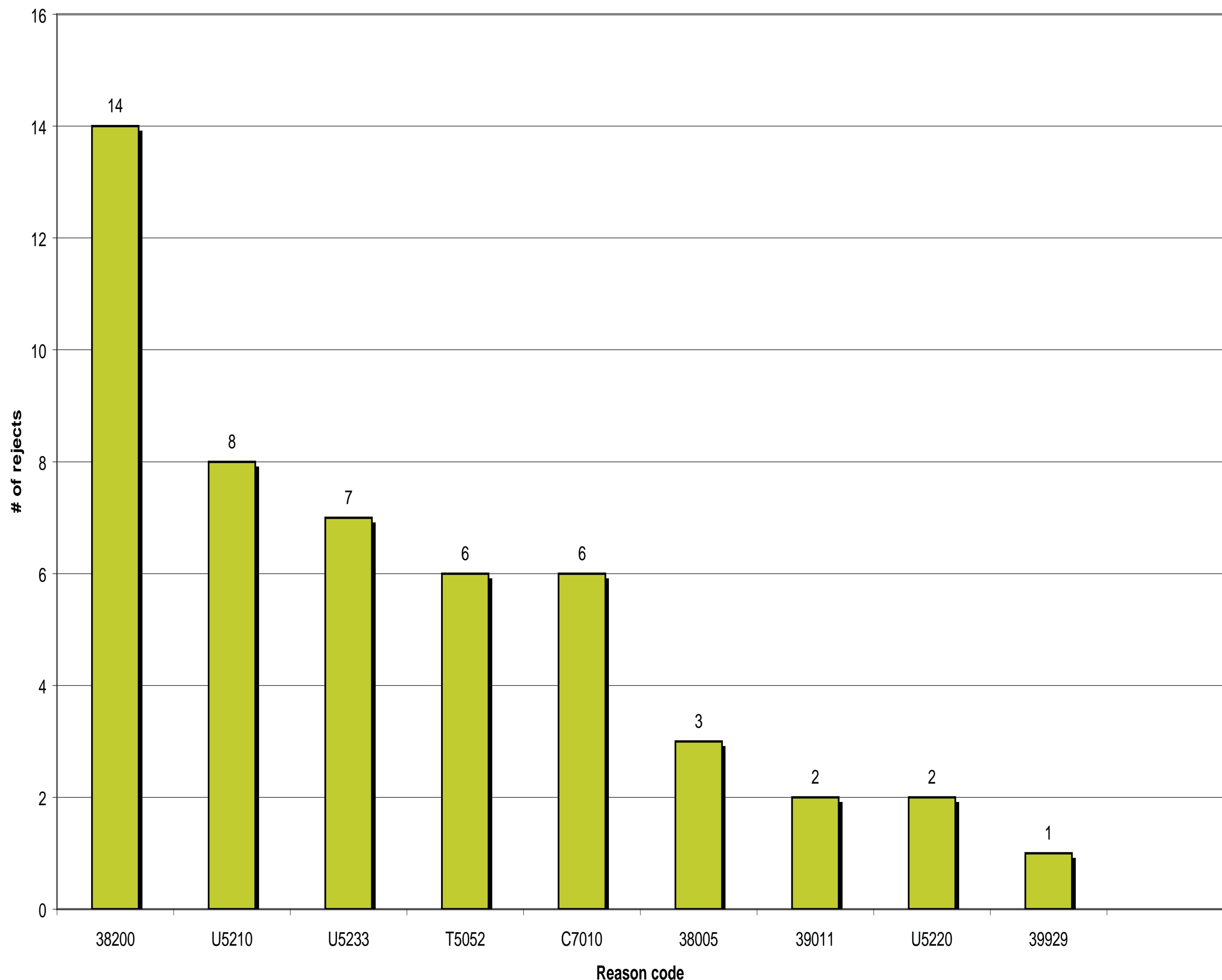
If the GHO has paid on the claim, you must submit the appropriate code and/or condition code “69” on the claim.

Condition code 69 – IME/DGME/N&A payment only. Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/Nursing and Allied Health). ❖

Source: CMS Pub. 100-04, Chapter 25-Completing and Processing the Form CMS-1450 Data Set
CMS Pub 100-04, Chapter 2, Section 30.12; Chapter 3, Section 20.8

Top inquiries, return to provider, and reject claims for June 2009 (continued)

U.S. Virgin Islands Part A top rejects for July 2009



Frequent asked question related to reason code 38200

Q: We are receiving reject reason code 38200, indicating the claim is an exact duplicate of a previously submitted claim where there are fields on the history and processing claim that are the same. What steps can we take to avoid this reason code?

A: You are receiving this reason code due to the claim information matching for the following fields:

- Health Insurance Claim (HIC) number, type of bill (TOB) (all three positions of any TOB), provider number, statement from date of service, statement through date of service, total charges (0001 revenue line), revenue code, and HCPCS and modifiers (if required by revenue code file).

To avoid this reject reason code in the future, verify the status of your claims prior to refilling by one of these ways:

1. In the direct data entry (DDE) system, pull the beneficiary HIC number to verify the history of the claims you have submitted and the status/location of the claims. Note: you cannot see a claim that was submitted by another facility.
2. Contact the IVR at 1-877-602-8816. Three breakdowns are available: Claim status, return to provider and pending claims.
3. Review the weekly 201 report to look for the history of the beneficiary's claims, which can be pulled through DDE.
4. Review the remittance advice to look for the history of the beneficiary's claims.

If the claim is in a "T" status, which is return to provider, you should correct the claim and resubmit. When making a correction or adjustment to a processed claim, change the TOB to xx7 for adjustment or xx8 for cancellation/voiding prior to resubmitting the claim. ❖

Source: Provider Outreach and Education

General Coverage

Diabetes self-management training certified diabetic educator

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 A/B Medicare administrative contractors [A/B MACs]) for diabetes self-management training (DSMT) services provided to Medicare beneficiaries.

Impact on Providers

This article is based on change request (CR) 6510 which recognizes the American Association of Diabetes Educators (AADE) as an approved DSMT national accreditation organization. CR 6510 also implements the following exception for DSMT in rural areas: an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by the Centers for Medicare & Medicaid Services (CMS) may furnish training and is deemed to meet the multidisciplinary team requirement.

Background

The CMS announced in their final notice published in the *Federal Register* (Volume 74, February 27, 2009) that the AADE is approved as a national accreditation organization to furnish DSMT and is recognized as a national accrediting organization for accrediting entities to furnish outpatient DSMT to Medicare beneficiaries. See the *Federal Register* (V74, February 27, 2009) on the Internet at *http://edocket.access.gpo.gov/2009/pdf/E9-3287.pdf*.

Providers and suppliers of DSMT services may submit requests for accreditation through the AADE, and Medicare contractors shall recognize the AADE as an approving entity for the DSMT program billable through Medicare.

In addition, if providers/suppliers had a valid AADE certificate disapproved by their Medicare contractor, they may ask their contractor to reprocess that application.

