MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Deductible, coinsurance, and premium rates
Medicare payments for calendar year 2010 4

Advance beneficiary notices of noncoverage
Billing for services related to voluntary use of modi ers associated with ABN ...6

Non-emergency ground ambulance services
Coverage requirements and analysis of payment data related to the ambulance bene t ...14

Outpatient mental health treatment limitation
Effective January 1 2014, Medicare will pay for this bene t at the 80 percent rate of the physician fee schedule ...19

Local coverage determinations
Revisions to existing LCDs coverage guidelines ...23

Hospital outpatient departments
Most hospitals will receive an in ation update of 2.1 percent in their payment rates for services furnished to a Medicare bene ciary in outpatient departments ...27

End-stage renal disease services
Implementation of payment updates to ESRD facilities for calendar year 2010 ...31

Skilled nursing facility services
Implementation of new edtis established to ensure proper processing of ambulance claims subject to the consolidation billing requirements ...33

CORF/ORF services
Therapy cap values for calendar year 2010 ...36

Features

About this Bulletin ... 3
General Information ... 4
General Coverage ... 18
Local Coverage Determinations ... 23
Hospital Services ... 27
End-Stage Renal Disease ... 31
Skilled Nursing Facility Services ... 33
CORF/ORF Services ... 36
Rural Health Clinic Services ... 37
Electronic Data Interchange ... 38
Educational Resources ... 40

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
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[ ] Compliance Of cer
[ ] DRG Coordinator
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Table of Contents

In This Issue 1
Table of Contents.. 2

About this Bulletin
About the *Medicare A Bulletin* 3
Quarterly Provider Update............................... 3

General Information
Medicare deductible, coinsurance, and premium rates for 2010 4
January 2010 quarterly average sales price update and revision to prior files.................... 5
Billing for services related to voluntary uses of advance beneficiary notices of noncoverage .. 6
Processing claims rejecting for gender/ procedure conflict 7
New tougher standards in calculation of improper Medicare payment rates for 2009 .. 8
Flu season is upon us...................................... 9
H1N1 flu prompts HHS secretary to lift certain program requirements 9
Fraud prevention message for Florida Medicare summary notice 9
2010 update of the durable medical equipment, prosthetics, orthotics, and supplies fee schedule.................................... 9

Ambulance Services
Medicare coverage of non-emergency ground ambulance services......................... 12
Medicare Benefit Policy Manual update for ambulance services.................................... 14

Claim and Inquiry Summary Data
Top inquiries, return to provider, and reject claims for October 2009 15

General Coverage
Changes to the laboratory NCD edit software for January 2010 18
Outpatient mental health treatment limitation . 19
Reasonable charge 2010 update for splints, casts, dialysis supplies and equipment, and certain intraocular lenses............................. 20

Local Coverage Determinations
LCD table of contents 23

Hospital Services
Payment rate changes for services in hospital outpatient departments and ambulatory surgical centers......................... 27
Processing of noncovered ICD-9-CM procedure codes on inpatient hospital claims 28
Update to the 2010 inpatient prospective payment system personal computer PRICER.. 28

Hospital Services (continued)
Inpatient psychiatric facility prospective payment system PC PRICER released....29
Round one rebid of the durable medical equipment, prosthetics, orthotics, and supplies competitive bidding program – phase 8A: Hospital exception 29

ESRD Services
Implementation of changes in end-stage renal disease payment for calendar year 2010 – MIPPA Section 153.......................31
Proposed rule for new PPS for renal dialysis facilities.......................................32

SNF Services
Denial of claims for ambulance services rendered to beneficiaries in Part A skilled nursing facility stays 33
Skilled nursing facility prospective payment system PRICER updated..........................34
Publishing minimum data set 3.0 update and resident assessment instrument manual...35
Five-star quality rating system – November News.......................................35

CORF/ORF Services
Therapy cap values for calendar year 2010..36

Rural Health Clinic Services
Medicare rural health clinics and federally qualified health centers payment rate increases 37

Electronic Data Interchange
Further clarification of instructions on using 837 institutional claim adjustment segments for MSP Part A claims 38
Claim status category code and claim status code update 39

Educational Resources
Educational Events
Upcoming POE events 40

Preventive Services
November is American Diabetes Month 41
Message for providers on H1N1 outreach..42
November 19 was the Great American Smokeout 43

Order form for Medicare Part A materials ..44

Important Addresses, Phone Numbers and Web sites – Florida...........................45
Important Addresses, Phone Numbers and Web sites – U.S.Virgin Islands 46

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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) noti cation parameters.

The Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important noti cations 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 scal 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 speci c 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-speci c 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 rst part of the publication.
- Coverage guidelines and billing issues targeting speci c facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-speci c 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 noti cation of new nalized 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 scal 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 speci c 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 bene ciaries.

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 noti cation of all additions to the QPU. ❖

General Information

Medicare deductible, coinsurance, and premium rates for 2010

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

Provider types affected

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

Impact on providers

This article is based on change request (CR) 6690, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2010.

2010 Part A hospital insurance (HI)

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

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

In addition, a bene ciary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during an illness episode. The 2010 deductible and coinsurance amounts are in the following table.

Table 1

2010 Part A hospital insurance (HI)			
Deductible	$1,100.00		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
	$275.00	$550.00	$137.50

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

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2010 Part A premiums are listed in the following table.

Table 2

Voluntary enrollees Part A premium schedule for 2010	
Base premium (BP)	$461.00 per month
Base premium with 10 percent surcharge	$507.10 per month
Base premium with 45 percent reduction	$254.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	$279.40 per month

2010 Part B supplementary medical insurance (SMI)

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

For 2010, the standard premium for SMI services is $110.50 a month; the deductible is $155.00 a year; and the coinsurance is 20 percent. The Part B premium is in uenced by the bene ciary's income and may be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6690, which is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R61GI.pdf*.

Medicare deductible, coinsurance, and premium rates for 2010 (continued)

Additional information

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

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Source: CMS Pub. 100-01, Transmittal 61, CR 6690

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January 2010 quarterly average sales price update and revision to prior 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], scal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) for services provided to Medicare bene ciaries.

Provider action needed

This article is based on change request (CR) 6708, which instructs Medicare contractors to download and implement the January 2010 ASP drug pricing le for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2009, July 2009, April 2009, and January 2009 les. Medicare will use the January 2010 ASP and not otherwise classi ed (NOC) drug pricing les to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 4, 2010, with dates of service January 1, 2010, through March 31, 2010. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

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.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. Note that payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) under a separate CR.

The following table shows how the quarterly payment les will be applied (for those les that are released):

Files	Effective dates of service
January 2010 ASP and NOC les	January 1, 2010, through March 31, 2010
October 2009 ASP and NOC les	October 1, 2009, through December 31, 2009
July 2009 ASP and NOC les	July 1, 2009, through September 30, 2009
April 2009 ASP and NOC les	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC les	January 1, 2009, through March 31, 2009

Additional information

The of cial instruction (CR 6708) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1854CP.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: MM6708
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Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1854, CR 6708

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Billing for services related to voluntary uses of advance beneficiary notices of noncoverage

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

Provider types affected

Physicians, hospitals and other providers, and suppliers who bill Medicare fiscal intermediaries (FI) or A/B Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6563, from which this article is taken, announces recent instructions for the use of modifiers in association with advance beneficiary notices (ABN). Specifically, effective April 1, 2010, two HCPCS level II modifiers have been updated to distinguish between voluntary, and required, uses of liability notices. Those modifiers are:

- **Modifier GA** has been redefined to mean "Waiver of liability statement issued as required by payer policy," and should be used to report when a required ABN was issued for a service.
- A new **modifier GX** has been created with the definition "Notice of liability issued, voluntary under payer policy" and is to be used to report when a voluntary ABN was issued for a service.

Make sure that your billing staffs are aware of these ABN modifier changes.

Background

In CR 6136 (revised form CMS-R-131 Advance Beneficiary Notice of Noncoverage) released September 5, 2008, CMS revised instructions for providers in the use of ABNs. Prior to these instructions, providers who voluntarily issued patients notices announcing that particular services were either excluded from Medicare coverage by statute, or were services for which no Medicare benefit category exists, used the Notice of Exclusion from Medicare Benefits form (NEMB – now a retired form) or notices that they developed themselves.

With these revised instructions, providers for the first time were allowed to use ABNs to voluntarily provide such notices. (You can read the *MLN Matters®* article associated with this CR by going to the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf*.)

CR 6563, from which this article is taken, announces that two HCPCS level II modifiers have been updated to allow the voluntary uses of liability notices to be distinguished from the required uses. Specifically, **modifier GA** has been redefined to mean "Waiver of liability statement issued as required by payer policy." It should only be used to report when a required ABN was issued for a service, and should not be reported in association with any other liability-related modifier and should continue to be submitted with covered charges. Please note that Medicare systems will now deny institutional claims submitted with **modifier GA** as a beneficiary liability (rather than subjecting them to possible medical review), and the beneficiary will have the right to appeal this determination. Medicare processing of professional claims with this modifier is not changing.

In addition, a new **modifier GX**, has been created with the definition "Notice of liability issued, voluntary under payer policy" which should be used to report when a voluntary ABN was issued for a service. You may use the modifier GX to provide beneficiaries with voluntary notice of liability regarding services excluded from Medicare coverage by statute, and in these cases, you may report it on the same line as certain other liability-related modifiers. Please note that the modifier GX must be submitted with noncovered charges only, and your FI or A/B MAC will deny the claim as a beneficiary liability.

You should be aware of some details in the use of these modifiers.

Modifier GA

- Medicare systems will automatically deny lines submitted with the **modifier GA** and covered charges on institutional claims
- Medicare systems will assign beneficiary liability to claims automatically denied when the **modifier GA** is present
- Medicare will use claim adjustment reason code 50 (These are noncovered services because this is not deemed a 'medical necessity' by the payer) when denying lines due to the presence of the **modifier GA**.

Modifier GX

- Medicare systems will recognize and allow the **modifier GX** on claims, but will return your claim if the **modifier GX** is used on any line reporting covered charges
- Medicare systems will allow the **modifier GX** to be reported on the same line as the following modifiers that indicator beneficiary liability: **Modifier GY** (Item or service statutorily excluded or does not meet the definition of any Medicare benefit), **modifier TS** (Follow-up service)
- Medicare systems will return your claim if the **modifier GX** is reported on the same line as any of the following liability-related modifiers:

  Modifier EY – no doctor's order on file

  Modifier GA, GL – medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

  Modifier GZ – item or service expected to be denied as not reasonable and necessary

  Modifier KB – beneficiary requested upgrade for ABN, more than four modifiers identified on claim

  Modifier QL – patient pronounced dead after ambulance is called

  Modifier TQ – basic life support transport by a volunteer ambulance provider

Billing for services related to voluntary uses of advance beneficiary notices of noncoverage (continued)

- Medicare systems will automatically deny lines (using claim adjustment reason code 50) submitted with the **modifier GX** and noncovered charges, and will assign beneficiary liability to claims automatically denied when the **modifier GX** is present.

Note: Other than the policy and processing changes described in CR 6563, all other policies and processes regarding noncovered charges and liability continue as stated in the *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 60 (Provider Billing of Noncovered Charges) and in the requirements defined in previous change requests.

Additional information

You may find more information about billing for services related to voluntary uses of advance beneficiary notices of noncoverage by going to CR 6563, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1840CP.pdf*.

You will find the updated *Medicare Claims Processing Manual,* Chapter 1 (General Billing Requirements), Section 60 (Provider Billing of Noncovered Charges) as an attachment to that CR.

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*.

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Processing claims rejecting for gender/procedure conflict

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6638, which provides instructions for completing Part A and Part B claims for gender specific services for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

Caution – what you need to know

Claims for some beneficiaries are being rejected by Medicare systems due to gender specific edits, and this is resulting in inappropriate denials for Part A and Part B claims. CR 6638 instructs that for Part A claims processing, institutional providers should report condition code 45 (ambiguous gender category) on inpatient or outpatient services that can be subjected to gender specific editing (i.e., services that are considered female or male only) for the above defined beneficiaries. CR 6638 instructs physicians and nonphysician practitioners that for Part B professional claims the modifier KX (requirements specified in the medical policy have been met) should be billed on the detail line with any procedure code(s) that are gender specific for the affected beneficiaries.

Go – what you need to do

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

Background

Claims for some services for beneficiaries described above may be inadvertently denied due to sex related edits unless these services are billed properly.

As a result of the number of subject claims received that are being denied due to sex/diagnosis and sex/procedure edits, the National Uniform Billing Committee (NUBC) approved condition code 45 (ambiguous gender category) to identify these unique claims and to allow the sex related edits to be processed correctly.

CR 6638 instructs institutional providers submitting Part A claims to report condition code 45 (ambiguous gender category) on inpatient or outpatient services for affected beneficiaries where the service performed is gender specific (i.e., services that are considered female or male only). Providers should use this claim-level condition code to identify these unique claims and to allow the sex related edits to be processed correctly by Medicare systems and allow the service to continue normal processing.

The **modifier KX**, which is defined as "Requirements specified in the medical policy have been met", is a multipurpose informational modifier for Part B professional claims. In addition to its other existing uses, the **modifier KX** should also be used to identify services that are gender specific (i.e., services that are considered female or male only) for affected beneficiaries on claims submitted by physicians and nonphysician practitioners to Medicare carriers and MACs. Use of the **modifier KX** will alert the carrier/MAC that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, and that the service should be allowed to continue with normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.

