MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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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:

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Vol. 12, No. 12
December 2010

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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:

Medicare Publications
1-904-361-0723

THE FCSO MEDICARE A BULLETIN

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

President Obama signs the Medicare and Medicaid Extenders Act of 2010

New law includes sustainable growth rate fix through December 2011

On Wednesday, December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA). This new law prevents a scheduled payment cut for physicians who treat Medicare patients from taking effect. The Centers for Medicare & Medicaid Services (CMS) is pleased that this law has addressed key issues for beneficiaries and providers and they are actively engaged in implementing these changes.

CMS is also working to implement several important new provisions for Medicare beneficiaries made possible by the Affordable Care Act – the health reform law. In 2011:

- Beneficiaries who reach the prescription drug coverage gap, known as the donut hole, will receive a 50 percent discount when buying Part D-covered brand-name prescription drugs.
- Virtually all Medicare beneficiaries are eligible to receive many free preventive care services and a free annual wellness visit.

These provisions will improve care for Medicare beneficiaries and we encourage you to share this information with your patients. More information on these Affordable Care Act provisions may be found at *http://www.medicare.gov/* and at *http://www.healthcare.gov*. Healthcare.gov also contains a timeline and other key information about the new law and a highly praised insurance finder for coverage options in public and private insurance programs, which family members and friends of Medicare beneficiaries may find useful.

Below please find technical summaries of key provisions of the MMEA along with some information about how these changes may affect providers and provider billing.

Physician payment update

Section 101 of the MMEA prevents a payment cut for physicians that would have taken effect on January 1, 2011. While the physician fee schedule update will be zero percent, other changes to the relative value units (RVUs) used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2011. CMS is currently developing the 2011 Medicare physician fee schedule (MPFS) to implement the zero percent update, and we expect all 2011 claims to be processed timely, in compliance with the new legislation.

Extension of Medicare physician work geographic adjustment floor

Current law requires payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 103 of the MMEA extends the existing 1.0 floor on the "physician work" geographic practice cost index, through December 31, 2011. As with the physician payment update, this change will be accomplished through a revised 2011 MPFS.

Extension of physician fee schedule mental health add-on payments

For calendar year 2010, certain mental health services' payment rates continued to be increased by five percent. Section 107 of the MMEA extends the five percent increase in payments for these mental health services, through December 31, 2011. Similar to the zero percent update and the physician work geographic adjustment floor extension, the five percent increase will be reflected in the revised 2011 MPFS.

Extension of Medicare Modernization Act Section 508 Reclassifications

Section 102 of the MMEA extends Section 508 and special exception hospital reclassifications from October 1, 2010, through September 30, 2011. Effective April 1, 2011, Section 102 also requires 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 Section 102 of the MMEA shall be assigned an individual special wage index effective April 1, 2011. If the Section 508 or special exception hospital's wage index applicable for the period beginning on October 1, 2010, and ending on March 31, 2011, is lower than the period beginning on April 1, 2011, and ending on September 30, 2011, the hospital shall be paid an additional amount that reflects the difference between the wage indices. The provision applies to both inpatient and outpatient hospital payments. For hospital outpatient payments, a special exception hospital's reclassified wage index will be applicable from January 1, 2011, through December 31, 2011.

Extension of exceptions process for Medicare therapy caps

Section 104 of the MMEA 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, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,870. For occupational therapy services, the limit is $1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

President Obama signs the Medicare and Medicaid Extenders Act of 2010 (continued)

Extension of moratorium on independent laboratory billing for the technical component (TC) of physician pathology services furnished to hospital patients

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 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 2010, the MMEA restores the moratorium through 2011. Therefore, independent laboratories may continue to 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, 2011, through December 31, 2011.

Extension of ambulance add-on payments

The provisions that were extended by Section 106 of the MMEA are: (1) the three percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the two percent increase for covered ground ambulance transports that originate in urban areas; (2) the provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services; and (3) the provision relating to payment for ground ambulance services where the base rate is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density.

All of these payment provisions are extended through December 31, 2011.

Extension of outpatient hold harmless provision

Section 108 of the MMEA extends the outpatient hold harmless provision, effective for dates of service on and after January 1, 2011, through December 31, 2011, to rural hospitals with 100 or fewer beds and to all sole community hospitals and essential access community hospitals regardless of bed size.

Extension of Medicare reasonable cost payment for clinical lab tests furnished to hospital patients in certain rural areas

Section 109 of the MMEA extends the reasonable cost payment for clinical lab tests furnished 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, 2011, through June 30, 2012. This could affect services furnished as late as June 30, 2013.

If your hospital qualifies under Section 109, you do not need to take any action. Your hospital will receive reasonable cost reimbursement for an entire year, starting with the facility cost reporting period beginning on or after July 1, 2011.

Repeal of the delay of RUG-IV

Section 202 of the MMEA repeals the delay of the skilled nursing facility (SNF) prospective payment system (PPS) resource utilization group version IV (RUG-IV) classification system. Therefore, RUG- IV will continue to remain in effect from October 1, 2010, as previously implemented by the final SNF payment regulation for FY 2011. All claims processing activities shall proceed in accordance with the existing instructions.

Please be on the alert for more information pertaining to the Medicare and Medicaid Extenders Act of 2010. Finally, as a reminder, beginning on January 3, 2011, eligible professionals, eligible hospitals, and critical access hospitals can register for the Medicare and Medicaid electronic health records incentive programs. For more information, please visit the website at *http://www.cms.gov/EHRIncentivePrograms*.

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

Source: CMS PERL 201012-23

The 'Physician Payment and Therapy Relief Act of 2010' extends 2.2 percent MPFS update

On Tuesday, November 30, 2010, President Obama signed into law, "The Physician Payment and Therapy Relief Act of 2010." This law extends through Friday, December 31, 2010, the 2.2 percent update to the Medicare physician fee schedule (MPFS) that has been in effect for MPFS claims with dates of service of Tuesday, June 1, 2010, through Tuesday, November 30, 2010. Payments for 2010 services under the MPFS will continue without delay.

Please watch your listservs and your contractor's website for more information, should Congressional action prevent the 2011 negative update from going into effect on Saturday, January 1, 2011.

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

Source: CMS PERL 201012-06

Update to Medicare deductible, coinsurance and premium rates for 2011

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, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 7224 which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2011.

Background

2011 Part A – Hospital insurance (HI)

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for day 61-90 spent in the hospital.

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

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for day 21 through 100 of skilled nursing facility (SNF) services furnished during a spell of illness. The 2011 inpatient deductible is $1,132.00. The coinsurance amounts are shown below in the following table:

Hospital coinsurance		SNF coinsurance
Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
$283.00	$566.00	$141.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) benefits without a premium payment. In addition, The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium. Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2011 Part A premiums are as follows:

Voluntary enrollees Part A premium schedule for 2011	
Base premium (BP)	$450.00 per month
Base Premium with 10 percent surcharge	$495.00 per month
Base premium with 45 percent reduction (for those with 30-39 quarters of coverage)	$248.00 (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	$272.80 per month

2011 Part B – Supplementary medical insurance (SMI)

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

For 2011, the standard premium for SMI services is $115.40 a month; the deductible is $162.00 a year; and the coinsurance is 20 percent. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 7224, which is available at *http://www.cms.gov/Transmittals/downloads/R65GI.pdf*.

Additional information

The official instruction, CR 7224, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R65GI.pdf*.

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

MLN Matters® Number: MM7224
Related Change Request (CR) #: 7224
Related CR Release Date: November 19, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R65GI
Implementation Date: January 3, 2011

Important reminder on the upcoming timely claim filing requirement

The Centers for Medicare & Medicaid Services (CMS) would like to remind Medicare fee-for-service (FFS) physicians, providers, and suppliers submitting claims to Medicare for payment, as a result of the Patient Protection and Affordable Care Act (PPACA), effective immediately, all claims for services furnished on or after January 1, 2010, must be received by your Medicare contractor no later than one calendar year (12 months) from the date of service on the claim or Medicare will deny the claim.

If you have Medicare FFS claims with service dates from October 1, 2009, through December 31, 2009, those claims must be received by December 31, 2010, or Medicare will deny them. Claims with services dates from January 1, 2009, to October 1, 2009, keep their original December 31, 2010, deadline for filing.

In general, the start date for determining the one-year timely filing period is the date of service or "From" date on the claim. For institutional claims that include span dates of service (i.e., a "From" and "Through" date on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness. For claims submitted by physicians and other suppliers that include span dates of service, the line item "From" date is used for determining the date of service for claims filing timeliness.

For additional information about the new maximum period for claims submission filing dates, contact your Medicare contractor, or review the *MLN Matters* articles listed below related to this subject:

- MM6960 – "Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 – Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months" at *http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf*
- MM7080 – "Timely Claims Filing: Additional Instructions" at *http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf*

You may also listen to a podcast on this subject by visiting *http://www.cms.gov/CMSFeeds/02_listofpodcasts.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 201011-56 & 201012-10

Annual wellness visit including personalized prevention plan services

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

Provider types affected

This article is for physicians, nonphysician practitioners, and providers submitting claims to Medicare contractors (carriers, Medicare administrative contractors [MACs], and/or fiscal intermediaries [FIs]) for services provided to Medicare beneficiaries.

Provider action needed

The Affordable Care Act provides for an annual wellness visit (AWV), including personalized prevention plan services (PPPS) for Medicare beneficiaries as of January 1, 2011. Change request (CR) 7079 provides the requirements for the AWV, which are summarized in this article. Make sure billing staff are aware of these services and how to bill for them.

Background

Pursuant to Section 4103 of the Affordable Care Act of 2010 , the Centers for Medicare & Medicaid Services (CMS) amended Sections 411.15(a)(1) and 411.15 (k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This amendment's expanded coverage is subject to certain eligibility and other limitations that allow payment for an AWV, including PPPS, for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply to the AWV. The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B.

Who is eligible to provide the AWV with PPPS?

- A physician who is a doctor of medicine or osteopathy (as defined in Section 1861(r)(1) of the Social Security Act (the Act), or
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in Section 1861(aa)(5) of the Act), or
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) of a physician as defined in the first bullet point of this section.

What is included in an initial AWV with PPPS?

The initial AWV providing PPPS provides for the following services to an eligible beneficiary by a health professional:

- Establishment of an individual's medical/family history.
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
- Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.

Annual wellness visit including personalized prevention plan services (continued)

- Detection of any cognitive impairment that the individual may have as defined in this section.
- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.
- Review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
- Establishment of a written screening schedule for the individual, such as a checklist for the next five to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.
- Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
- Voluntary advance care planning (as defined in this section) upon agreement with the individual.
- Any other element(s) determined appropriate by the Secretary of Health and Human Services through the national coverage determination (NCD) process.

What would be included in a subsequent AWV/PPPS?

In subsequent AWVs, the following services would be provided to an eligible beneficiary by a health professional:

- An update of the individual's medical/family history.
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS.
- Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- An update to the written screening schedule for the individual as that schedule is defined in this section, which was developed at the first AWV providing PPPS.
- An update to the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWV providing PPPS.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.
- Voluntary advance care planning (as defined in this section) upon agreement with the individual.
- Any other element(s) determined by the Secretary through the NCD process.

Note: Voluntary advanced care planning refers to verbal or written information regarding an individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions and whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

Billing requirements

Two new HCPCS codes will be implemented January 1, 2011, through the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE).

G0438: Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit, (Short descriptor – Annual wellness first)

G0439: Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit, (Short descriptor – Annual wellness subseq)

Effective for services on or after January 1, 2011, Medicare contractors will pay claims containing these codes provided the requirements for coverage and eligibility are met. Institutional providers need to submit these claims via types of bill (TOB) 12x, 13x, 22x, 23x, 71x, 77x, or 85x. Institutional providers will be paid as follows:

- For services performed on a 12x TOB and 13x TOB, hospital inpatient Part B and hospital outpatient, payment shall be made under the MPFS.
- For TOBs 22x and 23x, skilled nursing facilities will be paid based on the MPFS.
- Rural health clinics (TOB 71x) and federally qualified health centers (TOB 77x) will be paid based on the all-inclusive rate.

Annual wellness visit including personalized prevention plan services (continued)

- For services performed on an 85x TOB, critical access hospital (CAH), pay based on reasonable cost.
- CAHs claims (submitted on TOB 85x with revenue codes 096x, 097x, and 098x) will be paid based on MPFS.
- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

Other billing requirements

Remember that G0438 is for the first AWV only. Thus, submission of G0438 for a beneficiary for whom a claim with code G0438 has already been paid will result in a denial of the later G0438 with a claim adjustment reason code (CARC) of 149 (Lifetime benefit maximum has been reached for the service/benefit category.) and a remittance advice remarks code (RARC) of N117 (This service is paid only once in a patient's lifetime.).

Remember also that the G0438 or G0439 must not be billed within 12 months of a previous billing of a G0402 (IPPE), G0438, or G0439 for the same beneficiary. Such subsequent claims will be denied with a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) and a RARC of N130 (Consult plan benefit documents/guidelines for information about restrictions for this service).

If a claim for a G0438 or G0439 is submitted within the first 12 months after the effective date of the beneficiary's first Medicare Part B coverage, it will also be denied as that beneficiary is eligible for the IPPE or "Welcome to Medicare" physical. Such claims with G0438 or G0439 will be denied with a CARC of 26 (Expenses incurred prior to coverage) and a RARC of N130.

Additional information

The official instruction, CR 7079, was issued to your carrier, FI, or A/B MAC via two transmittals. The first modified the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R2109CP.pdf*. The second transmittal updates *the Medicare Benefit Policy Manual*, which is at *http://www.cms.gov/Transmittals/downloads/R134BP.pdf*. See these two transmittals for more complete details regarding this benefit.

If you have questions, please contact your carrier, FI, 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: MM7079
Related Change Request (CR) #: 7079
Related CR Release Date: December 3, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R134BP and R2109CP
Implementation Date: April 4, 2011

Waiver of coinsurance and deductible for preventive services

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

Provider types affected

This article is for physicians, hospitals, and other providers who submit claims to Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MAC) for providing preventive services to Medicare beneficiaries.

What you need to know

Change request (CR) 7012, from which this article is taken, implements the changes in Section 4104 of The Affordable Care Act. The CR announces that (effective for dates of service on or after January 1, 2011) Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the initial preventive physical examination (IPPE), the annual wellness visit (AWV), and for those preventive services that: 1) are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and 2) are appropriate for the individual.

Background

Sections of The Affordable Care Act amend sections of The Social Security Act to require changes in payment (with respect to deductible and

coinsurance/copayment) for identified preventive services: In addition, The Affordable Care Act waives the deductible and coinsurance/copayment for the IPPE and the AWV. The changes apply in all settings in which the services are furnished.

The following preventive services are covered by Medicare:

- Pneumococcal, influenza, and hepatitis B vaccine and administration
- Screening mammography
- Screening pap smear and screening pelvic examination
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training (DSMT)
- Bone mass measurement
- Screening for glaucoma
- Medical nutrition therapy (MNT) services
- Cardiovascular screening blood test
- Diabetes screening tests
- Ultrasound screening for abdominal aortic aneurysm (AAA), and
- Additional preventive services (identified for coverage through the national coverage determination (NCD) process. Currently, these are limited to human immunodeficiency virus (HIV) testing).

Waiver of coinsurance and deductible for preventive services (continued)

Preventive services that do not have a USPSTF grade A or B

The Affordable Care Act waives the deductible and coinsurance/copayment for many of the preventive services listed above because those services have a recommendation grade of A or B by the USPSTF. In other cases, the deductible and coinsurance are waived because the preventive services are clinical laboratory tests to which the deductible and coinsurance do not apply according to another section of the statute.

Several preventive services covered by Medicare do not have a USPSTF recommendation grade of A or B. These include digital rectal examinations provided as prostate screening tests; glaucoma screening; DSMT services; and barium enemas provided as colorectal cancer screening tests. In the case of a screening barium enema, the deductible is waived under another section of the statute. The deductible continues to apply to the other services and coinsurance/copayment also continues to apply to all of them.

The table in CR 7012 provides a complete list of the Healthcare Common Procedure Coding System (HCPCS) codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the AWV. CR 7012 is available at *http://www.cms.gov/Transmittals/downloads/R739OTN.pdf*.

Extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic or therapeutic

The Affordable Care Act waives the Part B deductible for colorectal cancer screening tests that become diagnostic. The Medicare policy is that the deductible is waived for all surgical procedures (*Current Procedural Terminology* (*CPT*) code range of *10000* to *69999*) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. Modifier "PT" has been created effective January 1, 2011, and providers and practitioners should append the modifier PT to a least one *CPT* code in the surgical range of *10000* to *69999* on a claim for services furnished in this scenario.

Additional information

You may find more information about the waiver of coinsurance and deductible for preventive services by going to CR 7012, located at *http://www.cms.gov/Transmittals/downloads/R739OTN.pdf*.

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: MM7012
Related Change Request (CR) #: 7012
Related CR Release Date: July 30, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R739OTN
Implementation Date: January 3, 2011

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines

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

Provider action needed

The article is based on change request (CR) 7234 which establishes separate billing codes for each brand-name influenza vaccine product under Common Procedure Terminology (*CPT*) code *90658* and describes the process for updating the new specific Healthcare Common Procedure Coding System (HCPCS) codes and their payment allowances for Medicare during the 2010-2011 influenza season.

Background

CMS has created specific HCPCS codes and payment allowances to replace *CPT* code *90658* for Medicare billing purposes for the 2010-2011 influenza season.

Key points of CR 7234

The following describes the process for updating these specific HCPCS codes for Medicare payment effective for dates of service on or after October 1, 2010.

Effective for claims with dates of service on or after January 1, 2011, the following *CPT* code will no longer be payable for Medicare:

CPT code	Short description	Long description
90658	Flu vaccine, 3 yrs & >, im	*Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use*

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines (continued)

Effective for claims with dates of service on or after October 1, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short description	Long description
Q2035	Afluria vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	Flulaval vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037	Fluvirin vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	Fluzone vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	NOS flu vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

Note: *CPT 90658* describes the regular dose vaccine that is supplied in a multi-dose vial for use in patients over three years of age. For dates of service on or after October 1, 2010, HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 (as listed in the table above) will replace the *CPT* code *90658* for Medicare payment purposes during the 2010-2011 influenza season. However, these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when *CPT* code *90658* will no longer be recognized.

This instruction does not affect any other *CPT* codes. It is very important to distinguish between the various *CPT* and HCPCS codes which describe the different formulations of the influenza vaccines (i.e. pediatric dose, regular dose, high dose, preservative free, etc.). As a reference, the quarterly Part B drug pricing files includes a set of National Drug Code (NDC) to HCPCS crosswalks available online at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/*.

