MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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

Table of Contents

Medicare A Bulletin

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

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

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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 website *http://medicare.fcso.com.*

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education website. 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 website 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 website at *http://www.cms.gov/QuarterlyProviderUpdates/*.

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

GENERAL INFORMATION

Claims submitted for items or services furnished to Medicare beneficiaries in state or local custody under a penal authority

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

Provider types affected

This article applies to physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B MACs) for services provided to Medicare beneficiaries in state or local penal custody.

What you need to know

This article is based on change request (CR) 6880 which updates billing instructions and claim processing requirements to fully implement the policy for Medicare beneficiaries in state or local custody that was outlined in CR 6544. CR 6880 rescinds and fully replaces CR 6544, and revises the *Medicare Claims Processing Manual*, Chapter 1, Section 10.4 and the *Medicare Benefit Policy Manual*, Chapter 17, Section 50.3.3(3). These revisions are included as attachments to CR 6880.

Background

The Medicare program does not pay for services if:

- The beneficiary has no legal obligation to pay for the services
- No other person or organization has a legal obligation to provide or pay for that service.

Also, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services. See the Social Security Act Section 1862 (a)(2)&(3) at *http://www.socialsecurity.gov/OP_Home/ssact/title18/1862.htm*.

In the fiscal year (FY) 2008 inpatient prospective payment system (IPPS) final rule (72 FR 47409 and 47410; see *http://edocket.access.gpo.gov/2007/pdf/07-3820.pdf*), the Centers for Medicare & Medicaid Services (CMS) clarified its regulations at 42 CFR 411.4(b) (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr411_main_02.tpl*) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are:

- Under arrest
- Incarcerated
- Imprisoned
- Escaped from confinement
- Under supervised release
- On medical furlough
- Required to reside in mental health facilities
- Required to reside in halfway houses
- Required to live under home detention
- Confined completely or partially in any way under a penal statute or rule.

42 CFR 411.4(b) describes the special conditions that must be met in order for Medicare to make payment for individuals who are in custody and states:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody
2. The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Note: Your Medicare contractor will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources. In addition, the state or local entity must document its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, your Medicare contractor will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the state or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

The Centers for Medicare & Medicaid Services (CMS) maintains a file of incarcerated beneficiaries, obtained from the Social Security Administration (SSA) that is used to edit claims.

To avoid improper denial of claims, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above should indicate this fact with the use of a the **modifier QJ** on claims for such services.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals should identify the incarceration period by billing as noncovered all days, services and charges that overlap the incarceration period.

Claims submitted for items or services furnished to Medicare beneficiaries in state or local custody... (continued)

Additional information

The official instruction, CR 6880, was issued to your carrier, FI, A/B MAC, and DME MAC in two transmittals. The first transmittal modifies the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R1944CP.pdf*.

The second transmittal is at *http://www.cms.gov/Transmittals/downloads/R122BP.pdf* and it contains the revised portion of the *Medicare Benefit Policy Manual* regarding this change.

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

MLN Matters® Number: MM6880
Related Change Request (CR) Number: 6880
Related CR Release Date: April 9, 2010
Related CR Transmittal Number: R1944CP and R122BP
Effective Date: July 9, 2010
Implementation Date: July 9, 2010

Source: CMS Pub. 100-04, Transmittal 1944, CR 6880

Timely filing requirements for Medicare fee-for-service claims

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

The period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the *Code of Federal Regulations* (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time for submission of all Medicare FFS claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, **must be filed within one calendar year after the date of service**. In addition, Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010.

The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

Section 6404 of the PPACA also permits the Secretary of Health & Human Services to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking.

Please be on the alert for more information pertaining to the PPACA. ❖

Source: CMS PERL 201004-02

Zero percent update extended through May 31

President Obama on Thursday signed into law the "Continuing Extension Act of 2010." This law extends through May 31, 2010, the zero percent update to the Medicare physician's fee schedule that was in effect for claims with dates of service January 1-March 31. The law is retroactive to April 1. As a result, effective immediately, claims with dates of service April 1 and later, which Medicare contractors were holding, were being released for processing and payment. Please keep in mind that the statutory payment floors still apply and, therefore, clean electronic claims cannot be paid before 14 calendar days after the date they are received by Medicare contractors (29 calendar days for clean paper claims).

Given the uncertainty regarding MPFS claims with dates of service June 1, 2010, and later, please watch your listservs and your contractor's website for more information. ❖

Source: CMS PERL 201004-27

Medicare travel allowance fees for collection of specimens

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 6864 which updates the Medicare travel allowance fees for collection of specimens for calendar year (CY) 2010. The Centers for Medicare & Medicaid Services (CMS) will issue annual updated travel allowance amounts via a recurring update CR. Be sure billing staff knows of these changes.

Background

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

The travel allowance, which is intended to cover the estimated travel costs of collecting a specimen (including the laboratory technician's salary and travel expenses), is made only if a specimen collection fee is also payable. The travel codes allow for such payment either on a per mileage basis (Healthcare Common Procedure Coding System [HCPCS] code P9603 – Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually traveled), or on a flat rate per trip basis (HCPCS code P9604 – Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge).

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor. The 2010 travel allowances are:

Per-mile travel allowance (HCPCS Code P9603)

The per-mile travel allowance is to be used when the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated when specimens are also drawn from non-Medicare patients in the same trip. CR 6864 instructs your contractor to pay for HCPCS code P9603, when the average trip to the patients' homes exceeds 20 miles round trip, at a total of $0.95 per mile. This includes:

- The federal mileage rate of $0.50 per mile plus
- An additional $0.45 per mile to cover the technician's time and travel costs.

Your contractor has the option to establish a higher per mile rate for HCPCS code P9603, in excess of the minimum $0.95 per mile, if local conditions warrant it. In addition, the minimum mileage rate will be reviewed and updated in conjunction with the CLFS as needed.

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

CR 6864 also instructs your contractor to pay for HCPCS code P9604 on a flat-rate trip basis travel allowance of $9.50 per trip.

Note: At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles that are not actually traveled by the laboratory technician.

Please keep in mind that Medicare allows your contractor to choose either the mileage or flat rate basis for payment, and to also choose how to set each type of allowance. Finally, remember that your contractor will not search their files to either retract payment or retroactively pay claims; however, should adjust claims that you bring to their attention.

Additional information

You may find the official instruction, CR 6864, issued to your carrier, FI, or A/B MAC by visiting the CMS website at *http://www.cms.hhs.gov/Transmittals/downloads/R1933CP.pdf*.

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

MLN Matters® Number: MM6864
Related Change Request (CR) Number 6864
Related CR Release Date: March 19, 2010
Related CR Transmittal Number: R1933CP
Effective Date: January 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1933, CR 6864

Reporting of recoupment for overpayment on the remittance advice

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries. Change request (CR) 6870 does not apply to suppliers billing durable medical equipment (DME) MACs.

Provider action needed

This article is based on CR 6870 which instructs Medicare system maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national recovery audit contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You may review Section 1893 *http://www.ssa.gov/OP_Home/ssact/title18/1893.htm*.

The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) may begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. (See the *MLN Matters*® article related to CR 6183 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf*.)

Under the scenario just described, the RAC has to report the actual recoupment in two steps:

- **Step I:** Reversal and correction to report the new payment and negate the original payment (actual recoupment of money does not happen here)
- **Step II:** Report the actual recoupment.

Recovered amounts reduce the total payment and are clearly reported in the remittance advice (RA) to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR 6870 instructs the Medicare system maintainers (Fiscal intermediary standard system – FISS and multi carrier system – MCS) how to report on the RA when:

- An overpayment is identified
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an internal control number (ICN) or document control number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I Claim level:

The original payment is taken back and the new payment is established.

Provider level:
PLB03-1 – PLB reason code FB (forward balance)
PLB 03-2 shows the detail:

Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#

Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II Claim level:

No additional information at this step.

Provider level:
PLB03-1 – PLB reason code WO (overpayment recovery)
PLB 03-2 shows the detail:

Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#

Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above. decision

Reporting of recoupment for overpayment on the remittance advice (continued)

Additional information

CMS provides more information including an overview of and recent updates for the RAC program at *http://www.cms.gov/RAC/*.

You may find the *Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers* on the CMS website at *http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

The official instruction, CR 6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R659OTN.pdf*.

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

MLN Matters® Number: MM6870
Related Change Request (CR) Number: 6870
Related CR Release Date: March 19, 2010
Related CR Transmittal Number: R659OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-20, Transmittal 659, CR 6870

Safety announcement from the FDA – High-dose Zocor and increased risk of muscle injury

FDA drug safety communication, March 19, 2010: Ongoing safety review of high-dose Zocor® (simvastatin) and increased risk of muscle injury

The U.S. Food and Drug Administration (FDA) is informing the public about an increased risk of muscle injury in patients taking the highest approved dose of the cholesterol-lowering medication, Zocor® (simvastatin) 80 mg, compared to patients taking lower doses of simvastatin and possibly other drugs in the "statin" class. This information is based on review of data from a large clinical trial and data from other sources.

The clinical trial data being reviewed is from the Study of the Effectiveness of Additional Reductions in Cholesterol and Homocysteine (SEARCH) trial. The agency is also reviewing data from other clinical trials, observational studies, adverse event reports, and data on prescription use of simvastatin to understand the relationship between high-dose simvastatin use and muscle injury better (see Data Summary section).

The muscle injury, also called myopathy, is a known side effect with all statin medications. Patients with myopathy generally have muscle pain, tenderness or weakness, and an elevation of a muscle enzyme in the blood (creatine kinase). The higher the dose of statin used, the greater the risk of developing myopathy. The risk of myopathy is also increased when simvastatin, especially at the higher doses, is used with certain drugs (see simvastatin dose limitations at *http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm204882.htm#TableofSimvastatinDoseLimitations*).

The most serious form of myopathy is called rhabdomyolysis. It occurs when a protein (myoglobin) is released as muscle fibers break down. Myoglobin can damage the kidneys. Patients with rhabdomyolysis may have dark or red urine and fatigue, in addition to their muscle symptoms. Damage to the kidneys from rhabdomyolysis can be so severe that patients may develop kidney failure, which can be fatal.

Known risk factors for developing rhabdomyolysis include age (> 65 years), low thyroid hormone levels (hypothyroidism), and poor kidney function. Myopathy and rhabdomyolysis are listed as possible side effects in the simvastatin and other statin drug labels.

Healthcare professionals should:

- Understand that rhabdomyolysis is a rare adverse event reported with all statins.
- Be aware of the potential increased risk of muscle injury with the 80 mg dose of simvastatin compared to lower doses of simvastatin and possibly other statin drugs.
- Follow the recommendations in the simvastatin label regarding drugs that may increase the risk for muscle injury when used with simvastatin (see simvastatin dose limitations at *http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm204882.htm#TableofSimvastatinDoseLimitations*).

Safety announcement from the FDA – High-dose Zocor and increased risk of muscle injury (continued)

Patients should:

- Not stop taking simvastatin unless told to by their healthcare professional.
- Talk to their healthcare professional about any questions they have about the use of simvastatin.
- Call their healthcare professional if they experience any of the following: muscle pain, tenderness or weakness, urine that is dark or red-colored, or unexplained tiredness.

This communication is in keeping with FDA's commitment to inform the public about its ongoing safety review of drugs. The agency will update the public as soon as this review is complete.

**Simvastatin is sold as a single-ingredient generic medication and as the brand name, Zocor. It is also sold in combination with ezetimibe as Vytorin; and niacin as Simcor.*

Additional information for patients

Patients currently using 80 mg simvastatin should:

- Know that rhabdomyolysis is a rare side effect reported with all statin medications.
- Not stop taking simvastatin unless told to by their healthcare professional.
- Review their medical history and current medications with their healthcare professional to determine if they should continue using simvastatin.
- Talk to their healthcare professional about any questions or concerns they have about simvastatin.
- Call their healthcare professional if they have muscle pain, tenderness or weakness, dark or red colored urine, or unexplained tiredness.
- Report any side effects with simvastatin to FDA's MedWatch program using the information at the bottom of the page in the "Contact Us" box.

Additional information for healthcare professionals

FDA recommends that healthcare professionals should:

- Understand that rhabdomyolysis is a rare adverse event reported with all statins.
- Be aware of the potential increased risk of muscle injury with the 80 mg dose of simvastatin compared to lower doses of simvastatin and possibly other statin drugs.
- Review patients' medical history and medications to determine if simvastatin is clinically appropriate.
- Discuss with patients the benefits and risks, including the risk of myopathy and rhabdomyolysis, of simvastatin therapy.
- Be aware of potential drug-drug interactions with simvastatin.
- Report any adverse events associated with the use of simvastatin to FDA's MedWatch program using the information in the "Contact Us" box at the bottom of the page.

Data summary

FDA's review of the SEARCH trial is part of the agency's continuing effort to evaluate the risk of muscle injury with simvastatin; this review includes evaluating data from clinical trials, observational studies, and adverse event reports, as well as data on prescription use of simvastatin.

The SEARCH trial evaluated over 6.7 years the number of major cardiovascular events (heart attack, revascularization, and cardiovascular death) in 6031 patients taking 80 mg of simvastatin compared to 6033 patients taking 20 mg of simvastatin. All patients in the study had previously had a heart attack.

Preliminary SEARCH trial results revealed that more patients in the simvastatin 80 mg group developed myopathy compared to patients in the simvastatin 20 mg group (52 [0.9 percent] cases compared to 1 case [0.2 percent]). Further, FDA's preliminary analyses of the primary data suggest that 11 (0.02 percent) of the patients in the simvastatin 80 mg group developed rhabdomyolysis compared to no patients in the simvastatin 20 mg group.

In 2008, the agency alerted the public about an increased risk of developing rhabdomyolysis when doses greater than 20 mg of simvastatin are given with amiodarone. The agency also included information about this drug interaction in its Summer 2008 issue of the FDA Drug Safety Newsletter (*http://www.fda.gov/Drugs/DrugSafety/DrugSafetyNewsletter/ucm109176.htm*) and in its November 2008 Patient Safety News broadcast (*http://www.accessdata.fda.gov/psn/transcript.cfm?show=81*).

In March 2010, FDA approved a labeling revision for simvastatin based on interim results from an ongoing clinical trial – the Heart Protection Study 2 (HPS2). The revised label states that patients of Chinese descent should not receive simvastatin 80 mg with cholesterol-modifying doses of niacin-containing products. Further, the revised label recommends caution when such patients are treated with simvastatin 40 mg or less in combination with cholesterol-modifying doses of niacin-containing products. The interim HPS2 results showed that the incidence of myopathy was higher in patients of Chinese descent (0.43 percent) compared with patients not of Chinese descent (0.03 percent) taking 40 mg simvastatin plus cholesterol-modifying doses (≥1 g/day) of a niacin-containing product. It is not known if the increased risk for myopathy observed in these patients applies to other patients of Asian descent.

Safety announcement from the FDA – High-dose Zocor and increased risk of muscle injury (continued)

Moreover, FDA has requested that the sponsor of simvastatin change the product labeling to instruct healthcare professionals to avoid prescribing simvastatin doses greater than 40 mg daily when patients are taking the medication diltiazem, due to an increased risk for myopathy.

A 2010 review of prescription-drug use data conducted by FDA found that, despite dose limitations and drug-drug interaction precautions included in the simvastatin drug label, patients are continuing to be prescribed higher doses of simvastatin with other medications that are known to increase the risk for rhabdomyolysis.

It is important for healthcare professionals to consider the potential risks and known benefits of simvastatin compared to other cholesterol-lowering therapies when deciding to use simvastatin. Healthcare professionals should also carefully review patients' medications for potential drug-drug interactions before prescribing or dispensing simvastatin.

This communication is in keeping with FDA's commitment to inform the public about its ongoing safety review of drugs. The agency will update the public as soon as this review is complete.

View the following communication on the FDA website at *http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm204882.htm*: FDA drug safety communication: Ongoing safety review of high-dose Zocor (simvastatin) and increased risk of muscle injury. ❖

Source: CMS PERL 201003-48

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Transition to new CMS banking contracts

The Centers for Medicare & Medicaid Services (CMS) recently awarded new banking contracts to U.S. Bank and JP Morgan Chase. Medicare providers do not have to take any action. However, providers should be aware that the Medicare payments may be made by a different bank than in the past because of these new banking contractors.

The following Medicare claim processing contractors will remain with JP Morgan Chase:

- Cahaba Government Benefit Administrators
- Pinnacle Business Solutions
- First Coast Service Options
- Palmetto GBA (except for A/B MAC Jurisdiction 1)
- Wisconsin Physician Service

Providers that bill to these contractors will not experience any change.

The following Medicare claim processing contractors will transition to JP Morgan Chase on June 1, 2010:

- Palmetto A/B MAC Jurisdiction 1
- Trailblazer

The following contractors will transition to U.S. Bank on June 1, 2010:

- CIGNA Government Services
- Highmark Medicare Services
- National Government Services
- NHIC
- Noridian Administrative Services. ❖

Source: CMS PERL 201004-06

April 2010 quarterly provider specific file update

The April 2010 quarterly provider specific files (PSF) **statistical analysis software** (SAS) data files are now available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp* in the Downloads section. If you use the provider specific SAS file data, please go to the page above and download the latest version of the PSF files.

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

The April 2010 quarterly provider specific files (PSF) **text** data files are now available on the CMS website at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp* in the Downloads section.

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

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

Source: CMS PERL 201004-24

Centers for Medicare & Medicaid Services public website address change

The Centers for Medicare & Medicaid Services (CMS) changed its website address by removing the "hhs" from the address. The new address is *http://www.cms.gov/*. Existing bookmarks and links from other websites will continue to work following this address change. ❖

Source: CMS PERL 201004-11

Change in provider enrollment timeliness standards for certain paper applications

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

Provider types affected

This article is for all physicians, nonphysician practitioners, and other suppliers submitting paper Medicare enrollment applications to carriers and A/B Medicare administrative contractors [A/B MAC]).

Provider action needed

This article, based on change request (CR) 6807, provides you with information regarding the revised provider enrollment processing timeliness standards for certain Medicare enrollment applications. These include: (1) CMS-855I initial application; (2) CMS-855B initial applications; and (3) change requests and reassignments. Timeliness standards for Internet-based provider enrollment chain and ownership system (PECOS) enrollment applications and Part A providers are not affected by CR 6807. Please be sure that your business office is aware of these changes.