Processing claims rejecting for gender/procedure conflict (continued)

Additional information

The of cial instruction, CR 6638, 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/R1839CP.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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Related CR Release Date: October 28, 2009
Related CR Transmittal Number: R1839CP
Effective Date: April 1, 2010
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Source: CMS Pub. 100-04, Transmittal 1839, CR 6638

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New tougher standards in calculation of improper Medicare payment rates for 2009

Part of administration-wide strategy to eliminate errors and prevent waste and fraud

As part of the Obama administration's goal of reducing waste, fraud, and abuse in Medicare, the Department of Health & Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) signi cantly revised and improved its calculations of Medicare fee-for-service (FFS) error rates in 2009, re ecting a more complete accounting of Medicare's improper payments than in past years. These improvements will provide CMS with more complete information about errors so that the agency can better target improper payments.

"The Obama administration is committed to strengthening and improving the Medicare and Medicaid systems and doing everything we can to be responsible and vigilant stewards of these programs that millions of Americans rely upon," said HHS Secretary Kathleen Sebelius. "From the very start of the Administration, the President has directed all the agencies across government to use honest budgeting and to take the hardest, most detailed look possible at what was happening with taxpayer dollars inside our agencies and inside critical programs. This year, we made the call to stop calculating our error rate in fee-for-service Medicare the way that the previous administration did and to start using a more rigorous method in calculating this rate in keeping with our mandate to root out errors and fraud."

The Medicare, Medicaid and Children's Health Insurance Program (CHIP) improper payment rates are issued annually as part of the HHS agency nancial report.

While improper payment rates are not necessarily an indicator of fraud in Medicare or any other federal health care program, they do provide HHS, CMS, and its partners who are responsible for the oversight of Medicare and Medicaid funds a more complete assessment of how many errors need to be xed.

"If we aren't honest about the problem, there is no way we can get to a solution. Through a more stringent review of Medicare claims, we've been able to establish a more complete accounting of errors, enabling CMS to take more actionable steps to further reduce the error rate and identify abusive or potentially fraudulent actions before they become problems," said Sebelius. "This change in calculating the error rate is just one part of our larger Administration-wide effort to reduce waste, fraud and abuse in health care. In addition to the establishment of HEAT, the joint task force that was established earlier this year with the Department of Justice, we've taken aggressive steps at HHS and CMS to improve our oversight of the Medicare trust funds and the taxpayer dollars that pay for the health care of millions of older and vulnerable Americans."

"As we move forward in our review of the Medicare and Medicaid error rate data, we expect to be able to determine if there are speci c trends that can better help us identify weaknesses in our programs or systems," said Acting CMS Administrator Charlene Frizzera. "We hope to be able to use data available through the use of new electronic health record reporting that can help in the design of new and innovative approaches to nding emerging trends and vulnerabilities in high risk areas such as durable medical equipment and home health."

Sebelius and Frizzera also pointed out the HHS and the CMS would invest more time and resources into working with providers to eliminate errors through increased and improved training and education outreach.

"It's important that we continue to work closely with doctors, hospitals and other health care providers to make sure they understand and follow the more comprehensive fee-for-service requirements," said Frizzera. "We are committed to working closely with them to reduce the rate of improper payments."

The entire press release is available at *https://www.cms.hhs.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 200911-31

Flu season is upon us

The Centers for Medicare & Medicaid Services (CMS) encourages providers to begin taking advantage of each of ce visit to encourage your patients with Medicare to get seasonal u shots. Flu shots are their best defense against combating u this season. And don't forget – health care workers also need to protect themselves.

Medicare provides coverage of the u vaccine without any out-of-pocket costs to the Medicare patient as a part B bene t. No deductible or copayment/coinsurance applies. Note that in uenza vaccine is not a Part D covered drug.

For more information about Medicare coverage of the seasonal in uenza vaccine and its administration, as well as related educational resources for health care professionals, please go to the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

For information on Medicare policies related to H1N1 in uenza, please go to the CMS Web site at *http://www.cms.hhs.gov/H1N1*.

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

Source: CMS PERL 200910-42

H1N1 flu prompts HHS secretary to lift certain program requirements

Secretary of Health & Human Services Kathleen Sebelius has invoked her waiver authority under Section 1135 of the Social Security Act. This allows for the waiver or modi cation of certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that suf cient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and for the time periods covered by the 1135 authority.

Requests by providers to operate under the exibilities afforded by the waiver should be sent to the state survey agency or CMS regional of ce. Please visit the Centers for Medicare & Medicaid Services Web site for details on what's required to submit a waiver request: *http://www.cms.hhs.gov/H1N1/Downloads/RequestingAWaiver101.pdf*.

Further information on the 1135 waiver process may be found at *http://www.cms.hhs.gov/H1N1/*. ❖

Source: CMS PERL 200910-44

Fraud prevention message for Florida Medicare summary notice

Beginning no later than November 6, 2009, through September 30, 2012, First Coast Service Options Inc. will print the general message number 24.15 on all Medicare summary notices (MSNs) issued to bene ciaries in Florida. This message will be placed on the rst page in the fraud section:

English

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

Spanish

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

Source: CMS JSM 10035, October 29, 2009

2010 update of the durable medical equipment, prosthetics, orthotics, and supplies fee schedule

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], scal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for items or services paid under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule need to be aware of this article.

Provider action needed

This article, based on change request (CR) 6720, advises you of the calendar year (CY) 2010 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data les, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the *Background* section below. Please note that the fee schedule for HCPCS code E2227 (Manual wheelchair accessory, gear reduction drive wheel, each) is being revised, effective January 1, 2010, to remove pricing information for one product that was used in calculating payment for E2227. That product was erroneously classi ed as a gear reduction drive wheel when the code was established. Providers should be aware that your Medicare contractor will not adjust previously processed claims for the HCPCS code E2227 with dates of service on or after January 1, 2009, through December 31, 2009, if they are submitted for adjustments. These changes are effective for DMEPOS provided on or after January 1, 2010. Be sure your billing staffs are aware of these changes.

2010 update of the durable medical equipment, prosthetics, orthotics, and supplies fee schedule (continued)

Background

CR 6720 provides instructions regarding the 2010 annual update for the DMEPOS fee schedule. payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by sections 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 *Code of Federal Regulations* (CFR) section 414.102 for parenteral and enteral nutrition (PEN).

Key points of change request 6720

The DMEPOS fee schedule le will be available on or after November 17, 2009, for state Medicaid agencies, managed care organizations, and other interested parties at *http://www.cms.hhs.gov/DMEPOSFeeSched/* on the CMS Web site.

2010 Fees for HCPCS labor payment codes K0739, L4205, L7520 are effective January 1, 2010, and those rates are as follows:

State	K0739	L4205	L7520
AK	25.27	28.79	33.88
AL	13.41	19.99	27.14
AR	13.41	19.99	27.14
AZ	16.59	19.97	33.39
CA	20.58	32.83	38.26
CO	13.41	19.99	27.14
CT	22.40	20.45	27.14
DC	13.41	19.97	27.14
DE	24.71	19.97	27.14
FL	13.41	19.99	27.14
GA	13.41	19.99	27.14
HI	16.59	28.79	33.88
IA	13.41	19.97	32.49
ID	13.41	19.97	27.14
IL	13.41	19.97	27.14
IN	13.41	19.97	27.14
KS	13.41	19.97	33.88
KY	13.41	25.60	34.71
LA	13.41	19.99	27.14
MA	22.40	19.97	27.14
MD	13.41	19.97	27.14
ME	22.40	19.97	27.14
MI	13.41	19.97	27.14
MN	13.41	19.97	27.14
MO	13.41	19.97	27.14
MS	13.41	19.99	27.14
MT	13.41	19.97	33.88
NC	13.41	19.99	27.14
ND	16.72	28.73	33.88
NE	13.41	19.97	37.84
NH	14.40	19.97	27.14
NJ	18.10	19.97	27.14
NM	13.41	19.99	27.14
NV	21.37	19.97	36.99
NY	24.71	19.99	27.14
OH	13.41	19.97	27.14
OK	13.41	19.99	27.14
OR	13.41	19.97	39.03
PA	14.40	20.56	27.14
PR	13.41	19.99	27.14
RI	15.99	20.58	27.14
SC	13.41	19.99	27.14
SD	14.99	19.97	36.28
TN	13.41	19.99	27.14
TX	13.41	19.99	27.14
UT	13.45	19.97	42.27
VA	13.41	19.97	27.14
VI	13.41	19.99	27.14
VT	14.40	19.97	27.14
WA	21.37	29.30	34.80
WI	13.41	19.97	27.14
WV	13.41	19.97	27.14
WY	18.70	26.65	37.84

The following new codes are effective as of January 1, 2010:

- A4264, A4466, L2861, L3891, L8692, K0739, and K0740, all of which have no assigned payment category
- A4336, A4360, and A4456, which are in the ostomy, traheostomy, and urological supplies payment category
- E0433 in the oxygen and oxygen equipment category
- E0136 in the capped rental category, and
- L5973, L8031, L8032, L8627, L8628, L8629, and Q0506, all of which are in the prosthetics and orthotics category.

The fee schedule amounts for the above new codes will be established as part of the July 2010 DMEPOS fee schedule update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2010, through June 30, 2010. The new codes are not to be used for billing purposes until they are effective on January 1, 2010.

2010 update of the durable medical equipment, prosthetics, orthotics, and supplies fee schedule (continued)

The following codes are being deleted from the HCPCS effective January 1, 2010, and are therefore being removed from the DMEPOS fee schedule files:

A4365	L1825	L3701	E2223	L1901	L3909
E2393	L2770	L3911	L0210	L3651	L6639
L1800	L3652	L1815	L3700		

For gap-filling purposes, the 2009 deflation factors by payment category are listed as follows:

Factor	Category
0.508	Oxygen
0.511	Capped rental
0.512	Prosthetics and orthotics
0.650	Surgical dressings
0.707	Parenteral and enteral nutrition

HCPCS code E2227 (Manual wheelchair accessory, gear reduction drive wheel, each) was added to the HCPCS effective January 1, 2008. The fee schedule for code E2227 was calculated using pricing information for two products; however, the fee schedule is being revised effective January 1, 2010, to remove pricing information for one product that was erroneously classi ed as a gear reduction drive wheel when the code was established. Contractors will not adjust previously processed claims for the code E2227 with dates of service on or after January 1, 2009 through December 31, 2009, if they are submitted for adjustments.

CY 2010 fee schedule update factor

Under the Act, the DMEPOS fee schedule amounts are being updated for 2010 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2009. Since the percentage change in the CPI-U for the 12-month period ending with June of 2009 is negative (-1.41 percent), the percentage increase in the CPI-U used to update the DMEPOS fee schedule amounts for 2010 is 0 percent.

2010 update to the labor payment rates

Since the percentage increase in the consumer price index (CPI) for the 12-month period ending with June of the previous year is negative for 2010, a zero percent change is applied to the labor payment amounts for 2010 for codes K0739, L4205, and L7520.

2010 national monthly payment amounts for stationary oxygen equipment

CMS will also implement the 2010 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2010.

The fee schedule le is being revised to include the new national 2010 monthly payment rate of $173.17 for stationary oxygen equipment. The payment rates are being adjusted for the new oxygen generating portable equipment (OGPE) class. The revised 2010 monthly payment rate of $173.17 includes the zero percent update due to the -1.41 percent CPI-U change. The budget neutrality adjustment for 2010 caused the 2010 rate to decrease from $175.79 to $173.17.

When updating the oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS code E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

Additional information

The of cial instruction, CR 6720, issued to your Medicare contractor regarding this change, may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1853CP.pdf*.

CR 6720 includes the revisions that will be made to the *Medicare Claims Processing Manual*, Chapter 23 – Fee Schedule Administration and Coding Requirements.

More information on durable medical equipment prosthetics, orthotics, and supplies is available on the CMS Web site at *http://www.cms.hhs.gov/center/dme.asp*.

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

MLN Matters® Number: MM6720
Related Change Request (CR) Number: 6720
Related CR Release Date: November 13, 2009
Related CR Transmittal Number: R1853CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1853, CR 6720

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the speci c statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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 ll it out. We want to know how well the entire site and speci c 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.

Ambulance Services

Medicare coverage of non-emergency ground ambulance services

First Coast Service Options (FCSO) became the Centers for Medicare & Medicaid Services' (CMS) Medicare administrative contractor (MAC) for Puerto Rico and the U.S. Virgin Islands on March 1, 2009. In preparation for this new responsibility, FCSO evaluated paid claims data to identify potential Medicare program vulnerabilities in Puerto Rico and the U.S. Virgin Islands. An extreme data anomaly was quickly identified regarding reimbursement for non-emergency ambulance services.

This article provides an overview of the coverage requirements for the Medicare program's ambulance benefit, FCSO's analysis of ambulance data in Puerto Rico and the U.S. Virgin Islands, and corrective actions that have been or will be taken by FCSO as a result of that analysis.

Coverage requirements for Medicare's ambulance benefit

The Medicare ambulance benefit is contained in the Social Security Act and further defined in the *Code of Federal Regulations* and CMS administrative manuals that may be found at http://www.cms.hhs.gov/Manuals/. Under existing laws and regulations, the Medicare ambulance benefit is limited to situations where the patient's medical condition requires transportation by ambulance, as further discussed below:

> "Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services." (Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 10, Section 10.2.1.)

As outlined in CMS' administrative manuals and FCSO's local coverage determination (LCD) for ambulance transportation, the presence or absence of a physician's order and/or certificate of medical necessity for transport by ambulance does not necessarily prove or disprove the medical necessity of the transport. In addition to meeting the coverage requirements quoted above, ambulance services must meet all other Medicare program coverage criteria including vehicle and crew requirements and covered origins/destinations. Ambulance services denied on the basis of coverage requirements are not subject to a waiver of liability provisions. As a result, in such situations, the patient is liable for the service.

