MEDICARE A Bulletin
A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

[ ] Medicare Manager

[ ] Reimbursement Director

[ ] Chief Financial Officer

[ ] Compliance Officer

[ ] DRG Coordinator

[ ] ____________________

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[ ] ____________________

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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

## Additional ICD-9 diagnosis and procedure code analysis and processing direction

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

### Provider types affected

This article is for hospitals, home health agencies, skilled nursing facilities, and other providers who bill fiscal intermediaries, (FI), regional home health intermediaries (RHHI), or Medicare administrative contractors (A/B MAC) for providing institutional services to Medicare beneficiaries.

### What you need to know

Change request (CR) 6851, from which this article is taken, announces that (effective January 1, 2011) the Centers for Medicare & Medicaid Services (CMS) is expanding the number of ICD-9 diagnosis and procedure codes processed on institutional claims. Please see the *Background* section, below for details.

### Background

In CR 6797 (Institutional Online Screens Changes for Version 005010 Related to ICD-10, Institutional Online Screens Changes for Additional Medical Codes, and Changes Needed to Process Additional Medical Codes – Analysis Only), released on January 8, 2010, CMS announced the need to perform an analysis of the institutional online fiscal intermediary standard system (FISS) and the national claims history (NCH) system to determine what changes are required to allow for additional, and larger, ICD-9 diagnosis and procedure codes. You may find CR 6797 on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R618OTN.pdf*.

CR 6851 continues and completes this process by announcing that, effective January 1, 2011, CMS is expanding the number of ICD-9 diagnosis and procedure codes it will accept and process on institutional claims.

This expansion is being done to allow for: 1) Adding additional ICD-9 other (secondary) diagnosis codes (from eight codes to 24 codes) as well as additional associated present on admission (POA) codes; and 2) Adding additional ICD-9 other (secondary) procedure codes (from five codes to 24 codes).

**Note:** CMS will be able to accept and process additional ICD-9/POA codes effective January 1, 2011.

### Additional information

You may find the official instruction, CR 6851, issued to your FI, RHHI, or A/B MAC by visiting the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R648OTN.pdf*.

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

*MLN Matters*® Number: MM6851
Related Change Request (CR) Number: 6851
Related CR Release Date: March 5, 2010
Related CR Transmittal Number: R648OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-20, Transmittal 648, CR 6851

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## Physician consultation codes no longer valid for Medicare

In December 2009, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6740 instructing that as of January 1, 2010, *Current Procedural Terminology (CPT)* consultation codes *99241-99245* and *99251-99255* are no longer valid for Medicare Part B billing. Because this affects Part A billing as well, CMS will be issuing a separate CR to address Part A billing as it relates to these services. In the interim, hospices should look to CR 6740 for instructions (excluding those related to the use of **modifier AI**) as to how to bill for these services. CR 6740 is available at *http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf*. ❖

Source: CMS PERL 201002-42

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## July 2010 quarterly average sales price update and revision to prior files

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

### Provider types affected

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors [MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) are affected by this issue.

### What you need to know

This article is based on change request (CR) 6805 which instructs Medicare contractors to download and implement the July 2010 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised April 2010, January 2010, October 2009, and July 2009 files. Medicare will use the July 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2010, with dates of service July 1, 2010, through September 30, 2010.

### Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions.

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

| Files | Effective Dates of Service |
|---|---|
| July 2010 ASP and NOC files | July 1, 2010, through September 30, 2010 |
| April 2010 ASP and NOC files | April 1, 2010, through June 30, 2010 |
| January 2010 ASP and NOC files | January 1, 2010, through March 31, 2010 |
| October 2009 ASP and NOC files | October 1, 2009, through December 31, 2009 |
| July 2009 ASP and NOC files | July 1, 2009, through September 30, 2009 |

### Additional information

The official instruction (CR 6805) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1922CP.pdf*.

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

MLN Matters® Number: MM6805
Related Change Request (CR) Number: 6805
Related CR Release Date: February 19, 2010
Related CR Transmittal Number: R1922CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1922, CR 6805

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## April 2010 average sale price drug file is available

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

Source: CMS PERL 201003-40

## Internet-based PECOS for physicians, nonphysician practitioners, and solely-owned organizations

To assist in protecting, completing, and submitting your Medicare enrollment application via Internet-based provider enrollment, chain and ownership system (PECOS), the following enrollment reminders and tips are being provided by the Centers for Medicare & Medicaid Services (CMS).

**Protect your privacy:** Physicians and nonphysician practitioners need to take steps to ensure that their Medicare enrollment information does not get into the hands of people who may use that information to commit fraud. (See the document titled, "Medicare Physicians and Non-Physician Practitioners – Protecting Your Privacy, Protecting Your Medicare Enrollment Record." This document may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/MedPhysPrivacy.pdf*.)

**Organizations must be enrolled before individuals:** Before a physician or nonphysician practitioner can reassign their benefits to a medical group or clinic other than the one they solely own, the medical group or clinic must have an approved enrollment record in PECOS.

**Initial enrollment application for an individual:** Physicians and nonphysician practitioners who have not enrolled or updated their Medicare enrollment since November 2003 will need to complete an initial enrollment application. PECOS does not contain information for physicians and nonphysician practitioners enrolled before November 2003 who have not updated their enrollment record since that time.

**Using Internet-based PECOS:** CMS suggests you use Internet-based PECOS because it is faster and more efficient than the paper enrollment application process. Before you begin to use Internet-based PECOS, you should:

- Be sure that you have the national provider identifier (NPI) that was assigned to you as an individual and, if you solely own an organization provider, the NPI assigned that was assigned to your organization.
- Review the document titled "Internet-based PECOS – Getting Started Guide for Physicians and Non-Physician Practitioners." This document may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf*.

**Internet-based PECOS limitations:** While Internet-based PECOS supports most Medicare enrollment application actions, there are some limitations. A physician or nonphysician practitioner cannot use Internet-based PECOS for the following:

- Change his/her name or social security number
- Reassign benefits to another supplier if that supplier does not have an approved enrollment record in PECOS
- Change in nonphysician practitioner specialty type, or
- Change an existing business structure. For example:
  - A sole owner of an enrolled Professional Association, Professional Corporation, or LLC cannot change the business structure to a sole proprietorship, or
  - An enrolled sole proprietorship cannot be changed to a solely-owned Professional Association, Professional Corporation, or LLC.

**Finalizing submission and responding to development request:** After submitting an enrollment application via Internet-based PECOS, you:

- Must print, sign and date (blue ink recommend) the certification statement(s) and mail the certification statement(s) and supporting documentation to the appropriate Medicare contractor. The Medicare contractor will not begin to process your enrollment application until it receives a signed and dated certification statement.
- May be asked to make corrections or submitted additional documents by the Medicare contractor. In order for your application to be processed, you must submit this information.

**Reporting responsibilities:** Physicians and nonphysician practitioners enrolled in the Medicare program have reporting responsibilities. See the Download section for information about your reporting responsibilities at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

**More information:** For more information about Internet-based PECOS, including contact information for the External User Services (EUS) Help Desk, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll* and select the "Internet-based PECOS" tab on the left side of screen.

EUS Help Desk provides assistance physicians and nonphysician practitioners if they encounter an application navigation or systems problem with Internet-based PECOS. A navigation problem occurs when a practitioner is unable to determine how to use Internet-based PECOS.

Physicians and nonphysician practitioners who have problems with their user IDs or password should contact the NPI enumerator at 1-800-465-3203. ❖

Source: CMS PERL 201003-09

### 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 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/*.

## Medicare terminates drug plan contract with Fox Insurance Co.

### Members will be provided access to drugs while transitioning to new plans

The Centers for Medicare & Medicaid Services (CMS) has terminated its contract with Fox Insurance Co. After an onsite review of the plan and its services, CMS determined that the plan's significant deficiencies of not meeting Medicare's requirements to provide enrollees with prescription drugs according to recognized standards of care jeopardized the health and safety of Fox enrollees. CMS found that Fox committed a series of violations, including improperly denying its enrollees coverage of critical HIV, cancer, and seizure medications. The termination of the contract is effective immediately.

The immediate termination will not impact or delay access to drugs for the more than 123,000 Medicare beneficiaries currently enrolled in Fox plans. All enrollees will obtain their drugs through LI-NET, a program run by Medicare and administered by Humana, to ensure that beneficiaries receive their Medicare prescription drugs. Fox enrollees will be able to choose a new Medicare prescription drug plan through May 1, 2010. Medicare will enroll current enrollees who do not choose a plan into a new plan.

"The immediate termination of Fox as a Medicare prescription drug plan demonstrates our commitment to protecting the health of some of their most vulnerable enrollees from getting necessary drugs, in some cases life-sustaining medicines. CMS's immediate action was essential to protect members' health and safety – an integral part of our contract with all Medicare beneficiaries," said Jonathan Blum, acting director of CMS' Center for Drug and Health Plan Choices. "Fox enrollees also need to know that they are not losing their drug coverage and will continue to have access to needed medicines. We will be sending letters explaining the steps we are taking to ensure they continue to get their medicines. They may also call 1-800-MEDICARE or their local state health insurance assistance programs if they have questions."

CMS issued an enrollment and marketing sanction to Fox on Feb. 26, 2010, because the organization was not following Medicare rules for providing prescription drug coverage to its enrollees. After an onsite audit, which ran between March 2 and March 4, CMS found Fox's problems persisted and it continued to subject its enrollees to obstacles in getting needed and, in many cases, life-sustaining medicines. CMS also found that many of the obstacles were in place to limit access to high-cost drugs, which could have led to enrollees' clinical needs not being met. In many cases, Fox enrollees were required to have unnecessary and invasive medical procedures before they were able to obtain drugs. Fox was unable to satisfactorily address these compliance concerns and furnish medicines to its Medicare enrollees.

Among the audit findings, CMS found include:

- Failing to provide access to Medicare prescription drugs benefits by imposing unapproved prior authorization and step therapy criteria that made it more difficult for beneficiaries to get drugs that are protected by law.
- Failing to meet the appeal deadlines established for the plan.
- Failing to comply with Medicare regulations requiring enrollees to be transitioned to new drugs at the beginning of the new plan year.
- Failing to notify enrollees about prior authorization and step therapy determinations as required by Medicare.

According to CMS auditors, Fox was unable to address satisfactorily compliance concerns cited in the enrollment and marketing sanction and meet contractual obligations to provide medicines to Medicare beneficiaries enrolled in their plans.

"We take our oversight role of Medicare prescription drug plans seriously," said Blum. "We review and take action on all complaints received about Medicare health and drug plans and will take appropriate and immediate actions wherever necessary."

CMS encourages Medicare prescription-drug plan enrollees having concerns with access to drug coverage to contact 1-800-MEDICARE (1-800-633-4227) or the state health insurance assistance program (SHIP) to help get them resolved. Medicare enrollees, their families and their caregivers can contact a SHIP near them by visiting *http://www.medicare.gov/Contacts/staticpages/ships.aspx*.

**Note:** States in which the Fox plan was available were: Arkansas, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Missouri, North Carolina, New Jersey, New York, Nevada, Ohio, Pennsylvania, South Carolina, Texas, and West Virginia. ❖

Source: CMS PERL 201003-23

## Correction to processing of noncovered revenue codes

*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 MM6774 to reflect revisions to change request (CR) 6774. The CR release date, transmittal number, and the Web address for accessing CR 6774 were revised. All other information remains the same. The *MLN Matters* article MM6774 was published in the February 2010 *Medicare A Bulletin* (pages 5-6).

### Provider types affected

All providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], and A/B Medicare administrative contractors [MAC]) for Medicare beneficiaries are affected.

*Correction to processing of noncovered revenue codes (continued)*

## Provider action needed

This article, based on CR 6774, explains that claims containing an institutional service line submitted with a revenue code that is not valid for Medicare billing will only be returned to the provider if the line is submitted with covered charges or the claim indicates that beneficiary liability may apply. Affected providers should ensure that their billing staffs are aware of these changes that are effective for claims processed on or after July 6, 2010.

## Background

In October 2004, the Centers for Medicare & Medicaid Service (CMS) issued Transmittal 332, Change Request (CR) 3416, entitled "New Policy and Refinements on Billing Non-covered Charges to Fiscal Intermediaries (FIs)." This transmittal completed a series of instructions that established requirements for processing noncovered charges on institutional claims and for correctly assigning financial liability for noncovered charges. One underlying premise of those instructions was that any institutional provider should be able to submit a claim line with noncovered charges for any service that the provider delivered and that Medicare systems should process that noncovered line to completion without payment. This premise is consistent with the goals of administrative simplification and increasing automated coordination of benefits across various payers.

Those instructions contained one significant omission in that they did not take into account the fact that Medicare systems currently determine whether a particular revenue code is valid for Medicare billing without regard to whether the revenue code line is submitted as noncovered. Each Medicare contractor that processes institutional claims maintains a revenue code file which lists the revenue codes that are valid for each type of bill. If a provider submits a claim with a revenue code that is not listed on the revenue code file as valid for the submitted type of bill, the claim is returned to the provider. This should happen when the revenue code line is submitted with covered charges, but the claim should not be returned if it is submitted entirely with noncovered charges.

Medicare systems will be changed so that a revenue code line submitted with entirely noncovered charges and no indication that beneficiary liability may apply will not be returned to the provider. Such claims should be processed to completion without payment, assigning liability to the provider. CR 6774 revises Medicare systems to ensure this outcome. CR 6774 also contains miscellaneous clarifications to Chapter 1, General Billing Requirements, in the Medicare Claims Processing Manual and those clarifications, which do not change any Medicare policies, are attached to CR 6774.

## Additional information

The official instruction, (CR 6774), issued to your Medicare contractor regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1928CP.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: MM6774 – Revised
Related Change Request (CR) Number: 6774
Related CR Release Date: March 5, 2010
Related CR Transmittal Number: R1928CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1928, CR 6774

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# Point-of-origin for admission or visit codes update to the UB-04 (CMS-1450) manual code list

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6801 to reflect revisions to change request (CR) 6801. Reference to article MM6757 was added to the table. In addition, the CR transmittal number, release date, and the Web address for accessing CR 6801 were revised. All other information remains the same. The *MLN Matters* article MM6801 was published in the February 2010 *Medicare A Bulletin* (pages 4-5).

## Provider types affected

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

## Provider action needed

### STOP – impact to you

This article is based on change request (CR) 6801, which updates the point-of-origin for admission or visit codes to the UB-04 (CMS-1450) manual code list.

### CAUTION – what you need to know

The following point-of-origin for admission or visit (formerly source of admission) codes (discontinued by the National Uniform Billing Committee (NUBC)) will be discontinued for use by Medicare systems: '7' – discontinued effective July 1, 2010; 'B' – discontinued effective July 1, 2010; and 'C' – discontinued effective July 1, 2010. In addition, point of origin

***Point-of-origin for admission or visit codes update to the UB-04 (CMS-1450) manual code list (continued)***

for admission or visit code '1' example and definition language has been updated, though the processing of code '1' is not being changed. Also, point of origin for admission or visit code '2' definition language has been updated, though the processing of code '2' is not being changed.

### GO – what you need to do

Be sure billing staff are aware of these changes.

## Background

The Centers for Medicare & Medicaid Services (CMS) health insurance claim Form UB-04 and its electronic equivalence has a required field (form locator [FL] 15) on all institutional inpatient claims and outpatient registrations for diagnostic testing services. FL 15 indicates the point of patient origin for the admission or visit of the claim being billed.

