Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

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In this issue

CMS fraud prevention: Automated provider screening and national site visit initiatives

Provider types affected

This *MLN Matters*® special edition article is intended for all providers and suppliers, who enroll in the Medicare program and submit fee-for-service (FFS) claims to fiscal intermediaries (FIs), carriers, A/B Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs), for services provided to Medicare beneficiaries.

What you need to know

This article provides you with the latest information about the Centers for Medicare & Medicaid Services (CMS) national fraud prevention program (NFPP) initiative. The initiative includes additional tools to assist CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process itself. This article describes two new processes that CMS now employs as part of the provider enrollment process:

1. Automated provider screening, and
2. Implementation of a new national site visit contractor that will conduct site visits to certain providers and suppliers.

This NFPP is intended to protect the Medicare program and to ensure that correct program payment is made only for covered appropriate and reasonable services provided to Medicare beneficiaries by legitimate providers of care.

Key Information

National fraud prevention program (NFPP)

The NFPP is an integral part of the CMS fraud prevention initiative. The NFPP also enables CMS to proactively identify and respond to suspicious behavior, thus making the Agency more effective at fighting health care fraud than ever before. The NFPP focuses on two key program integrity gateways: provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' comprehensive program integrity strategy is designed to stop fraudsters at every step of the process so CMS is now better able to:

- Identify and prevent bad actors from enrolling in Medicare;
- Identify and remove bad actors that are already in its programs; and
- Identify and prevent payment of fraudulent claims by responding with quick administrative action.

(continued on Page 3)

Contents

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

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Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

Find out first: Subscribe to FCSO eNews

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Fraud *(continued)*

Automated provider screening: Ensuring program integrity at the provider enrollment stage

CMS is implementing an automated provider screening (APS) process that will screen providers and suppliers by automating data checks and developing methods to proactively identify fraud, waste, and abuse. APS will validate provider and supplier enrollment application information using various public and private databases as well as automatically check other referential databases. APS is expected to be fully implemented mid-2012 and it will:

- Reduce provider and supplier enrollment application processing time since there will be less manual review of the databases currently used in the verification process;
- On a continual basis, monitor the veracity and accuracy of all provider and supplier enrollment data including the status of licensure, sanctions or exclusions, and adverse legal actions;
- Assess the individual level of risk each provider and supplier presents to the Medicare program; and
- Be used by CMS and Medicare contractors (FIs, MACs, etc.) to verify, update, and act on relevant information found during the enrollment process- and on a continual enrollment basis.

APS is designed to ensure that Medicare enrolls only qualified providers and suppliers who meet and maintain compliance with its enrollment requirements.

National site visit contractor: Ensuring program integrity at the provider enrollment stage

CMS has implemented a site visit verification process using a national site visit contractor (NSVC). The site visit verification process is a screening mechanism to prevent questionable providers and suppliers from enrolling in the Medicare program. The NSVC will conduct site visits for all providers and suppliers except for the durable medical equipment (DMEPOS) which will continue to be conducted by the national supplier clearinghouse. The NSVC will verify enrollment related information during the site visit and collect specific information based on pre-defined checklists.

MSM Security Services, LLC was awarded the national site visit contract. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits. Inspectors performing the site visits will be employees of MSM, CES or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.

Additional information

To learn more about the predictive analytics process, refer to *MLN Matters*® special edition article SE1133, titled "Predictive Modeling Analysis of Medicare Claims." The article is available at *http://www.cms.gov/MLNMattersArticles/Downloads/SE1133.pdf*.

To learn more about the CMS Fraud Prevention Initiative, visit the "Fraud Prevention Toolkit" Web page at *http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp*.

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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 update to Chapter 15 of the *Program Integrity Manual* Part V

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers that submit claims to Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs) and home health and hospice Medicare administrative contractors (HHH MACs) for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7797, which implements changes to Chapter 15 of the *Program Integrity Manual* (PIM)—Medicare enrollment. CR 7797 focuses on the reasons for returning CMS-855 applications in Section 15.8.1 and the policies for rejecting CMS-855 applications in Section 15.8.2 of the PIM. Please make sure your staff is familiar with these changes.

Key points

Providers and suppliers who bill Medicare carriers, FIs, A/B MACs and HHH MACs should take note of the following:

- Your Medicare contractor may return a form CMS-855 submission only in the following instances:
  - The applicant sent its paper form CMS-855 to the wrong contractor;
  - The contractor received the application more than 60 days prior to the effective date listed on the application (though this does not apply to: (a) providers and suppliers submitting a form CMS-855A application, (b) ambulatory surgical centers (ASCs), or (c) portable X-ray suppliers (PXRSs);
  - The contractor received an initial application from (a) a provider or supplier submitting a Form CMS-855A application, (b) an ASC, or (c) a PXRS, more than 180 days prior to the effective date listed on the application;
  - An old owner or new owner in a change of ownership (CHOW) submitted its application more than 90 days prior to the anticipated date of the sale (though this only applies to form CMS-855A applications);
  - The contractor can confirm that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application;
  - The provider or supplier submitted an initial application prior to the expiration of a reenrollment bar; and/or
  - The application is not needed for the transaction in question.

Providers and suppliers who bill Medicare carriers and A/B MACs take note of the following:

- If, under Section 15.8.2 of Chapter 15, a physician, non-physician practitioner, or physician or non-physician practitioner group fails to provide requested information regarding its form CMS-855 submission within the designated timeframe, the contractor will reject (rather than deny) the application.

Additional information

The official instruction, CR 7797, issued to your Medicare carrier, FI, RHHI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R415PI.pdf*. Attached to CR 7997 is the revised PIM Chapter, which further details the reasons for return/rejection.

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

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Related CR Release Date: April 13, 2012
Effective Date: May 14, 2012
Related CR Transmittal #: R415PI
Implementation Date: May 14, 2012

Redesigned Medicare summary notices

Provider types affected

This *MLN Matters*® special edition article is informational in nature and is intended for all providers who provide Medicare-covered services in the Medicare fee-for-service (FFS) program.

Background

The Centers for Medicare & Medicaid Services (CMS) has announced the redesign of the statement that informs Medicare beneficiaries about their claims for Medicare benefits.

What you need to know

CMS will make the redesigned statement, known as the Medicare summary notice (MSN), available online. Starting in 2013, CMS will mail the MSN to beneficiaries quarterly.

The MSN redesign is part of a new initiative, "Your Medicare Information: Clearer, Simpler, At Your Fingertips". This initiative aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand.

CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for people who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

Features of the redesigned MSN

The redesign of the MSN includes several features that are not available in the current MSN, including:

- A clear notice on how to check the form for important facts and potential fraud;
- An easy-to-understand snapshot of:
  - The beneficiary's deductible status,
  - A list of the providers they saw, and
  - Whether Medicare approved their claims;
- Clearer language, including consumer-friendly descriptions for medical procedures;
- Definitions of all the column headers present in the form;
- Larger fonts to make it easier to read; and
- Information on preventive services available to Medicare beneficiaries.

For more information

The redesigned MSN is available on *www.mymedicare.gov*, which is Medicare's secure online service for personalized information regarding Medicare benefits and services.

To see a side-by-side comparison of the former and redesigned MSNs, visit *http://www.cms.gov/apps/files/msn_changes.pdf*.

To view the CMS press release on the MSN redesign, visit: *http://www.CMS.gov/apps/media/press/release.asp?Counter=4298*.

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Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both *English* and *Spanish.* Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published from October 2011 through September 2012.

To order an annual subscription, complete the *Medicare A Connection Subscription Form.*

Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

Note: This article was revised on March 27, 2012, to reflect the revised change request (CR) 7633 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the Web address for accessing CR 7633 have been revised. Also, the article reflects the addition of claim adjustment reason code (CARC) 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same. This information was previously published in the December 2011 *Medicare A Connection*, Pages 29-31.

Provider types affected

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

Provider action needed

This article is based on CR 7633, which announces that effective with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol screening, and for those that screen positive, up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women. Make sure your billing staff is aware of these changes.

Background

Pursuant to Section 1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare program. CMS reviewed the USPSTF's "B" recommendation and supporting evidence for "Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse" preventive services and determined that all three criteria were met.

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >7 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

Effective for claims with dates of service October 14, 2011, and later, CMS shall cover annual alcohol screening, and for those that screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,
- who are competent and alert at the time that counseling is provided; and,
- whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the four behavioral counseling interventions must be consistent with the 5As approach that has been adopted by the USPSTF to describe such services:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

(continued on next page)

Alcohol *(continued)*

Note: Two new G codes, G0442 (Annual Alcohol Misuse Screening, 15 minutes), and G0443 (Brief face-to-face behavioral counseling for Alcohol Misuse, 15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE). For claims with dates of service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443. Deductible and coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2012, with TOBs 13x, 71x, 77x, and 85x and release those claims beginning April 2, 2012. For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443:

- 01 – general practice
- 08 – family practice
- 11 – internal medicine
- 16 – obstetrics/gynecology
- 37 – pediatric medicine
- 38 – geriatric medicine
- 42 – certified nurse midwife
- 50 – nurse practitioner
- 89 – certified clinical nurse specialist
- 97 – physician assistant

For purposes of this covered service, the following place of service (POS) codes are applicable:

- 11 – physician's office
- 22 – outpatient hospital
- 49 – independent clinic
- 71 – state or local public health clinic

Claims processing/payment information

When claims for G0442 or G0443 are submitted with a place of service (POS) code that is not applicable, line-items on those claims will be denied using:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service."
- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed advance beneficiary notice (ABN) is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Medicare will deny claims for G0442 or G0443 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: "The rendering provider is not eligible to perform the service billed." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95: "This provider type/provider specialty may not bill this service."
- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Rural health clinics (RHCs) using type of bill (TOB) 71x and federally qualified health centers (FQHCs) using TOB 77x may submit additional revenue lines containing G0442 or G0443. Medicare will pay G0442 and G0443 in TOBs 71x and 77x based on the all-inclusive payment rate. However, Medicare will not pay G0442 or G0443 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply to claims for the initial preventive physical examination (IPPE), claims containing modifier 59, or to 77x claims containing diabetes self-management training or medical nutrition therapy services. If G0442 or G0443 is billed when an encounter/visit with the same line item date of service, Medicare will assign:

- Group code CO to the G0442/G0443 revenue lines; and
- RARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

(continued on next page)

Alcohol *(continued)*

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0442 or G0443 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 5: "The procedure code/bitt type is inconsistent with the place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M77: "Missing/incomplete/invalid place of service."
- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Medicare will allow payment for both G0442 and G0443 on the same date (except in RHCs and FQHCs), but will not pay for more than one G0443 service on the same date. However, Medicare will allow both a claim for the professional service and, for TOB 13x and TOB 85x without a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0443 that exceed the limit of one on the same date of service will be denied using:

- CARC 151: "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."
- RARC M86: "Service denied because payment already made for same/similar procedure within set time frame."
- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Medicare will track payments for G0442 screening services and G0443 counseling services so as to not permit payment for G0442 more than once in a 12-month period, and for G0443 no more than 4 times in a 12-month period, beginning with the date of the G0442 service. Claim lines exceeding these limits will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, and ELGH) along with HICR changes.