FCSO's LCD for ambulance transportation includes the following medical indications that could support the medical necessity for non-emergency ground ambulance services:

- The beneficiary is bed confined before and after the ambulance trip and meets all other criteria (see note below).
- There is a risk of physical injury to the patient or others requiring observation during transport.
- The patient requires ongoing IV meds/fluids during transportation and a heparin/saline lock is contraindicated.
- Medical treatment and/or observation during transport are required to prevent endangering the beneficiary's health.

Note: "Bed confined" is defined as the inability to get up from bed without assistance, the inability to ambulate, and the inability to sit in a chair (including a wheelchair). All three conditions must be met in order for the patient to be considered "bed confined." "Bed confined" is not synonymous with bed rest or non-ambulatory. Additionally, bed confinement, by itself, is neither sufficient nor necessary to determine coverage for Medicare ambulance benefits.

As outlined in the "Limitations" section of FCSO's LCD, non-emergency ground ambulance services are not covered in the following situations:

- Transportation to a funeral home
- Transfer from one residence to another
- Transfer from a hospital, which has appropriate facilities and staff for treatment, to another hospital
- Transportation via ambi-buses, ambulettes, stretcher vans, wheelchair vans, mobility assistance vehicle (MAV), medicabs, vans, privately owned vehicles and taxicabs
- Transportation to a dialysis facility for maintenance dialysis, unless the patient's condition justifies the medical necessity of the transport
- Patient refuses to be transported.

In all cases, appropriate patient, medical, and other relevant documentation must be kept on file and presented to FCSO upon request. As per CMS Pub 100-08, Chapter 3, Section 3.5.1.1, contractors, like FCSO, have the authority to implement prepayment edits designed to prevent payment for noncovered and/or incorrectly coded services and to select targeted claims for review prior to payment.

Analysis of payment data for ambulance services in Puerto Rico and the U.S. Virgin Islands

As noted earlier, FCSO quickly identified an extreme data anomaly related to non-emergency ambulance services provided in Puerto Rico and the U.S. Virgin Islands. More specifically, our analysis of paid claims data for procedure code A0428 – ambulance service, basic life support, non-emergency transport (BLS), revealed that utilization in

Medicare coverage of non-emergency ground ambulance services (continued)

Puerto Rico for this procedure code was over 1,000 percent higher than the rest of the United States. For the second half of 2008, Medicare spent $236,789 per 1,000 Puerto Rico beneficiaries for HCPCS code A0428, as compared to only $20,140 per 1,000 beneficiaries in the rest of the United States. Furthermore, FCSO found that approximately 25 percent of all Medicare Part B payments in Puerto Rico were for non-emergency ambulance services, as compared to less than 5 percent in the rest of the United States.

Data analysis also revealed that 95 percent of non-emergency ambulance utilization in Puerto Rico involved repetitive transportation of dialysis patients to/from their dialysis facilities as compared to less than five percent in Florida. Although dialysis patients may have multiple health issues, the vast majority can safely and routinely travel by means other than an ambulance.

A similar utilization problem was identified in the U.S. Virgin Islands, although to a much lesser extent. In the first half of 2007, for example, utilization of HCPCS code A0428 was 155 percent higher than the rest of the United States. At that time, the U.S. Virgin Islands ranked third in the United States in utilization of HCPCS code A0428; however, more recent data shows a significant drop in utilization beginning in early 2008.

Further findings and required corrective actions

Medicare does not have a "transportation" benefit but rather an "ambulance" benefit for patients whose physical conditions are such that they require one-on-one medical monitoring and treatment while being transported to/from a Medicare-covered destination to obtain necessary diagnostic or therapeutic treatment. FCSO's LCD references CMS Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 10, which outlines ambulance vehicle requirements, ambulance crew requirements, and other coverage requirements. As stated in section 10.1.2, "Basic Life Support ambulances must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle."

Furthermore, the condition of the patient must be such that they require the services of such medical personnel because without constant medical monitoring and/or treatment during transportation, the patient's health could/would be endangered. The medical records FCSO has reviewed and claims history for the vast majority of the patients being transported by ambulance suppliers billing non-emergency transports in Puerto Rico, and previously in U.S. Virgin Islands, do not support that these patients meet these requirements.

Site visits to dialysis facilities have further validated that patients are being transported to/from dialysis treatments, up to three times per week, and that the majority of these patients do not meet Medicare's ambulance benefit requirements. Patients have been observed, for example, arriving in ambulances and walking from the ambulance into the facility as well as riding as passengers in the front of the ambulance. Interviews with patients and dialysis facility staff, including the nephrologists managing dialysis treatments, indicate the majority of patients are capable of traveling safely to/from their dialysis appointments without monitoring or treatment provided by ambulance personnel. In fact, most certificates of medical necessity for these transports are not signed by the patient's treating nephrologist but rather by a primary care physician who may, or may not, be involved with the patient's care.

As the MAC for jurisdiction 9, FCSO is responsible for ensuring the appropriateness of all fee-for-service Medicare payments in Florida, Puerto Rico, and the U.S. Virgin Islands. Immediately after taking over as the MAC, FCSO became concerned about reimbursement for non-emergency ambulance transportation in the islands and developed and implemented an LCD to specifically address this issue. All ambulance suppliers billing non-emergency transports in Puerto Rico and the U.S. Virgin Islands were invited to attend education sessions on April 16, 2009, to discuss FCSO's concerns, provide feedback, and review the proposed LCD. Additional education was provided via webcasts and teleconferences prior to the LCD becoming effective June 30, 2009.

Regrettably, claims data for services provided after these educational sessions and implementation of the LCD do not demonstrate the degree of expected changes in bills for non-emergency ambulance transportation in Puerto Rico. As mentioned earlier, there has been a change in billing patterns in the U.S. Virgin Islands, although FCSO believes some degree of program vulnerability continues.

Therefore, FCSO will implement a prepayment claim edit effective for claims processed on or after December 15, 2009, that will require the submission of medical records prior to payment for the majority of non-emergency ground ambulance BLS transports to/from dialysis facilities billed by ambulance suppliers in Puerto Rico and the U.S. Virgin Islands. In addition, FCSO will continue to support additional prepayment editing and other activities carried out by the zone program integrity contractor (ZPIC), SafeGuard Services LLC (SGS), which is responsible for fraud case investigation and development. Isolated ambulance billing issues also have been identified for specific ambulance suppliers in Florida. Specific review actions will be initiated for those providers.

Providers should respond to FCSO's additional development requests by submitting the appropriate medical documentation to the address indicated on the additional development letter. The medical record should include:

- Documentation of dispatch instructions
- A detailed description of the patient's condition at the time of transport in order for FCSO to determine whether other means of transportation were contraindicated
- A description of specific monitoring and/or treatments ordered and performed/ administered during transport
- Mileage transported
- A physician's certification statement

Please refer to FCSO's LCD for a more details regarding documentation requirements.

Medicare coverage of non-emergency ground ambulance services (continued)

FCSO understands that there is a need for a public transportation infrastructure that meets the needs of beneficiaries in Puerto Rico and the U.S. Virgin Islands. However, given the limited nature of the program's ambulance benefit, Medicare cannot pay for non-emergency ambulance services that are not medically necessary. We encourage health care providers to work with civic and community leaders to promote the use of alternative means of transportation, where it is available, and to identify other solutions where such alternatives do not exist.

For additional information, please refer to:

- Social Security Act 1861(s) (7)
- Social Security Act 1834(1)
- 42 CFR Section 410.40 and 410.41
- 42 CFR Part 414, Subpart H
- Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 10
- Pub 100-04, *Medicare Claims Processing Manual*, Chapter 15

Note: FCSO LCDs: Puerto Rico, L29955; U.S Virgin Islands, L29955 – may be accessed through the FCSO Medicare provider Web site at *http://medicare.fcso.com/Coverage_Find_LCDs_and_NCDs/*. ❖

Medicare Benefit Policy Manual update for ambulance services

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

Provider types affected

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

Provider action needed

This article, based on CR 6707, advises you that the *Medicare Benefit Policy Manual* Chapter 10 – Ambulance Service Section 10.3 has been revised to incorporate consistent manual language to the definition of "The Destination." There is no change to policy. Please make sure your billing staffs are aware of this update.

Background

The *Medicare Benefit Policy Manual* Chapter 10 – Ambulance Service section 10.3 has been updated to incorporate consistent manual language. The change states that "an ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is covered only to the extent of the payment that would be made for bringing the service to the patient." The word "appropriate" has been added to that statement.

Additional information

The official instruction, CR 6707, issued to your Medicare contractor regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R115BP.pdf*.

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

MLN Matters® Number: MM6707
Related Change Request (CR) Number: 6707
Related CR Release Date: November 13, 2009
Related CR Transmittal Number: R115BP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-02, Transmittal 115, CR 6707

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

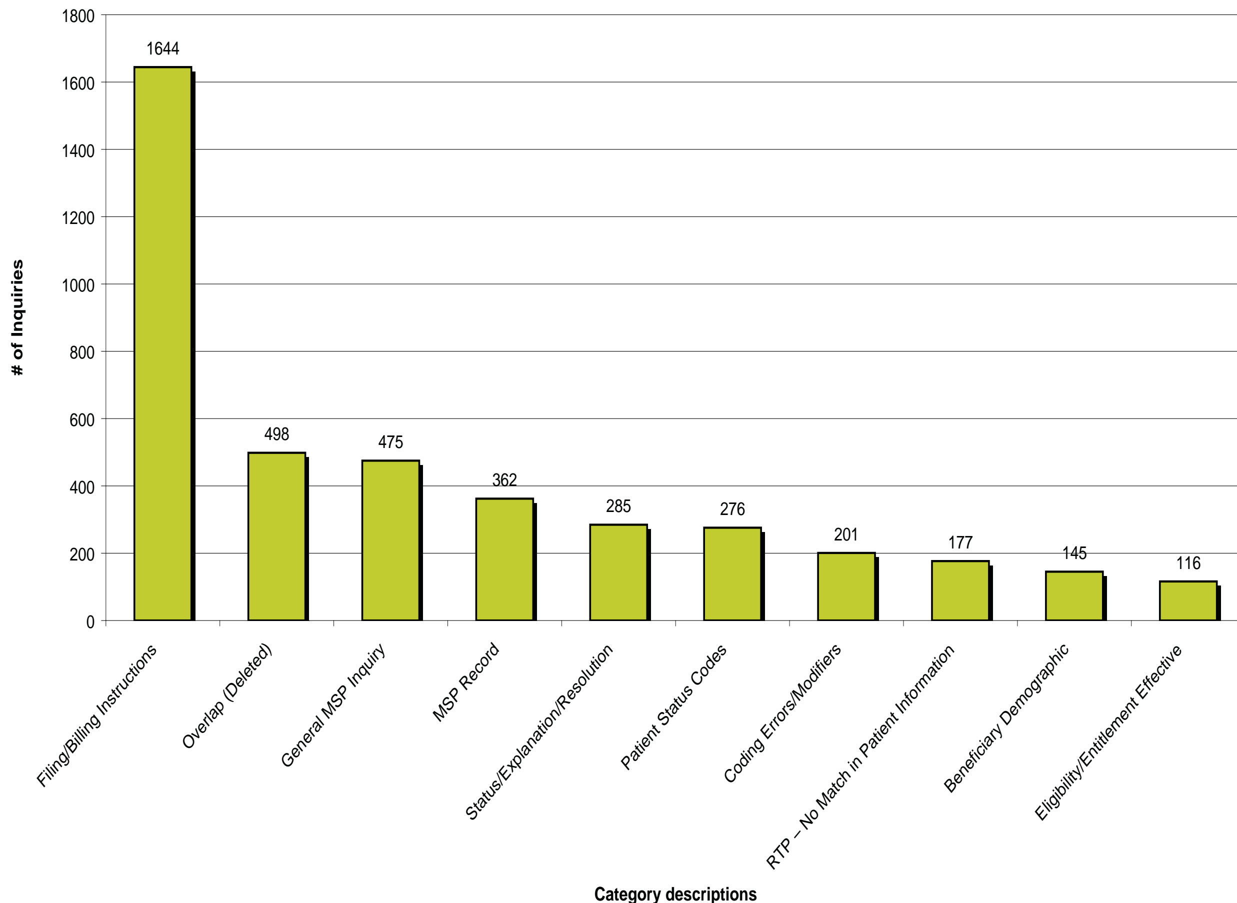
Claim and Inquiry Summary Data

Top inquiries, return to provider, and reject claims for October 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, and U.S. Virgin Islands providers during October 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 October 2009