Billing

In general, it is inappropriate for a provider to submit two claims for the same service on the same date. For dates of service between October 1, 2010, and December 31, 2010, the *CPT 90658* and the Q-codes will be valid for billing; however, providers may not bill Medicare for both the *CPT 90658* and any of the Q-codes for the same patient for the same date of service. Thus, if a provider vaccinates a beneficiary on any date between October 1, 2010, and December 31, 2010, the provider may either bill Medicare immediately using *CPT 90658*, or hold the claim and wait until January 1, 2011, to bill Medicare using the most appropriate Q-code. If a claim has already been submitted and processed using *CPT 90658*, then there is no need to use the Q-code for that same service.

For dates of service on or after January 1, 2011, providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered.

Payment

The Medicare Part B payment limits for influenza vaccines are 95 percent of the average wholesale price (AWP) except where the vaccine is furnished in a setting that follows a cost-based or prospective payment system under Medicare. For example, where the vaccine is furnished in the hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC), payment for the vaccine is based on reasonable cost.

For dates of service on or after October 1, 2010, the Medicare Part B payment allowances in other situations are:

HCPCS code	Allowance
Q2036	$7.439
Q2037	$13.253
Q2038	$12.593

No national payment limits are available for Q2035 and Q2039. The payment limits for these two codes will be determined by the local claims processing contractor.

For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for *CPT 90655* is $14.858.

Important notes

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Be aware that Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 7324. However, they will adjust such claims that you bring to their attention.

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines (continued)

Additional information

If you have questions, please contact your Medicare A/B MAC, carrier or FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
For complete details regarding this CR please see the official instruction (CR 7234) issued to your Medicare A/B MAC, carrier or FI. That instruction may be viewed by going to *http://www.cms.gov/Transmittals/downloads/R815OTN.pdf*.

CMS would like providers to be aware that educational products are available through the MLN catalogue free of charge. The MLN catalogue is available at *http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf*. The specific products that may be of interest to providers who use the information in MM7234 are as follows:

The *Medicare Preventive Services Quick Reference Information Chart*: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B) is available at *http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

The *Adult Immunizations* brochure provides a basic overview of Medicare's influenza, pneumococcal and hepatitis B vaccine benefits and is available at *http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf*.

MLN Matters® Number: MM7234
Related Change Request (CR): 7234
Related CR Release Date: November 19, 2010
Effective Date: October 1, 2010 unless otherwise specified
Related CR Transmittal #: R815OTN
Implementation Date: January 3, 2011

Influenza vaccine payment allowances – annual update for 2010-2011 season

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

Note: This article was revised on November 26, 2010, to reflect a correction to the payment rate for *Common Procedure Terminology* **(***CPT***)** *90655***,** as announced in change request (CR) 7234, issued on November 19, 2010. The corrected payment rate for *90655***,** as of September 1, 2010, is $14.858. All other information is the same. This information was previously published in the October 2010 *Medicare A Bulletin* page 6.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for influenza vaccines provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued CR 7120 in order to update payment allowances, effective September 1, 2010, for influenza vaccines when payment is based on 95 percent of the average wholesale price (AWP). CR 7120 refers only to the seasonal influenza vaccines. According to CR 6617, only the Level II Healthcare Common Procedure Coding System code G9142 is used to identify the H1N1 vaccine on Medicare claims. Therefore, *CPT* codes *90663*, *90664*, *90666*, *90667*, and *90668* will not be recognized on Medicare claims for the H1N1 vaccine.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

CR 7120 provides the payment allowances for the following seasonal influenza virus vaccines: *CPT* codes *90655*, *90656*, *90657*, *90658*, *90660*, and *90662* when payment is based on 95 percent of the AWP. The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year.

The Medicare Part B payment allowance in these situations for:

- *CPT 90655* is $14.858
- *CPT 90656* is $12.375
- *CPT 90657* is $6.297, and
- *CPT 90658* (for dates of service September 1, 2010 through December 31, 2010) is $11.368.

CPT 90660 (FluMist, a nasal influenza vaccine) or *CPT 90662* (Fluzone high-dose) may be covered if your Medicare claims processing contractor determines the use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance effective September 1, 2010, for *CPT 90660* is $22.316, and for *CPT 90662* is $29.213.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine. The current payment allowances for pneumococcal vaccines can be found on the quarterly drug pricing files.

Influenza vaccine payment allowances – annual update for 2010-2011 season (continued)

Additional information

Note that Medicare contractors will not search their files to adjust claims already processed prior to implementation of CR 7120. However they will adjust those claims that you bring to their attention.
The official instruction, CR 7120 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2071CP.pdf*.

If you have any questions, please contact your carrier, FI 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: MM7120 *Revised*
Related Change Request (CR) #: 7120
Related CR Release Date: October 22, 2010
Effective Date: September 1, 2010
Related CR Transmittal #: R2071CP
Implementation Date: November 24, 2010

Information on billing new Q-codes for influenza vaccine and roster billing

The Centers for Medicare & Medicaid Services (CMS) has created specific HCPCS codes and payment rates for Medicare billing purposes for the 2010-2011 influenza season. Effective for claims with dates of service on or after January 1, 2011, *CPT* code *90658* will no longer be payable by Medicare.

Effective for dates of service on or after October 1, 2010, the following new influenza HCPCS Q-codes will be payable by Medicare:

Q2035 (Afluria®)

Q2036 (Flulaval®)

Q2037 (Fluvirin®)

Q2038 (Fluzone®)

Q2039 (not otherwise specified flu vaccine)

CMS has instructed Medicare contractors to hold all claims containing the influenza HCPCS Q-codes with dates of service on or after October 1, 2010, until their systems are able to accept them for processing. The Medicare contractors' systems will be ready to process claims containing the HCPCS Q-codes no later than February 7, 2011. Medicare institutional providers also have the option to hold their claims containing the new influenza HCPCS Q-codes until February 7, 2011.

In addition, Medicare institutional providers should not submit claims with the new Influenza HCPCS Q-codes with dates of service on or after October 1, 2010, via roster billing. Medicare systems are unable to hold roster claims submitted by institutional providers. Therefore, Medicare institutional providers may submit their roster claims on an individual claim basis or hold their roster claims until February 7, 2011, and then submit as a roster bill at that time.

For further information, please see transmittal 815, change request 7234, issued on November 19, 2010.

Source: CMS PERL 201012-03

Take advantage of FCSO's exclusive PDS report

Did you know that FCSO's exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through FCSO's PDS's portal at *https://medicare.fcso.com/reporting/index.asp*, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business botton line.

Important update on PECOS and ordering/referring

At this time, the Centers for Medicare & Medicaid Services (CMS) has not turned on the automated edits that would deny claims for services that were ordered or referred by a physician or other eligible professional simply for lack of an approved file in the provider enrollment chain and ownership system (PECOS). CMS is working diligently to resolve backlog and other system issues and will provide ample advance notice to the provider and beneficiary communities before CMS begins any such automatic denials. While there are some rumors that the edits will be turned on in January, CMS wants to reiterate that no date has been announced yet (January 3 or otherwise) as to when ordering/referring edits will be turned on.

Physicians or other eligible professionals not currently enrolled in PECOS should take the initiative to enroll sooner rather than later. There are three ways to verify that you have an enrollment record in PECOS:

- Check the ordering referring report on the CMS website, available at *http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp*. If you are listed on that report, you have a current enrollment record in PECOS.
- Use Internet-based PECOS to look for your PECOS enrollment record, available at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*. If no record is displayed, you do not have an enrollment record in PECOS.
- Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Visit *http://www.cms.gov/MedicareProviderSupEnroll/* for the "Medicare Fee-For-Service Contact Information" list (in the *Downloads* section).

If you are not yet in PECOS, the best way to submit your application is through internet-based PECOS. For more information, visit *http://questions.cms.gov/app/answers/detail/a_id/10038/*.

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

Source: CMS PERL 201011-54

Physicians and nonphysician practitioners excluded from deactivation in Medicare due to inactivity

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

Provider types affected

Physicians and nonphysician practitioners (NPPs) who need to enroll in the Medicare Program for the sole purpose of ordering and referring items and services for Medicare beneficiaries are excluded from the process that would deactivate them after 12 consecutive months of non-billing.

Provider action needed

This article is for certain physicians and NPPs who have the unique enrollment scenarios of enrolling for the sole purpose of ordering and referring items and services for Medicare beneficiaries. These physicians and NPPs do not and will not send claims to a Medicare contractor for the services they furnish and shall be excluded from the 12-month non-billing deactivation process. The supplier types affected are listed in the *Background* section of this article.

Background

The Centers for Medicare & Medicaid Services (CMS) instructs Medicare contractors to deactivate the records of physicians and NPPs who have had no activity in submitting claims to Medicare contractors for 12 consecutive months. However, CMS excludes certain physicians and NPPs from this deactivation process and has instructed Medicare contractors accordingly. The supplier types that are excluded from deactivation for non-billing include the following physicians and NPPs who are employees of Department of Veterans Affairs (DVA), Department of Defense (DOD), or Public Health Service (PHS) and employees of Medicare enrolled federally qualified health center (FQHC), critical access hospital (CAH), and rural health clinic (RHCs):

- Doctor of medicine or osteopathy
- Doctor of dental medicine
- Doctor of dental surgery
- Doctor of podiatric medicine
- Doctor of optometry
- Doctor of chiropractic medicine
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner

Physicians and nonphysician practitioners excluded from deactivation in Medicare due to inactivity (continued)

- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

In addition, the following supplier types, regardless of their employment, are excluded from the deactivation process:

- Pediatric medicine physicians (specialty 37), and
- Oral surgery (dentist only, specialty 19)

Additional information

If you have questions, contact your designated Medicare contractor at its toll free number, which is available at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE1034 Related Change Request (CR) #:N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Expansion of Medicare telehealth services for calendar year 2011

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 (NPP), hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal Intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7049 to alert providers that 14 Healthcare Common Procedure Coding System (HCPCS) codes were added to the list of Medicare telehealth services for:

- Individual and group kidney disease education (KDE) services
- Individual and group diabetes self-management training (DSMT) services
- Group medical nutrition therapy (MNT) services
- Group health and behavior assessment and intervention (HBAI) services, and
- Subsequent hospital care and nursing facility care services.

Make sure your billing staffs are aware of these changes.

Background

As noted in the 2011 Medicare physician fee schedule final rule published on November 29, 2010, CMS is adding 14 codes to the list of Medicare distant site telehealth services for individual and group KDE services, individual and group DSMT services, group MNT services, group HBAI services, and subsequent hospital care and nursing facility care services. Payment for these services will be made at the applicable physician fee schedule (PFS) payment amount for the service of the physician or practitioner. CR 7049 adds the relevant policy instructions to the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* and those changes may be reviewed by consulting CR 7049 at *http://www.cms.gov/Transmittals/downloads/R2032CP.pdf* and *http://www.cms.gov/Transmittals/downloads/R131BP.pdf*.

Key points of CR 7049

CMS is adding the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services
  - HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour); and
  - HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour).
- Individual and group DSMT services (with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training):
  - HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes), and
  - HCPCS code G0109 (Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes).

Expansion of Medicare telehealth services for calendar year 2011 (continued)

- Group MNT and HBAI services, *Current Procedural Terminology* (*CPT*) codes: *97804* (*Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes*), *96153* (*Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients*), and *96154* (*Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)*);
- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days; CPT codes
  - *99231 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit)*
  - *99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication)*
  - *99233(Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit)*
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days, *CPT* codes:
  - *99307 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit)*
  - *99308 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit)*
  - *99309 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit)*
  - *99310 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit)*

Note: The frequency limitations on subsequent hospital care and subsequent nursing facility care delivered through telehealth do not apply to inpatient telehealth consultations. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS codes (G0406, G0407, G0408, G0425, G0426, or G0427) when reporting consultations furnished via telehealth.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the

Expansion of Medicare telehealth services for calendar year 2011 (continued)

physician or practitioner of record or the attending physician or practitioner.

- For dates of service (DOS) on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier.
- For dates of service on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier by critical access hospitals (CAHs) that have elected method II on TOB 85x.

Additional information

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

MLN Matters® Number: MM7049
Related CR Release Date: August 20, 2010
Related CR Transmittal #: R2032CP and R131BP
Related Change Request (CR) #: 7049
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Reasonable charge update for 2011 for splints, casts, and certain intraocular lenses

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

Provider types affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries, [FIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

Provider action needed

Change request (CR) 7225, from which this article is taken, instructs your carriers, FIs, and MACs how to calculate reasonable charges for the payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Make sure your billing staff is aware of these changes.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, and for intraocular lenses implanted (codes V2630, V2631, and V2632) in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Beginning January 1, 2011, reasonable charges will no longer be calculated for payment of home dialysis supplies and equipment for method II end-stage renal disease (ESRD) patients. Section 153 of Medicare Improvements for Patients and Providers Act (MIPPA) amended section 1881(b) of the Act to require the implementation of an ESRD bundled payment system effective January 1, 2011. The ESRD prospective payment will provide an all-inclusive single payment to ESRD facilities (i.e. hospital-based providers of services and renal dialysis facilities) that will cover all the resources used in providing outpatient dialysis treatment, including dialysis supplies and equipment that are currently separately payable to method II DME suppliers.

CR 7225 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501. The inflation indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the consumer price index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. The 2011 payment limits for splints and casts will be based on the 2010 limits that were announced in CR 6691 last year, increased by 1.1 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2010. The IIC update factor for 2011 is 1.1 percent.

Reasonable charge update for 2011 for splints, casts, and certain intraocular lenses (continued)

A list of the 2011 payment limits for splints and casts are listed in the table that follows.

Code	Payment limit
A4565	$7.84
Q4001	$44.60
Q4002	$168.58
Q4003	$32.04
Q4004	$110.92
Q4005	$11.81
Q4006	$26.62
Q4007	$5.92
Q4008	$13.31
Q4009	$7.89
Q4010	$17.75
Q4011	$3.94
Q4012	$8.88
Q4013	$14.36
Q4014	$24.21
Q4015	$7.18
Q4016	$12.10
Q4017	$8.30
Q4018	$13.23
Q4019	$4.16
Q4020	$6.62
Q4021	$6.14
Q4022	$11.08
Q4023	$3.09
Q4024	$5.54

Code	Payment limit
Q4025	$34.44
Q4026	$107.54
Q4027	$17.23
Q4028	$53.78
Q4029	$26.34
Q4030	$69.33
Q4031	$13.17
Q4032	$34.66
Q4033	$24.57
Q4034	$61.10
Q4035	$12.28
Q4036	$30.56
Q4037	$14.99
Q4038	$37.55
Q4039	$7.51
Q4040	$18.76
Q4041	$18.22
Q4042	$31.11
Q4043	$9.12
Q4044	$15.56
Q4045	$10.58
Q4046	$17.02
Q4047	$5.28
Q4048	$8.51
Q4049	$1.93

Additional information

The official instruction, CR 7225 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2100CP.pdf*.

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: MM7225
Related CR Release Date: November 19, 2010
Related CR Transmittal #: R2100CP
Related Change Request (CR) #: 7225
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

January changes to the DMEPOS program

What Medicare-enrolled providers, physicians, treating practitioners, discharge planners, social workers, and pharmacists need to know.

Medicare is phasing in a new program that changes the amount Medicare pays for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and requires Medicare contract suppliers to furnish these items in most cases. Health care providers play a key role in helping their patients understand how they will be affected by this change and what they need to do in order to continue to have Medicare pay for the high-quality equipment and supplies they need.

Effective January 1, 2011, if your patients with original Medicare live in or visit one of the communities listed below, and must obtain any of the equipment or supplies included in the program (also listed below), they will almost always have to use Medicare contract suppliers for Medicare to help pay for the item.

The first nine areas included in the new program are:

1. Charlotte – Gastonia – Concord, NC, SC
2. Cincinnati – Middletown, Ohio, Kentucky, Indiana
3. Cleveland – Elyria – Mentor, Ohio

January changes to the DMEPOS program (continued)

4. Dallas – Fort Worth – Arlington, Texas
5. Kansas City, Missouri, Kansas
6. Miami – Fort Lauderdale – Pompano Beach, Florida
7. Orlando – Kissimmee, Florida
8. Pittsburgh, Pennsylvania
9. Riverside – San Bernardino – Ontario, California

The products and equipment included in the program are:

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

If your patients currently rent oxygen and oxygen equipment or durable medical equipment, they may be able to continue renting these items from their current supplier when the program takes effect, if the supplier decides to participate in the program as a "grandfathered" supplier.

Medicare has a variety of resources available to help you understand the new program at *http://www.cms.gov/DMEPOSCompetitiveBid/*; DMEPOS Competitive Bidding Program *Medicare Learning Network*® (*MLN*) fact sheets may be found at *http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf*.

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

Third-party websites*. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

Source: CMS PERL 201011-55

January quarterly update to Correct Coding Initiative edits

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

Provider types affected

Physicians and providers submitting claims to Medicare carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries are impacted by this issue.

Provider action needed

This article is based on change request (CR) 7210, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in October 2010.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) *Current Procedural Terminology* (*CPT*) *Manual*
- National and local policies and edits
- Coding guidelines developed by national societies
- Analysis of standard medical and surgical practice, and
- Review of current coding practice.

The latest package of CCI edits, version 17.0, is effective January 1, 2011, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

- Column 1/ Column 2 Correct Coding Edits, and
- Mutually Exclusive Code (MEC) Edits.

Additional information about CCI, including the current CCI and MEC edits, is available at *http://www.cms.gov/NationalCorrectCodInitEd*.

Additional Information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at *http://www.cms.gov/manuals/downloads/clm104c23.pdf*. The official instruction (CR 7081) issued to your carrier or A/B MAC regarding this change is at *http://www.cms.gov/Transmittals/downloads/R2097CP.pdf*. If you have any questions, please contact your 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: MM7210
Related Change Request (CR) #: 7210
Related CR Release Date: November 19, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2097CP
Implementation Date: January 3, 2011

National modifier and condition code to identify items or services related to the 2010 oil spill

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

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries related, in whole or in part, to the 2010 oil spill in the Gulf of Mexico.

Provider action needed

This article is based on change request (CR) 7087 which identifies a new modifier and a new condition code that must be used to identify items or services related to the 2010 oil spill in the Gulf of Mexico. Be sure your billing staff is aware of these changes. You should begin to place the modifier or condition code on claims submitted as of January 3, 2011.