Background

While the Centers for Medicare & Medicaid Services (CMS) encourages physicians and nonphysician practitioners and other suppliers to submit a complete enrollment application and applicable supporting documentation at the time of filing, the revised processing standards will afford physicians, nonphysician practitioners and other suppliers with additional time to respond to a Medicare contractor development requests.

Below is a summary of the timeliness standards found in CR 6807.

- Medicare contractors shall process 80 percent of all initial CMS-855I applications where no contractor development is needed within 60 calendar days of receipt, and 95 percent of such applications within 90 calendar days of receipt. (Development refers to the need for the Medicare contractor to contact the provider for additional information.) In addition, contractors shall process 80 percent of all initial CMS-855I applications where one development request is made by the contractor within 90 days of receipt; and the contractor shall process 70 percent of all initial MS-855I applications where at least two development request are made by the contractor within 90 calendar days of receipt.
- For 855B initial applications submitted by suppliers other than independent diagnostic testing facilities (IDTFs), Medicare contractors shall process 80 percent of these applications where no contractor development is needed within 60 calendar days of receipt , and 95 percent of such applications within 90 calendar days of receipt. In addition, contractors shall process 80 percent of all initial CMS-855B applications where one development request is made by the contractor within 90 days of receipt; and the contractor shall process 70 percent of all initial CMS-855B applications where at least two development requests are made by the contractor within 90 calendar days of receipt.
- For initial 855B applications submitted by IDTFs, Medicare contractors shall process 70 percent of such applications where no contractor development is needed within 90 calendar days of receipt, 80 percent of such applications within 120 calendar days of receipt, and 95 percent of such applications within 180 calendar days of receipt.

For additional information about provider enrollment processing timeliness standards, see the manual revision attached to CR 6807 and the Web address for accessing that CR is in the next section of this article.

Additional information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

The official instruction, CR 6807, issued to your Medicare contractor regarding this change, may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R329PI.pdf*.

Visit the Medicare provider-supplier enrollment page, designed to provide Medicare enrollment information for providers, physicians, nonphysician practitioners, and other suppliers on the CMS website at *http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage*.

MLN Matters® Number: MM6807
Related Change Request (CR) Number: 6807
Related CR Release Date: March 19, 2010
Related CR Transmittal Number: R329PI
Effective Date: June 21, 2010
Implementation Date: June 21, 2010

Source: CMS Pub. 100-08, Transmittal 329, CR 6807

The Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The Centers for Medicare & Medicaid Services (CMS) is working hard to implement expeditiously the new law.

Medicare fee-for-service provisions within the law have varying effective dates and our first priority is to address provisions with the earliest effective dates. CMS is committed to assuring Medicare providers are well informed as early as possible. For that reason, CMS is urging you to be on the alert for notices and instructions from CMS and from your Medicare fiscal intermediary, carrier, or Medicare administrative contractor, on forthcoming policy and operational changes as we implement the PPACA. ❖

Source: CMS PERL 201003-54

2010 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing is available on the FCSO Medicare website at *http://medicare.fcso.com/MEDPARD/*. ❖

Source: CMS Pub. 100-04, Transmittal 1832, CR 6637

New data format for Medicare national correct coding initiative edit files

Beginning with the April 2010 update, the Centers for Medicare & Medicaid Services (CMS) will now post the national correct coding initiative (NCCI) edit files in Microsoft Excel® 2007 and in text formats. Because Excel 2007 can support a larger number of rows, each code range will be contained in one file as opposed to multiple files. This should correct the incompatibility issues that some of our users experienced last quarter with the Excel 2003 files.

Please be aware that Excel 2003 and earlier versions of the software have a maximum row count of 65,536.

Some of the NCCI edit files exceed the maximum row count. If you do not have Excel 2007, please use the text format to import the data into an application that can support larger files.

For more information on NCCI edits, and to download the files, visit the Web page at *http://www.cms.gov/NationalCorrectCodInitEd/*. ❖

Source: CMS PERL 201004-01

Final 2011 payment policies for Medicare Advantage and prescription drug plans

Background: On April 5, 2010, the Centers for Medicare & Medicaid Services (CMS) announced the capitation rates for Medicare Advantage (MA) plans for 2011. The 2011 rate announcement was accompanied by the final 2011 call letter for Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans.

CMS stated in the 2011 advance notice that, if new legislation was enacted after the advance notice was released, but before the rate announcement was published, changes would be incorporated into the announcement. As required by Section 1102 of the Health Care and Education Reconciliation Act of 2010, the capitation rates for 2011 are the same as the capitation rates for 2010.

In rate announcements from previous years, CMS included final estimates of the national per capital growth percentages (MA growth percentages) as well as tables summarizing the key assumptions that were used to develop the MA growth percentages. The final estimates of the MA growth percentages were used to trend the capitation rates from previous years to the payment year. Given that the capitation rates for 2011 are the same as the capitation rates for 2010, the MA growth percentages have no relevance for the 2011capitation rates.

Therefore, this rate announcement does not include final estimates of the MA growth percentages or the associated key assumptions tables.

The rate announcement also contains the following key changes in response to this new legislation:

- CMS will not implement the new CMS-HCC and CMS-HCC ESRD dialysis and risk adjustment models or the recalibrated frailty factors in 2011.
- CMS will maintain the 2011 state ESRD rates at the 2010 amounts.
- As required by the Patient Protection and Affordable Care Act of 2010, CMS will calculate the government Part D premium subsidy amounts for low-income beneficiaries using the basic Part D premium plans before the premiums are reduced by Part C rebates. This will help ensure that the premium subsidy in each Part D region provides low-income beneficiaries with a sufficient choice of plans for which they would incur no premium liability.

The rate announcement also contains a discussion of the provisions in the health reform legislation that begin to close the Part D coverage gap in 2011 and the effect of these provisions on Part D plan bids.

In addition to changes resulting from new legislation, the following key changes or updates have been made to the advance notice and draft call letter in response to public comments received from beneficiary advocacy groups, associations, congressional agencies, members of the public, and health plans:

Final 2011 payment policies for Medicare Advantage and prescription drug plans (continued)

- CMS describes the methodology that will be used to adjust the 'default' risk scores for new enrollees to reflect the predicted costs of full risk enrollees in chronic care special need plans.
- CMS notes that for beneficiaries to receive reimbursement for clinical trial services, beneficiaries (or providers acting on their behalf) must notify their plan that they have received clinical trial services and provide documentation of the cost sharing incurred, such as a Medicare summary notice (MSN). CMS will explore ways that this information can be provided to plans in the future to alleviate the potential burden on beneficiaries.
- CMS states that, at this time, low-income beneficiaries who originally chose to enroll in their current plan will not be reassigned, but several methods to make beneficiaries more aware of their options are being considered. CMS will also continue to evaluate the merits of reassigning beneficiaries based on beneficiary drug utilization.
- CMS announces that we intend to issue a regulation proposing to authorize the release of Part C and Part D payment data.

Annual parameter updates to Medicare Part D benefits are unchanged (with the exception of a $10 increase in the initial coverage limit).

Part D Benefit Parameters	2010	2011
Defined Standard Benefit		
Deductible	$310	$310
Initial Coverage Limit	$2,830	$2,840
Out-of-Pocket Threshold	$4,550	$4,550
Minimum Cost-sharing for Generic/Preferred Multi-Source Drugs in the Catastrophic Phase	$2.50	$2.50
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	$6.30	$6.30
Retiree Drug Subsidy		
Cost Threshold	$310	$310
Cost Limit	$6,300	$6,300

Note: The changes from 2010 to 2011 are rounded to the closest appropriate unit.

The final rate announcement and call letter may be viewed at *http://www.cms.gov/MedicareAdvtgSpecRateStats/*. ❖

Source: CMS PERL 201004-14

Expiration of various payment provisions under the Medicare program

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 and re-issued this special edition *MLN Matters* article to reflect the impact of the Patient Protection and Affordable Care Act (on the therapy caps exceptions process and on billings by independent laboratories for the technical component of physician pathology services furnished to hospital patients. The article was published in the January 2010 *Medicare A Bulletin* (page 4).

Provider types affected

All Medicare providers should take note of this article.

Provider action needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected providers that a number of Medicare payment provisions, such as the therapy cap exceptions process and allowing independent laboratories to bill for the technical component of physician pathology services furnished to hospital patients, have been extended as a result of the Patient Protection and Affordable Care Act (PPACA). Previously, these provisions were to sunset as of December 31, 2009.

Extension of moratorium that allows independent laboratories to bill for the technical component of physician pathology services furnished to hospital patients

On March 23, 2010, President Obama signed into law the PPACA, which extends the moratorium that allows independent laboratories to bill for the TC of physician pathology services furnished to patients in hospitals, effective for claims with dates of service on and after January 1, 2010, through December 31, 2010.

In the final physician fee schedule regulation published in the Federal Register on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. At the request of industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the

Expiration of various payment provisions under the Medicare program (continued)

implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the previous extension of the moratorium expired at the end of 2009, Section 3104 of the PPACA restored the moratorium retroactive to January 1, 2010. Therefore, independent laboratories may now submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2010, through December 31, 2010. If an independent laboratory previously submitted a claim for services covered by this provision and the claim was denied, the laboratory may contact its Medicare contractor for further instructions.

Extension of therapy cap exceptions process

Section 3103 of the PPACA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the **modifier KX**, when an exception is appropriate, for services furnished on or after January 1, 2010, through December 31, 2010.

Therapy caps are determined on a calendar year basis, so all patients began a new cap year on January 1, 2010. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,860. For occupational therapy services, the limit is $1,860. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Please be on the alert for more information pertaining to the PPACA.

MLN Matters® Number: SE0931 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2010
Related CR Transmittal Number: N/A
Implementation Date: As soon as possible

Source: CMS Special Edition *MLN Matters*® Article SE0931

Sunset payment of Indian Health Services

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 and re-issued this special edition *MLN Matters* article to reflect the impact of the Patient Protection and Affordable Care Act on the Indian Health Services (IHS). In essence, the new Act permanently extends Section 630 of the MMA retroactive to January 1, 2010. See the rest of this article to see how the new law impacts your claims. The article was published in the January 2010 *Medicare A Bulletin* (page 6).

Provider types affected

IHS tribe and tribal organizations and facilities submitting claims to Medicare contractors.

Provider action needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that, per the provisions of section 630 of the MMA, certain Part B services will no longer be covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, on March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. Section 2902 of the new law permanently extends Section 630 of the MMA, retroactive to January 1, 2010.

The services involved include the following:

- Durable medical equipment, prosthetics, and orthotics
- Therapeutic shoes
- Clinical laboratory services
- Surgical dressings, splints and casts
- Drugs (those processed by the J4 A/B Medicare administrative contractor (MAC) and the DME MACs)
- Ambulance services
- Influenza and pneumonia vaccinations
- Screening and preventive services.

Indian Health Service providers, suppliers, physicians and other practitioners should contact their Medicare contractor for further guidance regarding IHS claims affected by the new law, for dates of service January 1, 2010, and after, which were denied, prior to implementation of the new law.

Sunset payment of Indian Health Services (continued)

Note: It will take approximately two weeks for your Medicare contractor to update their systems to be able to pay correctly for these services. You may want to wait until the claims processing system is updated before submitting any new claims containing these IHS services. CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue.

Please be on the alert for more information pertaining to the Patient Protection and Affordable Care Act.

MLN Matters® Number: SE0930 – Revised
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: January 1, 2010
Implementation Date: As soon as possible

Source: CMS Special Edition *MLN Matters*® Article SE0930

HCPCS public meeting agendas for drugs, biologicals and radiopharmaceuticals

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of the May 4-5, 2010, HCPCS public meeting agendas for drugs, biologicals and radiopharmaceuticals.

These documents and the link for the corresponding public meeting registrations are located on the HCPCS website at *http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp*. ❖

Source: CMS PERL 201004-12

2010 Part D symposium

The Centers for Medicare & Medicaid Services (CMS) would like to cordially thank you for attending the 2010 Part D symposium on March 18, 2010. We received very positive feedback from participants and presenters. The Part D symposium presentations are now available online under the download section at *http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp*.

We hope you found the symposium a valuable opportunity to discuss Medicare Part D trends and experiences with the community. ❖

Source: CMS PERL 201004-18

Transcripts for the ICD-10-CM national provider conference call now available

The written and oral transcripts of the basic introduction to ICD-10-CM national provider conference call, which was conducted by the Centers for Medicare & Medicaid Services on March 23, 2010, are now available in the Downloads section at *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*. ❖

Source: CMS PERL 201004-32

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.

AMBULANCE SERVICES

Ambulance services – update to the medical condition list and instructions

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

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6896 which updates the *Medicare Claims Processing Manual* (Chapter 15 (Ambulance), Section 40 (Medical Conditions List and Instructions).

Caution – what you need to know

CR 5442 (Transmittal 1185, February 23, 2007) provided for an update to the ambulance fee schedule medical conditions list and instructions found in the *Medicare Claims Processing Manual*. Subsequently, CR 6347 (Transmittal 1696, March 6, 2009) communicated many revisions and updates to most of Chapter 15 of the *Medicare Claims Processing Manual*. However, the updated Section 40 (Medical Conditions List and Instructions) was not updated properly to reflect the updates made by CR 5442. Therefore, CR 6896 updates Section 40, Chapter 15, of the *Medicare Claims Processing Manual*.

Go – what you need to do

CR 6896 is issued primarily for educational guidance and to help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 6896 is being issued to reflect the updates and revisions to the *Medicare Claims Processing Manual* (Chapter 15 [Ambulance], Section 40 [Medical Conditions List and Instructions]), and the following includes the revised Section 40. These updates and revisions will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service.

Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage, not simply the Healthcare Common Procedure Coding System (HCPCS) code or the condition code by themselves. All current Medicare ambulance policies remain in place.

The Centers for Medicare & Medicaid Services (CMS) issued the medical conditions list as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act [HIPAA]) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some Medicare contractors have local coverage determinations (LCD) in place that cite ICD-9-CM that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the medical conditions list in CR 6896 is available for those who do find it helpful in justifying that services are reasonable and necessary. (CR 6896 is available at *http://www.cms.gov/Transmittals/downloads/R1942CP.pdf*.

The medical conditions list in CR 6896 is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and may be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word "plus." In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word "plus") and at least one other ICD-9-CM code from the second part of the alternative listing (after the word "plus"). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes.

Ambulance services – update to the medical condition list and instructions (continued)

Example:

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 [from the alternative column on the medical conditions list]). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the "plus any other code" requirement when using the alternative list for this condition [abnormal vital signs]). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other abnormal clinical findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the Medicare contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical conditions/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an advanced life support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a basic life support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when medical review is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Medicare contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

Information on appropriate use of transportation indicators

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

Air and ground transportation indicators

Transportation indicator C1 indicates an interfacility transport (to a higher level of care) determined necessary by the originating facility based upon the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.

Transportation indicator C2 indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.

Transportation indicator C3 may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately advanced level service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.

Transportation indicator C4 indicates that an ambulance provided a medically necessary transport,

Ambulance services – update to the medical condition list and instructions (continued)

but the number of miles on the claim form appears to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

Ground only transportation indicators

Transportation indicator C5 has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.
For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year old beneficiary who has undergone cataract surgery at the Eye Surgery Center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes mellitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

Transportation indicator C6 has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

Transportation indicator C7 is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., normal saline, lactate ringers, 5% dextrose in water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.

Air only

All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

Transportation indicator D1 long distance: patient's condition requires rapid transportation over a long distance.

Transportation indicator D2: Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.

Transportation indicator D3: Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of hospital time to maximize clinical benefits to the patient.

Transportation indicator D4: Pick up point not accessible by ground transportation.

The revised *Medicare Claims Processing Manual* (Chapter 15, Section 40) is included as an attachment to CR 6896, and in the attachment you can review the medical conditions list which is set up as a series of tables divided into the following principal sections:

- Emergency conditions – non-traumatic
- Emergency conditions – trauma
- Non-emergency
- Transportation indicators
- Air ambulance transportation indicators

Additional information

The official instruction, CR 6896, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1942CP.pdf*.

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

MLN Matters® Number: MM6896
Related Change Request (CR) Number: 6896
Related CR Release Date: April 2, 2010
Related CR Transmittal Number: R1942CP
Effective Date: May 3, 2010
Implementation Date: May 3, 2010

Source: CMS Pub. 100-04, Transmittal 1942, CR 6896

Extension of add-on provisions for ambulance services

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). PPACA Sections 3105 and 10311 impact certain ambulance payment provisions. It should be noted that PPACA Section 3105 establishes the implementation date as April 1, 2010. PPACA Section 10311 revises Section 3105 and changes the implementation date retroactive to January 1, 2010.

The PPACA extends increases in the ambulance fee schedules for covered ground ambulance transports that originated in rural areas by three percent and for covered ground ambulance transports that originated in urban areas by two percent retroactive to January 1, 2010, through December 31, 2010. The new law similarly extends the provision for air ambulance services provided in any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for services furnished on December 31, 2006.

Finally, the PPACA extends retroactive to January 1, 2010, and through December 31, 2010, Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which established the super rural bonus.

The Centers for Medicare & Medicaid Services is working to implement these three ambulance provisions of the PPACA expeditiously.

Be on the alert for more information about these ambulance provisions and their impact on your past and future claims.

In addition, be on the alert for more information pertaining to the Patient Protection and Affordable Care Act. ❖

Source: CMS PERL 201004-10

The revised Ambulance Fee Schedule fact sheet is now available

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 print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*.

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

Source: CMS PERL 201004-09

ELECTRONIC HEALTH RECORDS

Six states to receive federal matching funds for electronic health record incentives program

In another key step to further states' role in developing a robust U.S. health information technology (HIT) infrastructure, the Centers for Medicare & Medicaid Services (CMS) recently announced additional federal matching funds for certain state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009 (Recovery Act).

EHRs will improve the quality of health care for the citizens of Vermont and make their care more efficient. The records make it easier for the many providers who may be treating a Medicaid patient to coordinate care. Additionally, EHRs make it easier for patients to access the information they need to make decisions about their health care.