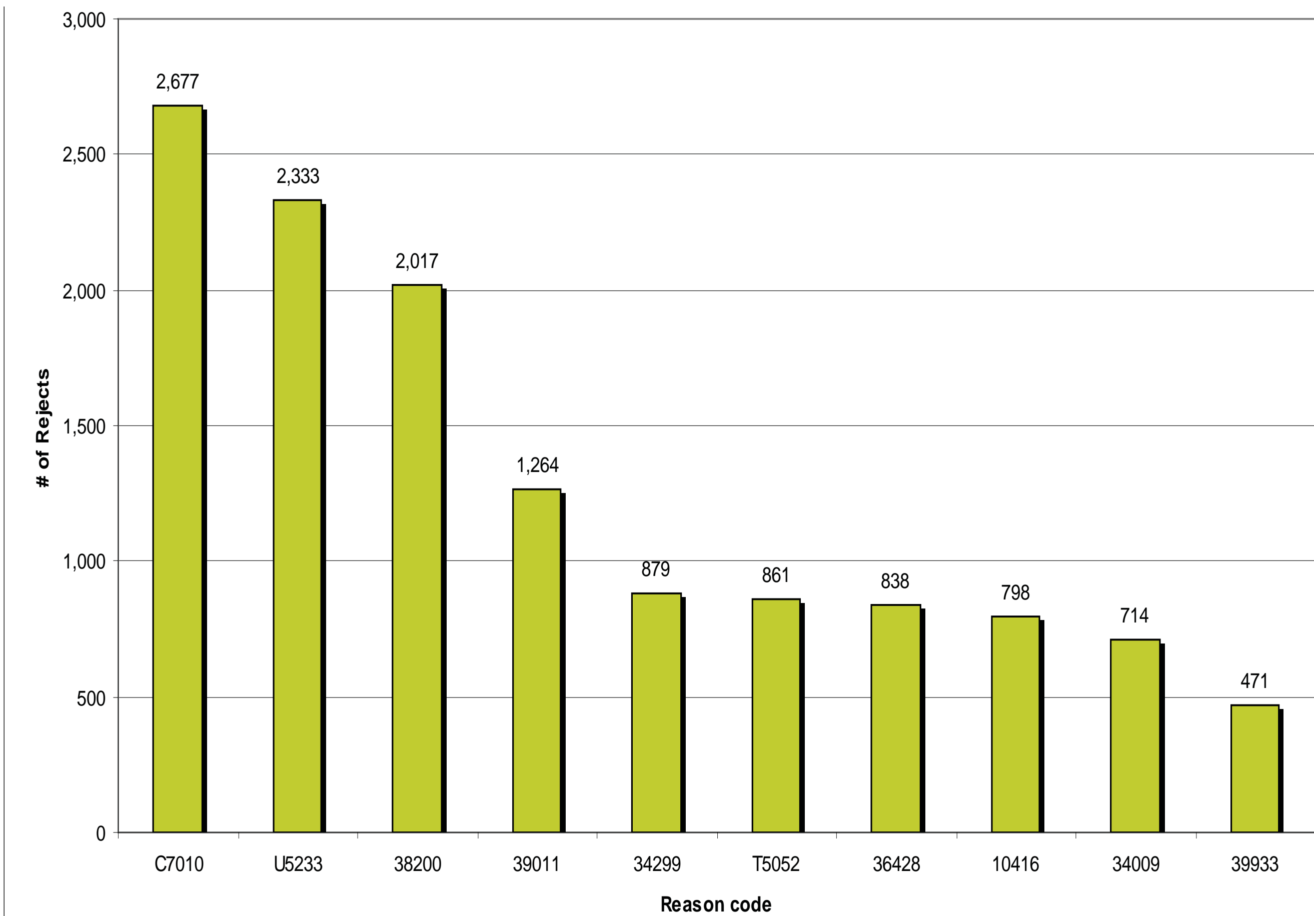


Find your favorites fast – use Quick Find

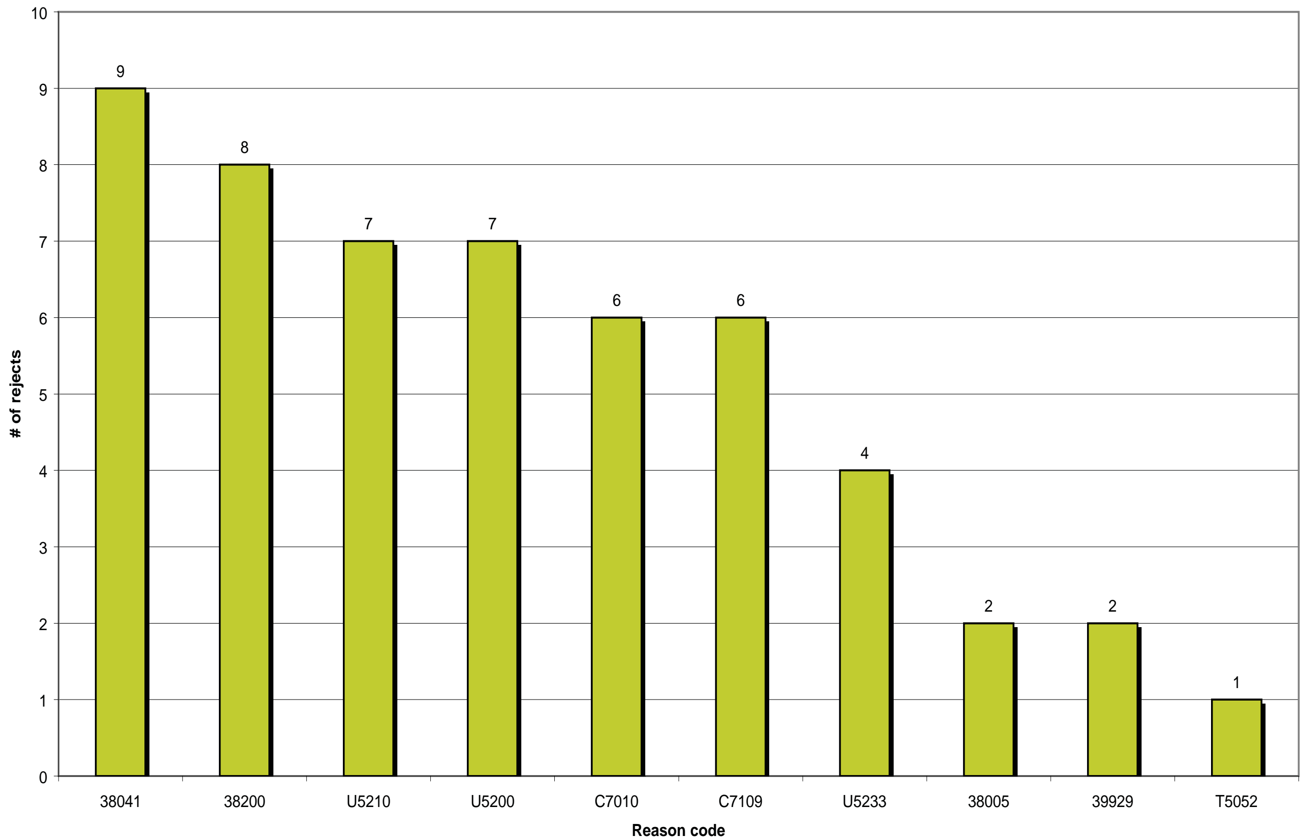
Looking for the fastest way to nd your favorite sections of our Web site? It's easy – just use the Quick Find navigational tool. Located on the left-hand side of every page, this convenient drop-down menu allows you to jump to the most popular pages on the site – with just one click. You'll nd links to the Part A and Part B homepages as well as quick links to the procedure-diagnosis lookup tool, local coverage determinations (LCDs), fee schedules, publications, and more. Find out how easy is to nd what you need fast – use Quick Find.

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

Florida Part A top rejects for October 2009

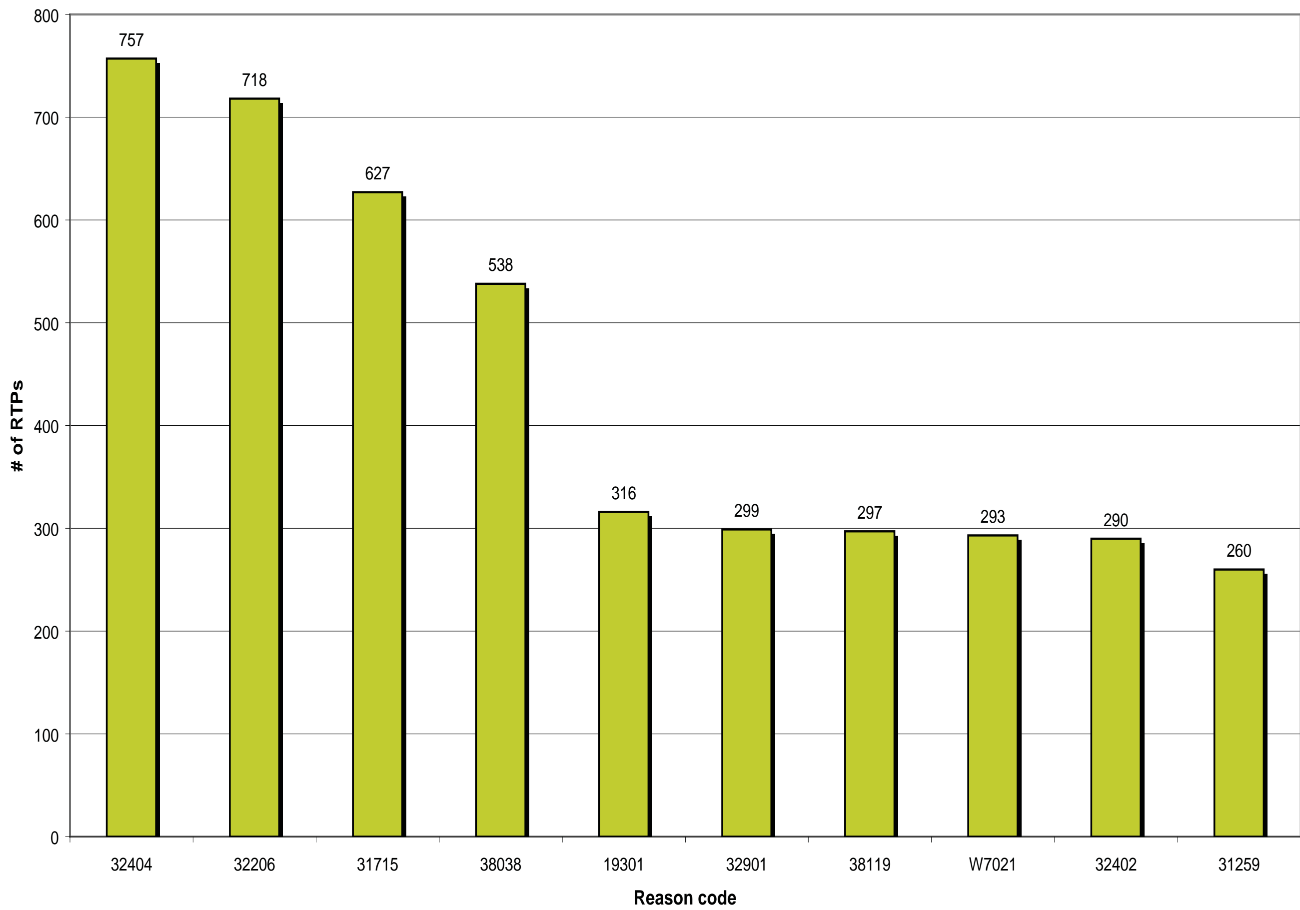


U.S. Virgin Islands Part A top rejects for October 2009

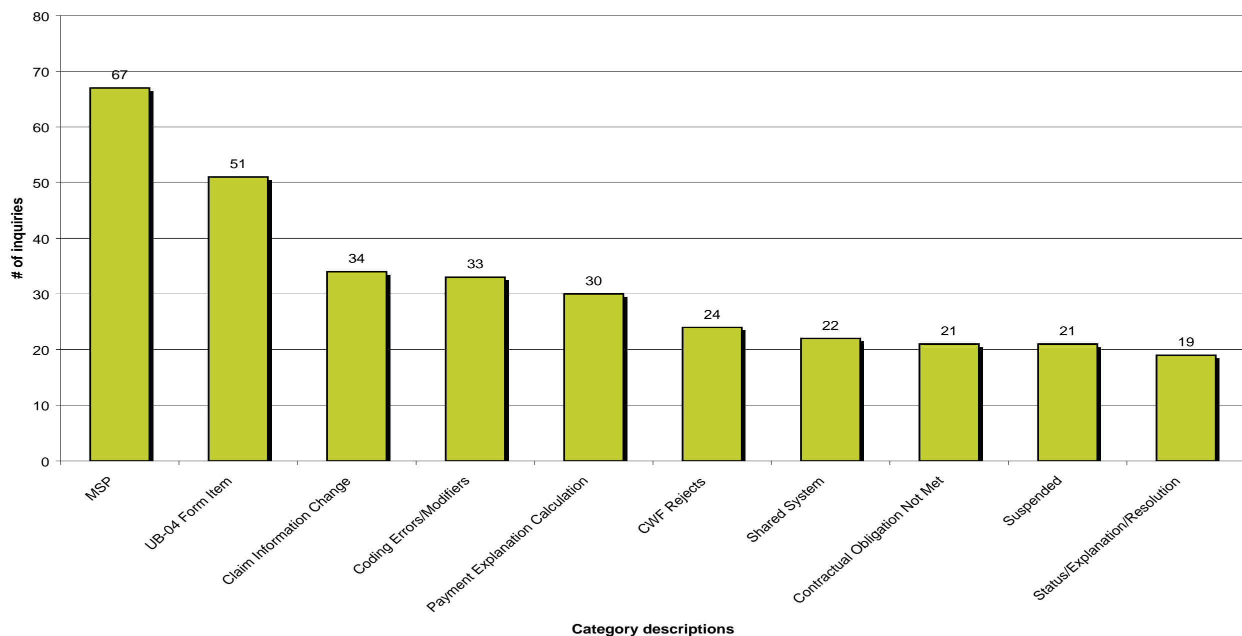


Top inquiries, return to provider, and reject claims for October 2009 (continued)

Florida Part A top RTPs for October 2009



Puerto Rico and U.S. Virgin Islands Part A top inquiries for October 2009



General Coverage

Changes to the laboratory national coverage determination edit software for January 2010

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], or Part A/B Medicare administrative contractors [A/B MACs]) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6717 which announces the changes that will be included in the January 2010 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in October 2009. Be sure billing staff are aware of the changes in this article.

Background

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

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

CR 6717 announces changes to the laboratory edit module for changes in laboratory NCD code lists for January 2010. These changes become effective for services furnished on or after January 1, 2010. The changes that are effective for dates of service on and after January 1, 2010 are as follows:

For serum iron studies

Delete ICD-9-CM codes 453.50-453.52 from the list of ICD-9-CM codes that are **covered** by Medicare for the serum iron studies (190.18) NCD.