Background

As a result of the oil spill in the Gulf of Mexico, the Centers for Medicare & Medicaid Services (CMS) plans to monitor the potential health and cost impacts of the oil spill on Medicare beneficiaries, in both the short and long-term. In order to ensure that such health care services and costs are properly identified, CMS is requiring that every Medicare fee-for-service claim be specifically identified if it is for an item or service furnished to a Medicare beneficiary, where the provision of such item or service is related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico (hereafter referred to as the "Gulf oil spill") and/or circumstances related to such oil spill, including but not limited to subsequent clean-up activities.

Claims from physicians, other practitioners, and suppliers must be annotated with the modifier "CS" for each line item where the item or service is so related. Similarly, claims from institutional billers must be annotated with a condition code of "BP" when the entire claim is so related or with the "CS" modifier for each relevant line item when only certain line items are so related. The modifier and condition code are to be used for claims with dates of service on or after April 20, 2010.

The long description of the CS modifier is as follows: "Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities."

The short description of the CS modifier is: "Gulf Oil Spill Related."

The title of the BP condition code is "Gulf oil spill related" and its definition is as follows: "This code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities."

Note: CMS requests provider, physician and supplier assistance in identifying previously processed claims related to an illness, injury or condition caused or exacerbated either directly or indirectly by the 2010 Gulf oil spill. CMS encourages providers, physicians and suppliers to contact their Medicare contractor to identify services or claims – submitted and processed prior to the creation of the Gulf oil spill modifier and condition code – that should have the CS modifier and/or the BP condition code appended.

Additional information

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

The official instruction (CR 7087) issued to your Medicare MAC, carrier and/or FI is available at *http://www.cms.gov/Transmittals/downloads/R2021CP.pdf*.

MLN Matters® Number: MM7087	Related Change Request (CR) #: 7087
Related CR Release Date: August 6, 2010	Effective Date: April 20, 2010
Related CR Transmittal #: R2021CP	Implementation Date: January 3, 2011

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.

Indian Health Service facilities and tribal provider's use of PECOS

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

Note: *MLN Matters*® article MM7174 was revised on November 30, 2010, to add references to SE0914, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE0914.pdf*, and MM6231, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6231.pdf*, for further information on using Internet-based PECOS. This information was previously published in the November 2010 *Medicare A Bulletin* page 10.

Provider types affected

Tribal or Indian Health Service (IHS) providers wanting to enroll or who are currently enrolled in the Medicare program.

Provider action needed

This article is based on change request (CR) 7174, which informs Indian Health Service (IHS) facilities and tribal providers initially enrolling in the Medicare program or submitting changes of enrollment information that they may use the Internet-based provider enrollment, chain and ownership system (PECOS) to do so.

Background

Currently, Indian Health Service (IHS) facilities and tribal providers are permitted to enroll in Medicare Part A and B using the paper enrollment process only. The Internet-based PECOS routes enrollment applications to the correct Medicare contractor based on the provider/supplier type and their practice location, but it is not currently designed to route IHS and tribal enrollment applications to TrailBlazer Health Enterprises, LLC (TrailBlazer), the single designated Medicare contractor responsible for enrolling this provider type. For this reason, IHS facilities and tribal providers have not been able to use Internet-based PECOS.

CR 7174 is establishing an interim process to allow IHS facilities and tribal providers to use Internet-based PECOS to initially enroll in the Medicare program or submit changes of information.

If IHS facilities or tribal providers choose to use Internet-based PECOS, they will be responsible for mailing to TrailBlazer the following as part of the interim process:

1. A cover letter to indicate they are seeking to enroll as an IHS facility or tribal provider or updating their current enrollment information;
2. The Internet-based PECOS certification statement; and
3. Any other applicable supporting documentation.

The TrailBlazer addresses are as follows:

Part A
Part A Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650458
Dallas, TX 75265-0458

Part B
Part B Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650544
Dallas, TX 75265-0544

This interim process shall remain in effect until PECOS system changes are implemented to route all electronic enrollment applications received from IHS facilities and tribal providers directly to TrailBlazer.

Additional information

The official instruction, CR 7174, issued to your carriers, fiscal intermediaries (FIs), and Part A/Part B Medicare administrative contractors (A/B MACs) regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R358PI.pdf*. If you have any questions, please contact your carriers, FIs, or A/B MACs at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7174 *Revised*
Related CR Release Date: October 28, 2010
Related CR Transmittal #: R358PI
Related Change Request (CR) #: 7174
Effective Date: November 29, 2010
Implementation Date: November 29, 2010

Reopening certain claims denied when MSP data deleted or terminated

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

Note: This article was revised on December 6, 2010, to reflect a revision to change request (CR) 6625. The implementation date has been changed to July 5, 2011. The CR release date, transmittal number, and the Web address for accessing CR 6625 has been revised. All other information is the same. This information was previously published in the August 2010 *Medicare A Bulletin* page 7.

Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, Medicare administrative contractors (A/B MAC), or durable medical equipment contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

What you need to know

CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen group health plan (GHP) Medicare secondary payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the *Background* section for more details.

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

1) Reopen certain MSP claims when certain MSP records are deleted, or
2) Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare secondary payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional information

You may find the official instruction, CR 6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting *http://www.cms.gov/Transmittals/downloads/R2112CP.pdf*.

If you have any questions, please contact your FI, RHHI, carrier, 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: MM6625 *Revised*
Related Change Request (CR) #: 6625
Related CR Release Date: December 3, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2112CP
Implementation Date: July 5, 2011

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

2011 ambulance inflation factor and productivity adjustment

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

Provider types affected

This article is for providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

Provider action needed

Change request (CR) 7042, from which this article is taken, provides the ambulance inflation factor (AIF) for CY 2011. The AIF for CY 2011 is -0.1 percent. CR 7042 also includes updates to Chapter 15, Section 20.4 of the Medicare Benefit Policy Manual to incorporate a multi-factor productivity adjustment. Be sure billing staff are aware of the changes.

Background

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

Remember that Part B coinsurance and deductible requirements apply to these services.

Specifically, this section of the Act provides for a 2011 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act (ACA) amended Section 1834(l) (3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The following table displays the AIF for CY 2011 and for the previous eight years.

Ambulance inflation factor by calendar year	
2011	-0.1 percent
2010	0.0 percent
2009	5.0 percent
2008	2.7 percent
2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

Additional information

The official instruction, CR 7042, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2104CP.pdf*.

If you have any questions, please contact your carrier, FI, 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: MM7042
Related Change Request (CR) #: 7042
Related CR Release Date: November 19, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2104CP
Implementation Date: January 3, 2011

Fractional mileage amounts submitted on ambulance claims

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

Provider types affected

This article is for providers and suppliers of ambulance services who bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]) for those services.

What you need to know

Change request (CR) 7065, from which this article is taken, provides a new procedure for reporting fractional mileage amounts on ambulance claims, effective for claims for dates of service on or after January 1, 2011. Prior to that date, mileage is reported by rounding the total mileage up to the nearest whole mile. Be sure billing personnel are aware of this change that requires ambulance providers and suppliers to report to the nearest tenth of a mile for total mileage of less than 100 miles on ambulance claims as of January 1, 2011.

Background

Currently, the *Medicare Claims Processing Manual*, Chapter 15, Sections 30.1.2 and 30.2.1 require that ambulance providers and suppliers submitting claims to Medicare contractors use the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. According to these instructions from the Centers for Medicare & Medicaid Services (CMS), providers and suppliers are required to round the total mileage up to the nearest whole mile, including trips of less than one whole mile. For example, if the total number of round trip miles traveled equals 9.5 miles, the provider or supplier enters 10 units on the claim form or the corresponding loop and segment of the ANSI X12N 837

Fractional mileage amounts submitted on ambulance claims (continued)

electronic claim. For ambulance suppliers submitting claims to the Medicare carriers or A/B MACs, the *Medicare Claims Processing Manual*, Chapter 26, Section 10.4 additionally states that at least one unit must be billed in Item 24G on the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12N 837P electronic claim. Therefore, if a supplier travels less than one mile during a covered trip, the supplier would enter one unit on the claim form with the appropriate HCPCS code for mileage.

In the CY 2011 Medicare physician fee schedule (MPFS) final rule, CMS established a new procedure for reporting fractional mileage amounts on ambulance claims to improve reporting and payment accuracy. The final rule requires that, effective January 1, 2011, all Medicare ambulance providers and suppliers bill mileage that is accurate to a tenth of a mile.

Note: Currently the hardcopy UB-04 form cannot accommodate fractional billing, therefore, hardcopy billers will continue to use previous ambulance billing instructions provided in effect prior to January 1, 2011, that is, providers that are permitted to file paper UB-04 claims will continue to round up to the nearest whole mile until further notice from CMS.

Effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers must report mileage units rounded up to the nearest tenth of a mile for all claims (except hard copy billers that use the UB-04) for mileage totaling less than 100 covered miles. Providers and suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). Medicare contractors will truncate mileage units with fractional amounts reported to greater than one decimal place (e.g., 99.99 will become 99.9 after truncating the hundredths place).

For trips totaling 100 miles and greater, suppliers must continue to report mileage rounded up to the nearest whole number mile (e.g., 999). Medicare contractors will truncate mileage units totaling 100 and greater that are reported with fractional mileage; (e.g., 100.99 will become 100 after truncating the decimal places).

For mileage totaling less than one mile, providers and suppliers must include a "0" prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Medicare contractors will automatically default "0.1" unit when the total mileage units are missing in Item 24G of the CMS-1500 claim form.

Additional information

The official instruction, CR 7065, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2103CP.pdf*.

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

MLN Matters® Number: MM7065
Related Change Request (CR) #: 7065
Related CR Release Date: November 19, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2103CP
Implementation Date: January 3, 2011

PROVIDER SATISFACTION SURVEY

2011 Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services is conducting its annual administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). The survey is designed to collect quantifiable data on provider satisfaction with the performance of your Medicare contractor. The MCPSS will be sent to a random sample of approximately 33,000 Medicare fee-for-service providers and suppliers. CMS is listening and wants to hear from you about the services provided by your Medicare contractor. If you are selected to participate, please take a few minutes and complete this important survey. To learn more about the MCPSS, please visit *http://www.cms.gov/mcpss* or *https://www.mcpsstudy.org*.

Source: JSM 11044

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/*.

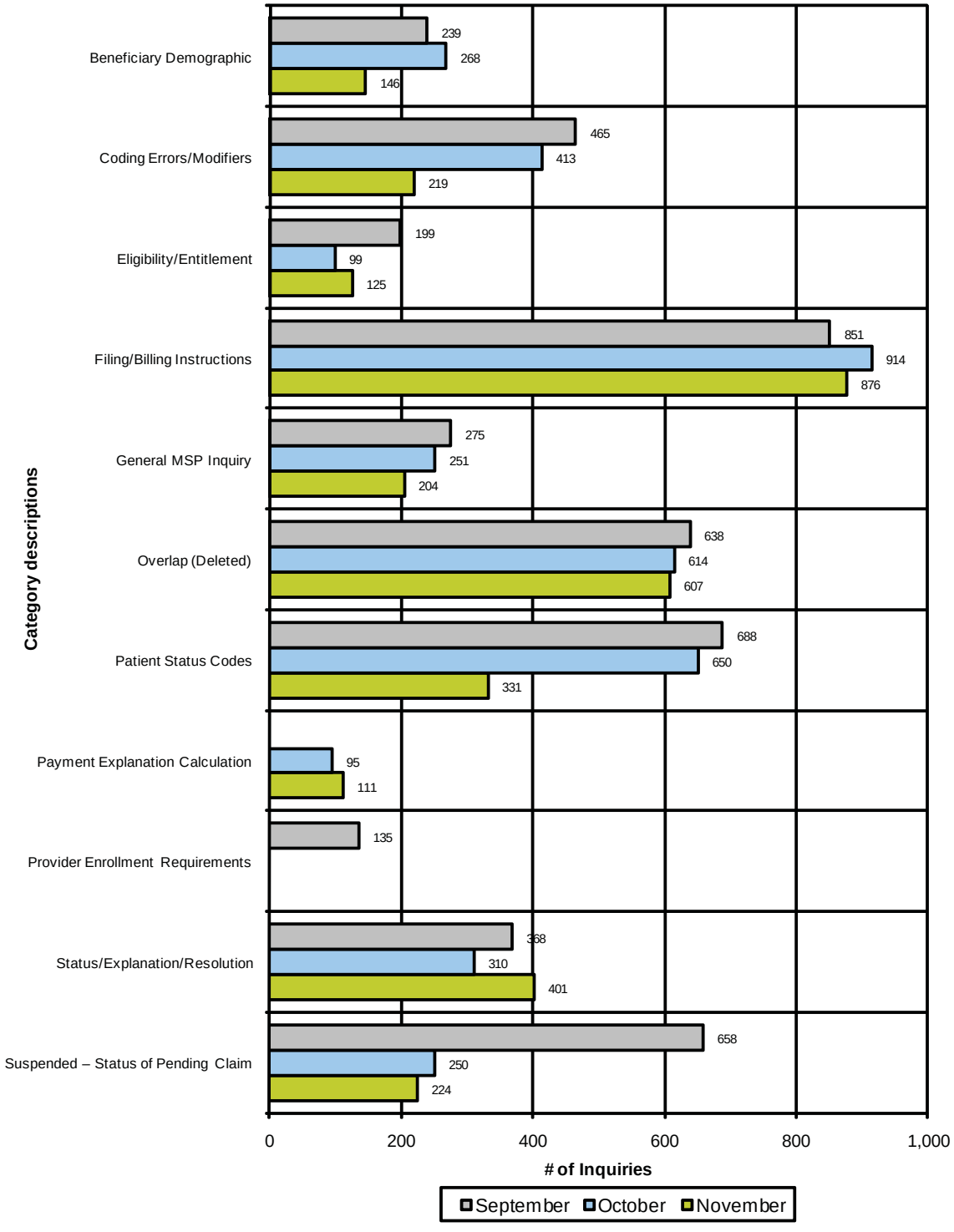
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for September-November 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 September-November 2010.

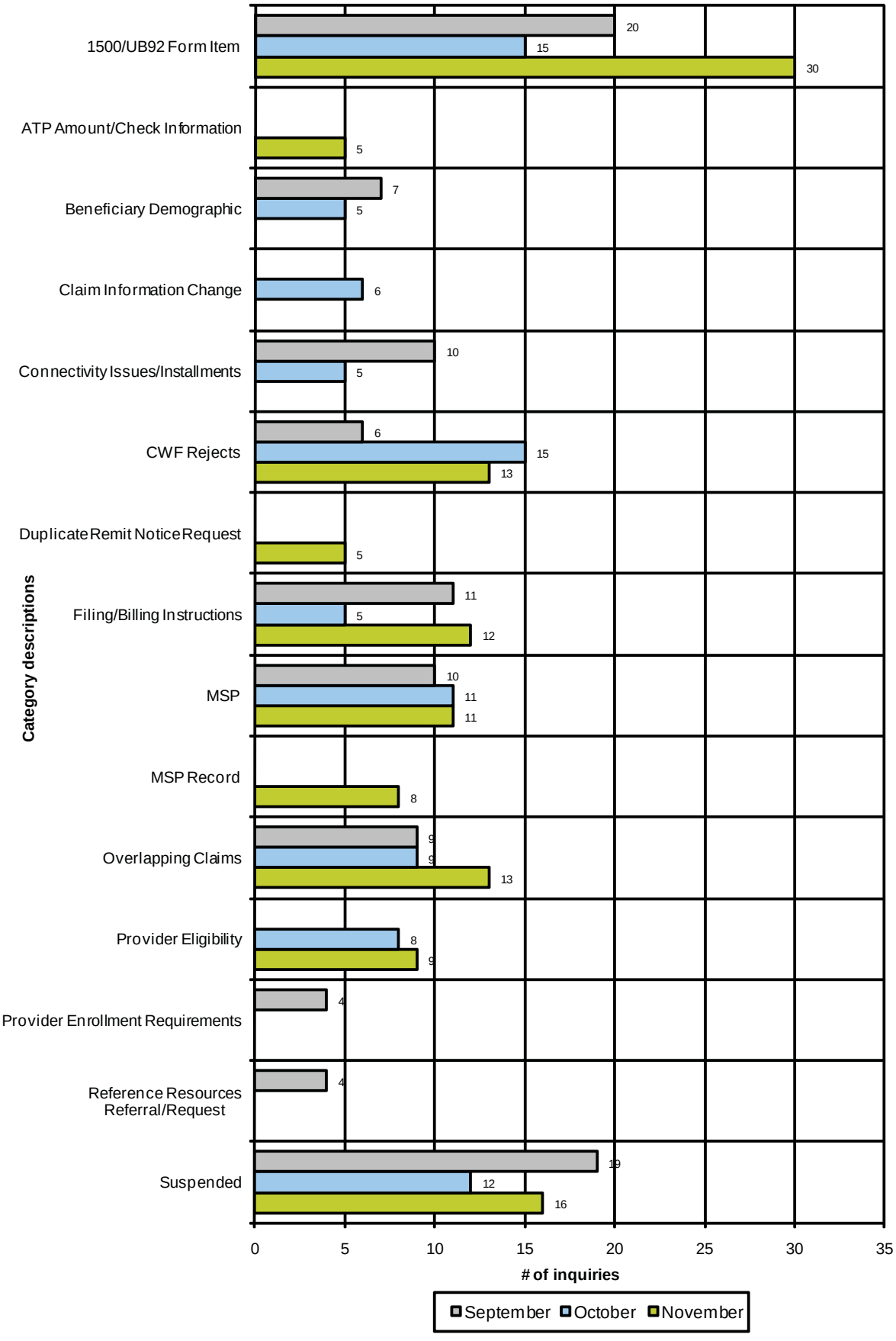
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for September-November 2010