Additional information

If you have questions, please contact your Medicare Carrier, 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 7633, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the "*National Coverage Determinations Manual*" at *http://www.cms.gov/Transmittals/downloads/R138NCD.pdf*. The second transmittal at *http://www.cms.gov/Transmittals/downloads/R2433CP.pdf* modifies the *Medicare Claims Processing Manual*.

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Screening for depression in adults

Note: This article was revised on March 27, 2012, to reflect the revised change request (CR) 7637 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the Web address for accessing CR7637 have been revised. Also, the article reflects the addition of claim adjustment reason code (CARC) 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same. This information was previously published in the December 2011 *Medicare A Connection*, Pages 32-34.

Provider types affected

Physicians, non-physician practitioners, rural health clinics (RHCs), and federally qualified health centers (FQHCs) who bill Medicare contractors (carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on CR 7637, which informs Medicare contractors that, effective for claims with dates of service on and after October 14, 2011, Medicare will cover annual depression screening for adults in the primary care setting.

Caution – what you need to know

Effective October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Medicare contractors will recognize new Healthcare Common Procedure Coding System (HCPCS) code, G0444, annual depression screening, 15 minutes, as a covered service.

Note: This code will appear on the January 2012 Medicare physicians fee schedule update. The type of service (TOS) for HCPCS code G0444 is 1. Effective October 14, 2011, beneficiary coinsurance and deductibles do not apply to claim lines with annual depression screening, G0444. For dates of service on or after October 14, 2011, through December 31, 2011, Medicare contractors will use their pricing for paying G0444 and update their HCPCS files accordingly.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding this change. Be sure your staffs are aware of this change.

Background

Among persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25 percent of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Older adults have the highest risk of suicide of all age groups. These patients are important in the primary care setting because 50-75 percent of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39 percent were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are not limited to, feeling sad or empty; less interest in daily activities; weight loss or gain when not dieting; less ability to think or concentrate; tearfulness, feelings of worthlessness, and thoughts of death or suicide.

Section1861(ddd) of the Social Security Act permits the Centers for Medicare & Medicaid Services (CMS) to add coverage of “additional preventive services” through the national coverage determination (NCD) process if all of the following criteria are met:

- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

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Depression *(continued)*

Screening for depression in adults is recommended with a grade of B by the USPSTF. The CMS reviewed the USPSTF recommendations and supporting evidence for screening depression in adults preventive services and determined that the criteria listed above was met, enabling the CMS to cover these preventive services.

Thus, effective October 14, 2011, Medicare covers annual screening for adults for depression in a primary care setting, as defined below, that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD:

- A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers (ASCs), independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.
- Effective for claims with dates of service on and after April 2, 2012, contractors shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):
  - 11 – office
  - 22 – outpatient hospital
  - 49 – independent clinic
  - 71 – state or local public health clinic
- At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient's primary care physician.
- Note: Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and web-based counseling are not separately reimbursable by Medicare and are not part of this NCD.
- Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place. Medicare coinsurance and Part B deductible are waived for this preventive service.

Claims processing/payment information

When claim line items for annual depression screening (G0444) are submitted with a POS code that is not applicable, they will be denied using:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service."
- Group code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file.
- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

RHCs using type of bill (TOB) 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0444 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0444 separately with another encounter/visit on the same day billed on TOBs 71x

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Depression *(continued)*

or 77x. This does not apply, however, to claims with the initial preventive physical examination (IPPE) containing modifier 59 or to 77x claims containing diabetes self-management training or medical nutrition training services. If G0444 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- Group code CO to the G0444 revenue line; and
- RARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system (OPPS). Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0444 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 170: "Payment is denied when performed/billed by this type of provider." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428: "Not covered when performed in this place of service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

For claims processed on or after April 2, 2012, Medicare will allow payment for G0444 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service, and, for TOB 13x, and TOB 85x when the revenue code is not 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0444 that exceed this limit will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) will display a next eligibility date for this service and the multi-carrier system desktop tool shall display the HCPCS G0444 depression screening sessions.

A MACs/FIs shall hold institutional claims received before April 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting HCPCS G0444.

Additional information

The official instruction, CR 7637, was issued to your carrier, FI, or A/B MAC regarding this change via two transmittals. The first transmittal updates the *National Coverage Determinations Manual* and is available at *http://www.cms.gov/Transmittals/downloads/R139NCD.pdf*. The second transmittal is at *http://www.cms.gov/Transmittals/downloads/R2431CP.pdf* and it updates the *Medicare Claims Processing Manual*.

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: MM7637 Revised
Related Change Request (CR) #: 7637
Related CR Release Date: March 23, 2012
Effective Date: October 14, 2011
Related CR Transmittal #: R139NCD and R2431CP
Implementation Date: April 2, 2012

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

Intensive behavioral therapy (IBT) for cardiovascular disease (CVD)

Note: This article was revised on March 27, 2012, to reflect the revised change request (CR) 7636 issued on March 23, 2012. As a result, in this article, the CR release date, transmittal number, and the web address for accessing CR 7637 have been revised. Also, the article reflects the addition of CARC 50 on the remittance replies on claims line items submitted with the GZ modifier. All other information is the same. This information was previously published in the December 2011 *Medicare A Connection*, Pages 35-37.

Provider types

Affected primary care practitioners in a primary care setting such as the beneficiary's family practice physician, internal medicine physician, or nurse practitioner in the doctor's office who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs)) for providing intensive behavioral therapy (IBT) for cardiovascular disease (CVD) to Medicare beneficiaries.

Provider action needed

This article is based on CR 7636 which states that effective for claims with dates of service on and after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers IBT for CVD, inclusive of one face-to-face CVD risk reduction visit annually. The Medicare patient receiving this care must be competent and alert at the time the service is rendered and the service must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Ensure that your billing staffs are aware of this update. Background According to Section 1861 of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

1) Reasonable and necessary for the prevention or early detection of illness or disability;

2) Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and

3) Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for IBT for CVD and determined that the criteria listed above was met, enabling CMS to cover this preventive service. Coverage of IBT for CVD, referred to as a CVD risk reduction visit, consists of the following three components:

1) Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;

2) Screening for high blood pressure in adults age 18 years and older; and,

3) Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

Key points

- A new HCPCS code, G0446, Annual, face-to-face IBT for CVD, individual, 15 minutes, will be included in the January 2012 updates of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE), effective for services on or after November 8, 2011.
- Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.
- For these services provided on or after November 8, 2011, through December 31, 2011, Medicare contractors will apply their pricing to claims for G0446 when billed for IBT for CVD.
- Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction visit annually for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.
- For the purposes of this covered service, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following provider specialty types may submit claims for CVD risk reduction visits:
  - 01 – general practice
  - 08 – family practice
  - 11 – internal medicine
  - 16 – obstetrics/gynecology
  - 37 – pediatric medicine
  - 38 – geriatric medicine
  - 42 – certified nurse midwife

(continued on next page)

Cardiovascular *(continued)*

- 50 – nurse practitioner
- 89 – certified clinical nurse specialist
- 97 – physician assistant

- Medicare contractors will pay claims for G0446 only when services are provided for the following place of service (POS):
  - 11 – physician's office;
  - 22 – outpatient hospital;
  - 49 – independent clinic; or,
  - 71 – state or local public health clinic.

Note: Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition. See below for information relative to these services billed on institutional claims by RHCs, type of bill (TOB) 71x, and FQHCs, TOB 77x.

- The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the "Five As" approach that has been adopted by the USPSTF to describe such services:
  - **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
  - **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
  - **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
  - **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
  - **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.
- Medicare contractors do not need to search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.

Claims processing/payment information

When IBT for CVD claims are submitted with a POS code that is not applicable, they will be denied using:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service."
- Group code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file.
- Group code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed (ABN) is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Medicare will deny claims for G0446 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: "The rendering provider is not eligible to perform the service billed." Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95: "This provider type/provider specialty may not bill this service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

RHCs using TOB 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0446 and

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Cardiovascular *(continued)*

Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0446 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply, however, to claims with the initial preventive physical examination (IPPE) containing modifier 59 or to 77x claims containing diabetes self-management training or medical nutrition training services. If G0446 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- Group code CO to the G0446 revenue line; and
- RARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0446 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge.

Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 170: "Payment is denied when performed/billed by this type of provider." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428: "Not covered when performed in this place of service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

For claims processed on or after April 2, 2012, Medicare will allow payment for G0446 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service and, for TOB 13x and TOB 85x with a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0446 that exceed this limit will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file. Also, per *MLN Matters*® article MM7228 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7228.pdf*, the presence of the GZ modifier will result in the addition of CARC of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, and ELGH) will display a next eligibility date for this service.

Additional information

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

The official instruction, CR 7636, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the *National Coverage Determinations Manual at http://www.cms.gov/Transmittals/downloads/R137NCD.pdf*. The second transmittal at *http://www.cms.gov/Transmittals/downloads/R2432CP.pdf* modifies the *Medicare Claims Processing Manual*.

MLN Matters® Number: MM7636 Revised
Related Change Request (CR) #: 7636
Related CR Release Date: March 23, 2012
Effective Date: November 8, 2011
Related CR Transmittal #: R137NCD and R2432CP
Implementation Dates: December 27 for local Medicare Contractor system edits; April 2, 2012, for Medicare shared system edits; and July 2, 2012, CWF provider screens and HICR changes

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

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (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 Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

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 website is considered the notice date.

Contents

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary. **Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **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.**

New LCDs

AJ9033: Bendamustine hydrochloride (Treanda®) – new LCD

LCD ID number: L32495 (Florida/Puerto Rico/U.S. Virgin Islands)

Bendamustine hydrochloride (Treanda®) is a bifunctional mechlorethamine derivative with alkylator and antimetabolite activities. The exact mechanism of action remains unknown, however, bendamustine hydrochloride appears to act primarily as an alkylator. It is believed to inhibit DNA, RNA, and protein synthesis and subsequently apoptosis.

Bendamustine hydrochloride is approved by the Food and Drug Administration (FDA) for injection for the treatment of patients with the following indications:

- Chronic lymphocytic leukemia (CLL). Efficacy relative to first line therapies other than chlorambucil has not been established.
- Indolent B-cell non-Hodgkin lymphoma (NHL) that has progressed during or within six months of treatment of rituximab or a rituximab-containing regimen.

