MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

[ ] Medicare Manager
[ ] Reimbursement Director
[ ] Chief Financial Officer
[ ] Compliance Officer
[ ] DRG Coordinator
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The *Medicare A Bulletin* is published monthly by First Coast Service Options Inc. Provider Outreach and Education division, to provide timely and useful information to Medicare Part A providers.

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

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About the *Medicare A Bulletin*

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

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

Who receives the *Bulletin*?

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

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

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

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

What is in the *Bulletin*?

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

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

The Medicare A Bulletin represents formal notice of coverage policies

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

Quarterly provider update

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

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

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

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

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

GENERAL INFORMATION

Holding of claims for services paid under the 2010 Medicare physician fee schedule

The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, nonphysician practitioners, and other providers of services paid under the Medicare physician fee schedule (MPFS), beginning January 1, 2010. In this regard, CMS has instructed its contractors to hold claims for services paid under the MPFS for up to the first 10 business days of January (January 1 through January 15) for 2010 dates of service. This should have minimum impact on provider cash flow because, by law, clean electronic claims are not paid any sooner than 14 calendar days (29 days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before December 31, 2009, will be processed and paid under normal procedures.

The holding of claims allows Medicare contractors time to receive the new, updated payment files and perform necessary testing before paying claims at the new rates. CMS has instructed contractors to begin processing claims at the new rates no later than January 19, 2010. Please note that most contractors are closed on the January 18 Martin Luther King Day holiday. Therefore, even absent a new update, most claims likely would not have been paid any sooner than January 19, 2010, given the aforementioned statutory 14-day payment floor.

CMS has extended the Medicare Part B 2010 annual participation enrollment program end date from January 31, 2010, to March 17, 2010; therefore, the enrollment period now runs from November 13, 2009, through March 17, 2010.

The effective date for any participation status change during the extension, however, remains January 1, 2010, and will be in force for the entire year.

Contractors will accept and process any participation elections or withdrawals, made during the extended enrollment period that are received or post-marked on or before March 17, 2010.

In addition, be on the alert for more information about other legislative provisions that may affect you. ❖

Source: CMS PERL 200912-31

Claims rejecting for reason code T5052

First Coast Service Options Inc. (FCSO) is experiencing a high volume of claims rejected with reason code T5052 due to claims submitted with invalid beneficiary's eligibility information. Here are three easy ways to find the correct beneficiary's eligibility information and avoid unnecessary reason code T5052 rejects:

1. Ask the beneficiary for their red, white and blue Medicare health insurance card. The card contains the correct beneficiary's name, the Medicare health insurance claim (HIC) number, and the entitlement and effective date to Medicare Part A or Part B.
2. Verify the beneficiary's eligibility data on the direct data entry (DDE) system ELGA (eligibility A) screen. Key the following information in the inquiry screen and press enter:
   - The beneficiary's HIC number
   - The first six characters of the beneficiary's last name
   - The first initial of the beneficiary's first name
   - The beneficiary's date of birth in this format: MMDDCCYY (month, day, century, year)
   - The requestor's ID (you may use your initials)
   - The Medicare contractor number. For Florida providers, enter 09101. For Puerto Rico and U.S. Virgin Islands providers, enter 09201
   - The Medicare provider number, not your national provider number (NPI)
   - The host site code if the information is not automatically pulled up in the Southern (SO) region. If you search another region, key one of the following two-character region codes: GL, GW, KY, MA, PA, NE, SE, or SW.
3. Contact the Part A interactive voice response unit (IVR) at 1-877-602-8816 if you do not have access to the DDE system.

Note: Do not use any nickname when keying the beneficiary's first name on the claim form. Always use the information indicated on the red, white and blue Medicare health insurance card or in the Medicare common working file (CWF). ❖

Source: Medicare Part A Direct Data Entry (DDE) Training Manual

Claims returned to provider for reason code 32206

First Coast Service Options Inc. (FCSO) is experiencing a high volume of claims returned to providers (RTP) for reason code 32206 due to an invalid revenue code for the type of bill submitted. Here are a few tips you may follow if you are receiving RTP claims for reason code 32206.

To verify if a revenue code is valid for your type of bill (TOB), use the direct data entry (DDE) system and follow the next steps:

- From the main menu, select option 1 – inquiry menu
- Once in the inquiry menu, select option 13 – revenue codes. Select this option when you need to determine:
  - The type of revenue codes allowed with certain type of bills
  - If the healthcare common procedure code is required
  - If a unit is required
  - If a rate is required
- On the revenue-code table inquiry, key the revenue code in question, e.g., 0420.

If you do not have access to the DDE system, access the Centers for Medicare & Medicaid Services (CMS) Internet-only-manual (IOM), Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Completing and Processing the Form CMS-1450 Data Set, Section 75.4, Form Locator 42 – Revenue Code. ❖

Source: CMS Internet-only Manual (IOM) Pub. 100-04 *Medicare Claims Processing Manua*l, Chapter 25 , Section 75.4

Claims rejecting for reason code 39011 due to timeliness of submission

First Coast Service Options Inc. (FCSO) is experiencing a high volume of claims rejected with reason code 39011 due to claims not submitted within the appropriate filing period. If you find your claims rejecting for reason code 39011, the Centers for Medicare & Medicaid Services (CMS) has the following well-defined guidelines for timely submission of claims. Medicare regulation at 42 CFR 424.44 defines the timely filing period for Medicare fee-for-service claims. In general, such claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year (October through December) are considered furnished in the following year; i.e., the time limit is the second year after the year in which services were furnished.
Based on this regulation, providers have a minimum of 15 months to a maximum of 27 months to file Medicare claims within the following established time-limit parameters:

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
October 1, 2010 – September 30, 2011	by December 31, 2012

Example: If the services are provided during the month of September, the provider has until December 31 of the following year (or 15 months) to submit the claim to Medicare. If the services are provided during the month of October, the provider has until December 31 of the second year (or 27 months) to submit the claim to Medicare.

Medicare determines whether a claim has been filed timely by comparing the date the services were furnished (line item date or claim statement "from" date) to the receipt date applied to the claim when it is received. If the span between these two dates exceeds the time limitation, the claim is considered to have been not timely filed.

When a claim is denied because it was filed after the timely filing period, the denial will not constitute an "initial determination." Thus, a claim that is denied because it was not filed timely is not subject to appeal. ❖

Source: CMS Internet-only Manual (IOM) Pub. 100-04 Medicare Claims Processing Manual, Chapter 1, Section 70

January 2010 average sales price file is available

The Centers for Medicare & Medicaid Services (CMS) has posted the January 2010 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. The ASP pricing files for January 2009 and October 2009 have also been updated. All are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links on that page). ❖

Source: CMS PERL 200912-21

The revised January 2010 ASP drug file is now available

The Centers for Medicare and Medicaid Services (CMS) has posted the revised January 2010 average sales price (ASP) drug file and crosswalk. All are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a19_2010aspfiles.asp*. ❖

Source: CMS PERL 200912-30

2010 holiday schedule

First Coast Service Options Inc. will observe the following holiday schedule in 2010:

Holiday closures: Florida and U.S. Virgin Islands

Date	Holiday
January 1 (Friday)	New Year's Day
January 18 (Monday)	Martin Luther King Jr. Day
April 2 (Friday)	Good Friday
May 31 (Monday)	Memorial Day
July 5 (Monday)	Independence Day (observed)
September 6 (Monday)	Labor Day
November 25 (Thursday)	Thanksgiving Holiday
November 26 (Friday)	Thanksgiving Holiday
December 23 (Thursday)	Christmas Holiday (observed)
December 24 (Friday)	Christmas Holiday

Holiday closures: Puerto Rico

Date	Holiday
January 1 (Friday)	New Year's Day
January 5 (Tuesday)	Day before Three Kings
January 6 (Wednesday)	Three Kings' Day
January 11 (Monday)	Eugenio Maria de Hostos
January 18 (Monday)	Martin Luther King Jr. Day
March 22 (Monday)	Emancipation Day
April 1 (Thursday)	Good Thursday (Jueves Santo)
April 2 (Friday)	Good Friday (Viernes Santo)
April 16 (Friday)	José de Diego
May 31 (Monday)	Memorial Day
July 5 (Monday)	Independence Day (observed)
July 26 (Monday)	Constitution Day
September 6 (Monday)	Labor Day
November 19 (Friday)	Discovery of Puerto Rico
November 25 (Thursday)	Thanksgiving Holiday
November 26 (Friday)	Thanksgiving Holiday
December 23 (Thursday)	Christmas Holiday (observed)
December 24 (Friday)	Christmas Holiday
December 31 (Friday)	New Year's Eve

2010 holiday schedule (continued)

Additional call center closures: Florida, Puerto Rico, and the U.S. Virgin Islands

Provider contact centers will be closed in observance of the following additional federal holidays:

Date	Holiday
February 15 (Monday)	Presidents Day
October 11 (Monday)	Columbus Day
November 11 (Thursday)	Veteran's Day

Interactive voice response (IVR): All providers

Toll-free telephone numbers:

Part A: 877-602-8816

Part B: 877-847-4992

Availability of specific claims information:

Part A: 7:00 a.m.-7:00 p.m., ET (Monday through Friday) and 7:00 a.m.-3:00 p.m., ET (Saturday)

Part B: 7:00 a.m.-6:30 p.m., ET (Monday through Friday) and 7:00 a.m.-3:00 p.m., ET (Saturday).

Note: Recorded information on current Medicare issues is available 24 hours a day, 7 days a week. Please refer to the *IVR Web page* for additional information. FCSO is committed to continuous improvement and providing the best service for our customers. ❖

Revisions to consultation services payment policy

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 and nonphysician practitioners (NPPs) who perform the initial evaluation and management (E/M) consultation for Medicare beneficiaries and submit claims to Medicare carriers, fiscal intermediaries, and/or Medicare administrative contractors (MACs) for those services. It is also intended for method II critical access hospitals (CAHs), which bill for the services of those physician and nonphysician practitioners who have reassigned their billing rights. This article only applies to physicians billing the Medicare fee-for-service program. It does not apply to Medicare Advantage or non-Medicare insurers.

Provider action needed

This article pertains to change request (CR) 6740, which alerts providers that effective January 1, 2010, the *Current Procedural Terminology* (*CPT*) consultation codes (ranges *99241-99245* and *99251-99255*) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents **where** the visit occurs and that identify the **complexity** of the visit performed. See the *Key points* section of this article for details.

Background

In the calendar year 2010 Medicare physician fee schedule (MPFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G-codes. The change will not increase or decrease Medicare payments. In place of the consultation codes, CMS increased the work relative value units (RVUs) for new and established office visits, increased the work RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6 that pertain to the use of the American Medical Association (AMA) *CPT* consultation codes (ranges *99241-99245* and *99251-99255*) are removed by CR 6740. (The Web address for viewing CR 6740 is in the *Additional information* section of this article.)

Key points of change request 6740

- Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA *CPT* consultation codes (ranges *99241-99245*, and *99251-99255*) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings.
- Effective January 1, 2010, local FIs and/or A/B MACs will no longer recognize AMA *CPT* consultation codes (ranges *99241-99245*, and *99251-99255*) for method II CAHs, when billing for the services of those physician and nonphysician practitioners who have reassigned their billing rights.
- Physicians may employ the 2009 consultation service codes, where appropriate, to bill for consultative services furnished up to and including December 31, 2009.
- Physicians who bill a consultation after January 1, 2010, will have the claim returned with a message indicating that Medicare uses another code for the service. The physician must bill another code for the service and may not bill the patient for a noncovered service.

Revisions to consultation services payment policy (continued)

- Rural health clinics (RHCs) and federally qualified health centers (FQHCs) will discontinue use of AMA *CPT* consultation codes *99241-99245* and *99251-99255* and should instead use *99201-99215* and *99304-99306*.
- Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.
- In the inpatient hospital setting and nursing facility setting, any physicians and qualified NPPs who perform an initial evaluation may bill an initial hospital care visit code (*99221-99223*) or nursing facility care visit code (*99304-99306*), where appropriate.
- In all cases, physicians will bill the available code that most appropriately describes the level of the services provided.
- The principal physician of record will append **modifier AI** (Principal physician of record), to the E/M code when billed. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient will bill only the E/M code for the complexity level performed.
- However, claims that include the **modifier AI** on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.
- For patients receiving hospital outpatient observation services who are not subsequently admitted to the hospital as inpatients, physicians should report *CPT* codes *99217-99220*. In the event another physician evaluation is necessary, the physician who provides the additional evaluation bills the office or other outpatient visit codes when they provide services to the patient.

  Example: If an internist orders observation services, furnishes the initial evaluation, and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established patient office or other outpatient visit codes as appropriate.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients and who are discharged on the same date, the physician should report *CPT* codes *99234-99236* (e.g. code *99234*-Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date). If the patient is an inpatient and another physician evaluation is necessary, the physician would bill the initial hospital day code as **appropriate (*CPT* codes *99221-99223*)**. Otherwise, physician should use the new or established patient office or other outpatient visit codes for a necessary evaluation.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients on the same date, the physician should report only the initial hospital care services codes (codes *99221-99223*). Medicare will pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code *99221*) for the initial hospital admission. Medicare will pay the office visit as billed and the Level 1 initial hospital care code. The principal physician of record, as previously noted, must append the **modifier AI** to the claim with the initial hospital care code.
- For patients receiving hospital outpatient observation services or inpatient care services (including admission and discharge services) for whom observation services are initiated or the hospital inpatient admission begins on the same date as the patient's discharge, the ordering physician should report *CPT* codes *99234-99236*.
- Emergency department visits (*CPT* codes *99281-99288*) – physician billing for emergency department services provided to patient by both patient's personal physician and emergency department (ED) physician. If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician may not bill.
- If the ED physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.
- Follow-up visits by the physician in the facility setting should be billed as subsequent hospital care visits for hospital inpatients and subsequent nursing facility care visits for patients in nursing facilities, as is the current policy.

Revisions to consultation services payment policy (continued)

- In the office or other outpatient setting where an evaluation is performed, physicians and qualified NPPs should report the *CPT* codes (*99201-99215*) depending on the complexity of the visit and whether the patient is a new or established patient to that physician.
- A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous three years. Examples of where a new patient office is not billable:
  - If the consultant furnishes a pre-operative consultation at the request of a surgeon on a beneficiary, the consultant has provided a professional service to the patient within the past three years and would not meet the requirements to bill a new patient office visit.
  - The consultant could not bill for a new patient office visit for a consultation furnished to a known beneficiary for a different diagnosis than he or she has previously treated if the patient was seen by the consultant in the prior three years.
  - The consultant furnishes a consultation to a known beneficiary in an outpatient setting different than the office (e.g. emergency department, observation where the patient was seen in the past three years). As the patient has been seen by the consultant within the past three years, a new patient office visit cannot be billed.
- In order for physicians to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet *CPT's* definition of a comprehensive history).
- Medicare may pay for an inpatient hospital visit or an office or other outpatient visit if one physician or qualified NPP in a group practice requests an evaluation and management service from another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge.
- Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:
  - Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or
  - Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Note: The first option may be easier from a billing and claims processing perspective.