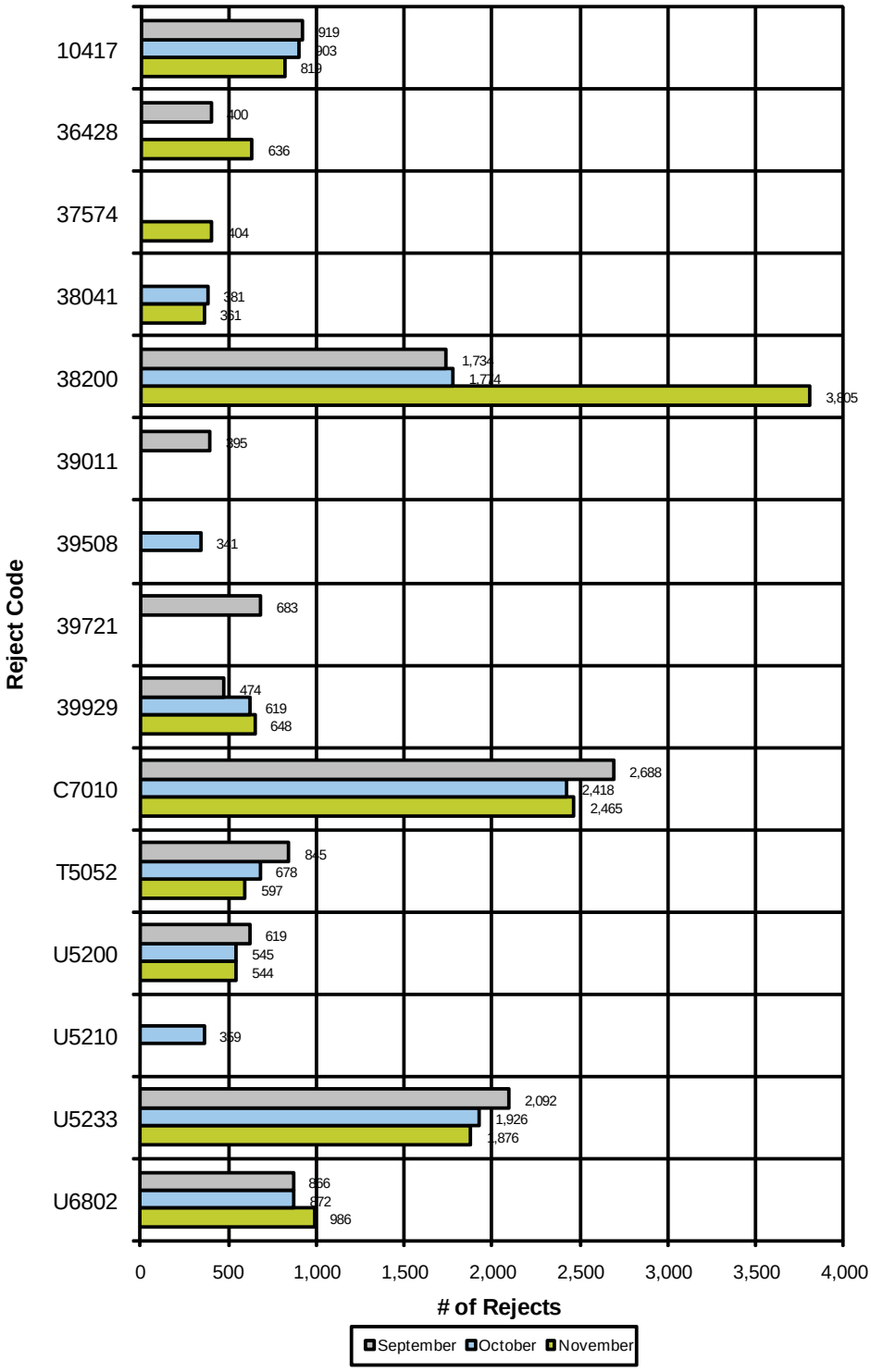
Top inquiries, return to provider, and reject claims for September-November 2010 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for September-November 2010



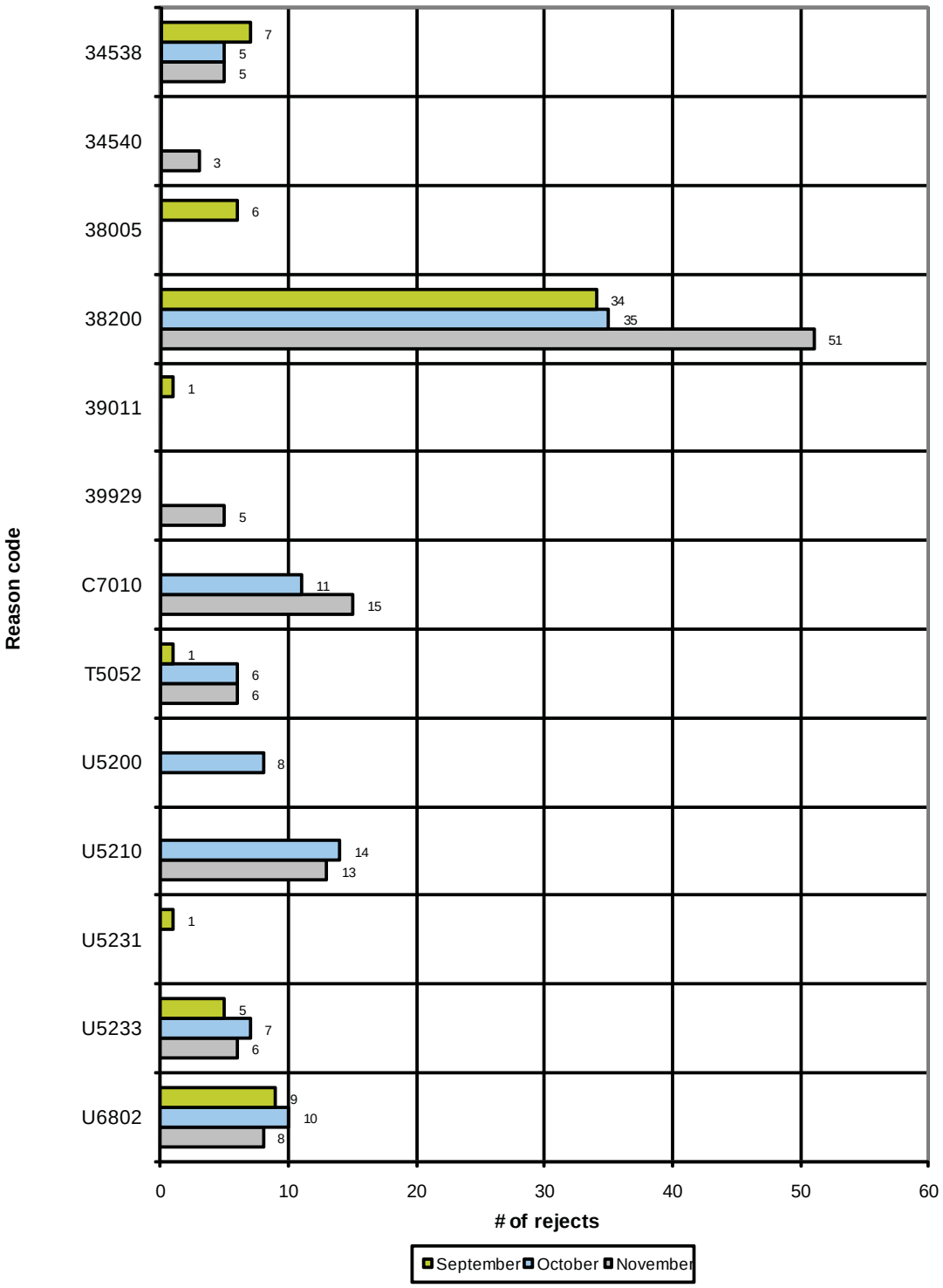
Top inquiries, return to provider, and reject claims for September-November 2010 (continued)

Florida Part A top rejects for September-November 2010



Top inquiries, return to provider, and reject claims for September-November 2010 (continued)

U.S. Virgin Islands Part A top rejects for September-November 2010

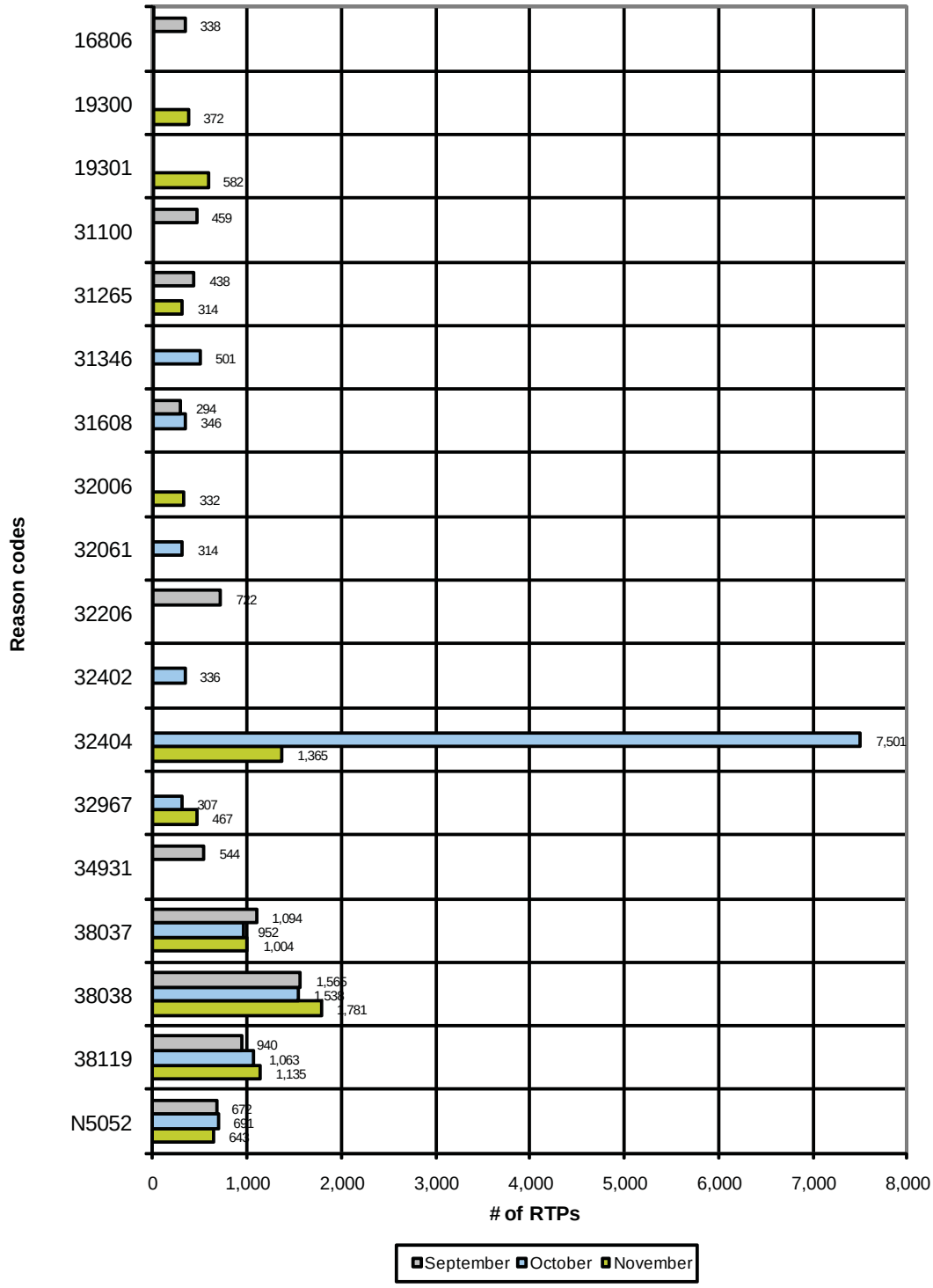


Keep Informed

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

Top inquiries, return to provider, and reject claims for September-November 2010 (continued)

Florida Part A top return to providers (RTPs) for September-November 2010



Educational Resources

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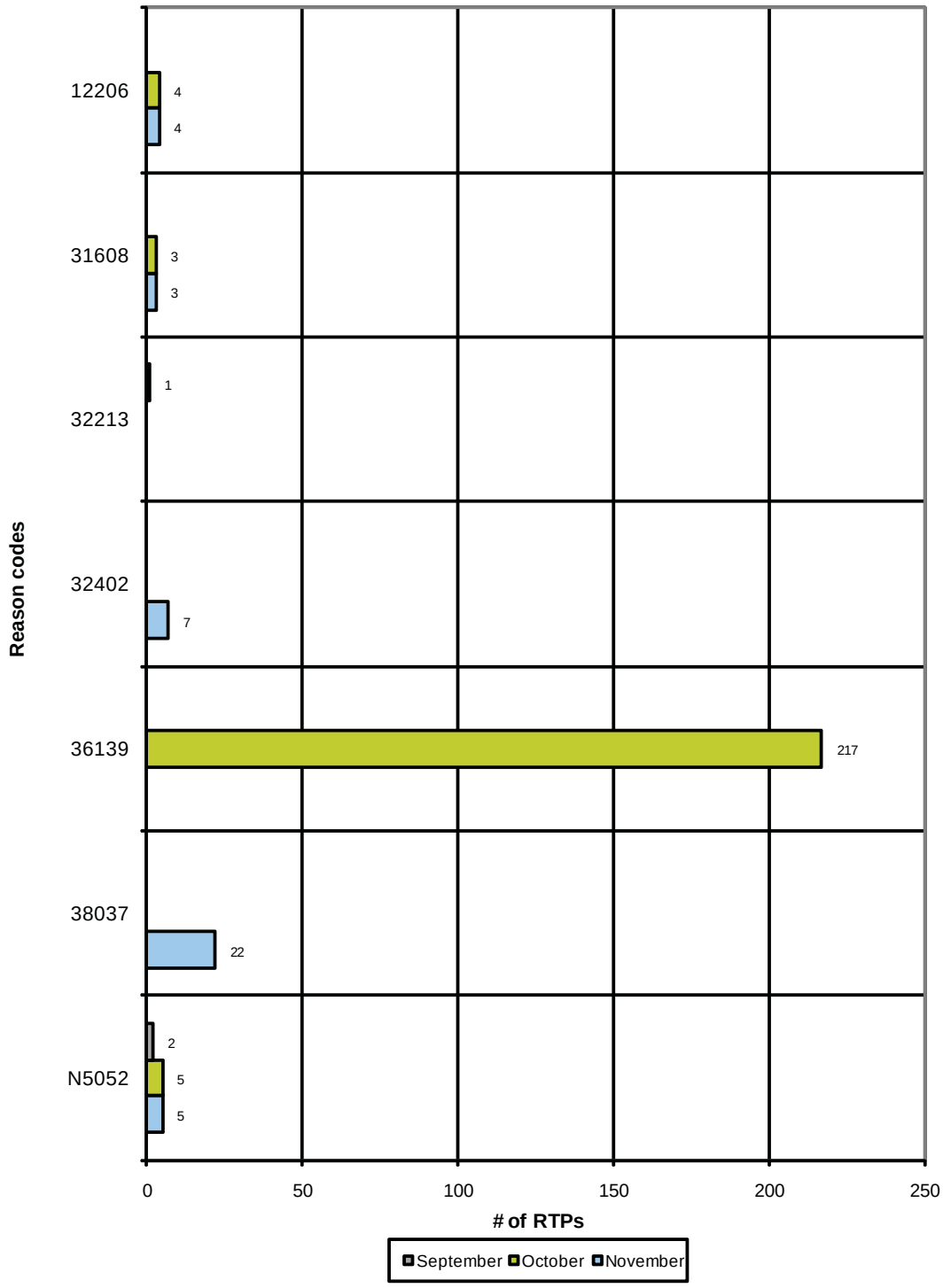
Top inquiries, return to provider, and reject claims for September-November 2010 (continued)

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



GENERAL COVERAGE

Billing clarification for positron emission tomography for identifying bone metastasis of cancer in the context of a clinical trial

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

Provider types affected

This article is for physicians, providers and suppliers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for providing sodium fluoride-18 positron emission tomography (NaF-18 PET) scans to identify bone metastasis of cancer for Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7125, which is being issued to clarify a requirement in CR 6861 regarding how these claims should be billed. Specifically, CR 7125 amends instructions for claims submitted for the professional component (PC), technical (TC) or global components. This article explains the specific claims handling instructions for claims submitted for each of these components. Please ensure that your billing staffs are aware of this clarification.

Background

This article explains that CR 7125 clarifies the requirement originally discussed in *MLN Matters*® article MM6861, which may be viewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM6861.pdf*. That requirement is being amended to state that only claims for the TC or global service require the radioactive tracer, Healthcare Common Procedure Coding System (HCPCS) A9580. Claims for the PC do not require HCPCS A9580, but must contain the appropriate modifier (PI or PS), PET/CT HCPCS procedure code, diagnosis code, and the modifier Q0.

CR 7125 also corrects the list of applicable PET or PET with CT *CPT* codes that can be used for bone metastasis on the claim and to remove CPT *78608* and *t8459* as they cannot be paid for bone metastasis with NaF-18. Finally, modifier KX (Requirements specified in the medical policy have been met) will be accepted for PC claims (modifier 26) for PET for bone metastasis (PET NaF-18) to differentiate these claims from PET for FDG in the context of a clinical trial. This modifier is not required on claims submitted to FIs, nor is it required on claims for the technical or global service.

Key points in CR 7125

1. Effective for claims with dates of service on or after February 26, 2010, NaF-18 PET oncologic claims billed with modifier TC or globally to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis that **must** include **all** of the following:
   - Modifier PI or PS
   - PET or PET/CT *CPT* code (*78811, 78812, 78813, 78814, 78815, 78816*)
   - ICD-9 cancer diagnosis code
   - Modifier Q0 – Investigational clinical service provided in a clinical research study, are present on the claim.
2. Effective for claims with dates of service on or after February 26, 2010, PET oncologic claims billed with modifier 26 and modifier KX to inform the initial treatment strategy or strategy or subsequent treatment strategy for bone metastasis **must** include **all** of the following:
   - Modifier PI or PS
   - PET or PET/CT *CPT* code (*78811, 78812, 78813, 78814, 78815, 78816*)
   - ICD-9 cancer diagnosis code
   - Modifier Q0 – Investigational clinical service provided in a clinical research study, are present on the claim.
3. Claims failing the requirements stated above will be returned as unprocessable with the following messages:
   - Claim adjustment reason code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.)
   - Remittance advice remark code (RARC) MA-130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.)
   - RARC M16 (Alert: See our website, mailings, or bulletins for more details concerning this policy/procedure/decision.)
   - CARC 167 (This (these) diagnosis(es) is (are) not covered.)
4. Claims billed with modifiers 26 and KX to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis billed with HCPCS A9580 will be returned as unprocessable using CARC 97 (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.).

Billing clarification for positron emission tomography for identifying..... (continued)

Additional information

The official instruction, CR 7125, issued to your carrier, FI, or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2096CP.pdf*.

MLN Matters® Number: MM7125
Related Change Request (CR) #: 7125
Related CR Release Date: November 19, 2010
Effective Date: February 26, 2010
Related CR Transmittal #: R2096CP
Implementation Date: February 22, 2011

2011 annual update for clinical laboratory fee schedule and laboratory services

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

Provider types affected

Clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) are affected.