This new local coverage determination (LCD) addresses FDA indications as well as the following off-label indications per the National Comprehensive Cancer Network (NCCN):

- Hodgkin Lymphoma- Classical Hodgkin lymphoma (Second-line or salvage therapy as a single agent with or without radiation therapy (RT) prior to autologous stem cell rescue for progressive disease or for relapsed disease in patients initially treated with chemotherapy with or without RT)
- Hodgkin Lymphoma- Lymphocyte predominant Hodgkin lymphoma (Second-line or salvage therapy as a single agent or in combination with rituximab with or without RT prior to autologous stem cell rescue for progressive disease or for relapsed disease in patients initially treated with chemotherapy with or without RT)
- Multiple myeloma (Salvage therapy on or off clinical trials as a single agent for disease relapse or for progressive or refractory disease)
- Waldenström's macroglobulinemia/Lymphoplasmacytic lymphoma (Used with or without rituximab as primary therapy, salvage therapy for disease that does not respond to primary therapy or for progressive or relapsed disease)

This new LCD was developed to outline indications and limitations of coverage and/or medical necessity, ICD-9-CM codes that support medical necessity, documentation requirements and utilization guidelines for bendamustine hydrochloride (Treanda®). A coding guidelines LCD attachment was also developed which includes information on the dosage and administration of bendamustine.

Effective date

This new LCD is effective for services rendered **on or after June 12, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.* 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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

A43201: Noncovered procedures – endoscopic treatment of gastroesophageal reflux disease (GERD) – new LCD

LCD ID number: L32487 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) describes endoscopic treatments of gastroesophageal reflux disease (GERD) that were evaluated for coverage. It was determined that the current published available evidence based on peer-reviewed literature is not sufficient to establish the long-term safety and efficacy of transesophageal endoscopic anti-reflux procedures as treatment for GERD. The LCD describes three transesophageal endoscopic approaches designed to treat GERD including endoscopic plication or suturing procedures; the use of radiofrequency (RF) energy; and submucosal injection or implantation of biocompatible bulking agents or polymer prosthetics. All of the procedures related to the endoscopic treatment of GERD are noncovered at this time, as new data becomes available, we will reconsider upon request.

Effective date

This new LCD is effective for services rendered **on or after June 12, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

A95920: Intraoperative neurophysiology testing – new LCD

LCD ID number: L32491 (Florida/Puerto Rico/U.S. Virgin Islands)

Intraoperative neurophysiology testing (IONT) is the use of electrophysiology methods to test the functional integrity of certain neural structures (e.g., nerves, spinal cord, and part of the brain) during certain surgeries. The principle goal of IONT is the identification of nervous system impairment in the hope that prompt intervention will prevent deficits such as muscle weakness, loss of sensation, hearing loss, and impairment of other bodily functions, and/or to provide functional guidance to the surgeon and anesthesiologist. Secondly, the mapping techniques used to identify critical structures in the nervous system are identified electrophysiologically; the surgeon avoids these structures to prevent neurological damage from occurring. Correctable factors that can occur during surgery include circulatory disturbance, excess compression from retraction, bony structures or hematomas, or mechanical stretching.

A new local coverage determination (LCD) has been developed to give indications and limitations of coverage and/or medical necessity, *CPT* codes, documentation requirements, utilization guidelines, and coding guidelines for IONT.

Effective date

This new LCD is effective for services rendered **on or after June 12, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Revisions to LCDs

ABOTULINUM TOXINS: Botulinum toxins – revision to the LCD

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

The local coverage determination (LCD) for botulinum toxins was most recently revised January 1, 2012. Since that time, revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to remove the off-label indication for Botox® to treat neurogenic urinary incontinence and to add the new Food and Drug Administration (FDA) label indication for the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury [SCI], multiple sclerosis [MS]) in adults who have an inadequate response to or are intolerant of anticholinergic medication. In addition, the "CMS National Coverage Policy" and the "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered **on or after March 29, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

AJ0897: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the LCD

LCD ID number: L32110 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised January 01, 2012. Since that time, a revision was made to the LCD based upon a request and revisions to the Food and Drug Administration's (FDA) label indications for Prolia®.

Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD clinical trial information and the following indications were added for Prolia®:

- Treatment of bone loss in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer
- Treatment of bone loss in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer

In addition, under the "ICD-9 Codes that Support Medical Necessity" section of the LCD the following diagnosis codes/requirements were added for Prolia® (HCPCS code J0897) and Boniva® (HCPCS code J1740):

Boniva®

- 198.5 Secondary malignant neoplasm of bone and bone marrow
- 731.0 Osteitis deformans without mention of bone tumor

Prolia®

For treatment of bone loss in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer, ICD-9-CM code 733.90 (Disorder of bone and cartilage, unspecified) is reported with ICD-9-CM code V10.3 and V07.52:

- V10.3 Personal history of malignant neoplasm of breast
- V07.52 Use of aromatase inhibitors

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AJ0897 *(continued)*

For treatment of bone loss in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer, ICD-9-CM code 733.90 is reported with ICD-9-CM code V10.46 and V58.69:

- V10.46 Personal history of malignant neoplasm of prostate
- V58.69 Long term (current) use of other medications

In addition, the "Documentation Requirements" section of the LCD was also updated to include the revisions to the FDA label indications for Prolia®.

Effective date

This LCD revision is effective for claims processed **on and after May 9, 2012,** or services rendered **on or after October 16, 2011**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.* 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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

AJ1745: Infliximab (Remicade™) – revision to the LCD

LCD ID number: L28890 (Florida)
LCD ID number: L28912 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for infliximab (Remicade™) was effective for services rendered 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 revision was made to the LCD based on a reconsideration request. Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, a reference was made to the new subheading of "Limitations" for individual consideration for Takayasu's disease (ICD-9-CM code 446.7). Under this new "Limitations" section of the LCD, language was given stating medical records may be requested for prepayment review when diagnosis code 446.7 is billed for infliximab (Remicade™). In addition, the "CMS National Coverage Policy," "Utilization Guidelines," and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for services rendered **on or after April 18, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

AJ9001: Doxorubicin, liposomal (Doxil) – revision to the LCD

LCD ID number: L28827 (Florida)
LCD ID number: L28860 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin, liposomal (Doxil) was effective for services rendered 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 revision was made to the LCD based on the Food and Drug Administration (FDA) label revision to approve the use of imported Lipodox to the United States on February 21, 2012. The "*CPT*/HCPCS Code "section of the LCD was revised to add HCPCS code C9399 and the descriptor "Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg."

Effective date

This LCD revision is effective for claims processed **on or after April 25, 2012,** for services rendered **on or after February 21, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.* 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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

AJ9041: Bortezomib (Velcade®) – revision to the LCD

LCD ID number: L28787 (Florida)
LCD ID number: L28789 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bortezomib (Velcade®) was most recently revised November 1, 2011. Since that time, a revision was made to add off-label diagnoses related to the indication of multiple myeloma per the National Comprehensive Cancer Network (NCCN) compendia for the administration route of subcutaneous injection and intravenous injection. The following ICD-9-CM codes were added under the section of the LCD titled "ICD-9 Codes that Support Medical Necessity."

- 203.10 (Plasma cell leukemia without mention of having achieved remission failed remission)
- 203.12 (Plasma cell leukemia in relapse)
- 203.80 (Other immunoproliferative neoplasms without mention of having achieved remission failed remission)
- 203.82 (Other immunoproliferative neoplasms in relapse)
- 238.6 (Neoplasm of uncertain behavior of other and unspecified sites and tissues, plasma cells)

In addition, the "Centers for Medicare & Medicaid Services (CMS) National Coverage Policy" section of the LCD was updated to include the references to CMS Manual System, *Medicare Program Integrity Manual*, Pub.100-08, Chapter 13, Section 13.1.3 and Social Security Act Section 1861(t)(2)(B). Verbiage was also updated under the "Indications and Limitations of Coverage and/or Medical Necessity" and "Sources of Information and Basis for Decision" sections of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 25, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

ANCSVCS: Noncovered services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised January 31, 2012. Since that time, a revision was made to the LCD. New Category III *CPT* codes and a HCPCS code from the Centers for Medicare & Medicaid Services (CMS) annual 2012 HCPCS update (change request [CR] 7540) 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 *0278T*, *0282T*, *0283T*, *0284T*, *0285T*, *0286T*, *0287T*, *0291T*, *0292T*, *0293T*, *0294T*, *0299T*, *0300T*, *0301T,* and HCPCS code C9732 were added to the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD.

Also, HCPCS code C1830 and unlisted *CPT* codes *99199* (when billed for the SNaP wound care system - a portable, non-powered, single use suction device with dressing kit, for wound management via application of negative pressure to the wound), and *20999* (when billed for the Magnetic resonance guided focused ultrasound surgery (MRgFUS) [e.g., ExAblate]) 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, HCPCS code C1830 and unlisted *CPT* code *99199* were added to the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Devices" section of the LCD; and unlisted *CPT* code *20999* was added to the "*CPT*/HCPCS Codes – Local Noncoverage Decisions –Procedures" section of the LCD.

In addition, unlisted *CPT* code *43499* (when billed for the EsophyX® System [transoral incisionless fundoplication TIF®]) was removed from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions – Procedures" section of the LCD and was added to the new LCD for Noncovered Procedures: Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD).

(continued on next page)

ANCSVCS *(continued)*

Effective date

This LCD revision is effective for services rendered **on or after June 12, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

ATHERSVCS: Therapy and rehabilitation services – revision to the LCD

LCD ID number: L28992 (Florida)
LCD ID number: L29024 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) and "coding guidelines" attachment for therapy and rehabilitation services were most recently revised January 1, 2012. Since that time, verbiage has been revised to reflect "until further notice" in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD under the subsection "Exception Process for Outpatient Therapy Caps" and in the LCD "Coding Guidelines" attachment under the subsection "Use of the KX Modifier." This revision was based on information received from the Centers for Medicare & Medicaid Services (CMS).

Effective date

This LCD revision is effective for services rendered **on and after March 1, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

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

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

The local coverage determination (LCD) for ibritumomab tiuxetan (Zevalin®) therapy was most recently revised September 3, 2009. Since that time, the LCD has been revised to update current Food and Drug Administration (FDA) indications regarding the removal of the Indium-111 imaging dose and dosimetry requirements previously required as part of the Zevalin® treatment regimen. Under the "Indications and Limitations of Coverage and/or Medical Nessecity" section of the LCD, language was revised to define Zevalin® and update current FDA indications. Also, the "*CPT*/HCPCS Codes" section of the LCD was revised to remove *CPT*/HCPCS codes *78802, 78004,* and A9542 related to In-111 Zevalin®. Reference to HCPCS code A9542 was removed from the "ICD-9 Codes that Support Medical Necessity" section of the LCD. In addition the "CMS National Coverage Policy," "Utilization Guidelines," and "Sources of Information and Basis for Decision" sections of the LCD were updated. The "Coding Guidelines" attachment was also updated with this new FDA information.