CR 6510 also amended the *Medicare Benefit Policy Manual* (Chapter 15 (Covered Medical and Other Health Services)) to clarify that there is an exception for who can provide DSMT in a rural area as follows:

"…Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. **There is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement."**

See the *Code of Federal Regulations* (CFR), Title 42, Chapter IV, Section 410.144(a)(4)(C)(ii) which describes the exception for DSMT in rural areas on the Internet at *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr410.144.pdf*.

Additional Information

The official instruction, CR 6510, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R109BP.pdf*.

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

MLN Matters® Number: MM6510
Related Change Request (CR) Number: 6510
Related CR Release Date: August 7, 2009
Related CR Transmittal Number: R109[B]P
Effective Date: March 30, 2009
Implementation Date: September 8, 2009

Source: CMS Pub. 100-02, Transmittal 109, CR 6510

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Appropriate use of modifier 50 and add-on Current Procedural Terminology codes for facet joint injection services

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

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FI) and Medicare administrative contractors (MAC)) for facet joint injections performed on Medicare beneficiaries.

Provider action needed

This article clarifies the appropriate use of modifier 50 and add-on codes for facet joint injection services. Physicians who perform facet joint injections on **both the right and left sides of one level of the spine must use modifier 50** with the appropriate *CPT* codes when submitting claims. Physicians who perform facet joint injections **on multiple levels on the same side of the spine must use the *CPT* add-on codes** to represent these additional levels injected, **instead of using modifier 50.** Physicians should ensure that billing staffs are aware of this clarification.

Background

Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. The CPT codes used for facet joint injections are:

Facet joint injection *CPT* codes and descriptions

CPT Code	Description
64470	*Injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical/ thoracic; single level*
64472 (add-on)	*Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; cervical/ thoracic; each additional level*
64475	*Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/ sacral; single level*
64476 (add-on)	*Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/ sacral; each additional level*

The primary *CPT* codes, *64470* and *64475*, are used for a single injection in the cervical/thoracic or lumbar/ sacral area of the spine, respectively. Each primary code has an associated **add-on code for use when injections are provided at multiple spinal levels.** The add-on *CPT* codes are *64472* (cervical/thoracic) and *64476* (lumbar/sacral).

Bilateral injections are performed on the right and left sides of one joint level. The Centers for Medicare & Medicaid Services (CMS) requires physicians **to indicate a bilateral injection by using billing modifier 50 and the appropriate *CPT* code.** If a physician performs multiple bilateral injections, modifier 50 should accompany each facet joint injection *CPT* code.

The Office of the Inspector General (OIG) recently conducted a medical record review of facet joint injection services performed in 2006 and released a final report, entitled, "Medicare Payments for Facet Joint Injection Services," OEI-05-07-00200. **The OIG found that physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50.** This report is viewable on the Internet at *http://www.oig.hhs.gov/oei/reports/oei-05-07-00200.pdf*.

To summarize, when facet joint injections are performed on both the right and left sides of a level of the spine, physicians must use modifier 50 and the appropriate primary *CPT* code. When facet joint injections are performed at more than one level, physicians must use add-on *CPT* codes *64472* or *64476* to represent additional levels of the spine injected.

Additional information

The official instruction issued to your Medicare carrier, FI and/or MAC regarding this change, may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R526OTN.pdf*.

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

MLN Matters® Number: MM6518
Related Change Request (CR) Number: 6518
Related CR Release Date: July 31, 2009
Related CR Transmittal Number: R526OTN
Effective Date: August 31, 2009
Implementation Date: August 31, 2009

Source: CMS Pub. 100-20, Transmittal 560, CR 6518

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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

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Advance beneficiary notice

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

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

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NEW LCD IMPLEMENTATION

A77371: Stereotactic radiosurgery and stereotactic body radiation therapy – new LCD

LCD ID Number: L30364 (Florida/Puerto Rico/U.S. Virgin Islands)

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) are noninvasive means of administering high-dose radiotherapy to discreet tumor foci in cranial or extracranial locations respectively. The two forms of treatment share certain overarching principles, namely, the use of image guidance and related treatment delivery technology for escalating the radiation dose to the tumor with as little radiation dose to the surrounding tissue as possible. Both methods are achieved with a "sterotactic" technique, implying that fiducial reference markers serve to align the treatment machine so that an internal lesion is targeted accurately; however, notable differences in clinical applications emerge given the vastly different anatomic and clinical consideration between cranial and extracranial target lesions.

This local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity, documentation requirements and utilization guidelines for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT).

Effective date

This new LCD is effective for services provided **on or after October 5, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

A90862: Pharmacologic medication management for psychiatry services – new LCD

LCD ID Number: L30345 (Florida/Puerto Rico/U.S. Virgin Islands)

CPT code *90862* represents pharmacologic medication management and is intended for use by physicians or master's prepared psychiatric nurses with state authorized prescribing privileges who are prescribing pharmacological therapy for patients with psychiatric disorders. Pharmacologic medication management involves the assessment, monitoring, and prescribing of psychopharmacologic medication and includes no more than minimal psychotherapy. This *CPT* code should only be reported when the qualified clinician is providing in-depth evaluation and monitoring of psychopharmacologic medication and is personally coordinating medication decisions with the patient in a face-to-face encounter.

HCPCS code M0064 involves monitoring or changing psychopharmacologic medication and is intended for use by the physician, physician's assistant, or advanced registered nurse with psychiatric training and acting within the scope of practice during a face-to-face encounter with the patient without providing any psychotherapy.

The local coverage determination (LCD) includes indications and limitations, ICD-9-CM codes that support medical necessity, and documentation requirements to provide the coverage information for pharmacologic medication management for psychiatry services. These services are considered medically reasonable and necessary when used to provide management of psychopharmacologic medication.

Effective date

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

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

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Additions/Revisions to Existing LCDs

A11000: Debridement services – revision to the LCD

LCD ID Number: L28774 (Florida)
LCD ID Number: L28776 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for debridement 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, a revision was made based on recommendations from internal and external sources.
The following sections of the LCD were updated/revised:

- Under the "LCD Title" section of the LCD, the title was changed to "Wound debridement services."
- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, verbiage was added/deleted under the following sub headings:
  - "Skin Debridement (*CPT* codes *11000-11001*)"
  - "Surgical Debridement (*CPT* Codes *11040-11044*)"
  - "Active Wound Care Management"
- Added "Limitations" section to the LCD.
- Updated the "Documentation Requirements" section of the LCD.
- Updated the "Utilization Guidelines" section of the LCD, including clarification that all codes and all wounds are included on any given date or over time, for ulcers requiring more that eight total services.
- Updated the "Sources of Information and Basis for Decision" section of the LCD.
- Updated the LCD "Coding Guidelines" attachment.
- Updated the "Type of Bill Code" and "Revenue Codes" sections of the LCD

Effective date

The revisions to this LCD are effective for services provided **on or after September 30, 2009.**
First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

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A51784: Anorectal manometry and EMG – revision to the LCD

LCD ID Number: L28762 (Florida)
LCD ID Number: L28763 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for anorectal manometry and EMG of the urinary and anal sphincters 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 based on CMS Change Request 6561, Transmittal 1767, dated July 10, 2009. The descriptor for revenue code 076x has been changed to "Specialty Services," revenue code 0762 has been changed to "Observation Hours," and revenue code 0769 has been changed to "Other Specialty Services."