Impact on providers

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6991 which provides instructions for the calendar year (CY) 2011 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

Background

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*), and further amended by Section 3401 of the Affordable Care Act, the annual update to the local clinical laboratory fees for CY 2011 is -1.75 percent. The annual update to local clinical laboratory fees for CY 2011 reflects an additional multi-factor productivity adjustment as described by the Affordable Care Act. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2011 is 1.1 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Social Security Act (the Act) provides that payment for a clinical laboratory test is the lesser of:

- The actual charge billed for the test
- The local fee, or
- The national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

Note: The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National minimum payment amounts

For a cervical or vaginal smear test (Pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2011 national minimum payment amount is $14.87 percent ($15.13 minus the 1.75 percent update for CY 2011). The affected codes for the national minimum payment amount are shown in the following table:

88142	*88143*	*88147*	*88148*	*88150*
88152	*88153*	*88154*	*88164*	*88165*
88166	*88167*	*88174*	*88175*	G0123
G0144	G0145	G0147	G0148	P3000

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to data file

Internet access to the CY 2011 clinical laboratory fee schedule data file will be available after November 19, 2010, at *http://www.cms.gov/ClinicalLabFeeSched*. Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2011 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 22, 2010, CMS hosted a public meeting to solicit input on the payment relationship between CY 2010 codes and new CY 2011 *Current Procedural Terminology* (*CPT*) codes. CMS posted a summary of the meeting and the tentative payment determinations at *http://www.cms.gov/ClinicalLabFeeSched* on the CMS website. Additional written comments from the public were

2011 annual update for clinical laboratory fee schedule and laboratory services (continued)

accepted until October 29, 2010, and a summary of the public comments and the rationale for the final payment determinations are posted on the same CMS website.

Pricing information

The CY 2011 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2011, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2011 clinical laboratory fee schedule also includes codes that have a modifier QW to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the CY 2011 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

- New code *82930* is priced at the same rate as code *82926*.
- New code *83861* is priced at the same rate as code *83909*.
- New code *84112* is priced at the same rate as code *82731*.
- New code *85598* is priced at the same rate as code *85597*.
- New code *86481* is priced at the same rate as code *86480*.
- New code *86902* is priced at the same rate as code *86905*.
- New code *87501* is priced at the sum of the rates of codes 87521 and 83902.
- New code *87502* is priced at the sum of the rates of codes 87801 and 83902.
- New code *87503* is priced at the sum of the rates of codes 83901 and 83896.
- New code *87906* is priced at half of code 87901.
- Healthcare Common Procedure Coding System (HCPCS) code G0434 is priced at the same rate as code G0430.
- HCPCS code G9143 is priced at the sum of the rates of codes *83891, 83900, 83901, 83912*, three times the rate of code *83896*, and three times the rate of code *83908*. A two-character modifier indicates that this test's use is limited to a coverage with evidence development (CED) study.
- HCPCS code G0432 is priced at the same rate as code *86703*.
- HCPCS code G0433 is priced at the same rate as code *86703*.
- HCPCS code G0435 is priced at the same rate as code *87804*.
- Reconsidered code *84145* is priced at the same rate as code *82308*.
- Reconsidered code *84431* is priced at the same rate as code *84443*.
- Reconsidered code *86352* is priced at twice the sum of the rates of codes *86353* and *82397*.
- HCPCS code G0430 is deleted beginning January 1, 2011.
- HCPCS code G0431 is priced at five times the rate of HCPCS code G0430.
- New code *84155QW* is priced at the same rate as code *84155* beginning January 1, 2010.
- New code *87809QW* is priced at the same rate as code *87809* beginning January 1, 2008.

For CY 2011, there are no new test codes that need to be gap-filled.

Laboratory costs subject to reasonable charge payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, (see *http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html*) the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1)(see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*). The inflation-indexed update for CY 2011 is 1.1 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8 (see *http://www.cms.gov/manuals/downloads/clm104c23.pdf*).

If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual* (Chapter 8, Section 60.3; see *http://www.cms.gov/manuals/downloads/clm104c08.pdf*) instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system.

Blood products

P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

2011 annual update for clinical laboratory fee schedule and laboratory services (continued)

Also, the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual* (Chapter 3, Section 20.5 through 20.54; see *http://www.cms.gov/Manuals/IOM/list.asp#TopOfPage*):

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on the Social Security Act (Section 1842(o)). The payment limits based on that provision, including the payment limits for codes P9041, P9043, P9046, P9047 and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine

86850	*86860*	*86870*	*86880*	*86885*	*86886*
86890	*86891*	*86900*	*86901*	*86903*	*86904*
86905	*86906*	*86920*	*86921*	*86922*	*86923*
86927	*86930*	*86931*	*86932*	*86945*	*86950*
86960	*86965*	*86970*	*86971*	*86972*	*86975*
86976	*86977*	*86978*	*86985*		

Reproductive medicine procedures

89250	*89251*	*89253*	*89254*	*89255*	*89257*
89258	*89259*	*89260*	*89261*	*89264*	*89268*
89272	*89280*	*89281*	*89290*	*89291*	*89335*
89342	*89343*	*89344*	*89346*	*89352*	*89353*
89354	*89356*				

Additional information

If you have questions, please contact your Medicare A/B MAC, carrier and/or FI at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction associated with this CR 6991, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2106CP.pdf*.

MLN Matters® Number: MM6991
Related Change Request (CR) #: 6991
Related CR Release Date: November 24, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2106CP
Implementation Date: January 3, 2011

Signature on requisitions for clinical diagnostic laboratory tests

In the November 29, 2010, Medicare physician fee schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified nonphysician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective January 1, 2011. A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.

Although many physicians, nonphysician practitioners (NPPs), and clinical diagnostic laboratories may be aware of, and are able to comply with, this policy, CMS is concerned that some physicians, NPPs, and clinical diagnostic laboratories are not aware of, or do not understand, this policy. CMS will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS will post this information on its website at *http://www.cms.gov/ClinicalLabFeeSched* and use other channels to communicate with providers to ensure this information is widely distributed. Once the first quarter's educational campaign is fully underway, CMS will expect requisitions to be signed.

Source: JSM 11097

Clinical laboratory fee schedule – 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

Clinical laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for clinical laboratory services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7239 which revises the payment of travel allowances, either on a per mileage basis (P9603) or on a flat rate basis (P9604) for calendar year (CY) 2010.

Caution – what you need to know

Note that Medicare contractors will not re-process claims that were processed before the new rates were implemented unless you bring such claims to their attention.

Go – what you need to do

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

Background

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. Also, the travel codes allow for payment of the travel allowance either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604), and payment of the travel allowance is made only if a specimen collection fee is also payable.

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 per flat rate trip basis travel allowance (P9604) for 2010 is $9.50. The per mile travel allowance (P9603) is $0.95 cents per mile and is used in situations where the average trip to the patients' home is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using 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. Medicare contractors have the option of establishing a higher per mile rate in excess of the minimum $0.95 per mile if local conditions warrant it. At no time is a laboratory allowed to bill for more miles than are reasonable or for miles that are not actually traveled by the laboratory technician.

The Centers for Medicare & Medicaid Services (CMS) reviews the minimum mileage rate and updates it in conjunction with the clinical laboratory fee schedule (CLFS) as needed.

Note: Because of confusion that some laboratories have had regarding the per mile fee basis and the need to claim the minimum distance necessary for a laboratory technician to travel for specimen collection, some Medicare contractors have established local policy to pay based on a flat rate basis only.

Additional information

The official instruction, CR 7239 issued to your carrier, A/B MAC, or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2110CP.pdf*.

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

To review examples of scenarios that further clarify the travel allowances you may go to *http://www.cms.gov/MLNMattersArticles/downloads/MM6195.pdf* and read the Additional information section of MM6195.

MLN Matters® Number: MM7239
Related Change Request (CR) #:7239
Related CR Release Date: December 3, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R2110CP
Implementation Date: January 3, 2011

Ventricular assist devices as destination therapy

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

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for ventricular assist device (VAD) implantation services provided to Medicare beneficiaries.

What you need to know

Effective for claims with dates of service on or after November 9, 2010, The Centers for Medicare & Medicaid Services (CMS) has expanded coverage for VAD implantation as destination therapy as reasonable and necessary when the device has received Food and Drug Administration (FDA) approval for a destination therapy indication and only for patients with New York Heart Association (NYHA) Class IV end-stage ventricular heart failure who are not candidates for a heart transplant and who meet all specific conditions as outlined in the revised *Medicare National Coverage Determinations* (*NCD*) *Manual* (Chapter 1, Section 20.9).

Background

A ventricular assist device (VAD) or left ventricular assist device (LVAD) is surgically attached to one or both intact ventricles and is used to assist a damaged or weakened native heart in pumping blood. Medicare currently covers these devices for three general indications:

1. Postcardiotomy
2. Bridge to transplantation
3. Destination therapy.

Destination therapy is for patients who are not candidates for heart transplantation and require permanent mechanical cardiac support. Coverage for destination therapy is currently restricted based on patient selection criteria including:

- New York Heart Association (NYHA) class
- Time on optimal medical management
- Left ventricular ejection fraction, and
- Peak oxygen consumption.

Note: VADs implanted for destination therapy are only covered when performed in a hospital that is Medicare approved to provide this procedure.

CR 7220 instructs that, effective for claims with dates of service on and after November 9, 2010, CMS has determined that the evidence is adequate to conclude that VAD implantation as destination therapy improves health outcomes and is reasonable and necessary when:

- The device has received FDA approval for a destination therapy indication, and only for patients with New York Heart Association (NYHA) class IV end-stage ventricular heart failure who are not candidates for heart transplant, and
- Who meet all of the following conditions:
  - Have failed to respond to optimal medical management (including beta-blockers, and Antiotensin-Converting Enzyme (ACE) inhibitors if tolerated) for at least 45 of the last 60 days, or have been balloon pump-dependent for seven days, or IV inotrope-dependent for 14 days
  - Have a left ventricular ejection fraction (LVEF) < 25 percent, and
  - Have demonstrated functional limitation with a peak oxygen consumption of ≤14 ml/kg/min unless balloon pump ot inotrope dependent or physicially unable to perform the test.

Note: There are no changes to existing claims processing requirements/editing for VADs as destination therapy.

Additional Information

The official instruction, CR 7220, issued to your carriers, FIs, and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R129NCD.pdf*.

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

MLN Matters® Number: MM7220
Related Change Request (CR) #: 7220
Related CR Release Date: December 8, 2010
Effective Date: November 9, 2010
Related CR Transmittal #: R129NCD
Implementation Date: January 6, 2011

Dermal injections for treatment of facial lipodystrophy syndrome

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

Note: This article was revised on November 26, 2010, to reflect a revised change request (CR) 6953, which was issued on November 24, 2010. The CR was revised to clarify billing procedures for services performed in the outpatient hospital setting and to update the claims adjustment reason code for line item denials for relevant services performed prior to March 23, 2010. This article was revised to reflect this clarification and update. This information was previously published in the October 2010 *Medicare A Bulletin* pages 38-40.

Provider types affected

This article is for physicians, hospitals, and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors [A/B MACs]) for facial lipodystrophy services provided to Medicare beneficiaries.

What you need to know

This article is based on CR 6953 which informs Medicare contractors that, effective for claims with dates of service on and after March 23, 2010, dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in human immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Background

The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial lipodystrophy syndrome (LDS) for human immunodeficiency virus (HIV)-infected Medicare beneficiaries. LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or highly active antiretroviral therapy (HAART). Due to their appearance, patients with LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

Nationally-covered indications

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Nationally noncovered indications

- Dermal fillers that are not approved by the FDA for the treatment of LDS, and
- Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

Claim coding/pricing information

Effective with the July 2010 Healthcare Common Procedure Coding System (HCPCS) update, the July Medicare physician fee schedule (MPFS), and the July integrated outpatient code editor (IOCE):

- HCPCS codes Q2026, Q2027, and G0429 will be designated for dermal fillers Sculptra® and Radiesse®
- HCPCS codes Q2026, Q2027, and G0429 are effective for dates of service on or after March 23, 2010
- HCPCS codes Q2026 and Q2027 are contractor-priced under the July MPFS, and
- HCPCS code G0429 is payable under the July MPFS.

However, because HCPCS Q2026, Q2027, and G0429 are not considered valid HCPCS until implementation of the July 2010 HCPCS update, providers will not be able to bill and receive payment for these HCPCS codes prior to July 6, 2010.

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the dermal filler product. This code provides a payment mechanism to hospital outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) providers until average sales price (ASP) or wholesale acquisition cost (WAC) pricing information becomes available. When ASP or WAC pricing information becomes available, the temporary HCPCS code will be deleted and separate payment will be made under the OPPS and ASC payment systems for HCPCS Q2026, Q2027, and G0429.

For institutional non-OPPS claims, Medicare contractors will use current payment methodologies for claims for dermal injections for treatment of LDS.

Hospital and ASC billing instructions

For ASC claims, providers must bill covered dermal injections for treatment of LDS by having all the required elements on the claim:

- A line with HCPCS codes Q2026 or Q2027 with a line item date of service (LIDOS) on or after March 23, 2010
- A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010, and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

Medicare will deny line items on institutional claims where the LIDOS is prior to March 23, 2010.

Note to ASCs: For line item dates of service on or after March 23, 2010, and until pricing information is made available to price OPPS claims, LDS claims shall contain the temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

For outpatient facilities, hospitals should bill:

- HCPCS code G0429 with a date of service on or after March 23, 2010, and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Liposystophy).

Dermal injections for treatment of facial lipodystrophy syndrome (continued)

Note on all hospital claims: An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

Practitioner billing instructions

Practitioners must bill covered claims for dermal injections for treatment of LDS by having all the required elements on the claim:

- A date of service (LIDOS) on or after March 23, 2010
- HCPCS codes Q2026 or Q2027
- A line with HCPCS code G0429, and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

Note: An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage based on the individual Medicare contractor's policy.

Billing for services prior to Medicare coverage

ASCs and practitioners billing for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following messages upon their Medicare denial:

- Claim adjustment reason code (CARC) 26: Expenses incurred prior to coverage.
- Remittance advice remark code (RARC) N386: This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- Group code: contractual obligation (CO)

Medicare beneficiaries whose provider bills Medicare for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following Medicare summary notice (MSN) message upon the Medicare denial:

- 21.11 - This service was not covered by Medicare at the time you received it.

Billing for services not meeting comorbidity coverage requirements

Hospitals and practitioners billing for dermal injections for treatment of LDS on patients that do not have on the claim both ICD-9-CM diagnosis codes of 042 and 272.6, indicating HIV and lipodystrophy will receive the following messages upon their Medicare claims denial:

- **CARC 50**: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- **Group code**: contractual obligation (CO)

Medicare beneficiaries who do not meet Medicare comorbidity requirements of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) and whose provider bills Medicare for dermal injections for treatment of LDS will receive the following MSN message upon the Medicare denial:

- 15.4 - The information provided does not support the need for this service or item.

Additional information

The official instruction, CR 6953, issued to your carrier, FI, and A/B MAC regarding this change via two transmittals. The first transmittal revised the *Medicare NCD Manual* and it may be viewed at *http://www.cms.gov.Transmittals/downloads/R122NCD.pdf*. The second transmittal revises the *Medicare Claim Processing Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R2105CP.pdf*.

If you have any questions, please contact your carrier, FI, 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: MM6953 *Revised*
Related Change Request (CR) #: 6953
Related CR Release Date: November 24, 2010
Effective Date: March 23, 2010
Related CR Transmittal #: R122NCD and R2105CP
Implementation Date: July 6, 2010

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

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Advance beneficiary notice

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

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

NEW LCD IMPLEMENTATION

A77402: Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – new LCD

LCD ID number: L31512 (Florida/Puerto Rico/U.S. Virgin Islands)

There are several treatment options for basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) of the skin including surgical excision and radiation therapy. This local coverage determination (LCD) will focus solely on radiation therapy (RT) for basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) stage T1. Stage T1 lesions are defined as lesions ≤2 cm.

Non-melanoma skin cancers (NMSC), also known as basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) are the most common forms of skin cancer. Basal cell carcinoma develops from the deep epidermis skin cells and can most commonly be found on sun exposed areas such as the face, ears, hands and forearms. Basal cell carcinomas are generally slow growing. Squamous cell carcinoma, like basal cell, typically are found on sun exposed areas of the skin, but can also occur on areas of the skin that have had previous trauma (burns, scars) or areas that have inflammatory conditions. Squamous cell carcinoma develops from the middle layer of the epidermis and can be slow or fast growing and can invade surrounding structures.

External beam radiation therapy (EBRT), also known as teletherapy, is therapy aimed at the lesion/tumor from an x-ray source outside the patients' body, usually a linear accelerator ("linacs") which produce X-rays (photons) or electrons. Electrons are useful in treating superficial lesions because the dose is aimed at the surface and dissipates as it goes deeper, thus sparing underlying tissue. Electrons usually have an energy range from 4-25 MV. Therapeutic X-rays (photons) can have energies in the kV range (at least 50 kV or greater) or, more typically, in the MV range. EBRT treatment is usually given over a series of daily treatments called fractions that can span over a few weeks (2-9). There are several methods used to administer EBRT: conventional, 3D conformal, intensity modulated radiation therapy (IMRT), tomographic, and stereotactic radiosurgery.

Brachytherapy unlike EBRT administers radiation therapy within or in contact with the body. Brachytherapy can be low dose rate (LDR) or high dose rate (HDR). LDR involves placing the radiation source directly into or next to the tumor. HDR treatment is delivered with dose rates greater than or equal to 1200 cGy per hour. The high intensity radio elements used in HDR have a radioactivity level high enough that prevents manual handling and loading of the applicator.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines for this service.

Effective date

This new LCD is effective for services provided **on or after February 13, 2011.** 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. ❖

A92250: Fundus photography – new LCD

LCD ID number: L31496 (Florida/Puerto Rico/U.S. Virgin Islands)

Fundus photography is a procedure involving the use of a retinal camera to photograph the regions of the vitreous, retina, choroid and optic nerve for diagnostic purposes. These photographs are also used for therapeutic assessment of recently performed retinal laser surgery and to aid in the interpretation of fluorescein angiography.

First Coast Service Options Inc. (FCSO) Medicare will cover fundus photography if accompanied by fluorescein dye angiography when used to evaluate abnormalities or degeneration of the macula, the peripheral retina or the posterior pole. Fundus photography may be covered as a stand-alone procedure, without fluorescein dye angiography, following recently performed non-surgical or surgical treatment for macular pathology.

Preglaucoma, borderline glaucoma, and glaucoma are generally slow disease processes which can be followed by modalities other than fundus photography. Baseline studies will, however, be allowed when performed by the treating physician as part of initial glaucoma eye care.