This batch is part of a rolling announcement we began in November 2009. To date, including the new states, we will have awarded a total of $50.16 million to 32 states and territories.

Colorado	$798,000
Mississippi	$1.47 million
North Carolina	$2.29 million
Nevada	$1.05 million
Utah	$396,000
Wyoming	$596,000
Subtotal	$6.60 million

Additional information on implementation of the Medicaid-related provisions of the Recovery Act's EHR incentive payment program may be found on the CMS website at *http://www.cms.gov/Recovery/11_HealthIT.asp*.

The six states' press releases, issued on March 24, 2010, are available on the CMS website at *https://www.cms.gov/apps/media/press_releases.asp*. ❖

Source: CMS PERL 201003-49

Preparing professionals for a nationwide health care transformation

Health Information Technology for Economic and Clinical Health (HITECH) update

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

April 7, 2010

I know that health care providers are concerned about implementing new health information technology and finding professionals who can operate and maintain such systems. I know many clinicians are unsure how they will develop or strengthen their skill set to incorporate using health information technology (IT) efficiently and effectively without jeopardizing their communication with patients during a clinical visit. It seems like a daunting transformation to clinicians themselves and, indeed, for our health are system overall.

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) recognized that the success of this health IT journey depends on people: people who are passionate about improving patient care, and who are supported in making those improvements.

To this end, the Department of Health & Human Services awarded $84 million to 16 institutions of higher education to fund the Health IT Workforce Development Program, which focuses on several key resources required to rapidly expand the availability of health IT professionals who will support broad adoption and use of health IT in the provider community. Those resources include:

- A community college training program to create a workforce that can facilitate the implementation and support of an electronic health care system
- Quality educational materials that institutions of higher education can use to construct core instructional programs
- A competency examination program to evaluate trainee knowledge and skills acquired through nondegree training programs
- Additional university programs to support certificate and advanced degree training

The Workforce Development Program is one of the best examples of the depth of thought behind the HITECH Act. We could spend many billions of dollars developing, incentivizing, and implementing health IT solutions, but without an effectively trained workforce, our efforts would fall short of their ultimate goal of improving patient care. These efforts, designed in collaboration with the National Science Foundation, Department of Education, and the Department of Labor, are estimated to reduce the shortfall of qualified health IT professionals by 85 percent.

I congratulate the Workforce Development Program awardees and look forward to working with them on this important initiative. Those who take advantage of professional training in health IT provided through award recipients will find opportunities for interesting, challenging, and important work. Not only do these opportunities represent new jobs, they represent promising careers in a growing sector of our economy.

Sincerely,

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

Source: CMS PERL 201004-17

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/*.

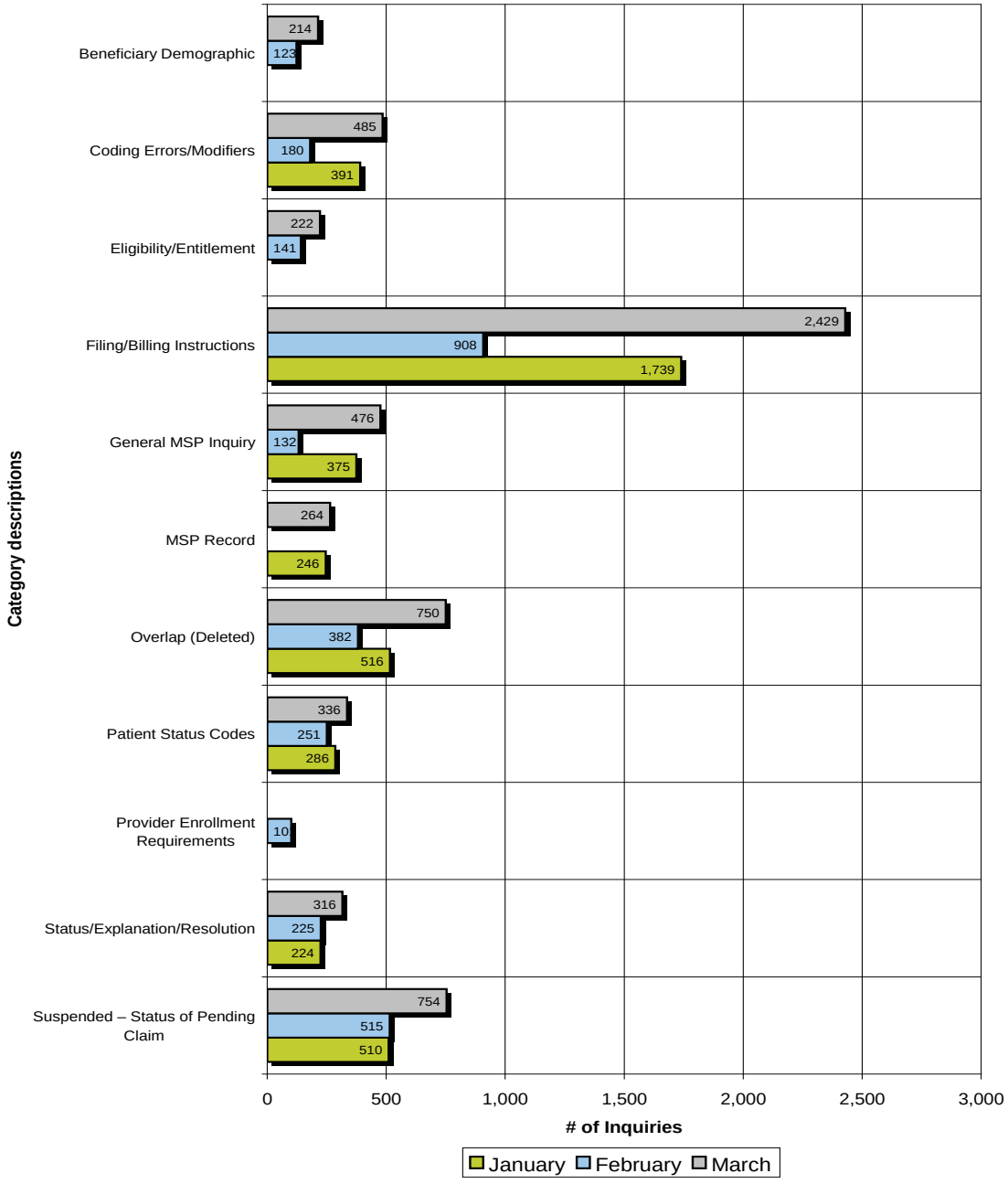
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for January-March 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 January-March 2010.

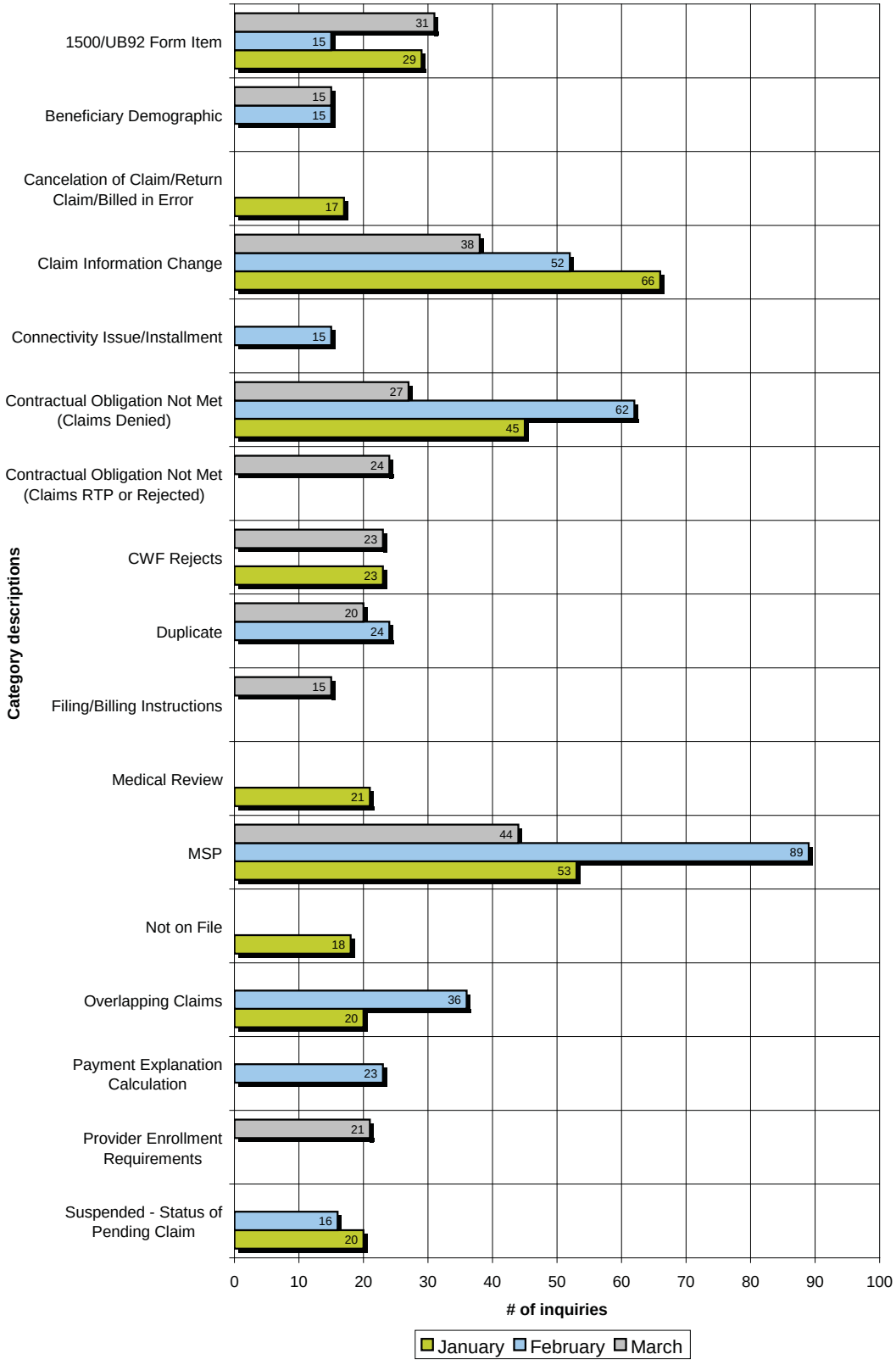
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for January-March 2010



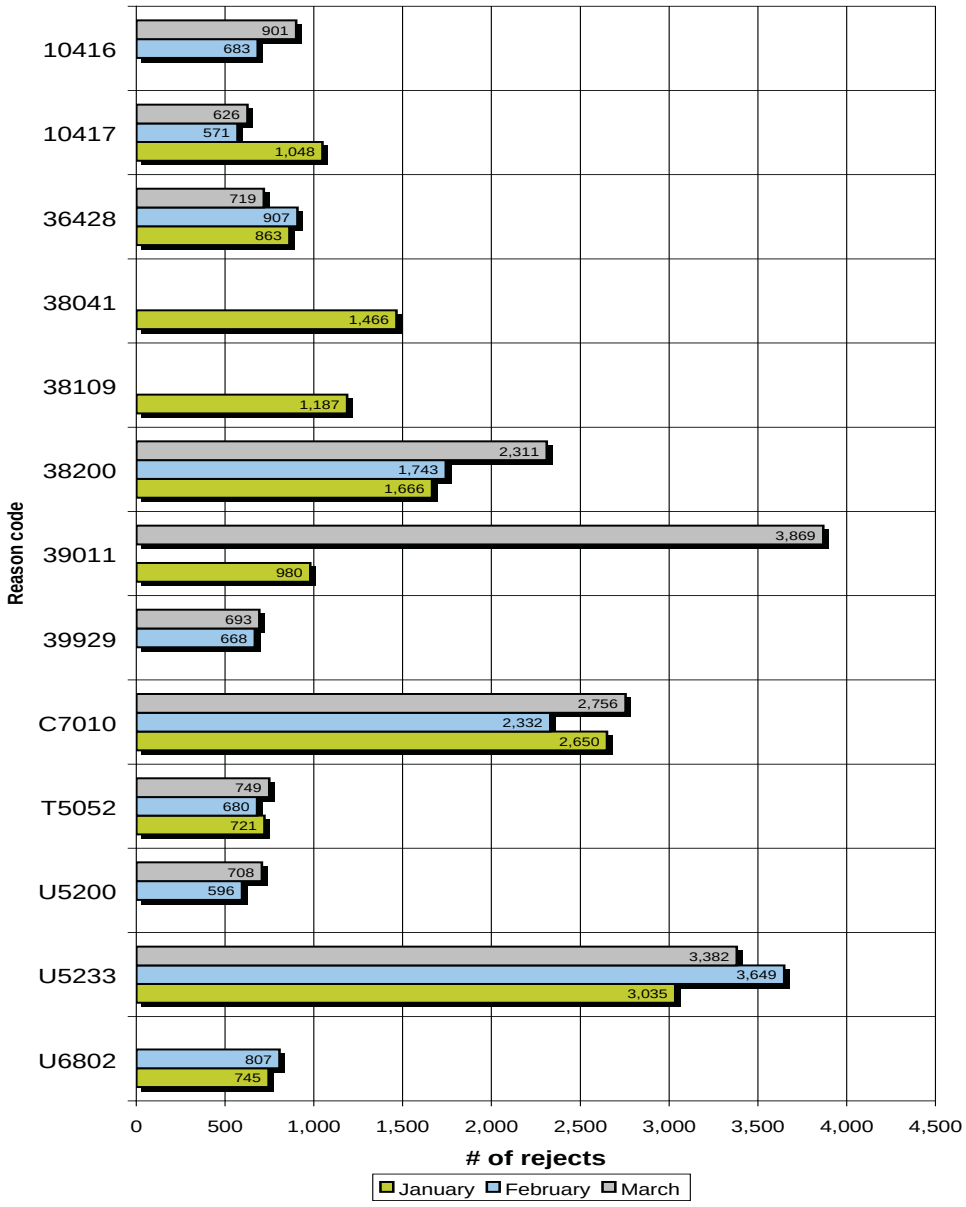
Top inquiries, return to provider, and reject claims for January-March 2010 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for January-March 2010



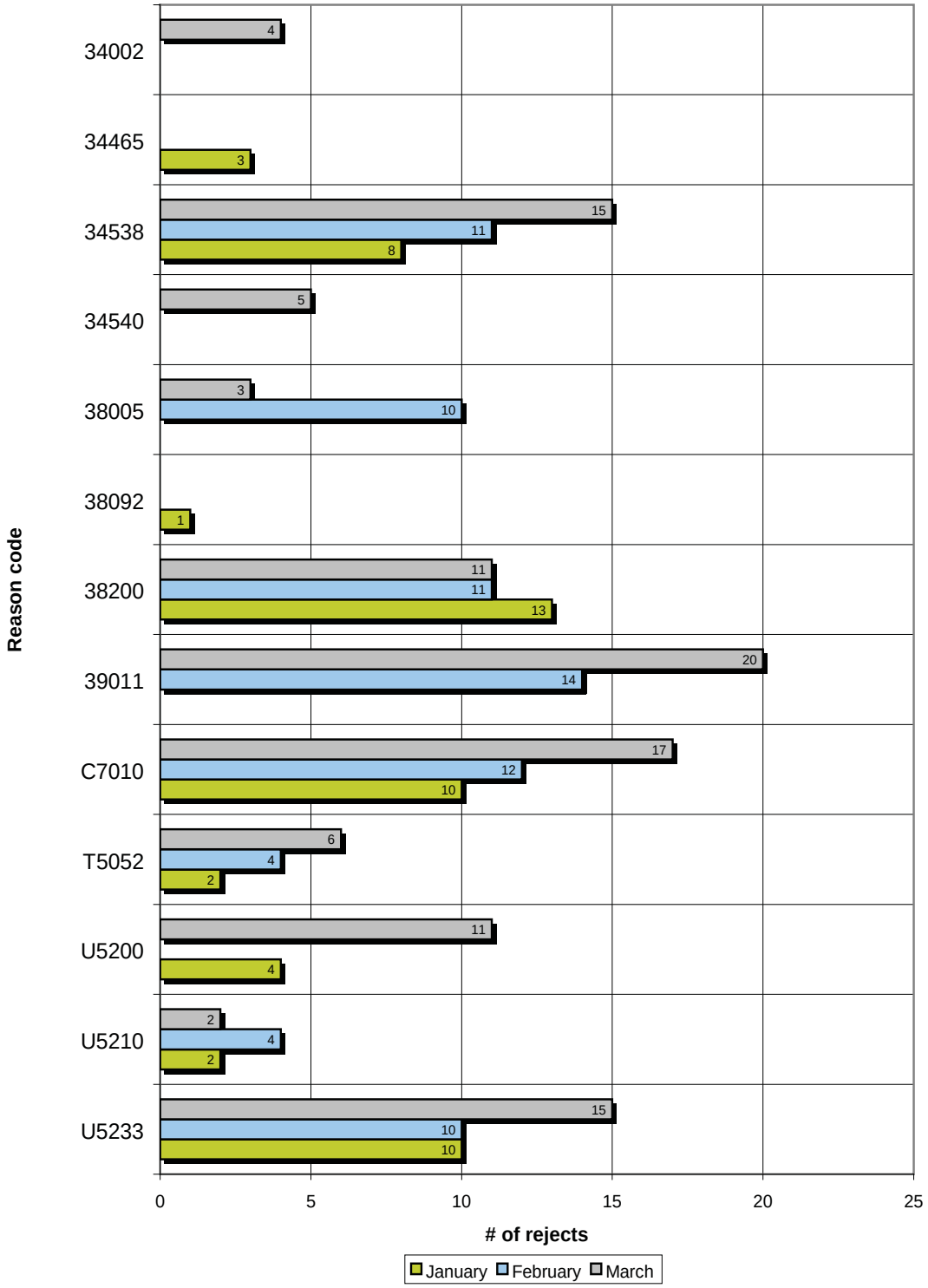
Top inquiries, return to provider, and reject claims for January-March 2010 (continued)