Effective date

This LCD revision is effective for claims processed **on or after April 25, 2012**, for services rendered **on or after November 18, 2011**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.* 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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

A36470: Treatment of varicose veins of the lower extremity – revision to the LCD

LCD ID number: L28999 (Florida)
LCD ID number: L29031 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for treatment of varicose veins of the lower extremity was most recently revised June 14, 2011. Since that time, revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD under the subheading "Endovenous ablation therapy." Language was corrected and updated to reflect the following verbiage: one post-operative ultrasound will be allowed for follow-up care when endovenous radiofrequency ablation (ERFA) or endovenous laser treatment (EVLT) is performed. The medical record must clearly indicate that the reason for the follow up ultrasound is related to the ERFA or EVLT procedure performed.

Effective date

This LCD revision is effective for services rendered **on or March 27, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

A67221: Ocular photodynamic therapy (OPT) with verteporfin – revision to the LCD

LCD ID number: L28939 (Florida)
LCD ID number: L28960 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ocular photodynamic therapy (OPT) with verteporfin was effective for services rendered 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 revision was made to the LCD based on a reconsideration request. Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD a subheading for "Limitations" was added with verbiage to include the off-labeled indication of central serous retinopathy (CSR) (ICD-9-CM code 362.41) to be reviewed on an individual consideration basis with specified criteria. In addition, the "Utilization Guidelines" section of the LCD and "Coding Guidelines" attachment were updated regarding CSR on an individual consideration basis. Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after April 18, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

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A84999: Gene expression profiling panel for use in the management of breast cancer treatment – revision to the LCD

LCD ID number: L28849 (Florida)
LCD ID number: L28882 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for gene expression profiling panel for use in the management of breast cancer treatment was effective for services rendered 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, based on a reconsideration request, the LCD has been revised to add estrogen positive breast carcinoma with 1-3 positive nodes to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 10, 2012**. First Coast Service Options Inc. LCDs are available through the Centers for Medicare & Medicaid Services (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*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.

Note: To review active, future, and retired LCDs for jurisdiction 9 (J9), please *click here*.

Additional Information

Self-administered drug (SAD) list – Part A: C9399/J1324

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

Effective for services rendered **on or after May 19, 2012,** the following drugs have been added to the MAC J-9 Part A SAD list.

- C9399 Injection: Sylatron (peginterferon alfa-2b)
- C9399 Injection: Firazyr (icatibant)
- C9399 Injection: Exenatide injection [Byetta®]
- C9399 Injection: Anakinra [Kineret ™] 100 mg
- C9399 Injection: Peginterferon alpha 2a [Pegasys®]

In addition, Enfuvirtide [Fuzeon™] has been on the SAD list as HCPCS code J3490 and has now been updated to reflect the correct HCPCS code J1324.

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

The First Coast Service Options Inc. (FCSO) SAD lists are available through the CMS Medicare coverage database at *http://medicare.fcso.com/Self-administered_drugs/*.

76499: Digital tomosynthesis (3D Mammography)

Digital breast tomosynthesis (3-D Mammography) is a new imaging technology used to detect breast cancer. Currently, the clinical literature does not demonstrate significant improvement in health outcomes compared to traditional 2D mammography, though clinical studies are ongoing. Medicare covers diagnostic mammography when medically reasonable and necessary and screening mammography per the preventive services benefit.

Per the Centers for Medicare & Medicaid Services (CMS) Medicare Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 20.1, Preventive and Screening Services, *the Mammography Quality Standards Act (MQSA) provides specific standards regarding those qualified to perform screening and diagnostic mammograms and how they should be certified. The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards.*

Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the Food and Drug Administration (FDA) to continue to operate. The FDA Center for Devices and Radiological Health is responsible for collecting certificate fees and surveying mammography facilities (screening and diagnostic).

At this time, there is no national Medicare statement that distinguishes 2D from 3D mammography techniques. Until such clarification, 2D and 3D mammography will be reimbursed the same in Medicare Part B if program requirements are met.

Currently, there is not a consensus on the billing and coding of digital breast tomosynthesis as providers have been using the G codes for direct digital image, the unlisted code-(noting that it is not a “direct” digital technique), or both. In order to ensure beneficiary access to routine care, mammography screening and diagnostic testing, MAC J9 will allow the medically reasonable and necessary diagnostic or screening mammography under the Medicare benefit as the applicable G code reimbursement only (one payment for service) and it is recommend that *76499* for breast tomosynthesis be billed with the appropriate G code.

- *76499 Unlisted diagnostic radiographic procedure* (Use for Digital Breast Tomosynthesis [3-D Mammography])
- G0202 Screening mammography, producing direct digital image, bilateral, all views
- G0204 Diagnostic mammography, producing direct digital image, bilateral, all views
- G0206 Diagnostic mammography, producing direct digital image, unilateral, all views
- *77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)*
- *77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)*

Of note, because digital breast tomosynthesis (DBT) is a new mammographic modality, facilities wanting to use DBT on patients must meet all MQSA (Mammography Quality Standards Act) applicable requirements. See the Food and Drug Administration (FDA) website at *http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/FacilityCertificationandInspection/ucm243765.htm?utm_source=fdaSearch&utm_medium=website&utm_term=dbt&utm_content=3.*

CARC, RARC, MREP, and PC Print update

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, suppliers, and vendors representing physicians/providers/suppliers receiving remittance advice from 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.

Provider action needed

Stop –impact to you

This article is based on change request (CR) 7775 which updates claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), Medicare Remit Easy Print (MREP), and PC Print for Medicare.

Caution – what you need to know

CR 7775 instructs Medicare contractors and the shared system maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR (CR 7683 Transmittal 2372 published on December 22, 2011). It also instructs fiscal intermediary standard system (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software respectively. Be sure your billing staff is aware of these changes.

Go – what you need to do

If you use the MREP or PC Print software, be sure to download the updated software when available. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, valid CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment for Medicare.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual “Stop Date” posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is

deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 7775, Medicare contractors must implement on the date specified on the WPC website.

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CARC *(continued)*

The discrepancy between the dates may arise because the WPC website is updated only three times a year and may not match the CMS release schedule.

CR 7775 lists only the changes that have been approved since the last code update CR (CR 7683 Transmittal 2372), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

The WPC website (at *http://www.wpc-edi.com/Reference*) has four listings available for both CARC and RARC:

1. **All:** All codes including deactivated and to be deactivated codes are included in this listing.
2. **To Be Deactivated:** Only codes to be deactivated at a future date are included in this listing.
3. **Deactivated:** Only codes with prior deactivation effective date are included in this listing.
4. **Current:** Only currently valid codes are included in this listing.

Note: In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare.

Claim adjustment reason code (CARC):

A national code maintenance committee maintains the health care CARCs. The committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see *http://www.wpc-edi.com/Reference*.

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule.

The following new CARC were approved by the code committee in January, and must be implemented, if appropriate for Medicare, by July 2, 2012.

New codes – CARC:

None

Modified codes – CARC:

Code	Modified narrative	Effective date
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/ contractor.	November 1, 2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	November 1, 2012

Deactivated codes – CARC:

None

Remittance advice remark codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1

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CARC *(continued)*

Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Medicare uses the standard code sets (CARC and RARC) for paper remittance advice as well.

New codes – RARC:

Code	Code narrative	Effective date
N547	A refund request (frequency type code 8) was processed previously.	March 6, 2012
N548	Alert: Patient's calendar year deductible has been met.	March 6, 2012
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.	March 6, 2012
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.	March 6, 2012
N551	Payment adjusted based on the ambulatory surgical center (ASC) quality reporting program.	March 6, 2012
N552	Payment adjusted to reverse a previous withhold/ bonus amount.	March 6, 2012
N553	Payment adjusted based on a low income subsidy (LIS) retroactive coverage or status change.	March 6, 2012

Modified codes – RARC:

Code	Modified narrative	Effective date
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	March 6, 2012
N206	The supporting documentation does not match the information sent on the claim.	March 6, 2012

Additional information

The official instruction, CR 7775, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.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: MM7775
Related Change Request (CR) #: CR 7775
Related CR Release Date: April 6, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R2442CP
Implementation Date: July 2, 2012

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Claim status category and claim status codes update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit 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.

What you need to know

This article is based on change request (CR) 7793 which explains that the Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at *http://www.wpc-edi.com/content/view/180/223/*. The code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012.

Background

HIPAA requires all health care benefit payers to use claim status category codes and claim status codes to report the status of submitted claim(s). Only codes approved by the national Code Maintenance Committee in the X12 276/277 health care claim status request and response format are to be used. Proprietary codes may not be used in the X12 276/277 to report claim status.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The code sets are available at *http://www.wpc-edi.com/content/view/180/223/* or *http://www.wpc-edi.com/codes*. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012. The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by July 2, 2012.

Additional Information

The official instruction, CR 7793, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2436CP.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*.

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Related Change Request (CR) #: CR 7793
Related CR Release Date: March 30, 2012
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Related CR Transmittal #: R2436CP
Implementation Date: July 2, 2012

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Guidance for correct claims submission when secondary payers are involved

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for providers, physicians, and suppliers who bill Medicare contractors (Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and carriers (hereafter referred to as Medicare contractors)) for services provided to Medicare beneficiaries.

Provider action needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.

Remember: A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

Background

Collect full beneficiary health insurance information

It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare secondary payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the *MSP Manual* in Chapter 3, Section 20.2.1 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf*. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

Identify and bill the correct primary payer

Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first. After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a patient is seen for multiple services, each service should be billed to the appropriate primary payer.

Accident related claims

If the beneficiary has an open MSP liability (L), no-fault (NF), or workers' compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. DO NOT deny treatment.

To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. **If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.**
2. If the beneficiary has both a group health plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice

(*continued on next page*)

Secondary (*continued*)

information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.

3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

If you believe a claim was inappropriately denied:

- Ensure that you have submitted a correctly completed claim to the appropriate payer(s).
- Contact your Medicare contractor if you still have reason to believe a claim was denied inappropriately.
- You may need to provide information to your Medicare contractor that demonstrates why the claim was denied inappropriately. For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

Contact the coordination of benefit contractor (COBC) at 1-800-999-1118 if a beneficiary's MSP record needs to be updated.

- The COBC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the COBC at (734) 957-9598, or the beneficiary may need to be on the line to validate the change.
- Please do not call the COBC to adjust claims or about mistaken payments. They will not be able to assist you.

Key points

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.
- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the COBC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, federal program coverage changes, or any other insurance coverage information.