The point of origin for admission or visit (formerly source of admission) codes '7', 'B', and 'C' (discontinued by the National Uniform Billing Committee (NUBC)) will be discontinued for use by the fiscal intermediary standard system (FISS) effective July, 1, 2010. In addition, Point of Origin for Admission or Visit code '1' example and definition language has been updated (the processing of code '1' is not being changed), and Point of Origin for Admission or Visit code '2' definition language has been updated (the processing of code '2' is not being changed). These revisions are shown in the following table:

### Form locator (FL) 15 – point of origin for admission or visit

**Required:** The provider enters the code indicating the source of the referral for this admission or visit.

| Code structure: | | |
|---|---|---|
| **1** | **Non-health care facility point of origin** (physician referral)<br>**Effective July 1, 2010:**<br>**Non-health care facility point of origin**<br>**Usage note:** Includes patients coming from home, a physician's office, or workplace.<br>**Effective July 1, 2010**<br>Examples: Includes patients coming from **home or workplace.** | **Inpatient:** The patient was admitted to this facility upon an order of a physician.<br>**Effective July 1, 2010:**<br>**Inpatient:** The patient was admitted to this facility. |
| | | **Outpatient:** The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). It includes non-emergent self-referrals.<br>**Effective July 1, 2010:**<br>**Outpatient:** The patient presented to this facility for outpatient services. |
| **2** | Clinic or physician's office | **Inpatient:** The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.<br>**Effective July 1, 2010:**<br>**Inpatient:** The patient was admitted to this facility. |
| | | **Outpatient:** The patient was referred to this facility for outpatient or referenced diagnostic services.<br>**Effective July 1, 2010**<br>**Outpatient:** The patient presented to this facility for outpatient services. |
| **7** | Emergency room (ER) | **Inpatient:** The patient was admitted to this facility after receiving services in this facility's emergency room department.<br>**Discontinued July 1, 2010** |
| **B** | Transfer from another home health agency | The patient was admitted to this home health agency as a transfer from another home health agency.<br>**Discontinued July 1, 2010. See condition code 47 as discussed in the article on the CMS Web site at** *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6757.pdf*. |
| **C** | Readmission to same home health agency | The patient was readmitted to this home health agency within the same home health episode period.<br>**Discontinued July 1, 2010. See condition code 47 as discussed in the article on the CMS Web site at** *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6757.pdf*. |

*Point-of-origin for admission or visit codes update to the UB-04 (CMS-1450) manual code list (continued)*

### Additional information

The official instruction, CR 6801, issued to your 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/R1929CP.pdf*.

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

*MLN Matters*® Number: MM6801 – Revised
Related Change Request (CR) Number: 6801
Related CR Release Date: March 9, 2010
Related CR Transmittal Number: R1929CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1929, CR 6801

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

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6563 to reflect revisions to change request (CR) 6563. The CR release date, transmittal number, and the Web address for accessing CR 6563 were revised. All other information remains the same. The *MLN Matters* article MM6563 was published in the January 2010 *Medicare A Bulletin* (pages 14-15).

### Provider types affected

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

### What you need to know

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

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

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

### Background

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

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

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

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

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

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

### Modifier GA

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

### Modifier GX

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

  **Modifier EY** – no doctor's order on file

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

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

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

  **Modifier QL** – patient pronounced dead after ambulance is called

  **Modifier TQ** – basic life support transport by a volunteer ambulance provider
- Medicare systems will automatically deny lines (using claim adjustment reason code 50) submitted with the **modifier GX** and noncovered charges, and will assign beneficiary liability to claims automatically denied when the **modifier GX** is present.

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

## Additional information

You may find more information about billing for services related to voluntary uses of advance beneficiary notices of noncoverage by going to CR 6563, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1921CP.pdf*.

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

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

*MLN Matters*® Number: MM6563 – Revised
Related Change Request (CR) Number: 6563
Related CR Release Date: February 19, 2010
Related CR Transmittal Number: R1921CP
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1921, CR 6563

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### 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.

# Implementation of home health agency program safeguard provisions

*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 MM6750 to reflect revisions to change request (CR) 6750 to include this note that clarifies that the new requirements are effective for CMS-855A applications received on or after 1, 2010. Applications received prior to January 1, 2010, will be handled in accordance with the policies in place prior to January 1, 2010. All other information remains the same. The *MLN Matters* article MM6750 was published in the January 2010 *Medicare A Bulletin* (pages 16-17).

## Provider types affected

Home health agencies (HHAs) submitting claims to Medicare contractors (fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

## Provider action needed

This article is based on change request (CR) 6750, which implements two provisions from the home health agency (HHA) prospective payment system final rule (CMS-1560-F). The first provision requires an HHA whose Medicare billing privileges have been deactivated to undergo a state survey or obtain accreditation from a CMS-approved accrediting organization prior to having its billing privileges reactivated. The second provision holds that an HHA may not undergo a change of ownership or transfer of ownership if the effective date of the change or transfer occurs within 36 months of: (1) the effective date of the provider's enrollment in Medicare, or (2) the effective date of the last ownership change or transfer for the HHA. The provider must instead enroll as a new HHA, undergo a state survey or obtain accreditation from a CMS-approved accrediting organization, and sign a new provider agreement.

## Background

An "ownership change" includes any of the following:

- Change of ownership (CHOW)
- Acquisition/merger
- Consolidation
- Change request reporting a five percent or greater ownership change (including , stock transfer or asset sale), or
- Change request reporting a change in partners, regardless of the percentage of ownership involved.

If a Medicare contractor receives an application for an ownership change from an HHA, it will determine whether the effective date of the transfer is within 36 months of either the effective date of the provider's initial enrollment in Medicare or last ownership change. The Medicare contractor will verify the effective date of the ownership transfer by requesting a copy of the transfer agreement, sales agreement, bill of sale, etc., rather than relying upon the projected date of the sale listed on the application.

If the transfer date falls within the 36-month period after the effective date of the provider's enrollment in Medicare or last ownership change, the Medicare contractor will return the application and notify the provider that, per 42 CFR 424.550(b), the HHA must:

- Enroll as an initial applicant
- Obtain a new state survey or accreditation from a CMS-approved accrediting organization after it has submitted its initial enrollment application and the Medicare contractor has made a recommendation for approval to the state
- Sign a new provider agreement as part of the initial enrollment.

As the new owner must enroll as a new provider, the Medicare contractor will also deactivate the HHA's billing privileges if the sale has already occurred. If the sale has not occurred, the contractor will alert the HHA that it must submit a CMS-855A voluntary termination application (see on the CMS Web site *http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf*).

If the transfer date is more than 36 months after the effective date of the provider's enrollment in Medicare or most recent ownership change, the application may be processed normally, without the need for a new state survey or an approval from an approved accreditation organization.

## Additional information

The official instruction, CR 6750, issued to your 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/R318PI.pdf*.

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

*MLN Matters*® Number: MM6750 – Revised
Related Change Request (CR) Number: 6750
Related CR Release Date: December 18, 2009
Related CR Transmittal Number: R318PI
Effective Date: January 1, 2010
Implementation Date: January 1, 2010

Source: CMS Pub. 100-08, Transmittal 318, CR 6750

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# Electronic Health Records

## Electronic health records cooperative agreement awards

### The following is a message from Dr. David Blumenthal on advancing health information exchange

The Health Information Technology Agency announced on February 12 the first cooperative agreement awards authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act. It marks a major milestone in the journey towards nationwide adoption and meaningful use of health information technology (health IT). One set of awards provides $386 million to 40 states and qualified state-designated entities to rapidly build capacity for exchanging health information across the health care system both within and between states through the State Health Information Exchange Cooperative Agreement Program (*http://healthit.hhs.gov/portal/server.pt?open=512&objID=1488&mode=2*). The other awards provide $375 million to create 32 Health Information Technology Regional Extension Centers (RECs) (*http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&mode=2*)that will support the efforts of health professionals, starting with priority primary care providers, to become meaningful users of electronic health records (EHRs). Additional awards will be made in both programs over the coming weeks. Together, these programs will help modernize the use of health information, improving the quality and efficiency of care for all Americans.

As part of the State Health Information Exchange Cooperative Agreement Program, states will play a leadership role in achieving health information exchange (HIE) to meet health reform goals. The funds awarded will be used to establish and implement plans for statewide HIE by creating the appropriate governance, policies, and technical services required to support HIE. Developing this state-level capability will help us break down the current barriers to HIE and help providers to qualify for Medicare and Medicaid incentives under the HITECH Act. The awards will also strongly encourage states to consider participating in the Nationwide Health Information Network as an approach to HIE. This would create a pathway toward seamless, nationwide HIE.

While the state HIE awards will strengthen capacity for health information exchange, the Health Information Technology Extension Program awards will establish RECs to deliver direct outreach, education, and technical assistance services to health care providers in their regions. Each REC will focus most intensively on the physicians, physician assistants, and nurse practitioners who work as part of individual and small group primary care practices, as well as those who dedicate themselves to providing health care to the underserved. Primary care providers in small practices provide the great majority of such services in the U.S. but have limited resources to implement, meaningfully use, and maintain EHR systems. On-site technical assistance for these priority primary care providers will be a key service offered by the RECs. RECs will assist providers who have not adopted EHRs, as well as those who have but need help progressing to meaningful use. RECs will also help providers keep health information private and secure.

The Health Information Technology Extension Program and the State Health Information Exchange Cooperative Agreement Program  are critical components to the end of a nationwide interoperable, private and secure electronic health information system. I look forward to working in collaboration with each state and REC as they establish their programs, begin work within their communities, and promote the transformation of our health care system. I applaud each awarded entity for its dedication to the mission of improving the quality of health care and for the leadership and guidance it will provide.

Sincerely,

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

The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology.

Source: CMS PERL 201002-37

## Proposed rule for the certification programs for health information technology

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

On March 2, 2010, the Secretary of the Department of Health & Human Services (HHS) released a notice of proposed rulemaking (NPRM) outlining the proposed approach for establishing a certification program to test and certify electronic health records (EHRs). The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) mandates the development of a certification program that will give purchasers and users of EHR technology assurances that the technology and products have the necessary functionality and security to help meet meaningful use criteria.

While we are making significant strides toward modernizing our health-care system, these efforts will only succeed if providers and patients are confident that their health information systems are safe and functional.

The proposed rule incorporates two phases of development for the certification program to ensure that eligible professionals and eligible hospitals are able to adopt and implement certified EHR technology in time to qualify for meaningful use incentive payments. The rulemaking process will take time, so this phased approach provides a bridge to detailed guidelines to support an ongoing program of testing and certification of health IT.

The first proposed program creates a temporary certification process under which the national coordinator would authorize organizations to assume many of the responsibilities that will eventually be fulfilled under the permanent certification program. For the permanent certification program, the rule proposes transitioning much of the responsibility for testing and certification to organizations in the private sector.

Publication of the proposed rule on the Establishment of Certification Programs for Health Information Technology is an important first step in bringing structure and cohesion to the evaluation of EHRs, EHR modules, and potentially other types of health IT. The programs will help support end users of certified products, and ultimately serve the interests of each patient by ensuring that their information is securely managed and available where and when it is needed.

Your input is essential to bringing this important process to fruition. We encourage your participation in the open public comment period.

Additional information on both of these programs and how you can comment may be found through the HHS news release and at *http://HealthIT.HHS.Gov*.

The vision of the HITECH Act is unfolding rapidly, and all of us at ONC look forward to continuing to work with you to achieve the meaningful use of EHRs.

Sincerely,
David Blumenthal, M.D., M.P.P.

National Coordinator for Health Information Technology U.S. Department of Health & Human Services

Source: CMS PERL 201003-07

# Provider Satisfaction Survey

## Medicare contractor provider satisfaction survey information

### Attention fee-for-service providers and suppliers, have you responded?

The Centers for Medicare & Medicaid Services (CMS) wants to hear from you about your satisfaction with the services provided by the Medicare fee-for-service (FFS) contractor that processes and pays your Medicare claims. CMS is now conducting the fifth national administration of the Medicare contractor provider satisfaction survey (MCPSS). The results of this annual survey are used by CMS to monitor trends, improve contractor oversight, and increase efficiency of the Medicare program. The MCPSS provides contractors with more insight into their provider communities and allows them to make process improvements based on provider feedback.

In January, CMS notified approximately 30,000 Medicare FFS providers and suppliers that they were randomly selected to participate in the 2010 study. CMS urges all selected health care providers and suppliers to take a few minutes to complete and return this important survey.

CMS recognizes that each provider and supplier's time is limited; therefore, if you have been notified that you were selected to participate in this study and have not yet done so, we welcome you to designate a proxy who you believe to be the most knowledgeable person in your practice to answer the survey questions on your behalf. This person may be your management or billing personnel or other knowledgeable designee. You may designate a proxy to respond on your behalf by e-mailing the designated proxy's name, telephone number, mailing and e-mail addresses to SciMetrika (*mcpss@scimetrika.com*), the public health consulting firm, contracted by CMS to administer the MCPSS study. SciMetrika will then send survey instructions to the designee to facilitate a quick completion of the survey without interrupting your day-to-day operations.

***Medicare contractor provider satisfaction survey information (continued)***

If you prefer to personally respond to the survey questions yourself and no longer have your online survey tool access information or need help accessing the survey tool, please call the MCPSS Provider Helpline at 1-800-835-7012 or send an e-mail to *mcpss@scimetrika.com*. Someone on the MCPSS team will be happy to assist you.

The views of every health care professional asked to participate in the 2010 study are very important to the success of this study, as each one of you represents many other organizations that are similar in size, practice type, and geographical location. Please complete and return your survey today. CMS is waiting to hear from you.

**Note:** Only providers and suppliers already notified that they have been randomly selected to take part in the 2010 MCPSS may participate in this study. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

For more information about the MCPSS, please visit the CMS MCPSS Web site at *http://www.cms.hhs.gov/mcpss*, or read the CMS *MLN Matters* special edition article SE1005 featuring the survey at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf*. ❖

Source: CMS PERL 201003-30

## The Centers for Medicare & Medicaid Services needs your feedback

The Centers for Medicare & Medicaid Services (CMS) is conducting the fifth national administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey is designed to collect quantifiable data on providers' satisfaction with the performance of the Medicare fee-for-service (FFS) contractors that process and pay their Medicare claims. CMS conducts the MCPSS on an annual basis and uses the results for Medicare contractor oversight and process improvement initiatives.

In January, CMS notified approximately 30,000 Medicare FFS providers and suppliers that they had been randomly selected to participate in the 2010 MCPSS study. As representatives of the more than 1.5 million providers nationwide who serve Medicare beneficiaries across the country, these providers and suppliers have an opportunity to give CMS valuable feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor.

If you have been notified that you were selected to participate in this study and have not yet done so, CMS is listening and wants to hear from you. Please take a few minutes to go online and complete your survey via a secure online Internet survey tool. Responding online is a convenient, easy, and quick way to provide CMS with your feedback. Survey questionnaires may also be submitted by mail, secure fax, and over the telephone. The survey takes approximately 20 minutes to complete.

CMS has contracted with SciMetrika, a public health consulting firm, to administer this important survey and report statistical data to CMS. If you received notification that you were selected to participate in the MCPSS study and you no longer have your online survey tool access information or need help accessing the survey tool, please call the MCPSS Provider Helpline at 1-800-835-7012 or send an email to *MCPSS@scimetrika.com*.

**Note:** Only providers and suppliers notified that they have been randomly selected to take part in the 2010 MCPSS may participate in this study. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

For more information about the MCPSS, please visit the CMS MCPSS Web site at *http://www.cms.hhs.gov/mcpss*, or read the CMS MLN Matters special edition article featuring the survey at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf*.