Effective date

This LCD revision is effective for services provided **on or after August 10, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

A62263: Percutaneous lysis of epidural adhesions – revision to the LCD

LCD ID Number: L28948 (Florida)
LCD ID Number: L28969 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for percutaneous lysis of epidural adhesions 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 include endoscopic lysis of epidural adhesions. Additionally, the following revisions were made to the LCD:

- Title changed to Endoscopic and percutaneous lysis of epidural adhesions
- Updated the "Sources of Information and Basis for Decision" section of the LCD
- Updated the "CPT/HCPCS Code" section of the LCD to include *CPT* code *64999* for billing endoscopic lysis of epidural adhesions
- Coding guidelines revised
- Addition of verbiage to include treatment of the cervical and thoracic regions of the vertebrae
- Updated the "ICD-9 Codes that Support Medical Necessity" section of the LCD to include ICD-9-CM codes:

  722.0 722.4 722.81 722.82 723.0 723.4 724.01 724.02

Effective date

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

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

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A77301: Intensity modulated radiation therapy (IMRT) – revision to the LCD

LCD ID Number: L28892 (Florida)
LCD ID Number: L28914 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intensity modulated radiation therapy (IMRT) 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 following sections of the LCD:

- The revisions in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD include the following:
  - Statement added to specify that indications will include some left breast tumors due to risk to immediately adjacent cardiac and pericardial structures, and selected right breast cases in larger volume breast and larger chest wall separation distances.
  - The following new sections have been added under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD:
    - Patient-Specific IMRT Treatment Verification
    - Use of Clinical Treatment Planning in IMRT (*CPT* codes *77261-77263*) Prior to the Specific IMRT Treatment Plan (*CPT* code *77301*)
    - Use of Simulation-Aided Field Setting in IMRT (*CPT* codes *77280-77295*)
    - Use of Intensity Modulated Radiotherapy Plan (*CPT* code *77301*), Including Dose Volume Histograms for Target and Critical Structure Partial Tolerance Specification
    - Use of Basic Radiation Dosimetry Calculation, Central Axis Depth Dose Calculation, TDF, NSD, Gap Calculation, Off-Axis Factor, Tissue Inhomogeneity Factors, Calculation of Non-Ionizing Radiation Surface and Depth Dose, as Required During Course of Treatment, Only When Prescribed by the Treating Physician (*CPT* code *77300*) in IMRT
    - Use of Teletherapy Isodose Plan in IMRT (*CPT* codes *77305-77321*)
    - Use of Brachytherapy Isodose Plan in IMRT (*CPT* codes *77326-77328*)
    - Use of Special Dosimetry in IMRT (*CPT* code *77331*)
    - Use of Treatment Devices (e.g., "Blocks") in IMRT (*CPT* codes *77332-77334*)
    - Use of Continuing Medical Physics Consultation in IMRT (Weekly Physics QA: *CPT* code *77336*)

A77301: Intensity modulated radiation therapy (IMRT) (continued)

- Use of Special Medical Radiation Physics Consultation in IMRT (*CPT* code *77370*)
- Use of Other Radiation Treatment Delivery on the Same Day as IMRT Treatment Delivery (*CPT* codes *77418*, *0073T*)
- Radiation Treatment Management (*CPT* code *77427*)
- Use of "Special Treatment Procedure" in IMRT (*CPT* code *77470*)
- Image Guided Radiation Therapy (IGRT) Codes (*CPT* codes *76950*, *77014*, *77421*)
- Steroscopic X-ray Guidance (*CPT* code *77421*)

- The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to provide limited coverage for *CPT* codes *0073T*, *77301* and *77418*.
- The "Documentation Requirements" section of the LCD has been revised to include requirements in regard to clinical treatment planning (*CPT* codes *77261-77263*), special treatment procedure (*CPT* code *77470*) and physician supervision (*CPT* code *77421*).
- The "Utilization Guidelines" section of the LCD has been revised to include a statement that special treatment procedure (*CPT* code *77470*) should not be reported more than once during the course of therapy.
- The "Sources of Information and Basis for Decision" section of the LCD has been updated.

Effective date

This LCD revision is effective for services provided **on or after October 5, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

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AOOS: Outpatient observation services – revision to the LCD

LCD ID Number: L28941 (Florida)
LCD ID Number: L28962 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for outpatient observation 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 based on CMS change request 6561, Transmittal 1767, dated July 10, 2009. The descriptor for revenue code 0762 has been changed to "Observation Hours."

Effective date

This LCD revision is effective for services provided **on or after August 10, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

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 last revised on April 6, 2009. Since that time, the "CPT/HCPCS Codes" section of the LCD has been revised to add *CPT* code *97755 (Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes)*. The "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD have also been revised to add a new section, "Assistive Technology Assessment (*CPT* code *97755*)."

Effective date

This LCD revision is effective for services provided **on or after August 11, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

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Hospital Services

Temporary payment delay on hemophilia services

The Centers for Medicare & Medicaid Services (CMS) has notified Medicare contractors of a system operational issue involving inpatient claims containing hemophilia services where the add-on payment is not calculated correctly. An emergency system release to correct this obstacle is scheduled for September 7, 2009, and First Coast Service Options Inc. (FCSO) will identify the affected claims and adjust them accordingly.

Providers billing for hemophilia services under the following criteria may expect a temporary payment interruption.

Type of bill 11x

Statement from date less than July 1, 2009

Statement through date equal to or greater than July 1, 2009

Revenue code 636

Diagnosis code of 286.0, 286.1, 286.2, 286.3, 286.4, 286.5 or 286.7

HCPCS code affected: J7186, J7187, J7189, J7190, J7192, J7193, J7194, J7195, J7197, and J7198

Prospective payment provider = Y

No action required by providers

FCSO will perform adjustment and reprocess the affected claims to allocate the correct payment for hemophilia services processed between July 6, 2009, and September 6, 2009. ❖

Source: CMS JSM 09387, August 10, 2009

Policy and payment changes for inpatient stays in acute and long-term care hospitals

Final rule will not reduce 2010 inpatient rates for acute care hospitals

The Centers for Medicare & Medicaid Services (CMS) announced that acute care hospitals will receive an inflation update in their payment rates of 2.1 percent in fiscal year 2010. Earlier this year, CMS had proposed to reduce payments to account for the effect of increases in aggregate payments due to changes in hospital coding practices that do not reflect increases in patient's severity of illness.