The local coverage determination (LCD) for fundus photography has been developed to provide the indications and limitations of coverage and/or medical necessity , ICD-9-CM codes that support medical necessity, documentation requirements, utilization guidelines and sources of information and basis for decision for this service. An LCD "Coding Guidelines" attachment has also been developed for this service.

Effective date

This new LCD is effective for services provided **on or after February 13, 2011.** 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. ❖

A95921: Autonomic function tests – new LCD

LCD ID number: L31465 (Florida/Puerto Rico/U.S. Virgin Islands)

The autonomic nervous system (ANS) is the part of the peripheral nervous system that acts as a control system functioning largely below the level of consciousness, and controls visceral functions. The ANS affects heart rate, digestion, respiration rate, salivation, perspiration, diameter of pupils, maturation, and sexual arousal. It is classically divided into two subsystems: the parasympathetic nervous system and sympathetic nervous system. With regard to function, the ANS is usually divided into sensory (afferent) and motor (efferent) subsystems.

ANS testing checks for imbalances in the part of the body that controls many autonomic processes including heart rate, blood pressure, gastrointestinal function, and sweating.

A local coverage determination (LCD) has been developed for autonomic function tests (AFT) based on review findings of a wide spread probe review. Results of this review showed a majority of ANS testing was used as a screening tool on patients with chronic medical conditions, and had little or no impact on the treatment or care plan of the patients. This LCD gives indications and limitations of coverage, documentation requirements, utilization guidelines, ICD-9-CM codes and coding guidelines for the following *CPT* codes:

95921 – Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio

95922 – Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt

95923 – Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential

Effective date

This new LCD is effective for services provided **on or after January 23, 2011.** 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. ❖

AHAE: Selective treatment for HAE with Cinryze™, Berinert®, and ecallantide – new LCD

LCD ID number: L31508 (Florida/Puerto Rico/U.S. Virgin Islands)

Hereditary Angioedema (HAE) is a very rare inherited disease caused by low levels or improper function of a blood protein called C1 inhibitor (C1 – INH). HAE is caused by a genetic defect of chromosome 11. The incidence of HAE is estimated at 1 out of 50,000 individuals. There are three types of HAE. Approximately 85% of those diagnosed have Type 1 HAE, in which the individuals have low levels of normal C1-INH. Type II HAE patients represent approximately 15% of those diagnosed with the disease and they have normal or elevated levels of C-1 INH, but it does not function correctly. Type III HAE is extremely rare and is an estrogen dependent form of angioedema and it only occurs in women. HAE affects the blood vessels and can cause the affected individuals to develop rapid swelling and or pain of the hands, feet, limbs, face, intestinal tract, larynx or trachea. The internal swelling of the intestines may cause pain, nausea, and vomiting. The swelling of the airway may cause difficulty in swallowing, change in voice pitch or difficulty breathing and can be potentially life-threatening.

This new local coverage determination (LCD) gives indications and limitations of coverage, documentation requirements, utilization guidelines, and an ICD-9-CM code for the following HCPCS codes:

J0597: Injection, C-1 esterase inhibitor (human), Berinert, 10 units

J0598: Injection, C-1 esterase inhibitor (human), Cinryze, 10 units

J1290: Injection, ecallantide, 1 mg

Effective date

This new LCD is effective for services provided **on or after January 23, 2011.** 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

A11000: Wound debridement services – revision to the LCD

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

This local coverage determination (LCD) for wound debridement services was most recently revised on September 30, 2009. Since that time, a revision was made to the LCD to add additional diagnosis codes based on a reconsideration request.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the following diagnosis code ranges and codes were added:

885.0 – 885.1: Traumatic amputation of thumb (complete) (partial)

886.0 – 886.1: Traumatic amputation of other finger(s) (complete) (partial)

887.0 – 887.7: Traumatic amputation of arm and hand (complete) (partial)

895.0 – 895.1: Traumatic amputation of toe(s) (complete) (partial)

896.0 – 896.3: Traumatic amputation of foot (complete) (partial)

897.0 – 897.7: Traumatic amputation of leg(s) (complete) (partial)

997.60: Amputation stump, unspecified complication

997.62: Amputation stump complication, infection (chronic)

Effective date

This LCD revision is effective for services provided **on or after January 1, 2011.** 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. ❖

A70551: Magnetic resonance imaging of the brain – revision to the LCD

LCD ID number: L28904 (Florida)
LCD ID number: L28926 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for magnetic resonance imaging of the brain was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009 , for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a list of diagnosis codes was added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to ensure the Part A and Part B LCDs for magnetic resonance imaging of the brain are consistent across the jurisdiction.

Effective date

This LCD revision is effective for services provided **on or after January 14, 2011.** 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. ❖

A72141: Magnetic resonance imaging of the spine – revision to the LCD

LCD ID number: L28906 (Florida)
LCD ID number: L28928 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for magnetic resonance imaging of the spine was effective for services provided on or after February 16, 2009 for Florida, and on or after March 2, 2009 for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a list of diagnosis codes was added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD to ensure the Part A and Part B LCDs for magnetic resonance imaging of the spine are consistent across the jurisdiction.

A72141: Magnetic resonance imaging of the spine (continued)

Effective date

This LCD revision is effective for services provided **on or after January 14, 2011.** 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. ❖

A77055 Screening and diagnostic mammography – revision to the LCD

LCD ID number: L29048 (Florida)
LCD ID number: L29049 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for screening and diagnostic mammography was most recently revised on October 1, 2009. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2034, change request (CR) 7038, dated August 24, 2010, to add bill type 77x (Federally Qualified Health Centers [FQHCs]) under the "Type of Bill Code" section and added revenue codes 0521 and 0524 under the "Revenue Code" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 3, 2011,** for services provided **on or after January 1, 2011.** 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. ❖

A77078 Bone mineral density studies – revision to the LCD

LCD ID number: L28766 (Florida)
LCD ID number: L28767 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was most recently revised on July 13, 2010. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2034, change request (CR) 7038, dated August 24, 2010, to add bill type 77x (Federally Qualified Health Centers [FQHCs]) under the "Type of Bill Code" section and added revenue codes 0521 and 0524 under the "Revenue Code" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 3, 2011,** for services provided **on or after January 1, 2011.** 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. ❖

A92081: Visual field examination – revision to the LCD

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

The local coverage determination (LCD) for visual field examination was most recently revised on November 5, 2009. Since that time, a list of diagnosis codes was added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, which also includes a dual diagnosis requirement. This is to ensure the Part A and Part B LCDs for visual field examination are consistent across the jurisdiction.

Effective date

This LCD revision is effective for services provided **on or after January 14, 2011.** 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. ❖

A92132: Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the LCD

LCD ID number: L28982 (Florida)
LCD ID number: L29015 (Puerto Rico/U.S. Virgin Islands)

The most recent revision to local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) is effective January 1, 2011. In addition, a revision has been made in regard to the National Correct Coding Initiative (CCI) edits which identify fundus photography (*CPT* code *92250*) and scanning computerized ophthalmic diagnostic imaging (SCODI) (*CPT* code *92133* or *92134*) as mutually exclusive of one another when performed on the same day on the same eye.

Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (CPT code 92133 or 92134) are generally mutually exclusive of one another in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier 59 to CPT code 92250 (National Correct Coding Initiative Policy Manual, Chapter 11, Section G, Ophthalmology). The physician is not precluded from performing fundus photography and posterior segment SCODI on the same eye on the same day under appropriate circumstances (i.e., when each service is necessary to evaluate and treat the patient).

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to add a new "Limitations" section under the "Indications of Coverage for Posterior Segment SCODI" section to add language regarding performing fundus photography and scanning computerized ophthalmic diagnostic imaging, posterior segment (SCODI) on the same day on the same eye. A table has also been added to outline diagnoses which will be considered medically reasonable and necessary for fundus photography and posterior segment SCODI (*CPT* code *92133* or *92134*) when performed on the same eye on the same day. The "Documentation Requirements" section has been revised to indicate medical record documentation requirements when fundus photography and posterior segment SCODI are performed on the same eye on the same day.

Effective date

This LCD revision is effective for services provided **on or after February 13, 2011.** 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. ❖

A93875: Non-invasive extracranial arterial studies – revision to the LCD

LCD ID number: L28937 (Florida)
LCD ID number: L28958 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for non-invasive extracranial arterial studies was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised in the "Limitations" section, under the fourth bullet to indicate *CPT* code *93875* is of limited usefulness and will only be reimbursed when billed to represent ocular pneumoplethysomography (OPG-GEE) in evaluating a patient with ischemic optic neuropathy. The following statement has also been added to this section of the LCD: Performance of both non-invasive extracranial arterial studies (*CPT* codes *93880* or *93881*) and non-invasive evaluation of extremity veins (*CPT* codes *93965, 93970* or *93971*) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available to Medicare upon request.

The "Training Requirements" section of the LCD has been revised in the third paragraph, under the third seriation, regarding a qualified physician to add: ASN: Neuroimaging Subspecialty Certification.

The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add two new section headers, "The following ICD-9-CM code applies only to *CPT* code *93875*" and "The following ICD-9-CM codes apply only to *CPT* codes *93880* and *93882*". ICD-9-CM code 377.41 has been moved under "The following ICD-9-CM code applies only to *CPT* code *93875*".

The "Documentation Requirements" section of the LCD has been revised to add the following statements: The provider is responsible for ensuring the medical necessity of procedures and maintaining the medical record, which must be available to Medicare upon request. Non-invasive vascular studies are medically reasonable and necessary only if the outcome will potentially impact the diagnosis or clinical course of the patient. Providers billing Medicare are encouraged to obtain additional information from referring providers and/or patients or medical records to determine the medical necessity of studies performed. Referring physicians are required to provide appropriate diagnostic

A93875: Non-invasive extracranial arterial studies (continued)

information to the performing provider. Performance of both non-invasive extracranial arterial studies (*CPT* codes *93880* or *93881*) and non-invasive evaluation of extremity veins (*CPT* codes *93965*, *93970* or *93971*) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available to Medicare upon request. The "Sources of Information and Basis for Decision" section of the LCD has also been updated.

The LCD "Coding Guidelines" attachment has also been revised to add the following statements: *CPT* code *93875* is of limited usefulness and will only be reimbursed when billed to represent ocular pneumoplethysomography (OPG-GEE) in evaluating a patient with ischemic optic neuropathy. Performance of both non-invasive extracranial arterial studies (*CPT* codes *93880* or *93881*) and non-invasive evaluation of extremity veins (*CPT* codes *93965, 93970* or *93971*) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). When an uninterpretable study results in performing another type of study, only the successful study should be billed.

Effective date

This LCD revision is effective for services provided **on or after January 23, 2011.** 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.

A93965: Non-invasive evaluation of extremity veins – revision to the LCD

LCD ID number: L28936 (Florida)
LCD ID number: L28957 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for non-invasive evaluation of extremity veins was most recently revised on October 1, 2010. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised under the "Indications" section, in the fourth bullet, to state the following:

Evaluation of patient with symptomatic varicose veins such as stasis ulcer of the lower leg, significant pain and significant edema that interferes with activities of daily living that have not resolved following three months of conservative therapy, and symptoms are suspected to be secondary to venous insufficiency, and testing is performed to confirm this diagnosis by documenting venous valvular incompetence prior to an invasive therapeutic intervention, which meets criteria for medical necessity as outlined in FCSO Medicare LCD Treatment of varicose veins of the lower extremity.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has also been revised to add a "Limitations" section, which includes the following:

- Performance of both physiological testing (*CPT* code *93965*) and duplex scanning (*CPT* codes *93970* or *93971*) of extremity veins during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available to Medicare upon request. Note: Reimbursement of physiologic testing will not be allowed after a duplex scanning has been performed.
- Since the signs and symptoms of arterial occlusive disease and venous disease are so divergent, the performance of simultaneous arterial and venous studies during the same encounter should be rare. Consequently, documentation must clearly support the medical necessity of both procedures if performed during the same encounter, and be available to Medicare upon request.
- Non-invasive vascular studies are considered medically necessary only if the outcome will potentially impact the clinical course of the patient. For example, if a patient is (or is not) proceeding on to other diagnostic and/or therapeutic procedures regardless of the outcome of non-invasive studies, and non-invasive vascular procedures will not provide any unique diagnostic information that would impact patient management, then the non-invasive procedures are not medically necessary. If it is obvious from the findings of the history and physical examination that the patient is going to proceed to angiography, then non-invasive vascular studies are not medically necessary.
- Performance of both non-invasive extracranial arterial studies (*CPT* codes *93880* or *93881*) and non-invasive evaluation of extremity veins (*CPT* codes *93965, 93970* or *93971*) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available to Medicare upon request.
- When an uninterpretable study results in performing another type of study, only the successful study should be billed. For example, when an uninterpretable non-invasive physiologic study (*CPT* code *93965*) is performed which results in performing a duplex scan (*CPT* codes *93970* or *93971*), only the duplex scan should be billed.

A93965: Non-invasive evaluation of extremity veins (continued)

- It is not considered medically reasonable and necessary to study asymptomatic varicose veins.

The "Training Requirements" section of the LCD has been revised to add an additional example of certification in vascular technology for non-physician personnel, "Registered Phlebology Sonographer (RPhS)", which is provided by "Cardiovascular Credentialing International (CCI)". The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add ICD-9-CM codes 453.75, 453.76, 453.85, and 453.86. The "Documentation Requirements" section of the LCD has also been revised to add language regarding services billed by providers other than the ordering provider; documentation requirements when performing both physiologic studies and duplex scanning during the same encounter, when performing arterial and venous studies during the same encounter, and when performing non-invasive extracranial arterial studies and non-invasive evaluation of extremity veins during the same encounter.

The LCD "Coding Guidelines" attachment has also been revised to add language regarding the performance of both physiological testing and duplex scanning during the same encounter; to add language regarding performing non-invasive extracranial arterial studies and non-invasive evaluation of extremity veins during the same encounter; and to add language to indicate that all services/procedures performed on the same date of service for the same patient by the same provider should be submitted on the same claim.

Effective date

This LCD revision is effective for services provided **on or after January 23, 2011.** 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.

AG0104: Colorectal cancer screening – revision to the LCD

LCD ID number: L28803 (Florida)
LCD ID number: L28805 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for colorectal cancer screening was most recently revised on October 1, 2010. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2034, change request (CR) 7038, dated August 24, 2010, to add bill type 77x (Federally Qualified Health Centers [FQHCs]) under the "Type of Bill Code" section and to add revenue codes 0520, 0521, 0524, 0525, 0527, and 0528 to the "Revenue Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 3, 2011,** for services provided **on or after January 1, 2011.** 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. ❖

AG0108: Diabetes outpatient self-management training – revision to the LCD

LCD ID number: L28821 (Florida)
LCD ID number: L28854 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for diabetes outpatient self-management training was most recently revised on March 30, 2009. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2034, change request (CR) 7038, dated August 24, 2010, to add bill type 77x (Federally Qualified Health Centers [FQHCs]) under the "Type of Bill Code" section and to add revenue code 0522 to the "Revenue Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 3, 2011, for** services provided **on or after January 1, 2011.** 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. ❖

AJ2820: Sargramostim (GM-CSF, Leukine®) – revision to the LCD

LCD ID number: L28981 (Florida)
LCD ID number: L29014 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for sargramostim (GM-CSF, Leukine®) was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009 ,for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a list of diagnosis codes was added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD as well as the LCD "Coding Guidelines" attachment to ensure the Part A and Part B LCDs/Coding Guidelines for sargramostim (GM-CSF, Leukine®) are consistent across the jurisdiction.

Effective date

This LCD revision is effective for services provided **on or after January 14, 2011.** 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. ❖

AJ9201: Gemcitabine (Gemzar®) – revision to the LCD

LCD ID number: L28847 (Florida)
LCD ID number: L28880 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for gemcitabine (Gemzar®) was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, under the off-labeled indications portion of the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the indication of advanced or recurrent endometrial carcinoma used as a single agent or in combination with other chemotherapy drugs was added. Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis code 182.0 (Malignant neoplasm of corpus uteri, except isthmus [Endometrium]) was added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services provided **on or after December 15, 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: Noncovered services – revision to the LCD

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

The most recent revision to local coverage determination (LCD) for noncovered services will be effective January 1, 2011. Since that time, a revision was made to the LCD. Two Category III *CPT* codes from the Centers for Medicare & Medicaid Services (CMS) July 2010 Update, Change Request (CR) 6974, CR 6996, and CR 7008 were evaluated and were determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, Category III *CPT* codes *0226T* and *0227T* were added to the noncovered services LCD.

Under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD, the following Category III *CPT* codes were added:

0226T *Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed*

0227T *Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)*

In addition, *CPT* codes *43499* (EsophyX® System [transoral incisionless fundoplication TIF®]) and *CPT* code *64999* (Minimally invasive lumbar decompression [MILD] procedure) were added to the LCD under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD based on an evaluation of these services. *CPT* code *97139* (MicroVas® therapy) was added to the LCD under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Devices" section of the LCD based on an evaluation of this service.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has also been revised to update the language to reflect medically reasonable and necessary criteria for coverage at the local level. In addition, the language in the "Documentation Requirements" section of the LCD has been revised.

ANCSVCS: Noncovered services (continued)

Effective date

This LCD revision is effective for services provided **on or after February 13, 2011.** 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. ❖

2011 HCPCS local coverage determination changes

First Coast Service Options Inc. (FCSO) has revised local coverage determinations (LCDs) impacted by the 2011 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly.