**CMS urges you to please take a few moments to complete your survey today.** ❖

Source: CMS PERL 201002-43

### 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.

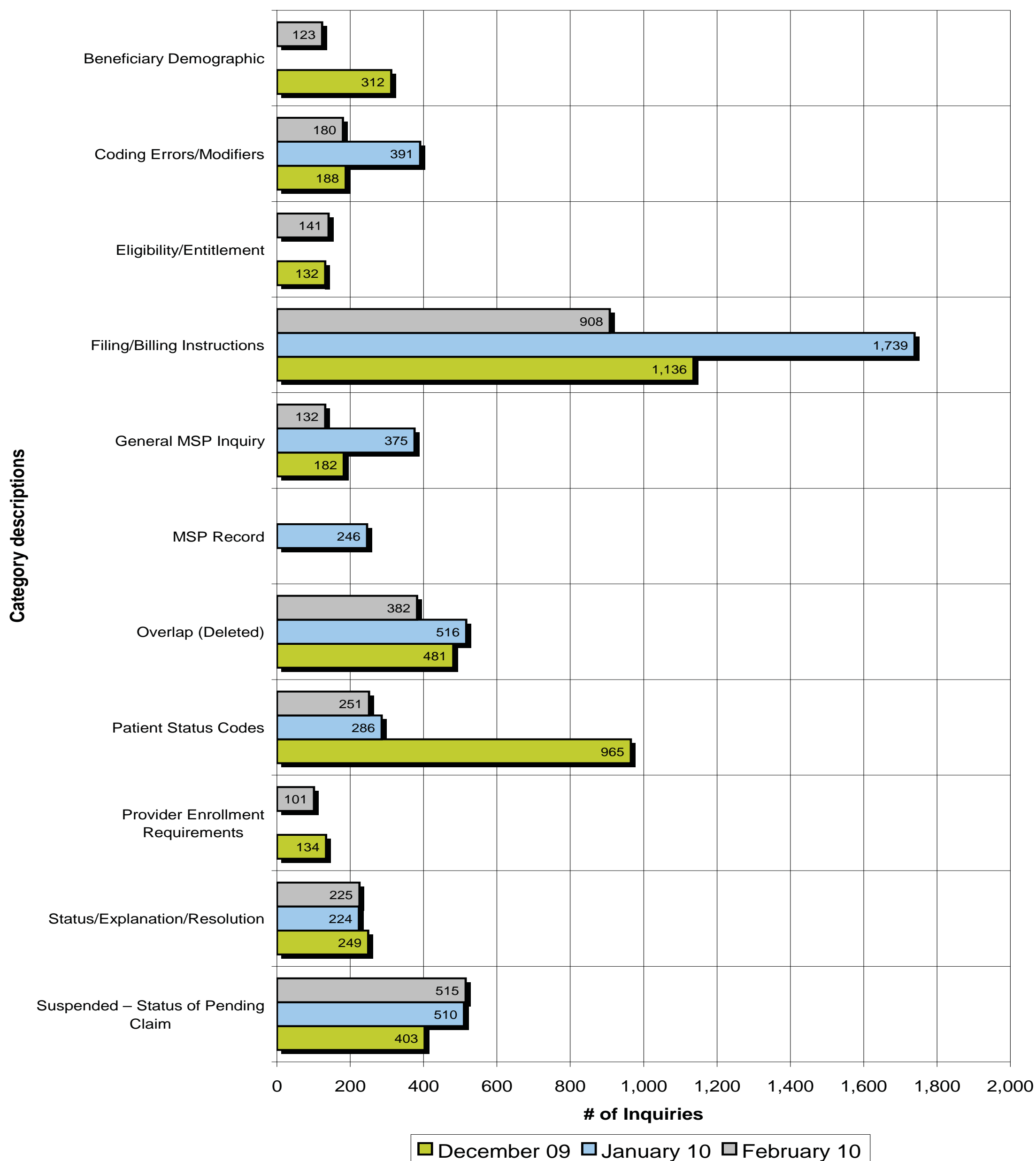
# Claim and Inquiry Summary Data

## Top inquiries, return to provider, and reject claims for December 2009-February 2010

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 December 2009-February 2010.

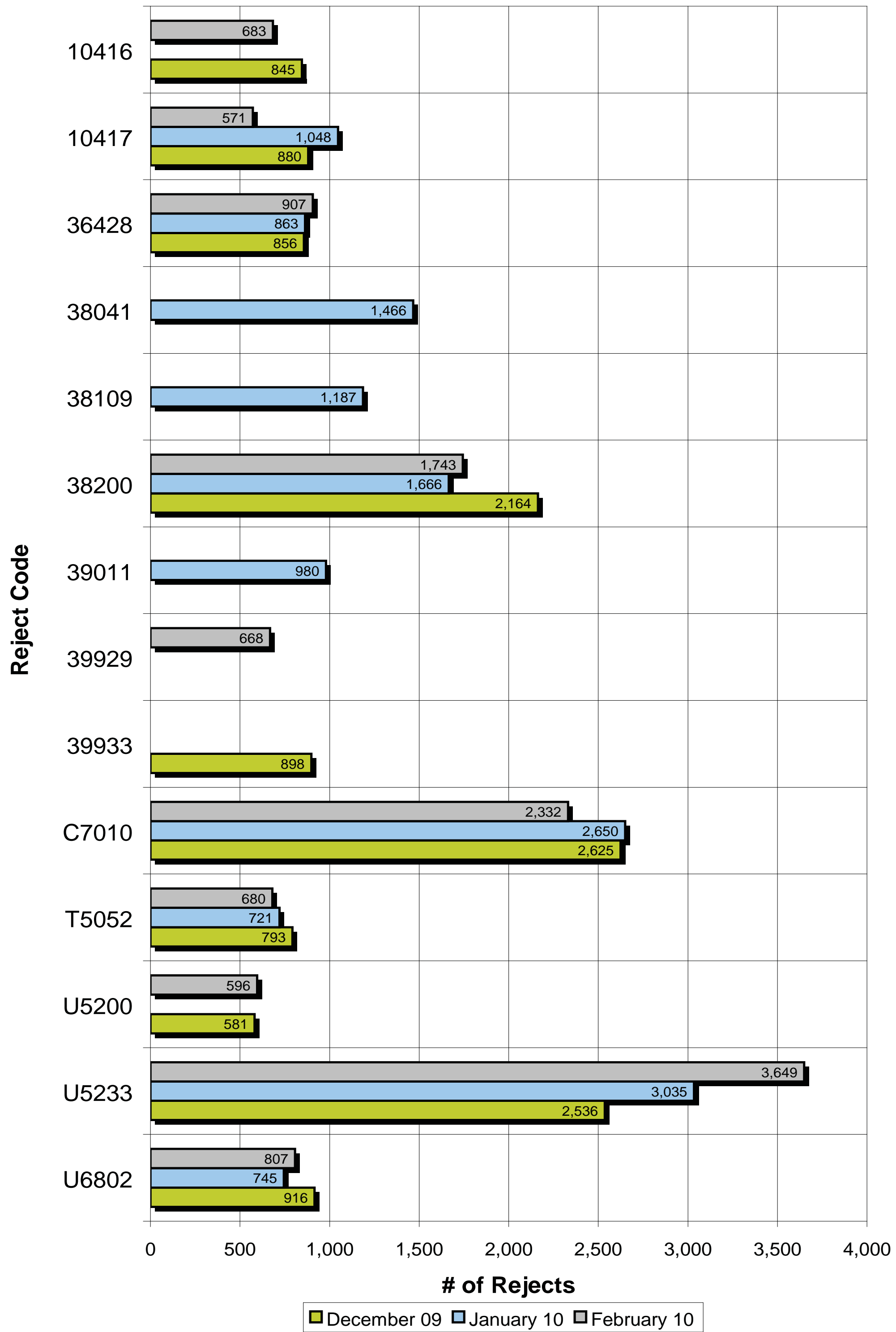
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

### Florida Part A top inquiries for December 2009-February 2010



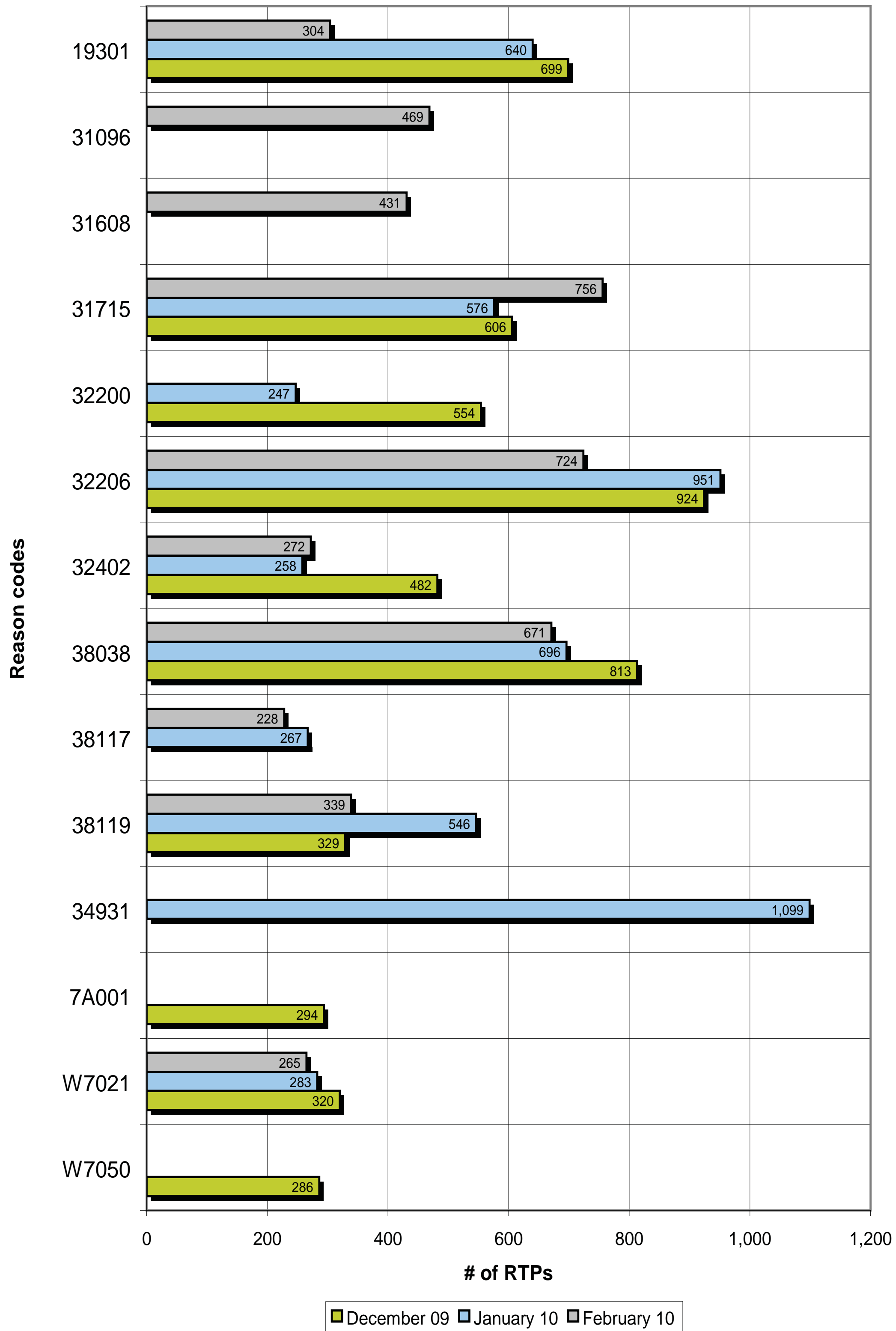
*Top inquiries, return to provider, and reject claims for December 2009-February 2010 (continued)*

## Florida Part A top rejects for December 2009-February 2010



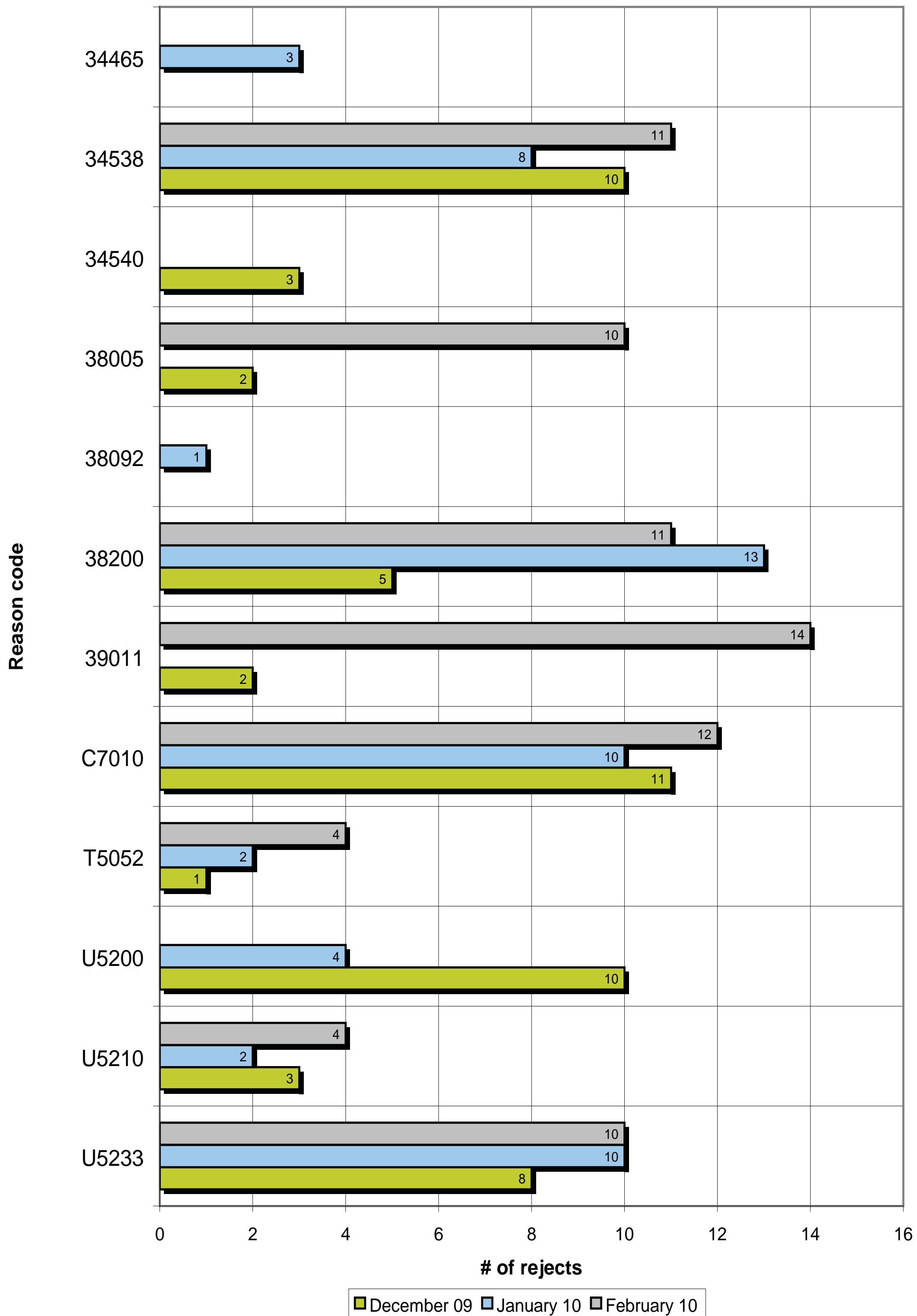
*Top inquiries, return to provider, and reject claims for December 2009-February 2010 (continued)*