The update was included in a final rule making policy changes and setting payment rates for inpatient services in general acute care hospitals paid under the inpatient prospective payment system (IPPS), as well as long-term care hospitals (LTCHs), paid under the LTCH PPS. The changes will be effective beginning with **discharges on or after October 1, 2009.**

To view the entire press release, visit the CMS Web site at *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 200908-01

Payment and policy updates for inpatient rehabilitation facilities

New rules clarify and strengthen patient selection and care requirements

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates inpatient rehabilitation facility (IRF) payment rates for fiscal 2010 and adopts a new regulatory framework that clarifies the coverage criteria (including provisions regarding patient selection and care) for IRFs that will be effective on January 1, 2010. The final rule applies to more than 200 freestanding IRFs and just under 1,000 IRF units in acute care hospitals and, except as otherwise specified, is effective for discharges occurring on or after October 1, 2009.

The coverage criteria provisions are intended to ensure that Medicare beneficiaries who need the intensive rehabilitation services provided in IRFs continue to have access to high quality care. The January 1, 2010, effective date for these provisions will allow facilities time to change their operations as needed to comply with the final regulation. The new regulatory scheme will replace the prior policies, including those contained in HCFAR 85-2-1 (a 1985 ruling that was issued by CMS, then called Health Care Financing Administration). CMS plans to issue a notice in the *Federal Register* that will rescind HCFAR 85-2-1, effective January 1, 2010. CMS also plans to draft new guidance regarding the new coverage criteria that it will place in the *Medicare Benefit Policy Manual* (MBPM). As amended, the MBPM will provide detailed policy guidance regarding CMS's interpretations of the coverage criteria regulations adopted under this rule.

To view the entire press release, visit the CMS Web site at *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 200908-01

July 2009 quarterly provider specific file update

The July 2009 quarterly provider specific file (PSF) statistical analysis software (SAS) data files have been revised and are now available on the Centers for Medicare & Medicaid Services (CMS) Web site in the Downloads section at *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp*.

If you use the provider specific SAS file data, please go to the page above and download the latest version of the PSFs.

Note: These are the quarterly data sets for the provider specific data for public use in SAS format.

The July 2009 quarterly PSF **text** data files have been revised and are now available on the CMS Web site in the Downloads section at *http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp*.

If you use the provider specific text file data, please go to the page above and download the latest versions of the PSF.

Note: These are the quarterly data sets for the provider specific data for public use in text format. ❖

Source: CMS PERL 200907-30

Update to the inpatient psychiatric facility prospective payment system rate year 2010

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

Note: CMS has revised *MLN Matters* article MM6461 to reflect changes made to change request (CR) 6461. The CR was revised to show a corrected labor-related share of 75.889 percent and a corrected non-labor-related share of 24.111 percent. The CR release date, transmittal number, and the Web address for accessing CR 6461 were also changed. All other information remains the same. The *MLN Matters* article MM6461 was published in the June 2009 *Medicare A Bulletin* (page 23).

Provider types affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the inpatient psychiatric facility prospective payment system (IPF PPS).

Impact on providers

CR 6461, from which this article is taken, identifies changes required as part of the annual inpatient psychiatric facility (IPF PPS) update for rate year (RY) 2010. These changes are effective July 1, 2009, and are applicable to IPF discharges occurring during the RY beginning on July 1, 2009, through June 30, 2010. This is the fourth RY update to the IPF PPS. The applicable previous year update is detailed in *MLN Matters*® article MM6077 and may be reviewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6077.pdf*.

Make sure that your billing staffs are aware of these IPF PPS changes.

Background

Under the IPF PPS, payments to inpatient psychiatric facilities are based on a federal per diem base rate that:

- Includes both inpatient operating and capital-related costs (including routine and ancillary services); but
- Excludes certain pass-through costs (i.e., bad debts, and graduate medical education).

CMS is required to update this IPF PPS annually. The RY update is effective July 1 – June 30 of each year and the Medicare severity-diagnosis related groups (MS-DRGs) and ICD-9-CM codes are updated on October 1 of each year.

Key points

Market basket update

CMS uses the rehabilitation/psychiatric/long-term care (RPL) market basket to update the IPF PPS portion of the blended payment rate (that is the federal per diem base rate).

PRICER updates

For the IPF PPS RY 2010, (July 1, 2009 – June 30, 2010) the following are effective for discharges on July 1, 2009 through June 30, 2010:

- The federal per diem base rate is $651.76
- The fixed dollar loss threshold amount is $6,565.00
- The IPF PPS will use the FY 2009 unadjusted pre-floor, pre-reclassified hospital wage index
- The labor-related share is 75.889 percent
- The non-labor related share is 24.111 percent
- The electroconvulsive therapy (ECT) rate is $280.60.

Cost to charge ratios

The national urban and rural cost-to-charge ratios (CCR) for the IPF PPS RY 2010 are displayed in the following table:

Cost to charge ratio	Median	Ceiling
Urban	0.5300	1.7647
Rural	0.6515	1.7381

CMS is applying the national median CCRs to the following situations:

- For new IPFs that have not yet submitted their first Medicare cost report, CMS is using these national ratios until the facility's actual CCR can be computed using

Update to the inpatient psychiatric facility prospective payment system rate year 2010 (continued)

the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.

- The IPFs whose operating or capital CCR is in excess of three-standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the FI or A/B MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

MS-DRG update

The code set and adjustment factors are unchanged for RY 2010.

Note: For the FY 2009 pre-floor, pre-reclassified hospital wage index CMS is using the updated wage index and the wage index budget neutrality factor of 1.0009.

Additional information

To see the official instruction (CR 6461) issued to your Medicare FI or A/B MAC, visit the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1780CP.pdf*.

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

MLN Matters® Number: MM6461 – Revised
Related Change Request (CR) Number: 6461
Related CR Release Date: July 24, 2009
Related CR Transmittal Number: R1780CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1780, CR 6461

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2009 IPPS PC and HH PPS PC PRICER changes

Inpatient prospective payment system (IPPS) personal computer (PC) PRICER updated

The IPPS PC PRICER for fiscal year (FY) 2009 has been updated with the April 2009 provider data. If you use the IPPS PC PRICERs, go to *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp* and download the FY 2009.6 version of the PC PRICER, updated 07/29/2009, located under the Downloads section.

Home health prospective payment system PPS (HH PPS) personal computer (PC) PRICER

The HH PPS PC PRICER logic for calendar year 2009 and the provider data distributed with the HH PPS PC PRICER have been updated as of July 2009. If you use the HH PPS PC PRICER, go to *http://www.cms.hhs.gov/PCPricer/05_HH.asp* and download the latest versions of the PC PRICER, located under the Downloads section. ❖

Source: CMS PERL 200907-36

Critical Access Hospital Services

Payment of bilateral procedures in a method II critical access hospital

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

Provider Types Affected

Method II critical access hospitals (CAH) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for bilateral procedure services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6526 which implements payment for bilateral procedures performed in method II critical access hospitals (CAHs), in cases where the physician reassigns billing rights to the method II CAH.