LCD title	2011 changes
AG0104 Colorectal Cancer Screening (**Coding Guidelines only**)	• Added verbiage related to modifier PT (Colorectal cancer screening test; converted to diagnostic test or other procedure).
AJ0128 Abarelix for the Treatment of Prostate Cancer	• Retired local coverage determination as HCPCS code J0128 was deleted. The drug was withdrawn from the United States market.
AJ0205 CEREDASE/CEREZYME	• Deleted HCPCS code J1785 • Added HCPCS codes J1786
AJ7186 Hemophilia Clotting Factors	• Deleted HCPCS code C9267 • Added HCPCS code J7184 • Changed "Contractor's Determination Number" to AJ7184
AJ9280 Mitomycin (Mutamycin®, Mitomycin-C)	• Deleted HCPCS codes J9290 and J9291
AJ9350 Topotecan Hydrochloride (Hycamtin®)	• Deleted HCPCS code J9350 • Added HCPCS code J9351 • Changed Contractor's Determination Number to AJ9351
ANCSVCS Noncovered Services	• Descriptor change for *CPT* codes *0184T, 0191T, 0208T, 0209T, 0210T, 0211T, 0212T, 0219T, 0220T, 022*1T, and *0222*T • Deleted *CPT* codes *0160T* (replaced with new *CPT* code *90867*) and *0161T* (replaced with new *CPT* code *90868*) • Removed *CPT* code *90663* • Added *CPT* codes *90644, 90664, 90666, 90667, 90668, 92227* and *92228* to the "Local Noncoverage Decisions" section of the LCD.
AQutenza® Qutenza® (capsaicin) 8% patch	• Deleted HCPCS code C9268 and replaced with J7335
ASKINSUB Skin Substitutes	• Deleted HCPCS code Q4109 • Added HCPCS codes Q4117-Q4121 to the "Non-Covered Products" section of the LCD • Descriptor change for HCPCS codes Q4101-Q4108, Q4110-Q4113, and Q4115 • Verbiage was revised in the "Coding Guidelines" attachment to reflect code description changes for *CPT* codes *97597* and *97598* • Verbiage was added in the "Coding Guidelines" attachment to reflect new HCPCS codes G0440 and G0441
ATHERSVCS Therapy and Rehabilitation Services	• Added information related to status indicator change from "E" to "A" for *CPT* code *95992*. • Added information related to therapy cap (Change Request 7300)
AXiaflex® Collagenase clostridium histolyticum (Xiaflex®)	• Deleted HCPCS code C9266 and replaced with J0775

2011 HCPCS local coverage determination changes (continued)

LCD title	2011 changes
A01991 Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services **(Coding Guidelines only)**	• Descriptor change for *CPT* codes *64479, 64480, 64483,* and *64484*
A11000 Wound Debridement Services	• Deleted *CPT* codes *11040* and *11041* • Added *CPT* codes *11045*, *11046*, and *11047* • Descriptor change for *CPT* codes *11042*, *11043*, *11044*, *97597* and *97598*.
A17311 Mohs Micrographic Surgery (MMS) **(Coding Guidelines only)**	• Descriptor change for *CPT* code *88332*
A61885 Vagal Nerve Stimulation (VNS) for Intractable Depression	• Deleted *CPT* code *64573* • Added *CPT* codes *64568, 64569,* and *64570*
A64702 Surgical Decompression for Peripheral Polyneuropathy	• Descriptor change for *CPT* codes *64708, 64712*, and *64714*
A72192 Computed Tomography of the Abdomen and Pelvis	• Added *CPT* codes *74176, 74177,* and *74178*
A77371 Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) **(Coding Guidelines only)**	• Deleted *CPT* code *61795*
A92135 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	• Deleted *CPT* codes *92135* and *0187T* • Added *CPT* codes *92132*, *92133*, and *92134* • Changed "Contractor's Determination Number" to A92132
A93224 Electrocardiographic Monitoring for 24 hours (Holter Monitoring)	• Descriptor change for *CPT* codes *93224, 93225, 93226*, and *93227* • Deleted *CPT* codes *93230, 93231, 93232, 93233, 93235, 93236*, and *93237* • Changed "LCD Title" to "External Electrocardiographic Recording"
A93501 Cardiac Catheterization	• Deleted *CPT* codes *93501, 93510, 93511, 93514, 93524, 93526, 93527, 93528*, and *93529* • Added *CPT* codes *93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460*, and *93461* • Changed Contractor's Determination Number to A93451
A93922 Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries	• Descriptor change for *CPT* code *93922, 93923,* and *93924*

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

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO's LCD lookup, available at *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

HOSPITAL SERVICES

Errors in the inpatient prospective payment system PRICER update

Errors were discovered with the "post acute transfer" calculation and the calculation for the MA_HSP in the fiscal year (FY) 2011 inpatient prospective payment system personal computer PRICER. A corrected version has been updated on the Centers for Medicare & Medicaid Services (CMS) website. If you use the FY 2011 INP PPS PC PRICER, please go to the CMS Web page at *http://www.cms.gov/PCPricer/03_inpatient.asp* and download the latest version of the FY 2011 PC PRICER. This PC PRICER is for claims dated from October 1, 2010, to September 30, 2011. The update is dated December 10, 2010.

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

Source: CMS PERL 201012-09

Hospital providers excluded from the advanced diagnostic imaging accreditation requirement

For advanced diagnostic imaging furnished in a hospital outpatient setting, hospital outpatient departments would bill for the technical component of the procedure and be paid under outpatient prospective payment system (OPPS). The physician would bill separately for the professional component and be paid under the physician fee schedule for professional service.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required all suppliers that are paid under the physician fee schedule and furnishing the technical component of certain advanced diagnostic imaging to be accredited by January 1, 2012. For more information, please visit *http://www.cms.gov/MedicareProviderSupEnroll*.

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

Source: CMS PERL 201012-15

New and revised inpatient prospective payment system facts sheets available

The following new and revised fact sheets are available in a downloadable format.

- *Hospital Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals* fact sheet (revised October 2010) – provides an overview of the Deficit Reduction Act of 2005, lists affected hospitals, a table of HACs and codes, and 10 categories of HACs to help providers learn more about the HAC program.
  http://www.cms.gov/HospitalAcqCond/downloads/HACFactsheet.pdf
- *Present on Admission Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals* fact sheet (revised October 2010) – clarifies for providers how to apply present on admission (POA) indicators to diagnosis codes for certain healthcare claims and clarify if the diagnosis was present at the time of admission.
  http://www.cms.gov/MLNProducts/downloads/wPOAFactSheet.pdf
- *Revised Acute Care Hospital Inpatient Prospective Payment System* fact sheet (November 2010) – provides information about the basis for acute care hospital inpatient prospective payment system payment, payment rates, and how payment rates are set.
  http://www.cms.gov/MLNProducts/downloads/AcutePaymtSysfctsht.pdf

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

Source: CMS PERL 201012-16

Website survey

We would like to hear your comments and suggestions on the website 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.

CRITICAL ACCESS HOSPITAL SERVICES

Incentive payment to a critical access hospital paid under the optional method

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

Provider types affected

CAHs under the optional method who provide primary care services to Medicare beneficiaries and bill Medicare administrative contractors (A/B MACs) or fiscal intermediaries (FIs) are impacted by this issue.

Provider action needed

Stop – impact to you

The Affordable Care Act provides for a 10 percent Medicare incentive payment for primary care services effective 2011 through 2015. Payments will be made on a quarterly basis.

Caution – what you need to know

The Affordable Care Act defines a primary care practitioner as: (1) a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (2) a nurse practitioner, clinical nurse specialist, or physician assistant, and in all cases, for whom primary care services accounted for at least 60 percent of the allowed charges under the Medicare physician fee schedule (MPFS) for the practitioner in a prior period as determined appropriate by the Secretary.

Go –what you need to do

See the *Background* section below for specifics.

Background

Section 5501(a) of The Affordable Care Act revises section 1833 of The Social Security Act and will add a new paragraph "Incentive Payments for Primary Care Services". The Social Security Act now states that in the case of primary care services furnished on or after January 1, 2011 and before January 1, 2016, by a primary care practitioner, there also shall be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under the MPFS.

Note: The former "quarterly health professional shortage area (HPSA) and scarcity report for critical access hospital (CAHs)" is now known as the "special incentive remittance for CAHs". This change is necessary as primary care incentive program (PCIP) payments are made for all primary care services furnished by eligible primary care practitioners, regardless of the geographic location where the primary care services are furnished.

The PCIP payments will be based on 10 percent of 115 percent of the MPFS amount that the CAH was paid for the professional service.

Primary care services

The Affordable Care Act defines primary care services as those services identified by the following *CPT* codes:

- *99201* through *99215* for new and established patient office or other outpatient evaluation and management (E/M) visits
- *99304* through *99340* for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (eg, boarding home), or custodial care E/M services; and domiciliary, rest home (eg, assisted living facility), or home care plan oversight services, and
- *99341* through *99350* for new and established patient home E/M visits.

These codes are displayed in the following table. All of these codes remain active in calendar year (CY) 2011 and there are no other codes used to describe these services.

Primary care services eligible for primary care incentive payments in CY 2011

CPT code	Description
99201	*Level 1 new patient office or other outpatient visit*
99202	*Level 2 new patient office or other outpatient visit*
99203	*Level 3 new patient office or other outpatient visit*
99204	*Level 4 new patient office or other outpatient visit*
99205	*Level 5 new patient office or other outpatient visit*
99211	*Level 1 established patient office or other outpatient visit*
99212	*Level 2 established patient office or other outpatient visit*
99213	*Level 3 established patient office or other outpatient visit*
99214	*Level 4 established patient office or other outpatient visit*

Incentive payment to a critical access hospital paid under the optional method (continued)

CPT code	Description
99215	*Level 5 established patient office or other outpatient visit*
99304	*Level 1 initial nursing facility care*
99305	*Level 2 initial nursing facility care*
99306	*Level 3 initial nursing facility care*
99307	*Level 1 subsequent nursing facility care*
99308	*Level 2 subsequent nursing facility care*
99309	*Level 3 subsequent nursing facility care*
99310	*Level 4 subsequent nursing facility care*
99315	*Nursing facility discharge day management; 30 minutes*
99316	*Nursing facility discharge day management; more than 30 minutes*
99318	*Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment.*
99324	*Level 1 new patient domiciliary, rest home, or custodial care visit*
99325	*Level 2 new patient domiciliary, rest home, or custodial care visit*
99326	*Level 3 new patient domiciliary, rest home, or custodial care visit f*
99327	*Level 4 new patient domiciliary, rest home, or custodial care visit*
99328	*Level 5 new patient domiciliary, rest home, or custodial care visit*
99334	*Level 1 established patient domiciliary, rest home, or custodial care visit*
99335	*Level 2 established patient domiciliary, rest home, or custodial care visit*
99336	*Level 3 established patient domiciliary, rest home, or custodial care visit*
99337	*Level 4 established patient domiciliary, rest home, or custodial care visit*
99339	*Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes*
99340	*Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more*
99341	*Level 1 new patient home visit*
99342	*Level 2 new patient home visit*
99343	*Level 3 new patient home visit*
99344	*Level 4 new patient home visit*
99345	*Level 5 new patient home visit*
99347	*Level 1 established patient home visit*
99348	*Level 2 established patient home visit*
99349	*Level 3 established patient home visit*
99350	*Level 4 established patient home visit*

Eligibility for payment under the primary care incentive payment program

For primary care services furnished on or after January 1, 2011, and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of nonphysician practitioners, enrolled in Medicare with a primary care specialty designation of 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charges under the MPFS (excluding hospital inpatient care and emergency department visits) for such practitioner during the time period that has been specified by the Secretary of Health and Human Services.

If a claim for a primary care service is submitted by a CAH paid under the optional method for an eligible primary care physician's or nonphysician practitioner's professional services, the "other provider" field on the claim must be populated by the eligible primary care practitioner's national provider identifier (NPI) in order for the primary care service to qualify for the incentive payment. Primary care services potentially eligible for the incentive payment and furnished on different days must be submitted on separate CAH claims so a determination about the eligibility of the service based on the rendering practitioner can be made. If the CAH claim for a single date of service includes more than one primary care professional service, the incentive payment for all primary care services for that date, shall be made to the CAH on behalf of the eligible primary care practitioner based on the NPI in the "other provider" field. In addition to the CAH NPI, the "other provider" NPI shall be shown on the special incentive remittance for CAHs.

Incentive payment to a critical access hospital paid under the optional method (continued)

PCIP payments to critical access hospitals

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

The 10 percent PCIP payment is payable to a CAH billing under the optional method for the primary care professional services of eligible primary care physicians and nonphysician practitioners who have reassigned their billing rights to CAH. The incentive payment is paid based on 10 percent of the 115 percent of the MPFS amount paid to the CAH for those professional services. PCIP payments are calculated by Medicare contractors and made quarterly on behalf of the eligible primary care physician or nonphysician practitioner to the CAH for the primary care services furnished by the practitioner in that quarter.

The Affordable Care Act authorizes payment under the PCIP beginning in CY 2011 as an additional payment amount for specified primary care services without regard to any additional payment for the service under the existing health professional shortage area (HPSA) physician bonus payment program. Therefore, eligible primary care physicians and nonphysician practitioners furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011.

Additional information

The official instruction, CR 7115 issued to your A/B MAC or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2081CP.pdf*.

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

MLN Matters® Number: MM7115
Related Change Request (CR) #:7115
Related CR Release Date: December 3, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2081CP
Implementation Date: April 4, 2011

Ambulance services paid to critical access hospitals

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

Provider types affected

This article is for critical access hospitals (CAHs) paid for outpatient services under the optional method (also referred to as "method II") and for CAHs and entities owned and operated by CAHs that bill Medicare administrative contractors (A/B MACs) or fiscal intermediaries (FIs) for ambulance services provided to Medicare beneficiaries.

Provider action needed

The article is based on change request (CR) 7219 and implements section 3128 of the Affordable Care Act. Section 3128 increased payment for outpatient facility services for CAHs paid under the optional method from 100 percent of reasonable cost to 101 percent of reasonable cost and increased payment for ambulance services furnished by CAHs or an entity owned and operated by a CAH where there is no other supplier or provider of ambulance services within a 35 mile drive of the CAH or the entity from 100 percent of reasonable cost to 101 percent of reasonable cost, applicable to services furnished on and after January 1, 2004. CR 7219 is effective April 1, 2011. (Although these adjustments apply to services provided on or after January 1, 2004, no prior adjustments are needed to payments as these CAHs were already paid at 101 percent of reasonable cost due to cost reporting instructions.)

Key points of CR 7219

- Effective April 1, 2011, Medicare will pay for CAH ambulance services, including Indian Health Service (IHS) CAHs, with a hospital-based ambulance service on type of bill (TOB) 85x with revenue code 054x (ambulance) and condition code B2 (critical access hospital ambulance attestation) based on 101 percent of reasonable cost.
- Effective April 1, 2011, Medicare will pay for CAH outpatient facility services under the optional method based on 101 percent of reasonable cost.
- When the 35 mile rule for cost-based payment is not met, the CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the CAH is paid based on the ambulance fee schedule.

Ambulance services paid to critical access hospitals (continued)

- When the 35 mile rule for cost-based payment is not met, the IHS/Tribal CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the IHS/Tribal CAH is paid based on the ambulance fee schedule.

Additional information

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

If you would like to see the manual changes that detail payment for ambulance services furnished by certain CAHs (*Medicare Claims Processing Manual* Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)) and Indian Health Service/Tribal Billing (*Medicare Claims Processing Manual* Chapter 15 – Ambulance) as well as complete details regarding this CR please see the official instruction (CR 7219) issued to your Medicare A/B MAC or FI. That instruction may be viewed by going to *http://www.cms.gov/Transmittals/downloads/R2102CP.pdf*.

MLN Matters® Number: MM7219
Related Change Request (CR): 7219
Related CR Release Date: November 19, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2102CP
Implementation Date: April 4, 2011

ESRD Services

Implementation of changes in ESRD payment for CY 2011

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs] for ESRD services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7237 which implements changes in end-stage renal disease (ESRD) payment for calendar year (CY) 2011.

Caution – what you need to know

CR 7237 implements the following changes in ESRD payment for CY 2011:

a 2.5 percent increase to the ESRD composite rate portion of the blended payment amount, which results in a CY 2011 composite rate of $138.53 ($135.15 x 1.025) [note: This 2.5 percent increase does not apply to the drug add-on adjustment to the composite rate]; a wage index adjustment to reflect the current wage data; a reduction in the wage index floor from 0.6500 to 0.6000, then after applying a budget neutrality of 1.056929, the wage index floor is 0.64320; a drug add-on adjustment of 14.7 percent; updated wage index values for the ESRD composite rate (to include the budget neutrality factor of 1.056929); and updated wage index values for the ESRD prospective payment system (PPS) (which does not include the budget neutrality factor).

Go – what you need to do

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

Background

The Social Security Act (Section 1881(b)(12)) as amended by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 (Section 623), resulted in the Centers for Medicare & Medicaid Services (CMS) making a number of revisions to the composite rate payment system, as well as payment for separately billable drugs furnished by ESRD facilities. You may review the Social Security Act (Section 1881(b)(12)) at *http://www.ssa.gov/OP_Home/ssact/title18/1881.htm* and MMA Section 623 at *http://aspe.hhs.gov/mits/text/titleVI/623.html*.

The Social Security Act (Section 1881(b)(14)(F)) [as added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; Section 153(b)) and amended by the Affordable Care Act, Section 3401(h))] required that the composite rate portion of the blended payment amount be increased in CY 2011 by the ESRD market basket percentage increase factor (the "ESRD market basket").

CR 7237 implements the following changes in ESRD payment for CY 2011:

- A 2.5 percent increase to the ESRD composite rate portion of the blended payment amount, which results in a CY 2011 composite rate of $138.53 ($135.15 x 1.025). Note: This 2.5 percent increase does not apply to the drug add-on adjustment to the composite rate.
- A wage index adjustment to reflect the current wage data
- A reduction in the wage index floor from 0.6500 to 0.6000, then after applying a budget neutrality of 1.056929, the wage index floor is 0.64320
- A drug add-on adjustment of 14.7 percent
- Updated wage index values for the ESRD composite rate (to include the budget neutrality factor of 1.056929), and
- Updated wage index values for the ESRD PPS (which does not include the budget neutrality factor).

In addition to the updates listed above, there have been several changes that affect how payment is made to ESRD facilities beginning January 1, 2011. The Social Security Act (Section 1881(b)(14)(E)(i)) requires a 4-year transition (phase-in) from the current composite payment system to the ESRD PPS, and Section 1881(b)(14)(E)(ii) requires ESRD facilities to make a one-time election to be excluded from the transition:

- Electing to be excluded from the four-year transition means that the ESRD facility would receive payment for renal dialysis services based on 100 percent of the payment rate established under the ESRD PPS, rather than a blended rate under each year of the transition based in part on the payment rate under the current payment system and in part on the payment rate under the ESRD PPS.
- Electing to go through the 4-year transition means that (as of January 1, 2011) the ESRD facility would be paid in the first year a blended amount that will consist of 75 percent of the basic case-mix adjusted composite payment system

Implementation of changes in ESRD payment for CY 2011 (continued)

and the remaining 25 percent would be based on the ESRD PPS payment. For further details regarding the ESRD PPS transition, see the *MLN Matters*® article related to CR 7064 (Transmittal R2033CP; dated August 20, 2010). That article is at *http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf*.

For CY 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount during the ESRD PPS four-year transition (CYs 2011 through 2013).

Additional Information

The official instruction, CR 7237, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R135BP.pdf*.

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

MLN Matters® Number: MM7237
Related Change Request (CR) #: 7237
Related CR Release Date: December 10, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R135BP
Implementation Date: January 3, 2011

Website survey

We would like to hear your comments and suggestions on the website 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.