Additional information

Specific claim-based issues or questions (including claim processing) should be addressed to the Medicare claims processing contractor at their toll-free number found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the COBC's toll-free lines. For more information on contacting the COBC or the Medicare coordination of benefits process, visit the Medicare coordination of benefits Web page at *http://www.cms.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation/index.html*.

The *Medicare Learning Network* (*MLN*) has *a Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff* (ICN 006903) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MSP_Fact_Sheet.pdf.* This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the COBC.

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Questionable billing by suppliers of lower limb prostheses

Provider types affected

This *MLN Matters*® special edition article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What you need to know

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit. The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare administrative contractors (MACs), three Zone Program Integrity Contractors (ZPICs), and two DME Program Safeguard Contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;
- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last 5 years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

Findings

In 2009, the study found that:

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring physicians.
3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage

(*continued on next page*)

Prostheses (*continued*)

of beneficiaries with unusual combinations of prostheses.

4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
   - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
   - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
   - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

Recommendations

The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. In response to the first recommendation, to implement additional claims processing edits, CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

In response to the second recommendation, to strengthen monitoring of billing for lower limb prostheses, CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

In response to the third recommendation, to implement requirements for a face-to-face encounter to establish a beneficiary's need for prostheses, CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

In response to the fourth recommendation, to revise the local coverage determination, CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

In response to the fifth recommendation, to enhance screening for currently enrolled suppliers of lower limb prostheses, CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

In response to the sixth recommendation, to take appropriate action on the suppliers with questionable billing, CMS concurred and stated it would share the information with the DME MACs and the recovery audit contractors. Recovery audit contractors review Medicare claims on a post payment basis to identify inappropriate payments.

The following section reviews Medicare policy for coverage of lower limb prostheses.

Key points

Medicare requirements for lower limb prostheses

Provisions of the Social Security Act (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

(*continued on next page*)

Prostheses (*continued*)

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers must take into account the beneficiary's history, current condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain prostheses that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening – limited, moderate, and high – based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level.

Lastly, recent legislation established a face-to-face encounter requirement for certain DMEPOS. For specified DMEPOS that require a written order prior to delivery, the referring physician must document that a physician, physician assistant, nurse practitioner, or clinical nurse specialist has had a face-to-face encounter with the beneficiary before writing the order for the item.

Note: You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide. You may want to review *MLN Matters*® article SE1201 at *http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf* for important reminders on the requirements for ordering and referring physicians.

Additional information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at *http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf*.

MLN Matters® Number: SE1213
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
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Implementation Date: N/A

Pharmacy billing for drugs provided "incident to" a physician service

Note: This article was revised on April 10, 2012, to reflect the revised change request (CR) 7397 issued on April 4. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7397 were revised. All other information remains the same. This information was previously published in the December 2011 *Medicare A Connection*, Pages 55-56.

Provider types affected

Pharmacies that submit claims for drugs to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), A/B Medicare administrative contractors (A/B MACs), and durable medical equipment Medicare administrative contractors (DME MACs)) are affected.

What you should know

This article is based on CR 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided "incident to" a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined.

This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

Background

Pharmacies billing drugs

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the durable medical equipment DME MAC. The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When drugs may not be billed by pharmacies to Medicare Part B

Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician's office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered "incident to" a physician's service and pharmacies may not bill Medicare Part B under the "incident to" provision.

Payment limits

The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under the outpatient prospective payment system (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Additional information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2437CP.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*.

The following manual sections regarding billing drugs and biological and "incident to" services may be helpful:

- *Medicare Claims Processing Manual*, Chapter 17, Sections 20.1.3 and 50.B, available at *http://www.cms.gov/manuals/downloads/clm104c17.pdf*
- *Medicare Benefit Policy Manual*, Chapter 15, Sections 50.3 and 60.1, available at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*.

MLN Matters® Number: MM7397 Revised
Related Change Request (CR) #: 7397
Related CR Release Date: April 4, 2012
Effective Date: January 1, 2013
Related CR Transmittal #: R2437CP
Implementation Date: January 1, 2013

Billing for donor post-kidney transplant complication services

Note: This article was revised on April 3, 2012, to correct the claim examples at the end of the article. All other information is the same. This information was previously published in the November 2011 *Medicare A Connection*, Pages 52-54.

Provider types affected

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

What you need to know

Change request (CR) 7523 does not convey any new or changed policy, but does convey clarification language for two Medicare manuals. This clarification is being provided to ensure consistency among all Medicare contractors in processing claims for donor post-kidney transplant complications services. Be sure your staff is aware of the clarifications.

Key points of CR 7523

Section 140.9 of Chapter 11 of the *Medicare Benefit Policy Manual* is being updated to show the following:

The donor of an organ for a Medicare transplant is covered for an unlimited number of days of care in connection with the organ removal operation. Days of inpatient hospital care used by the donor in connection with the organ removal operation shall not be charged against either party's utilization record.

Regarding donor follow-up:

- Expenses incurred by the transplant center for routine donor follow-up care are included in the transplant center's organ acquisition cost center.
- Follow-up services performed by the operating physician are included in the 90-day global payment for the surgery. Beyond the 90-day global payment period, follow-up services are billed using the recipient's health insurance claim number.
- Follow-up services billed by a physician other than the operating physician for up to 3 months should be billed under the recipient's health insurance claim number.

Regarding donor complications:

- Expenses incurred for complications that arise with respect to the donor are covered only if they are directly attributable to the donation surgery. Complications that arise after the date of the donor's discharge will be billed under the recipient's health insurance claim number. This is true of both facility cost and physician services. Billings for donor complications will be reviewed.
- In all of these situations, the donor is not responsible for co-insurance or deductible.

In addition, CR 7523 is adding language to Section 90.1.3 of Chapter 3 of the *Medicare Claims Processing Manual* to provide clarifications as follows:

- Expenses incurred for complications that arise with respect to the donor are covered and separately billable only if they are directly attributable to the donation surgery.
- All covered services (both institutional and professional) for complications from a Medicare covered transplant that arise after the date of the donor's transplant discharge will be billed under the recipient's health insurance claim number and are billed to the Medicare program in the same manner as all Medicare Part B services are billed.
- All covered donor post-kidney transplant complication services must be billed to the account of the recipient (i.e., the recipient's Medicare number).
- Modifier Q3 (Live Kidney Donor and Related Services) appears on each covered line of the claim.
- Institutional claims will be required to also include:
  - Occurrence code 36 (Date of Inpatient Hospital Discharge for covered transplant patients); and
  - Patient relationship code 39 (Organ Donor).

Sample claims appear at the end of this article to provide examples of the above coding instructions.

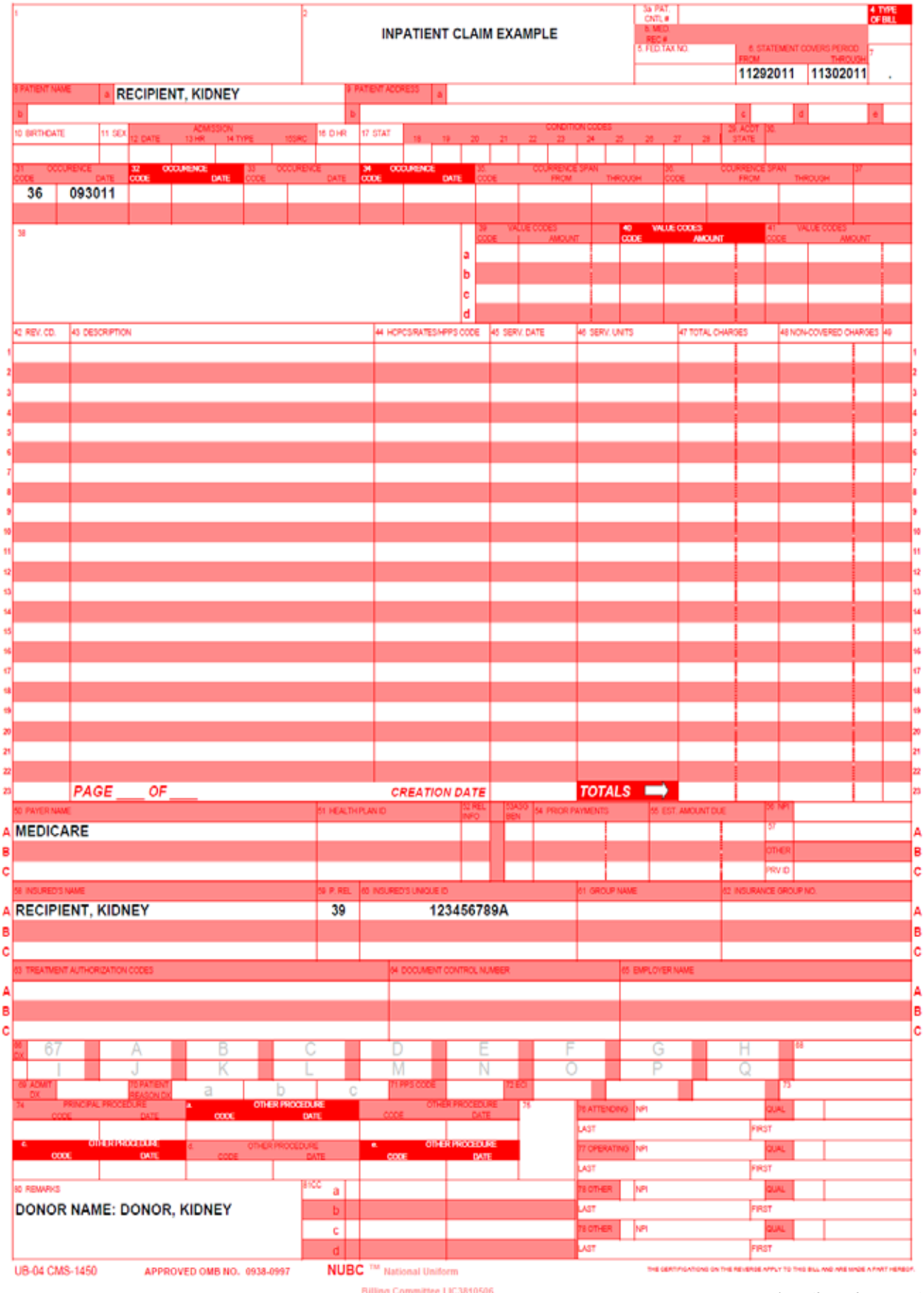
Additional Information

The official instruction, CR 7523, was issued to your RHHI, FI or A/B MAC via two transmittals. The first modifies the *Medicare Benefit Policy Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R148BP.pdf* and the second at *http://www.cms.gov/Transmittals/downloads/R2334CP.pdf* modifies the *Medicare Claims Processing Manual*.