## Florida Part A top return to providers (RTPs) for December 2009-February 2010



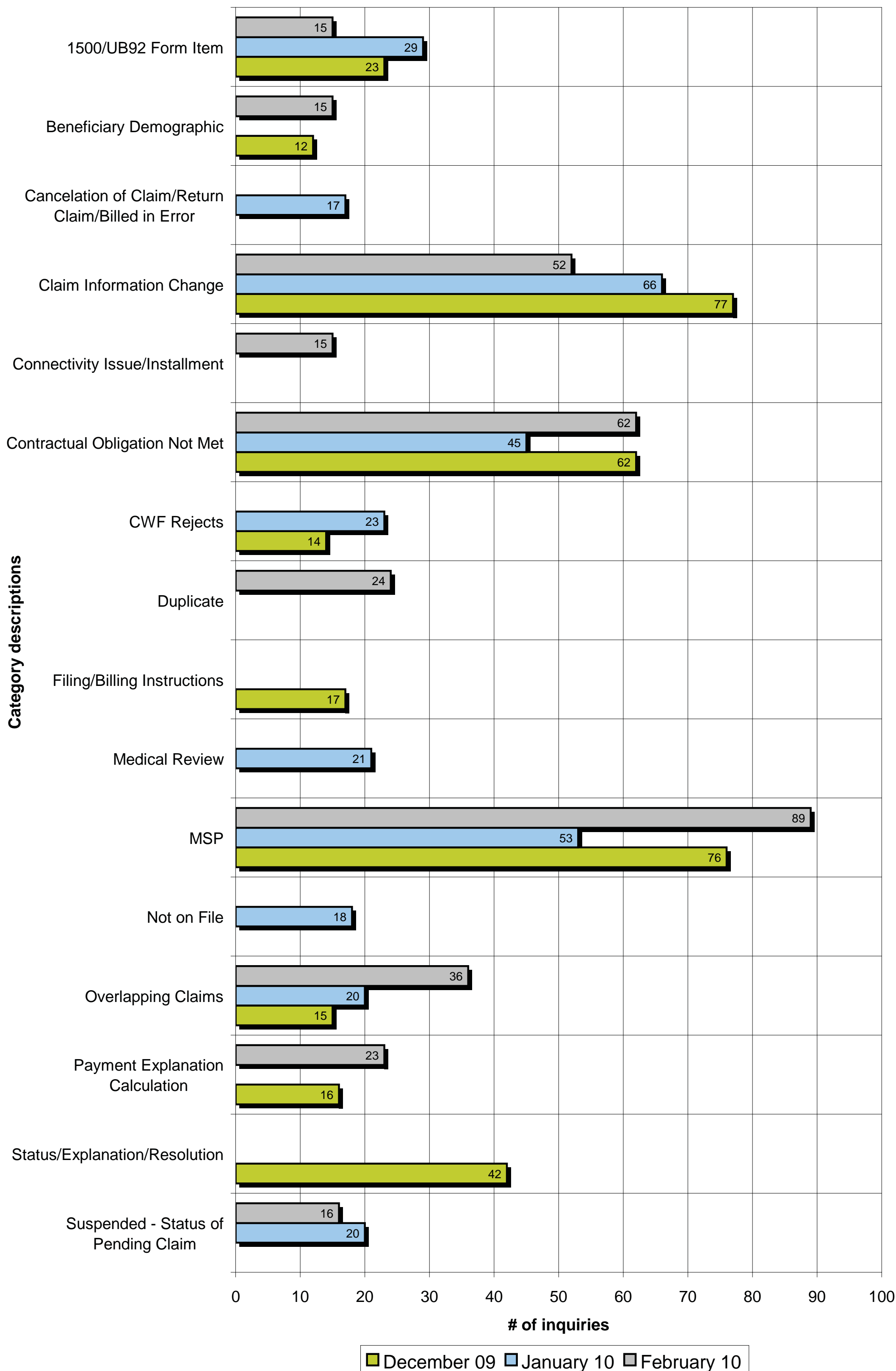
*Top inquiries, return to provider, and reject claims for December 2009-February 2010 (continued)*

## U.S. Virgin Islands Part A top rejects for December 2009-February 2010



*Top inquiries, return to provider, and reject claims for December 2009-February 2010 (continued)*

## Puerto Rico and U.S. Virgin Islands Part A top inquiries for December 2009-February 2010



# General Coverage

## Signature requirements for medical review purposes – guidelines for authentication of Medicare services

The Centers for Medicare & Medicaid Services (CMS) requires that any Medicare service provided or ordered must be **authenticated** by the author – the one who provided or ordered that service. Authentication may be accomplished through the provision of a hand-written or an electronic signature; however, stamp signatures are unacceptable.

In addition, any documentation submitted to substantiate the medical necessity for a service billed to Medicare must clearly identify the patient, date of service, and the provider of the service. The purpose of the authentication (signature) requirement is to ensure that the services rendered have been accurately and appropriately documented, reviewed, and authenticated.

### Summary of signature guidelines – acceptable forms of authentication

The following methods of authentication have been deemed **acceptable** by CMS:

- **Handwritten signature** – a mark or a sign placed on a medical document to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services specified in the medical entry. Requirements for this form of authentication are dependent upon whether the signature is considered legible or illegible.
    - **Legible signature** – acceptable forms of presentation:
        - Legible full signature
        - Legible first initial and last name
        - Initials placed above a typed or printed name
        - Initials *accompanied by a signature log* – lists the typed or printed name of the author associated with initials or an illegible signature. Signature logs may be included on the page where the initials or illegible signature is used, or it may be submitted as a separate document.
        - Initials *accompanied by an attestation statement* – must be signed and dated by the author of the medical record entry, must be associated with a specific medical entry, and must contain sufficient information to identify the beneficiary.

      **Note:** An unsigned handwritten note may be accepted as authentication when other entries on the same page are in the same handwriting and have been signed.
    - **Illegible signature** – acceptable forms of presentation:
        - Illegible signature placed above a typed or printed name
        - Illegible signature where the letterhead, addressograph, or other information on the page indicates the identity of the individual who signed the entry. For example, the provider's name could be circled to indicate the identity of the individual who signed the entry.
        - Illegible signature *accompanied by a signature log* – lists the typed or printed name of the author associated with initials or an illegible signature. Signature logs may be included on the page where the initials or illegible signature is used, or it may be submitted as a separate document.
        - Illegible signature *accompanied by an attestation statement* – must be signed and dated by the author of the medical record entry, must be associated with a specific medical entry, and must contain sufficient information to identify the beneficiary.
- **Electronic signatures** – an electronic sound, symbol, or process attached to or logically associated with an electronic medical record to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services specified in the medical entry.
    - Electronic signatures must be authenticated, safeguarded against misuse and modification, and should be easily identifiable as electronic, rather than typewritten, signatures.
    - As the individual represented by the electronic signature bears responsibility for the authenticity of the information, physicians are strongly encouraged to check with their attorneys and malpractice insurers regarding the use of alternative signature methods.

### Summary of signature guidelines – unacceptable forms of authentication

The following methods of authentication have been deemed **unacceptable** by CMS and may result in a comprehensive error rate testing (CERT) findings:

- Unsigned, typed note with provider's typed name.
- Unsigned, typed note without provider's typed name
- Unsigned, handwritten note (only entry on the page)

*Signature requirements for medical review purposes – guidelines for authentication of Medicare services (continued)*

- Illegible signature that is not placed above a typed or printed name
- Illegible signature that is not identified in a letterhead or addressograph
- Illegible signature that is not accompanied by a signature log or attestation statement
- Stamp signature
- "Signature on file"

### Summary of signature guidelines – 20-day timeframe documentation requests

If a claim reviewer requests an attestation statement or a signature log to authenticate a medical record, the organization that billed the claim **must** submit the documentation to the requestor **within 20 calendar days.**

The **20-day timeframe begins when:**

- The reviewer makes actual phone contact with the provider, **or**
- The reviewer's request letter is received by the U.S. post office

### Signature requirements – exceptions

- **Certification of terminal illness for hospice** – a facsimile of an original written or electronic signature is an acceptable form of authentication for certification of terminal illness for hospice.
- **Orders for clinical diagnostic tests** – an unsigned order for a clinical diagnostic test that is accompanied by signed medical documentation that demonstrates the treating physician's intent for the test to be performed is an acceptable form of authentication for the test.

**Note:** Other regulations and CMS instructions regarding signature requirements, such as timeliness standards for particular benefits, take precedence over the guidelines listed above. In cases where the relevant regulation, coverage determination, or CMS manual outlines specific signature requirements (e.g., signatures on plans of care must be signed before those services are rendered), those signature requirements will take precedence.

### e-Prescribing (eRx) signature requirements

Electronic prescribing is the transmission of prescription or prescription-related information through electronic media. Health care professionals can electronically transmit new prescriptions as well as responses to renewal requests directly to a pharmacy through a qualified eRx system, which eliminates the necessity for writing or faxing prescriptions for non-controlled substances.

**Note:** CMS defines a "qualified eRx system" as one that meets the Medicare Part D requirements described in Standards for Electronic Prescribing (42 CFR 423.160 [http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms0018ifc.pdf#page=4]).

- **e-Prescribing for Part B drugs: Non-controlled substances** – if a provider submits an order for a non-controlled substance through a qualified eRx system, the provider is not required to produce a signed hardcopy as evidence to substantiate the drug order.
- **e-Prescribing for Part B drugs: Controlled substances** – the Drug Enforcement Agency (DEA) does not permit the prescribing of controlled substances through e-Prescribing systems; therefore, only a signed (pen and ink) hardcopy of the prescription will be accepted as evidence to substantiate a drug order for controlled substances.

**Note:** CMS outlines signature requirements for medical documentation as well as exceptions to the guidelines in the Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1.

Source: CMS Pub. 100-08, Transmittal 327, CR 6698

## Percutaneous transluminal angioplasty of the carotid artery concurrent with stenting

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

### Provider types affected

Physicians and providers who may wish to submit claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for percutaneous transluminal angioplasty (PTA) with stenting of the carotid arteries are affected.

### Provider action needed

This article is based on change request (CR) 6839 which announces that for claims with dates of service on and after December 9, 2009, contractors will be aware that there is revised language specific to embolic protection devices (EPDs) for PTA concurrent with carotid artery stenting (CAS) system placement in Food and Drug Administration (FDA)-approved post-approval studies, and PTA concurrent with CAS system placement in patients at high risk for carotid endarterectomy. The revised language specific to EPDs is located in Pub. 100-03, national coverage determination (NCD) 20.7.B.3 and 20.7.B.4, and Pub. 100-04, Chapter 32, Section 160. Make sure your billing staff is aware of the revised language.

### Background

Under the previous NCD policy, patients at high risk for carotid endarterectomy (CEA) who have symptomatic carotid artery stenosis equal to or greater than 70 percent are covered for procedures performed using FDA-approved CAS systems with EPDs in facilities approved by the Centers for Medicare & Medicaid Services (CMS) to perform CAS procedures.

***Percutaneous transluminal angioplasty of the carotid artery concurrent with stenting (continued)***

In addition, patients at high risk for CEA with symptomatic carotid artery stenosis between 50 percent and 70 percent and patients at high risk for CEA with asymptomatic carotid artery stenosis equal to or greater than 80 percent are covered in accordance with the category B investigational device exemption (IDE) clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (*Medicare National Coverage Determinations (NCD) Manual* 310.1), or in accordance with the NCD on CAS post-approval studies (*Medicare National Coverage Determinations (NCD) Manual* 20.7B). If deployment of the EPD is not technically possible, then the procedure should be aborted given the risks of CAS without distal embolic protection.

### Policy

CMS internally generated a reconsideration of Section 20.7B4 of the *Medicare National Coverage Determinations (NCD) Manual*. CMS made no changes in the covered patient groups for PTA of the carotid artery concurrent with stenting, but slightly revised the language regarding EPDs. In the final decision, effective December 9, 2009, CMS retained existing coverage for the following with a slight revision to the language regarding EPDs:

- For patients who are at high risk for CEA and who also have symptomatic carotid artery stenosis equal to or greater than 70 percent, coverage is limited to procedures performed using FDA-approved CAS systems and FDA-approved or FDA-cleared EPDs.
- For patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50 percent and 70 percent, in accordance with the category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (*Medicare National Coverage Determinations (NCD) Manual* 310.1), or in accordance with the NCD on CAS post-approval studies (*Medicare National Coverage Determinations (NCD) Manual* 20.7B), coverage is limited to procedures performed using FDA-approved CAS systems and FDA-approved or FDA-cleared EPDs. (If deployment of the EPD is not technically possible, and not performed, then the procedure is not covered.).
- For patients who are at high risk for CEA and have asymptomatic carotid artery stenosis equal to or greater than 80 percent, in accordance with the category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (*Medicare National Coverage Determinations (NCD) Manual* 310.1), or in accordance with the NCD on CAS post-approval studies (*Medicare National Coverage Determinations (NCD) Manual* 20.7B), coverage is limited to procedures performed using FDA-approved CAS systems and FDA-approved or FDA-cleared EPDs.

The use of an FDA-approved or cleared EPD is required. If deployment of the EPD is not technically possible and not performed, then Medicare does not cover the procedure.

**Note:** This CR does not require new or revised claims processing instructions.

### Additional information

For complete details regarding this CR, please see the official instruction (CR 6839) issued to your Medicare carrier, FI, or A/B MAC on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1925CP.pdf*.

The CAS facilities "approved facilities" Web site link in Publication 100-03, The *National Coverage Determinations Manual*, may be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp*.

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

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Related CR Release Date: March 5, 2010
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Source: CMS Pub. 100-04, Transmittal 1925, CR 6839

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## CPT/HCPCS codes to avoid rejections/denials due to gender/procedure conflict

As a result of transgender and hermaphrodite issues, Medicare Part A and Part B claims have encountered an increase in claims being rejected/denied due to gender specific diagnosis and procedure edits.

Effective for dates of service on and/or after April 1, 2010, change request (CR) 6638 instructs the following:

**Part A claims:** Institutional providers must report **condition code 45** (Ambiguous gender category) on inpatient or outpatient services that may be subjected to gender specific editing (i.e., services that are considered female or male only) for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

**Part B claims:** Physicians and nonphysician practitioners billing Part B professional claims must bill **modifier KX** (Requirements specified in the medical policy have been met) on the detail line with any procedure code(s) that are gender specific for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

***CPT/HCPCS codes to avoid rejections/denials due to gender/procedure conflict (continued)***

### Gender specific CPT/HCPCS codes

To assist providers in decreasing the number of rejections/denials, First Coast Service Options has identified gender specific *CPT*/HCPCS codes that the Medicare processing systems will denied/reject for services processed on or after April 5, 2010. The common working file error codes are also indicated:

| Mammography (error codes 59x5 and 5361) | | | | | | |
|---|---|---|---|---|---|---|
| *76083* | *76085* | *76092* | *77052* | *77057* | G0202 | G0203 |

| PAP smear (error codes 84x1 and 536a) | | | | | | |
|---|---|---|---|---|---|---|
| G0123 | G0124 | G0141 | G0143 | G0144 | G0145 | G0147 |
| G0148 | P3000 | P3001 | Q0091 | Q0060 | Q0061 | |

| Pelvic/breast exam (error code 84x4) |
|---|
| G0101 |

| Prostate screen (error codes 84x6 and 5388) | | | | |
|---|---|---|---|---|
| *55873* | G0102 | G0103 | G0160 | G0161 |

Source: CMS Pub. 100-04, Transmittal 1877, CR 6638

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## Questions and answers on reporting physician consultation services

*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 initial evaluation and management (E/M) services previously reported by *Current Procedural Terminology (CPT)* consultation codes for Medicare beneficiaries and submitted claims to Medicare carriers and/or Medicare administrative contractors (MACs) for those services. It is also intended for method II critical access hospitals, which bill for the services of those physicians and NPPs who have reassigned their billing rights, and hospices where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice.