- All physicians and qualified NPPs need to follow the E/M documentation guidelines, which are available on the CMS Web site at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*.
- Medicare contractors will use the following threshold times to determine if the prolonged services codes *99354* and/or *99355* can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes. Threshold time for prolonged visit codes *99354* and/or *99355* billed with office outpatient visit are as follows (all times in minutes):

Code	Typical time for code	Threshold time to bill code *99354*	Threshold time to bill codes *99354* and *99355*
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105
99326	45	75	120

Revisions to consultation services payment policy (continued)

Code	Typical time for code	Threshold time to bill code *99354*	Threshold time to bill codes *99354* and *99355*
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

- Threshold time for prolonged visit codes *99356* and/or *99357* billed with inpatient setting codes are as follows (all times in minutes):

Code	Typical time for code	Threshold time to bill code *99356*	Threshold time to bill codes *99356* and *99357*
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

- Appropriate documentation is required to support the billing of the prolonged visit codes.
- The existing rules for counting time for purposes of meeting the prolonged care threshold times continue to apply. In particular, the *Medicare Claims Processing Manual*, Chapter 12, 30.6.15.1.C, provides that physicians may count only the duration of direct face-to-face contact between the physician and the patient for these purposes, and may not include time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient.

Revisions to consultation services payment policy (continued)

Additional information

The official instruction, CR 6740, issued to Medicare MACs and carriers regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf*.

The E/M documentation guidelines are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*.

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

MLN Matters® Number: MM6740
Related Change Request (CR) Number: 6740
Related CR Release Date: December 14, 2009
Related CR Transmittal Number: R1875CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1875, CR 6740

Claim crossover process

The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work before attempting to balance bill their patients' supplemental insurers.

As stated in *MLN Matters*® article SE0909, available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0909.pdf*, this process takes approximately 15 work days after Medicare's reimbursement is made. Do not balance bill until you have received written confirmation from Medicare that your patients' claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over.

Remittance advice remark codes MA18 or N89 on your Medicare remittance advice (MRA) represent Medicare's intention to cross your patients' claims over. Medicare will continue to issue supplemental notifications to all participating providers, physicians, and suppliers informing them if claims targeted for crossover, as evidenced by MA18 or N89 on the MRA, do not actually result in successful crossover transmissions.

Members of the supplemental payer/Medigap market are noting higher than average receipts of Medicare Part A paper claims that are preceding the arrival of Medicare's 837 institutional COB crossover claims. The arrival of paper claims in advance of Medicare crossover claims is resulting in supplemental payer receipt of duplicate claims. This trend is particularly pronounced among hospital providers within the states of Iowa, Missouri, and Wisconsin.

Current trending suggests that approximately 99 percent of all claims that Medicare identifies for crossover, as cited on your MRA, actually are crossed over by CMS' coordination of benefits contractor (COBC). The remaining percentage error out at the COBC due to HIPAA compliance issues or related data errors, resulting in the provider, physician, or supplier's receipt of a Medicare-generated special notification letter specifying the reason for the claim's failure to cross over. This trending demonstrates that the crossover process is becoming more reliable all the time. CMS requests that providers, physicians, and suppliers ensure that the trend continues. ❖

Source: CMS PERL 200911-08

Accreditation deadline for pharmacies was January 1, 2010

Since the President signed Public Law 111-072 postponing the accreditation deadline for pharmacies until January 1, 2010, the Centers for Medicare & Medicaid Services reminded pharmacies who had not been accredited to do so by January 1, 2010.

Pharmacies going through the accreditation process are encouraged to resolve any outstanding issues on their accreditation report so that the accrediting organization can make an accreditation determination in advance of the January 1, 2010, deadline.

The durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) accrediting organization will notify the national supplier clearinghouse (NSC) when the organization is accredited.

Pharmacies that do not plan to remain enrolled in the DMEPOS Medicare program are strongly encouraged to notify their customers as soon as possible. This will give their customers an opportunity to find another DMEPOS supplier. ❖

Source: CMS PERL 200912-04

Annual update of HCPCS codes used for home health consolidated billing

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries during an episode of home health care.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS). Make sure your billing staff is aware of these changes.

What you need to know

Change request (CR) 6662 provides the annual HH consolidated billing update effective January 1, 2010.

The following two HCPCS codes are added to the home health consolidated billing supply code list. Code A4456 is a new code that replaces code A4365 which is deleted below.

Added HCPCS code	Descriptor
A4360	Disposable external urethral clamp or compression device with pad and/or pouch
A4456	Ostomy adhesive remover wipe

The following HCPCS code is deleted from the home health consolidated billing supply code list.

Deleted HCPCS code	Descriptor
A4365	Ostomy adhesive remover wipe

Background

The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the HH PPS. With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Additional information

The official instruction (CR 6662) issued to your Medicare carrier/FI/RHHI/MAC is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1827CP.pdf*.

If you have questions, please contact your Medicare carrier/FI/RHHI/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: MM6662
Related Change Request (CR) Number: 6662
Related CR Release Date: October 9, 2009
Related CR Transmittal Number: R1827CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1827, CR 6662

AMBULANCE SERVICES

Ambulance inflation factor 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 of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

What you need to know

Change request (CR) 6631, from which this article is taken, provides the ambulance inflation factor (AIF) for calendar year (CY) 2010. The AIF for CY 2010 is zero (0).

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2010 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the AIF.

The following table displays the AIF for CY 2010 and for the previous seven years.

Ambulance inflation factor by CY	
2010	0.0 percent
2009	5.0 percent
2008	2.7 percent
2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

Additional information

The official instruction, CR 6631, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1861CP.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: MM6631
Related Change Request (CR) Number: 6631
Related CR Release Date: November 27, 2009
Related CR Transmittal Number: R1861CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1861, CR 6631

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.

PROVIDER SATISFACTION SURVEY

Provider participation essential to success of 2010 Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) has announced that data collection for the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) will begin in January 2010 and conclude in April 2010. The primary goal of the annual MCPSS is to objectively measure provider satisfaction levels with regard to the performance of the fee-for-service (FFS) contractors responsible for the processing and payment of more than $280 billion in Medicare claims each year.

SciMetrika, LLC, a public health consulting firm, will be responsible for all aspects of the 2010 survey administration including printing and mailing survey materials, processing all completed surveys, analyzing the data, and reporting the results. All fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, Medicare administrative contractors (MACs), and durable medical equipment (DME) MACs will be included in the national administration of this important survey.

Goals of the Medicare Contractor Provider Satisfaction Survey

- Provide feedback from providers to FFS Medicare contractors so they may implement process improvement initiatives
- Establish a uniform measurement of provider satisfaction with contractor performance
- Satisfy the requirements of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) to measure provider satisfaction levels

Contractor performance rated on seven key business functions

Of the 1.2 million Medicare providers (physicians, health care practitioners, and facilities) who provide service for Medicare beneficiaries, approximately 30,000 will be invited to participate in the 2010 MCPSS; the goal is to obtain approximately 400 completed surveys per contractor sample. Those surveyed will be asked to rate their FFS contractor(s) using a scale of 1 to 5 on each of the business functions listed below, with "1" representing "not at all satisfied" and "5" representing "completely satisfied."

The MCPSS offers randomly selected providers and suppliers the opportunity to rate their contractor(s) on the following seven key business functions of the provider-contractor relationship:

1. Provider outreach and education
2. Provider inquiries
3. Claim processing
4. Appeals
5. Medical review
6. Provider enrollment
7. Provider audit and reimbursement.

Annual survey helps improve contractor performance and program efficiency

CMS uses the findings of the annual MCPSS as a benchmark for monitoring future trends and for improving the oversight of contractor performance as well as the efficiency of the Medicare program administration. In addition, the survey provides contractors with greater insight into their provider communities and allows them to initiate process improvements based on provider feedback.

Providers chosen to participate in the MCPSS also represent other organizations similar in size, practice type, and geographical location; therefore, the views of every respondent are critical to the success of this important study.

Medicare providers are strongly encouraged to complete and return their surveys promptly. Responses may be submitted via a secure Internet site, a telephone interview, or via mail or fax (if a paper copy of the survey instrument is requested) and will be kept strictly confidential.

How to obtain additional information and MCPSS updates

Data collection reports and study updates will be available, beginning January 2010, at *https://www.mcpsstudy.org/*, and the final results of the 2010 MCPSS will be accessible via an online reporting system in August 2010. For further information about the 2010 survey, please visit the MCPSS Web page at *http://www.cms.hhs.gov/MCPSS/*. ❖

Source: CMS JSM 10062, November 25, 2009

New Feedback page

One of the trends identified in the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) was our providers' preference to have more ways to communicate with us. Our new Feedback page offers our customers the convenience of a central "hub" for communication and includes three interactive feedback, available at *http://medicare.fcso.com/feedback/*.

Fifth annual Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about the services provided by your Medicare fee-for-service (FFS) contractor that processes and pays your Medicare claims.

CMS is in the process of conducting the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions:

- Provider inquiries
- Provider outreach & education
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit & reimbursement.

The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate in the 2010 MCPSS will be notified starting in January. If you are selected to participate, please take a few minutes to complete this important survey.

Providers and suppliers may complete the survey on the Internet via a secure Web site or by mail, fax, or telephone. To learn more about the MCPSS, please visit on the CMS Web site *http://www.cms.hhs.gov/MCPSS*. ❖

Source: CMS PERL 200912-10

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.

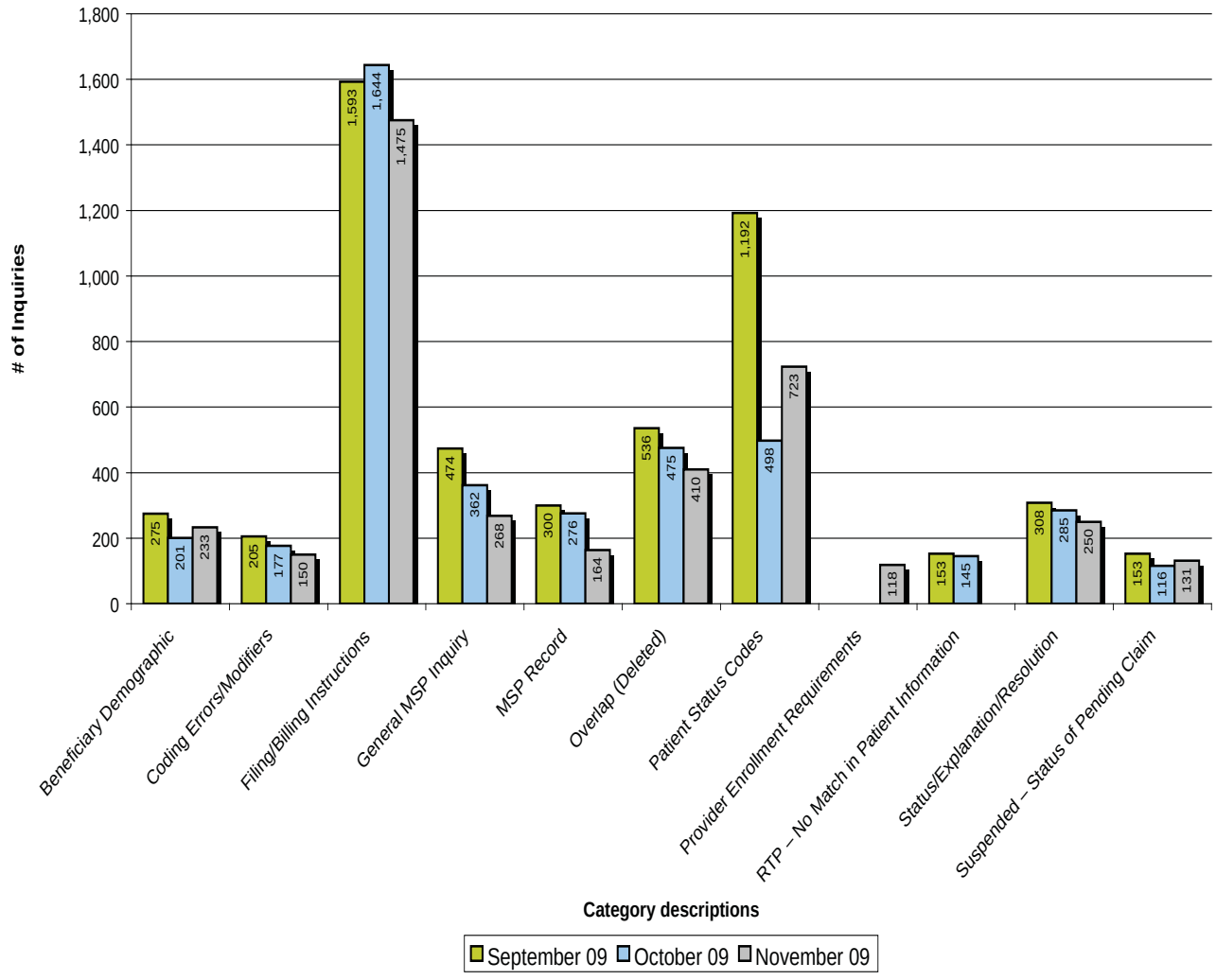
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for September-November 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 Sepember-November 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 September-November 2009

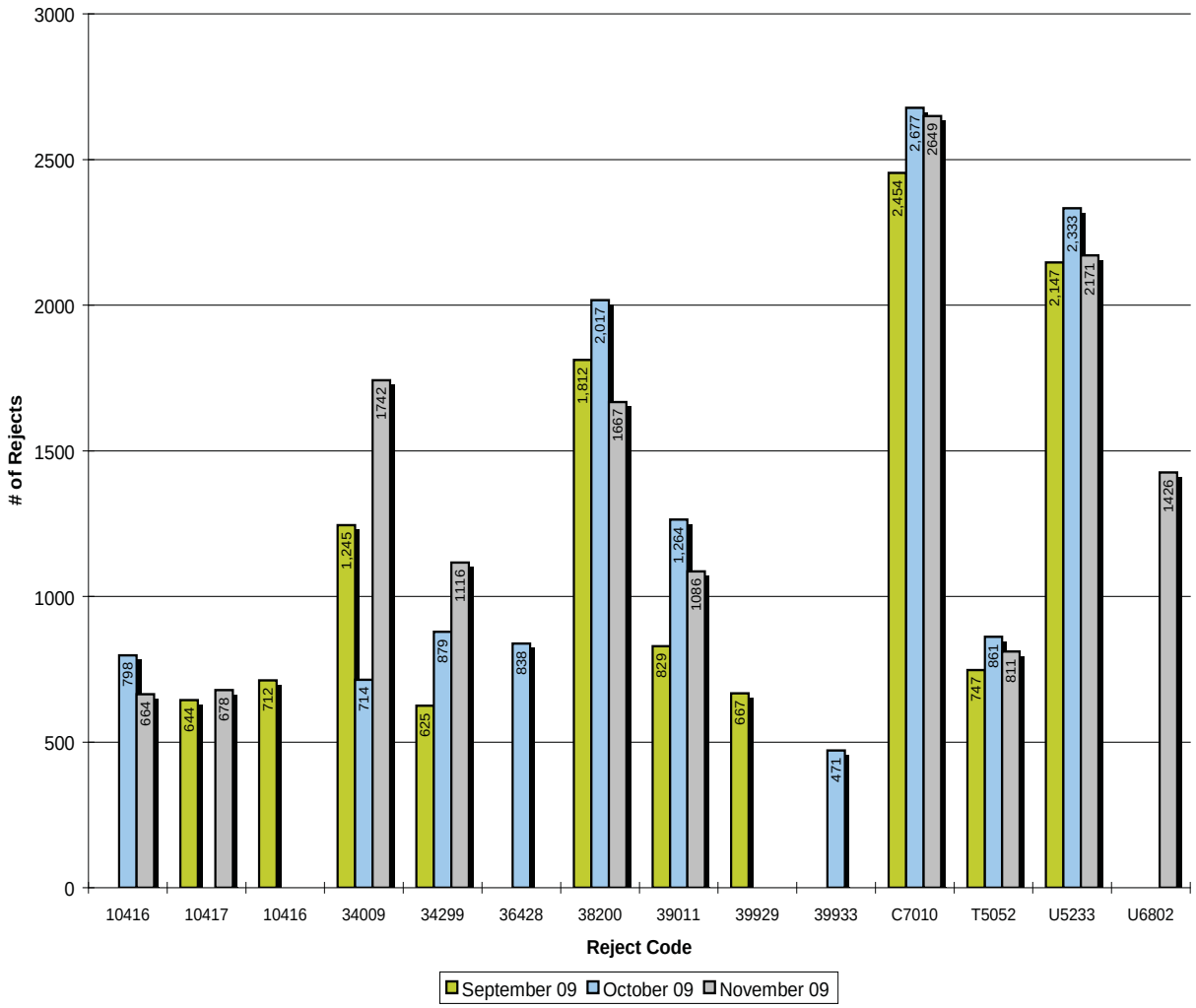


Find your favorites fast – use Quick Find

Looking for the fastest way to find 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 find 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 find what you need fast – use Quick Find.