Florida Part A top rejects for January-March 2010



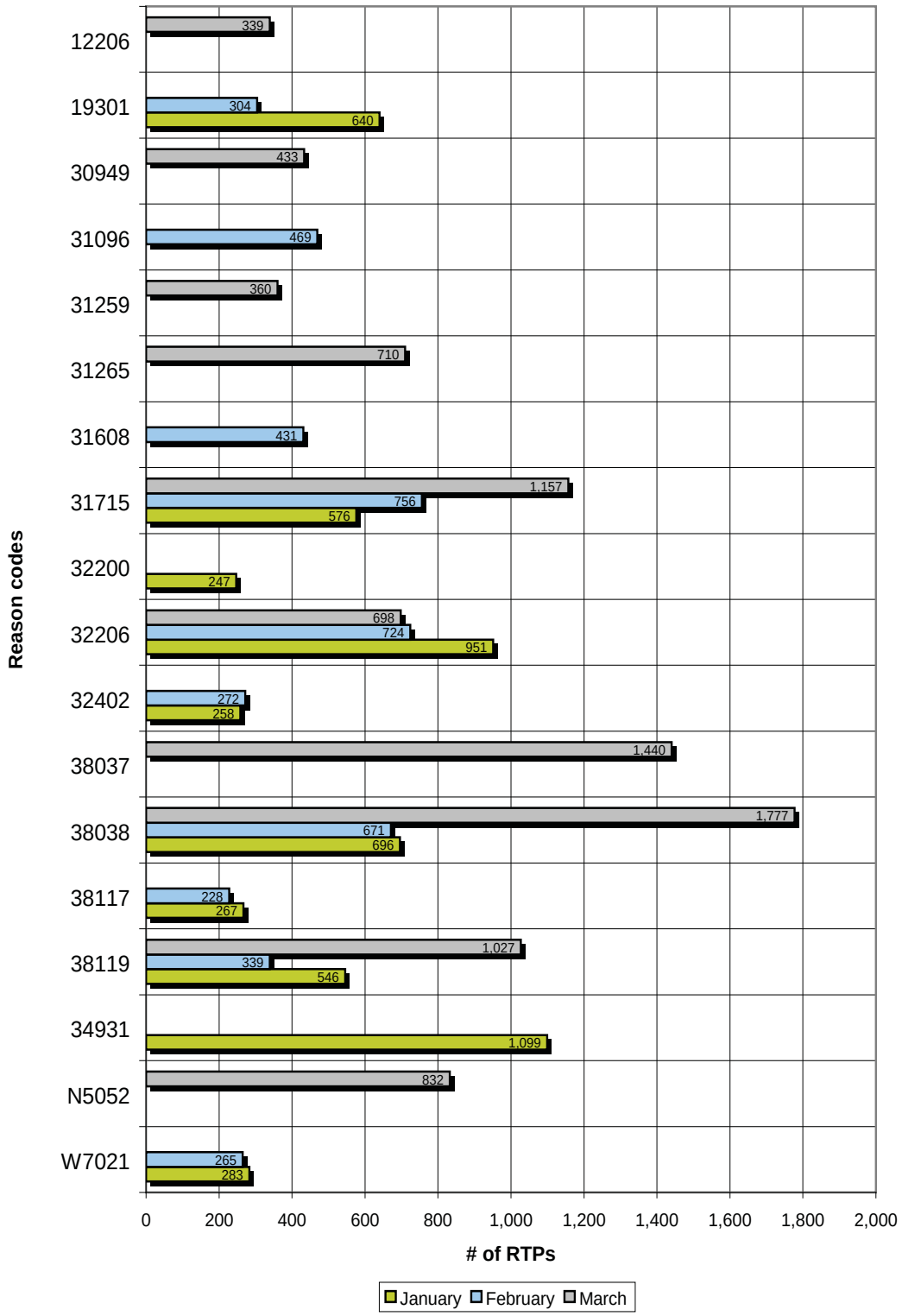
Top inquiries, return to provider, and reject claims for January-March 2010 (continued)

U.S. Virgin Islands Part A top rejects for January-March 2010



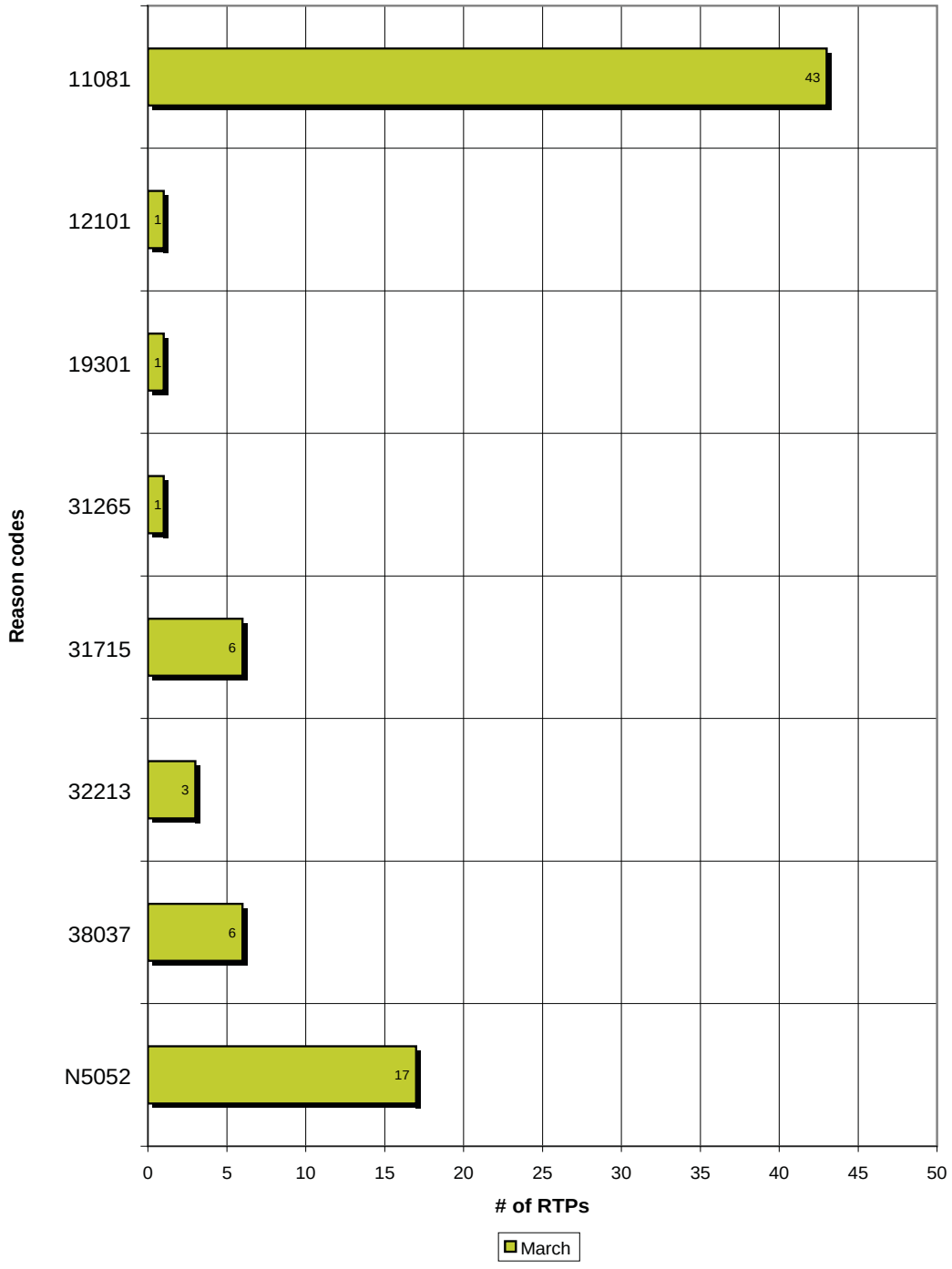
Top inquiries, return to provider, and reject claims for January-March 2010 (continued)

Florida Part A top return to providers (RTPs) for January-March 2010



Top inquiries, return to provider, and reject claims for January-March 2010 (continued)

U.S. Virgin Islands Part A top return to providers (RTPs) for March 2010



GENERAL COVERAGE

Outpatient intravenous insulin treatment

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, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MACs)) for providing outpatient intravenous insulin therapy (OIVIT) to Medicare beneficiaries.

What you need to know

On December 23, 2009, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) announcing the noncoverage decision on the use of outpatient intravenous insulin therapy (OIVIT).

Specifically, CMS has determined (effective for claims with dates of service on or after December 23, 2009) that the evidence does not support a conclusion that OIVIT improve health outcomes in Medicare beneficiaries. Therefore, OIVIT is not reasonable and necessary for any indication under section 1862(a)(1)(A) of the Social Security Act and services comprising an OIVIT regimen are therefore nationally noncovered under Medicare when furnished pursuant to an OIVIT regimen. You should ensure that your billing staffs are aware of this NCD.

Background

CMS (on December 23, 2009) issued a national noncoverage decision on the use of OIVIT. Change request (CR) 6775, from which this article is taken, provides details about this decision.

The term OIVIT refers to an outpatient regimen that integrates pulsatile or continuous intravenous infusion of insulin via any means guided by the results of measuring:

- Respiratory quotient, and/or
- Urine urea nitrogen (UUN), and/or
- Arterial, venous, or capillary glucose, and/or
- Potassium concentration, and
- Performed in scheduled recurring periodic-intermittent episodes.

Most commonly delivered in pulses (but sometimes as a more conventional drip solution), the insulin administration is an adjunct to the patient's routine oral agent or insulin-based diabetic (or other disease) management regimen, typically performed on an intermittent basis (often weekly), and frequently performed chronically without duration limits.

Note: OIVIT is also sometimes termed cellular activation therapy (CAT), chronic intermittent intravenous insulin therapy (CIIT), hepatic activation therapy (HAT), intercellular activation therapy (iCAT), metabolic activation therapy (MAT), pulsatile intravenous insulin treatment (PIVIT), pulse insulin therapy (PIT), and pulsatile therapy (PT).

Coding outpatient intravenous insulin therapy

For use with this noncoverage decision, effective April 5, 2010, CMS will create a new HCPCS code (G9147) that is to be implemented with the April 2010 integrated outpatient code editor (IOCE) and Medicare physician fee schedule database (MPFSDB). You should use this new code on claims that you submit for noncovered OIVIT and any services compromising an OIVIT regimen with dates of service on and after December 23, 2009.

Effective April 5, 2010, *Current Procedural Terminology* (*CPT*) code *99199* (*Unlisted Special Service, Procedure, or Report*) should not be used when billing noncovered OIVIT and any services comprising an OIVIT regimen. Your FI, carrier, or A/B MAC will return any such claims that you submit with *99199* unprocessable using the following messages:

Claim adjustment reason code (CARC) 189 – NOS or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.

Remittance advice remark code (RARC) N56 – The procedure code billed is not correct/valid for the services billed or the date of service billed.

RARC MA66 –Missing/incomplete/invalid principal procedure code.

In addition, effective April 5, 2010, *CPT* code *94681* (exhaled air analysis O2/CO2) must not be used on claims billing for noncovered OIVIT and any services comprising an OIVIT regimen or for claims billing diabetes-related conditions 250.00-250.93. Such claims submitted with *CPT* code *94681* will also be returned as unprocessable using the following messages:

CARC 11 – The diagnosis is inconsistent with the procedure.

RARC N56 – The procedure code billed is not correct/valid for the services billed or the date of service billed.

RARC MA66 – Missing/incomplete/invalid principal procedure code.

Effective April 5, 2010, when HCPCS code G9147 is billed on claims for noncovered OIVIT and any services comprising an OIVIT regimen for dates of service on and after December 23, 2009, Medicare contractors will deny the claim with the following messages:

Medicare summary notice (MSN) 16.10: Medicare does not pay for these item(s) or service(s)

CARC 96: Noncovered charge(s)

CARC M51: Missing/Incomplete /Invalid Procedure Code(s)

Outpatient intravenous insulin treatment (continued)

RARC N386: This decision was based on an NCD. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available on the CMS website at *http://www.cms.gov/mcd/search.asp*.

If you do not have Web access, you may contact the contractor to request a copy of the NCD.

Note: Prior to April 5, 2010, noncovered OIVIT claims with dates of service on and after December 23, 2009, should be processed as they currently are now using NOS *CPT* code *99199* and *CPT* code *94681***.** On April 5, 2010, these codes should no longer be used for noncovered OIVIT claims and new HCPCS code G9147, created for this purpose, should be used in their place.

Please remember that individual components of OIVIT may have medical uses in conventional treatment regimens for diabetes and other conditions; and in these contexts, coverage may be determined by other local or national Medicare determinations, and do not pertain to OIVIT.

For examples of these uses you might want to look at the *Medicare National Coverage Determinations Manual* Sections 40.2, (Home Glucose Monitors), Section 40.3 (Closed-loop Blood Glucose Control Devices), Section 190.20 (Blood Glucose Testing), and Section 280.14 (Infusion Pumps. You may also want to look at the *Medicare Claims Processing Manual*, Chapter 18, Section 90, on Diabetes Screening. These manuals are available at *http://www.cms.gov/Manuals/IOM/list.asp*.

In addition, you should know that your contractors will not automatically search their files for claims with dates of service between December 23, 2009, and April 5, 2010, but may go back and adjust claims that you bring to their attention.

Additional information

You may find more information about noncoverage of OIVIT by going to CR 6775, which was issued via two transmittals. The first transmittal, located at *http://www.cms.gov/Transmittals/downloads/R117NCD.pdf*, contains the updated *Medicare National Coverage Determinations Manual* sections related to CR 6775. The second transmittal, located at *http://www.cms.gov/Transmittals/downloads/R1930CP.pdf*, contains the updated sections of the *Medicare Claims Processing Manual*.

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

MLN Matters® Number: MM6775
Related Change Request (CR) Number: 6775
Related CR Release Date: March 9, 2010
Related CR Transmittal Number: R117NCD and R1930CP
Effective Date: December 23, 2009
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1930, CR 6775

Billing split/shared consultation services

This article is a clarification to a concern expressed by some providers regarding the following question and answer in the special edition *MLN Matters* article SE1010:

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.

In a recent open door forum, the Centers for Medicare & Medicaid Services provided the following clarification:

Since Medicare no longer recognizes consultation codes, the existing split/shared rules that correspond to the evaluation and management service (E/M) codes that the provider must now use in place of the consultation codes will apply. Therefore, a provider can split/share a consultation-type service when using an applicable split/shared E/M code (such as hospital or office/outpatient E/M codes).

The guidelines regarding split/shared visits may be found in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 12, Sections 30.6.1-30.6.14. ❖

Source: CMS Special Edition *MLN Matters*® Article SE1010

Signature guidelines for medical review purposes

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

Provider types affected

This article is for physicians, nonphysician practitioners, and suppliers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), carriers, regional home health intermediaries (RHHIs) and/or durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for e-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for reviews conducted on or after the implementation date of April 16, 2010.

Please note that all signature requirements in CR 6698 are effective retroactively for comprehensive error rate testing (CERT) for the November 2010 report period.

Background

Those contractors who review Medicare claims include MACs, affiliated contractors (ACs), the CERT contractors, recovery audit contractors (RACs), program safeguard contractors (PSCs), and zone program integrity contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Medicare fee-for-service (FFS) program.

The previous language in the *Program Integrity Manual (PIM)* required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds e-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

Exception 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

Exception 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the *Medicare Benefit Policy Manual*, Chapter 15, Section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

Exception 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, national coverage determination (NCD), local coverage determination (LCD) and CMS manuals are silent on whether the signature is legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g., MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

- If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.
- Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.

Signature guidelines for medical review purposes (continued)

Example: The claim selected for review is for a hospital visit on October 4. The additional documentation request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.

- **Definition of a signature log**: Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- **Definition of an attestation statement**: In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

  "I, _____[print full name of the physician/ practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."
- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.
- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
  - In the situations where the guidelines indicate "**signature requirements met**," the reviewer will consider the entry.
  - In situations where the guidelines indicate "**contact provider and ask a non-standard follow-up question**," the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
  - In the situations where the guidelines indicate "**signature requirements not met**," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic prescribing

Electronic prescribing (e-Prescribing) is the transmission of prescription or prescription-related information through electronic media. e-Prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-Prescribing network. With e-Prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. e-Prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified r-Prescribing system. For Medicare Part B medical review purposes, a qualified e-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the

Signature guidelines for medical review purposes (continued)

official standards for electronic prescribing, 42 CFR 423.160 Standards for Electronic Prescribing, you may go to *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf*.

- When Part B drugs, other than controlled substances, have been ordered through a qualified e-Prescribing system, the reviewer will **not** require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall **not** accept as a valid order any controlled substance drugs that are ordered through any e-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.
- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified e-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified e-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified e-Prescribing system, the reviewer shall **not** require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional information

The official instruction, CR 6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R327PI.pdf*.

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

MLN Matters® Number: MM6698
Related Change Request (CR) Number 6698
Related CR Release Date: March 16, 2010
Related CR Transmittal Number: R327PI
Effective Date: March 1, 2010
Implementation Date: April 16, 2010

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

Medicare expands coverage for treating facial lipodystrophy syndrome in people living with HIV

On March 23, 2010, the Centers for Medicare & Medicaid Services (CMS) announced its decision to cover facial injections for Medicare beneficiaries who experience symptoms of depression due to the stigmatizing appearance of severely hollowed cheeks resulting from the drug treatment for human immunodeficiency virus (HIV). **This decision is effective immediately.**

Facial lipodystrophy syndrome (LDS) is a localized loss of fat from the face, causing an excessively thin appearance in the cheeks. In some cases, facial LDS may be a side effect of certain kinds of medications (antiretroviral therapies) that individuals receive as part of an HIV infection treatment regimen.

The facial LDS may leave people living with HIV looking gaunt and seriously ill, which may stigmatize them as part of their HIV-infection status. Individuals who take these medications and experience facial LDS side effects may suffer psychological effects related to a negative self-image. These effects may lead people living with HIV to discontinue their antiretroviral therapies. The new decision allows for treatment of individuals who experience symptoms of depression due to the appearance changes from facial LDS.

The injections included in this coverage decision are "fillers" that have been approved by the U.S. Food and Drug Administration (FDA) to be injected under the skin in the face to help fill out its appearance specifically for treatment of facial LDS. Data show that these injections can improve patient self-image, relieve symptoms of depression, and may lead to improved compliance with anti-HIV treatment.