**This article only applies to the services of physicians and NPPs paid under the Medicare fee-for-service (FFS) program. It does not revise existing policies or rules governing Medicare Advantage or non-Medicare insurers. Physicians, NPPs, method II critical access hospitals, and hospices to which the revised policy applies are subsequently referred to as providers throughout this publication.**

### Provider action needed

This article pertains to change request (CR) 6740, which alerts providers that effective January 1, 2010, the *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 must report each E/M service, including visits that could be described by *CPT* consultation codes, with an E/M code payable under the Medicare physician fee schedule (MPFS) that represents **where** the visit occurs and that identifies the **complexity** of the visit performed.

### Background

In the calendar year (CY) 2010 MPFS final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the payment of all *CPT* consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation HCPCS G-codes. The change does not increase or decrease Medicare payments. In the case of *CPT* codes for E/M services that may be reported in CY 2010 for E/M services previously paid by the *CPT* 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 Publication 100-4, Chapter 12, Section 30.6 of the *Medicare Claims Processing Manual* 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.)

*Questions and answers on reporting physician consultation services (continued)*

## Questions and answers

The following questions and answers are offered to address some of the key questions you may have regarding these changes:

Q. When will providers and Medicare contractors stop reporting and paying the *CPT* consultation codes for consultative E/M services that could be described by the *CPT* consultation codes?

A. Medicare ceased recognizing the *CPT* consultation codes for payment effective for services furnished on or after January 1, 2010.

Q. Does this policy apply to other Medicare products, such as Medicare Advantage?

A. This policy applies to providers billing the Medicare fee-for-service program. If a provider is furnishing an E/M service that could be described by a *CPT* consultation code to a Medicare Advantage patient, the provider should contact the Medicare Advantage plan for its policy.

Q. Is CMS going to crosswalk the *CPT* consultation codes that are no longer recognized to the E/M codes for each setting in which an E/M service that could be described by a *CPT* consultation code may be furnished?

A. No, providers must bill the E/M code (other than a *CPT* consultation code) that describes the service they provide in order to be paid for the E/M service furnished. The general guideline is that the provider should report the most appropriate available code to bill Medicare for services that were previously billed using the *CPT* consultation codes. For services that could be described by inpatient consultation *CPT* codes, CMS has stated that providers may bill the initial hospital care service *CPT* codes and the initial nursing facility care *CPT* codes, where those codes appropriately describe the level of service provided. When those codes do not apply, providers should bill the E/M code that most closely describes the service provided.

Q. How should providers bill for services that could be described by *CPT* inpatient consultation codes *99251-99252*, the lowest two of five levels of the inpatient consultation *CPT* codes, when the minimum key component work and/or medical necessity requirements for the initial hospital care codes *99221-99223* are not met?

A. There is not an exact match of the code descriptors of the low level inpatient consultation *CPT* codes to those of the initial hospital care *CPT* codes. For example, one element of inpatient consultation *CPT* codes *99251* and *99252*, respectively, requires "a problem focused history" and "an expanded problem focused history." In contrast, initial hospital care *CPT* code *99221* requires "a detailed or comprehensive history."

Providers should consider the following two points in reporting these services. First, CMS reminds providers that *CPT* code *99221* may be reported for an E/M service if the requirements for billing that code, which are greater than *CPT* consultation codes *99251* and *99252*, are met by the service furnished to the patient. Second, CMS notes that subsequent hospital care *CPT* codes *99231* and *99232*, respectively, require "a problem focused interval history" and "an expanded problem focused interval history" and could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by *CPT* consultation code *99251* or *99252*.

Q. How will Medicare contractors handle claims for subsequent hospital care *CPT* codes that report the provider's first E/M service furnished to a patient during the hospital stay?

A. While CMS expects that the *CPT* code reported accurately reflects the service provided, CMS has instructed Medicare contractors to not find fault with providers who report a subsequent hospital care *CPT* code in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Q. How will more reporting of initial hospital care *CPT* codes instead of *CPT* consultation codes affect the review of claims by Medicare contractors?

A. CMS has alerted MAC audit staff as well as Medicare recovery audit contractors of its expectation that physicians may bill more E/M codes for initial hospital care in place of billing inpatient CPT consultation codes.

CMS has also alerted contractors to expect a different proportion of various initial hospital care *CPT* codes under the new policy. CMS expects contractors to consider that these may be appropriate changes when making decisions about whether to pursue medical review and other types of claims review.

Q. How should providers bill for E/M services that cannot be described by any *CPT* E/M code that is payable by Medicare?

A. These services must be reported with *CPT* code *99499* (*Unlisted evaluation and management service*). Reporting *CPT* code *99499* requires submission of medical records and contractor manual medical review of the service prior to payment, and CMS expects reporting of this E/M code to be unusual.

Q. Because *CPT* consultation codes are no longer recognized by CMS for payment, is the definition of transfer of care no longer relevant?

A. Yes, CMS agrees that discontinuing recognition of the *CPT* consultation codes for payment renders the issues regarding the definition of what constitutes a transfer of care no longer relevant.

Q. When is it appropriate for providers to report critical care services in the context of furnishing an E/M service that could be described by a *CPT* consultation code?

A. Providers should continue to follow the existing *CPT* guidelines for reporting critical care codes.

*Questions and answers on reporting physician consultation services (continued)*

Q. What constitutes a new versus an established patient? Can a provider bill an office/outpatient new patient visit code and/or an initial hospital-care service code for a patient seen within the past three years but for a new problem?

A. The rules with respect to new and established patient office visits are unchanged. Providers should follow the guidance in Publication 100-04, Chapter 12, Section 30.6.7 of the *Medicare Claims Processing Manual*:

> Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a three-year period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an X-ray or EKG, etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

Q. Will Medicare contractors accept the *CPT* consultation codes when Medicare is the secondary payer?

A. Medicare will also no longer recognize the *CPT* consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, providers must bill an appropriate E/M code for the E/M services previously reported and paid using the *CPT* consultation codes. If the primary payer for the service continues to recognize *CPT* consultation codes for payment, providers 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 *CPT* 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.

Q. Can a provider provide an advance beneficiary notice (ABN) to the beneficiary and then bill his or her charge for the consultation after the consultation is billed and denied by Medicare?

A. No, when a *CPT* consultation code is reported to Medicare, the claim is not denied. Instead, the claim is returned to the provider for a different *CPT* code because Medicare recognizes another code for payment of E/M services that may be described by *CPT* consultation codes. Once the claim is resubmitted to report an appropriate, payable E/M code (other than a *CPT* consultation code) for a medically reasonable and necessary E/M service, the beneficiary can only be billed any applicable Medicare deductible and coinsurance amounts that apply to the covered E/M service.

Q. Can a provider who furnished an E/M service that could be described by a *CPT* consultation code to a Medicare beneficiary bill the beneficiary for his or her charge for the service after providing an ABN?

A. No, an ABN cannot be employed in these circumstances, because ABNs are applicable only where denial of payment is anticipated on grounds of the medical necessity requirement under section 1862(a)(1)(A) of the Social Security Act. E/M services previously reported using CPT consultation codes may be medically reasonable and necessary. *CPT* consultation codes *99241-99245* and *99251-99255* are now assigned status indicator "I," which means that these codes are not valid for Medicare purposes, and explicitly provides that "Medicare uses another code for the reporting of, and payment for these services."

Q. Can providers count floor/unit time toward the time threshold that must be met to bill a prolonged service with direct (face-to-face) patient contact in the inpatient setting?

A. 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, Section 30.6.15.1.C, provides that providers may count only the duration of direct face-to-face contact between the provider 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.

Q. Can a new patient office visit *CPT* code be billed to report an E/M service that could be described by a *CPT* consultation code when a patient is seen for a pre-operative consultation at the request of a surgeon, even if the consulting provider has provided a professional service to the beneficiary within the past three years?

A. Publication 100-04, Chapter 12, Section 30.6.7 of the *Medicare Claims Processing Manual* states:

> "Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.
> For example, if a professional component of a previous procedure is billed in a three-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an X-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient."

CMS has not adopted any revisions to the previous policies, regarding the billing of E/M codes as a result of the new policy on *CPT* consultation codes (other

***Questions and answers on reporting physician consultation services (continued)***

than allowing providers who would previously have billed the inpatient *CPT* consultation codes to bill the initial hospital and nursing home visit *CPT* codes where those codes appropriately describe the services furnished). Therefore, the requirements of Publication 100-04, Chapter 12, Section 30.6.7.A of the *Medicare Claims Processing Manual* remain in effect. In the situation where a patient is seen for a pre-operative consultation when the consulting provider has furnished a professional service to the beneficiary in the past three years, that provision precludes the provider from billing a new patient office visit *CPT* code.

Q. When may initial nursing facility (NF) care codes be reported for E/M services that could be described by CPT consultation codes?

A. Physicians may bill an initial NF care *CPT* code for their first visit during a patient's admission to a NF in lieu of the *CPT* consultation codes these physicians may have previously reported, when the conditions for billing the initial NF care *CPT* code are satisfied. The initial visit in a skilled nursing facility (SNF) and nursing facility must be furnished by a physician except as otherwise permitted as specified in CFR Section 483.40(c)(4).

The initial NF care *CPT* codes *99304-99306* are used to report the initial E/M visit in a SNF or NF that fulfills federally-mandated requirements under Section 483.40(c).

Q. What E/M code should physicians report for an initial E/M service that could be described by a *CPT* consultation code but that does not meet the requirements for reporting an initial NF care *CPT* code?

A. In these cases, physicians and other practitioners may bill a subsequent NF care *CPT* code in lieu of the *CPT* consultation codes they may have previously reported. Otherwise, the subsequent NF care *CPT* codes *99307-99310* are used to report either a federally-mandated periodic visit under Section 483.40(c), or any E/M service prior to and after the initial physician visit that is reasonable and medically necessary to meet the medical needs of the individual resident.

Q. When may NPPs furnish an initial NF E/M service?

A. In the NF setting, an NPP, who is enrolled in the Medicare program and is not employed by the facility, may perform the initial visit when the state law permits this (See this exception in Publication 100–04, Chapter 12, Section 30.6.13.A of the *Medicare Claims Processing Manual*). A NPP who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. As discussed in the CY 2010 MPFS proposed rule (74 FR 33543), the long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.

Q. How should E/M services previously reported by *CPT* consultation codes and provided in a split/shared manner be billed?

A. The split/shared rules applying to E/M services remain in effect, including those cases where services would previously have been reported by *CPT* consultation codes.

Q. Does the policy of no longer recognizing *CPT* consultation codes for the purposes of Medicare billing apply to billing for physicians' services in hospices, where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice?

A. Yes, when hospices bill Part A for the services of physicians, they must use *CPT* codes that are paid under the MPFS. Since the *CPT* consultation codes are no longer recognized for payment under the MPFS, hospices must follow the same guidelines for reporting E/M services as physicians billing Part B. Hospices should use the most appropriate E/M codes to bill for E/M services furnished by physicians that could be described by *CPT* consultation codes.

Q. Will appending **modifier A1** (Dressing for one wound) instead of the appropriate **modifier AI** (Principal physician of record) to the *CPT* code for an initial hospital or nursing home E/M service furnished by the principal physician of record affect payment to the provider for that service?

A. Because **modifier AI** (not **modifier A1**) is the appropriate modifier to identify an initial hospital or nursing home E/M service by the patient's principal physician of record, payment to the provider for the E/M service could be affected. Some Medicare contractors may reject an E/M code reported with **modifier A1** as an invalid procedure code/modifier combination and, therefore, payment for the E/M service would not be made. In that case, the provider should submit a corrected claim-reporting **modifier AI** appended to the E/M code. If an E/M code with **modifier A1** appended has already been submitted and paid, the provider does not need to submit a corrected claim but should report the appropriate **modifier AI** on future claims for initial hospital or nursing home E/M services when the E/M service is furnished by the principal physician of record. Providers should contact their Medicare contractor for further assistance if necessary.

Q. Do admitting physicians still get paid if they do not report the **modifier AI**?

A. Yes, the use of the modifier is for informational purposes only.

Q. The transmittal, "Revisions to Consultation Services Payment Policy" (Transmittal # R1875CP, also referred to as CR 6740), indicates that the *CPT* consultation codes are **not valid** for Medicare. It also states Medicare uses a different code to report the service. However, the *MLN Matters*® article directed to providers states the consult codes are **noncovered.** When it comes to reporting services, there is a definite difference in these two terms. Please clarify.

***Questions and answers on reporting physician consultation services (continued)***

A. The question refers to the following passage in the original *MLN Matters*® article:

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.

The *MLN Matters*® article is being reissued to clarify this passage, consistent with the answer to the question that follows. The provider may not bill the patient in lieu of billing Medicare and may not have the patient sign an ABN to hold the patient personally responsible for the payment. CMS did not intend for this passage to suggest that E/M services that could be described by *CPT* consultation codes are noncovered. Rather, CMS intended to indicate that providers may not bill the patient for the E/M service that could be described by a *CPT* consultation code as though the E/M service was noncovered, as is now clarified in the reissued article. However, some people have interpreted the passage to suggest that providers cannot bill for an E/M service that could be described by a *CPT* consultation code because it is a noncovered service. The following language may clarify what CMS was trying to say in the cited passage:

Providers who bill an E/M service after January 1, 2010 using one of the *CPT* consultation codes (ranges *99241-99245*, and *99251-99255*) will have the claim returned with a message indicating that Medicare uses another code for reporting and payment of the service. To receive payment for the E/M service, the claim should be resubmitted using the appropriate E/M code as described in this article. Although CMS has eliminated the use of the *CPT* consultation codes for payment of E/M services furnished to Medicare fee-for-service patients, those E/M services themselves continue to be covered services if they are medically reasonable and necessary and, therefore, an ABN is not applicable. Furthermore, the patient may not be billed for the E/M service instead of Medicare.

Q. Does the new policy violate HIPAA rules by requiring providers to bill for E/M services that could be described by *CPT* consultation codes using codes other than the ones designated by *CPT*, which is the adopted code set under the law?

A. The HIPAA regulations place certain requirements on health plans. One of those requirements is that "a health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction." In addition, a health plan must "accept and promptly process any standard transaction that contains code sets that are valid" and *CPT*-4 has been accepted as the standard medical data code set for, among other things, physician services. However, the regulations also state that "all parties [must] accept these codes within their electronic transactions . . . [but does not require] payment for all of these services."

As of January 1, 2010, Medicare will no longer recognize for payment *CPT* consultation codes. Instead, CMS is instructing providers to use the most appropriate office or inpatient E/M code to report E/M services that could be described by *CPT* consultation codes. This policy change was adopted after going through notice and comment rulemaking and the payment rates for certain E/M services were increased to maintain budget neutrality and to ensure all providers were being paid equivalently for equivalent work. Further, CMS is not changing the definition of any of the existing E/M codes as a result of this policy.

Claims with the *CPT* consultation codes are not rejected. Instead, Medicare accepts a claim that reports a *CPT* consultation code, processes it, and returns the claim to the provider to report an E/M code for the service that is recognized by Medicare for payment because CMS does not pay for the *CPT* consultation codes. In other words, accepting claims with *CPT* codes (including consultation codes) from the adopted code set, and then processing (paying, denying, or returning the claim to the provider to report a code that is recognized by Medicare for payment) those claims in accordance with the MPFS ensures that Medicare is fulfilling its obligation to "accept" and "process" standard transactions that contain valid code sets.

It is not the intention of CMS to cause confusion or make the Medicare program more administratively complex.

## Additional information

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

The related *MLN Matters* article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf*.