Top inquiries, return to provider, and reject claims for September-November 2009 (continued)

Florida Part A top rejects for September-November 2009

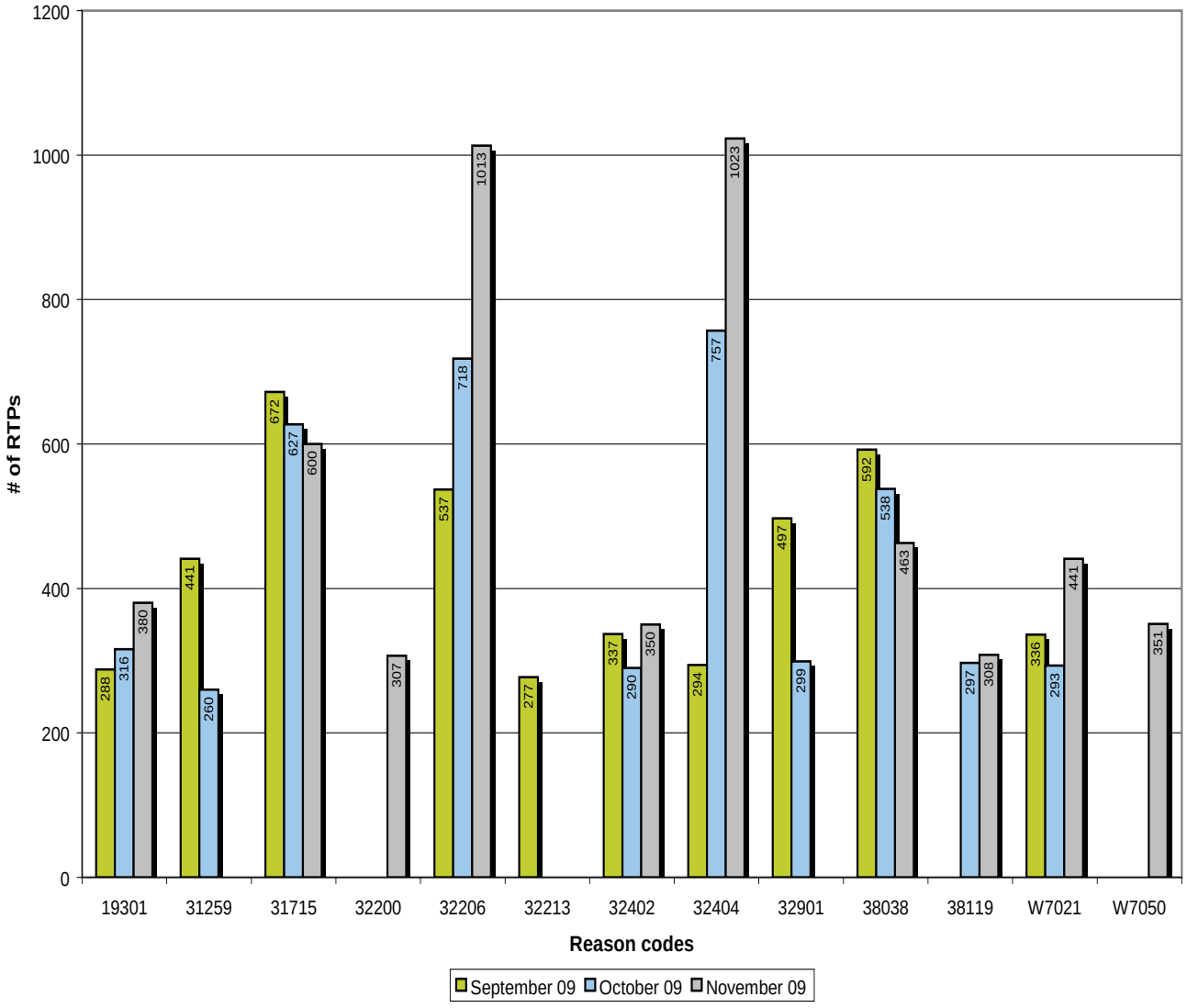


Access to beneficiary's hospice election to avoid reject code C7010

The common working file (CWF) provides information on the status of a beneficiary's hospice election. Users of the direct data entry (DDE) system may verify patient's eligibility information by using the eligibility inquiry access (ELGA) screen. Additionally, providers may contact the interactive voice response (IVR) unit by calling 1-877-602-8816. For instructions, refer to the Part A IVR operating guide. ❖

Top inquiries, return to provider, and reject claims for September-November 2009 (continued)

Florida Part A top RTPs for September-November 2009

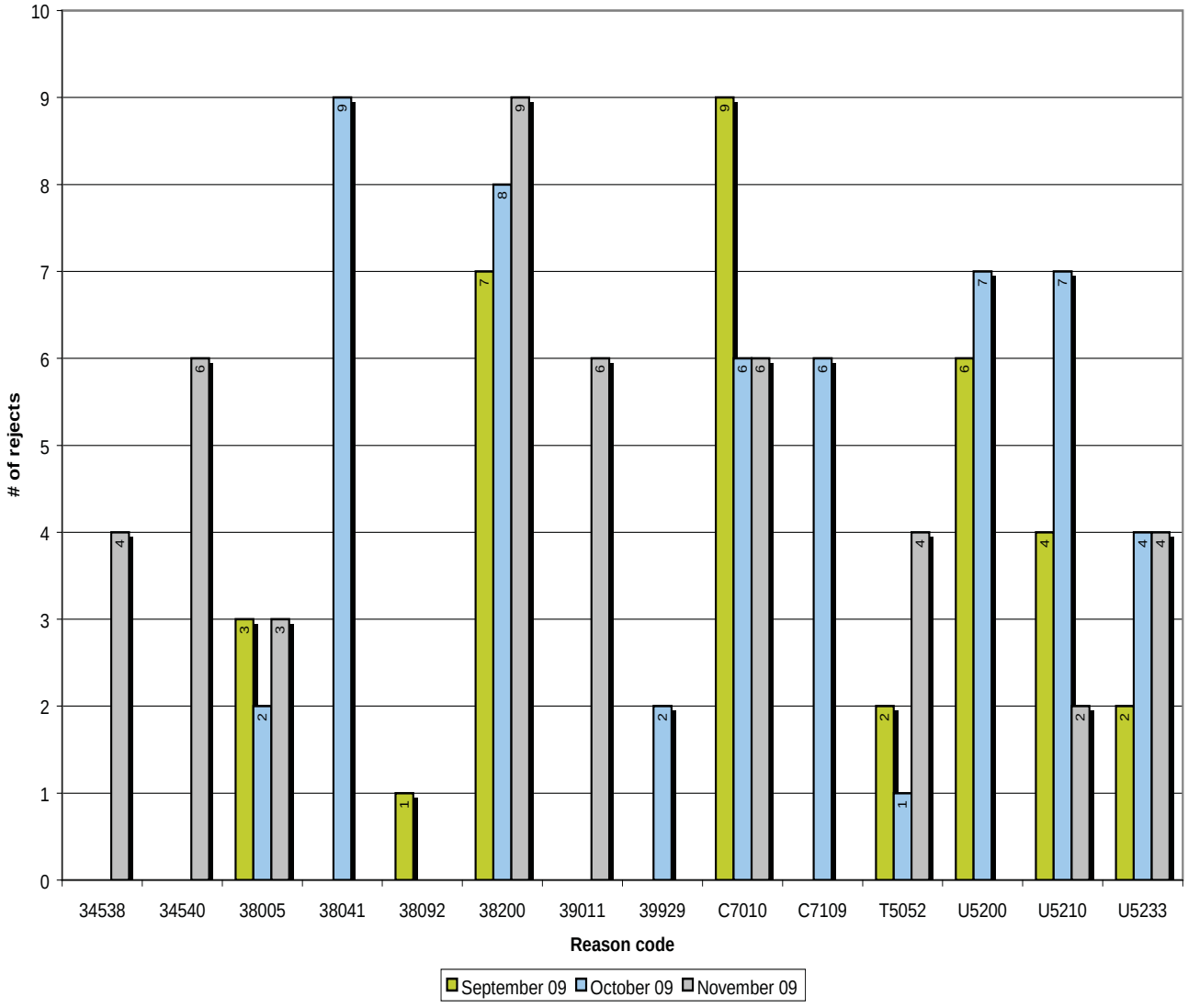


Keep Informed

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 find ways to improve Medicare billing and payment efficiency.

Top inquiries, return to provider, and reject claims for September-November 2009 (continued)

U.S. Virgin Islands Part A top rejects for September-November 2009

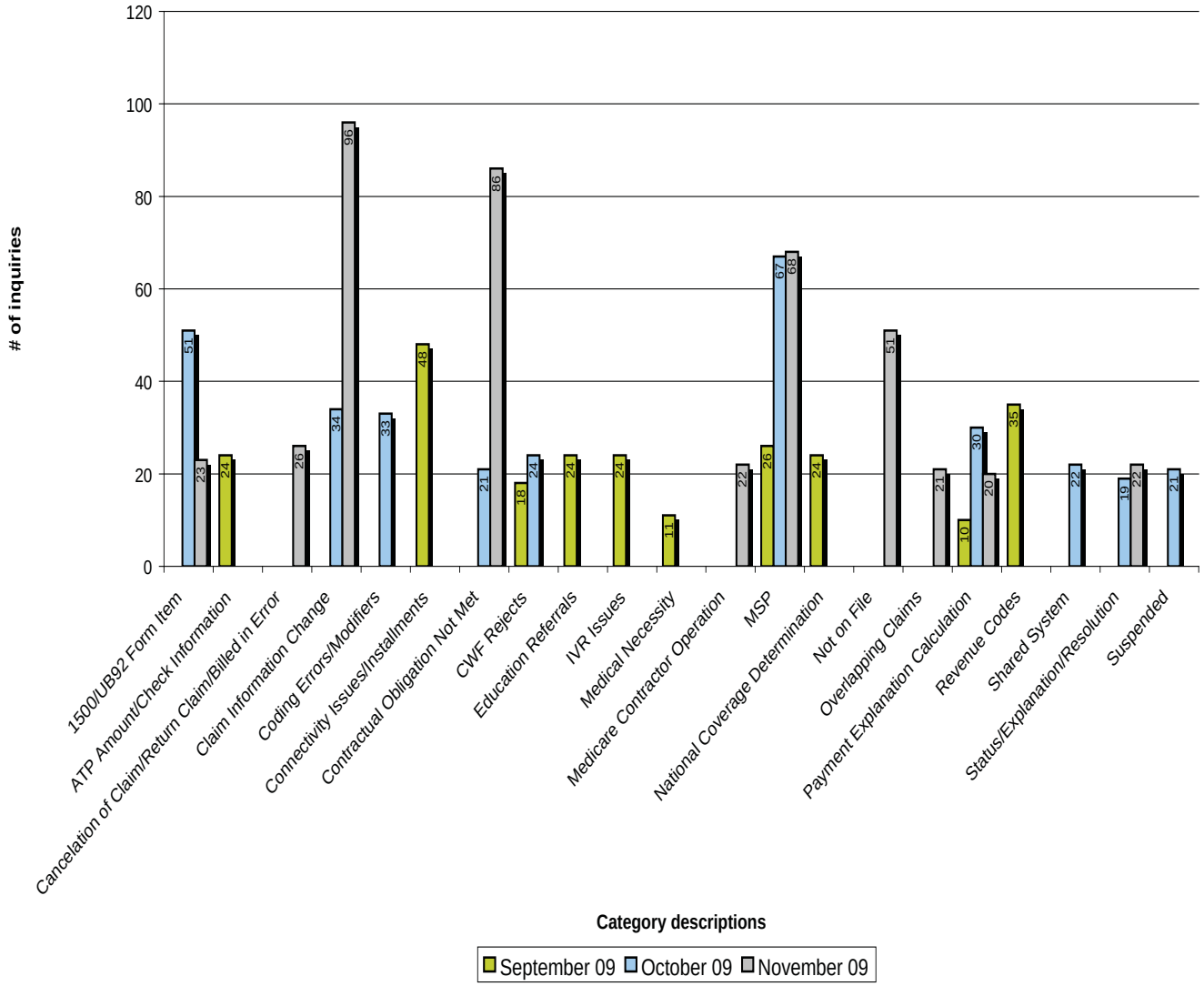


Educational Resources

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.

Top inquiries, return to provider, and reject claims for September-November 2009 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for September-November 2009



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.*

GENERAL COVERAGE

FDG positron emission tomography imaging for cervical cancer

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 who provide F-18 flouro-D-glucose (FDG) positron emission tomography (PET) imaging services should be aware of this article if they bill Medicare carriers, fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for those services provided to Medicare beneficiaries with cervical cancer.

What you need to know

Change request (CR) 6753, from which this article is taken, announces a national coverage determination (NCD) regarding FDG PET imaging for cervical cancer.