"Today's decision marks an important milestone in Medicare's coverage for HIV-infection therapies," said Barry M. Straube, M.D., CMS Chief Medical Officer and Director of the Agency's Office of Clinical Standards & Quality. "Helping people living with HIV improve their self-image and comply with anti-HIV treatment can lead to better quality of life and, ultimately, improve the quality of care that beneficiaries receive."

The final decision is posted on the CMS website at *http://www.cms.gov/mcd/viewdecisionmemo.asp?id=234*. ❖

Source: CMS PERL 201003-44

Automatic implantable cardiac defibrillator services provided in a clinical study

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

Provider types affected

This article is for all providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for ICD services rendered to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6867 and updates the list of ICD-9-CM diagnosis codes not requiring the HCPCS **modifier Q0 (zero)** for implantable cardiac defibrillator (ICD) services provided in a clinical study. Be sure your billing staff knows of this change.

Key point of change request 6867

ICD-9-CM diagnosis code **V12.53** (effective October 1, 2007) **does not** require a **modifier Q0** for payment. The following is a complete list of diagnosis codes that do not require **modifier Q0**.

Diagnosis codes that do not require either modifier QR (for dates of service prior to January 1, 2008) or modifier Q0 (for dates of service on or after January 1, 2008)

ICD-9-CM code	Secondary prevention diagnosis
427.1	Ventricular tachycardia
427.41	Ventricular fibrillation
427.42	Ventricular flutter
427.5	Cardiac arrest
427.9	Cardiac dysrhythmia, unspecified
V12.53	Personal history of sudden cardiac arrest
996.04	Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator
V53.32	Fitting and adjustment of other device, automatic implantable cardiac defibrillator

Further, when any of these codes do appear on an ICD claim, the **modifier QR** is not required. However, it should be noted that providers are permitted to append the **modifier QR** for secondary prevention diagnoses if they deem it appropriate, i.e., that data is submitted to a data collection registry.

Background

Requiring reporting of HCPCS modifier QR to identify primary prevention indications for ICDs

On March 8, 2005, CR 3604, Transmittal (TR) 497, was issued to provide instructions to Centers for Medicare & Medicaid Services (CMS) contractors on how to process ICD implantations under newly expanded coverage. Among other specifications, CR 3604 informed CMS contractors that one of the requirements for covering the new indications is that the patient be enrolled in a data collection system.

Currently, CMS identifies claims through the procedure code for defibrillator implantation and the **absence** of five specified arrhythmia codes and two codes often used when the device is being replaced. It has come to CMS' attention that one other code should be included on this list – V12.53, personal history of sudden cardiac arrest, bringing the total number of diagnosis codes to eight.

Replacing of HCPCS modifier QR with Q0 (zero)

CR 5805 was issued on January 18, 2008 (after CR 3604 was issued). Among other things, CR 5805 replaced HCPCS modifier QR with HCPCS modifier Q0, effective for dates of service on or after January 1, 2008. To review the *MLN Matters*® article related to CR 5805 you may go to the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM5805.pdf*.

Providers take note: Effective for claims with dates of service on or after April 1, 2005, for 427.89 and on or after October 1, 2007, for V12.53, your Medicare contractors will adjust as appropriate claims brought to their attention that were denied because the diagnosis code V12.53 and lacked the **modifier Q0** for dates of service on or after January 1, 2008, or lacked the **modifier QR** for dates of service prior to January 1, 2008.

Automatic implantable cardiac defibrillator services provided in a clinical study (continued)

Additional information

The official instruction and the revised *Medicare Claims Processing Manual* instruction associated with CR 6867, issued to your Medicare MAC, FI or carrier regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R663OTN.pdf*.

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

MLN Matters® Number: MM6867
Related Change Request (CR) Number: 6867
Related CR Release Date: March 26, 2010
Related CR Transmittal Number: R663OTN
Effective Date: October 1, 2007 for ICD-9-CM V12.53
Implementation Date: July 6, 2010

Source: CMS Pub. 100-20, Transmittal 663, CR 6867

Positron emission tomography (NaF-18) to identify bone metastasis of cancer

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 other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) when providing NaF-18 positron emission tomography (PET) scans to identify bone metastasis of cancer for Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6852 and states that effective for claims with dates of service on and after February 26, 2010, be aware that NaF-18 PET oncologic claims to inform initial treatment strategy (PI) or subsequent treatment strategy (PS) for suspected or biopsy proven **bone metastasis are covered, but only in the context of a clinical study**. All other claims for NaF-18 PET oncology claims are noncovered.

Background

On June 4, 2009, the Centers for Medicare & Medicaid Services (CMS) opened a reconsideration of section 220.6 of the *National Coverage Determinations (NCD) Manual* to review evidence on the use of NaF-18 (sodium fluoride-18) imaging (NaF-18 PET) to identify bone metastasis of cancer. CMS proposes that the evidence is not sufficient to determine that the results of NaF-18 PET imaging to identify bone metastases improve health outcomes of beneficiaries with cancer.

Therefore, this use is not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act (the Act).

However, CMS proposes that the available evidence is sufficient to determine that NaF-18 PET imaging, to identify symptomatic or strongly suspected bone metastasis of cancer to inform the initial antitumor treatment strategy or to guide subsequent antitumor treatment strategy after the completion of initial treatment, is reasonable and necessary under Section 1862(a)(1)(E) through coverage with evidence development (CED) when the beneficiary's treating physician determines that the NaF-18 PET study is needed, and when the beneficiary is enrolled in, and the NaF-18 PET provider is participating in, specific types of prospective clinical studies as outlined in Section 220.6 of the NCD Manual.

Key points of change request 6861

NaF-18 PET oncologic claims:

- With dates of service on or after February 26, 2010, Medicare contractors will accept and pay the claims as specified in the revised Section 220.6.19 of the NCD Manual, to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven bone metastasis **only in the context of a clinical study**.

  Note: NaF-18 PET also applies to NaF-18 PET/CT**.**

- With dates of service on or after February 26, 2010, contractors **will return as unprocessable** (professional) or **return to provider** the claims to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis that do not include **all** of the following are present on the claim:
  - Modifier PI or PS
  - PET or PET/CT *CPT* codes *78608, 78811, 78812, 78813, 78814, 78815, 78816*
  - ICD-9-CM cancer diagnosis code
  - HCPCS A9580 (sodium fluoride F-18, diagnostic, per study dose, up to 30 millicuries)
  - Modifier Q0 – Investigational clinical service provided in a clinical research study that is in an approved clinical research study.

  Note: For institutional claims, continue to include diagnosis code V70.7 and condition code 30 to denote a clinical study.

Positron emission tomography (NaF-18) to identify bone metastasis of cancer (continued)

- Effective for claims with dates of service on or after February 26, 2010, when returning NaF-18 PET claims to providers, they will use the following messages depending on the reason for return:
  - Claims returned for not having the Q0 and either the PI or PS modifier will reflect claim adjustment reason code (CARC) of 4 (The procedure is inconsistent with the modifier used or a required modifier is missing.), remittance advice remark code (RARC) MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.), and RARC M16 (Alert: See our website, mailings, or bulletins for more details concerning this policy/procedure/decision.)
  - Such claims submitted without HCPCS A9580 will be returned with RARC M20 (Missing/incomplete/invalid HCPCS)
  - Such claims submitted without an ICD-9 cancer diagnosis code will contain CARC 167 (This (these) diagnosis(es) is (are) not covered).
- Although this coverage decision is effective February 26, 2010, it will not be fully implemented until a clinical study is ready to enroll providers and patients. Medicare will notify providers and beneficiaries where these services may be accessed, as they become available, via the CMS coverage page at *http://www.cms.gov/center/coverage.asp*.

Additional information

The official instruction, CR 6861, was issued to your Medicare MAC, FI or carrier regarding this change via two transmittals. The first modifies the Medicare NCD Manual and is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R119NCD.pdf*.

The second revises the Medicare *Claims Processing Manual* and it may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1937CP.pdf*.

Attached to the NCD transmittal is the revised Section 220.6.19 of the *NCD Manual*.

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

MLN Matters® Number: MM6861
Related Change Request (CR) Number: 6861
Related CR Release Date: March 26, 2010
Related CR Transmittal Number: R1937CP and R119NCD
Effective Date: February 26, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1937, CR 6861

Special instructions for specific test codes paid under the clinical laboratory fee schedule

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

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article is based on change request (CR) 6852, which provides special instructions for the proper use of *Current Procedural Terminology* (*CPT*) codes *80100, 80101*, and *80101QW*, as well as HCPCS codes G0430, G0430QW, G0431, and G0431QW as of April 1, 2010. Be sure your billing staff is aware of the changes outlined in this article.

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) hosts an annual public meeting concerning new test codes that have been established by the *CPT* committee and that will be covered by Medicare and paid based on the clinical laboratory fee schedule (CLFS).

Special instructions for specific test codes paid under the clinical laboratory fee schedule (continued)

During calendar year (CY) 2009, effective for January 1, 2010, two new G codes were established: G0430 and G0431. Some providers were incorrectly using *CPT* codes *80100* and *80101*. Therefore, CMS created two new G codes to operate in place of and alongside existing *CPT* codes *80100* and *80101*.

In addition, those clinical laboratories that require a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver had been utilizing *CPT* code *80101QW*. In order to ensure that clinical laboratories that require a CLIA certificate of waiver are also billing correctly whether the drug screen test performed is for a single drug class or multiple drug classes, effective April 1, 2010, two additional G codes were established – G0430QW and G0431QW.

Key points of change request 6852

Each test code discussed in CR 6852 is currently described as follows by the American Medical Association (AMA) (*CPT* codes) and HCPCS (G codes):

80100	*Drug screen, qualitative; multiple drug classes chromatographic method, each procedure*
80101	*Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
80101QW	*Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
G0430	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
G0430QW	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
G0431	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class
G0431QW	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class.

For purposes of the CLFS, beginning with dates of service on or after April 1, 2010, when performing a qualitative drug screening test for multiple drug classes that uses chromatographic methods, *CPT* code *80100* is the appropriate code to bill.

New test code G0430 was created to limit the billing to one time per procedure and to remove the limitation of the method (chromatographic) when this method is not being used in the performance of the test. As a result, when a clinical laboratory that does not require a CLIA certificate of waiver performs a qualitative drug screening test for multiple drug classes that does not use chromatographic methods, new test code G0430 is the appropriate code to bill.

When a clinical laboratory that does require a CLIA certificate of waiver performs a qualitative drug screening test for multiple drug classes that does not use chromatographic methods, new test code G0430QW is the appropriate code to bill.

Remember: New test code G0431 is a direct replacement for *CPT* code *80101*. For purposes of the CLFS, effective with dates of service on or after April 1, 2010, new test code G0431 should be utilized by those clinical laboratories that do not require a CLIA certificate of waiver. Those clinical laboratories that do require a CLIA certificate of waiver should utilize new test code G0431QW. Effective April 1, 2010, Medicare will no longer cover *CPT* code *80101*, and *CPT* code *80101QW* will be deleted.

Additional information

The official instruction, CR 6852, issued to your Medicare MAC, FI or carrier regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R653OTN.pdf*.

A related article, MM6657 which provides instructions for the CY 2010 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment, may be reviewed on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6657.pdf*.

For additional information regarding the CY 2010 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment see special edition *MLN* article SE1001 on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/SE1001.pdf*.

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

MLN Matters® Number: MM6852
Related Change Request (CR) Number: 6852
Related CR Release Date: March 19, 2010
Related CR Transmittal Number: R653OTN
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-20, Transmittal 653, CR 6852

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 website *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 website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the FCSO *eNews* mailing list. It is very easy to do. Simply go to our educational website *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

Table of contents

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 website at *http://medicare.fcso.com*.

NEW LCD IMPLEMENTATION

A46930: Destruction of internal hemorrhoid(s) by infrared coagulation (IRC) – new LCD

LCD ID Number: L30860 (Florida/Puerto Rico/U.S. Virgin Islands)

Infrared coagulation (IRC) is one of several non-surgical outpatient therapies for the treatment of internal hemorrhoids without the need for anesthesia. Infrared coagulation involves direct application of infrared waves that penetrates the tissue and converts to heat, promoting coagulation of vessels and fixation of the hemorrhoidal tissue. The amount of tissue destruction depends on the intensity and duration of the application. It is recommended that the infrared probe be applied for 1.5 seconds to the apex of each internal hemorrhoid and be repeated three times on each hemorrhoid. Infrared coagulation involves direct application of infrared waves resulting in protein necrosis, and is considered useful only in the treatment of Stage 1 and Stage II hemorrhoids, without significant prolapse. IRC is associated with high rates of recurrence when substantial prolapse is present. Multiple (two-six) hemorrhoids may be treated at one time using IRC.

This local coverage determination (LCD) has been developed to provide indications and limitations, documentation requirements and utilization guidelines for the destruction of internal hemorrhoid(s) by infrared coagulation (IRC). In addition, a "Coding Guidelines" LCD attachment has been developed for this service, which includes information regarding the 90 day global period and related modifier utilization. A list of procedure codes that should be used to report nonthermal methods of removal and destruction of hemorrhoids has also been included.

Effective date

This new LCD is effective for services provided **on or after June 7, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

A82306: Vitamin D; 25 hydroxy, includes fraction(s), if performed – new LCD

LCD ID Number: L30866 (Florida/Puerto Rico/U.S. Virgin Islands)

Vitamin D, a group of fat-soluble prohormones, is an essential vitamin. There are two major types of vitamin D (vitamin D2 and vitamin D3) that are collectively known as calciferol. They are essential for promoting calcium absorption and maintaining adequate serum calcium and phosphate concentrations to enable mineralization of bone and prevent hypocalcemic conditions. Vitamin D2 (ergocalciferol) is obtained from foods of plant origin and vitamin D3 (cholecalciferol) is obtained from foods of animal origin and ultraviolet light-stimulated conversion of 7-dehydrocholestral in the skin. Vitamin D is stored in the human body as calcidiol (25-hydroxyvitamin D). Serum concentration of 25(OH) D is the best indicator of vitamin D status.

Vitamin D deficiencies are the result of dietary inadequacy, impaired absorption and use, increased requirement, or increased excretion. Vitamin D deficiency may occur when usual intake is lower than recommended levels over a period of time, or when exposure to sunlight is limited. Vitamin D deficiency may also result from the inability of the kidneys to convert the vitamin D to its active form. Vitamin D toxicity may cause symptoms including nausea, vomiting, poor appetite, constipation, weakness, and weight loss as well as elevation in the blood level of calcium which in turn may lead to mental status changes, and heart rhythm abnormalities.

This local coverage determination (LCD) has been developed to provide indications and limitations, documentation requirements and utilization guidelines for this service.

Effective date

This new LCD is effective for services provided **on or after June 7, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

AJ2562: Plerixafor (Mozobil®) – new LCD

LCD ID Number: L30872 (Florida/Puerto Rico/U.S. Virgin Islands)

The availability of stem cell growth factors has lead to the treatment of certain types of cancers by performing peripheral blood stem cell transplants (PBSCT). Performing PBSCT allows a patient to be treated with higher doses of drugs such as chemotherapy or with radiation therapy. PBSCT is a process by which blood-forming cells that have been destroyed by cancer treatment are replaced after the patient has been treated with chemotherapy or radiation therapy. Two types of cancers commonly treated with PBSCT are non-Hodgkin's lymphoma (NHL) and multiple myeloma (MM). NHL is a type of cancer that forms in the cells that make up the immune system and is either fast or slow growing. MM is a type of cancer that forms in the plasma cells (white blood cells). In order to proceed to the process of performing a PBSCT, the stem cells must be collected through a process called apheresis. To increase the number of stem cells released into the blood stream for collection, the patient may be given a drug called a growth factor (colony stimulating factor).

Plerixafor (Mozobil®) is not a growth factor. It is a reversible inhibitor of the CXCR4 chemokine receptor and blocks binding of its cognate ligand, stomal cell-derived factor-1α (SDF-1α). SDF-1α and CXCR4 are recognized to play a role in the trafficking and homing of human hematopoietic stem cells (HSCs) to the marrow compartment.

Plerixafor (Mozobil®) is a hematopoietic stem cell mobilizer approved by the Food and Drug Administration (FDA) to be used for the following indication:

Mozobil® is indicated to be used in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma.

This local coverage determination (LCD) has been developed to provide indications and limitations, documentation requirements and utilization guidelines. In addition, a "Coding Guidelines" LCD attachment has been developed for this service, which includes information regarding proper coding of diagnosis codes and an outline of a typical treatment regimen since this drug must be given in conjunction with Neupogen®.

Effective date

This new LCD is effective for services provided **on or after June 7, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

AJ2796: Romiplostim (Nplate®) – new LCD

LCD ID Number: L30876 (Florida/Puerto Rico/U.S. Virgin Islands)

Romiplostim (Nplate®) is an injectable thrombopoietin (TPO) receptor agonist that stimulates bone marrow megakaryocytes to produce platelets. It is used in patients with (idiopathic) thrombocytopenic purpura (ITP) whose degree of thrombocytopenia (i.e., bleeding condition in which the blood does **not** clot as it should due to low platelet counts) and clinical condition increase the risk for bleeding.

Romiplostim (Nplate®) is available only through a restricted distribution program called Nplate® NEXUS (Network of Experts Understanding and Supporting Nplate® and Patients) Program. Under this program, only prescribers and patients registered with the Nplate® NEXUS Program are able to prescribe, administer, and receive romiplostim (Nplate®).

This local coverage determination (LCD) is based upon the U.S. Food and Drug Administration (FDA) approved indication for patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP), ICD-9-CM code 287.31, who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy and are registered (including the prescriber) with the Nplate® NEXUS Program.

The LCD has been developed to outline indications and limitations of coverage, documentation requirements, and utilization guidelines. In addition, a "Coding Guidelines" LCD attachment has been developed for this service.