Medicare manuals are available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

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

If you have questions, please contact your Medicare MAC 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: SE1010
Related Change Request (CR) Number: 6740
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
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Implementation Date: January 4, 2010
Source: CMS Special Edition *MLN Matters*® Article SE1010

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# Revisions to consultation services payment policy

*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 MM6740 to clarify some language and to add a reference to a related *MLN Matters* special edition article SE1010. All other information remains the same. The *MLN Matters* article MM6740 was published in the December 2009 *Medicare A Bulletin* (pages 7-11).

## 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 (FI), 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 billing for physicians services under 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 must 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 HCPCS 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.
- Providers who bill an E/M services after January 1, 2010, using one of the *CPT* consultation codes (ranges 99241-99245 and 99251-99255) will have the claim returned with a message indicating that Medicare uses another code for reporting and payment of the service. To receive payment for the E/M service, the claim should be resubmitted using the appropriate E/M code as described in this article. Although CMS has eliminated the use of the CPT consultation codes for payment of E/M services furnished to Medicare fee-for-service patients, those E/M services themselves continue to be covered services if they are medically reasonable and necessary and, therefore, an ABN is not applicable. Furthermore, the patient may not be billed for the E/M service instead of Medicare.
- 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 the E/M codes that most appropriately describe the E/M services that could be described by the *CPT* consultation codes.
- 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

***Revisions to consultation services payment policy (continued)***

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.
- 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

***Revisions to consultation services payment policy (continued)***

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 |
| *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 |

***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* |
|---|---|---|---|
| *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 (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.

## Additional information

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

You may also want to review the related article SE1010 (Questions and Answers on Reporting Physician Consultation Services), which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf*.

The E/M documentation guidelines are available on the CMS Web site 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*.

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

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## Medically unlikely edits

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised change request 6712. Transmittal 617, dated January 8, 2010, is being rescinded and replaced with Transmittal 652, dated March 17, 2010. This change request (1) clarifies the reference to the manual section authorizing MUEs to Pub. 100-08, *Medicare Program Integrity Manual***,** Chapter 3, Section 3.5.1, and (2) clarifies the name of files for the final DME list of medically unlikely edits (MUEs). All other information remains the same. The article related to CR 6712 was published in the January 2010 *Medicare A Bulletin* (pages 5-6).

The Centers for Medicare & Medicaid Services (CMS) developed the medically unlikely edit (MUE) program to reduce the paid claim-error rate for Medicare claims. Change request (CR) 6512 provides updates and clarifications to MUE requirements established in 2006.

### Background

The medically unlikely edits are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/*CPT* code descriptors, *CPT* coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/*CPT* code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/*CPT* code on the vast majority of appropriately reported claims.

**Note:** The MUE program provides a method to report medically reasonable and necessary UOS in excess of an MUE.

### Key points

All Medicare claim processing contractors, including contractors using the fiscal intermediary shared system (FISS) shall adjudicate MUEs **against each line of a claim rather than the entire claim.** Thus, if a HCPCS/*CPT* code is changed on more than one line of a claim by using *CPT* modifiers, the claim processing system separately adjudicates each line with that code against the MUE.

In addition, fiscal intermediaries (FIs), carriers and Medicare administrative contractors (MACs) processing claims shall deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/*CPT* code on the claim line. Providers may appeal the denied claim lines.

Since each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of *CPT* modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE. The following CPT modifiers will accomplish this purpose:

*59* *Distinct procedural service*

*76* *Repeat procedure by same physician*

*77* *Repeat procedure by another physician*

*91* *Repeat clinical diagnostic laboratory test*

Anatomic modifiers (e.g., RT, LT, F1, F2)

**Note:** Providers/suppliers should use modifier 59 only if no other modifier describes the service.

On or about October 1, 2008, CMS announced that it would publish at the start of each calendar quarter the majority of active MUEs and post them on the MUE Web page at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage*.

Note that, at the onset of the MUE program, all MUE values were confidential, and for use only by CMS and CMS contractors. Since October 1, 2008, CMS has published most MUE values at the start of each calendar quarter. However, some MUE values are not published and continue to be confidential information for use by CMS and CMS contractors only. The confidential MUE values shall not be shared with providers/suppliers or other parties outside the CMS contractor's organization. The files referenced in the business requirements of this CR contain both published and unpublished MUE values. In the MUE files each HCPCS code has an associated "publication indicator". A publication indicator of "0" indicates that the MUE value for that code is confidential, is not in the CMS official publication of the MUE values, and should not be shared with providers/suppliers or other parties outside the CMS contractor's organization. A publication indicator of "1" indicates that the MUE value for that code is published and may be shared with other parties.

The full set of MUEs is available for the CMS contractors only via the Baltimore data center. A test file will be available about two months before the beginning of each quarter, and the final file will be available about six weeks before the beginning of each quarter. Note that MUE file updates are a full replacement. The MUE adds, deletes, and changes lists will be available about five weeks before the beginning of each quarter.

### Medically unlikely edit program policy

The national correct coding initiative (NCCI) contractor produces a table of MUEs. The table contains ASCII text and consists of six columns. (Refer to Appendix 1 – Tabular Presentation of the Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare carrier system (MCS), one for contractors using the VIPS Medicare system (VMS), and one for the contractors using the fiscal intermediary shared system (FISS).

Contractors shall apply MUEs to claims with a date of service on or after the beginning effective date of an edit and before or on the ending effective date.

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, *Program Integrity Manual (PIM)*, Chapter 3, Section 3.5.1, indicates that

***Medically unlikely edits (continued)***

automated review is acceptable for medically unlikely cases and apparent typographical errors.

CMS will set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

Since claim lines are denied, denials may be appealed.

Appeals shall be submitted to local contractors not the MUE contractor, Correct Coding Solutions, LLC.

Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and contractors will download via the network data mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI contractor. The NCCI contractor may refer those concerns to CMS, and CMS may act to change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. A provider/supplier shall not issue an advance beneficiary notice of noncoverage (ABN) in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE. The denied units of service shall be a provider/supplier liability.

CMS will distribute the MUEs as a separate file for each shared system when the quarterly NCCI edits are distributed.

The Appendix 1 – *Tabular Presentation of the Format for the MUE Transmission* is available on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R652OTN.pdf*.

Change Request (CR) Number: 6712 – Revised
CR Release Date: March 17, 2010
CR Transmittal Number: R652OTN
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Source: CMS Pub. 100-20, Transmittal 652, CR 6712

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**Web site survey**

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

# Local Coverage Determinations

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

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

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

## Effective and notice dates

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

## Electronic notification

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

## More information

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

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

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### Advance beneficiary notice

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

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

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# Additional Medical Information

## Self-administered drug (SAD) list

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services provided on or after May 1, 2010, the following drugs have been added to the MAC J9 Part A SAD list.

C9399 liraglutide (Victoza®)

C9399 golimimab (Simponi®)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

First Coast Service Options Inc. SAD lists are available at *http://medicare.fcso.com/Self-administered_drugs/*. ❖

## 93042: Rhythm ECG, 1-3 leads; interpretation and report only

A review of utilization data of *CPT* code *93042* (*Rhythm ECG, 1-3 leads;interpretation and report only*) has revealed that providers are billing interpretation of EKG rhythm strips obtained from telemetry or cardiac monitoring equipment within hospitals or other facilities.

Electrocardiography (ECG) is the graphic representation of electrical activity within the heart. Electrodes placed on the body in predetermined locations sense this electrical activity, which is then recorded for review and interpretation. The ECG tracing is appropriately billed when performed as a stand-alone test, on a dedicated machine specifically for the purpose of the diagnosis of an arrhythmia or during its treatment.

Interpretation and/or performance of a rhythm strip performed as a separate service from continuous cardiac or telemetry monitoring with the result being an official interpretation and written report would be considered for Medicare reimbursement. The appropriate rhythm strip *CPT* codes (*93040-93042*) should be used and the documentation should support the medical necessity of the service.

Interpretation of a rhythm strip from cardiac monitoring equipment in settings including, but not limited to, inpatient hospital, emergency room and ambulance is not separately allowable. It is included as part of the medical decision portion of a physician's evaluation and management (E/M) services. Simply signing the report printed out by the ECG monitoring equipment is not acceptable documentation for billing and interpretation of a rhythm strip. ❖

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# Hospital Services

## Accumulation of claims with condition code 04 on the provider statistical and reimbursement report

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

### Provider types affected

Inpatient prospective payment system (PPS) hospitals, inpatient rehabilitation PPS hospitals, and long-term care hospitals LTCHs PPS that submit informational claims for indirect medical education (IME)/graduate medical education (GME)/nursing and allied health to Medicare fiscal intermediaries (FI) or Medicare administrative contractors (A/B MACs) are affected by this change.

### What you need to know

Change request (CR) 6784, from which this article is taken, announces that (effective for discharges on or after July 1, 2010) all hospital informational-only claims that you submit with condition code 04 (informational only bill) will begin to accumulate on the provider statistical and reimbursement report (PS & R) report type 118 (Inpatient – Part A Managed Care), which summarizes services billed under Part A for Medicare managed care patients in order to receive reimbursement for GME and IME. You should make sure that your billing staffs are aware of this change.

### Background

Currently, claims that you submit for IME, GME and nursing and allied health with both condition codes (CC) 04 (information only bill) and CC 69 are sent to the provider statistical and reimbursement system (PS and R), report type 118.

With the recently released CRs that address capturing days for supplemental security income purposes:

1) CR 5647 – Capturing Days on Which Medicare Beneficiaries are Entitled to Medicare Advantage (MA) in the Medicare/Supplemental Security Income (SSI) Fraction, released on July 20, 2007 (found on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5647.pdf*)
2) CR 6329 – Providers Submitting Information Regarding Medicare Beneficiaries Entitled to Medicare Advantage (MA) for Fiscal Year (FY) 2006 for the Medicare/Supplemental Security Income (SSI), released on March 6, 2009 (found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6329.pdf*), it became necessary to also capture condition code 04-only claims in the PS & R, so that the data will be available to both providers and Medicare contractors.

Therefore, CR 6784, from which this article is taken, announces that effective for **discharges on or after July 1, 2010,** all hospital informational-only claims that you submit with condition code 04 will also begin to accumulate on the PS & R report type 118.

### Additional Information

The official instruction issued to your FI or MAC is on the CMS Web site at *http://www.cms.hhs.gov/transmittals/downloads/R644OTN.pdf*.

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

*MLN Matters*® Number: MM6784
Related Change Request (CR) Number: 6784
Related CR Release Date: February 26, 2010
Related CR Transmittal Number: R644OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-20, Transmittal 644, CR 6784

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## Supervision requirements for therapeutic services in critical access hospitals

The Centers for Medicare & Medicaid Services (CMS) will instruct all of its Medicare contractors not to evaluate or enforce the supervision requirements for therapeutic outpatient services provided in critical access hospitals (CAHs) for the duration of calendar year (CY) 2010. CMS will revisit the issue of supervision for therapeutic services provided to hospital outpatients in CAHs through the annual rulemaking cycle for CY 2011.

CMS continues to expect CAHs to fulfill all other Medicare program requirements when providing services to Medicare beneficiaries and when billing Medicare for those services. While CMS is instructing contractors not to enforce the supervision requirements in CAHs for CY 2010, CMS continues to emphasize quality and safety for services provided to all patients in CAHs. ❖

Source: CMS JSM 10187, March 18, 2010

## Revised long-term care hospital prospective payment system fact sheets

The revised long-term care hospital prospective payment system (LTCH PPS) fact sheets (March 2010), which help Medicare Part A providers better understand the various aspects of the LTCH PPS, are now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network* Web site.

- The *Long-Term Care Hospital Prospective Payment System: Interrupted Stay* fact sheet, which includes updated information on the LTCH interrupted stay policy, is available at *http://www.cms.hhs.gov/MLNProducts/downloads/LTCH-IntStay.pdf*.
- The *Long-Term Care Hospital Prospective Payment System: News* fact sheet, which includes an overview of the LTCH rate year (RY) 2010 final rule, is available at *http://www.cms.hhs.gov/MLNProducts/downloads/LTCH-News.pdf*.
- The *Long-Term Care Hospital Prospective Payment System: Payment Adjustment Policy* fact sheet, which includes updates to the LTCH 25-percent threshold rule, is available at *http://www.cms.hhs.gov/MLNProducts/downloads/LTCHPaymentAdjustPolicy.pdf*.
- The *Long-Term Care Hospital Prospective Payment System: Short-Stay Outliers* fact sheet, which includes updates to the LTCH short-stay outlier (SSO) payment adjustment policy, is available at *http://www.cms.hhs.gov/MLNProducts/downloads/LTCH-ShortStay.pdf*.
- The Long-Term Care Hospital Prospective Payment System: High Cost Outliers fact sheet, which includes updates to the LTCH high-cost outlier payment policy, is available at *http://www.cms.hhs.gov/MLNProducts/downloads/LTCH-HighCost.pdf*. ❖

Source: CMS PERL 201003-29

## Fiscal year 2010 inpatient prospective payment system PC PRICER updated

The fiscal year (FY) 2010 inpatient prospective payment system (IPPS) personal computer (PC) PRICER has been updated for FY 2010 claims with recent provider data from January 2010 and a correction of the PRICER version. You may access the inpatient IPPS PC PRICER page, *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*, and download the latest version of the FY 2010 PC PRICER. ❖

Source: CMS PERL 201002-40

## Fiscal year 2009 inpatient prospective payment system PC PRICER updated

The fiscal year (FY) 2009 inpatient prospective payment system (PPS) personal computer (PC) PRICER has been updated on the Web for FY 2009 claims with corrected provider data from January 2010. If you use the FY 2009 inpatient PPS PC PRICER, go to *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*, and download the latest version of the PC PRICER. ❖

Source: CMS PERL 201003-16

## Rate year 2009 inpatient psychiatric facility PPS PC PRICER updated

The inpatient psychiatric facility (IPF) prospective payment system (PPS) personal computer (PC) PRICER for rate year (RY) 2009 has been updated with corrected January 2010 provider data. The version for RY 2009 is available on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you use the IPF PPS PC PRICER for RY 2009, please go to the page *http://www.cms.hhs.gov/PCPricer/09_inppsy.asp* and download the latest versions of the IPF PPS 2009 PC PRICER, posted March 5, 2010. ❖

Source: CMS PERL 201003-12

## Fiscal year 2009 inpatient rehabilitation facility PPS PC PRICER updated

The fiscal year (FY) 2009 inpatient rehabilitation facility (IRF) prospective payment system (PPS) personal computer (PC) PRICERs have been updated with corrected January 2010 provider specific file (PSF) data and is ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.hhs.gov/PCPricer/06_IRF.asp*. If you use the IRF PPS PC PRICERS, please go to the page above and download the latest FY 2009 version of the PRICER, posted March 5, 2010, in the Downloads section. ❖

Source: CMS PERL 201003-20

# Skilled Nursing Facility Services

## Five-star quality rating system – March news

The five-star provider preview report is available now for viewing. Providers may access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of minimum data set.

### Provider preview access information

- Visit the MDS state welcome page available on the state servers where you submit MDS data to review your results.
- To access these reports, select the certification and survey provider enhanced reports (CASPER) reporting link located at the bottom of the login page.
- Once in the CASPER system:
  - Click on the "folders" button and access the five-star report in your "st LTC facid" folder
  - Where st is the two-digit postal code of the state in which your facility is located
  - "Facid" is the state assigned "facid" of your facility.

*BetterCare@cms.hhs.gov* is available to address any five-start rating questions and concerns.

*Nursing Home Compare* was update with March five-star data on Thursday, March 25, 2010.