Specifically, (effective for claims with dates of service on and after November 10, 2009) the Centers for Medicare & Medicaid Services (CMS) ends the coverage with evidence development (CED) requirements for FDG PET for cervical cancer; and will cover only one FDG PET for cervical cancer for staging in beneficiaries with biopsy-proven tumors when the treating physician determines that the study is needed to determine the location and/or extent of the tumor for specific therapeutic purposes related to initial treatment strategy (as outlined in the *Medicare National Coverage Determination Manual*, Section 220.6.17 (FDG PET for Oncologic Conditions (Various Effective Dates).

Background

CR 6753 announces an NCD regarding FDG PET imaging for cervical cancer (including FDG PET/CT). It provides that, effective November 10, 2009 (as the result of a reconsideration request), CMS:

- Ended CED prospective data collection requirements for the use of FDG PET imaging in the initial staging of cervical cancer related to initial treatment strategy
- Determined that there is no credible evidence that the results of FDG PET imaging are useful in making the initial diagnoses of cervical cancer; or in improving health outcomes
- Announced that FDG PET is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (the Act) and, therefore, CMS noncovers FDG PET imaging for initial diagnosis of cervical cancer related to initial treatment strategy.

As a result, CR 6753 provides that (effective for claims with dates of service on and after November 10, 2009), CMS will cover only one initial FDG PET study for staging in beneficiaries who have biopsy-proven cervical cancer when the treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to initial treatment strategy:

- To determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure, or
- To determine the optimal anatomic location for an invasive procedure, or
- To determine the anatomic extent of the tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

Note: Exception to this policy: CMS continues to noncover FDG PET for the initial diagnosis of cervical cancer related to initial treatment strategy.

Billing changes

Effective for claims with dates of service on or after November 10, 2009, your carrier, FI, or MAC will accept FDG PET oncologic claims that you bill to inform initial treatment strategy; specifically for staging in beneficiaries who have biopsy-proven cervical cancer when the beneficiary's treating physician determines the FDG PET study is needed to determine the location and/or extent of the tumor as specified above. **Please note that for these claims, modifier Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical research study) is no longer necessary for FDG PET services for cervical cancer.**

In addition, your carrier, FI, or MAC will "return as unprocessable/return to provider" your claims for FDG PET for cervical cancer billed to inform initial treatment if all the following are not present:

- PET or PET/CT *Current Procedural Terminology* (*CPT*) code (*78608, 78811, 78812, 78813, 78814, 78815*, or *78816*)
- Modifier PI (PET Tumor initial treatment strategy)
- ICD-9 cervical cancer diagnosis code.

Failure to use the correct codes will result in the following messages:

Claim Adjustment Reason Code 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.

Remittance Advice Remark Code (RARC) MA130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.

RARC M16: Alert: See our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

You should be aware that while your carrier, FI, or

FDG Positron emission tomography imaging for cervical cancer (continued)

MAC will not search their files for FDG PET oncologic cervical cancer claims for initial treatment strategy, for dates of service November 10, 2009, through January 3, 2010, they will adjust such claims that you bring to their attention.

Additional information

The official CR 6753 was issued in two transmittals, one announcing the NCD as added to the *Medicare NCD Manual* and the other transmittal providing the revised *Medicare Claims Processing Manual* instructions. You may find these transmittals at *http://www.cms.hhs.gov/Transmittals/downloads/R110NCD.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1888CP.pdf*, respectively.

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

MLN Matters® Number: MM6753
Related Change Request (CR) Number: 6753
Related CR Release Date: January 6, 2010
Related CR Transmittal Number: R1888CP and R110NCD
Effective Date: November 10, 2009
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1888, CR 6753

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

LOCAL COVERAGE DETERMINATIONS

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

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Advance beneficiary notice

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

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

NEW LCD IMPLEMENTATION

A01991: Monitored anesthesia care for certain interventional pain services – new LCD

LCD ID Number: L30561 (Florida/Puerto Rico/U.S. Virgin Islands)

Monitored anesthesia care (MAC) is a specific anesthetic service for a diagnostic or therapeutic procedure. This new LCD specifically addresses the use of MAC with certain interventional pain management procedures (*CPT* codes *20550, 20551, 20552, 20553, 27096, 62310, 62311, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494,* and *64495*) where current practice supports that local anesthesia alone, inclusive of these procedures, is typical. For certain patients, the addition of mild sedation (physician service not separately payable) or moderate (conscious) sedation (*CPT* codes *99143-99150*), may be part of these minimally invasive procedures. As outlined in this LCD, the addition of MAC, a second physician service (or other qualified anesthesia provider service), to the episode of care for these services must meet, but not exceed, the patient's medical need and be furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition.

The specific indications and limitations of coverage outlined in the LCD are represented by the following *CPT* codes:

01991 *Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position*

01992 *Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position*

Medicare will consider MAC medically reasonable and necessary when the patient's condition requires the presence of a second physician represented by an anesthesiologist or qualified anesthesia provider in addition to the provider performing the procedure. The patient's medical condition or nature of the procedure must require the presence of an anesthesiologist or qualified anesthesia provider to administer the sedation if utilized, to manage the airway and vital signs, and to continually assess the patient for clinical problems and treat appropriately to ensure patient safety and comfort. The presence of an underlying condition alone or a stable treatable condition is not sufficient evidence that monitored anesthesia care is medically reasonable and necessary. In addition to indications and limitations, the LCD also includes documentation requirements, utilization guidelines and a "Coding Guidelines" attachment.

Medicare pays for reasonable and necessary MAC services on the same basis as other anesthesia services. When the patient's condition does not meet medical necessity as outlined in the indications and limitations of this LCD, the provider must append the GA or GZ modifiers, as appropriate, along with the QS modifier. This will result in the appropriate denial of the services for the interventional pain management services as outlined above. MAC claims with the required QS modifier without the GA/GZ modifier should only be billed when MAC clearly meets the reasonable and necessary criteria for interventional pain injection procedures outlined in this LCD.

Effective date

This new LCD is effective for services provided **on or after January 25, 2010.** 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. ❖

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 find 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*.

A23700: Manipulation under anesthesia (MUA) – new LCD

LCD ID Number: L30563 (Florida/Puerto Rico/U.S. Virgin Islands)

Manipulation under anesthesia (MUA) is a non-invasive procedure, which combines manual manipulation of a joint with a general anesthetic. Patients who are unable to tolerate manual procedures due to pain, spasm, muscle contractures, or guarding may benefit from the use of general anesthesia prior to manipulation. Because the patient's protective reflex mechanism is absent under anesthesia, manipulation using a combination of specific short lever manipulations, passive stretches, and specific articular and postural kinesthetic maneuvers, in order to break up fibrous adhesions and scar tissue around the joint and surrounding tissue, is made less difficult. MUA should only be performed on select patients who have failed to respond to conservative therapy.

This local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity, CPT/HCPCS codes, ICD-9-CM codes that support medical necessity, documentation requirements, utilization guidelines, and coding guidelines for MUA.

Effective date

This new LCD is effective for services provided **on or after January 25, 2010.** 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. ❖

A90999: Frequency of hemodialysis services – new LCD

LCD ID Number: L30566 (Florida/Puerto Rico/U.S. Virgin Islands)

End stage renal disease (ESRD) occurs from the destruction of normal kidney tissues over a long period of time. The loss of kidney function in ESRD is usually irreversible and permanent. Dialysis is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis. Both types are acceptable modes of treatment for ESRD and are covered by the Medicare ESRD benefit. National guidelines can be viewed in the *Medicare Benefit Policy Manual*, Pub 100-02, Chapter 11, Section(s) 10 and 30.1 and the *Medicare Claims Processing Manual*, Pub 100-04, Chapter 8, Section 10.

Hemodialysis is a process by which blood passes through an artificial kidney machine and the waste products diffuse across a manmade membrane into a bath solution known as dialysate after which the cleansed blood is returned to the patient's body. Hemodialysis is accomplished usually in three four-hour sessions, three times per week. Hemodialysis sessions which exceed the frequency of three sessions per week must be medically reasonable and necessary.

This local coverage determination (LCD) has been developed to provide indications and limitations of coverage, ICD-9-CM codes, utilization guidelines, coding guidelines and documentation requirements for individuals who may require additional hemodialysis sessions beyond the Medicare ESRD benefit of three sessions per week.

Effective date

This new LCD is effective for services provided **on or after January 25, 2010.** 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. ❖

ADDITIONS/REVISIONS TO EXISTING LCDS

A78460: Myocardial perfusion imaging – revision to the LCD

LCD ID Number: L28934 (Florida)
LCD ID Number: L28955 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for myocardial perfusion imaging was last revised on October 1, 2009. Since that time, the "ICD-9 Codes that Support Medical Necessity" section of the LCD for *CPT* codes 78460, *78461, 78464, 78465, 78478* and *78480* has been revised to add ICD-9-CM code V58.69 (Long-term [current] use of other medications). ICD-9-CM code V58.69 should be used as a secondary code only and should not be billed as the primary diagnosis. The "Documentation Requirements" section of the LCD has also been revised to indicate: The medical record must document when significant resting electrocardiogram (ECG) abnormalities are present, or a medication is being used and cannot be withdrawn, that would interfere with the interpretation of a stress ECG, resulting in the selection of a myocardial perfusion study.

Effective date

This LCD revision is effective for services provided **on or after December 17, 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. ❖

ABOTULINUM TOXINS: Botulinum toxins – revision to the LCD

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

The local coverage determination (LCD) for botulinum toxins was last revised on April 16, 2009. Since that time, there have been several revisions to this LCD.

- The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised in accordance with the U.S. Food and Drug Administration (FDA), to update the established drug names for "botulinum toxin type A" to "onabotulinumtoxinA" and to update the established drug name for "botulinum toxin type B" to "rimabotulinumtoxinB". The LCD "Coding Guidelines" attachment has also been revised accordingly.

  ### Effective date

  The above revisions to the LCD are effective for services provided on or after the FDA approval date of **July 31, 2009**.

- Botulinum toxin "abobotulinumtoxinA (Dysport™)" was approved by the FDA on April 29, 2009, for the treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain in both toxin-naïve and previously treated patients. In this regard, a new section has been added under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, "FDA indication for Dysport™". The "CPT/HCPCS Codes" section of the LCD has been revised to include HCPCS code C9399 (Unclassified drugs or biologicals) and the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add a new section "HCPCS code C9399 (abobotulinumtoxinA [Dysport™])" and applicable ICD-9-CM codes 333.83 (Spasmodic torticollis) and 723.5 (Torticollis, unspecified). The "Sources of Information and Basis for Decision" section of the LCD has also been updated, as well as the LCD "Coding Guidelines" attachment to include coding and billing information for abobotulinumtoxinA (Dysport™).

  ### Effective date

  The above revisions to the LCD are effective for services provided on or after the FDA approval date of **April 29, 2009.**

- The LCD "Coding Guidelines" attachment has also been revised to delete *CPT* codes *95860, 95869* and *95870* from the list of electromyography guidance codes that may be covered if the physician has difficulty in determining the proper injection site.

  ### Effective date

  This above revision to the LCD "Coding Guidelines" attachment is effective for services provided **on or after November 12, 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. ❖

Intravitreal bevacizumab (Avastin®) – revision to the LCD

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

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) was last revised on October 1, 2009. Since that time, the LCD has been revised in the "Indications" section under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to indicate the anticipated dosage is 1.25 mg (0.05ml) or less, on a yearly average of every four to six weeks, as needed, by aseptic intravitreal injection into affected eye. Treatment continues on a monthly basis until the abnormal neovascularization, vitreous hemorrhage, macular edema, subretinal fluid, and/or pigment epithelial detachment is resolved.

In addition, the "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add ICD-9-CM code 362.29 (Other nondiabetic proliferative retinopathy) and the statement under the list of ICD-9-CM codes has been revised to indicate: *Per ICD-9-CM coding manual, ICD-9-CM code 362.07 requires a dual diagnosis. ICD-9-CM code 362.07 must be used with a code for diabetic retinopathy (ICD-9-CM codes 362.01-362.06).

The third bullet under the "Documentation Requirements" section of the LCD has also been revised to indicate: Test results to firmly establish diagnosis by fluorescein angiogram or optical coherence tomography (OCT) for individuals with proliferative diabetic retinopathy, diabetic macular edema, retinal neovascularization, central retinal vein occlusion, venous tributary (branch) occlusion, exudative macular degeneration, and retinal edema. Tests to confirm the established diagnosis are not required for rubeosis iridis, or in the case of a vitreous hemorrhage in which the neovascularization cannot be visualized.

The "Sources of Information and Basis for Decision" section of the LCD has also been updated.

Effective date

This LCD revision is effective for services provided **on or after December 8, 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. ❖

AJ9025: Azacitidine (Vidaza®) – revision to the LCD

LCD ID Number: L28780 (Florida)
LCD ID Number: L28784 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for azacitidine (Vidaza®) 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 reconsideration request was evaluated and the following revisions were made to the LCD:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for azacitidine (Vidaza®), acute myeloid leukemia was added as an off-label indication
- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the diagnosis code range 205.00-205.02 was added to the LCD
- 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 December 10, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

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

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

The local coverage determination (LCD) for the list of Medicare noncovered services was updated on January 1, 2010, with the implementation of the 2010 HCPCS annual update. Since that time, a revision was made to add *CPT* code *86849 [Unlisted immunology procedure* (AlloMap® testing)] under the "Local Noncoverage Decisions-Laboratory Procedures" section of the LCD.

This revision was a result of an evaluation for AlloMap® testing for heart transplant recipients. Review of the evidence-based literature demonstrated that this test is investigational/experimental and currently can only be performed by one laboratory located in California. Therefore, *CPT* code *86849* with the above description was added to the list of Medicare noncovered services LCD.

ANCSVCS: The list of Medicare noncovered services – revision to the LCD (continued)

Effective date

This LCD revision is effective for services provided **on or after January 25, 2010.** 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. ❖

AVISCO: Viscosupplementation therapy for knee – revision to the LCD

LCD ID Number: L28934 (Florida)
LCD ID Number: L28955 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised on July 16, 2009. Since that time, there have been several revisions to this LCD.

- It has come to the attention of First Coast Service Options Inc. (FCSO) that providers are using more than one viscosupplementation agent within the same course of treatment. Therefore, the "Utilization Guidelines" section of the LCD was revised to clarify that once a course of treatment has been initiated with one agent, it should be completed with the same agent.

  ### Effective date

  The above LCD revision is effective for claims processed **on or after November 5, 2009**.

- Additionally, HCPCS code C9399 was removed and a parenthetical explanation was added under HCPCS code J7322 in the "CPT/HCPCS Codes" section of the LCD to provide instructions when billing for Synvisc-one. The LCD "Coding Guidelines" attachment has also been revised accordingly.

  ### Effective date

  The above LCD revision is effective for services provided **February 26, 2009, through December 31, 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. ❖

2010 HCPCS Part A local coverage determination changes

First Coast Service Options Inc. (FCSO) has revised the Part A local coverage determinations (LCDs) impacted by the 2010 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly.