Caution – what you need to know

Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on the lesser of the actual charges or 150 percent of the Medicare physician fee schedule (MPFS) amount when the procedure is authorized as a bilateral procedure. Modifier 50 is used for bilateral procedures and this article provides information on claims submission for these procedures. CR 6526 implements the 150 percent payment adjustment for bilateral procedures.

Go – what you need to do

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

Background

The Social Security Act (Section 1834(g)(2)(B); see on the Internet *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) states that professional services included within outpatient critical access hospital (CAH) services, will be paid 115 percent of such amounts as would otherwise be paid under this part if such services were not included in the outpatient CAH services. The Centers for Medicare & Medicaid Services (CMS) establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. See 42 CFR 414.40 on the Internet at *http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr414.42.pdf*. This includes the use of the 50 modifier (bilateral procedure).

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

Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on lesser of the actual charges or 150 percent of the Medicare physician fee schedule (MPFS) amount when the procedure is authorized as a bilateral procedure. CR 6526 implements the 150 percent payment adjustment for bilateral procedures. Medicare contractors use payment policy indicators associated with certain procedures in the MPFS in processing claims and determining payment.

Bilateral procedures rendered by a physician that has reassigned their billing rights to a method II CAH are payable by Medicare when the procedure is authorized as a bilateral procedure and is billed on TOB 85x with revenue code (RC) 96x, 97x or 98x and the 50 modifier (bilateral procedure). Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported.

> Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported.

If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure should be reported on a single line item with modifier 50 and one as a service unit. Whenever the 50 modifier is appended, the appropriate number of service units is one.

Modifiers LT (left side) and RT (right side) are not to be reported when the 50 modifier applies. Claims with the LT and RT modifiers will be returned to the provider (RTP) when modifier 50 applies. See the *Medicare Claims Processing Manual*, Chapter 4, section 20.6 on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf* for more information on the use of the 50, LT and RT modifiers.

If a procedure can be billed as bilateral but is not authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 3), the procedure is to be reported on a single line item with the 50 modifier and one service unit. Payment is made based on the lesser of the actual charges or 100 percent of the MPFS amount for each side of the body.

The January 2010 integrated outpatient code editor (IOCE) specifications will include a change to edit 74 (units greater than one for bilateral procedures billed with modifier 50). At that time, claims submitted on TOB 85x with revenue code (RC) 96x, 97x or 98x , a Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) code with a bilateral indicator of '1' or '3', modifier 50 and more than one service unit on the same line will be returned to the provider.

Payment of bilateral procedures in a method II critical access hospital (continued)

Medicare uses the bilateral surgery payment policy indicators on the MPFS to determine if the 150 percent payment adjustment is payable for a specific HCPCS/CPT code. The MPFS database is located on the CMS Web site at *http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp*.

Medicare contractors have access to the payment policy indicators via the physician fee schedule payment policy indicator file in their claims processing systems.

In summary, Medicare contractors will:

- Return to provider (RTP) bilateral procedures submitted on TOB 85x with RC 96x, 97x or 98x when the HCPCS/*CPT* code billed with the 50 modifier, has a payment policy indicator of '0', '2', or '9'.
  - **Payment policy indicator 0** – 150 percent payment adjustment for bilateral procedures **does not apply.** The bilateral procedure is inappropriate for codes in this category because of physiology or anatomy or the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
  - **Payment policy indicator 2** – 150 percent payment adjustment for bilateral procedures **does not apply.** The relative value units (RVUs) are based on a bilateral procedure because the code descriptor states that the procedure is bilateral, the codes descriptor states that the procedure may be performed either unilaterally or bilaterally, or the procedure is usually performed as a bilateral procedure.
  - **Payment policy indicator 9** – concept **does not apply.**
- RTP bilateral procedures submitted on TOB 85x with RC 96x, 97x or 98x when the bilateral procedure code is billed with the RT and LT modifiers and the payment policy indicator is '1' or '3'. This includes claims with a bilateral procedure and modifiers LT and RT on the same claim line or claims with the same bilateral procedure on two claim lines with the same line item date of service (LIDOS), one claim line with modifier RT and another claim line with modifier LT.
  - **Payment policy indicator 1** – 150 percent payment adjustment for bilateral procedures **does apply.**
  - **Payment policy indicator 3** – 150 percent payment adjustment for bilateral procedures **does not apply.** Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.
- Pay for bilateral procedures on TOB 85x with RC 96x, 97x or 98x, one service unit and modifier 50 when the HCPCS/CPT code has a payment policy indicator of '1' based on the lesser of the actual charges or the 150 percent payment adjustment for bilateral procedures as follows: (facility specific MPFS amount times bilateral procedure adjustment (150 percent) minus (deductible and coinsurance)) times 115 percent.
- Pay for bilateral procedures on TOB 85x with RC 96x, 97x or 98x and modifier 50 and one service unit when the HCPCS/CPT code has a payment policy indicator of '3' based on the lesser of the actual charges or 200 percent of the MPFS amount as follows: (facility specific MPFS amount times 200 percent (100 percent for each side) minus (deductible and coinsurance)) times 115 percent.

Note: Although the 150 percent payment adjustment does not apply to payment policy indicator '3', modifier 50 may be billed with these procedures. When billed with the 50 modifier, payment is based on the lower of the actual charges or 200 percent of the MPFS amount.

- Calculate payment using all payment modifiers associated with the line item.

Example 1

Modifiers 50, AS (physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) and 80 (assistant surgeon) are submitted on the line. The line item HCPCS/*CPT* code is authorized for both bilateral surgery and assistant at surgery. Payment would be made based on the lesser of the actual charges or the following calculation: (facility specific MPFS amount times bilateral procedure adjustment (150 percent) times assistant at surgery reduction (16 percent) times nonphysician practitioner adjustment (85 percent) minus (deductible and coinsurance)) times 115 percent.

Example 2

Modifiers 50 and 62 (two surgeons) are submitted on the line. The line item HCPCS/CPT code is authorized for both bilateral surgery and co-surgery. Payment would be made based on the lesser of the actual charges or the following calculation: (facility specific MPFS amount times bilateral procedure adjustment (150 percent) times co-surgery reduction (62.5 percent) minus (deductible and coinsurance)) times 115 percent.

Note: Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date of CR 6526, but will adjust claims brought to their attention.

Additional information

The official instruction, CR 6526, issued to your FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1777CP.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*.

Payment of bilateral procedures in a method II critical access hospital (continued)

MLN Matters® Number: MM6526
Related Change Request (CR) Number: 6526
Related CR Release Date: July 24, 2009
Related CR Transmittal Number: R1777CP
Effective Date: January 1, 2008
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1777, CR 6526

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2010 Annual Update for the Health Professional Shortage Area Bonus Payments

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

Provider Types Affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries in HPSAs.

What You Need to Know

Change request (CR) 6581, from which this article is taken, alerts providers that the 2010 file will be posted to the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS will create a new automated HPSA bonus payment file for claims with dates of service on or after January 1, 2010, through December 31, 2010 and post it to the Web site in early December of 2009.