If you have any questions, please contact your RHHI, 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: MM7523 Revised
Related Change Request (CR) #: 7523
Related CR Release Date: October 28, 2011
Effective Date: April 1, 2012 for claims processing, but policy effective November 28, 2011
Related CR Transmittal #: R148BP and R2334CP
Implementation Date: April 2, 2012

Kidney (*continued*)



INPATIENT CLAIM EXAMPLE

6. STATEMENT COVERS PERIOD FROM	11292011
THROUGH	11302011
8 PATIENT NAME a	RECIPIENT, KIDNEY
36	36 093011
50 PAYER NAME A	MEDICARE
58 INSURED'S NAME A	RECIPIENT, KIDNEY
59 P REL	39
60 INSURED'S UNIQUE ID	123456789A
80 REMARKS	DONOR NAME: DONOR, KIDNEY

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS/RATES/HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

PAGE ___ OF ___ CREATION DATE TOTALS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform

(*continued on next page*)

Kidney (*continued*)

OUTPATIENT CLAIM EXAMPLE

11292011 11292011

RECIPIENT, KIDNEY

36 093011

AAAAA Q3

ZZZZZ Q3

PAGE ___ OF ___ CREATION DATE TOTALS

MEDICARE

RECIPIENT, KIDNEY 39 123456789A

DONOR NAME: DONOR, KIDNEY

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform

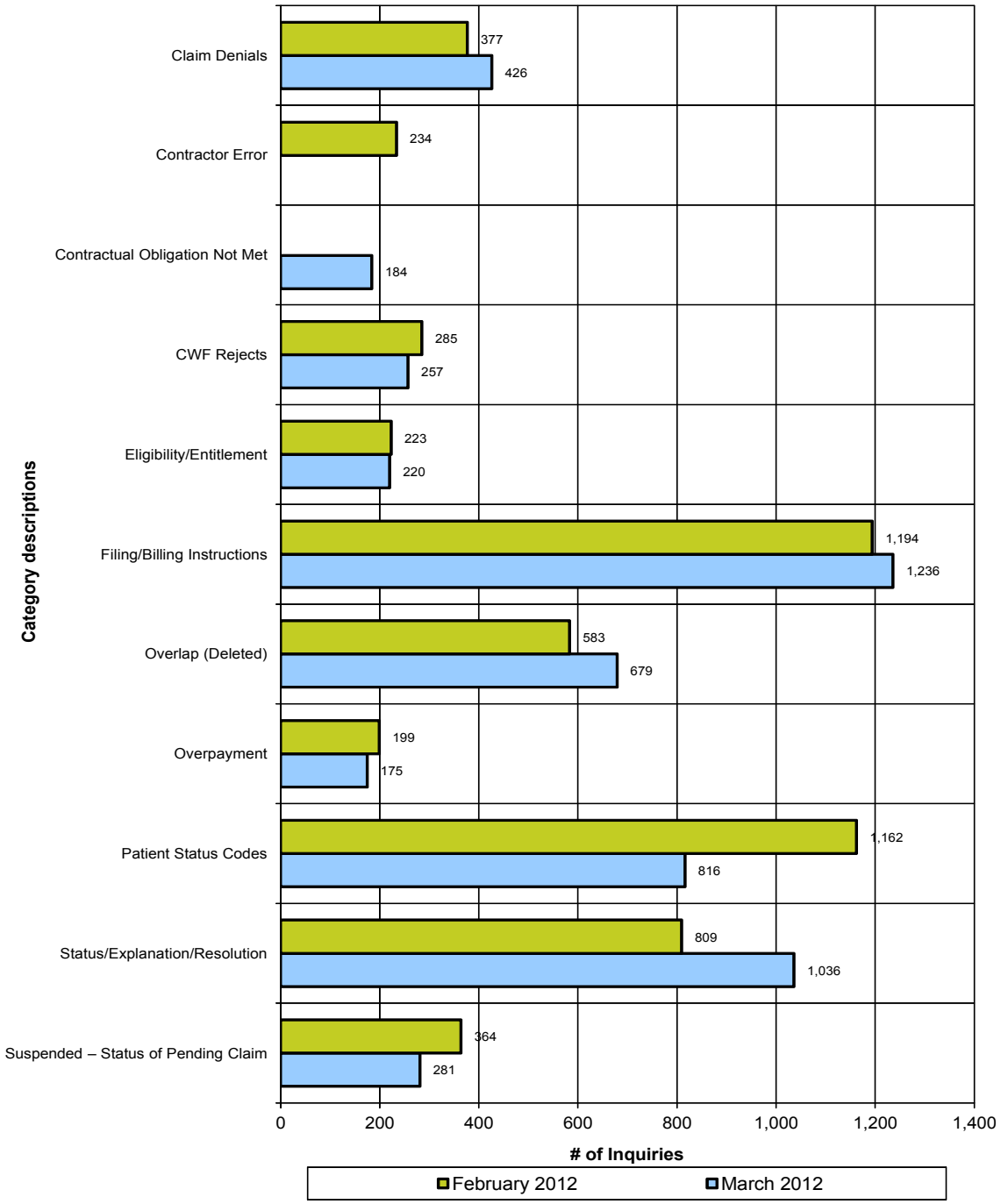
Billing Committee LIC3810506

Top inquiries, rejects, and return to provider claims – February-March 2012

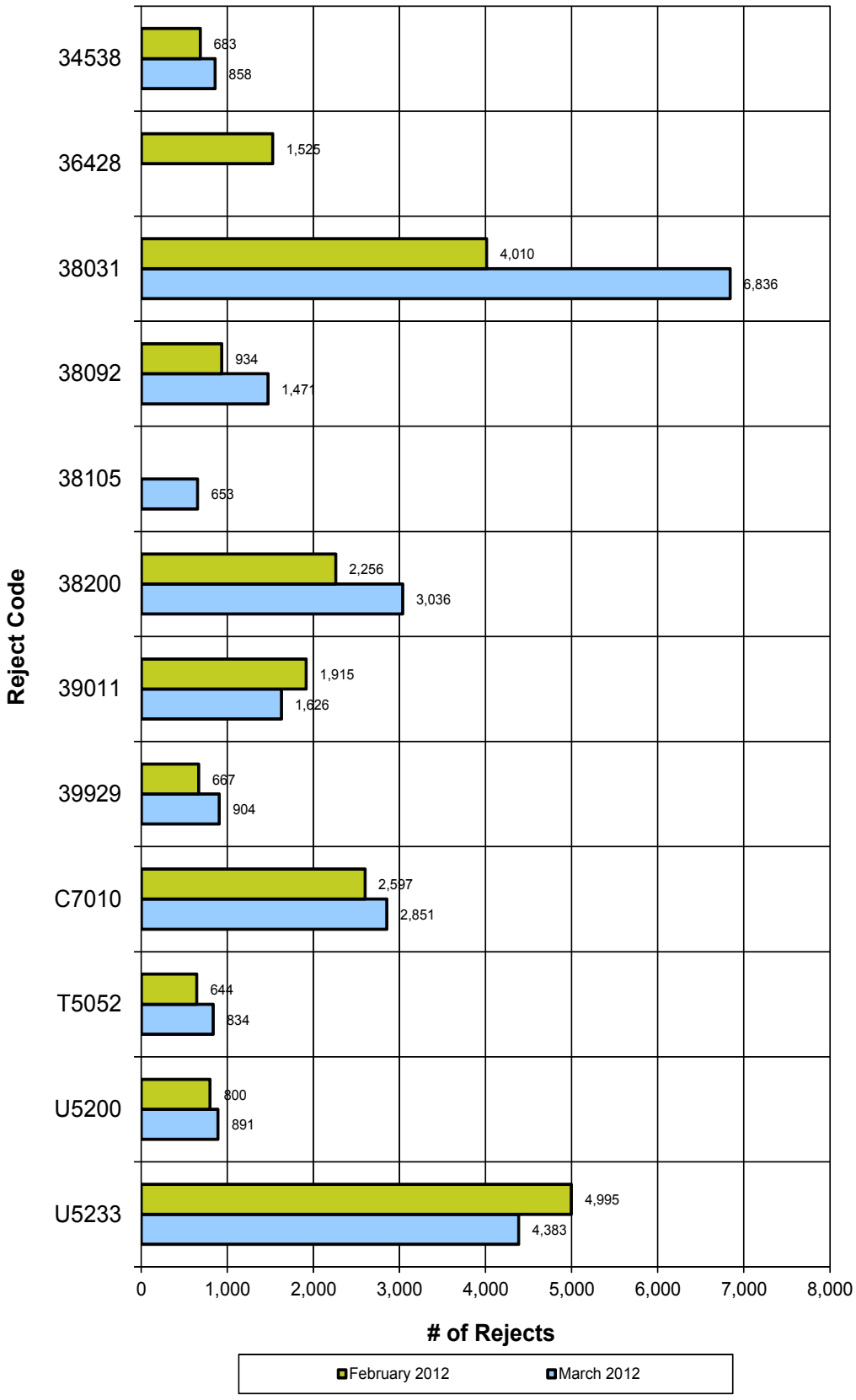
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during February and March 2012.

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*.