RURAL HEALTH CLINIC SERVICES

Payment rate increases for rural health clinics and federally qualified health centers

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

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal Intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for RHC and FQHC services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7101 which provides instructions for the calendar year (CY) 2011 payment rate Increases for rural health clinic (RHC) and federally qualified health center (FQHC) services.

Background

In accordance with the Social Security Act (Section 1833(f) at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*), the Centers for Medicare & Medicaid Services (CMS) is increasing the calendar year (CY) payment rates for RHCs and FQHCs effective for services on or after January 3, 2011, through December 31, 2011 (i.e., CY 2011) as follows:

- The RHC upper payment limit per visit is increased from $77.76 to $78.07 effective January 3, 2011, through December 31, 2011 (i.e., CY 2011). The 2011 rate reflects a 0.4 percent increase over the 2010 payment limit in accordance with the rate of increase in the Medicare economic index (MEI).
- The FQHC upper payment limit per visit for urban FQHCs is increased from $125.72 to $126.22 effective January 3, 2011, through December 31, 2011 (i.e., CY 2011); and the maximum Medicare payment limit per visit for rural FQHCs is increased from $108.81 to $109.24 effective January 3, 2011, through December 31, 2011. The 2011 FQHC rates reflect a 0.4 percent increase over the 2010 rates in accordance with the rate of increase in the MEI.

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

Additional information

The official instruction, CR 7101, issued to your FI or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2123CP.pdf*. If you have any questions, please contact your FI or MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7101
Related Change Request (CR) #: 7101
Related CR Release Date: December 21, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2123CP
Implementation Date: January 3, 2011

ELECTRONIC DATA INTERCHANGE

Problems with the HIPAA Eligibility Transaction System

On December 4, a new release of the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) was installed. The system had been extensively tested with a number of clearinghouses. Although it performed well in the test environment, the system could not support the production traffic and was backed out on December 6.

The system upgrade was designed to address increasing demands (e.g., volume of transactions) and correct connection problems that have been especially problematic during peak hours (9:00 a.m.-2:00 p.m. ET).

The Centers for Medicare & Medicaid Services (CMS) is aware of the impact of the current performance and connection problems on Medicare providers using this system to get needed beneficiary eligibility information. CMS regrets the inconvenience and want to assure the provider and clearinghouse community that correcting HETS problems is their top priority. Your continued patience is appreciated. HETS status information will be communicated to HETS submitters as information becomes available.

Source: CMS PERL 201012-13

How to use and report PLB codes on remittance advice

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 [FIs], regional home health intermediaries [RHHIs], carriers, A/B Medicare administrative contractors [MACs] and durable medical equipment MACs [DME MACs]) for Medicare beneficiaries are affected.

Provider action needed

Change request (CR) 7068 provides instructions to Medicare Carriers, MACs, FIs, and RHHIs about using and reporting PLB codes on the remittance advice (RA). It also includes instruction for DME MACs for reporting RAC recoupment when there is a time difference between the creation of the accounts receivable and actual recoupment of money.

The attachment in CR 7068 provides a list of PLB codes to be reported on the 835 as well as the paper remittance advice and a crosswalk between the HIGLAS PLB codes and the ASC X12 Transaction 835 PLB codes to ensure that PLB code reporting on the RA is consistent and uniform across the board.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national recovery audit contractors (RAC) program to be in place by January 1, 2010. The goal of the recovery audit 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 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.

Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Publication. L.108-173) which amended Title XVIII of the Social Security Act (the Act) has added a new paragraph (f) to Section 1893 of the Act, the Medicare Integrity Program. 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 can begin no earlier than the 41st day (see CR 6183 – Transmittal 141, issued September 12, 2008), and can happen only when a valid request for a redetermination has not been received within that period of time.

Under the scenario just described, the RA 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.

In a previous CR (Transmittal 659, CR 6870), Medicare carriers, FIs and A/B MACs were instructed to provide enough detail 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 7068 instructs DME MACs how to report on the RA when an overpayment is identified and also when Medicare actually recoups the overpayment in a future RA.

Incentive payment to a critical access hospital paid under the optional method (continued)

RAC recoupment reporting – DME claims only
Step I:
Claim level:
The original claim payment is taken back and the new payment is established (reversal and correction).

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

PLB-03-2
1-2: 00
3-19: Adjustment CCN#
20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the service level. If the service 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:

PLB-03-2
1-2: 00
3-19: adjustment CCN#
20-30: HIC#

PLB04 shows the actual amount being recouped

A demand letter is also sent to the provider when the accounts receivable (A/R) is created – Step I. This document contains a control number for tracking purpose that is also reported on the RA.

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

Note: CR 7068 instructions, regarding recoupment, apply to both 004010A1 and 005010 versions of ASC X12 Transaction 835 and standard paper remittance (SPR). In some very special cases the HIC # may have to be truncated to be compliant with the 004010A1 Implementation Guide.

PLB code reporting

The RA reports payments and adjustments to payments at 3 levels: a) service, b) claim, and c) provider.
The adjustments at the service and the claim level are reported using 3 sets of codes:

- Group codes
- Claim adjustment reason codes (CARCs), and
- Remittance advice remark codes (RARCs).

Provider level adjustments are reported using the PLB codes. The PLB code list is an internal code list that can be changed only when there is a change in the version.

In version 004010A1, the following PLB codes are available for use: 50, 51, 72, 90, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, AND ZZ. In version 005010, two new codes – AH and HM – have been added, and code ZZ has been deleted. The other change in version 005010 is the way situational field PLB03-2 for reference identification is used.

Field	Version 00401A1	Version 005010
PLB03-1		AH – additional code HM – additional code ZZ – deleted code
PLB03-2	Max: 30 **Position 1-2**: Medicare intermediaries must enter the applicable Medicare code **Position 3-19**: Financial control number or the provider level adjustment. number or other pertinent identifier **Position 20-30**: Health insurance claim (HIC) number	Max: 50 Required when a control, account or tracking number applies to this adjustment as reported in field PLB03-1 No Medicare specific codes.

Incentive payment to a critical access hospital paid under the optional method (continued)

HIGLAS uses additional PLB codes from the X12 standard that are not in the implementation guide (IG) or technical report (TR) 3. Medicare must use only those codes that are included in the IG/TR3 to report on the 835.

HIGLAS PLB codes and ASC X12 crosswalk

Currently CMS is transitioning to HIGLAS, and some contractors are still not under HIGLAS. CR 7068 applies to both HIGLAS and non-HIGLAS contractors with the goal of uniform and consistent reporting on the 835 across the board. Secondly, CMS is also in the process of implementing version 005010/005010A1. Attachment – 835 PLB code mapping is applicable to version 004010A1 as well as 005010A1.

The PLB codes to report on the 835 and HIGLAS and HIPAA PLB crosswalk may be found in the attachment in CR 7068.

Additional information

For complete details regarding this CR, please see the official instruction (Transmittal 812 CR 7068) issued to your Medicare contractor at *http://www.cms.gov/transmittals/downloads/R812OTN.pdf*. You may also want to review the following *MLN Matters*® articles:

- Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf*
- Reporting of Recoupment for Overpayment on the Remittance Advice (RA) at *http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf*

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

MLN Matters® Number: MM7068
Related Change Request (CR) #:7068
Related CR Release Date: November 12, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R812OTN
Implementation Date: April 4, 2011; July 5, 2011, for institutional providers and DME suppliers

Take advantage of FCSO's exclusive PDS report

Did you know that FCSO's exclusive Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Accessible through FCSO's PDS portal at *https://medicare.fcso.com/reporting/index.asp*, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specified time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your bottom line.

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events

January – February 2011

Topic – Bimonthly Medicare Part A ACT: Medicare data and CMS initiatives

When: Tuesday, January 18

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

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

Topic – Medicare Part A Open Forum on medical documentation/physician signature

When: Tuesday, January 25

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

Type of Event: Webcast **Focus:** Florida

Topic – Virtual Medifest 2011 – Registration opening soon

When: February 21-25

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

Type of Event: Face-to-face event **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 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 Web site, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

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

PREVENTIVE SERVICES

Have a healthy holiday season by taking advantage of Medicare-covered preventive services

The Centers for Medicare & Medicaid Services asks the provider community to help their patients with Medicare have a healthy holiday season by encouraging eligible patients to take advantage of Medicare-covered preventive services. Medicare provides coverage of a variety of preventive services and screenings to help providers detect illnesses early, when treatment works best.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by encouraging them to take advantage of Medicare-covered preventive services, during the holiday season and into the New Year.

For more information

CMS has developed several educational products related to Medicare-covered preventive services. They are all available, free of charge, from the *Medicare Learning Network®*:

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network®* (*MLN*) educational products for health care professionals related to Medicare-covered preventive services.
  http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- *MLN Matters Provider Educational Articles Related to Medicare-covered Preventive Benefits* – provides links to educational articles with the latest information on changes to Medicare-covered preventive services, including the latest coverage and coding information, and changes due to the Affordable Care Act.
  http://www.cms.gov/MLNProducts/Downloads/MLNPrevArticles.pdf
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings. Available as a downloadable PDF only.
- *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- *Quick Reference Information: Medicare Immunization Billing* – this newly-updated chart provides coding, coverage, and billing information on the seasonal influenza virus, pneumococcal, and hepatitis B vaccines.
  http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services.
  http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

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

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

Source: CMS PERL 201012-16

Quick reference chart available for immunization billing

The Medicare Preventive Services Quick Reference Information: Medicare Immunization Billing chart, which includes coding, coverage, and billing information for the seasonal influenza, pneumococcal, and hepatitis B vaccines, has been updated and is available for download, free of charge, from the *Medicare Learning Network®* at *http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf*. Additionally, hard copies will be available at a later date.

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

Source: CMS PERL 201012-16

2010-2011 seasonal influenza resources for health care professionals

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

Note: This article was revised on November 29, 2010, to include a reference to *MLN Matters*® article MM7234 (New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines). All other information is the same. This information was previously published in the October 2010 *Medicare A Bulletin* pages 70-72.

Provider types affected

All Medicare fee-for-service (FFS) physicians, nonphysician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider action needed

- Keep this special edition *MLN Matters* article and refer to it throughout the 2010-2011 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the New Year.
- Don't forget to immunize yourself and your staff.

Introduction

Annual outbreaks of seasonal flu typically occur from the late fall through early spring. Typically, 5 to 20 percent of Americans catch the seasonal flu; with about 36,000 people dying from flu-related causes.[1] Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu vaccine. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Get the flu vaccine, not the flu.

Unlike last flu season patients needed to get both a seasonal vaccine and a separate vaccine for the H1N1 virus, this season, a single seasonal flu vaccine will protect your patients, your staff, and yourself.

The seasonal flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

MLN Matters seasonal influenza articles

- MM7120: Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season at *http://www.cms.gov/MLNMattersArticles/downloads/MM7120.pdf*
- SE1026: Important News About Flu Shot Frequency for Medicare Beneficiaries at *http://www.cms.gov/MLNMattersArticles/downloads/SE1026.pdf*
- MM7124: 2010 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at *http://www.cms.gov/MLNMattersArticles/downloads/MM7124.pdf*
- MM6608: Influenza Vaccine Payment Allowances – Annual Update for 2009-2010 Season at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6608.pdf*
- MM5511: Update to Medicare Claims Processing Manual, Chapter 18, Section 10 for Part B Influenza Billing at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf*
- MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf*
- MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf*

2010-2011 seasonal influenza resources for health care professionals (continued)

- MM7234: New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines at *http://www.cms.gov/MLNMattersArticles/downloads/MM7234.pdf*

MLN seasonal influenza related products for health care professionals

- *Quick Reference Information: Medicare Part B Immunization Billing* – this two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF at *http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf*.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Third Edition* – this updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file at *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- The Medicare Preventive Services Series Part 1 Web-Based Training Course (WBT) – this WBT contains lessons Medicare-covered preventive vaccinations, including the seasonal influenza vaccine. To take the course, visit the Medicare Preventive Services Educational Products page at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*. Scroll down to "Related Links Inside CMS" and choose "Web-Based Training (WBT) Modules."
- *Medicare Preventive Services Adult Immunizations Brochure* – this two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available as a downloadable PDF file at *http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf*.
- *Quick Reference Information: Medicare Preventive Services* – this two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes seasonal influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file at *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- *MLN Preventive Services Educational Products Web Page* – this *Medicare Learning Network* (*MLN*) Web page provides descriptions of all *MLN* preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp) for easy access*.

Other CMS resources

- CMS Adult Immunizations Web page is at *http://www.cms.gov/AdultImmunizations*.
- CMS frequently asked questions are available at *http://questions.cms.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi*.
- *Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2: Immunizations available at *http://www.cms.gov/manuals/downloads/bp102c15.pdf*.
- *Medicare Claims Processing Manual*: Chapter 18, Preventive and Screening Services available at *http://www.cms.gov/manuals/downloads/clm104c18.pdf*.
- Medicare Part B drug average sales price payment amounts influenza and pneumococcal vaccines pricing found at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/01_overview.asp*.

Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009-2010 flu season:

- **Advisory Committee on Immunization Practices** are at *http://www.cdc.gov/vaccines/recs/acip/default.htm*.
- **American Lung Association's Influenza (Flu) Center** is at *http://www.lungusa.org*. This website provides a flu clinic locator at *http://www.flucliniclocator.org*. Individuals can enter their zip code to find a flu clinic in their area. Providers may also obtain information on how to add their flu clinic to this site.

Other sites with helpful information include:

- **Centers for Disease Control and Prevention** - *http://www.cdc.gov/flu*

2010-2011 seasonal influenza resources for health care professionals (continued)

- **Flu.gov** - *http://www.flu.gov*
- **Food and Drug Administration** - *http://www.fda.gov*
- **Immunization Action Coalition** - *http://www.immunize.org*
- **Indian Health Services** - *http://www.ihs.gov/*
- **National Alliance for Hispanic Health** - *http://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** -*http://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** -*http://www.nlm.nih.gov/medlineplus/immunization.html*
- **National Network for Immunization Information** -*http:/www.immunizationinfo.org*
- **National Vaccine Program** - *http://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Promotion** - *http://odphp.osophs.dhhs.gov*
- **Partnership for Prevention** - *http://www.prevent.org*, and
- **World Health Organization** - *http://www.who.int/en*.

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

MLN Matters Number: SE1031 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

1 Flu.gov. 2010. About the Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2010 [cited 16 August 2010]. Available from the World Wide Web: http://www.flu.gov/individualfamily/about/index.html

December 5-11 is National Influenza Vaccination Week

This national health observance was established to highlight the importance of continuing influenza vaccination, as well as fostering greater use of the flu vaccine after the holiday season and into January and beyond. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare get their flu vaccine. National Influenza Vaccination Week presents an excellent opportunity for you to place greater emphasis on flu prevention.

The Centers for Disease Control and Prevention (CDC) is encouraging everyone six months of age and older to get vaccinated against the seasonal flu. The CDC has designated the following special days:

Monday, December 6 – Family Vaccination Day
Tuesday, December 7 – Chronic Conditions Day
Wednesday, December 8 – Employee Health Day
Thursday, December 9 – Older Adults Vaccination Day
Friday, December 10 – Young Adults Vaccination Day

Please use these designated days to encourage family members, seniors and your staff to get their seasonal flu vaccine. Remember, Medicare pays for the seasonal flu vaccine and its administration for all beneficiaries with no co-pay or deductible. Protect your patients. Protect your family. Protect yourself. Get your flu vaccine – not the flu. More information is available at *http://www.cdc.gov/flu/nivw/*.

More information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, is available at *http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf* and *http://www.cms.gov/AdultImmunizations*.

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

Source: CMS PERL 201012-01

OTHER EDUCATIONAL RESOURCES

The MLN can help you find answers to your Medicare claim questions

The *Medicare Learning Network*® (*MLN*) provides plenty of accurate answers to your Medicare questions. As a billing or coding professional, you need Medicare information at your fingertips. That is why experts developed the *Medicare Learning Network Suite of Products and Resources for Billing and Coding Professionals* just for you. The suite contains easy-to-understand, accessible, and free Medicare program information.

To access a detailed listing of all of the products you need to correctly submit claims the first time, visit the MLN Educational Web Guides page at *http://www.cms.gov/MLNEdWebGuide*. On the left-hand side of the page, click on the *Medicare Learning Network Suite of Products and Resources for Billing and Coding Professionals*.

Equip yourself today with critical reimbursement solutions from the official source for Medicare fee-for-service provider information.

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

Source: CMS PERL 201011-51

'Medicare Claim Review Programs: MR, NCCI Edits, CERT, and RAC' booklet revised

The *Medicare Learning Network*® (*MLN*) has revised the *Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC* booklet, which is designed to provide education on the different Centers for Medicare & Medicaid Services (CMS) claim-review programs and assist providers in reducing payment errors -- in particular, coverage and coding errors. It includes frequently asked questions (FAQs), resources, and an overview of the various programs, including medical review (MR), national correct coding initiative (NCCI), recovery audit contractor (RAC), and the comprehensive error rate testing (CERT) program. This product is suggested for all Medicare fee-for-service (FFS) providers and is available in downloadable format at *http://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf*.

Additionally, please visit the MLN Provider Compliance Web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp* for additional resources designed to educate Medicare FFS providers about the common billing errors and other improper activities identified through these programs.

Source: CMS PERL 201012-08

Swing bed fact sheet

The revised fact sheet titled "Swing Bed" (November 2010), which provides information about the requirement hospitals and critical access hospitals must meet in order to be granted approval to furnish either acute or skilled nursing facility-level care via a swing-bed agreement, is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/SwingBedFactsheet.pdf*.

Source: CMS PERL 201012-08

Find your favorites fast – use Popular Links

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

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

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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
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MSPRC DPP debt recovery
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Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

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

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

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

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Repayment plans for Part A Participating providers
Cost reports (original and amended)
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Provider statistical and reimbursement (PS&R) reports
Cost report settlement (payments due to provider or program)
Interim rate determinations
TEFRA target limit and SNF routine Cost limit exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

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

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CMS-855 Applications
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Jacksonville, FL 32231-4021

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Jacksonville, FL 32202-4914

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Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

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Railroad retiree medical claims
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P. O. Box 10066
Augusta, GA 30999-0001

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Durable medical equipment claims
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Nashville, Tennessee 37202

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BENEFICIARY
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1-800-MEDICARE
1-800-633-4227
Speech and hearing impaired
1-800-754-7820

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

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Option 3
Direct data entry (DDE) support

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Electronic funds
(check return assistance only)

Option 6
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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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