For the latest five-star quality rating system information, please visit *http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp*. ❖

Source: CMS PERL 201003-19

**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.

# OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

## April 2010 integrated outpatient code editor (I/OCE) specifications version 11.0

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

### Type of bill Provider types affected

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

### Provider action needed

This article is based on change request (CR) 6882, which describes changes to the integrated outpatient code editor. Be sure billing staffs are aware of these changes.

### Background

CR 6882 describes changes to billing instructions for various payment policies implemented in the April 2010 OPPS update. The April 2010 integrated outpatient code editor (I/OCE) changes are also discussed in CR 6882.

**Note:** The full list of I/OCE specifications will no longer be included in these quarterly change requests. Those specifications may now be found on the CMS Web site at *http://www.cms.hhs.gov/OutpatientCodeEdit/*.

A summary of the changes for April 2010 is within Appendix M of Attachment A in CR 6882 and that summary is captured in the following key points.

### Key points of CR 6882 based on Appendix M of the I/OCE specifications

- Effective December 8, 2009, Medicare added HCPCS codes G0432, G0433 and G0435.
- Effective January 1, 2010, Medicare updates procedure/device edit requirements.
- Effective April 1, 2010, Medicare will:
  - Bypass sex conflict edits (#3 = diagnosis/sex; #8 = procedure/sex) if condition code 45 is present on the claim
  - Add new revenue codes 860 and 861 to the list of valid revenue codes
  - Modify appendices E and F to change the type of bill used by FQHCs, from 73x to 77x
  - Make HCPCS/APC SI changes (data change files)
  - Implement version 16.0 of the NCCI (as modified for applicable institutional providers)
  - Add new modifier GX to the valid modifier list
  - Create 508-compliant versions of the specifications and summary of data changes documents for publication on the CMS Web site.

### Additional Information

For complete details regarding this change request, please see the official instruction (CR6882) issued to your Medicare FI or carrier on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1927CP.pdf*.

The I/OCE instructions are attached to CR 6882 and will also be posted on the CMS Web site at *http://www.cms.hhs.gov/OutpatientCodeEdit/*.

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: MM6882
Related Change Request (CR) Number: 6882
Related CR Release Date: March 5, 2010
Related CR Transmittal Number: R1927CP
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Source: CMS Pub. 100-04, Transmittal 1927, CR 6882

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# April 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], Medicare administrative contractors [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) 6857, which describes changes to the OPPS to be implemented in the April 2010 OPPS update. Be sure billing staffs are aware of these changes.

## Background

### April 2010 OPPS update

Change request (CR) 6857 describes changes to and billing instructions for various payment policies implemented in the April 2010 OPPS update. The April 2010 integrated outpatient code editor (I/OCE) and OPPS PRICER will reflect the HCPCS, ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in this notification.

April 2010 revisions to I/OCE data files, instructions, and specifications are provided in CR 6857, "April 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.1."

## Key OPPS updates for April 2010

1. **Procedure and device edits for April 2010**
   Procedure-to-device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device-to-procedure edits require 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 updated lists of both types of edits may be found under "Device, Radiolabeled Product, and Procedure Edits" on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

2. **Editing of hospital Part B inpatient services**
   Blood and blood products are not included in the list of services that may be covered when furnished to persons who are inpatients, but for whom no Medicare inpatient coverage is available. Therefore, no Part B payment may be made for them.
   The *Medicare Claims Processing Manual,* Chapter 4, Section 240.1 is revised to add revenue codes 038x (blood and blood components) and 039x (administration, processing and storage for blood and blood components) to the table of revenue codes that are not allowed to be reported on a claim for payment of services furnished to hospital inpatients for whom there is no Medicare Part A coverage of their inpatient hospital care (type of bill [TOB] 12x).
   The instruction is also revised to reflect that these edits are currently locally controlled by the Medicare A/B MAC or FI and are not imbedded in the fiscal intermediary standard system.
   For more information, you may view the *Medicare Benefits Policy Manual*, Chapter 6, Section 2 for the services for which payment may be made under the Part B Medicare hospital outpatient benefit for services to hospital inpatients and the *Medicare Claims Processing Manual,* Chapter 4, Section 240 for claims processing instructions for these claims.

3. **Clarification to coding requirements for pulmonary rehabilitation services furnished on or After January 1, 2010**
   Section 140.4 .1 (Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010), Chapter 32 in the *Medicare Claims Processing Manual,* is being revised to reflect instructions to hospitals and practitioners' offices for reporting respiratory or pulmonary services furnished to a patient when those services do not meet the diagnosis and coverage criteria for pulmonary rehabilitation services.

4. **Warfarin testing**
   Effective August 3, 2009, Medicare covers pharmacogenomic testing to predict warfarin responsiveness only in the context of an approved, clinical study, in addition to the coverage criteria outlined in the *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Section 90.1, and in the *Medicare Claims Processing Manual,* Chapter 32, Section 240. New level II HCPCS code G9143 was developed to enable implementation of this new coverage policy. Pharmacogenomic testing for warfarin response is a once-in-a-lifetime test absent any reason to believe that the patient's personal genetic characteristics would change over time.
   Under the hospital OPPS, HCPCS code G9143 will be assigned status indicator "A" effective in the April 2010 update, and payment for this lab test will be made under the clinical lab fee schedule (CLFS). However, because of CLFS payment requirements and the timing of creation of the new code, HCPCS code G9143 does not appear in the CY 2010 CLFS with an assigned rate. Therefore, its CY 2010 payment will be determined by Medicare FIs and/or A/B MACs.
   Medicare FIs and/or A/B MACs will determine the hospital outpatient payment rate for HCPCS code G9143 in the same manner that payment rates for unlisted laboratory CPT codes are currently determined. The reporting hospital's FI or A/B MAC will contact the carrier or A/B MAC in the reporting hospital's jurisdiction to obtain an appropriate payment amount for HCPCS code G9143. If that carrier or A/B MAC cannot provide a payment amount for the service, then to establish a payment rate, the hospital's FI or A/B MAC should contact the carrier or A/B MAC in the jurisdiction of the reference laboratory that performed

*April 2010 update of the hospital outpatient prospective payment system (continued)*

the test. If neither carrier nor A/B MAC has a payment amount for HCPCS code G9143 and the FI or A/B MAC for the reporting hospital determines that the service is covered, that FI or A/B MAC must determine the payment amount. Further information on billing and coverage for warfarin testing may be found in CR 6715 issued December 18, 2009, (under transmittals 111 and 1880). These transmittals are available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R111NCD.pdf* and http://www.cms.hhs.gov/Transmittals/downloads/R1889CP.pdf.

**Table 1—Warfarin Testing**

| HCPCS | Long Descriptor | APC | SI |
|---|---|---|---|
| G9143 | Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s) | NA | A |

### 5. Human immunodeficiency virus screening tests

The Centers for Medicare and Medicaid Services (CMS) has determined that screening for human immunodeficiency virus (HIV) infection, which is recommended with a grade of A by the U.S. Preventive Services Task Force (USPSTF) for certain individuals, is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Therefore, effective December 8, 2009, Medicare covers HIV screening tests for beneficiaries that are at increased risk for HIV infection per the USPSTF guidelines and beneficiaries that are pregnant whose diagnosis of pregnancy is known during the third trimester and at labor.

Three new level II HCPCS G-codes were created to implement this new coverage decision. The three HCPCS G-codes (G0432, G0433, and G0435) describe both standard and Food and Drug Administration (FDA)-approved rapid HIV screening tests. Under the hospital OPPS, HCPCS G-codes G0432, G0433, and G0435 will be assigned status indicator "A" effective in the April 2010 update. Payment for these tests will be made under the CLFS.

However, because of CLFS payment requirements and the timing of creation of the new codes, HCPCS codes G0432, G0433, and G0435 do not appear in the CY 2010 CLFS with assigned rates. Therefore, payment for them must be determined by Medicare FIs and/or A/B MACs. Medicare FIs and/or A/B MAC will determine the hospital outpatient payment rates for HCPCS codes G0432, G0433, and G0435 in the same manner that the payment rates for unlisted laboratory *Current Procedural Terminology (CPT)* codes are currently determined.

The reporting hospital's FI or A/B MAC will contact the carrier or A/B MAC in the reporting hospital's jurisdiction to obtain an appropriate payment amount for HCPCS codes G0432, G0433, and G0435. If that carrier or A/B MAC cannot provide a payment amount for the service, then to establish a payment rate, the hospital's FI or A/B MAC should contact the carrier or A/B MAC in the jurisdiction of the reference laboratory that performed the test. If neither carrier nor A/B MAC has a payment amount for the HCPCS G-code and the FI or A/B MAC for the reporting hospital determines that the service is covered, that FI or A/B MAC must determine the payment amount. Further information on coverage for HIV screening tests under this new coverage decision may be found in a separate CR, which will be released shortly.

**Table 2—HIV testing**

| HCPCS | Long Descriptor | APC | SI |
|---|---|---|---|
| G0432 | Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening | NA | A |
| G0433 | Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening | NA | A |
| G0435 | Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening | NA | A |

### 6. Billing for drugs, biologicals, and radiopharmaceuticals

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

Hospitals are reminded 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 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.

*April 2010 update of the hospital outpatient prospective payment system (continued)*

a. **Drugs and biologicals with payments based on average sales price (ASP) effective April 1, 2010**
For CY 2010, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of average sales price (ASP) plus four percent, which provides payment for both the acquisition and pharmapoverhead 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 and pharmacy overhead costs of these pass-through items. For the second 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 program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2010, Medicare would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute. In the CY 2010 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, Medicare will incorporate changes to the payment rates in the April 2010 release of the OPPS PRICER. The updated payment rates, effective April 1, 2010, will be included in the April 2010 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site.

b. **Drugs and biologicals with OPPS pass-through status effective April 1, 2010**
Six drugs and biologicals have newly been granted OPPS pass-through status, effective April 1, 2010. These items, along with their descriptors and APC assignments, are identified in Table 3 below.

**Table 3—Drugs and biologicals with New OPPS pass-through status effective April 1, 2010**

| HCPCS code | Long descriptor | APC | Status indicator effective April 1, 2010 |
|---|---|---|---|
| C9258 | Injection, telavancin, 10 mg | 9258 | G |
| C9259 | Injection, pralatrexate, 1 mg | 9259 | G |
| C9260 | Injection, ofatumumab, 10 mg | 9260 | G |
| C9261 | Injection, ustekinumab, 1 mg | 9261 | G |
| C9262 | Fludarabine phosphate, oral, 1 mg | 9262 | G |
| C9263 | Injection, ecallantide, 1 mg | 9263 | G |

c. **Updated payment rate for HCPCS code J9031 effective January 1, 2009 through March 31, 2009**
The payment rate for one HCPCS code was incorrect in the January 2009 OPPS PRICER. The corrected payment rate is listed in Table 4 below and has been installed in the April 2010 OPPS PRICER, effective for services furnished on January 1, 2009, through implementation of the April 2009 update.

**Table 4—Updated payment rate for HCPCS code J9031 effective January 1, 2009 through March 31, 2009**

| HCPCS code | Status indicator | APC | Short descriptor | Corrected payment rate | Corrected minimum unadjusted copayment |
|---|---|---|---|---|---|
| J9031 | K | 0809 | Bcg live intravesical vac | $118.96 | $23.79 |

**Note:** Medicare contractors may adjust as appropriate claims previously paid under the OPPS brought to their attention that:

1. Have dates of service that fall on or after January 1, 2009, but prior to April 1, 2009
2. Contain HCPCS code listed in Table 4 above
3. Were originally processed prior to the installation of the April 2010 OPPS PRICER.

d. **Updated payment rates for certain HCPCS codes effective October 1, 2009 through December 31, 2009**
The payment rates for several HCPCS codes were incorrect in the October 2009 OPPS PRICER. The corrected payment rates are listed in Table 5 below and have been installed in the April 2010 OPPS PRICER effective for services furnished on October 1, 2009, through implementation of the January 2010 update.

*April 2010 update of the hospital outpatient prospective payment system (continued)*

**Table 5—Updated payment rates for certain HCPCS codes effective October 1, 2009 through December 31, 2009**

| HCPCS code | Status indicator | APC | Short descriptor | Corrected payment rate | Corrected minimum unadjusted copayment |
|---|---|---|---|---|---|
| 90371 | K | 1630 | Hep b ig, im | $113.78 | $22.76 |
| J1458 | K | 9224 | Galsulfase injection | $333.49 | $66.70 |
| J2278 | K | 1694 | Ziconotide injection | $6.38 | $1.28 |
| J2323 | K | 9126 | Natalizumab injection | $7.97 | $1.59 |

**Note:** Providers should also note that Medicare contractors may adjust as appropriate claims previously paid under the OPPS brought to their attention that:

1. Have dates of service that fall on or after October 1, 2009, but prior to January 1, 2010
2. Contain HCPCS code listed in Table 5 above
3. Were originally processed prior to the installation of the April 2010 OPPS PRICER.

**e. 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.

**f. Correct reporting of units for drugs**

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

**Examples:**

If the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4.

Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 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.

**g. Reporting of outpatient diagnostic nuclear medicine procedures**

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.

***April 2010 update of the hospital outpatient prospective payment system (continued)***

As was 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. This situation is extremely rare and it is expected that the majority of hospitals will not encounter this situation.

7. **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. FIs and/or 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

For complete details regarding this CR please see the official instruction issued to your Medicare FI, RHHI, or A/B MAC, which may be viewed by going to the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1924CP.pdf*.

Detailed information about OPPS is available on the CMS Web site at *http://www.cms.hhs.gov/HospitalOutpatientPPS/05_OPPSGuidance.asp*.

A fact sheet entitled, *Hospital Outpatient Prospective Payment System (OPPS)*, may be found in the *Medicare Learning Network* catalog. This fact sheet provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set. The document may be viewed on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf*.

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

*MLN Matters*® Number: MM6857
Related Change Request (CR) Number: 6857
Related CR Release Date: February 26, 2010
Related CR Transmittal Number: R1924CP
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1924, CR 6857

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

### Use the PDS report to improve your Medicare billing operations

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

# Educational Events

## Upcoming provider outreach and educational events
### April 2010 – June 2010

**Topic – Medicare secondary payer (MSP) claim submission direct data entry (DDE) vs. HIPAA version 4010A1**

When: Tuesday, April 13, 2010

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

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

**Topic – Provider enrollment**

When: Wednesday, April 14, 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 – Hot Topics**

When: Tuesday, May 11, 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 – Medifest educational event – Orlando, Florida**

When: Tuesday and Wednesday, June 8 and 9, 2009

Time: 8:00 a.m. – 5:00 p.m. ET **Delivery language:** English (selected seminars also in Spanish)

Type of Event: In person seminar/symposium **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.

**Please Note:**

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

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

Keep checking our Web site, *www.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.

### Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the FCSO Medicare training Web site, download the recording of the event, and listen to the webcast when you have the time.

### Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses now offer CEUs. Learn more on the FCSO Medicare training Web site and explore our catalog of online courses. ❖

# Preventive Services

## March is National Nutrition Month

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

### Medicare coverage

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

**Note:** For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [glomerular filtration rate (GFR) 13-50 ml/min/1.73m2].[1]

### What can you do?

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

### For more information

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

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals** – this newly revised comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including medical nutrition therapy and other services for Medicare beneficiaries with diabetes.

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

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

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

- **Quick Reference Information: Medicare Preventive Services** – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including medical nutrition therapy.

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

- **Diabetes-related services brochure** – this tri-fold brochure provides health-care professionals with an overview of Medicare coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes.