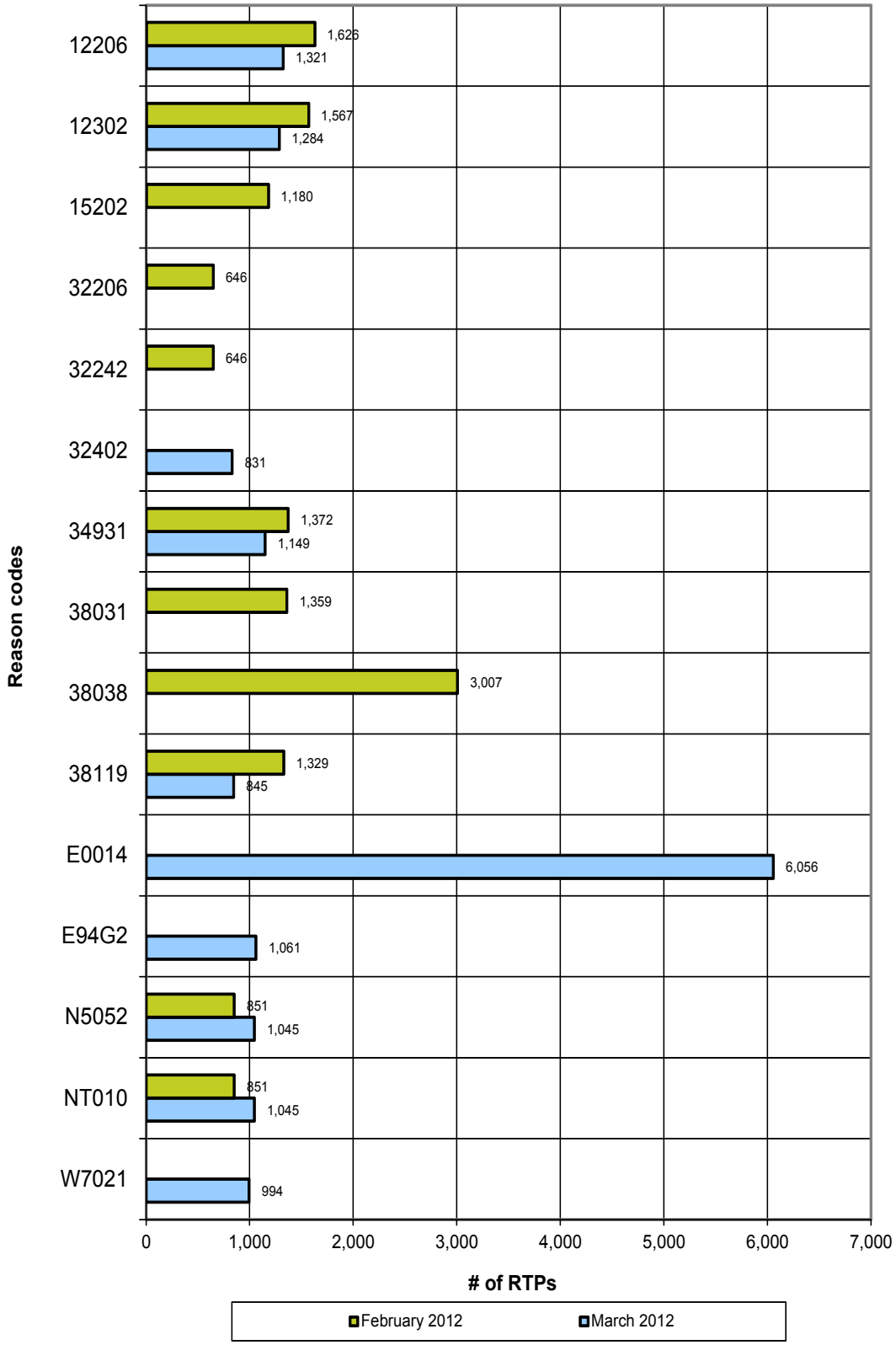
Part A top inquiries for February-March 2012



Part A top rejects for February-March 2012



Part A top return to providers (RTPs) for February-March 2012



Information for Medicare fee-for-service providers about the Middle Class Tax Relief and Job Creation Act of 2012

Provider types affected

This *MLN Matters*® special edition article is intended for all providers who provide Medicare-covered services in the fee-for-service (FFS) program.

What you need to know

On February 22, 2012, President Obama signed into law the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act). This law, which extended several provisions of the Temporary Payroll Tax Cut Elimination Act of 2011 (Continuation Act), contained several provisions that impact Medicare fee-for-service providers, as outlined below.

Physician payment update

Section 3003 of the Jobs Creation Act extended the zero percent update for claims with dates of service on or after January 1, 2012, to February 29, 2012, all the way through December 31, 2012.

Note: The new law did NOT extend:

- Section 307 of the Continuation Act (the five percent physician fee schedule mental health add-on payment); or
- Section 309 of the Continuation Act (the special 2011 payment rates for bone mass measurements).

The Centers for Medicare & Medicaid Services (CMS) revised the 2012 Medicare physician fee schedule (MPFS) to reflect the expiration of both of these provisions.

This provision does not affect claims with dates of service prior to March 1, 2012. Medicare contractors posted the new mental health and bone density rates no later than March 15, 2012.

Extension of Medicare physician work geographic adjustment floor

Section 3004 of the law has extended the existing 1.0 floor on the physician work geographic practice cost index through December 31, 2012. As with the physician payment update, the revised 2012 MPFS will reflect this extension.

Extension of Medicare Modernization Act Section 508 reclassifications

Section 3001 of the law extends Section 508 reclassifications and certain special exception wage indexes from December 1, 2011, through March 31, 2012.

This section requires removing Section 508 and special exception wage date from the calculation of the reclassified wage index, if doing so raises the reclassified wage index for this period.

CMS shall assign all hospitals that receive Section 508 reclassifications and inpatient special exception reclassifications to a special wage index effective for October 2011 through March 2012.

CMS shall apply these provisions to both inpatient and outpatient hospital payments.

From January 1 through June 30, 2012, a special wage index will be applicable for affected hospital outpatient payments, special exception hospitals, and reclassified hospitals.

CMS shall make hospital inpatient and outpatient payments under both Section 302 of the Continuation Act and Section 3001 of the Job Creation Act by June 30, 2012.

Extension of outpatient hold harmless payments

Section 3002 of the law extends outpatient hold harmless payments through December 31, 2012, for:

- Rural hospitals, and
- Sole community hospitals with 100 or fewer beds.

Note: The law did NOT extend hold harmless payments for sole community hospitals with more than 100 beds. These payments expired February 29, 2012.

Extension of exceptions process for Medicare therapy services

Section 3005 of the law extends the exceptions process for outpatient therapy caps from March 1, 2012, through December 31, 2012, with some modifications to current therapy policies.

Outpatient therapy service providers must submit the KX modifier on their therapy claims when they are requesting an exception to the cap for medically necessary services that they furnished through December 31, 2012.

In addition, the new law includes changes related to therapy services that a therapist furnishes in a hospital Outpatient Department (OPD). These changes impact the annual therapy cap in 2012 as well as the applicability of the therapy cap exception process.

CMS will provide more information about the changes that affect hospital OPDs in the future. You can also find additional information about the exception process for therapy services in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Section 10.3 at *http://www.cms.gov/manuals/downloads/clm104c05.pdf*.

CMS determines therapy caps on a calendar year basis. Therefore, all beneficiaries began a new cap for outpatient therapy services they received on January

(continued on next page)

Fee-for-service *(continued)*

1, 2012. For physical therapy and speech language pathology services combined, the 2012 limit for beneficiary-incurred expenses is $1,880.

There is a separate cap for occupation therapy services, which is also $1,880 for 2012.

Deductible and coinsurance amounts for therapy services count toward the accrued amount before a beneficiary reaches the cap and also apply for services above the cap where the provider used the KX modifier.

Section 3005 also mandates that Medicare perform an annual medical review of therapy services that a therapist furnished beginning on October 1, 2012, when the therapist requested an exception when the beneficiary reached a dollar aggregate threshold amount of $3,700, including OPD therapy services, for a year.

There are two separate $3,700 aggregate annual thresholds: one for physical therapy and speech-language pathology services, and another for occupational therapy services.

Finally, Section 3005 requires that claims for all therapy services that therapists furnish on or after October 1, 2012, include the national provider identifier (NPI) of the physician who reviews the therapy plan. CMS will issue additional information about all of these new requirements later this year.

Extension of moratorium on qualified pathologists and independent laboratory billing for the technical component of physician pathology services furnished to hospital patients

Section 3006 of the law extends the moratorium through June 30, 2012. Therefore, those qualified pathologists and independent laboratories that are eligible may continue to submit claims for the technical component of physician pathology services that they furnish to hospital patients, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date they furnish the service.

This policy continues to be effective for claims with dates of service on or after March 1, 2012, through June 30, 2012.

Extension of ambulance add-on payments

Section 3007 of the law extends the following Continuation Act ambulance payment provisions through December 31, 2012:

- The three percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the 2 percent increase for covered ground ambulance transports that originate in urban areas;
- The provision relating to air ambulance services that continues to treat any area that was designated as rural on December 31, 2006, as rural for purposes of payment under the ambulance fee schedule; and
- The provision relating to payment for ground ambulance services that increases the base rate for transports that originate in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus).

Suppliers of ambulance services that this provision affects may continue billing as usual.

Additional information

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: SE1215
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

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Emergency March 2012 update to the CY 2012 Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs) and/or Part A/B Medicare administrative contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the MPFS.

What you need to know

This article is based on change request (CR) 7767, which summarizes the Middle Class Tax Relief and Job Creation Act (MCTRJCA) of 2012. This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect on March 1, 2012. The new law extends the current zero percent update for such services through December 31, 2012. All updates will be reflected in the revised 2012 MPFS. Please be sure your staffs are aware of these changes.

Medicare contractors will not search their files to adjust claims already processed prior to implementation of these changes. However, they will adjust any impacted claims that you bring to their attention.

Background

Payment files were issued to contractors based upon the calendar year (CY) 2012 MPFS final rule, published in the *Federal Register* on November 28, 2011, as modified by the final rule correction notice, published in the *Federal Register* on January 4, 2012, and relevant statutory changes applicable January 1, 2012. On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) became law and suspended the automatic negative update that would have taken effect with current law. TPTCCA temporarily allowed for a zero percent update to the MPFS from January 1, 2012, until February 29, 2012.

On February 22, 2012, President Obama signed into law the MCTRJCA, extending the TPTCCA zero percent update to the end of the calendar year, December 31, 2012. This new legislation contains a number of Medicare provisions which change or extend Medicare fee-for-service policies.

This one-time notification addresses the specific changes to the payment files resulting from the MCTRJCA effective March 1, 2012. The Centers for Medicare & Medicaid Services (CMS) is also correcting payments for all anesthesia codes for CY 2011 and for the first part of CY 2012.

Medicare physician fee schedule revisions and updates

Included in the MCTRJCA are extensions to:

1. The moratorium that allows certain pathologists and independent laboratories to bill for the Technical Component (TC) of physician pathology services furnished to hospital patients through June 30, 2012;
2. The exceptions process for Medicare Therapy Caps; and
3. The continuation of the Medicare Physician Work Geographic Adjustment Floor.

Further, the MCTRJCA discontinues:

1. The Minimum Payment for Bone Mass Measurement; and
2. The Physician Fee Schedule Mental Health 5 percent Add-On Payments.

Extension of moratorium for technical component (TC) for physician pathology services

Under previous law, including, most recently, Section 305 of the TPTCCA, a statutory moratorium allowed pathologists and independent laboratories meeting specific criteria to bill a carrier or an A/B MAC for the TC of physician pathology services furnished to hospital patients. This moratorium was set to expire on February 29, 2012. However, Section 3006 of the MCTRJCA extends the moratorium through June 30, 2012.

Pathologists and independent laboratories that had an arrangement with a hospital that was in effect as of July 22, 1999, under which a laboratory furnished the TC of physician pathology services to fee-for-service Medicare beneficiaries who were hospital inpatients or outpatients, and submitted claims for payment for the TC to a carrier may continue to bill for and receive Medicare payment for these services. This policy is effective for claims with dates of service (DOS) through June 30, 2012.

Medicare therapy caps exceptions

Section 3005 of the MCTRJCA extends the exceptions process for Medicare therapy caps, effective for dates of service on and after March 1, 2012, through December 31, 2012. Therapy providers may continue to request an exception to the cap by submitting therapy claims with KX modifiers for services during this period. The KX modifier should continue to be used by providers when they know that the therapy

(continued on next page)

Emergency *(continued)*

cap has already been met, and documentation exists to substantiate that the therapy services are medically necessary. Your Medicare contractor will continue to process claims containing the KX modifier.