LCD title	2010 changes
ABOTULINUM TOXINS – Botulinum Toxins	• Descriptor change for HCPCS codes J0585 and J0587. • Changed HCPCS code C9399 to HCPCS code J0586. • Deleted HCPCS code J3590 from the "Coding Guidelines" attachment.
Intravitreal Bevacizumab (Avastin®)	• Deleted HCPCS code Q2024 • Added HCPCS code C9257
AJ7186 – Hemophilia Clotting Factors	• Descriptor change for HCPCS code J7192.
AJ9170 – Docetaxel (Taxotere®)	• Deleted HCPCS code J9170. • Added HCPCS code J9171. • Changed contractor's determination number to AJ9171.

2010 HCPCS local coverage determination changes (continued)

LCD title	2010 changes
ANCSVCS – The List of Medicare Non-covered Services	• Descriptor change for *CPT* code *95806*. • Deleted *CPT* codes *0144T**, *0170T**, and *0194T** from the "Local Noncoverage Decisions" section of the local coverage determination (LCD). • Deleted *CPT* codes *0062T* and *0063T* from the "National Noncoverage Decisions" section of the LCD. • Added *CPT* code *22899* (Percutaneous intradiscal annuloplasty, any method other than electrothermal) to the "National Noncoverage Decisions" section of the LCD. • Added *CPT* codes *0205T**, *0206T**, *0207T**, *0208T*, *0209T*, *0210T*, *0211T*, *0212T*, *0213T**, *0214T**, *0215T**, *0216T**, *0217T**, *0218T**, *0219T**, *0220T**, *0221T**, *0222T**, *46707**, *84145**, and *83987** to the "Local Noncoverage Decisions" section of the LCD.
AVISCO – Viscosupplementation Therapy For Knee	• Deleted HCPCS code J7322. • Added HCPCS code J7325.
A36470 – Treatment of Varicose Veins of the Lower Extremity	• Descriptor change for *CPT* code *37760*. • Added *CPT* code *37761*.
A55873 – Cryosurgical Ablation of the Prostate	• Descriptor change for *CPT* code *55873*.
A0145T Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	• Deleted *CPT* codes *0145T*, *0146T*, *0147T*, *0148T*, *0149T*, *0150T*, and *0151T*. • Added *CPT* codes *75571*, *75572*, *75573*, and *75574*. • Deleted *CPT* code *0144T* from the "Coding Guidelines" attachment. • Changed contractor's determination number to A71275.
A0067T – Computed Tomographic Colonography	• Deleted *CPT* code *0067T*. • Added *CPT* codes *74261* and *74262*. • Deleted *CPT* code *0066T* from the "Coding Guidelines" attachment. • Added *CPT* code *74263* to the "Coding Guidelines" attachment as informational only and noted that it is noncovered. • Changed contractor's determination number to A74261.
A78460 – Myocardial Perfusion Imaging	• Deleted *CPT* codes *78460*, *78461*, *78464*, *78465*, *78478*, and *78480*. • Added CPT codes *78451*, *78452*, *78453*, and *78454*. • Changed contractor's determination number to A78451.
A85692 – Syphilis Test	• Descriptor change for CPT codes *86592* and *86593*. • Deleted *CPT* code *86781*. • Added *CPT* code *86780*.
A93701 – Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	• Descriptor change for *CPT* code *93701*.
A95860 – Electromyography and Nerve Conduction Studies	• Added *CPT* code *95905*.

* = Investigational

First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. ❖

Source: CMS Pub. 100-04, Transmittal 1813, CR 6620

RETIRED LCDS

AIRF: Inpatient rehabilitation facilities – retired LCD

LCD ID Number: L28891 (Florida)
LCD ID Number: L28913 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for inpatient rehabilitation facilities 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, based on change request 6699, for inpatient rehabilitation services, the coverage requirements are to be updated in the Centers for Medicare & Medicaid Services (CMS) manual system, Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110. Therefore, a determination was made to retire this LCD.

Effective date

This LCD retirement is effective for services provided **on or after January 1, 2010.** 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

Teletherapy radiation treatment guidance

Currently, there are several technologies that address guidance for the delivery of radiation therapy. The utility of inter-fraction (usually imaging) versus intra-fraction guidance with intensity modulated radiation therapy (IMRT) or other delivery systems is emerging and more information is being published.

First Coast Service Options Inc. (FCSO) currently does not have a positive coverage statement for the various systems. FCSO sees no basis for the payment of claims for multiple guidance procedures for the same date of treatment delivery. After review of the literature and discussions with some experts in the field, it seems reasonable to reimburse for one procedure for guidance/localization/tracking if the service is reasonable and necessary for the given episode of care.

Therefore, when a radiation treatment guidance code is applicable (not included in the treatment delivery service), FCSO will consider only one of the following procedure codes for possible coverage and payment on a given treatment delivery date of service. As always, the medical record documentation must support that the service is reasonable and necessary for that patient's episode of care.

76950 *Ultrasonic guidance for placement of radiation therapy fields*

77014 *Computed tomography guidance for placement of radiation therapy fields*

77280 *Therapeutic radiology simulation-aided field setting; simple*

77399 *Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services*

77421 *Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*

0197T *Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g. 3D positional tracking, gating, 3D surface tracking), each fraction of treatment*

Of note, *CPT* codes *76950, 77014*, and *77421* are image guided radiation therapy (IGRT) codes and have pricing in the outpatient prospective payment system (OPPS) and the Medicare carrier system (MCS). *CPT* category III code *0197T* is an emerging technology code that is contractor priced in the MCS. It describes the Calypso® technology or other services that would meet the descriptor. The unlisted *CPT* code *77399* and *CPT* code *77280* are broad descriptors. It is recommended that *CPT* code *77280* not be used for guidance with treatment delivery.

HOSPITAL SERVICES

Preventing the misuse of modifiers PA, PB, and PC on incoming claims

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

Provider types affected

Physicians, nonphysician practitioners, and hospitals submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article, based on change request (CR) 6718, advises you that **modifiers PA, PB and PC** are often being submitted incorrectly on claims. This can cause incorrect denials. The Centers for Medicare & Medicaid Services (CMS) issued CR 6718 to direct contractors on handling incorrect claims in order to alleviate the issue. These detailed instructions are explained in the background section of this article. Your billing staffs need to be aware of the proper uses of the **modifiers PA, PB, and PC**. The instructions are in MM6405, available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6405.pdf*.

Background

This article is based on CR 6718, which clarifies billing instructions and claims processing for information provided in a previous article MM6405. CR 6718 does not change the policy for the coverage or noncoverage of the adverse events described in MM6405.

CR 6405, "Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient," a revised version of which was issued on September 25, 2009, implemented billing procedures for these adverse events.

CMS has learned that the modifiers described in the CR 6405 are, in many cases, being submitted incorrectly by the providers. In particular, some providers are using the modifier PC to represent the professional component of a service. **This is incorrect. The modifier PC is defined as "Wrong Surgery on a Patient."** The incorrect use of this modifier results in claims being incorrectly denied. Medicare contractors will follow the requirements in CR 6718 to help prevent claims from being processed with modifiers incorrectly submitted on them.

Medicare contractors will:

- Suspend, review, and develop all claim lines that are submitted with modifiers PA, PB, or PC
- Contact the provider to determine whether the claims are related to one of the adverse events as described by the modifiers PA, PB, or PC.

If the contractor determines that the modifiers PA, PB, or PC have been incorrectly submitted, they will:

- Reject (return to provider) Part A outpatient claims
- Return Part B claims as unprocessable with:
  - Claim adjustment reason code 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.), and
  - Remittance advice remark code MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note: Some providers or their billing services may be incorrectly using the HCPCS modifier PC to indicate the professional component for certain services not related to surgical error when the *CPT* modifier *26* should have been used. Please be aware that the incorrect use of the PC modifier on Medicare claims will result in a Part A claim being returned to the provider, and a Part B claim being returned as unprocessable.

Additional Information

The official instruction, CR 6718, issued to your Medicare contractor regarding this change may be viewed on the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R1867CP.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: MM6718
Related Change Request (CR) Number: 6718
Related CR Release Date: December 4, 2009
Related CR Transmittal Number: R1867CP
Effective Date: January 15, 2009
Implementation Date: No later than January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1867, CR 6718

Fiscal year 2010 inpatient prospective payment system PC PRICER updated

The fiscal year (FY) 2010 inpatient prospective payment system (PPS) personal computer (PC) PRICER has been updated on the Web for FY 2010 claims. Go to the Inpatient PPS PC PRICER page *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*, under the Downloads section.

The inpatient PPS PC PRICER user manual for FY 2010 has also been updated with new information for processing FY 2010 claims. If you use the FY 2010 inpatient PPS PC PRICER, please go to the page above and download the latest versions of the PC PRICER and user manual. ❖

Source: CMS PERL 200912-13

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CORF/ORF SERVICES

2010 annual update to the therapy code list

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

Provider types affected

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for outpatient rehabilitation therapy services should take note of this article.

Provider action needed

This article is based on change request (CR) 6719, which updates the therapy code list for calendar year (CY) 2010 with one "sometimes therapy" code *92520* (*laryngeal function studies [ie, aerodynamic testing and acoustic testing*]). Note that this code always represents therapy services when performed by therapists and requires the use of a therapy modifier.

Background

The Social Security Act (Section 1834(k)(5); see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm* on the Internet) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology 2010 Edition* (HCPCS/*CPT-4*) is the coding system used for the reporting of these services. The additions, changes, and deletions to the therapy code list reflect those made in the CYs 2009 and 2010 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, Fourth Edition (HCPCS/*CPT-4*).

CR 6719 updates the therapy code list by adding one "sometimes therapy" code for CY 2010 shown in the table. Note that this code always represents therapy services when performed by therapists and requires the use of a therapy modifier.

Therapy code	Descriptor
92520	*Laryngeal function studies (ie, aerodynamic testing and acoustic testing)*

In addition, CR 6719 announces that *95992* (*Standard Canalith repositioning procedure(s), (e.g., Epley maneuver, Semont maneuver), per day*) is being removed from the therapy code list effective January 1, 2010.
Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Chapter 5, which is available on the Centers for the Medicare & Medicaid Services Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf*.

Additional information

You may also find more information about the therapy code List at *http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage*.

The official instruction, CR 6719, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1850CP.pdf*.

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

MLN Matters® Number: MM6719
Related Change Request (CR) Number: 6719
Related CR Release Date: November 13, 2009
Related CR Transmittal Number: R1850CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1850, CR 6719

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Integrated outpatient code editor PC (interactive and batch) re-write

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

Provider types affected

This article is for all providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Medicare administrative contractors (MACs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for outpatient services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6709, which notifies providers of the intended re-write of the integrated outpatient code editor (IOCE) personal computer (PC) software (interactive and batch) to the Java programming language with InstallAnywhere for installation software. Be sure billing staffs using the PC-based IOCE are aware of these changes. Once the rewrite is complete, such staff will need to obtain the new version.

Background

Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) as amended by the Workforce Investment Act of 1998 (P.L. 105-220), specifically, subsection 508(a)(1), requires that when the federal government procures electronic and information technology (EIT), the EIT must allow federal employees and individuals of the public with disabilities comparable access to and use of information and data that is provided to federal employees and individuals of the public without disabilities.

Therefore, per 36 CFR 1194 (508 Standards), regardless of format, all Web content or communications materials produced, including text, audio or video, must conform to applicable Section 508 standards. All contractors (including subcontractors) or consultants responsible for preparing or posting content must comply with applicable Section 508 accessibility standards, and where applicable, those set forth in the referenced policy or standards documents.

The new PC-based IOCE software will:

- Make the interactive product fully comply to current Section 508 accessibility standards for electronic and information technology
- Standardize current Java-based development platform technology to streamline future development and increase re-usability.

Note: This re-write does not affect the mainframe version of the IOCE installed and run by Medicare's fiscal intermediary shared system (FISS) on a quarterly basis. The inputs/outputs to the IOCE batch PC program will not change. It also does not affect the content of the IOCE.

Additional information

The official instruction (CR 6709) issued to your Medicare MAC and/or FI is available on the Centers for Medicare & Medicaid Services (CMS) at *http://www.cms.hhs.gov/Transmittals/downloads/R599OTN.pdf*.

CMS also has a Web-based training module on the OCE. The module is available on the Internet at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1*.

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

MLN Matters® Number: MM6709
Related Change Request (CR) Number: 6709
Related CR Release Date: November 20, 2009
Related CR Transmittal Number: R599OTN
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-20, Transmittal 599, CR 6709

January 2010 update of the hospital outpatient prospective payment system

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6751, which describes changes to the OPPS to be implemented in the January 2010 OPPS update. Be sure billing staffs are aware of these changes.

Background

CR 6751 describes changes to and billing instructions for various payment policies implemented in the January 2010 OPPS update. The January 2010 integrated outpatient code editor (I/OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in this notification.

The January 2010 revisions to the I/OCE data files, instructions, and specifications are provided in CR 6761, "January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0." Once CR 6761 is issued, a related *MLN Matters*® will be available on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6761.pdf*.

The remainder of this article provides details on the changes conveyed by CR 6751.

Changes to device edits for January 2010

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code.

Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS rate setting.

The most current edits for both types of device edits may be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

Failure to pass these edits will result in the claim being returned to the provider.

Billing for "sometimes therapy" services that may be paid as non-therapy services for hospital outpatients

Section 1834(k) of the Act, as added by Section 4541 of the Balanced Budget Act (BBA), allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Social Security Act (or the Ac)t, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare physician fee schedule (MPFS).

The list of therapy codes, along with their respective designation, may be found on the CMS Web site at *http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage*.

Two of the designations that are used for therapy services are: "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by an individual outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as "sometimes therapy" services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals **should not** append the therapy **modifier GP** (physical therapy), **modifier GO** (occupational therapy), or **modifier GN** (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the "sometimes therapy" codes listed in the table below.

To receive payment under the MPFS, when "sometimes therapy" services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy **modifier GP**, **GO**, or **GN**, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for "sometimes therapy" codes furnished as therapy services in the hospital outpatient department and paid under the MPFS.

Effective January 1, 2010, *CPT* code *92520 (Laryngeal function studies (ie, aerodynamic testing and acoustic testing)*), is newly designated as a "sometimes therapy" service under the MPFS. *CPT* code *92520* is not a new code, however, its "sometimes therapy" designation is new and effective January 1, 2010. Under the OPPS, hospitals will receive separate payment when they bill *CPT* code *92520* as a non-therapy service.

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The list of HCPCS codes designated as "sometimes therapy" services that may be paid as non-therapy services when furnished to hospital outpatients as of January 1, 2010 is displayed in the following table.