For gamma glutamyl transferase

Add ICD-9-CM codes 453.50-453.52 to the list of ICD-9-CM codes that are **covered** by Medicare for the gamma glutamyl transferase (190.32) NCD.

Note: Effective dates for the following codes were inadvertently changed to July 1, 2009, with the July 1, 2009, quarterly release. The correct actual effective dates were October 1, 2007, and those dates will be reinstated with the January 2010 release of Medicare edit module.

For prothrombin time (PT)

Revise the effective date from July 1, 2009, to October 1, 2007, for the following ICD-9-CM codes that are listed for the prothrombin time (PT) (190.17) NCD:

200.30	200.31	200.32	200.33	200.34
200.35	200.36	200.37	200.38	200.40
200.41	200.42	200.43	200.44	200.45
200.46	200.47	200.48	200.50	200.51
200.52	200.53	200.54	200.55	200.56
200.57	200.58	200.60	200.61	200.62
200.63	200.64	200.65	200.66	200.67
200.68	200.70	200.71	200.72	200.73
200.74	200.75	200.76	200.77	200.78
202.70	202.71	202.72	202.73	202.74
202.75	202.76	202.77	202.78	

For serum iron studies

Revise the effective date from July 1, 2009, to October 1, 2007, for the following ICD-9-CM codes that are listed for the serum iron studies (190.18) NCD:

200.30	200.31	200.32	200.33	200.34
200.35	200.36	200.37	200.38	200.40
200.41	200.42	200.43	200.44	200.45
200.46	200.47	200.48	200.50	200.51
200.52	200.53	200.54	200.55	200.56
200.57	200.58	200.60	200.61	200.62
200.63	200.64	200.65	200.66	200.67
200.68	200.70	200.71	200.72	200.73
200.74	200.75	200.76	200.77	200.78
202.70	202.71	202.72	202.73	202.74
202.75	202.76	202.77	202.78.	

For gamma glutamyl transferase

Revise the effective date from July 1, 2009, to October 1 2007, for the following ICD-9-CM codes that are listed for the gamma glutamyl transferase (190.32) NCD:

200.30	200.31	200.32	200.33	200.34
200.35	200.36	200.37	200.38	200.40
200.41	200.42	200.43	200.44	200.45
200.46	200.47	200.48	200.50	200.51
200.52	200.53	200.54	200.55	200.56
200.57	200.58	200.60	200.61	200.62
200.63	200.64	200.65	200.66	200.67
200.68	200.70	200.71	200.72	200.73
200.74	200.75	200.76	200.77	200.78
202.70	202.71	202.72	202.73	202.74
202.75	202.76	202.77	202.78.	

Changes to the laboratory national coverage determination edit software for January 2010 (continued)

Note: Medicare contractors will adjust claims affected by the above three categories if you bring such claims to their attention.

Additional information

The of cial instruction (CR6717) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1847CP.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: MM6717
Related Change Request (CR) Number: 6717
Related CR Release Date: November 6, 2009
Related CR Transmittal Number: R1847CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1847, CR 6717

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Outpatient mental health treatment limitation

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

Provider types affected

This article is of special interest to physicians, clinical psychologists (CPs), clinical social workers (CSWs), nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), rural health clinics (RHCs), federally quali ed health centers (FQHCs), and comprehensive outpatient rehabilitation facilities (CORFs) who submit claims to Medicare administrative contractors (A/B MACs), scal intermediaries (FIs), or carriers, for mental health services provided to Medicare bene ciaries.

Provider action needed

Change request (CR) 6686 alerts providers that the Centers for Medicare & Medicaid Services (CMS) is phasing out the outpatient mental health treatment limitation (the limitation) over a ve year period, from 2010-2014. Effective January 1, 2014, Medicare will pay outpatient mental health services at the same rate as other Part B services, that is, at 80 percent of the physician fee schedule.

Background

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends section 1833(c) of the Social Security Act (the Act) to phase out the outpatient mental health treatment limitation over a ve year period, from 2010-2014. The limitation has resulted in Medicare paying only 50 percent of the approved amount under the physician fee schedule for outpatient mental health treatment rather than 80 percent that is paid for most other services.

Key points of CR 6686

Section 102 of MIPPA requires that the current 62.5 percent outpatient mental health treatment limitation (effective since the inception of the Medicare program until December 31, 2009) will be reduced as follows:

January 1, 2010-December 31, 2011 – the limitation percentage is 68.75 percent (of which Medicare pays 55 percent and the patient pays 45 percent)

January 1, 2012-December 31, 2012 – the limitation percentage is 75 percent (of which Medicare pays 60 percent and the patient pays 40 percent)

January 1, 2013-December 31, 2013 – the limitation percentage is 81.25 percent (of which Medicare pays 65 percent and the patient pays 35 percent), and

January 1, 2014-onward – the limitation percentage is 100 percent, at which time Medicare pays 80 percent and the patient pays 20 percent.

Note: For RHCs and FQHCs, the amount the patient pays may differ from the percentages shown above if the charges are not equal to the encounter rate for the clinic.

Services not subject to the limitation

- **Medicare will not apply the limitation on type of bill (TOB) 75x:** Since CORFs do not provide mental health therapeutic services; the limitation does not apply to CORF services.

  Note: *CPT* code *96152* is the only *CPT* code allowed for behavioral health services provided in a CORF, and this service is not subject to the limitation.

- **Diagnosis of Alzheimer's disease or related disorder**: When the primary diagnosis reported for a particular service is Alzheimer's disease or as an Alzheimer's related disorder, your Medicare contractor will look to the nature of the service that has been rendered in determining whether it is subject to the limitation.

  - Alzheimer's disease is coded 331.0 in the "International Classi cation of Diseases, 9th Revision", which is outside the diagnosis code range 290-319 that represents mental, psychoneurotic and personality disorders that are potentially subject to the limitation.

Outpatient mental health treatment limitation (continued)

- Additionally, Alzheimer's related disorders are identi ed by Medicare contractors under ICD-9-CM codes that are outside the 290-319 diagnosis code range. Typically, treatment provided to a patient with a diagnosis of Alzheimer's disease or a related disorder represents medical management of the patient's condition (**such as described under *CPT* code *90862* or any successor code) and is not subject to the limitation.** *CPT* code *90862* describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
- However, when the **primary** treatment rendered to a patient with a diagnosis of Alzheimer's disease or a related disorder is **solely psychotherapy, it is subject to the limitation.**

Additional information

The of cial instruction, CR 6686, was issued via three transmittals to your Medicare FI, carrier, or A/B MAC regarding this change. The rst transmittal, available at *http://www.cms.hhs.gov/Transmittals/downloads/R60GI.pdf*, revises the *Medicare General Information, Eligibility and Entitlement Manual*.

The second transmittal revises the *Medicare Benefit Policy Manual* and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R114BP.pdf*.

The third transmittal revises the Medicare Claims Processing Manual an is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1843CP.pdf*.

If you have questions, please contact your Medicare FI, carrier, 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: MM6686
Related Change Request (CR) Number: 6686
Related CR Release Date: October 30, 2009
Related CR Transmittal Number: R51GI, R114BP, and R1843CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1843, CR 6686

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Reasonable charge 2010 update for splints, casts, dialysis supplies and equipment, and certain intraocular lenses

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

Provider types affected

Physicians, providers, and suppliers, billing Medicare contractors (carriers, scal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses, should be aware of this article.

Provider action needed

The payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 CFR 405.501.

Change request (CR) 6691, from which this article is taken, instructs your carriers, FIs, MACs, and DME MACs how to calculate reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2010. Make sure your billing staff are aware of these changes.

Background

CR 6691 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2010.

The in ation-indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an in ation adjustment factor or the percentage change in the consumer price index for all urban consumers (CPI-U)(United States city average) for the 12-month period ending with June of 2009.

Since the percentage change in the CPI-U for the 12-month period ending with June 2009 is negative (-1.41 percent), the IIC update factor for 2010 is 0 percent. The 2010 payment limits for splints and casts will be based on the 2009 limits that were announced in CR 6221 last year. Those limits are repeated in Attachment A at the end of this article. In addition, please note that: 1) Payment for intraocular lenses is only made on a reasonable charge basis for lenses implanted in a physician's of ce; and 2) The Q-codes should be used for splints and casts when supplies

Reasonable charge 2010 update for splints, casts, dialysis supplies and equipment, and certain intraocular lenses (continued)

are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast. An attachment to CR 6691 lists the 2010 payment limits for splints and casts.

CR 6691 instructs your carrier or MAC to: 1) Compute 2010 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Of ce) using actual charge data from July 1, 2008, through June 30, 2009; and 2) Compute 2010 IIC amounts for these codes that were not paid using gap- lled payment amounts in 2009.

For codes identi ed in the following four tables, CR 6691 instructs DME MACs to compute 2010 customary and prevailing charges using actual charge data from July 1, 2008, through June 30, 2009; and to compute 2010 IIC amounts for these codes that were not paid using gap- lled amounts in 2009.

Dialysis supplies billed with modifier AX

A4215	A4216	A4217	A4244	A4245	A4246
A4247	A4248	A4450	A4452	A4651	A4652
A4657	A4660	A4663	A4670	A4927	A4928
A4930	A4931	A6216	A6250	A6260	A6402

Dialysis supplies billed without modifier AX

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis equipment billed with modifier AX

E0210NU	E1632	E1637	E1639

Dialysis equipment billed without modifier AX

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Additional information

Detailed instructions for calculating:

- Reasonable charges are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments)
- Customary and prevailing charges are located in *Medicare Claims Processing Manual,* Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge), and
- The IIC are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (In ation Indexed Charge [IIC] for Nonphysician Services).

The *Medicare Claims Processing Manual* is available at *http://www.cms.hhs.gov/manuals/IOM/list.asp*.

For complete details regarding this CR please see the of cial instruction (CR 6691) issued to your Medicare FI, carrier, MAC, or DME MAC. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1834CP.pdf*.

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

Attachment A

Code	Payment Limit
A4565	$7.75
Q4001	$44.11
Q4002	$166.75
Q4003	$31.69
Q4004	$109.71
Q4005	$11.68
Q4006	$26.33
Q4007	$5.86
Q4008	$13.17
Q4009	$7.80
Q4010	$17.56

Code	Payment Limit
Q4011	$3.90
Q4012	$8.78
Q4013	$14.20
Q4014	$23.95
Q4015	$7.10
Q4016	$11.97
Q4017	$8.21
Q4018	$13.09
Q4019	$4.11
Q4020	$6.55
Q4021	$6.07

Reasonable charge 2010 update for splints, casts, dialysis supplies and equipment, and certain intraocular lenses (continued)

Attachment A (continued)

Code	Payment Limit
Q4022	$10.96
Q4023	$3.06
Q4024	$5.48
Q4025	$34.07
Q4026	$106.37
Q4027	$17.04
Q4028	$53.19
Q4029	$26.05
Q4030	$68.58
Q4031	$13.03
Q4032	$34.28
Q4033	$24.30
Q4034	$60.44
Q4035	$12.15

Code	Payment Limit
Q4036	$30.23
Q4037	$14.83
Q4038	$37.14
Q4039	$7.43
Q4040	$18.56
Q4041	$18.02
Q4042	$30.77
Q4043	$9.02
Q4044	$15.39
Q4045	$10.46
Q4046	$16.83
Q4047	$5.22
Q4048	$8.42
Q4049	$1.91

MLN Matters® Number: MM6691
Related Change Request (CR) Number: 6691
Related CR Release Date: October 23, 2009
Related CR Transmittal Number: R1834CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1834, CR 6691

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Did you know?

If you are enrolled in Medicare but have not submitted a CMS-855 since 2003, you are required to submit a complete application. Providers and suppliers should follow the instructions for completing an initial enrollment application.

LOCAL COVERAGE DETERMINATIONS

In accordance with publications speci ed 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 scal intermediary's LCDs and review guidelines are consistent with accepted standards of medical practice.

Table of contents

Additions/revisions to existing LCDs

A92081: Visual field examination 24
AJ9055: Cetuximab (Erbitux®) 24
APULMDIAGSVCS: Pulmonary diagnostic services 24

Retired LCDs

AJ9213: Interferon, alfa-2a (Roferon®-A) 25
AOOS: Outpatient observation services 25

Additional Medical Information

Administration of Synvisc and Synvisc-one 25
Billing and coding information for prostate biopsies 26

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 noti cation 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

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 bene ciary noti cation (ABN) signed by the bene ciary.
- **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 le an ABN signed by the bene ciary.
- 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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Additions/Revisions to Existing LCDs

A92081: Visual field examination – revision to the LCD

LCD ID Number: L29006 (Florida)
LCD ID Number: L29038 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for visual field examination 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 to the LCD to provide clarification when it is medically reasonable and necessary for providers to perform repeat visual field examinations.

Repeat visual field examinations for patients undergoing surgery of the upper eyelid(s) and brow are considered medically reasonable and necessary. The initial (taped) and repeat (untaped) visual field examination should be performed on the same date of service.

Effective date

This LCD revision is effective for claims processed **on or after November 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. ❖

AJ9055: Cetuximab (Erbitux®) – revision to the LCD

LCD ID Number: L28802 (Florida)
LCD ID Number: L28804 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cetuximab (Erbitux®) 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 to the LCD based on new prescribing information for indications and usage of Erbitux® for colorectal cancer by the Food and Drug Administration (FDA).