Outpatient therapy claims processing

Section 3005 also requires additional changes to outpatient therapy claims processing beginning October 1, 2012. These changes include (1) the temporary inclusion of therapies provided in outpatient hospital settings to the therapy cap and the exception process, (2) an additional threshold beyond which therapy services require manual medical review, and (3) the reporting of the national provider identifier of the physician that reviews the therapy plan of care. The Centers for Medicare & Medicaid Services (CMS) will issue a separate change request detailing the requirements for these October 2012 changes.

Geographic practice cost index

The MCTRJCA extends the TPTCCA continuation of the 1.0 floor on the physician work geographic practice cost index through to the end of the calendar year, December 31, 2012. The March 1, 2012 MPFS database (MPFSDB) will reflect this extension.

Bone mass measurement

The MCTRJCA discontinues the minimum payment for bone mass measurement, dual-energy X-ray absorptiometry (DXA) services described *CPT* codes *77080* (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine*)) and *77082* (*Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment*), effective March 1, 2012. The bone mass measurement payments will be calculated based on a standard PFS methodology for the March 1, 2012, update of the physician fee schedule.

Mental health add-on

The MCTRJCA discontinues the 5 percent mental health add-on payments effective March 1, 2012. The 5 percent increase is no longer reflected in the revised MPFS payment files.

Additional information

The official instruction, CR 7767, issued to your Medicare Carrier, FI, RHHI or A/B MAC regarding this change may be viewed at *https://www.cms.gov/transmittals/downloads/R1058OTN.pdf*.

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

Additional information about the exception process for therapy services may be found in the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 5, Section 10.3 at *http://www.cms.gov/manuals/downloads/clm104c05.pdf*.

For background and policy information regarding payment to certain pathologists and independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to *MLN Matters*® articles MM5943 (*www.cms.gov/MLNMattersArticles/downloads/MM5943.pdf*) and MM5347 (*www.cms.gov/MLNMattersArticles/downloads/MM5347.pdf*).

MLN Matters® Number: MM7767 Revised
Related Change Request (CR) #: CR 7767
Related CR Release Date: March 14, 2012
Effective Date: March 1, 2012
Related CR Transmittal #: R1058OTN
Implementation Date: March 15, 2012

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April update to the CY 2012 Medicare physician fee schedule database

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 7745 and instructs Medicare contractors to download and implement a new MPFS Data Base (MPFSDB). On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) became law and suspended the automatic negative update that would have taken effect with current law. TPTCCA temporarily allowed for a zero percent update to the MPFS from January 1, 2012, until February 29, 2012. On February 22, 2012, the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) was signed into law and extended the zero percent update through December 31, 2012. This new legislation contains a number of Medicare provisions which change or extend Medicare fee-for-service (FFS) policies. Specific changes to the payment files resulting from the MCTRJCA and effective March 1, 2012, will be addressed in a separate change request.

Please make sure your billing staff is aware of these changes.

Background

Section 1848 (c) (4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. In order to reflect appropriate payment policy in line with the CY 2012 MPFS final rule, the MPFSDB has been updated effective January 1, 2012, and new payment files have been created. Contractors will be notified when they are available. The revised payment file names and a list of the changes can be found in the attachment to this recurring update notification.

The Centers for Medicare & Medicaid Services (CMS) is correcting payments for all anesthesia codes for CY 2011 and for the first part of CY 2012. New anesthesia conversion factor files will be made available for CY 2011 and CY 2012 as part of CR 7745. Practitioners may elect to have payments adjusted on claims for anesthesia services where the provided service dates fall between January 1, 2012, and March 1, 2012. The new 2012 anesthesia conversion factor file is to be used to adjust these payments, and it is the same file to be used to calculate anesthesia claims for the rest of the 2012 calendar year (file effective date from January 1, 2012, to December 31, 2012). Medicare contractors have been previously directed to start processing anesthesia claims with the revised 2012 anesthesia conversion factor file, with dates of service, March 1, 2012, and forward. Practitioners may also elect to have payments adjusted on claims for anesthesia services, where the provided service dates fall between January 1, 2011, and December 31, 2011. The new 2011 anesthesia conversion factor file is to be used to adjust these CY 2011 payments (file effective date from January 1, 2011, to December 31, 2011). Practitioners should contact their local Medicare contractor and bring to their attention these anesthesia payment adjustments, noting that the corrected conversion factors are different for CY 2011 and CY 2012.

Other key points of CR 7745

Healthcare Common Procedure Coding System (HCPCS) code *92227* outpatient prospective payment system imaging cap amounts are being included in the April update files. Their omission was due to a technical error and the error has been fixed to prevent this from happening again.

The following reflects additional key changes in the April update of the CY 2012 MPFSDB:

HCPCS codes with revised Medicare physician fee schedule payment indicators

HCPCS code: *43775*
Short descriptor: Lap sleeve gastrectomy
Global surgery: 090
Effective date: January 1, 2012

(continued on next page)

April *(continued)*

HCPCS code: *92072* Short descriptor: Fit contac lens for managmnt Bilateral surgery: 2 Effective date: January 1, 2012
HCPCS code: *4050F* Short descriptor: Ht care plan doc Procedure status: M Effective date: January 1, 2012

New HCPCS codes to be added with the effective date of April 1, 2012

HCPCS code	S0353	S0354	S0596	S3721	S8930
Procedure status	I	I	I	I	I
Short descriptor	Cancer treatment plan initial	Cancer treatment plan change	Phakic iol refractive error	Pca3 testing	Auricular electrostimulation
Long descriptor	Treatment planning and care coordination management for cancer initial treatment	Treatment planning and care coordination management for cancer established patient with a change of regimen	Phakic intraocular lens for correction of refractive error	Prostate cancer antigen 3 (pca3) testing	Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with the patient
Effective date	April 1, 2012	April 1, 2012	April 1, 2012	April 1, 2012	April 1, 2012

New HCPCS codes to be added with the effective date of January 1, 2012

HCPCS code	G8675	G8676	G8677	G8678	G8679	G8680
Procedure status	M	M	M	M	M	M
Short descriptor	BP Syst >= 140 mmHg	BP Diast >= 90 mmHg	BP Syst < 130 mmHg	BP Syst >=130 - 139 mmHg	BP Diast < 80 mmHg	BP Diast 80-89 mmHg
Effective date	January 1, 2012	January 1, 2012	January 1, 2012	January 1, 2012	January 1, 2012	January 1, 2012

New HCPCS codes to be added with the effective date of July 1, 2011

HCPCS code	G9148	G9149	G9150	G9151	G9152	G9153
Procedure status	R	R	R	R	R	R

(continued on next page)

April *(continued)*

Short descriptor	Medical Home Level I	Medical Home Level II	Medical Home Level III	MAPCP demo State	MAPCP demo community	MAPCP demo physician
Effective date	July 1, 2012	July 1, 2012	July 1, 2012	July 1, 2012	July 1, 2012	July 1, 2012

The following HCPCS codes are discontinued effective April 1, 2012:

HCPCS code	Short descriptor	Procedure status	Termination date
S3711	Circulating tumor cell test	D	April 1, 2012
S3713	KRAS mutation analysis	D	April 1, 2012
S3818	BRCA1 gene anal	D	April 1, 2012
S3819	BRCA2 gene anal	D	April 1, 2012
S3820	Comp BRCA1/BRCA2	D	April 1, 2012
S3822	Sing mutation brst/ovar	D	April 1, 2012
S3823	3 mutation brst/ovar	D	April 1, 2012
S3828	Comp MLH1 gene	D	April 1, 2012
S3829	Comp MSH2 gene	D	April 1, 2012
S3830	Gene test HNPCC comp	D	April 1, 2012
S3831	Gene test HNPCC single	D	April 1, 2012
S3835	Gene test cystic fibrosis	D	April 1, 2012
S3837	Gene test hemochromato	D	April 1, 2012
S3843	DNA analysis factor v	D	April 1, 2012
S3847	Gene test Tay-Sachs	D	April 1, 2012
S3848	Gene test Gaucher	D	April 1, 2012
S3851	Gene test canavan	D	April 1, 2012
S3860	Genet test cardiac ion-comp	D	April 1, 2012
S3862	Genet test cardiac ion-spec	D	April 1, 2012
S8049	Intraoperative radiation the	D	April 1, 2012

Additional information

The official instruction, CR 7745, issued to your carrier, FI, RHHI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2429CP.pdf*.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM7745
Related Change Request (CR) #: CR 7745
Related CR Release Date: March 23, 2012
Effective Date: January 1, 2012 (unless otherwise indicated)
Related CR Transmittal #: R2429CP
Implementation Date: April 2, 2012

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July 2012 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

Provider types affected

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

Provider action needed

Stop – impact to you

Medicare will use the July 2012 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 2, 2012, with dates of service July 1, 2012, through September 30, 2012.

Caution – what you need to know

Change request (CR) 7810, from which this article is taken, instructs your Medicare contractors to download and implement the July 2012 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised April 2012, January 2012, October 2011, and July 2011 files.

Go – what you need to do

You should make sure that your billing staffs are aware of the release of these July 2012 ASP Medicare Part B drug files.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see *http://www.cms.gov/manuals/downloads/clm104c04.pdf*)

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

Files	Effective for dates of service
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011

Additional information

You can find the official instruction, CR 7810, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2440CP.pdf*. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7810
Related Change Request (CR) #: CR 7810
Related CR Release Date: April 6, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R2440CP
Implementation Date: July 2, 2012

Educational Events

Upcoming provider outreach and educational events – May-June 2012

Internet-based PECOS class (Part A/B)

When: Tuesday, May 15
Time: 8 a.m. – 12 p.m. ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Therapy cap exception process and use of the KX modifier (Part A/B)

When: Tuesday, May 22
Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Medifest 2012 Orlando (A/B)

When: June 5-7
Time: 8 a.m. – 5 p.m. ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Two easy ways to register

1. **Online** – Visit our provider training website at *fcsouniversity.com*, logon 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 a New Account" 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.

2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 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: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

If you 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 *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

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Addresses

First Coast Service Options

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

Claims/correspondence
Florida:
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

Electronic claim filing
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

Freedom of Information Act requests
(relative to cost reports and audits)

Provider Audit and Reimbursement (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
General information, conditional payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections
Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

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

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail and courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)
DME, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CIGNA Government Services
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health and hospice intermediary
Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

Provider audit and reimbursement
904-791-8430

Provider education and outreach
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites

First Coast Service Options Inc. (Florida and U.S. Virgin Islands Medicare contractor)
medicare.fcso.com

Centers for Medicare & Medicaid Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

Medicare A *Connection*

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