Table 1 – Services designated as "sometimes therapy" that may be paid as non-therapy services for hospital outpatients as of January 1, 2010

HCPCS code	Long descriptor
92520	*Laryngeal function studies (ie, aerodynamic testing and acoustic testing)*
97597	*Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters*
97598	*Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters*
97602	*Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session*
97605	*Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters*
97606	*Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters*
0183T	*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*

Partial hospitalization APCs (APC 0172 and APC 0173)

For calendar year (CY) 2010, CMS is updating the two partial hospitalization program (PHP) per diem payment rates: APC 0172 (Level I partial hospitalization (3 services)) and APC 0173 (Level II partial hospitalization (4 or more services)). When a community mental health center (CMHC) or hospital outpatient department provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital would be paid through APC 0172. When the CMHC or hospital outpatient department provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital would be paid through APC 0173. The following table provides the updated per diem payment rates.

Table 2 – Updated per diem payment rates for partial hospitalization APCs

2010 APC	2010 long descriptor	Payment rate
0172	(Level I partial hospitalization (3 units of service))	$149.84
0173	(Level II partial hospitalization (4 units or more units of service))	$210.89

Payment for multiple imaging composite APCs

Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality are paid by applying a composite APC payment methodology. The services are paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The I/OCE logic determines the assignment of the composite APCs for payment. Prior to January 1, 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session.

The composite APC payment methodology for multiple imaging services utilizes three imaging families (ultrasound, CT and CTA, and MRI and MRA) and five composite APCs: APC 8004 (ultrasound composite); APC 8005 (CT and CTA without contrast composite); APC 8006 (CT and CTA with contrast composite); APC 8007 (MRI and MRA without contrast composite); and APC 8008 (MRI and MRA with contrast composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) is assigned.

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CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes for CY 2010. Specifically, we added *CPT* code *74261* (*computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material*) and *CPT* code *74262* (*computed tomographic (CT) colonography, diagnostic, including image postprocessing, with contrast materials(s) including non-contrast images, if performed*) to the CT and CTA family, and removed *CPT* code *0067T* (*computed tomographic (CT) colonography (ie, virtual colonoscopy); diagnostic*), which was replaced by these *CPT* codes.

The specified HCPCS codes within the three imaging families and five composite APCs for CY 2010 are provided in Table 3 of CR 6751, which is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1882CP.pdf*.

Cardiac rehabilitation services

CMS deleted Section 200.5 of Chapter 4 of the *Medicare Claims Processing Manual* and reserved it for future use. The coding requirements for cardiac rehabilitation services have been moved to Chapter 32 (Billing Requirements for Special Services), Section 140 (Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs). Section 140.1 contains coverage and coding requirements for cardiac rehabilitation services furnished on or before December 31, 2009. Sections 140.2 and 140.3 have been added and include coverage and coding requirements for cardiac rehabilitation and intensive cardiac rehabilitation services beginning January 1, 2010. The revised manual chapters are available as an attachment to CR 6751.

Pulmonary rehabilitation services

CMS added Section 140.4 to Chapter 32 (Billing Requirements for Special Services), Section 140 (Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs). It includes coverage and coding requirements for pulmonary rehabilitation services beginning January 1, 2010.

Outpatient observation services

CMS deleted Section 290.3 of Chapter 4 of the *Medicare Claims Processing Manual* and reserved it for future use. This section, "Billing and Payment for Observation Services Furnished Prior to January 1, 2006," is no longer relevant for claims processing purposes. In addition, CMS is making minor revisions to Section 290.5.2 (Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008) to reflect the change in the code descriptor of HCPCS code G0379 (Direct referral for hospital observation care), which is effective January 1, 2010.

Kidney disease education

Section 152(b) of MIPPA added kidney disease education (KDE) as a Medicare Part B covered benefit effective January 1, 2010, for beneficiaries diagnosed with stage IV chronic kidney disease (CKD). Medicare will cover up to and including six KDE sessions for beneficiaries referred by the physician managing the beneficiary's kidney condition when the beneficiary has been diagnosed with stage IV CKD. To be covered, these services must be furnished by a "qualified person". A qualified person is a physician, physician assistant, nurse practitioner, or clinical nurse specialist or a provider of services located in a rural area; or a hospital or critical access hospital (CAH) that is treated as being located in a rural area under Section 412.103 of the *Code of Federal Regulations* (CFR). Renal dialysis facilities and providers of services located outside a rural area, except for hospitals or CAHs that are treated as being located in a rural area under CFR Section 412.103, are excluded from the definition of a "qualified person."

KDE services furnished by rural providers of services, including a hospital or CAH that is treated as being located in a rural area under CFR Section 412.103, are paid under the Medicare physician fee schedule. KDE services should be reported using the HCPCS codes G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour) and G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour). Further information on billing, coverage, and payment of KDE services may be found in the *Medicare Benefit Policy Manual*, Chapter 15, Section 310 and the *Medicare Claims Processing Manual*, Chapter 32, Section 20, as discussed in CR 6557.

Billing for allogeneic and autologous stem cell transplant procedures

CMS added Section 231.11 to the *Medicare Claims Processing Manual*, Chapter 4, to clarify billing for allogeneic stem cell transplant procedures when provided in the outpatient setting. Allogeneic stem cell transplant procedures are payable under Part A or Part B depending upon whether the transplant takes place in the inpatient or outpatient setting. Payment for allogeneic stem cell acquisition services (including harvesting procedures) is packaged into the payment for the transplant procedure when provided in the outpatient setting. CMS also updated Chapter 4, Section 231.10 and Chapter 3, Section 90.3.3 to reflect that allogeneic stem cell transplant procedures may be billed and paid under Part B when provided in the hospital outpatient setting.

Payment for brachytherapy sources

For CY 2010, CMS proposed and finalized payment for brachytherapy sources using prospective rates based on Medicare claims data. For CY 2009 and most previous years, brachytherapy sources have been paid based on charges adjusted to a hospital's cost. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009 at hospitals' charges adjusted to the costs. CMS, therefore, has continued paying brachytherapy sources based on charges adjusted to cost for CY 2009. The status

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indicators of separately payable brachytherapy source HCPCS codes (except HCPCS code C2637) that were previously paid at charges adjusted to cost remain "U," which is the status indicator for separately payable brachytherapy sources irrespective of the payment methodology applied. CMS established status indicator "U" effective January 1, 2009.

These changes are reflected in the table below for all sources (with the exception of HCPCS code C2637, which is non-payable). In addition, because they will be paid prospectively beginning on January 1, 2010, brachytherapy sources will be eligible for outlier payments and for the rural sole community hospital (SCH) adjustment. The HCPCS codes for brachytherapy sources, long descriptors, status indicators, and APCs for CY 2010 are listed in Table 4, the comprehensive brachytherapy source table below.

Note: When billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See Transmittal 1259, CR 5623, issued June 1, 2007, for further information on billing for brachytherapy sources and the OPPS coding changes made for brachytherapy sources effective July 1, 2007. The MLN Matters® article related to CR 5623 is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5623.pdf*.

Table 4 – Comprehensive list of brachytherapy source HCPCS codes as of January 1, 2010

CY 2010 HCPCS code	CY 2010 long descriptor	CY 2010 SI	CY 2010 APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	U	2632
C1716	Brachytherapy source, non-stranded, gold-198, per source	U	1716
C1717	Brachytherapy source, non-stranded, high dose rate iridium-192, per source	U	1717
C1719	Brachytherapy source, non-stranded, non-high dose rate iridium-192, per source	U	1719
C2616	Brachytherapy source, non-stranded, yttrium-90, per source	U	2616
C2634	Brachytherapy source, non-stranded, high activity, iodine-125, greater than 1.01 mCi (NIST), per source	U	2634
C2635	Brachytherapy source, non-stranded, high activity, palladium-103, greater than 2.2 mCi (NIST), per source	U	2635
C2636	Brachytherapy linear source, non-stranded, palladium-103, per 1 mm	U	2636
C2637	Brachytherapy source, non-stranded, ytterbium-169, per source	B	N/A
C2638	Brachytherapy source, stranded, iodine-125, per source	U	2638
C2639	Brachytherapy source, non-stranded, iodine-125, per source	U	2639
C2640	Brachytherapy source, stranded, palladium-103, per source	U	2640
C2641	Brachytherapy source, non-stranded, palladium-103, per source	U	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	U	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	U	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	U	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	U	2699

Billing for drugs, biologicals, and radiopharmaceuticals

a. Reporting HCPCS codes for all drugs, biologicals, and radiopharmaceuticals

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

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available.

CMS' longstanding policy under the OPPS is to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services. While CMS does not require hospitals to use revenue code 0636 (pharmacy-extension of

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025x; drugs requiring detailed coding (a)) when billing for drugs and biologicals that have HCPCS codes, whether they are separately payable or packaged, CMS believes that a practice of billing all drugs and biologicals with HCPCS codes under revenue code 0636 would be consistent with National Uniform Billing Committee (NUBC) billing guidelines and would provide it with the most complete and detailed information for future rate setting. CMS' standard rate setting methodology is to rely on hospital cost and charge information as it is reported to us by hospitals through the claims data and cost reports.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned. Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

b. New CY 2010 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For CY 2010, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 5 below.

Table 5 – New CY 2010 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

CY 2010 HCPCS code	CY 2010 long descriptor	CY 2010 SI	CY 2010 APC
A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9254	Injection, lacosamide, 1 mg	K	9254
C9255	Injection, paliperidone palmitate, 1 mg	G	9255
C9256	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
J0586	Injection, abobotulinumtoxintypeA, 5 units	K	1289
J1680*	Injection, human fibrinogen concentrate, 100 mg	G	1290
J2793	Injection, rilonacept	K	1291
J9155	Injection, degarelix, 1 mg	G	1296
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg	G	1297

***Note:** HCPCS code J1680 is identified as a blood clotting factor and, as such, is subject to the CY 2010 blood clotting factor furnishing fee.

c. Other changes to CY 2010 HCPCS codes for certain drugs, biologicals, and radipharmaceuticals

Many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors that will be effective in CY 2010. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2009, and replaced with permanent HCPCS codes in CY 2010. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2010 HCPCS codes.

Table 6 – Other CY 2010 HCPCS code changes for certain drugs, biologicals, and radiopharmaceuticals

CY 2009 HCPCS code	CY 2009 long descriptor	CY 2010 HCPCS code	CY 2010 long descriptor
90378	*Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each*	*90378*	*Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each*
90663	*Influenza virus vaccine, pandemic formulation*	*90663*	*Influenza virus vaccine, pandemic formulation, H1N1*
90669	*Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use*	*90669*	*Pneumococcal conjugate vaccine, 7 valent, for intramuscular use*

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CY 2009 HCPCS code	CY 2009 long descriptor	CY 2010 HCPCS code	CY 2010 long descriptor
A9500	Technetium tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries	A9500	Technetium tc-99m sestamibi, diagnostic, per study dose
A9535	Injection, methylene blue, 1 ml	Q9968	Injection, non-radioactive, non-contrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	A9604	Samarium Sm-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries
C9245	Injection, romiplostim, 10 mcg	J2796	Injection, romiplostim, 10 micrograms
C9246	Injection, gadoxetate disodium, per ml	A9581	Injection, gadoxetate disodium, 1 ml
C9247	Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries	A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries
C9249	Injection, certolizumab pegol, 1 mg	J0718	Injection, certolizumab pegol, 1 mg
C9251	Injection, C1 esterase inhibitor (human), 10 units	J0598	Injection, C1 esterase inhibitor (human), 10 units
C9252	Injection, plerixafor, 1 mg	J2562	Injection, plerixafor, 1 mg
C9253	Injection, temozolomide, 1 mg	J9328	Injection, temozolomide, 1 mg
C9358	Dermal substitute, native, nondenatured collagen (SurgiMend Collagen Matrix), per 0.5 square cm	C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc
J0460	Injection, atropine sulfate, up to 0.3 mg	J0461	Injection, atropine sulfate, 0.01 mg
J0530	Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0540	Injection, penicillin G benzathine and penicillin G procaine, up to 1,200,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0550	Injection, penicillin G benzathine and penicillin G procaine, up to 2,400,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0585	Botulinum toxin type A, per unit.	J0585	Injection, onabotulinumtoxina, 1 unit
J0587	Botulinum toxin type B, per 100 units	J0587	Injection, rimabotulinumtoxinb, 100 units
J0835	Injection, cosyntropin, per 0.25 mg	J0833	Injection, cosyntropin, not otherwise specified, 0.25 mg
J0835	Injection, cosyntropin, per 0.25 mg	J0834	Injection, cosyntropin (cortrosyn), 0.25 mg
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg	*90379*	*Respiratory syncytial virus immune globulin (rsv-igiv), human, for intravenous use*

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CY 2009 HCPCS code	CY 2009 long descriptor	CY 2010 HCPCS code	CY 2010 long descriptor
J7192	Factor VIII (antihemophilic factor, recombinant) per i.u.	J7192	Factor VIII (antihemophilic factor, recombinant) per i.u., not otherwise specified
J7322	Hyaluronan or derivative, synvisc, for intra-articular injection, per dose	J7325	Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg
J9170	Injection, docetaxel, 20 mg	J9171	Injection, docetaxel, 1 mg
Q2009	Injection, fosphenytoin, 50 mg	Q2009	Injection, Fosphenytoin, 50 mg phenytoin equivalent
Q2023	Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per i.u.	J7185	Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per i.u.
Q2024	Injection, bevacizumab, 0.25 mg	C9257	Injection, bevacizumab, 0.25 mg

d. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2010

For CY 2010, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP plus four percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2010, a single payment of ASP plus six percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the first quarter of CY 2010, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP was suspended beginning January 1, 2009. Should the Part B drug CAP be reinstituted sometime during CY 2010, we would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP , as required by the statute.

In the CY 2010 OPPS/ASC final rule with comment period, CMS states that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as subsequent quarter ASP submissions become available. Effective January 1, 2010, payment rates for many drugs and biologicals have changed from the values published in the CY 2010 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2009. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2010 release of the OPPS PRICER. CMS is not publishing the updated payment rates in CR 6751. However, the updated payment rates effective January 1, 2010, may be found in the January 2010 update of the OPPS Addendum A and Addendum B on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp*.

e. Updated payment rates for certain HCPCS codes effective April 1, 2009 through June 30, 2009

The payment rates for several HCPCS codes were incorrect in the April 2009 OPPS PRICER. The corrected payment rates are listed below and have been installed in the January 2010 OPPS PRICER, effective for services furnished on April 1, 2009, through implementation of the July 2009 update. Claims processed with the incorrect rates will be adjusted if you bring such claims to the attention of your contractor.

Table 7 – Updated payment rates for certain HCPCS codes effective April 1, 2009 through June 30, 2009

CY 2009 HCPCS code	CY 2009 SI	CY 2009 APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
C9245	G	9245	Injection, romiplostim	$44.81	$8.79
J1260	K	0750	Dolasetron mesylate	$4.54	$0.91
J2778	K	9233	Ranibizumab injection	$399.55	$79.91

f. Updated payment rates for certain hcpcs codes Effective July 1, 2009, through September 30, 2009

The payment rates for several HCPCS codes were incorrect in the July 2009 OPPS PRICER. The corrected payment rates are listed below and have been installed in the January 2010 OPPS PRICER, effective for services furnished on July 1, 2009, through implementation of the October 2009 update. Claims processed with the incorrect rates will be adjusted if you bring such claims to the attention of your contractor.