You will find the annual HPSA bonus payment file and other important HPSA information on the CMS Web site at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/*.

You should also review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf* on the CMS Web site and following the instructions on the page.

Additional Information

The official instruction (CR6581) issued to your MAC, carrier, and/or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1789CP.pdf*.

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

MLN Matters® Number: MM6581
Related Change Request (CR) #: 6581
Related CR Release Date: August 7, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1789CP
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1789, CR 6581

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Section 148 of The Medicare Improvements for Patients and Providers Act

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6395 to reflect a revision to change request (CR) 6395, with a release date of July 30, 2009. The CR release date and transmittal number were revised. The Web address for accessing CR 6395 was also revised. All other information remains the same. The *MLN Matters* article MM6395 was published in the May 2009 *Medicare A Bulletin* (page 31-32).

Provider types affected

Critical access hospitals (CAHs) that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries. Rural health clinics (RHCs), federally qualified health clinics (FQHCs), and skilled nursing facilities (SNFs) may also want to review this article, which clarifies information regarding payment to these entities for laboratory tests performed at an RHC, an FQHC, or a SNF.

What you need to know

Change request (CR) 6395, from which this article is taken, announces a change in the payment methodology for CAHs submitting claims for certain outpatient clinical diagnostic laboratory tests.

Section 148 of The Medicare Improvements for Patients and Providers Act (continued)

As mandated by Section 148 of the Medicare Improvements for Patients and Providers Act (MIPPA), effective for services furnished on or after July 1, 2009, a CAH will be paid 101 percent of reasonable cost for outpatient clinical diagnostic laboratory tests even if the patient for whom these services are billed was not physically present in the CAH at the time the specimen is collected. In such cases, the CAH will receive 101 percent of reasonable cost for the outpatient clinical diagnostic laboratory test as long as the patient is an outpatient of the CAH and is receiving services directly from the CAH. For purposes of section 148, the patient is considered to be receiving services directly from the CAH if either one of the following qualifications is met:

1) The patient receives outpatient services in the CAH on the same day the specimen is collected, or
2) The specimen is collected by an employee of the CAH.

If the patient is physically present in the CAH or a facility that is provider based to the CAH at the time the specimen is collected, neither of the above two conditions need to be met.

For purposes of payment when a patient is located in a SNF and the CAH employee goes to the SNF to collect a specimen, the CAH will only receive payment at 101 percent of reasonable cost once the patient's Medicare Part A days have expired. Prior to the patient's Part A days expiring, payment for the collection of a lab specimen at an SNF is included in the SNF bundled payment.

For non-patients, tests are still to be billed on the type of bill (TOB) 14x and such claims will be paid based on the clinical laboratory fee schedule.

You should make sure that your billing staffs are aware of these changes.

Background

CR 3835 (Redefined Type of Bill (TOB), 14x, for Non-Patient Laboratory Specimens, issued on October 28, 2005), introduced a new definition of type of bill (TOB) 14x, to be used only for non-patient laboratory specimens, effective October 1, 2004; and also provided that CAHs billing a TOB 14x for a non-patient laboratory specimen would be reimbursed under the clinical laboratory fee schedule. (You may find the *MLN Matters®* article related to this CR on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3835.pdf*).

Tests for non-patients are still to be billed on the TOB 14x and such claims will be paid based on the clinical laboratory fee schedule.

However, CR 6395, from which this article is taken, changes the policy of who is considered an outpatient of a CAH when outpatient clinical diagnostic laboratory services are provided, effective for dates of service on or after July 1, 2009. Section 148 of MIPPA provides that the patient for whom the services are provided is no longer required to be physically present in the CAH at the time the specimen is collected; but must be an outpatient of the CAH (as defined by 42 CFR 410.2) as previously noted. If said outpatient requirements are met, a CAH may submit a TOB 85x for outpatient clinical diagnostic laboratory tests for such patients for dates of service **on or after July 1, 2009.** Such services will be paid at 101 percent of reasonable cost.

Note: Beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to CAH clinical laboratory services.

Please be aware that payment to a rural health clinic (RHC)/federally qualified health clinic (FQHC) for laboratory tests performed for a patient of that clinic/center is not included in the all-inclusive rate and may be billed separately by either the base provider for a provider-based RHC/FQHC, or by the physician for an independent or free-standing RHC/FQHC. If the RHC/FQHC is provider-based, payment for laboratory tests is to the base provider (i.e., hospital). If the RHC/FQHC is independent or freestanding, payment for laboratory tests is made to the practitioner (physician) via the clinical laboratory fee schedule.

Additional information

You may view CR 6395, the official instruction issued to your FI or MAC, on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1782CP.pdf*.

The updated *Medicare Claims Processing Manual,* Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Chapter 13 (Radiology Services and Other Diagnostic Procedures), and Chapter 16 (Laboratory Services), are included as an attachment to CR 6395.

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: MM6395 – Revised
Related Change Request (CR) Number 6395
Related CR Release Date: July 30, 2009
Related CR Transmittal Number: R1782CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1782, CR 6395

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Payment for co-surgeons in a method II critical access hospital

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

Note: CMS has revised *MLN Matters* article MM6319 to reflect a correction made to replace a reference to remark code M78 with a reference to remark code N180. The change request (CR) release date, transmittal number, and Web address for accessing CR 6319 were also revised. All other information remains the same. The *MLN Matters* article MM6319 was published in the February 2009 *Medicare A Bulletin* (pages 17-19).

Provider types affected

Method II critical access hospitals (CAHs) billing Medicare administrative contractors (A/B MACs) and/or fiscal intermediaries (FIs) for physicians that have reassigned their billing rights to the CAH on type of bill (TOB) 85x with revenue codes 96x, 97x, or 98x with modifier 62 for co-surgeon services rendered in a method II CAH to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6319 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR 6319 to highlight the revisions to the *Medicare Claims Processing Manual*, Chapter 4 dealing with payment for co-surgeons in a method II CAH.

Physicians billing on type of bill 85x for professional services rendered in a method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the method II CAH, payment is made to the CAH for professional services (revenue codes 96x, 97x or 98x). Medicare makes a payment for a co-surgeon when the procedure is authorized for a co-surgeon and the person performing the surgery is a physician. **CR 6319 implements the reduction in payment for co-surgeon services.** See the "*Key Points*" section for specifics regarding the revisions and the impact on claims for co-surgeon services in a method II CAH.

Background

When the billing rights are reassigned to the method II CAH, payment is made to the CAH for professional services (revenue codes 96x, 97x or 98x). Under some circumstances, the skills of two surgeons (each in a different specialty) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition.