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

- The CMS Web site provides additional information about the **MNT benefit** at *http://www.cms.hhs.gov/MedicalNutritionTherapy*
- To order copies of Medicare preventive services products, select the link for "MLN Product Ordering Page" on the MLN Products page at *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp*.
- For information to share with your Medicare patients, visit *http://www.medicare.gov/*.
- For more information about National Nutrition Month®, or to "Find a Registered Dietitian" consumers and health-care professionals may visit the American Dietetic Association's Web site at *http://www.eatright.org* to locate downloadable nutrition information for handouts and presentations.
- For more information on diabetes, including additional publications to help educate your patients about diabetes prevention and treatment, please visit the National Diabetes Education Program Web site at *http://www.ndep.nih.gov*.

***March is National Nutrition Month (continued)***

Thank you for your support in helping CMS spread the word about the benefits of good nutrition, healthful eating and the medical nutrition therapy benefit covered by Medicare that may help people with Medicare learn to control and manage their medical conditions. ❖

Source: CMS PERL 201003-14

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

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## National Colorectal Cancer Awareness Month – Dress in Blue Day

March is National Colorectal Cancer Awareness month. The Colon Cancer Alliance has designated Friday, March 5 as "Dress in Blue Day" to promote awareness about colorectal cancer and to encourage people to be screened. In addition, the entire month of March has been designated as National Colorectal Cancer Awareness Month.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for certain colorectal cancer screenings. Screening can help prevent and detect colorectal cancer in its earliest stages when outcomes are most favorable.

### Medicare-covered colorectal cancer screenings

Medicare provides coverage of colorectal cancer screenings for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered in place of the screening colonoscopy.

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

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

### For more information

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

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

  *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- **Cancer Screenings brochure** – this tri-fold brochure provides health care professionals with an overview of cancer screenings covered by Medicare, including colorectal cancer screening services.

  *http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf*
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare, including colorectal cancer screening.

  *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- **Quick Reference Information: Medicare Preventive Services** – this double-sided chart contains coverage, coding, and payment information for the many preventive services covered by Medicare, including colorectal cancer screening, in an easy-to-use quick-reference format.

  *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- To order hard copies of certain ***MLN* products**, including the *Cancer Screenings* brochure , visit the *MLN* homepage at *http://www.cms.hhs.gov/mlngeninfo*; scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page."
- For information to share with your **Medicare patients**, visit *http://www.medicare.gov*.
- **The American Cancer Society** offers free materials to help clinicians continue encouraging colorectal cancer screening among patients 50 and older at *http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp*.

***National Colorectal Cancer Awareness Month – Dress in Blue Day (continued)***

- **The National Colorectal Cancer Roundtable**, which is convened by the Centers for Disease Control and Prevention (CDC) and the American Cancer Society, provides resources for providers, including a guide for primary care physicians at *http://www.nccrt.org/*.
- For more information about **colorectal cancer**, please visit the Prevent Cancer Foundation at *http://www.preventcancer.org/education3c.aspx?id=1036*.
- For more information about **Dress in Blue Day**, please visit the Colon Cancer Alliance at *http://www.ccalliance.org/news_events_dress-in-blue.html*.

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

Source: CMS PERL 201003-05

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## March 23 is Diabetes Alert Day

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

### Medicare coverage of diabetes-related preventive services

Medicare provides coverage of the following diabetes-related services for qualified Medicare beneficiaries:

- Diabetes screening tests
- Diabetes self-management training (DSMT)
- Medical nutrition therapy (MNT)
- Glaucoma screening (e.g., dilated eye exam with an intraocular pressure [IOP] measurement)
- Diabetes supplies (e.g., glucose monitoring equipment and therapeutic shoes) and other services (e.g., foot care).

### What can you do?

As a trusted source of health care information, your patients rely on your recommendations. CMS requests your help to ensure that all of your eligible patients take advantage of diabetes-related preventive services covered by Medicare.

### For more information

The *Medicare Learning Network (MLN)* has developed several educational products related to diabetes-related preventive services covered by Medicare:

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – this comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including diabetes-related services.

  *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- The MLN Preventive Services Educational Products Web page – this Web site provides descriptions and ordering information for *MLN* preventive services educational products and resources, including diabetes-related services.

  *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including diabetes-related services.

  *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- Diabetes-Related Services brochure – this brochure provides an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes.

  *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*
- *Glaucoma Screening* brochure – this brochure provides an overview of Medicare's coverage of glaucoma screening tests, including the dilated eye exam with an IOP measurement.

  *http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf*

To order hardcopies of available Medicare preventive services products, including the brochures mentioned above, click on "MLN Product Ordering" in the "Related Links Inside CMS" section of the *MLN* preventive services educational products Web page listed above.

*March 23 is Diabetes Alert Day (continued)*

### Additional resources

- National Diabetes Education Program (NDEP) – this Web site offers numerous resources to help your patients delay or prevent the development of type 2 diabetes, as well as resources to help your patients manage diabetes to prevent serious complications.

  *http://ndep.nih.gov/index.aspx*
- Check out "Your GAME PLAN to Prevent Type 2 Diabetes: Information for Patients," a three-page booklet to help people assess their risk for developing diabetes and take steps to prevent diabetes.

  *http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=71*
- For patients with diabetes, "The Power to Control Diabetes is in Your Hands", contains information about diabetes and related Medicare benefits, which is available at the following link:

  *http://ndep.nih.gov/publications/OnlineVersion.aspx?NdepId=NDEP-38*
- Diabetes At Work.Org – this Web site contains information for employers to help them reduce health care costs and improve productivity by keeping employees healthy.

  *http://www.diabetesatwork.org/*
- American Diabetes Association – This Web site contains a wealth of information about diabetes, treatment, and prevention.

  *http://www.diabetes.org/*

Thank you for your support in helping CMS spread the word about the benefits diabetes-related preventive services covered by Medicare. ❖

Source: CMS PERL 201003-38

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## Medicare preventive services quick reference information charts

The Medicare preventive services quick reference information charts have been updated and are now available in downloadable format. This includes the following charts:

- *Quick Reference Information: Medicare Preventive Services*: This two-sided reference chart provides health care providers with coverage, coding, and payment information on the many preventive services covered by Medicare.
- *Quick Reference Information: Medicare Immunization Billing*: This two-sided reference chart provides coverage, coding and payment information on seasonal influenza, pneumococcal, and hepatitis B vaccinations covered by Medicare.
- *Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (IPPE)*: This two-sided reference chart provides a checklist of the elements of an IPPE, as well as coding information and frequently asked questions.

To view the revised charts, please visit the "Preventive Services Educational Products" page at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* and select the "Educational Products" link in the Downloads section.

Hard copies of all three charts will be available in the near future. ❖

Source: CMS PERL 201003-14

## We Heard the Bells: The Influenza of 1918 DVD now available

*We Heard the Bells: The Influenza of 1918*, a documentary that explores the experiences of Americans during the influenza pandemic of 1918, is now available to order, free of charge, on DVD.

The documentary features stories from survivors of the influenza pandemic that swept the United States in 1918. These stories serve to frame the key questions that apply to the current H1N1 pandemic. Award winning actress S. Epatha Merkerson (Law & Order) narrates the documentary that includes information about seasonal versus pandemic influenza, symptoms, immunizations, treatment, and research.

To order a copy of the DVD, please visit our product ordering Web site by first visiting our *Medicare Learning Network* page at *http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp*, then click on "MLN Product Ordering Page" in the "Related Links Inside CMS" section.

This product will also be available in a Spanish language translation at a later date. ❖

Source: CMS PERL 201002-38

# Other Educational Resources

## Revised educational booklets that make up the Guided Pathways curricula

The revised *Guided Pathways to Medicare* booklets (1st Quarter 2010), are available from the Centers for Medicare & Medicaid Services' (CMS) *Medicare Learning Network*. Guided Pathways leads Medicare fee-for-service (FFS) providers through a variety of resources organized by topic. Quickly explore these three easy-to-navigate online guides to learn important Medicare policy and requirements. Guided Pathways information is available at *http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp*.

### For all Medicare providers

Guided Pathways Basic Booklet January 2010 [PDF, 831KB] : Includes updated information on Medicare resources that provide a fundamental overview of the Medicare program.

*http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf*

### For Medicare FFS health care providers who enroll in Medicare using the 855A form

Guided Pathways Intermediate Part A Booklet January 2010 [PDF, 898KB] : Includes updated information on Medicare institutional requirements, reimbursement and coverage, Medicare services such as clinical trials, health care cost report information, MedPAC, Medicare approved facilities, demonstrations, enrollment reports, FFS statistics, the Medicare-Medicaid relationship, program rates and statistics, sustainable growth rates and conversion factors, and telehealth.

*http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Intermediate_PartA_Booklet.pdf*

### For Medicare FFS health care professionals and suppliers who enroll in Medicare using the 855B, 855I or 855S forms

Guided Pathways Intermediate Part B Booklet January 2010 [PDF, 1MB] : Includes updated information on Medicare professional/practitioner/supplier requirements, coverage and reimbursement, services by other practitioners, services by suppliers, coding, billing and reimbursement, durable medical equipment, prosthetics, orthotics, and supplies, independent diagnostic testing facility, and quality.

*http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Intermediate_PartB_Booklet.pdf*. ❖

Source: CMS PERL 201003-35

## Revised fact sheets from the Medicare Learning Network

The following revised fact sheets are now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The *Hospital Outpatient Prospective Payment System* fact sheet (January 2010) – provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set.
- The *Home Health Prospective Payment System* fact sheet (January 2010) – provides information about coverage of home health services and elements of the home health prospective payment system.
- The *Outpatient Maintenance Dialysis – End-Stage Renal Disease* fact sheet (January 2010) – provides information about the bundled end-stage renal disease (ESRD) prospective payment system for Medicare outpatient ESRD facilities that will replace the current basic case-mix adjusted composite payment system beginning January 1, 2011, the basic case-mix adjusted composite payment rate system, and separately billable items and services.
- The *Ambulatory Surgical Center Fee Schedule* fact sheet (January 2010) – provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined.

To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 201003-27

### 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.

## Revised facilitator's kit for facilitators, trainers, educators, and physicians

The revised *Medicare Resident, Practicing Physician, and Other Health Care Professional Training Facilitator's Kit* (October 2009), includes all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program. The kit, now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*, includes instructions for facilitators, customization guide, a PowerPoint® presentation with speaker notes, pre and post-assessments, master assessment answer keys, and a course evaluation tool.

This kit contains the following materials:

- *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (CD-ROM format)
- *Facilitator's Guide* (CD-ROM format)
- *Medicare Resident, Practicing Physician, and Other Health Care Professional Training: An Introduction Video* (DVD format).

To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 201003-32

## Special news from the Medicare Learning Network

The Centers for Medicare & Medicaid Services (CMS) continues to break new ground to enhance the Medicare fee-for-service outreach efforts. CMS is now using the following social media outlets to get information out to the Medicare audience as fast as possible.

- **LinkedIn:** Join the CMS group at *http://www.linkedin.com/in/CMSGov*.
- **YouTube:** Log on to the official CMS YouTube channel at *http://www.YouTube.com/CMSHHSGov* to view several videos currently available and more to come in the upcoming months.
- **Twitter:** Follow CMS' two accounts to get the latest updates on information you need know about CMS (including Medicare Learning Network updates) and Insure Kids Now.
  1. For CMS and *Medicare Learning Network* updates, visit *http://www.twitter.com/CMSGov* (Twitter handle = @ CMSGov)
  2. For Insure Kids Now updates, visit *http://www.twitter.com/IKNGov* (Twitter handle = @IKNGov)

Log on to see the latest.

The *CMS Website Wheel* has been revised and can now be ordered through the *Medicare Learning Network*.

The *CMS Website Wheel* is an informational resource that provides a variety of CMS Medicare related Web sites. To place an order, go to *http://www.cms.hhs.gov/MLNProducts/*, scroll to the downloads section of the page and select MLN Product Ordering Page, then select the CMS Website Wheel. ❖

Source: CMS PERL 201003-25

## The Medicare Appeals Process brochure now available

The revised *Medicare Appeals Process* brochure (January 2010), which provides an overview of the Medicare Part A and Part B administrative appeal process, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf*.

This brochure is available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, and it provides details on where to obtain more information about this appeals process. ❖

Source: CMS PERL 201002-38

## New fact sheet available on DMEPOS Competitive Bidding program

A new fact sheet entitled The *Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program – A Better Way for Medicare to Pay for Medical Equipment* (February 2010), is now available in downloadable format on the DMEPOS Competitive Bidding Web site. This fact sheet gives providers and suppliers an overview of the DMEPOS Competitive Bidding program as well as useful information regarding the benefits and inherent qualities of the program. The fact sheet may be downloaded from the following Web page *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp*. ❖

Source: CMS PERL 201003-14

## Revised fact sheet for Medicare fraud and abuse

The revised *Medicare Fraud & Abuse* fact sheet (February 2010) , available from the Centers for Medicare & Medicaid Services' (CMS) *Medicare Learning Network*, at *http://www.cms.hhs.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf* directs you to a number of sources of information pertaining to Medicare fraud and abuse and helps you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse. ❖

Source: CMS PERL 201003-36

## New fact sheet on the health professional shortage area payment system

The new *Health Professional Shortage Area (HPSA)* fact sheet (March 2010) is now available in downloadable format from the Centers for Medicare & Medicaid Services' *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/HPSAfctsht.pdf*.

This fact sheet provides general requirements and an overview of the health professional shortage area (HPSA) payment system. ❖

Source: CMS PERL 201003-17

## Revised fact sheet regarding the Medicare physician fee schedule

The *Medicare Physician Fee Schedule* fact sheet (March 2010) has been revised to include information about the two month zero percent (0 percent) update to the 2010 Medicare physician fee schedule (MPFS) effective for dates of service January 1, 2010, through March 31, 2010. This fact sheet, which also provides information about MPFS payment rates and the MPFS payment rates formula, is available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*. ❖

Source: CMS PERL 201003-15

## Revised clinical laboratory fee schedule fact sheet

The revised *Clinical Laboratory Fee Schedule* fact sheet (January 2010), which provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf*.

If you are unable to open the fact sheet, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201003-24

## Revised ambulance fee schedule fact sheet

The revised *Ambulance Fee Schedule* fact sheet (January 2010), which provides general information about the ambulance fee schedule including how payment rates are set for ground and air ambulance services, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf*. ❖

Source: CMS PERL 201003-03

## 2010 electronic prescribing educational products

The Centers for Medicare & Medicaid Services is pleased to announce the following updated 2010 Electronic Prescribing (eRx) Incentive program educational products to the eRx Web page at *http://www.cms.hhs.gov/ERxIncentive*.

2010 eRx educational resource documents : Several new educational resource documents for 2010 eRx are available on the "Educational Resources" link of the eRx Web page and include the following:

- 2010 eRx Incentive Program fact sheet: What's New for the 2010 eRx Incentive Program
- 2010 eRx Incentive Program Made Simple fact sheet

2010 electronic health record (EHR)-based reporting documents : Several documents related to EHR-based reporting for 2010 eRx have been updated and are now available on the "Alternative Reporting Mechanism" page of the eRx Web page, which include the following:

- 2010 EHR downloadable resource
- Qualified registries for 2010 PQRI and eRx reporting
- Qualified electronic health record (EHR) vendors for the 2010 Physician Quality Reporting Initiative (PQRI) and eRx Incentive Programs. ❖

Source: CMS PERL 201003-33

# 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)

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| | | CD-ROM $55 | | |
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***ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT***

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***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

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**Repayment Plans for Part A**
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**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

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

***SPECIAL DELIVERY***
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First Coast Service Options Inc.
532 Riverside Av.
Jacksonville, FL 32202-4914

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***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**
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**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***
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Jacksonville, FL 32232-5071

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P. O. Box 45097
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