Effective date

This new LCD is effective for services provided **on or after June 7, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

ADDITIONS/REVISIONS TO EXISTING LCDS

AJ9310: Rituximab (Rituxan®) – revision to the LCD

LCD ID Number: L28980 (Florida)
LCD ID Number: L29013 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was most recently revised on February 16, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. A reconsideration request was received asking First Coast Service Options Inc. (FCSO) to revise the LCD to include the new Food and Drug Administration (FDA) indication approved on February 18, 2010. The new indication allows Rituxan® to be administered for chronic lymphocytic leukemia (CLL) in combination with fludarabine and cyclophosphamide (Fc), for the treatment of patients with previously untreated and previously treated CD20-positive CLL. Previously FCSO covered the CLL as an off-label indication. The LCD has been revised to include CLL as an FDA-approved indication and has removed CLL from the off-label list of covered indications, under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services provided **on or after February 18, 2010,** for claims processed **on or after April 1, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

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

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

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on January 25, 2010. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS), Transmittals 117 and 1930, Change Request 6775, dated March 9, 2010. In this regard, *CPT* code *99199* used for pulsatile intravenous insulin therapy (PIVIT) has been deleted from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions, Procedures" section of the LCD.

Effective date

This revision is effective for claims processed **on or after April 14, 2010**, for services provided **on or after December 23, 2009**.

HCPCS code G9147 (outpatient intravenous insulin treatment [OIVIT] either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen [UUN]; and/or, arterial, venous or capillary glucose; and/or potassium concentration) is to be used on claims with dates of service on or after December 23, 2009, billing for noncovered OIVIT and any services comprising an OIVIT regimen.

As stated in the CMS transmittals referenced above, effective December 23, 2009, CMS determines that the evidence does not support a conclusion that OIVIT improves health outcomes in Medicare beneficiaries. Therefore, OIVIT is not reasonable and necessary for any indication under section 1862(a) (1) (A) of the Social Security Act, and services comprising an OIVIT regimen are nationally noncovered under Medicare when furnished pursuant to an OIVIT regimen.

OIVIT is also referred to as cellular activation therapy (CAT), chronic intermittent intravenous insulin therapy (CIIT), hepatic activation therapy (HAT), intercellular activation therapy (iCAT), metabolic activation therapy (MAT), pulsatile intravenous insulin treatment (PIVIT), pulse insulin therapy (PIT) and pulsatile therapy (PT).

This revision is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, contractors with the federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4)(2005)). First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

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

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

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on April 14, 2010. Since that time, a revision was made to the LCD to add *CPT* category III code *0206T* based on an evaluation, and to add twelve *CPT* laboratory codes with descriptors based on consistency with the Part B LCD for the list of Medicare noncovered services.

Under the "Local Noncoverage Decisions - Procedures" section of the LCD, *CPT* code *0206T (Algorithmic analysis, remote, of electrocardiographic-derived data with computer probability assessment, including report*) was added. Under the "Local Noncoverage Decisions – Laboratory Procedures" section, the following *CPT* codes with descriptors were added:

87512 Gardnerella vaginalis, quantification
87515 hepatitis B virus, direct probe technique
87520 hepatitis C, direct probe technique
87525 hepatitis G, direct probe technique
87526 hepatitis G, amplified probe technique
87527 hepatitis G, quantification
87531 Herpes virus-6, direct probe technique
87532 Herpes virus-6, amplified probe technique
87533 Herpes virus-6, quantification
87540 Legionella pneumophila, direct probe technique
87541 Legionella pneumophila, amplified probe technique
87542 Legionella pneumophila, quantification

Effective date

This revision is effective for services provided **on or after June 7, 2009**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

AZEVALIN: Ibritumomab tiuxetan (Zevalin®) therapy – revision to the LCD

LCD ID Number: L28888 (Florida)
LCD ID Number: L28910 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ibritumomab tiuxetan (Zevalin®) therapy was most recently revised on February 16, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. A reconsideration request was received asking First Coast Service Options Inc. (FCSO) to revise the LCD to include the new Food and Drug Administration (FDA) indication approved on September 3, 2009. The new indication allows Zevalin® to be administered for patients with previously untreated follicular non-Hodgkin's lymphoma (NHL) who achieve a partial or complete response to first-line chemotherapy. The LCD has been revised to include this new FDA indication under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services provided **on or after September 3, 2009,** for claims processed **on or after April 1, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

CODING INSTRUCTIONS

Xiaflex™ (collagenase clostridium histolyticum) – coding instructions

Xiaflex™ is approved by the Food and Drug Administration (FDA) for the treatment of adult patients with Dupuytren's contracture with a palpable cord. Xiaflex™ should only be administered by a health-care provider who is experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture. Xiaflex™ should only be injected into palpable cords with contractures of a metacarpophalangeal (MP) joint or a proximal interphalangeal (PIP) joint. The dose for each palpable cord is 0.58 mg. The patient returns approximately 24 hours after the injection so the physician can perform the stretching of the cord and splint application. Injection and finger extension procedures may be done at approximately four week intervals for a maximum of three injections per cord. Only one cord may be injected at a time. Other palpable cords may be injected in sequential order.

Because of the specific training requirements needed to identify and inject the cords, First Coast Service Options Inc (FCSO) only expects to see Xiaflex™ administered by physicians with specialized training in treating and injecting Dupuytren's contracture. There must be evidence of proper training maintained in the medical record and available to Medicare upon request. FCSO would also expect to only see ICD-9-CM code 728.6 (Contracture of palmar fascia) billed on claims for Xiaflex™.

Coding day 1

Providers are instructed to bill *CPT* code *26989* (*Unlisted procedure, hands or fingers*) and HCPCS code J3590 (Unclassified biologics) (Part B providers) or HCPCS code C9399 (Unclassified drugs or biologicals) (Part A providers). This represents the injection of the cord and the use of Xiaflex™.

Coding day 2

Providers are instructed to bill *CPT* code *26989*, which will represent the stretching of the cord and application of the splint.

Note: Providers must bill day one and day two on the same claim. Providers should not bill a separate evaluation and management (E/M) code or procedure code for splint application on claims for this drug and procedure. *CPT* code *26989* is currently not a covered service for ambulatory surgical centers (ASCs), therefore FCSO will not be allowing this service to be billed by an ASC at this time. ❖

Find LCDs faster on our new medical coverage page

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

HOSPITAL SERVICES

Billing and processing claims with unlimited occurrence span codes

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

Provider types affected

This article is for long-term care hospitals (LTCH), inpatient psychiatric facilities (IPF), and inpatient rehabilitation facilities (IRF) paid under their respective prospective payment systems (PPSs) and submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6777 which provides claims processing and billing instructions that allow claims to be billed as if no occurrence span codes (OSC) limitation exists on the claim. Be certain your billing staffs are aware of these Medicare changes.

Key points of change request 6777

- For claims that have been manually processed due to the fact the number of OSC periods exceeded the limitation of ten, Medicare FIs and MACs will work directly with hospitals to ensure such claims are appropriately processed.
- Additional payment will not be made for claims that were already paid manually.
- Medicare contractors will override timely filing for such claims.

Background

Special billing procedures when more than ten occurrence span codes apply to a single stay

LTCH, IPF, and IRF PPSs require a single claim to be billed for an entire stay. Interim claims may be submitted to continually adjust all prior submitted claims for the stay until the beneficiary is discharged. In some instances, significantly long stays having numerous OSCs may exceed the amount of OSCs allowed to be billed on a claim.

When a provider paid under the LTCH, IPF or IRF PPSs encounters a situation in which ten or more OSCs are to be billed on Form CMS-1450 or electronic equivalent, the provider must bill for the entire stay up to the through date of the 10th OSC for the stay (the through date for the statement covers period equals the through date of the tenth OSC). As the stay continues, the provider must only bill the 11th through the 20th OSC for the stay, if applicable. Once the twentieth OSC is applied to the claim, the provider must only bill the 21st through the 30th OSC for the stay, if applicable. Medicare's systems (the fiscal intermediary shared system [FISS]) retain the history of all OSCs billed for the stay to ensure proper processing (i.e., as if no OSC limitation exists on the claim).

An illustration of the billing procedure can be found in the official instruction for CR 6777 at the Web address provided below.

Additional information

The official instruction, CR 6777, issued to your Medicare MAC or FI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1946CP.pdf*.

A detailed set of billing scenarios is presented within CR 6777 to show how to bill for stays where more than 10 OSCs occur.

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

MLN Matters® Number: MM6777
Related Change Request (CR) Number: 6777
Related CR Release Date: April 15, 2010
Related CR Transmittal Number: R1946CP
Effective Date: October 1, 2002
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1946, CR 6777

Extension of the outpatient hold-harmless provision

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which extends the outpatient hold-harmless provision. This provision is effective for dates of service on and after January 1, 2010, through December 31, 2010, to rural hospitals with 100 or fewer beds and to all sole community hospitals and essential access community hospitals regardless of bed size.

Please be on the alert for more information pertaining to the PPACA and its impact on past and future claims. ❖

Source: CMS PERL 201003-56

Extension of reasonable cost payment for clinical lab tests furnished by hospitals with fewer than 50 beds in qualified rural areas

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

Provider types affected

Hospitals with fewer than 50 beds in qualified rural areas who submit claims to Medicare fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC) for providing clinical laboratory tests to Medicare beneficiaries are affected.

What you need to know

Change request (CR) 6873, from which this article is taken, announces that Section 3122 of the Patient Protection and Affordable Care Act re-institutes reasonable cost payment for clinical laboratory tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. For some hospitals this could affect services performed as late as June 30, 2012. You should make sure that your billing staffs are aware of this payment extension.

Background

1. On February 13, 2004, in response to Section 416 of the Medicare Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) issued CR 3130 to implement procedures to provide reasonable cost payment for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in qualified rural areas for cost reporting periods during the two-year period beginning on July 1, 2004.
2. On February 2, 2007, in response to Section 105 of the Tax Relief and Health Care Act (TRHCA) of 2006, CMS issued CR 5493 to extend the two-year provision outlined within CR 3130 for an additional cost-reporting year. Because CR 5493 was implemented beyond the original sun-setting date outlined in CR 3130, FIs and A/B MACs were instructed to adjust any claims for laboratory services that should have received reasonable cost payment under TRHCA, Section 105.
3. Section 107 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 extended these payments to include cost reporting periods beginning on or after July 1, 2004, through June 30, 2008. For some hospitals, this affected services performed as late as June 30, 2009.
4. Now in CR 6873, from which this article is taken, CMS announces that Section 3122 of the Patient Protection and Affordable Care Act re-institutes these payments for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. For some hospitals, this could affect services performed as late as June 30, 2012.

Please be aware that your FI or A/B MAC:

- Will use the Medicare ZIP code file to identify qualified rural areas that, in the context of CR 6873, are those with population densities in the lowest quartile of all rural county populations.
- Effective for the entire cost reporting period beginning on or after July 1, 2010, through June 30, 2011 will calculate payment on a reasonable cost basis for outpatient clinical laboratory services from qualified hospitals on a revenue code 030x line submitted on either a 12x or 13x type of bill (TOB).

Finally you should remember that your FI or A/B MAC will not hold beneficiaries liable for any deductible, coinsurance, or any other cost-sharing amount.

Additional information

You may find the official instruction, CR 6873, issued to your FI or A/B MAC by visiting the CMS website at *http://www.cms.gov/Transmittals/downloads/R1940CP.pdf*.

You will find the updated *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Section 30.3 (Method of Payment for Clinical Laboratory Tests – Place of Service Variation) as an attachment to that CR.

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

MLN Matters® Number: MM6873
Related Change Request (CR) Number: 6873
Related CR Release Date: April 2, 2010
Related CR Transmittal Number: R1940CP
Effective Date: Cost reporting periods starting on or after July 1, 2010, through June 30, 2011
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1940, CR 6873

New provisions impacting institutional providers

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). PPACA Sections 3401 and 3137 contain a number of provisions affecting institutional providers. The 3401 sections discussed below are effective April 1, 2010, while Section 3137(a) has October 1, 2009, and April 1, 2010 effective dates. The Centers for Medicare & Medicaid Services is working to implement these important provisions of PPACA expeditiously. Providers will begin seeing payments under these provision in the late April/early May timeframe. Be on the alert for more information about these provisions and their impact on past and future claims. The following paragraphs outline key provisions of PPACA:

Inpatient Acute Hospitals (Section 3401(a))

Section 3401(a) of PPACA imposes a 0.25 percentage point reduction to the inpatient prospective payment system (IPPS) hospital's market basket for fiscal year (FY) 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect IPPS rates for discharges occurring on or after April 1, 2010, through September 30, 2010.

Long-Term Care Hospitals (Section 3401(c))

Section 3401(c) of PPACA imposes a 0.25 percentage point reduction to the long-term care hospital's (LTCH) market basket for FY 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect LTCH rates for discharges occurring on or after April 1, 2010, through September 30, 2010.

Inpatient Rehabilitation Facilities (Section 3401(d))

Section 3401(d) of PPACA imposes a 0.25 percentage point reduction to the inpatient rehabilitation facility-market basket for FY 2010, effective for discharges on or after April 1, 2010. The reduction is also resulting in changes to the standard payment conversion factor, payment rates, and the outlier threshold amount.

Extension of Section 508 Hospital Reclassifications (Sections 3137(a) and 10317)

Sections 3137(a) and 10317 extend section 508 and special exception hospital reclassifications from October 1, 2009, through September 30, 2010. Effective April 1, 2010, Section 3137(a) and 10317 also require removing Section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by sections 3137(a) and 10317 will be assigned an individual special wage index effective April 1, 2010. If the Section 508 or special exception hospital's wage index applicable for the period beginning on October 1, 2009, and ending on March 31, 2010, is lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, the hospital will be paid an additional amount that reflects the difference between the wage indices. The provision applies to both inpatient and outpatient hospital payments.

Please be on the alert for more information pertaining to the PPACA. ❖

Source: CMS PERL 201004-31

Extension of moratorium on billing for technical component to hospital patients

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which extends the moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to patients in hospitals, effective for claims with dates of service on and after January 1, 2010, through December 31, 2010.

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. At the request of the industry to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed.

Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the previous extension of the moratorium expired at the end of 2009, Section 3104 of the PPACA restored the moratorium retroactive to January 1, 2010. Therefore, independent laboratories may now submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed.

This policy is effective for claims with dates of service on or after January 1, 2010, through December 31, 2010. If an independent laboratory previously submitted a claim for services covered by this provision and the claim was denied, the laboratory may contact its Medicare contractor for further instructions.

Please be on the alert for more information pertaining to the PPACA. ❖

Source: CMS PERL 201003-56

Medicare solicits nominees for the advisory panel on APC groups

Members to advise the Centers for Medicare & Medicaid Services (CMS) on the clinical integrity of the ambulatory payment classification (APC) groups and their payment weights

CMS is soliciting nominations for individuals to serve on the advisory panel on APC groups (the Panel) that advises the Secretary, Department of Health & Human Services, and the Administrator, CMS, about the clinical integrity of the APC groups and their associated weights, which are major elements of the Medicare hospital outpatient prospective payment system (OPPS). Nominations are due to CMS no later than Wednesday, May 26, 2010, 5 p.m. ET. There will be five vacancies on the Panel as of September 30, 2010.

On November 21, 2000, the Secretary signed the initial Charter establishing the APC panel. Since its initial chartering, the Secretary has renewed the APC Panel's Charter four times: on November 1, 2002; on November 1, 2004; effective November 21, 2006; and on November 2, 2008.

The APC panel may be composed of up to 15 members and a chair. The following requirements apply to all members of the Panel:

- Must be representatives of Medicare providers subject to payment under the hospital OPPS: hospitals, hospital systems, or other Medicare providers
- Cannot be consultants or independent contractors
- May be self-nominations or nominations submitted by Medicare providers and other interested organizations
- Must send a written statement that s/he is willing to serve as a member of the APC panel
- Must send a written statement that s/he works for a Medicare provider paid under the hospital OPPS
- Must submit his/her employer's Medicare provider number
- Must have technical expertise to enable them to participate fully in the Panel's work – such expertise encompasses the following:
  - hospital payment systems
  - hospital medical care delivery systems
  - provider billing systems
  - APC groups, Current Procedural Terminology codes, and alphanumeric Health Care Common Procedure Coding System codes
  - use of, and payment for, drugs, medical devices, and other services in the outpatient setting, as well as other forms of relevant expertise
- Must have a minimum of five years experience in their area(s) of expertise
- Must serve on a voluntary basis, without compensation, pursuant to advance written agreement
- Shall be entitled to receive reimbursement for travel expenses and per diem in lieu of subsistence, in accordance with standard government travel regulations

The Panel is technical in nature, and it shall deal with the following issues:

- Addressing whether procedures within an APC group are similar both clinically and in terms of resource use
- Evaluating APC group weights
- Reviewing the packaging of OPPS services and costs, including the methodology and the impact on APC groups and payment
- Removing procedures from the inpatient list for payment under the OPPS
- Using single and multiple procedure claims data for CMS' determination of APC group weights
- Addressing other technical issues concerning APC group structure

The current APC Panel membership and other information pertaining to the APC panel, including its charter, *Federal Register* notices, membership, meeting dates, agenda topics, and meeting reports may be viewed on the CMS website at *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp*.

The notice (CMS-1570-N) is available at *http://edocket.access.gpo.gov/2010/pdf/2010-6789.pdf*.

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Source: CMS PERL 201004-33

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Extension of reasonable cost payment for clinical laboratory tests

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Section 3122 of the PPACA re-institutes reasonable cost payment for clinical laboratory tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. This could affect services performed as late as June 30, 2012.

Qualified hospitals under Section 3122 do not need to take any action. You will receive reasonable cost reimbursement for an entire year, starting with your cost-reporting period beginning on or after July 1, 2010.

Please be on the alert for more information pertaining to the PPACA. ❖

Source: CMS PERL 201003-56

Proposed policy and payment rate changes for acute and long-term care hospitals

The Centers for Medicare & Medicaid Services (CMS) has proposed on April 19, 2010, the fiscal year (FY) 2011 policies and payment rates for inpatient services furnished to people with Medicare by both acute care hospitals and long-term care hospitals. The proposals are intended to ensure that Medicare pays appropriately for high quality, efficient and safe inpatient care.