Co-surgery refers to a single surgical procedure which requires the skill of two surgeons, each in a different specialty, performing parts of the same procedure simultaneously. It is not always co-surgery when two doctors perform surgery on the same patient during the same operative session. **Co-surgery has been performed if the procedure(s) performed is part of and would be billed under a single surgical procedure code.**

Medicare uses the payment policy indicators on the Medicare physician fee schedule database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific Healthcare Common Procedure Coding System/*Current Procedural Terminology* (HCPCS/*CPT*) code. The MPFSDB is located on the CMS Web site at www.*cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp*.

The revised *Medicare Claims Processing Manual* Chapter 4 (attached to CR 6319) outlines changes that impact five areas as follows:

1. Coding co-surgeon services rendered in a method II CAH
2. Use of payment policy indicators for determining procedures eligible for payment of co-surgeons
3. Payment of co-surgeon services rendered in a method II CAH
4. Co-surgeon Medicare summary notice (MSN) and remittance advice (RA) messages
5. Review of supporting documentation for co-surgeon services in a method II CAH.

Key points regarding claims for co-surgeon services in a method II CAH

- Medicare will accept claims for co-surgeon services submitted on type of bill 85x with revenue code 96x, 97x, or 98x if it contains either one claim line with a surgical HCPCS/*CPT* code and has modifier 62 or two claim lines with the same surgical HCPCS/CPT code with the same line item date of service, and modifier 62 on each line.
- In the situation just described where co-surgeon services are reported on two claim lines within the same claim, both lines must have modifier 62. Where only one line has modifier 62, Medicare will deny the line without modifier 62 with the following messages:
  - Medicare summary notice (MSN) 16.10 indicating: Medicare does not pay for this item or service
  - Remittance advice (RA) remark code N180, indicating: This item or service does not meet the criteria for the category under which it was billed
  - Group code of CO showing contractual obligation
  - Claim adjustment reason code (CARC) 4 denoting that the procedure code is inconsistent with the modifier used or a required modifier is missing.
- When billing for co-surgeon services, remember that Medicare will pay only when the services are rendered by two surgeons, each with a different specialty, and the claim carries modifier 62 to show there were two surgeons for co-surgery.
- The MPFSDB must reflect an acceptable payment policy indicator for the associated HCPCS/CPT code in order for the claim to be considered for payment. If the payment policy indicator is "0" indicating that co-surgeons are not permitted for that procedure, Medicare will deny the claim with the following:

Payment for co-surgeons in a method II critical access hospital (continued)

- MSN message 15.12, indicating Medicare does not pay for two surgeons for this procedure
- RA remark code N431 to show "service is not covered with this procedure"
- A group code of PR, showing patient responsibility
- A CARC of 54 to show: "Multiple physicians/ assistants are not covered in this case."

- Medicare contractors will develop co-surgeon services on TOB 85x with revenue code 96x, 97x or 98x and modifier 62 for the supporting documentation needed to establish medical necessity when the HCPCS/*CPT* code has a payment policy indicator of '1' showing that co-surgeons could be paid depending on supporting documentation.
- Medicare contractors will define the appropriate supporting documentation needed to establish medical necessity for co-surgeon services when the HCPCS/ *CPT* code has a payment policy indicator of '1'.
- Method II CAHs should remember that they will be liable for noncovered co-surgeon services unless they issue an appropriate advance beneficiary notice (ABN) when the payment policy indicator is '1'.
- Medicare contractors will deny co-surgeon services when the supporting documentation does not establish medical necessity when the payment policy indicator is '1'.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was issued:
  - **MSN message 36.1** – Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.
  - **RA Remark Code of M38** – The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
  - **Group code of PR** – Patient responsibility
  - **CARC code of 54** – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was not issued:
  - **MSN message 36.2** – It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within six months of the date of this notice. Future services of this type provided to you will be your responsibility.
  - **RA Remark Code M27** – The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
  - **Group code CO** – Contractual obligation
  - **CARC code 54** – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will develop co-surgeon services on type of bill (TOB) 85x with RC 96x, 97x or 98x and modifier 62 to establish that the two specialty requirement is met when the HCPCS/*CPT* code has a payment policy indicator of '2'.
- Medicare contractors will deny co-surgeon services when the two specialty requirement is not met, i.e., the two co-surgeons each have the same specialty. When denying such claims, Medicare will use the following messages:

  MSN message 21.21 – This service was denied because Medicare only covers this service under certain circumstances.

RA Remark code N95 – The provider type/provider specialty may not bill this service.

Group code PR – Patient responsibility.

CARC code 54 – Multiple physicians/assistants are not covered in this case.

- Medicare contractors will return to provider (RTP) co-surgeon services submitted on TOB 85x with RC 96x, 97x or 98x when the HCPCS/*CPT* code billed with modifier 62 has a payment policy indicator of '9', indicating the co-surgeon concept does not apply.
- Medicare contractors will determine if a clinician or a non-clinician medical reviewer should review the supporting documentation submitted for co-surgeon services.
- Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date. However, they will adjust such claims that you bring to their attention.

Payment for co-surgeons in a method II critical access hospital (continued)

- Finally, when Medicare pays for co-surgeon services, payment is the lesser of the actual charge or 62.5 percent of the MPFS payment minus deductible and coinsurance. Where payment rights are reassigned to a method II CAH, that CAH is paid 115 percent of that lesser payment amount.

Additional information

The official instruction (CR 6319) issued to your Medicare FI or A/B MAC is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1781CP.pdf*.

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

MLN Matters Number: MM6319 – Revised
Related Change Request (CR) Number: 6319
Related CR Release Date: July 29, 2009
Related CR Transmittal Number: R1781CP
Effective Date: January 1, 2008
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1781, CR 6319

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Timely Claim Filing Guidelines

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

Dates of Service	Last Filing Date
October 1, 2007 – September 30, 2008	by December 31, 2009
October 1, 2008 – September 30, 2009	by December 31, 2010
October 1, 2009 – September 30, 2010	by December 31, 2011

Skilled Nursing Facility Services

Payment rates for Medicare skilled nursing facilities

Case-mix adjustment recalibrated

The Centers for Medicare & Medicaid Services (CMS) announced adjustments to fiscal year (FY) 2010 payment rates to better reflect the cost of caring for Medicare beneficiaries in nursing homes.

The final rule calls for payments to Medicare skilled nursing facilities to be reduced by $360 million, or 1.1 percent lower than payments for FY 2009. This adjustment to nursing facility payments is an effort to rebalance an earlier adjustment to the case-mix indexes (CMIs) and better align Medicare payments with costs.

To view the entire press release, visit the CMS Web site at *http://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 200908-01

Revised fact sheet for the skilled nursing facility prospective payment system

The revised *Skilled Nursing Facility Prospective Payment System* fact sheet (August 2009), which provides the elements of the skilled nursing facility prospective payment system, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf*.

Visit the *Medicare Learning Network* – it's free. ❖

Source: CMS PERL 200908-21

Medicare Claims Processing Manual 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.

Note: CMS has revised *MLN Matters* article MM6407 to clarify the *CPT* codes that physicians (95992) and therapists (97112) are to use for canalith repositioning as noted in CR 6397. All other information is the same. The *MLN Matters* article MM6407 was published in the May 2009 *Medicare A Bulletin* (page 35).