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, language was added regarding analysis of K-ras mutation in codon 12 or 13, and that the use of Erbitux® is not recommended for the treatment of colorectal cancer in patients with these mutations. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services provided **on or after July 22, 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. ❖

APULMDIAGSVCS: Pulmonary diagnostic services – revision to the LCD

LCD ID Number: L28974 (Florida)
LCD ID Number: L28976 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pulmonary diagnostic services was last updated October 1, 2009. Since that time, First Coast Service Options Inc. (FCSO) has become aware that there are clinicians within the Medicare administrative contractor (MAC) J9 providing services that do not have access to the credentialing and licensing bodies as outlined in the LCD. Therefore, language has been added to assure that clinicians providing services to Medicare beneficiaries within the MAC J9 have received appropriate training in lieu of the credentialing and licensing requirements as outlined in the LCD.

Effective date

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

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

Retired LCDs

AJ9213: Interferon, alfa-2a (Roferon®-A) – retired LCD

LCD ID Number: L28894 (Florida)
LCD ID Number: L28916 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for interferon, alfa-2a (Roferon®-A) 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. The manufacturer announced on November 29, 2007, the discontinuation of the production of Roferon®-A for the United States market. It was estimated that the existing supply available for sale would be depleted in early to mid-2008. Therefore, First Coast Service Options Inc. (FCSO) has retired the LCD for interferon, alfa-2a (Roferon®-A).

Effective date

This LCD retirement is effective for services provided **on or after November 19, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

AOOS: Outpatient observation services – retired 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 last updated August 10, 2009. Since that time, the LCD was reviewed for accuracy of coverage and billing guidelines. It was determined that updating the LCD would be a re ection of national guidelines provided in the *Medicare Benefit Policy Manual*, Pub 100-02, Chapter 6, Section 20.6 and the *Medicare Claims Processing Manual*, Pub 100-04, Chapter 4, Section 290. Therefore, the LCD and “Coding Guidelines” attachment for outpatient observation services were retired.

Effective date

This LCD retirement is effective for services provided **on or after November 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. ❖

Additional Medical Information

Administration of Synvisc and Synvisc-one

It has recently come to the attention of First Coast Service Options Inc. (FCSO) that providers are using both Synvisc and Synvisc-one within a single course of treatment. The Food and Drug Administration (FDA) labeling in regards to the frequency of injections during a course of treatment for Synvisc vs. Synvisc-one are not the same. Synvisc is administered once per week for three weeks per course of treatment. Synvisc-one is administered as a one-time dose per course of treatment.

Providers should not switch or combine the use of Synvisc and Synvisc-one within the same course of treatment. The switching or combination within the same course of treatment is considered not medically reasonable and necessary. ❖

Find LCDs faster on our new medical coverage page

Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you’ll also nd the medical coverage news and resources you need more quickly and easily than ever before – try it today. *http://medicare.fcso.com/Landing/139800.asp*.

Billing and coding information for prostate biopsies

In the United States, prostate cancer is the most common cancer and the second leading cause of cancer deaths in men. If an abnormality is found on the digital rectal exam (DRE) or the prostate-speci c antigen (PSA) test, a biopsy of the prostate is typically ordered. This involves taking a very small sample of tissue from the prostate. A tiny amount of tissue is trapped in the needle while it is in the prostate and then the needle is pulled out. This is repeated in a number of locations through the prostate so as to minimize the chance of missing an area where cancer may be present.

Needle biopsies are commonly performed using ultrasonic guidance. After localizing the region, a physician uses ultrasound to guide the needle into a mass or region to obtain a specimen. The specimen is then sent to a pathology lab for appropriate analysis.

CPT code *55700 (Biopsy, prostate; needle or punch, single or multiple, any approach*) is used for a biopsy of the prostate from any approach.

- If imaging guidance is performed, *CPT* code *76942* (*Ultrasonic guidance for needle placement [eg. biopsy, aspiration, injection, localization device], imaging supervision and interpretation*) is billed in addition to *CPT* code *55700*.
- The surgical pathology code that is billed with *CPT* code *55700* is *CPT* code *88305* (*Level IV – Surgical pathology, gross and microscopic examination*).

CPT code *55706* (*Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance*) was established to report prostate saturation biopsies (PSB). This service was previously reported with category III CPT code *0137T* (*Biopsy, prostate, needle, saturation sampling for prostate mapping*), which was deleted January 1, 2009, and replaced with *CPT* code *55706*. PSB is typically performed after an initial diagnosis of prostate cancer when (1) initial biopsies obtained through the traditional method (*CPT* code *55700*) are equivocal or nondiagnostic and more extensive biopsying is needed to rule out prostate cancer (e.g., A patient with a rising prostate speci c antigen (PSA) with traditional biopsy revealing tissue suspicious but not diagnostic for prostate cancer); and (2) traditional biopsies reveal localized prostate cancer and the patient has elected focal tissue cryoablation. Since prostate saturation biopsy is performed under general anesthesia, it is not appropriate in the of ce setting.

Effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) implemented the following four new HCPCS codes to be used to report PSBs (*CPT* code *55706*) when submitted for evaluation:

G0416 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens

G0417 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens

G0418 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens

G0419 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens. ❖

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Hospital Services

Payment rate changes for services in hospital outpatient departments and ambulatory surgical centers

The Centers for Medicare & Medicaid Services (CMS) announced that most hospitals will receive an inflation update of 2.1 percent in their payment rates for services furnished to Medicare beneficiaries in outpatient departments. As required by Medicare law, CMS will reduce the update by 2.0 percentage points for hospitals that did not participate in quality data reporting for outpatient services or did not report the quality data successfully, resulting in a 0.1 percent update for those hospitals.

CMS also announced that ambulatory surgical centers (ASCs) will receive a 1.2 percent inflation update beginning January 1, 2010. CMS projects that the aggregate Medicare payments to more than 4,000 hospitals and community mental health centers in CY 2010 will be approximately $32.2 billion, while aggregate Medicare payments to approximately 5,000 ASCs will total $3.4 billion.

The payment updates are included in a final rule with comment period that revises payment policies and updates the payment rates for services furnished to beneficiaries during calendar year (CY) 2010 in hospital outpatient departments under the outpatient prospective payment system (OPPS) and in ASCs under a revised rate-setting methodology that was implemented January 1, 2008.

"The payment rates we are announcing for 2010 are intended to ensure that Medicare beneficiaries continue to receive high quality and efficient care in the most appropriate setting," said Jonathan Blum, director of the CMS Center for Medicare Management.

The final rule with comment period implements provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) that extend Medicare coverage to important rehabilitative and educational services intended to improve the health of patients diagnosed with certain respiratory, cardiac, and renal diseases. Beginning January 1, 2010, hospitals will be able to bill Medicare for new pulmonary and intensive cardiac rehabilitation services furnished in hospital outpatient departments to Medicare beneficiaries.

The final rule with comment period also provides payments to rural hospitals for kidney disease education services furnished in outpatient departments to Medicare beneficiaries with stage IV chronic kidney disease.

The final rule with comment period incorporates a payment adjustment for the hospital pharmacy overhead costs of separately payable drugs and biologicals. This adjustment better recognizes the overhead costs for these drugs and biologicals relative to those for drugs and biologicals that are packaged into Medicare's payment for the associated ambulatory payment classification (APC). As a result, CMS will pay hospitals for most separately payable drugs and biologicals administered in hospital outpatient departments at the manufacturer's average sales price (ASP) plus four percent. In order to maintain beneficiary access to safe, cost-effective health care, the final rule with comment period also modifies CMS's requirements for physician supervision to ensure that hospital outpatient services are appropriately supervised by physicians or other qualified practitioners.

In addition to hospital outpatient departments, the final rule with comment period includes policy changes and payment rates for services in ASCs and continues to expand the list of surgical procedures that Medicare will cover when performed in ASCs. The final rule with comment period seeks to ensure that beneficiaries have access to outpatient services in all appropriate settings, while improving the quality and efficiency of service delivery.

Under the Hospital Outpatient Department Quality Data Reporting Program (HOP QDRP), hospitals that did not participate in the program or did not successfully report the quality measures will receive an update in CY 2010 equal to the annual inflation update factor minus 2.0 percentage points for a net update of 0.1 percent. CMS will continue to require HOP QDRP participating hospitals to report the existing seven emergency department and peri-operative care measures, as well as the four existing claims-based imaging efficiency measures for the CY 2011 payment determination. CMS also will phase in a new HOP QDRP validation requirement to ensure that hospitals are accurately reporting measures for chart-abstracted data. In addition, CMS established procedures to make quality data collected under the HOP QDRP publicly available beginning with the third quarter of CY 2008.

The CY 2010 OPPS/ASC final rule with comment period will appear in the November 20 *Federal Register*. Comments on designated provisions are due by 5:00 p.m. (ET) on December 29, 2009. CMS will respond to comments in the CY 2011 OPPS/ASC final rule.

More information on the final CY 2010 policies for the OPPS and ASC payment system is available at OPPS *http://www.cms.hhs.gov/HospitalOutpatientPPS/*

ASC payment system: http://www.cms.hhs.gov/ASCPayment/ASCRN/. ❖

Source: CMS PERL 200911-02

Processing of noncovered ICD-9-CM procedure codes on inpatient hospital claims

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

Provider types affected

Hospitals submitting claims to Medicare administrative contractors (MAC) or scal intermediaries (FI) for procedures performed for Medicare bene ciaries are affected.

Provider action needed

Effective for inpatient discharges on or after April 1, 2010, hospitals must submit ICD-9-CM codes for noncovered procedures performed in the same inpatient stay with covered procedures on a separate claim. This article is based on CR 6547, which provides instructions to Medicare contractors for processing these claims for noncovered services, also referred to as no-pay claims. Be sure billing staffs are aware of these changes.

Background

Medicare uses ICD-9-CM codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-9-CM code, as well as any secondary diagnoses – some of which may be considered complications or comorbidities (CCs) or major complications or comorbidities (MCCs) for Medicare severity-diagnosis related group (MS-DRG) assignment. The circumstances of inpatient admission always govern selection of the principal diagnosis. Diagnosis codes should be reported to the highest level of speci city available – a code is invalid if it has not been coded to the full number of digits required for that code. For inpatient admissions involving procedures, hospitals must also report ICD-9-CM procedure codes for surgical and other procedures, up to six procedures on a claim.

Effective for inpatient discharges on or after April 1, 2010, hospitals must separate a hospital stay into two claims where both covered and noncovered ICD-9-CM procedure codes are reported:

- One claim with covered services/procedures unrelated to the noncovered ICD-9-CM procedures on a type of bill (TOB) 11x (with the exception of TOB 110), and
- The other claim with the noncovered services/procedures on a TOB 110 (no-pay claim).

Note that the statement covers period should match on both the covered and the noncovered claim.

No-pay claims submitted will be denied as noncovered, using the following on the remittance advice:

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

Group code used when a hospital issued notice of noncoverage (HINN) was not issued:
CO – Contractual obligation

Group code used when a HINN was issued:
PR – Patient responsibility

Additional information

The of cial instruction (CR 6547) issued to your 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/R1838CP.pdf*.

If you have questions, please contact your 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: MM6547
Related Change Request (CR) Number: 6547
Related CR Release Date: October 28, 2009
Related CR Transmittal Number: R1838CP
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1838, CR 6547

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Update to the 2010 inpatient prospective payment system personal computer PRICER

The scal year (FY) 2010 inpatient prospective payment system (IPPS) personal computer (PC) PRICER has been added to the Internet for FY 2010 claims. Go to the IPPS PC PRICER page, *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*, under the Downloads section. The FY 2009 IPPS PC PRICER has also been updated with the most recent provider data from October 2009. If you use the FY 2010 or 2009 IPPS PC PRICERs, please go to the page above and download the latest versions of the PC PRICERs. ❖

Source: CMS PERL 200910-45

Inpatient psychiatric facility prospective payment system PC PRICER released

The inpatient psychiatric facility prospective payment system (IPF PPS) PC PRICER for rate year RY 2010 is now available. The versions for claim dates from July 01, 2009, to September 30, 2009, and for claim dates from October 1, 2009, to June 30, 2010, have been made available on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you use the IPF PPS PC PRICER 2010, please go to the page, *http://www.cms.hhs.gov/PCPricer/09_inppsy.asp*, under the Downloads section, and download the latest versions of the IPF PPS PC PRICER, posted on October 23, 2009. ❖

Source: CMS PERL 200910-37

Round one rebid of the durable medical equipment, prosthetics, orthotics, and supplies competitive bidding program – phase 8A: Hospital exception

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

Provider types affected

This article is for hospitals that bill durable medical equipment Medicare administrative contractors (DME MACs) for speci c allowed competitively bid items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) to their patients on the day of discharge.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6677 to announce that hospitals may furnish certain competitively bid durable medical equipment (DME) items to their patients on the date of discharge without submitting a bid and being awarded a contract under the competitive bidding program round one rebid. The DME competitive bid items that a hospital may furnish upon discharge as part of this exception for round one rebid are walkers and related accessories. Note that this applies to claims received upon implementation of the DMEPOS competitive bidding program round one. That date is January 1, 2011, but the date is subject to change.

Key points of change request 6677

- Hospitals may furnish walkers and related accessories to their patients on the date of discharge whether or not the hospital has a contract under the DMEPOS competitive bidding program.
- Separate payment is not made for walkers and related accessories furnished by a hospital **on the date of admission** as payment for these items is included in the Part A payment for inpatient facility services.
- Hospitals as de ned below may furnish walkers and related accessories to their patients for use in the home on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier.
- To be paid for walkers and accessories as a non-contract supplier, hospitals should use the **modifier J4** and the national competitive bidding (NCB) indicator on the claim line in combination with the following **HCPCS codes: A4636, A4637, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0154, E0155, E0156, E0157, E0158, and E0159.**
- Hospital claims submitted for these items, for which Medicare does not nd a matching date of discharge will be denied with remittance advice messages B15 (Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying service/procedure had not been received/adjudicated.), M114 (This service was processed in accordance with rules and guidelines under the DMEPOS competitive bidding program or other demonstration project. For more information regarding these projects, contact your local contractor.), and MA13 (Alert: you may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.). Prior to denying these DME claims, Medicare will hold the claim for up to 15 business days to await the arrival of the hospital claim with the related discharge date. If such discharge is not processed by the end of the 15 business days, the DME claim will be denied.