The proposed rule does not address inpatient hospital related provisions of the recently enacted Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively referred to as the "Affordable Care Act"). CMS expects to provide further information on the implementation of health-care reform provisions in these laws that affect FY 2010 and FY 2011 inpatient prospective payment systems (IPPS) in the near future.

CMS is similarly proposing to update long-term care hospital (LTCH) rates by 2.4 percent for inflation and apply an adjustment of -2.5 percentage points for the estimated increase in spending in FYs 2008 and 2009 due to documentation and coding that did not reflect increases in patients' severity of illness. Based on these two proposed provisions and other proposed changes, CMS estimates that payments to LTCHs would increase by 0.8 percent or $41 million.

The proposed rule was placed on display at the *Federal Register* on April 20, and may be found under special filings at *http://www.federalregister.gov/inspection.aspx#special*.

CMS will accept comments on this proposed rule until June 18, and will respond to them in a final rule to be issued by August 1, 2010.

For more information, including supporting documentation, please see *http://www.cms.gov/AcuteInpatientPPS/IPPS2010/list.asp*.

Note: More information about the proposed rule, including the documentation and coding adjustment and the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program changes and hospital-acquired conditions (HAC) discussion, may be found in fact sheets on our Web page at *http://www.cms.gov/apps/media/fact_sheets.asp*.

To read the CMS press release issued on April 19, click here *http://www.cms.gov/apps/media/press_releases.asp*.

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

Source: CMS PERL 201004-30

Acumen's study on the Medicare wage index – final report Part II

In the fiscal year (FY) 2010 hospital inpatient prospective payment system final rule (74 FR 43824), the Centers for Medicare & Medicaid Services (CMS) discussed that the focus of Acumen's second final report on the wage index would be on the methodology of wage-index construction. The report would cover issues related to the definition of wage areas and methods of adjusting for differences among neighboring wage areas. Acumen's final report Part II is now available on its website.

The final report Part II may be found at *http://www.acumenllc.com/reports/cms/Medicare_Wage_Index_Part_2.pdf*.

To find all three Acumen wage-index reports – final report Part II, final report Part I, and the 2008 interim report, please access *http://www.acumenllc.com/reports/cms/*.

CMS contacts for the Acumen wage-index study:

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Valerie Miller, CMM (Valerie.Miller@cms.hhs.gov). ❖

Source: CMS PERL 201003-53

Inpatient rehabilitation facility prospective payment system PC PRICER updates

The inpatient rehabilitation facility (IRF) prospective payment system (PPS) personal computer (PC) PRICER for fiscal years (FY) 2008, FY 2009, and FY 2010 have been updated with corrected outlier calculation logic and are ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPricer/06_IRF.asp*. If you use the IRF PPS PC PRICER, please go to the page above and download the latest versions of the PRICER, posted March 26, 2010, in the Downloads section. ❖

Source: CMS PERL 201003-57

Inpatient prospective payment system PC PRICER update

The inpatient prospective payment system (PPS) personal computer (PC) PRICER for fiscal year (FY) 2009 has been updated on the Centers for Medicare & Medicaid Services website 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.gov/PCPricer/03_inpatient.asp* and download the latest version of the PC PRICER. ❖

Source: CMS PERL 201003-58

Update to the fiscal year 2010 inpatient prospective payment system PC PRICER

The inpatient prospective payment system (PPS) personal computer (PC) PRICER for fiscal year (FY) 2010 has been updated on the Centers for Medicare & Medicaid Services website for FY 2010 claims with corrected provider data from January 2010. To download the latest version of the PC PRICER, go to the Inpatient PPS PC PRICER page at *http://www.cms.gov/PCPricer/03_inpatient.asp*, under the Downloads section. ❖

Source: CMS PERL 201004-03

Update to the fiscal year 2010 inpatient prospective payment system PC PRICER with the April 2010 provider data

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

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Source: CMS PERL 201004-26

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ESRD Services

Dialysis adequacy, infection and vascular access reporting

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 this *MLN Matters* article to reflect changes made to related change request (CR) 6788 on March 17, 2010. The description of modifier V8 has been enhanced. The CR release date, transmittal number, and the Web address for accessing CR 6788 were also revised. All other information remains the same. The article was published in the February 2010 *Medicare A Bulletin* (pages 31-32).

Provider types affected

Renal dialysis facilities (RDFs) submitting claims to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries are impacted by this issue.

Provider action needed

STOP – impact to you

RDFs need to know that CR 6782 requires new quality data reporting for dialysis adequacy, infection and vascular access on all end-stage renal disease (ESRD) claims and **all ESRD hemodialysis claims with dates of service on or after July 1, 2010**.

CAUTION – what you need to know

The new data reporting will allow the Centers for Medicare & Medicaid Services (CMS) to implement an accurate **quality incentive payment for dialysis providers** by January 1, 2012, as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153c.

GO – what you need to do

Make sure that your billing staffs are aware of these new reporting and claim requirements described below.

Background

This article is based on CR 6782, which explains that section 153c of the MIPPA requires CMS to implement a quality based payment program for dialysis services effective January 1, 2012. CMS currently collects two monthly measurements of quality of care via the ESRD claims submitted by dialysis providers: hemoglobin or hematocrit as a measure of anemia management and urea reduction ratio (URR) as a measure of hemodialysis adequacy.

The source data for the two current quality measures are collected on dialysis provider claims. The anemia management quality measure uses the most recent hemoglobin or hematocrit lab value, collected using value codes 48 or 49 on type of bill 72x. The hemodialysis adequacy measure uses the current month's urea reduction ratio (URR) lab value, collected using Healthcare Common Procedure Coding Systems (HCPCS) modifiers G1 through G6 on hemodialysis line items (revenue center 082x and *CPT* code *90999*).

These two quality measures meet the minimum requirements as mandated in MIPPA section 153c. However, the URR measure of dialysis adequacy does not provide data for the entire ESRD dialysis population. Not having dialysis adequacy data for a segment of the dialysis population (peritoneal dialysis patients) is problematic in the development of a quality based payment program that will decrease provider payment by up to two percent based on quality outcome data because, with the missing data, CMS will not be able to assess all ESRD dialysis providers based on the same criteria.

MIPPA section 153c also requires the use of quality measures endorsed by a consensus organization. CMS recently reexamined and received National Quality Forum (NQF) endorsement for the ESRD quality measures. Both CMS and NQF found that dialysis adequacy is best measured by Kt/V (K-dialyzer clearance of urea; t-dialysis time; V-patient's total body water) for both hemodialysis and peritoneal dialysis patients. The NQF granted time-limited endorsement of URR for hemodialysis patients and recommended that CMS drop it in favor of Kt/V as soon as possible. While dialysis adequacy is measured monthly for in-center hemodialysis patients, dialysis adequacy is measured less frequently for peritoneal dialysis patients (at least every four months). Therefore, it is necessary to track both the date of the most recent measurement and the result of the most recent measurement.

Finally, MIPPA section 153c provides for the use of additional quality measures for the quality based payment program as determined by the Secretary of Health & Human Services. Two additional quality measures could easily be collected using HCPCS modifiers for hemodialysis patients to record vascular access. The first measure is use of an arteriovenous fistula with two needles, which is recognized as the best vascular access because it is associated with the least infections. The second measure is the use of any vascular catheter, which is recognized as the worst vascular access because it is associated with the most infections. Collecting vascular access data will allow CMS to develop a more robust quality based payment program in order to implement national policy without additional data collection burden on dialysis providers, who are already required to collect these data under the fistula first initiative.

Consequently, **CMS will require the reporting of the Kt/V reading and date of the reading, vascular access and infection data on ESRD claims with dates of service on or after July 1, 2010.** This new data reporting requirement will allow CMS to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by MIPPA, section 153c. The July 2010 implementation date is needed because the quality incentive payment must be in part based on provider improvement

Dialysis adequacy, infection and vascular access reporting (continued)

over time; thus, CMS requires an accurate measurement of baseline provider performance. CMS will require that providers continue to report the existing modifiers G1 through G6 for URR at this time.

New quality data required on all ESRD claims with dates of service on or after July 1, 2010:
Claim level codes

- **Value code D5:** Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within four months of the claim date of service.
- **Occurrence code 51:** Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the claim date of service.

In the event that the provider has not performed the Kt/V test for the patient, the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value. The occurrence code date should not be reported on the claim in the case of no Kt/V reading being reported. For dates of service on or after July 1, 2010, failure to report the D5 value code on the type of bill 72x will result in the claim being returned to the provider. Also, Medicare will return type of bill 72x with dates of service on or after July 1, 2010 to the provider if the claim does not contain occurrence code 51, except where there is a D5 value code with 9.99.

Line level codes to be reported on dialysis revenue code lines

- **Modifier V8:** Dialysis access-related infection present (documented and treated) during the billing month. Reportable dialysis access-related infection is limited to peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients. Facilities must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) if identified during the billing month. For individuals that receive different modalities of dialysis during the billing month and an infection is identified, the V8 code should only be indicated on the claim for the patient's primary dialysis modality at the time the infection was first suspected. Non-access related infections should not be coded as V8. If no dialysis-access related infection is present by this definition, providers should instead report modifier V9.
- **Modifier V9:** No dialysis-access related infection, as defined for modifier V8, present during the billing month. Dialysis access-related infection, defined as peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients must be reported using modifier V8. Providers must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) using modifier V8.

Note: Medicare systems will return to the provider type of bill 72x with dates of service on or after July 1, 2010 when either the modifier V8 or V9 is not present on each dialysis revenue code line (0821, 0831, 0841, or 0851).

New quality data required on All ESRD Hemodialysis claims with dates of service on or after July 1, 2010
Line level codes to be reported on hemodialysis revenue code lines:

Vascular access for ESRD hemodialysis patients – an indicator of the type of vascular access used for the delivery of hemodialysis at the last hemodialysis session of the month. The code is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider.

- **Modifier V5:** Any vascular catheter (alone or with any other vascular access)
- **Modifier V6:** Arteriovenous graft (or other vascular access not including a vascular catheter)
- **Modifier V7:** Arteriovenous fistula only (in use with two needles)

Note: Medicare systems will return to the provider type of bill 72x with dates of service on or after July 1, 2010 billing for hemodialysis when the latest line item date of service billing for revenue code 0821 does not contain one of the following modifiers: V5, V6, or V7.

The modifiers V5-V9 are effective January 1, 2010, and the Medicare integrated code editor has been updated to allow the reporting of these codes for claims with dates of service on or after January 1, 2010. Therefore, providers may voluntarily report these modifiers for claims with dates of service January 1, 2010 through, July 1, 2010.

Additional information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI or A/B MAC, which is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1898CP.pdf*.

The *Medicare Learning Network* catalog of products contains a fact sheet Outpatient Maintenance Dialysis – End-Stage Renal Disease fact sheet, which provides general information about Outpatient Maintenance Dialysis for ESRD, the composite payment rate system, and separately billable items and services. The fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/ESRDpaymtfctsht08-508.pdf*.

Dialysis adequacy, infection and vascular access reporting (continued)

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

MLN Matters® Number: MM6782 – Revised
Related Change Request (CR) Number: 6782
Related CR Release Date: March 17, 2010
Related CR Transmittal Number: R1932CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1932, CR 6782

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.

SKILLED NURSING FACILITY SERVICES

Update to the 2010 skilled nursing facility prospective payment system PRICER

Due to receiving quarterly provider data for April 2010, the fiscal year (FY) 2010 skilled nursing facility prospective payment system (SNF PPS) personal computer (PC) PRICER has been updated on the page *http://www.cms.gov/PCPricer/04_SNF.asp*, under the skilled nursing facilities (SNF PPS) PC PRICER. Please go to the page above and download the latest version of the PC PRICER.

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

Source: CMS PERL 201004-29

Five-star quality rating system – April 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 updated with April five-star data on Thursday, April 22, 2010.

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

Source: CMS PERL 201004-23

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.

CORF/ORF SERVICES

Extension of therapy cap exceptions process

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which extends the exceptions process for outpatient therapy caps (see Section 3103). Outpatient-therapy service providers may continue to submit claims with **modifier KX**, when an exception is appropriate, for services furnished on or after January 1, 2010, through December 31, 2010.

The therapy caps are determined on a calendar year basis, so all patients began a new cap year on January 1, 2010. For physical therapy and speech-language pathology services combined, the limit on incurred expenses is $1,860. For occupational therapy services, the limit is $1,860. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Please be on the alert for more information pertaining to the PPACA. ❖

Source: CMS PERL 201003-56

Comprehensive outpatient rehabilitation facility coverage

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 this *MLN Matters* article to clarify the language in the "What you need to know" section to refer to the correct types of therapy. All other information remains the same. The article was published in the October 2009 *Medicare A Bulletin* (pages 62-65).

Provider types affected

Comprehensive outpatient rehabilitation facilities who bill Medicare fiscal intermediaries (FI) and Medicare administrative contractors (A/B MAC) for providing comprehensive outpatient rehabilitation facility (CORF) services to Medicare beneficiaries.

What you need to know

Change request (CR) 6005, from which this article is taken, announces that, based on changes in the 2008 Medicare physician fee schedule (MPFS) regulation (published in the *Federal Register* on November 27, 2007), the *Medicare Benefit Policy Manual*, Chapter 12, (Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage) has been amended to clarify general requirements, covered and noncovered services, provisions of services, and particular CORF services

Specifically (effective January 1, 2008), these changes are incorporated in the manual: 1) Define that all CORF services must be directly related to the physical therapy (PT), occupational therapy (OT), speech language pathology (SLP) or respiratory therapy (RT) rehabilitation therapy plan of treatment; and 2) Clarify that the physician must wholly develop the rehabilitation therapy plan of treatment, 3) only a respiratory therapist (not a respiratory technician) can provide respiratory therapy, 4) social and psychological services (not mental health services) are core CORF services (which must be reasonable and medically necessary and directly related to the PT, OT, SLP, or RT rehabilitation therapy plan of treatment), and 5) that physician "incident-to" services cannot be provided in a CORF.

Make sure that your billing staffs are aware of these CORF manual changes.

Background

CR 6005 announces that (effective January 1, 2008) the *Medicare Benefit Policy Manual*, Chapter 12 (Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage) is amended to reflect changes announced in the 2008 MPFS regulation and to clarify general requirements, covered and noncovered services, provisions of services, and specific CORF services.

Note: A CORF's purpose is to permit the beneficiary to receive multidisciplinary rehabilitation services at a single location in a coordinated fashion. Section 1861 (cc) of the Social Security Act specifies that no service may be covered as a CORF service if it would not be covered as an inpatient hospital service when provided to a hospital patient. (This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care), but rather only that the service would be covered if provided in a hospital. The requirement for CORF outpatient mental health limitation is deleted.

The policy changes that CR 6005 announces are synthesized below.

- CORF services are covered **only** if they are medically necessary and relate directly to the rehabilitation of injured, disabled, or sick patients.

Required services

The CORF must provide these core services: a) CORF physicians' services, b) physical therapy services, and c) social and psychological services.

1. **CORF physician services** are those physician-performed professional services that are administrative in nature; such as consultation with, and medical

Comprehensive outpatient rehabilitation facility coverage (continued)

supervision of, nonphysician staff; patient case review conferences; utilization review; the review of the therapy/pathology plan of treatment, as appropriate; and other facility medical and administration activities necessary to provide skilled rehabilitation services (those that PTs, OTs, SLPs and RTs provide), and other services that directly relate to the rehabilitation plan of treatment.

Please be aware that diagnostic or therapeutic services that a CORF (or other) physician provides to a CORF patient are **not** CORF physician services. These services are separately payable to the physician under the MPFS, at the non-facility payment amount billed as if provided in the physician's office.

Remember that to become a CORF patient, a beneficiary must be under the care of a physician who certifies that he/she needs skilled rehabilitation services. If the referring physician does not specify the rehabilitation goals for PT, OT, SLP, or RT services; the CORF physician must established them. Further, either the referring physician or the CORF physician must establish, and sign, a rehabilitation plan of treatment prior to the beginning treatment.

In addition, the CORF physician or the referring physician, must review the treatment plan for respiratory therapy services at least every 60 days; and for physical therapy, occupational therapy, speech-language pathology, and for all other services at least once every 90 days; certifying that the plan is being followed and that the patient is making progress in attaining the established rehabilitation goals.

Note: The CORF physician must be present in the facility enough to ensure that CORF services are provided in accordance with accepted principles of medical practice, medical direction, and medical supervision.

2. **Physical therapy services** should comprise a clear majority of the total CORF services. To supervise CORF physical therapy services, the physical therapist must be on the CORF premises (or must be available to the physical therapy assistant through direct telecommunications for consultation and assistance) during the CORF's operating hours.

3. **Social and psychological services** are covered only if the patient's physician (or CORF physician) establishes that the services directly relate to the patients rehabilitation plan of treatment and are needed to obtain the rehabilitation goals. Social and psychological services include only those services that address the patient's response and adjustment to the rehabilitation treatment plan; rate of improvement and progress towards the rehabilitation goals; or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory plan of treatment.

   Notes: 1) CORF social and psychological services are the same, whether provided by either a qualified social worker or psychologist. Qualifications for individuals providing CORF social and psychological services are a Bachelors of Science for social workers and a Masters-level degree for psychologist; 2) Social and psychological services do not include services for mental health diagnoses.

Optional services

In addition to the above three required core services, the CORF may also furnish the following other covered and medically necessary items and services; as long as they directly relate to, and are consistent with, the rehabilitation treatment plan, and are necessary to achieve the rehabilitation goals.

1. **Occupational therapy services**

2. **Speech - language pathology services**

3. **Respiratory therapy services** include only those services that a qualified respiratory therapist can appropriately provide to CORF patients under a physician-established respiratory therapy plan of treatment, in accordance with current medical and clinical standards.

   These services include the physiological monitoring necessary to furnish them, and rather than paid separately, the payment is bundled into the payment for respiratory therapy services. Diagnostic and other medical services provided in the CORF setting are **not** considered CORF services, and therefore may **not** be included in a respiratory therapy plan of treatment because these are covered under separate benefit categories.

   Please take note that services performed by respiratory therapy technicians are **not** covered because the current medical standards for skilled respiratory therapy services provided to patients in the CORF setting require the educational requirements of respiratory therapists.