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.

Please note that physicians should use *CPT* code *95992* for canalith repositioning and therapists must use *CPT* code *97112* for canalith repositioning, as indicated in transmittal number 1691, change request 6397. The *MLN Matters®* article related to that transmittal is on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6397.pdf*.

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:

Medicare Claims Processing Manual clarifications for skilled nursing facility and therapy billing (continued)

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; and
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: Part B 22x (SNF inpatient part B) bill types 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 noncovered 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 22x (SNF inpatient part B) bill type.

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/R1733CP.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 – Revised
Related Change Request (CR) Number: 6407
Related CR Release Date: May 8, 2009
Related CR Transmittal Number: R1733CP
Effective Date: October 1, 2006
Implementation Date: April 27, 2009

Source: CMS Pub. 100-04, Transmittal 1733, CR 6407

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Web Site Survey

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

Electronic Data Interchange

Health-care provider taxonomy code updates effective October 1, 2009

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

If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level deletion (rejection) may occur. To ensure you do not receive a claim or file level rejection, it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system, please contact your software support vendor. ❖

Source: CMS Pub. 100-04, Transmittal 1794, CR 6598

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.

HHS delegates authority for the HIPAA security rule to Office for Civil Rights

On August 3, 2009, the Office for Civil Rights (OCR) announced that the Secretary of Health & Human Services (HHS) has delegated to the director of the OCR, the authority to administer and enforce the Health Insurance Portability & Accountability Act of 1996 (HIPAA) security rule. This action by Secretary Sebelius will improve HHS ability to protect individuals' health information by combining the authority for administration and enforcement of the federal standards for health information privacy and security called for in the HIPAA.

The transition of authority for the administration and enforcement of the security rule is expected to be seamless with no interruption in the management or processing of any complaints filed prior to the transition. Consumers may continue to submit HIPAA security complaints using the on-line resource – the administrative simplification enforcement tool (ASET), found at *https://htct.hhs.gov/aset/*. New security complaints may also be sent to the Office for Civil Rights. For more information and detailed instructions on how to submit a complaint to OCR, visit the OCR Web site at *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*. The transition of security complaints from CMS to OCR has no impact on how complaints about transactions and codes sets or unique identifiers are filed or processed. CMS retains its enforcement authority for these other HIPAA rules.

View the *Federal Register* notice of the delegation of authority at http://www.hhs.gov/ocr/privacy/srdelegationofauthority2009.pdf and the Secretary's press release at *http://www.hhs.gov/news/press/2009pres/08/20090803a.html*. ❖

Source: CMS PERL 200908-14

Third national Medicare fee-for-service educational call on HIPAA version 5010

5010: Taking EDI to the next level

Conference call details:

Date: September 9, 2009

Conference Title: Third National Medicare FFS Education Call on HIPAA Version 5010

Time: 2:00 p.m.-3:30 p.m. (ET)

The Centers for Medicare & Medicaid Services (CMS) will present the third in a series of national education conference calls focused on Medicare fee-for-service (FFS) implementation of HIPAA Version 5010. The presentation will cover Medicare FFS error handling transactions (TA1, 999, and 277CA), planned use of each transaction and applicable rules and exceptions for the Medicare FFS program. The presentation is geared to billing software programmers or developers that reside within provider organizations. A question and answer (Q&A) session will follow the presentation that will give participants an opportunity to ask questions of CMS' subject matter experts.

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, not to allow participation.

Registration will close at 2:00 p.m. (ET) on September 8, 2009, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call, participants need to go to *http://www2.eventsvc.com/palmettogba/090909*.
2. Fill in all required data.
3. Verify your time zone is displayed correctly the drop-down box.
4. Click "Register."
5. You will be taken to the "Thank you for registering" page and will receive a confirmation e-mail shortly thereafter.

Note: Please print and save the page, in the event that your server blocks the confirmation e-mails. If you do not receive the confirmation e-mail, please check your spam/junk mail filter as it may have been directed there.

A few days prior to the call (not before September 6th), check the Educational Resources page on CMS' 5010 Web page at *http://www.cms.hhs.gov/Versions5010andD0/40_Educational_Resources.asp* to obtain a copy of the presentation that will be used during the call.

Learn more about 5010 – visit CMS' dedicated page on the Web at *http://www.cms.hhs.gov/Versions5010andD0/*. ❖

Source: CMS PERL 200908-31

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Educational Events

Upcoming provider outreach and educational events

September 2009

Hot Topic Series – Medicare 2009 updates and changes

When: Wednesday, September 16, 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

Hot Topic Series – Medicare 2009 updates and changes

When: Tuesday, September 22, 2009

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

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

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. ❖

Discover your passport to Medicare training

- Register for live events.
- Explore online courses.
- Find CEU information.
- Download recorded events.

Learn more on FCSO's Medicare training Web site. ❖

Preventive Services

August is Immunization Awareness Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered vaccines. Medicare provides coverage for seasonal influenza, pneumococcal, and hepatitis B vaccines for qualified beneficiaries.

What can you do?

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

For more information

CMS has developed several educational products related to Medicare-covered immunization services:

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products, including Medicare-covered adult immunizations, and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- Quick Reference Information: Medicare Part B Immunization Billing – a double-sided chart that provides coverage and coding information on Medicare-covered immunizations. *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*
- Quick Reference Information: Medicare Preventive Services – a double-sided chart that provides coverage and coding information on Medicare-covered preventive services, including immunizations. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- Adult Immunizations brochure – this brochure provides information on risk factors and coverage for the season influenza, pneumococcal, and hepatitis B vaccines. *http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf*

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

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

Source: CMS PERL 200908-10

Other Educational Resources

ICD-10-Clinical Modification/Procedure Coding System publications

The following ICD-10-CM/PCS publications are available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

ICD-10-CM/PCS Myths & Facts (June 2009) – presents correct information in response to some myths regarding the ICD-10-clinical modification/procedure coding system, is now available in print format. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

ICD-10-CM-PCS Bookmark (revised August 2009) – provides information about the ICD-10-clinical modification/procedure coding system including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system may be found, is now available in downloadable format at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10ClinModBookmrk.pdf*. ❖

Source: CMS PERL 200908-14

Transcript available for the June 23 ICD-10 conference call

The written and audio transcript summaries of the "Introduction to ICD-10-CM/PCS for Physician Specialty Group Representatives" conference call, which was conducted by the Centers for Medicare & Medicaid Services on June 23, 2009, are now available in the Downloads section at *http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp*. ❖

Source: CMS PERL 200907-31

Order form for Medicare Part A materials

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

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

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ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

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Claim Status
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Coverage Guidelines
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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

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Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
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MSPRC DPP Debt Recovery
Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

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

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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

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P. O. Box 44021
Jacksonville, FL 32231-4021

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Jacksonville, FL 32202-4914

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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

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1-888-670-0940

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Transaction Support

Option 2
PC-ACE Support

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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
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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