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Table 8 – Updated payment rates for certain HCPCS codes effective July 1, 2009, through September 30, 2009

CY 2009 HCPCS code	CY 2009 SI	CY 2009 APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
C9354	G	9354	Veritas collagen matrix, cm2	$11.77	$2.31
C9364	G	9364	Porcine implant, Permacol	$18.46	$3.62
J1520	K	0921	Gamma globulin 7 CC inj	$102.15	$20.43

g. Correct reporting of biologicals when used as implantable devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

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

h. Correct reporting of units for drugs

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

i. Payment for therapeutic radiopharmaceuticals

Beginning in CY 2010, nonpass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data are unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, effective January 1, 2010, the status indicator for separately payable therapeutic radiopharmaceuticals is "K" to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Table 9 – Nonpass-through separately payable therapeutic radiopharmaceuticals effective January 1, 2010

CY 2010 HCPCS code	CY 2010 long descriptor	Final CY 2010 APC	Final CY 2010 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K

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CY 2010 HCPCS code	CY 2010 long descriptor	Final CY 2010 APC	Final CY 2010 SI
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

j. Reporting of outpatient diagnostic nuclear medicine procedures

CMS applies nuclear medicine procedure-to-radiolabeled product edits in the I/OCE effective January 2008 that require a radiolabeled product to be present on the same claim as a nuclear medicine procedure for payment under the OPPS to be made. These edits have been revised quarterly, based on information provided to us by members of the public with regard to certain clinical scenarios. CMS is updating the lists of nuclear medicine procedures and radiolabeled products for CY 2010. The complete list of updated nuclear medicine procedure-to-radiolabeled product edits can be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage*.

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.
As stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and we expect that the majority of hospitals will not encounter this situation.

k. Payment offset for pass-through diagnostic radiopharmaceuticals

Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in Transmittal 1702, CR 6416, issued March 13, 2009, pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used. The *MLN Matters*® article related to CR 6416 is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6416.pdf*.

Effective April 1, 2009, the diagnostic radiopharmaceutical reported with HCPCS code C9247 (Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G." Therefore, in CY 2009, when HCPCS code C9247 is billed on the same claim with a nuclear medicine procedure, CMS reduces the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 by the corresponding nuclear medicine procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made.
For CY 2010, HCPCS code C9247 is being replaced with HCPCS code A9582 (Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries) and HCPCS code A9582 will continue on pass-through status for CY 2010. Therefore, for CY 2010, HCPCS code A9582 will be assigned status indicator "G" and will be subject to the pass-through payment offset for pass-through diagnostic radiopharmaceuticals. The offset will cease to apply when this diagnostic radiopharmaceutical expires from pass-through status.
The "policy-packaged" portions of the CY 2010 APC payments for nuclear medicine procedures may be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage* in the download file labeled 2010 OPPS Offset Amounts by APC.
CY 2010 APCs to which nuclear medicine procedures are assigned and for which we expect a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in the following table.

Table 10 – APCs to which nuclear medicine procedures are assigned for CY 2010

CY 2010 APC	CY 2010 APC title
0307	Myocardial positron emission tomography (PET) imaging
0308	Non-myocardial positron emission tomography (PET) imaging
0377	Level II cardiac imaging
0378	Level II pulmonary imaging

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CY 2010 APC	CY 2010 APC title
0389	Level I non-imaging nuclear medicine
0390	Level I endocrine imaging
0391	Level II endocrine imaging
0392	Level II non-imaging nuclear medicine
0393	Hematologic processing & studies
0394	Hepatobiliary imaging
0395	GI tract imaging
0396	Bone imaging
0397	Vascular imaging
0398	Level I cardiac imaging
0400	Hematopoietic imaging
0401	Level I pulmonary imaging
0402	Level II nervous system imaging
0403	Level I nervous system imaging
0404	Renal and genitourinary studies
0406	Level I tumor/infection imaging
0408	Level III tumor/infection imaging
0414	Level II tumor/infection imaging

l. Introduction of payment offset for pass-through contrast agents

As discussed in the CY 2010 OPPS/ASC final rule with comment period, effective for pass-through contrast agents furnished on and after January 1, 2010, when a contrast-enhanced procedure that is assigned to a procedural APC with a "policy-packaged" drug amount greater than $20 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service, CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made.

CY 2010 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in the table below this section. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used.

For CY 2010, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in this section's table on the same date of service, a specific pass-through payment offset determined by the procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

Effective January 1, 2009, contrast agent HCPCS code C9246 (Injection, gadoxetate disodium, per ml) was granted pass-through status under the OPPS and was assigned status indicator "G." As the pass-through offset methodology was not in place for contrast agents in CY 2009, payments for HCPCS code C9246 were not reduced by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount).

For CY 2010, HCPCS code C9246 is being replaced with HCPCS code A9581 (Injection, gadoxetate disodium, 1 ml) and HCPCS code A9581 will continue on pass-through status for CY 2010. In addition, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) describes a contrast agent that has been granted pass-through status beginning January 1, 2010. Both HCPCS codes A9581 and A9583 will be assigned status indicator "G" and will be subject to the payment offset methodology for contrast agents. Therefore, in CY 2010 CMS will reduce the payment for HCPCS codes A9581 and A9583 by the estimated amount of payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast-enhanced procedure reported on the same claim on the same date as HCPCS code A9581 or A9583 if the contrast-enhanced procedure is assigned to one of the APCs listed in the table below. The "policy-packaged" portions of the CY 2010 APC payments that are the offset amounts may be found on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage* in the download file labeled 2010 OPPS offset amounts by APC.

When HCPCS code A9581 or A9583 is billed on a claim on the same date of service as one or more procedures assigned to an APC listed in the following table, the OPPS PRICER will identify the offset amount or amounts that apply to the contrast-enhanced procedures that are reported on the claim. Where there is a single contrast-enhanced procedure reported

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on the claim with a single occurrence of either HCPCS code A9581 or A9583, the OPPS PRICER will identify a single offset amount for the procedure billed and adjust the offset by the wage index value that applies to the hospital submitting the claim. Where there are multiple contrast procedures on the claim with a single occurrence of the pass-through contrast agent, the OPPS PRICER will select the contrast-enhanced procedure with the single highest offset amount and adjust the selected offset amount by the wage index value of the hospital submitting the claim. When a claim has more than one occurrence of either HCPCS code A9581 or A9583, the OPPS PRICER will rank potential offset amounts associated with the units of contrast-enhanced procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through contrast agent on the claim and adjust the total offset amount by the wage index value of the hospital submitting the claim. The adjusted offset amount will be subtracted from the APC payment for the pass-through contrast agent reported with either HCPCS code A9581 or A9583. The offset will cease to apply when each of these contrast agents expires from pass-through status.

Table 11. – APCs to which a pass-through contrast agent offset may be applicable for CY 2010

CY 2010 APC	CY 2010 APC title
0080	Diagnostic cardiac catheterization
0082	Coronary or non-coronary atherectomy
0083	Coronary or non-coronary angioplasty and percutaneous valvuloplasty
0093	Vascular reconstruction/fistula repair without device
0104	Transcatheter placement of intracoronary stents
0128	Echocardiogram with contrast
0152	Level I percutaneous abdominal and biliary procedures
0229	Transcatheter placement of intravascular shunts
0278	Diagnostic urography
0279	Level II angiography and venography
0280	Level III angiography and venography
0283	Computed tomography with contrast
0284	Magnetic resonance imaging and magnetic resonance angiography with contrast
0333	Computed tomography without contrast followed by contrast
0337	Magnetic resonance imaging and magnetic resonance angiography without contrast followed by contrast
0375	Ancillary outpatient services when patient expires
0383	Cardiac computed tomographic imaging
0388	Discography
0418	Insertion of left ventricular pacing elect.
0442	Dosimetric drug administration
0653	Vascular reconstruction/fistula repair with device
0656	Transcatheter placement of intracoronary drug-eluting stents
0662	CT Angiography
0668	Level I angiography and venography
8006	CT and CTA with contrast composite
8008	MRI and MRA with contrast composite

Drug administration services

As discussed in the CY 2010 OPPS/ASC final rule with comment period, drug administration services will continue to be reported using the full set of drug administration *CPT* codes with the following exception. CMS note that new *CPT* code 9*0470 (H1N1 immunization administration (intramuscular, intranasal), including counseling when performed)* has been created by *CPT* for administration of the H1N1 vaccine for CY 2010. We are assigning this code status indicator "E" for OPPS payment purposes in CY 2010. Hospitals that administer the H1N1 vaccine should continue to use HCPCS code

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G9141 (Influenza A (H1N1) drug administration (includes the physician counseling the patient/family) for services furnished on or after September 1, 2009. Further information related to H1N1 codes may be found in Transmittal 547, CR 6633, issued August 28, 2009.

Changes to OPPS PRICER logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2010. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2010. All coinsurance rates will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the inpatient deductible of $1,100.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2010. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. However, there will be a change in the fixed-dollar threshold in CY 2010. The estimated cost of a service must be greater than the APC payment amount plus $2,175 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2009 was $1,800.

e. For outliers for community mental health centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2010. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective January 1, 2010, MIPPA provisions authorizing payment for brachytherapy sources (status indicator "U") at charges reduced to cost expire, and PRICER will make payment based on final CY 2010 prospective payment rates. Note that the payment and copayment reduction for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) (section j.) will apply to brachytherapy sources beginning January 1, 2010. Brachytherapy sources are eligible to receive outlier payments. Brachytherapy sources are not subject to the wage adjustment, but do receive the adjustment for rural sole community hospitals and essential access community hospitals.

g. Effective January 1, 2010, MIPPA provisions authorizing payment for therapeutic radiopharmaceuticals at charges reduced to cost expire, and PRICER will make prospective payment based either on the ASP for those therapeutic radiopharmaceuticals for which manufacturers submit ASP data or on mean unit cost. Therapeutic radiopharmaceuticals without pass-through status will have a status indicator of "K" beginning in CY 2010. Like other drugs and biologicals, therapeutic radiopharmaceuticals are not eligible to receive outlier payments or the adjustment for rural sole community hospitals and essential access hospitals, and are not wage-adjusted.

h. Effective January 1, 2009, status indicator "R" is used to denote blood and blood products for payment purposes. Blood and blood products are eligible to receive outlier payments. Blood and blood products are not subject to wage adjustment, but do receive the adjustment for rural sole community hospitals and essential access community hospitals.

i. Effective January 1, 2010, no devices are eligible for pass-through payment in the OPPS PRICER logic. There are no associated APC offset amounts or specific logic assigning device payment to associated APC payment for determining outlier eligibility and payment.

j. Effective January 1, 2010, the OPPS PRICER will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their HOP QDRP reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

k. Effective January 1, 2010, there will be **one** diagnostic radiopharmaceutical receiving pass-through payment in the OPPS PRICER logic. For APCs containing nuclear medicine procedures, PRICER will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2010 APC payments for nuclear medicine procedures and may be found at *http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage* in the download file labeled 2010 OPPS offset amounts by APC.

l. Effective January 1, 2010, there will be **two** contrast agents receiving pass-through payment in the OPPS PRICER logic. For a specific set of APCs identified elsewhere in this update, PRICER will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with

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procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the "policy-packaged" portions of the CY 2010 APC payments for procedures using contrast agents and may be found on the CMS Web site.

m. PRICER will update the payment rates for drugs, biologicals, and therapeutic radiopharmaceuticals when those payment rates are based on ASP on a quarterly basis.

n. Effective January 1, 2010, CMS is adopting the FY 2010 inpatient prospective payment system (IPPS) post-reclassification wage index values with application of out-commuting adjustment authorized by section 505 of Pub. L. 108-173 to non-IPPS hospitals discussed below.

Wage indices for Non-IPPS hospitals eligible for the out-commuting adjustment authorized by Section 505 of Pub. L. 108-173

Wage indexes for Non-IPPS hospitals eligible for the out-commuting adjustment authorized by Section 505 of Public Law 108-173 may be found in Table 12 of CR 6751.

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries (FIs)/Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction (CR 6751) was issued to your Medicare A/B MAC and/or fiscal intermediary via two transmittals. The first transmittal, R1882CP, modifies the *Medicare Claims Processing Manual* and is located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1882CP.pdf*.

The second transmittal, R116BP, provides the revisions to the *Medicare Benefit Policy Manual* and that transmittal is located on that same site at *http://www.cms.hhs.gov/Transmittals/downloads/R116BP.pdf*.

If you have questions, please contact your Medicare A/B MAC or fiscal intermediary 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: MM6751
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Related CR Transmittal Number: R[1882]CP and R116BP
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1882, CR 6751

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.

Home health prospective payment system rate update for calendar year 2010

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

Provider types affected

Home health agencies (HHA) who bill regional home health intermediaries (RHHI) or Medicare administrative contractors (MAC) are impacted by this article.

Provider action needed

Change request (CR) 6747, from which this article is taken, updates the 60-day national episode rates and the national per-visit amounts under the home health prospective payment system (HH PPS) for calendar year (CY) 2010. It also refines the case mix methodology and rebases and revises the home health market basket for CY 2010. Note that for CY 2010 (effective for episodes with claim statement "Through" dates on or after January 1, 2010 and on or before December 31, 2010), Medicare home health payments for HHAs that report quality data (described below) will be increased by 2.0 percent, while payments for those HHAs that do not report quality data will be increased 0.0 percent. Be sure billing staff are aware of this article.

Background

Section 1895 (b)(3)(B)(v) of the Social Security Act (or Act) provides that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2010. The home health market basket percentage increase for CY 2010 is 2.0 percent.

Section 1895 (b)(3)(B)(v) of the Act also requires that home health agencies (HHAs) report quality data as determined by the Secretary of Health & Human Services. HHAs that do not report the required quality data will receive a two percent reduction to the home health market basket percentage increase for CY 2010. Consequently, those HHAs will not receive any increase for CY2010.

The following five tables show the rates for HHAs that **do** report the required quality data:

In order to establish new payments for CY 2010, the Centers for Medicare & Medicaid Services (CMS) starts with the CY 2009 national standardized 60-day episode payment and adjusts it to return the outlier funds that paid for the original five percent target for outlier payments. That figure is adjusted to account for the 2.5 percent outlier policy. Then it is increased by the home health market basket update for CY 2010 (2.0 percent). This figure is reduced by the 2.75 percent case-mix adjustment. Refer to Table 1 for the calculations, which yield the CY 2010 updated national standardized 60-day episode payment rate. These payments will be further adjusted by the individual episode's case-mix weight and wage index.