   Examples of specific RT CORF services include the respiratory therapist assessing the patient to determine the appropriateness of pursed lip breathing activity and checking the patient's oxygen saturation level (via pulse oximetry). If appropriate, the respiratory therapist may then provide the initial training in order to ensure that the patient can accurately perform this activity; and again check the patient's oxygen saturation level, or perform peak respiratory flow, or other respiratory parameters.

   These types of services are considered "physiological monitoring" and are bundled into the payment for Healthcare Common Procedure Coding System (HCPCS) codes G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes [includes monitoring]), G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes [includes monitoring]), and G0239 (Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals [includes monitoring]).

Comprehensive outpatient rehabilitation facility coverage (continued)

Another example of monitoring includes the provision of a 6-minute walk test that is typically conducted before the start of the patient's respiratory therapy activities, and the time to provide this walk "test" assessment can be included as part of the HCPCS code G0238.

Note: Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary to the treatment of the patient's condition and can usually be given to a patient during the course of treatment by any of the health personnel involved therein, e.g., physician, nurse, respiratory therapist.

4. **Prosthetic and orthotic devices** are covered, including the testing, fitting, or training in their use

5. **Nursing services** (which must be provided by an individual meeting the qualifications of a registered nurse [RN], rather than a licensed practical nurse [LPN]) are provided as an adjunct to the rehabilitation treatment plan of treatment, and must be reasonable and medically necessary. For example, a registered nurse may perform (including patient instruction): the proper procedure of "in and out" urethral catheterization, tracheostomy tube suctioning, or the cleaning for ileostomy or colostomy bags.

   Note: Nursing services may not be a substitute for or supplant the services of physical therapists, occupational therapists, speech-language pathologist and respiratory therapists, but instead must lend support to or further the rehabilitation services and goals.

6. **CORFs can provide pneumococcal, influenza, and hepatitis B vaccines to its patients provided** the facility is "primarily engaged in providing (by or under the supervision of a physician) restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons."

   Note: Because no drugs and biologicals are currently identified as appropriate to a therapy rehabilitation treatment plan, CORFs may not submit claims for drugs and biologicals.

7. **Supplies and durable medical equipment (DME)** – CORFs may not bill for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding *Current Procedural Terminology* code in the 29xxx series

8. **Physical therapy, occupational therapy, and speech-language pathology services** may be furnished in the patient's home, as CORF services, when payment for these therapy services is not otherwise made under the Medicare home health benefit, and

9. A single home PT, OT, or SLP environment evaluation visit, which includes evaluating the potential impact of the home environment on the rehabilitation goals, is limited to the services that one professional (who must be either a PT, OT, or SLP, as appropriate) provides, when the corresponding treatment plan identifies the home environment evaluation as necessary. The patient must be present during the home environment evaluation visit.

   Note: When, in addition to the required physical therapy, a CORF provides OT, SLP and/or RT services; the physical therapy services must represent the predominate rehabilitation **service.**

   Note: Hyperbaric oxygen services, infusion therapy services, cardiac rehabilitation services, or diagnostic sleep studies are not considered CORF services because they do not meet the definition, nor do they relate to the rehabilitation treatment plan. These, and other services not specifically listed as CORF services, may be covered under other Medicare benefits categories, such as physician services and diagnostic services.

Payment rules

The payment basis for CORF services is 80 percent of the lesser of: 1) the actual charge for the services; or 2) the MPFS amount for the service, when the MPFS establishes a payment amount for such service. Payment for CORF services under the PFS is made for all CORF services (PT, OT, SLP, RT, and the related nursing and social and psychological services); which are part of, or relate directly to, the rehabilitation treatment plan.

If there is no fee schedule amount for a covered CORF item or service, payment is based on the lesser of 80 percent of actual charges for the services provided or the amount determined by the local Medicare contractor.

Payment for covered **DME, orthotic and prosthetic devices and supplies** that a CORF provides is based on the lesser of 80 percent of actual charges; or the payment amount established under the DMEPOS fee schedule, or the single payment amount established under the DMEPOS competitive bidding program (provided that payment for such an item is not included in the payment amount for other CORF services).

Payment for CORF **social and psychological services** is made under the MPFS only for HCPCS Code G0409, as appropriate, only when billed using revenue codes 0560, 0569, 0910, 0911, 0914 and 0919.

Payment for CORF **respiratory therapy services** is made under the MPFS when provided by a respiratory therapist as defined at 42 CFR 485.70(j), only to the extent that these services support or are an adjunct to the rehabilitation plan of treatment, and only when billed using revenue codes 0410, 0412 and 0419. When provided as part of a CORF respiratory therapy rehabilitation treatment plan, separate payment is not made for diagnostic tests or for services related to physiologic monitoring services; which are bundled into other therapy services appropriately performed by respiratory therapist, such as HCPCS G-codes G0237, G0238, and G0239. These three HCPCS codes are specific to services provided under the respiratory therapy plan of treatment and, as such, are not designated as subject to the therapy caps.

Comprehensive outpatient rehabilitation facility coverage (continued)

CORF **nursing services** are paid under the MPFS for nursing services, but only when provided by a registered nurse, and only to the extent that these services support or are an adjunct to the rehabilitation services that PTs, OTs, SLPs, and RTs provide, and are consistent with the rehabilitation treatment plan. In addition, payment for CORF nursing services is made only when provided by a registered nurse, and coded with HCPCS code G0128 (Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each per 10 minutes beyond the first 5 minutes) is used to bill for these services, and only with revenue codes revenue 0550 and 0559.

Note: Services provided under the "incident to" benefit may not be recognized as CORF services. Services furnished by CORF personnel, including registered nurses, physical therapists, occupational therapists, speech-language pathologist and respiratory therapists are not considered furnished incident-to physician services.

Payment for covered **pneumococcal, influenza, and hepatitis B vaccines** provided in the CORF setting is based on 95 percent of the average wholesale price. The registered nurse provides administration of the vaccines using *CPT* code *90471*.

Finally, CR 6005 announces that the requirement for CORF outpatient mental health treatment limitation is deleted.

Additional information

This article only summarizes the CORF manual revision made by CR 6005 and you may find the complete details by reviewing CR 6005, located on the CMS website at *http://www.cms.gov/Transmittals/downloads/R111BP.pdf*.

You will find the updated *Medicare Benefit Policy Manual*, Chapter 12, (Comprehensive Outpatient Rehabilitation Facility [CORF] Coverage), as an attachment to CR 6005.

In addition, for specific payment requirements for CORF, items and services, see the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), which you may find on the CMS website at *http://www.cms.gov/manuals/downloads/clm104c05.pdf*.

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

MLN Matters® Number: MM6005 – Revised
Related Change Request (CR) Number: 6005
Related CR Release Date: September 25, 2009
Related CR Transmittal Number: R111BP
Effective Date: July 7, 2008
Implementation Date: October 26, 2009

Source: CMS Pub. 100-02, Transmittal 111, CR 6005

ELECTRONIC DATA INTERCHANGE

HIPAA version 5010 – Medicare administrative contractor requirements

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

Provider types affected

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

Provider action needed

This article is informational only for providers. It is based on change request (CR) 6472 which provides Medicare administrative contractors (MACs), and DME MACs, and the DME MACs common electronic data interchange (CEDI) contractor with requirements to prepare their systems to process ASC X12 (also known as ANSI ASC X12) version 005010 (both A/B and DME MACs) transactions and National Council for Prescription Drug Programs (NCPDP) version D.0 (only DME) transactions. While CR 6472 requires no action for providers, you may want to review *MLN Matters*® article SE0904 at *http://www.cms.gov/MLNMattersArticles/downloads/SE0904.pdf*, for an introductory overview of these HIPAA standards.

Background

The Secretary of the Department of Health & Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 as the next Health Insurance Portability and Accountability Act (HIPAA) transaction standards for covered entities to exchange HIPAA transactions. The DHHS published the final rule on January 16, 2009, which may be reviewed at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf*. The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing this next version of HIPAA transaction standards.

The purpose of CR 6472 is to provide the MACs and the DME MACs common electronic data interchange (CEDI) contractor with the necessary requirements to prepare their systems to process ASC X12 version 005010 (both A/B and DME MACs) and NCPDP version D.0 (only DME) transactions.

Note: The DHHS has promulgated in the final rule provisions which permit dual use of existing standards [ASC X12 4010A1 and NCPDP 5.1] and the new standards [ASC X12 version 5010 and NCPDP version D.0] from March 17, 2009 (the effective date) until January 1, 2012 (the compliance date) to facilitate testing (subject to trading partner agreement).

Additional information

The official instruction, CR 6472, issued to your MAC or DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R506OTN.pdf*.

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

MLN Matters® Number: MM6472
Related Change Request (CR) Number: 6472
Related CR Release Date: June 19, 2009
Related CR Transmittal Number: R506OTN
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-20, Transmittal 506, CR 6472

Claim status category code and claim status code update

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

Provider types affected

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

Provider action needed

This article, based on change request (CR) 6859, explains that the claim status codes and claim status category codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2010 meeting of the national code maintenance committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on or about March 1. At the January 2010 meeting, the committee also decided to allow the industry six months for implementation of newly added or changed codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on July 6, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national code maintenance committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

The official instruction, CR 6859, issued to your Medicare contractor regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1936CP.pdf*.

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

MLN Matters® Number: MM6859
Related Change Request (CR) Number: 6859
Related CR Release Date: March 26, 2010
Related CR Transmittal Number: R1936CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1936, CR 6859

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
May 2010 – September 2010

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

Topic – Hot Topics

When: Tuesday, July 13, 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, September 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

Two easy ways to register

Online – Visit our provider training website 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 website, *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 website, 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 website and explore our catalog of online courses. ❖

Register now for Medifest 2010

June 8-9 – Renaissance Orlando Hotel Airport (Orlando, Florida)

Register today for First Coast Service Options (FCSO) exciting Medicare educational event – Medifest 2010. This dynamic, face-to-face symposium will be held at the Renaissance Orlando Hotel Airport in Orlando, Fla., and is open to all members of our provider community. Take advantage of interactive Medicare educational workshops, learn from our knowledgeable subject-matter experts, and talk with representatives from companies offering products and services designed especially for Medicare providers.

You may join us for one or both days of this educational conference and choose from a wide selection of informative seminars and workshops designed to facilitate your continued success as a Medicare provider.

These are just some of the seminars and workshops that we've developed especially for our Part A providers:

- **935 Recoupment and Appeals process (A)** (English and Spanish): Medicare overpayments are costly to everyone – to providers as well as to the Medicare program. This interactive workshop offers you the opportunity to acquire a deeper understanding of the 935 recoupment process for Medicare overpayments and to learn your rights as well as your responsibilities if an overpayment occurs. We'll also discuss how to properly respond to a demand overpayment letter and guide you through the progressive levels of the appeal process.
- **Inpatient DRG (A)** (English): Gain a greater insight into FCSO's complex medical review process for inpatient hospital diagnosis related group (DRG) claims. During this informative seminar, we'll discuss specific medical review findings from FCSO's 2009 DRG probe and their correlation with common comprehensive error rate testing (CERT) errors. You'll also have the opportunity to explore potential steps that may assist you with the correct application of DRG codes and help you avoid costs associated with claim denials and overpayments.
- **Medical Documentation** (A) (English and Spanish): If it isn't documented, it hasn't been done. -- this adage has long been familiar to health care professionals and serves as a reminder of the importance of thorough medical documentation to ensure the receipt of accurate, timely reimbursement for furnished services. This interactive workshop, focusing on the institutional setting, will allow you to test your knowledge and teach you how to minimize avoidable costs created by insufficient or inaccurate medical documentation. You'll learn how to avoid common documentation errors, to properly respond to documentation requests, and avoid unnecessary recoupments associated with the CERT program, recovery audit contractor (RAC) reviews, and contractor probe reviews.
- **Medicare Claim Review Programs** (A/B): Few phrases inspire as much fear among providers as "claim review." But did you know that many of the Centers for Medicaid & Medicare Services' claim review programs are designed to help providers as much as they are meant to safeguard the Medicare claims process? This seminar will provide an overview of CMS' five claim review programs and explain their respective roles within the lifecycle of Medicare claims processing. You'll also learn how these pre- and post-payment review programs can impact your business, how to identify potential vulnerabilities in your practice or facility, and how to take proactive measures to prevent negative financial impacts.

Make sure to check our new Medifest page to view the **Medifest 2010** agenda and event updates.

Don't miss this valuable opportunity to expand your knowledge of the Medicare program and network with other health-care professionals.

Register for Medifest 2010 today. ❖

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.

PREVENTIVE SERVICES

April is National Cancer Control Month

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

Medicare covered cancer screenings

- Screening mammographies
- Screening pap tests
- Screening pelvic examination
- Colorectal cancer screening
- Prostate cancer screening

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 cancer screenings 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.gov/MLNProducts/35_PreventiveServices.asp
- **Cancer Screenings Brochure** – this brochure provides health care professionals with an overview of cancer screenings covered by Medicare.
  http://www.cms.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 cancer screenings.
  http://www.cms.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 cancer screenings, in an easy-to-use quick-reference format.
  http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **The Medicare Preventive Services Series: Part 3 Web-based training course (WBT)** – this WBT includes lessons on coverage, coding, and billing for Medicare-covered cancer screenings. To access the WBT, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "WBT Modules."

To order hard copies of certain *MLN* products, including the Cancer Screenings brochure and the quick reference information chart, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page"

For more information about National Cancer Control Month, please visit the American Cancer Society homepage at *http://www.cancer.org*.

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 cancer screening services and other preventive services covered by Medicare. ❖

Source: CMS PERL 201004-16

April 5-11 is National Public Health Week and April 7 is World Health Day

In the spirit of National Public Health Week and World Health Day, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for a variety of preventive services. By encouraging your Medicare patients to take advantage of covered preventive services, you can help them lead longer, fuller, healthier lives.

Medicare covered preventive services

Medicare provides coverage for the following preventive services for eligible Medicare beneficiaries:

- Abdominal aortic aneurysm screening
- Adult immunizations
- Bone mass measurements
- Cancer screenings
- Cardiovascular screenings
- Diabetes-related services and screenings
- Glaucoma screenings
- Smoking and tobacco-use cessation counseling
- Initial preventive physical examination

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 the many preventive services and screenings 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.gov/MLNProducts/35_PreventiveServices.asp
- **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.
  http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- **Quick Reference Information: Medicare Preventive Services** – this chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy-to-use quick-reference format.
  http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **The Preventive Services Educational Products PDF** – this PDF (document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more.
  http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf
- To order hard copies of certain *MLN* products, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page"

For more information about World Health Day, please visit the World Health Organization's website at *http://www.who.int/world-health-day/en*.

For more information about National Public Health Week, please visit the American Public Health Association's website at *http://www.nphw.org/nphw10/home1.htm*.

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 the many preventive services covered by Medicare. ❖

Source: CMS PERL 201004-08

OTHER EDUCATIONAL RESOURCES

Revised Web-based training course on fraud and abuse

The Medicare Fraud and Abuse Web-based training (WBT) course has been revised and is now available. The course provides information helpful for Medicare providers and suppliers involved in providing and billing for services to people with Medicare. This activity provides information that will increase awareness of Medicare fraud and abuse, provide information regarding correct billing practices, and help Medicare providers, suppliers, and staff to file claims correctly. The course offers continuing education credits; please see the course description page for details.

To access the course, go to the MLN Products page at *http://www.cms.gov/MLNProducts/*, and select the Web-based training modules link in the "Related Links Inside CMS" section. Once the Web-based training courses page is displayed, select the Medicare Fraud and Abuse WBT from the list provided. ❖

Source: CMS PERL 201004-25

New products from the Medicare Learning Network

The *Medicare Learning Network* (*MLN*) marketing brochure is available in print format at *http://www.cms.gov/MLNProducts/downloads/Medicare_Learning_Network_(MLN)_Marketing_Brochure.pdf*.

Do you want to be "in the know" when it comes to the *Medicare Learning Network*? Would you like to let your colleagues and employees in on a valuable secret that can help them with their Medicare fee-for-service business transactions? Then make sure to have plenty of print copies of the *MLN* marketing brochure on hand. This brochure details the various *MLN* products and is now available in print format.

The fact sheet titled Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance (February 2010) is available to download at *http://www.cms.gov/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf*.

This fact sheet provides general information and education for providers on how to bill when a beneficiary has both Medicare and Medicaid coverage.

To order a hard copy of these and other resources, *visit http://www.cms.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." ❖

Source: CMS PERL 201003-43

New educational materials from the Medicare Learning Network

The following are educational materials and other helpful resources now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The *Medicare Learning Network* video is now on YouTube
  Watch the *Medicare Learning Network* video now playing on the YouTube channel at http://www.youtube.com/watch?v=GOzh7kpAwUo.

  This information video provides you with information on what the *Medicare Learning Network* has to offer you in your Medicare business practices as well as other helpful resources that the Centers for Medicare & Medicaid Services (CMS) offers to Medicare fee-for-service providers.
  Don't forget, you can also order your copy of this video on DVD today; visit *http://www.cms.gov/MLNGenInfo*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." It's a great conference presentation.
- *The Medicare Preventive Services Quick Reference Information* charts, which include (1) *Quick Reference Information: Medicare Preventive Services*, (2) *Quick Reference Information: Medicare Immunization Billing*, and (3) *Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination*, have been updated and are now available in hardcopy format.

To order copies of these products, please visit the "Preventive Services Educational Products" page at: *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp* and select "MLN Product Ordering" in the "Related Links Inside CMS" section. ❖

Source: CMS PERL 201003-50

Order form for Medicare Part A materials

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

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2009 through September 2010.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				

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

Mail this form with payment to:

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

Contact Name:
_____

Provider/Office Name:
_____

Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
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(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Addresses

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

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

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

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

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

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

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

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

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

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

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

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

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

Other Important Addresses

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

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

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

Telephone Numbers

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

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

Speech and Hearing Impaired
1-877-660-1759

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

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
(check return assistance only)

Option 6
Automated Response Line

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

Seminar Registration Fax Number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

CREDIT BALANCE REPORT
Debt Recovery
1-904-791-6281
Fax
1-904-361-0359

Medicare Websites

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

BENEFICIARIES
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Centers for Medicare & Medicaid Services
www.cms.gov

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