Background

Section 302(b) (1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended section 1847 of the Social Security Act (the Act) to require the Secretary to establish and implement programs under which competitive bidding areas (CBAs) are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Part B (the "Medicare DMEPOS competitive bidding program").

On July, 15, 2008, section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the MMA and mandated certain changes to the competitive bidding program. One of these changes established an exception for hospitals from the competitive bidding program when they are furnishing certain items to their own patients during an admission or on the date of discharge.

A hospital under this exception **does not include a hospital-owned DME supplier.** Instead, a hospital is de ned in accordance with section 1861(e) of the Social Security Act. A DME supplier that furnishes the DME item to the hospital, which then furnishes the item to the patient on the date of discharge, must be a contract supplier in the competitive bidding program.

Round one rebid of the DMEPOS competitive bidding program – phase 8A: Hospital exception (continued)

Additional information

The of cial instruction (CR 6677) issued to your Medicare FI, DME/MAC, or A/B MAC is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R590OTN.pdf*.

For discussion of the program instructions designating the competitive bidding areas and product categories included in the DMEPOS competitive bidding program round one rebid in CY 2009 you may review MM6571 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6571.pdf*.

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

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 the competitive bidding implementation contractor (CBIC).

If you have questions, please contact your Medicare DME/MAC, 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: MM6677
Related Change Request (CR) Number: 6677
Related CR Release Date: November 6, 2009
Related CR Transmittal Number: R590OTN
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-20, Transmittal 590, CR 6677

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ESRD Services

Implementation of changes in end-stage renal disease payment for calendar year 2010 – MIPPA Section 153

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

Provider types affected

This article impacts hospital-based and independent dialysis facilities submitting claims to Medicare contractors (scal intermediaries [FIs] and Medicare administrative contractors [MACs]) for end-stage renal disease ESRD services provided to Medicare bene ciaries.

Provider action needed stop – impact to you

This article is based on CR 6679, which provides payment updates for ESRD facilities for calendar year (CY) 2010.

CAUTION – what you need to know

Effective January 1, 2010, section 153 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1881(b) (12) of the Social Security Act to require a one percent increase to the ESRD composite payment rate and that hospital-based dialysis facilities get paid the same composite payment rate as independent dialysis facilities. In addition to the MIPPA changes, other changes include: an update to the drug add-on adjustment to the composite payment rate, an update to the wage index adjustments to re ect current wage data, including a revised budget neutrality adjustment, and a reduction in the wage index oor.

GO – what you need to do

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

Background

For CY 2010, the Centers for Medicare & Medicaid Services (CMS) updated the composite payment rates for ESRD facilities. Upon implementation of CR 6679, the following changes will apply to claims from hospital-based and independent dialysis facilities:

- An update to the base-composite payment rate with a one percent increase resulting in a base rate of $135.15 for both hospital-based and independent renal dialysis facilities
- An update to the drug add-on adjustment for CY 2010 to the composite payment rate of 15.0 percent
- An update to the wage-index adjustments to re ect the current wage data
- A reduction in the wage-index oor from 0.7000 to 0.6500.

Note: The ESRD-payment changes will be effective for services on or after January 1, 2010.

Additional information

The of cial instruction, CR 6679, issued to your Medicare FI or A/B MAC may be viewed by going to the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R113BP.pdf*.

The fact sheet Outpatient Maintenance Dialysis End-Stage Renal Disease provides general information about outpatient maintenance dialysis for end-stage renal disease, the composite payment rate system, and separately billable items and services. The fact sheet is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymtfctsht08-508.pdf*.

If you have questions, please contact your Medicare 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: MM6679
Related Change Request (CR) Number: 6679
Related CR Release Date: October 30, 2009
Related CR Transmittal Number: R113BP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-02, Transmittal 113, CR 6679

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Proposed rule for new prospective payment system for renal dialysis facilities

The Centers for Medicare & Medicaid Services (CMS) has published a notice in the *Federal Register* (CMS-1418-N) extending the comment period for a proposed rule published in the *Federal Register* on September 29, 2009 (74 FR 49922). The proposed rule would implement a case-mix adjusted bundled prospective payment system (PPS) for Medicare outpatient end-stage renal disease (ESRD) dialysis facilities.

The proposed ESRD PPS would also replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD services. The comment period for the proposed rule, which would have ended on November 16, 2009, was extended to 5 p.m. on December 16, 2009. CMS also extended the availability of the audio recording of the October 23, 2009, ESRD PPS town hall meeting. The audio recording will be available through December 16, 2009. To access the recording, dial 1-800-642-1687 and, when prompted, enter conference ID: 33239635. ❖

Source: CMS PERL 200911-17

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 ll it out. We want to know how well the entire site and speci c 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.

Skilled Nursing Facility Services

Denial of claims for ambulance services rendered to beneficiaries in Part A skilled nursing facility stays

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

Provider types affected

Skilled nursing facilities (SNFs) and ambulance suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for ambulance services provided to Medicare beneficiaries should review this article.

Provider action needed

This article is based on change request (CR) 6700 which implements additional Medicare system checks to ensure that ambulance services that are subject to skilled nursing facility consolidated billing (SNF CB) rules (but that are billed separately as a Part B service) are denied when the date of service (DOS) on the ambulance claims overlap outpatient hospital claims that are rejected for SNF CB. SNF and ambulance billing staff should be aware of this issue.

Background

The Social Security Act (Section 1888(e); *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm*) established a Medicare prospective payment system (PPS) for skilled nursing facilities (SNF). Under the SNF PPS, most of the services that outside suppliers provide to SNF residents are included in the SNF Medicare Part A payments. Most ambulance services furnished to a beneficiary in a SNF Part A stay are subject to this rule as well (exceptions are discussed below). Accordingly, pursuant to the Social Security Act consolidated billing (CB) requirements, SNFs are responsible for billing Medicare Part A for these services. The outside suppliers may not separately bill Medicare but must obtain payment from the SNFs.

A Department of Health & Human Services Inspector General (IG) Report A-01-08-00505 dated August 25, 2009, (*http://oig.hhs.gov/oas/reports/region1/10800505.asp*) found that, on occasion, ambulance services that were subject to the SNF CB rule were improperly billed separately by the supplier. The IG Report stated in part:

> "Federal regulations (42 CFR Section 409.27(c)) state that the SNF benefit includes medically necessary ambulance transportation provided to a SNF resident during a covered Part A stay. Accordingly, when an ambulance supplier erroneously bills Medicare Part B for ambulances services included in the SNF's Part A consolidated billing payment, Medicare pays for the same service twice, once to the SNF and once to the ambulance supplier."

> "The SNF consolidated billing requirement applies only to those services that are provided to a SNF resident. As a result, ambulance transportation that begins or ends beneficiaries' SNF stays is excluded from consolidated billing. Federal regulations (42 CFR Section 411.15(p)(3)(iii)) also state that receiving certain emergency or intensive outpatient hospital services that are beyond a SNF's scope of care ends a beneficiary's status as a SNF resident. Accordingly, because the beneficiary receiving those specific emergency or intensive outpatient hospital services is temporarily not a SNF resident, ambulance transportation associated with those services is excluded from consolidated billing and may be billed to Medicare Part B."

You may review 42 CFR 409.27(c) and 42 CFR 411.15(p)(3)(iii) at *http://www.gpoaccess.gov/CFR/retrieve.html*.

As stated above, there are exceptions to the general rule that ambulance services furnished to a beneficiary in a SNF Part A stay are subject to SNF CB rules. In accordance with the *Medicare Claims Processing Manual* (Chapter 15, Section 30.2.2; refer to the Centers for Medicare & Medicaid Service (CMS) Web site *http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf*), ambulance payments associated with the following outpatient hospital service exclusions are paid under the ambulance fee schedule:

- Cardiac catheterization
- Computerized axial tomography (CT) scans
- Magnetic resonance imaging (MRIs)
- Ambulatory surgery involving the use of an operating room, including the insertion, removal, or replacement of a percutaneous esophageal gastrostomy (PEG) tube in the hospital's gastrointestinal (GI) or endoscopy suite
- Emergency services
- Angiography
- Lymphatic and venous procedures
- Radiation therapy.

The following ambulance transportation and related ambulance services for residents in a Part A stay are included in the SNF PPS rate and **may not be billed as Part B services by the supplier.** In these scenarios, the services provided are subject to SNF CB:

- A beneficiary's transfer from one SNF to another before midnight of the same day, for which the first SNF is responsible for billing the services to the Part A Medicare administrative contractor (MAC).
- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility.

Denial of claims for ambulance services rendered to beneficiaries in Part A skilled nursing facility stays (continued)

CR 6700 implements additional Medicare system checks to ensure that ambulance services that are subject to SNF CB rules (but that are billed separately as a Part B service) are denied when the date of service (DOS) on the ambulance claims overlap outpatient hospital claims that are rejected for SNF CB. The Medicare claims processing system will enforce SNF CB rules by subjecting claims for ambulance services to the following if-then logic:

- **If** a claim for a hospital outpatient service is rejected because it should have been billed and paid for according to SNF CB rules, **then** Medicare contractors will deny any ambulance service associated with the denied hospital outpatient service as the ambulance transportation is also subject to SNF CB rules, and conversely.
- **If** payment for a hospital outpatient service is not bundled into the SNF CB rate and is separately payable under Part B, **then** the ambulance service associated with that service is also separately payable under Part B.

Where claims are denied as a result of CR 6700, Medicare will use remittance advice reason code 190 (Payment is included in the allowance for a skilled nursing facility (SNF) quali ed stay.), remark code N106 (Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.), and group code CO (contractual obligation).

Note also that if Medicare processes an ambulance claim rst and later discovers that the ambulance service was provided during a SNF stay and the ambulance service should have been bundled under the SNF stay payment, Medicare will consider the separate ambulance claim payment as an overpayment and will initiate overpayment recovery procedures.

Additional Information

The of cial instruction, CR 6700, 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/R595OTN.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: MM6700
Related Change Request (CR) Number: 6700
Related CR Release Date: November 6, 2009
Related CR Transmittal Number: R595OTN
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-20, Transmittal 595, CR 6700,

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Skilled nursing facility prospective payment system PRICER updated

The scal year (FY) 2010 skilled nursing facility prospective payment system (SNF PPS) personal computer (PC) PRICER has been updated for FY 2010 claims. Go to the SNF PPS PC PRICER page, *http://www.cms.hhs.gov/PCPricer/04_SNF.asp*, under the Downloads section.

The FY 2009 SNF PPS PC PRICER has also been updated with the most recent provider data from October 2009. If you use the FY 2010.2 SNF PPS PC PRICER, please go to the page above and download the latest version of the PC PRICER. ❖

Source: CMS PERL 200910-42

Enrollment Application Reminder

Providers submitting a Medicare enrollment application CMS-855A, CMS-855B or CMS-855I must submit the **nine-digit ZIP** code for each practice location listed on the form.

Publishing minimum data set 3.0 update and resident assessment instrument manual

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the publishing of the minimum data set (MDS) 3.0, data item set, and data speci cations that will be implemented October 1, 2010. Information may be viewed on the MDS 3.0 Web page *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*.

The publishing of the MDS 3.0 resident assessment instrument (RAI) manual has been delayed. It is anticipated that chapters 1, 2, 3, 5, and 6 will be published in November. Chapter 4 (Care Area Assessments (CAAs)) and Appendix C (CAA resources) will be posted in December.

When published, the manual will include:

- Description and instructions for types of assessments and tracking documents
- Each MDS 3.0 item
- Care area assessment
- Submission and correction of MDS 3.0 records
- Skilled nursing facility and swing bed prospective payment system (PPS) policy for the MDS 3.0
- Resource utilization group (RUG-IV) classi cation system.

You will be noti ed when the materials are published.
Any questions may be directed to mds30comments@cms.hhs.gov.

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

Source: CMS PERL 200911-07

Five-star quality rating system – November news

1. The ve-star provider preview reports will be available no later than Thursday, November 19, 2009. Providers may access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of minimum data set data.

Provider preview access information:

- Visit the MDS state welcome page available on the state servers where you submit MDS data to review your results.
- To access these reports, select the certi cation and survey provider enhanced reports (CASPER) reporting link located at the bottom of the login page.
- Once in the CASPER reporting system:

  i. Click on the "folders" button and access the five-star report in your "st LTC facid" folder

  ii. Where st is the two-digit postal code of the state in which your facility is located

  iii. "Facid" is the state assigned "facid" of your facility.

2. The helpline will reopen in January 2010, for questions and concerns about the November data. Alternatively, providers can write to BetterCare@cms.hhs.gov.
3. Nursing Home Compare will update with November's ve-star data on Wednesday, November 25, 2009.
4. For the latest ve-star quality rating system information, please visit *http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp*. ❖

Source: CMS PERL 200911-30

Keep Informed

Join *e-News*, FCSO e-mailing list to receive the most current revisions and updates. Check our upcoming provider events calendar and learn how to register for free teleconferences and webcasts that will help you increase your knowledge of the Medicare program and nd ways to improve Medicare billing and payment ef ciency.

CORF/ORF Services

Therapy cap values for calendar year 2010

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

Provider types affected

This article is for providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], A/B Medicare administrative contractors [A/B MACs], and/or DME Medicare administrative contractors [DME MACs]) for physical therapy, speech-language pathology, and/or occupational therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6660, which describes the policy for outpatient therapy caps for 2010 and announces that therapy caps for 2010 will be $1860. Billing staff should be aware of these revised caps.