Table 1

National 60-day episode amounts updated by the home health market basket update for cy 2010, before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary

Total CY 2009 national standardized 60-day episode payment rate	Adjusted to return the outlier funds that paid for the original 5percent target for outlier payments	Adjusted to account for the 2.5percent outlier policy	Multiply by the home health market basket update (2.0percent)	Reduce by 2.75 percent for nominal change in case-mix	**CY 2010 national standardized 60-day episode payment rate**
$2,271.92	/ 0.95	X 0.975	X 1.020	X 0.9725	**$2,312.94**

The national standardized per-visit amounts are used to calculate low utilization payment adjustments (LUPAs) and outlier payments. The national per-visit amounts are as follows:

Table 2

National per-visit amounts for LUPAS (not including the increase in payment for a beneficiary's only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the home health market basket update for cy 2010, before wage index adjustment based on the site of service for the beneficiary

Home health discipline	CY 2009 per-visit rate	Adjusted to return the outlier funds that paid for the original five percent target for outlier payments	Adjusted to account for the 2.5percent outlier policy	Multiply by the CY 2010 home health market basket (2.0percent)	**CY 2010 per-visit rate**
Home health aide	$48.89	/ 0.95	X 0.975	X 1.02	**$51.18**

Home health prospective payment system rate update for calendar year 2010 (continued)

National per-visit amounts for LUPAS (not including the increase in payment for a beneficiary's only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the home health market basket update for cy 2010, before wage index adjustment based on the site of service for the beneficiary					
Home health discipline	CY 2009 per-visit rate	Adjusted to return the outlier funds that paid for the original five percent target for outlier payments	Adjusted to account for the 2.5percent outlier policy	Multiply by the CY 2010 home health market basket (2.0percent)	**CY 2010 per-visit rate**
Medical social services	$173.05	/ 0.95	X 0.975	X 1.02	**$181.16**
Occupational therapy	$118.83	/ 0.95	X 0.975	X 1.02	**$124.40**
Physical therapy	$118.04	/ 0.95	X 0.975	X 1.02	**$123.57**
Skilled nursing	$107.95	/ 0.95	X 0.975	X 1.02	**$113.01**
Speech-language pathology	$128.26	/ 0.95	X 0.975	X 1.02	**$134.27**

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. The CY 2010 LUPA add-on payment is updated in Table 3.

Table 3

CY 2010 LUPA add-on payment amounts				
CY 2009 LUPA add-on payment	Adjusted to return the outlier funds that paid for the original 5 percent target for outlier payments	Adjusted to account for the 2.5 percent outlier policy	Multiply by the home health market basket update (2.0 percent)	**CY 2010 LUPA Add-on payment**
$90.48	/ 0.95	X 0.975	X 1.02	**$94.72**

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The NRS conversion factor for CY 2010 payments is updated in Table 4a.

Table 4a

CY 2010 NRS conversion factor					
CY 2009 NRS conversion factor	Adjusted to return the outlier funds that paid for the original 5 percent target for outlier payments	Adjusted to account for the 2.5 percent outlier policy	Multiply by the home health market basket update (2.0 percent)	Reduce by 2.75 percent for nominal change in case-mix	**CY 2010 NRS conversion factor**
52.39	/ 0.95	X 0.975	X 1.02	X 0.9725	**$53.34**

The payment amounts for the various severity levels based on the updated conversion factor are shown in Table 4b.

Table 4b

Relative weights for the six-severity NRS system			
Severity level	Points (scoring)	Relative weight	**NRS payment amount**
1	0	0.2698	**$14.39**
2	1 to 14	0.9742	**$51.96**
3	15 to 27	2.6712	**$142.48**
4	28 to 48	3.9686	**$211.69**

Home health prospective payment system rate update for calendar year 2010 (continued)

Relative weights for the six-severity NRS system			
Severity level	Points (scoring)	Relative weight	**NRS payment amount**
5	49 to 98	6.1198	**$326.43**
6	99+	10.5254	**$561.42**

The following five tables show the rates for HHAs that DO NOT report the required quality data:

Section 1895 (b)(3)(B)(v) of the Act requires that if quality data is not submitted by an HHA, then the home health market basket percentage increase applicable to that provider's payments will be reduced by 2 percent. Therefore, the increase that is applied to CY 2010 payments to HHAs that do not report the required quality data is 0 percent (CY 2010 market basket update of 2.0 percent minus 2 percent). The CY 2010 National Standardized 60-Day Episode Payment Rate for HHAs who do not submit the required quality data is shown in Table 5 below.

Table 5

For HHAs that do not submit the required quality data – national 60-day episode amounts updated by the home health market basket update for cy 2010 minus 2 percent, before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary					
Total CY 2009 national standardized 60-day episode payment rate	Adjusted to return the outlier funds that paid for the original 5 percent target for outlier payments	Adjusted to account for the 2.5 percent outlier policy	Multiply by the home health market basket update (2.0 percent) minus 2 percent for a 0 percent update	Reduce by 2.75 percent for nominal change in case-mix	**CY 2010 national standardized 60-day episode payment rate for hhas that do not submit required quality data**
$2,271.92	/ 0.95	X 0.975	X 1.00	X 0.9725	**$2,267.59**

The national standardized per-visit amounts are used to calculate low utilization payment adjustments (LUPAs) and outlier payments. The national per-visit amounts for HHAs that do not submit the required quality data are as follows:

Table 6

For HHAs that do not submit the required quality data – national per-visit amounts for LUPAS (not including the increase in payment for a beneficiary's only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the home health market basket update for cy 2010 minus two percent, before wage-index adjustment based on the site of service for the beneficiary					
Home health discipline	CY 2009 per-visit rate	Adjusted to return the outlier funds that paid for the original five percent target for outlier payments	Adjusted to account for the 2.5 percent outlier policy	Multiply by the CY 2010 home health market basket (2.0 percent) minus two percent for a zero percent update	**CY 2010 per-visit rate for HHAs that do not submit required quality data**
Home health aide	$48.89	/ 0.95	X 0.975	X 1.00	**$50.18**
Medical social services	$173.05	/ 0.95	X 0.975	X 1.00	**$177.60**
Occupational therapy	$118.83	/ 0.95	X 0.975	X 1.00	**$121.96**
Physical therapy	$118.04	/ 0.95	X 0.975	X 1.00	**$121.15**
Skilled nursing	$107.95	/ 0.95	X 0.975	X 1.00	**$110.79**
Speech-language pathology	$128.26	/ 0.95	X 0.975	X 1.00	**$131.64**

Home health prospective payment system rate update for calendar year 2010 (continued)

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. This additional LUPA add-on amount for HHAs that do not submit the required quality data is updated in Table 7.

Table 7

For HHAs that do not submit the required quality data – CY 2010 LUPA add-on payment amounts				
CY 2009 LUPA add-on payment	Adjusted to return the outlier funds that paid for the original five percent target for outlier payments	Adjusted to account for the 2.5 percent outlier policy	Multiply by the CY 2010 home health market basket (2.0 percent) minus two percent for a zero percent update	**CY 2010 LUPA add-on payment for HHAs that do not submit required quality data**
$90.48	/ 0.95	X 0.975	X 1.00	**$92.86**

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2010 payments to HHAs that do not submit the required quality data, the NRS conversion factor is shown in Table 8a.

Table 8a

For HHAs that do not submit the required quality data -- CY 2010 NRS conversion factor					
CY 2009 NRS conversion factor	Adjusted to return the outlier funds that paid for the original 5 percent target for outlier payments	Adjusted to account for the 2.5 percent outlier policy	Multiply by the CY 2010 home health market basket (2.0 percent) minus 2 percent for a 0 percent update	Reduce by 2.75 percent for nominal change in case-mix	**CY 2010 NRS conversion factor for HHAs that do not submit required quality data**
52.39	/ 0.95	X 0.975	X 1.00	X 0.9725	**$52.29**

The payment amounts for the various severity levels based on the updated conversion factor are calculated in Table 8b.

Table 8b

For HHAs that do not submit the required quality data -- relative weights for the 6-severity NRS system			
Severity level	Points (scoring)	Relative weight	**NRS payment amount for HHAs that do not submit required quality data**
1	0	0.2698	**$14.11**
2	1 to 14	0.9742	**$50.94**
3	15 to 27	2.6712	**$139.68**
4	28 to 48	3.9686	**$207.52**
5	49 to 98	6.1198	**$320.00**
6	99+	10.5254	**$550.37**

Additional information

The official instruction (CR 6747) issued to your Medicare RHHI/MAC is available on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R1864CP.pdf*.

If you have questions, please contact your Medicare RHHI/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: MM6747
Related Change Request (CR) Number: 6747
Related CR Release Date: December 4, 2009
Related CR Transmittal Number: R1864CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1864, CR 5747

ELECTRONIC DATA INTERCHANGE

Update of remittance advice remark codes and claim adjustment reason codes

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

Provider types affected

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

Provider action needed

CR 6742, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs). The CR is effective January 1, 2010. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated three times a year – in early March, July, and November although the Committee meets every month. A national code maintenance committee maintains the CARCs. That Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. Both code lists are posted at *http://www.wpc-edi.com/Codes*.

The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6742.

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

Additional information

To see the official instruction (CR 6742) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1862CP.pdf*.

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

New codes – CARC

Code	Current narrative	Effective date per WPC posting
232	Institutional transfer amount. Note: Applies to Institutional claims only and explains the DRG amount differences when patients care crosses multiple institutions.	11/1/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	11/1/2009

Modified codes – CARC

Code	Current modified narrative	Effective date per WPC posting
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Code	Current modified narrative	Effective date per WPC posting
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
49	These are noncovered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
51	These are noncovered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
96	Noncovered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
107	Related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present	7/1/2010
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
152	Payer deems the information submitted does not support this length of service.	7/1/2010
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Code	Current modified narrative	Effective date per WPC posting
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
179	Patient has Not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is Not an "Alert".)	7/1/2010
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
148	Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided ((may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Code	Current modified narrative	Effective date per WPC posting
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 07/01/2010: Charges do Not meet qualifications for emergent/urgent care. Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.	7/1/2010

Deactivated codes – CARC

Code	Current narrative	Effective date
87	Transfer Amount	1/1/2012
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	1/1/2012

New codes – RARC

Code	Current narrative	Medicare initiated
N521	Mismatch between the submitted provider information and the provider information stored in our system.	No
N522	Duplicate of a claim processed as a crossover claim.	No

Modified codes – RARC

Code	Modified narrative	Medicare initiated
M39	The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.	No
M118	Letter to follow containing further information.	No
N59	Please refer to your provider manual for additional program and provider information.	No
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	No
N202	Additional information/explanation will be sent separately.	No

Deactivated codes – RARC

None

MLN Matters® Number: MM6742
Related Change Request (CR) Number: 6742
Related CR Release Date: November 27, 2009
Effective Date: January 1, 2010
Related CR Transmittal Number: R1862CP
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1862, CR 6742

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.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6723 to reflect revisions to change request (CR) 6723. The CR release date, transmittal number, and the Web address for accessing CR 6723 were revised. All other information remains the same. The *MLN Matters* article MM6723 was published in the November 2009 *Medicare A Bulletin* (page 39).

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 that is based on 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 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 category codes and claim status 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/R1874CP.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: December 14, 2009
Related CR Transmittal Number: R1874CP
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-04, Transmittal 1874, CR 6723

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
January 2010 – March 2010

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

Topic – Reject/Return to Provider (RTP) reason codes

When: Tuesday, February 9, 2010
Time: 10:00 a.m. – 11:30 a.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Hot Topics

When: Tuesday, March 9, 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 identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

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

Tips for using the FCSO provider training Web site

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

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

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

Please Note:

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

Registrant's Name: _____
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Provider's Name: _____
Telephone Number: _____ Fax Number: _____
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Keep checking our Web site, *http://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

Mini-poster to help educate Medicare beneficiaries about flu vaccines

The Centers for Medicare & Medicaid Services (CMS) would appreciate your help communicating with the public, especially seniors and vulnerable populations, that Medicare and Medicaid cover both the seasonal and H1N1 flu vaccines.

Seniors are encouraged to get their seasonal flu vaccine as soon as possible. The vaccine that protects against the 2009 H1N1 influenza virus (sometimes called swine flu) is a separate vaccine and is now available. The first available doses of this vaccine should be given to those at highest risk of infection and complications such as children, pregnant women, health care workers, and younger adults with certain medical conditions. There is some evidence that people 65 and older are less likely than younger people to be infected with the 2009 H1N1 influenza virus.

Please share this bilingual mini-poster (available at *http://www.cms.hhs.gov/AdultImmunizations/Downloads/FluPoster2009.pdf*) with your colleagues and encourage them to post it in places where Medicare patients will see and understand the need for their seasonal flu shot and that they can get the H1N1 vaccine once the high risk groups are vaccinated.

Medicare practitioners are encouraged to refer patients to *http://www.flu.gov/* if they need more information about the seasonal and H1N1 flu vaccines. Additional information for practitioners, mass immunizers, and others who want to bill Medicare for the flu vaccines may be obtained at *http://www.cms.hhs.gov/adultimmunizations/*.

The immunizers' question and answer guide (located in the Download section) also includes a list of regional CMS contacts (on page 55) that would be helpful for those wishing to organize a large scale immunization clinic for seniors.

CMS would appreciate any feedback you can give as to the use of this poster (e.g., did your colleagues post it in their offices, was it posted in senior centers, etc.). Thank you for your help in getting this important message to Medicare beneficiaries. ❖

Source: CMS PERL 200912-01

OTHER EDUCATIONAL RESOURCES

New MLN booklet on how to use the Medicare-coverage database search tool

Do you ever wonder about how to utilize search tools in selected areas of the CMS Web site? The searchable Medicare coverage database (MCD) contains all Medicare national coverage determinations (NCDs), national coverage analyses (NCAs), local coverage determinations (LCDs), and local policy articles.

The *Medicare Learning Network* (MLN) has produced a "How To" booklet (2.5 MB), that provides an explanation of the MCD, as well as how to use the search, indexes, reports, and downloads features. The How to Use the Medicare Coverage Database booklet (November 2009) may be located on the MLN publication page at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*.

Use search keywords "how to" to locate this publication quickly. Understanding the search tool is the best way to find the information for which you are looking. ❖

Source: CMS PERL 200912-11

Revised guided pathways booklets

Are you wondering how to find the latest and greatest resources by subject? The revised guided pathways (Nov. 2009) booklets incorporate existing *Medicare Learning Network (MLN)* products and other centers resources into well-organized sections that may help Medicare fee-for-service (FFS) providers and suppliers find information to understand and navigate the Medicare program.

These booklets guide learners to Medicare program resources, FFS policies and requirements. You may access the revised guided pathways (NOV 2009) booklets on the *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp*. ❖

Source: CMS PERL 200912-12

Revised Hospice Payment System fact sheet

The revised Hospice Payment System fact sheet (November 2009) is now available for download. This fact sheet provides general information about the Medicare hospice benefit including:

- Coverage of hospice services
- Certification requirements
- Election periods
- Patient coinsurance payments
- Caps on hospice payments
- Additional reporting required on hospice claims.

The fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*. ❖

Source: CMS PERL 200911-38

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

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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
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Medicare Provider Enrollment – ADA
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Jacksonville, FL 32231-0048

SPECIAL DELIVERY
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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
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

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Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