Background

The Balanced Budget Act 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 (signed Feb. 8, 2006) directed that a process for exceptions to therapy caps for medically necessary services be implemented. Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008, and Section 141 extended the effective date of the exceptions process to the therapy caps to December 31, 2009. The exceptions process will continue unchanged for the time frame directed by Congress.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1860 for calendar year (CY) 2010. For occupational therapy services, the limit is $1860 for CY 2010. The limit is based on incurred expenses and includes applicable deductible and coinsurance.

CR 6660 revises the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10 (Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General), and Section 20 (HCPCS Coding Requirement) to include the CY 2010 therapy caps, and this revision is included as an attachment to CR 6660.

Additional information

You may find out more about Medicare therapy services and resources on the Centers for Medicare and Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/therapyservices/*.

The official instruction, CR 6660, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1860CP.pdf*.

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

MLN Matters® Number: MM6660
Related Change Request (CR) Number: 6660
Related CR Release Date: November 23, 2009
Related CR Transmittal Number: R1860CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1860, CR 6660

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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

Rural Health Clinic Services

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

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

Provider types affected

This article is for RHCs and FQHCs submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6605 which provides instructions for the calendar year (CY) 2010 payment rate increases for rural health clinics (RHC) and federally qualified health centers (FQHC) services. Be sure to inform billing staff of these changes.

Background

In accordance with the Social Security Act (Section 1833(f)) (*http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) the Centers for Medicare & Medicaid Services (CMS) is increasing the calendar year (CY) payment rates for RHCs and FQHCs effective for services on or after January 1, 2010, through December 31, 2010 (i.e., CY 2010), as follows:

- The RHC upper payment limit per visit is increased from $76.84 to $77.76 effective January 1, 2010, through December 31, 2010 (i.e., CY 2010). The 2010 rate reflects a 1.2 percent increase over the 2009 payment limit in accordance with the rate of increase in the Medicare economic index (MEI) as authorized by the Social Security Act (Section1833(f)).
- The FQHC upper payment limit per visit for urban FQHCs is increased from $119.29 to $125.72 effective January 1, 2010, through December 31, 2010 (i.e., CY 2010), and the maximum Medicare payment limit per visit for rural FQHCs is increased from $102.58 to $108.81 effective January 1, 2010, through December 31, 2010 (i.e. CY 2010). The 2010 FQHC rates reflect a 1.2 percent increase over the 2009 rates, in accordance with the rate of increase in the MEI, plus an additional $5.00 increase mandated by Section 151 of the Medicare Improvements for Patients and Providers Act of 2008.

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

Additional information

The official instruction, CR 6605, 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/R1845CP.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: MM6605
Related Change Request (CR) Number: 6605
Related CR Release Date: November 6, 2009
Related CR Transmittal Number: R1845CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1845, CR 6605

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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

Further clarification of instructions on using 837 institutional claim adjustment segments for Medicare secondary payer Part A claims

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

Provider types affected

Providers submitting claims to Medicare contractors (scal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare bene ciaries.

Provider action needed stop – impact to you

In change request (CR) 6426, the Centers for Medicare & Medicaid Services (CMS) instructed providers that it must utilize the claim adjustment segment (CAS) in the 837I when submitting MSP claims to their Medicare contractor. CR 6426 also informed providers that they cannot submit MSP claims using direct data entry (DDE) since the DDE process does not support the CAS as found in the 837. CR 6426 elicited questions from providers that CMS is addressing in this special edition (SE) article.

Caution – what you need to know

CMS wants providers, who normally submit claims via DDE, to know that they may use the PCAce product Pro32 free billing software which has MSP billing capabilities including the required CAS to identify CAS segment adjustments. However, providers may use any 837 billing software deemed warranted to submit MSP claims.

Go – what you need to do

In addition to submitting Medicare secondary payer (MSP) claims with the CAS via the billing software, MSP adjustments should be submitted for MSP claims that were originally submitted via DDE on and prior to October 4, 2009 using the 837 transaction and billing software as noted above. DDE MSP adjustment claims will not be accepted. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

As stated in CR 6426, MSP provisions apply to situations where Medicare is not the bene ciary's primary insurance. Medicare's secondary payment for Part A MSP claims is based on:

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

CR 6426 reminded you to include CAS related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

As already mentioned, you may use the PC-ACE Pro32 free billing software, which has MSP billing capabilities including the required CAS to identify CAS adjustments. However, providers may use any 837 billing software deemed warranted to submit MSP claims. Check the Web site of your Medicare contractor for more details on billing software that they have available for you. You may nd their Web site address on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

Note: This article does not alter the credit balance reporting process.

Additional information

You may nd the *MLN Matters*® article related to CR 6426 on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6426.pdf*.

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

MLN Matters® Number: SE0928
Related Change Request (CR) Number: 6426
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE0928

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Claim status category code and claim status code update

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 submitting claims to Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], carriers, A/B Medicare administrative contractors [MAC] and durable medical equipment MACs or DME MACs]) for Medicare beneficiaries are affected.

Provider action needed

This article, based on change request (CR) 6723, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 were updated during the September 2009 meeting of the National Code Maintenance Committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on the Internet on November 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status codes and claim status category codes approved by the national Code Maintenance Committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the September 2009 committee meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on November 1, 2009. Medicare will implement those changes on January 4, 2010, as a result of CR 6723.

Additional information

The official instruction issued to your Medicare contractor regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1852CP.pdf*.

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

MLN Matters® Number: MM6723
Related Change Request (CR) Number: 6723
Related CR Release Date: November 13, 2009
Related CR Transmittal Number: R1852CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1852, CR 6723

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Find out first: Subscribe to FCSO eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options eNews, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So*, subscribe to eNews, and stay informed.*

Educational Events

Upcoming provider outreach and educational events

December 2009 – January 2010

Topic – Recovery audit contractor

When: Thursday, December 14, 2009

Time: 11:00 a.m. – 12:30 p.m. ET **Delivery language:** English

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

Topic – Discover your passport to Medicare training webcast

When: Wednesday, December 15, 2009, and January 6, 2010

Time: 10:00 a.m. – 11:30 a.m., and 3:00 p.m. – 4:30 p.m. ET **Delivery language:** English

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

Topic – Hot Topics

When: Tuesday, January 19, 2010

Time: 10:30 a.m. – 12:00 p.m. ET **Delivery language:** English

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

Topic – HIPAA version 5010

When: Thursday, January 21, 2010

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

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

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 identi er may enter "99999" in the NPI eld. 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 speci c course listed on the Instructor-Led Training (ILT) schedule page. For further assistance, contact FCSO Medicare training help desk at 1-866-756-9160 or send an e-mail to *fcsohelp@geolearning.com*.

Please Note:

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

Registrant's Name: ____________________

Registrant's Title: ____________________

Provider's Name: ____________________

Telephone Number: ____________________ Fax Number: ____________________

E-mail Address: ____________________

Provider Address: ____________________

City, State, ZIP Code: ____________________

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

Preventive Services

November is American Diabetes Month

Twenty four million adults and children in the United States suffer from diabetes. Complications from diabetes can include increased risk of heart disease, blindness, glaucoma, nerve damage, and kidney damage. However, detection and treatment of diabetes may prevent or delay many of these complications.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by educating them about their risk factors and encouraging them to take advantage of Medicare-covered diabetes detection and treatment services.

For more information

The Centers for Medicare & Medicaid Services (CMS) has developed several educational products related to Medicare-covered diabetes-related services, including:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – this recently revised comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including diabetes and glaucoma screening tests, diabetes self-management training, medical nutritional therapy, and supplies and other services for Medicare bene ciaries with diabetes.

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Diabetes-Related Services brochure – this recently updated brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare bene ciaries with diabetes.

http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf

Quick Reference Information: Medicare Preventive Services – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including diabetes and glaucoma screening tests, diabetes self-management training, medical nutritional therapy, and supplies and other services for Medicare bene ciaries with diabetes.

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for Medicare Learning Network (MLN) preventive services educational products and resources for health care professionals and their staff.

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Glaucoma Screening brochure – this recently updated brochure provides information on coverage for Medicare-covered glaucoma screenings, including the dilated eye examination.

http://www.cms.hhs.gov/MLNProducts/downloads/Glaucoma.pdf

Information for your use and materials for consumers and health professionals developed by the National Diabetes Education Program are available at *http://ndep.nih.gov/*.

For more information about American Diabetes Month, please visit the American Diabetes Association Web site at *http://www.diabetes.org/community-events/programs/american-diabetes-month/*.

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

Source: CMS PERL 200911-06

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Message for providers on H1N1 outreach

The Department of Health & Human Services thanks you for your work in communities across the country. As this year's u season continues, we want to provide you with up-to-date information about the new 2009 H1N1 virus, and also give you some easy-to-read information with the hope that it will reach people who need it the most.

We've also included an example of an e-mail that will allow you to share important resources with members of your community and help protect them from the H1N1 virus. Participation in this outreach effort is voluntary.

2009 H1N1 updates

Flu activity is already higher than what is seen during the peak of many regular u seasons. Almost all of the u viruses identi ed this season so far have been 2009 H1N1.

All states have placed orders for the 2009 H1N1 vaccine, and more orders are expected daily. Vaccine is arriving in thousands of places across the country. Because the vaccine distribution system varies by state, the vaccine situation on the ground may differ from community to community.

The 2009 H1N1 vaccine is taking longer to produce than manufacturers initially expected. Scientists, doctors, and manufacturers are working around the clock to produce this vaccine safely, effectively, and as quickly as the science allows. The U.S. Department of Health & Human Services, through state and local health departments, will continue to make the vaccine available as soon as it comes off the production line.

Clinical trials conducted by the National Institutes of Health and the vaccine manufacturers have shown that the new H1N1 vaccine is both safe and effective.

In the past, u pandemics have been characterized by multiple waves. Scientists and doctors recommend H1N1 vaccination even if u activity slows, as it could resume later in the season.

Please feel free to share any general feedback you receive for additional information and materials. Again, dissemination of this information is voluntary.

Outreach e-mail

Please copy and paste the information below:

Dear friend,

You've probably been hearing a lot this year about the H1N1 u. And you may have questions. You may have even had the u, or know a friend or neighbor who has been sick. This e-mail features some tools suggested by the U.S. Department of Health & Human Services to help you prevent the u, know what to do if you get sick, and nd a place to get vaccinated.

People recommended by the Centers for Disease Control and Prevention (CDC) to receive the vaccine as soon possible include:

- Health care workers
- Pregnant women
- People ages 25 through 64 with chronic medical conditions, such as asthma, heart disease, or diabetes
- Anyone from 6 months through 24 years of age
- People living with or caring for infants under six-months old.

A one-stop resource with the latest updates on the H1N1 u is *http://www.flu.gov/*.

On this site, you can nd information on how to prevent and treat the u, u essentials, and why the H1N1 vaccine is safe and recommended by health experts. To look up where to get vaccinated in your state, visit the vaccine locator. This information is updated regularly as more doses are shipped each week.

An additional resource is the CDC hotline, 1-800-CDC-INFO (1-800-232-4636), which offers services in English and Spanish, 24 hours a day, seven days a week.

Heard a rumor? Visit Myths & Facts to run a fact check.

Please forward this e-mail to your family, friends, co-workers and networks today. Let's work together to help keep our communities safe and healthy. ❖

Source: CMS PERL 200911-28

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November 19 was the Great American Smokeout

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep Medicare beneficiaries healthy by encouraging them to take advantage of Medicare-covered smoking and tobacco-use cessation counseling benefits.

Tobacco use contributed to more than 438,000 premature deaths in the United States annually between 1997 and 2001[1]. Additionally, tobacco continues to be the leading cause of preventable disease and death in the United States. Smoking can attribute to and exacerbate heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysm, and cataracts.

Medicare provides coverage of smoking and tobacco-use cessation counseling for beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use, or who take certain therapeutic agents whose metabolism or dosage is affected by tobacco use.

What you can do

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by educating them about their risk factors and encourage them to take advantage of Medicare-covered smoking and tobacco-use cessation counseling benefits.

For more information

CMS has developed several educational products related to Medicare-covered smoking and tobacco-use cessation counseling:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for *Medicare Learning Network* (MLN) preventive services educational products, including products related to Medicare-covered smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Quick Reference Information: Medicare Preventive Services – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

Smoking and Tobacco-Use Cessation Counseling brochure – this brochure provides information on coverage for Medicare-covered smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf

Please visit the MLN for more information on these and other Medicare fee-for-service educational products. For more information about the Great American Smokeout, please visit the American Cancer Society Web site at *http://acsf2f.com/gaso/index.html*.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate eligible beneficiaries about the importance of taking advantage of smoking and tobacco-use cessation counseling services and other preventive services covered by Medicare. ❖

[1] The American Cancer Society. 2009. Great American Smokeout: Tobacco-Related Cancer Statistics 2007 [online]. [cited 5 November 2009]. Available from the World Wide Web (*http://acsf2f.com/gaso/statistics.html*).

Source: CMS PERL 200911-25

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Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

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 2009 through September 2010.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name:

Provider/Office Name:

Telephone Number (include area code):

Mailing Address:

City:

State, ZIP Code:

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Important Addresses

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

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

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

Telephone Numbers

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

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

Speech and Hearing Impaired
1-877-660-1759

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

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds (check return assistance only)

Option 6
Automated Response Line

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

Seminar Registration Fax Number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

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

Medicare Web sites

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

Addresses

CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

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

MEDICARE SECONDARY PAYER
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P. O. Box 45267
Jacksonville, FL 32232-5267

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