MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education Web sites which may be accessed at: *http://www.fcso.com.*

Routing Suggestions:

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The *Medicare B Update!* is published monthly by First Coast Service Options, Inc. (FCSO) Provider Outreach and Education Division, to provide timely and useful information to Medicare Part B providers in Florida.

Questions concerning this publication or its contents may be faxed to 1-904-361-0723.

Third party Web sites:

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

The *Medicare B Update!* is a comprehensive publication developed by First Coast Service Options, Inc. (FCSO) for Part B providers in Florida.

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education Web site, *http://www.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM.

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to Florida Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us*. Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

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

Publication format

The *Update!* is arranged into distinct sections.

Following the table of contents, a letter from the carrier medical director (as needed), and an administrative information section, the *Update!* content information is categorized as follows.

- The claims section provides claim submission requirements and tips, plus correspondence (appeals and hearings) information.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by specialty *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **general information** section includes fraud and abuse, and National Provider Identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include **Educational resources**. Important **addresses,** and **phone numbers**, and **Web sites**.

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 Quarterly Provider Update by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI Web site at *http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage.*

Note: Beginning March 3, 2008, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN (CMS-R-131 [03/08]) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (CMS-R-131G), ABN-L (CMS-R-131L), and NEMB (CMS-20007). Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid. Additional information is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier **GZ** may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier **GZ** is billed, the provider assumes financial responsibility if the service or item is denied.

"GA" modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier **GA** (wavier of liability statement on file).

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Written appeals requests should be sent to:

Medicare Part B Redeterminations Appeals
PO Box 2360
Jacksonville, FL 32231-0018

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the prompts.

CLAIMS

2009 annual update for the health professional shortage area bonus payments

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

Provider types affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries in health professional shortage areas (HPSA).

What you need to know

Change request (CR) 6150, from which this article is taken provides your carriers, FIs, and A/B MACs with the names of the test and final files for the HPSA bonus payments for 2009 and alerts providers that the 2009 file will be posted to the Centers for Medicare & Medicaid Services (CMS) Web site when it is available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413[b]) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors in early December of each year. CR 6150, from which this article is taken, provides them the names of the test and final 2009 HPSA bonus payment files which contractors will use for the automated bonus payment for claims with dates of service on or after January 1, 2009, through December 31, 2009.

You will find the annual HPSA bonus payment file (as it becomes available) and other important HPSA information at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/* on the CMS Web site. You should also review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf* on the CMS Web site and following the instructions on the page.

Additional information

You may find the official instruction, CR 6150, issued to your carrier, FI, or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1582CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6150
Related Change Request (CR) #: 6150
Related CR Release Date: August 29, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1582CP
Implementation Date: January 5, 2009

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the prompts.

Quarterly update to Correct Coding Initiative edits, version 14.3, effective October 1, 2008

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

Provider types affected

Physicians who submit claims to Medicare carriers and A/B Medicare administrative contractors (A/B MACs).

Background

This article is based on change request (CR) 6169, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits.

The National Correct Coding Initiative developed by the Centers for Medicare & Medicaid (CMS) helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in:

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

Key points

The latest package of CCI edits, version 14.3, will be effective October 1, 2008. Version 14.3 of the CCI edits will include all previous versions and updates from January 1, 1996, to the present and will be organized into two tables:

- Column 1/Column 2 Correct Coding edits
- Mutually exclusive code (MEC) edits

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

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site.

The official instruction, CR 6169, issued to carriers and A/B MACs regarding this update may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1598CP.pdf* on the CMS Web site. If you have any questions, please contact your Medicare carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6169
Related Change Request (CR) #: 6169
Related CR Release Date: September 19, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1598CP
Implementation Date: October 6, 2008

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Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the prompts.

AMBULANCE

Section 1011 Ask the Contractor teleconference – ambulance suppliers

The national contractor for the Section 1011 program, TrailBlazer Health Enterprises®, is hosting the third of three Ask the Contractor teleconferences (ACT) on Thursday, October 30, 2008, from 1:00 p.m.- 3:00 p.m. (CT).

This ACT is designed for Section 1011 ambulance suppliers and will examine a variety of program issues.

Conference call details

Ask the Contractor teleconference -- ambulance suppliers
Thursday, October 30, 2008
1-3:00 p.m. (CT)

You may register for the event on the calendar of events page of the Section 1011 Web site, *http://www.trailblazerhealth.com/Section_1011/Default.aspx?urlRD=708*.

A confirmation e-mail with the dial-in information will be sent to the e-mail address provided when your registration is approved.

A question-and-answer session concludes the teleconference and you may e-mail your questions in advance through the close of business Thursday, October 23, 2008, to *mailto:section.1011@trailblazerhealth.com* with "Ask the Contractor" in the subject line.

Source: PERL 200809-37

July 2008 fee schedule for ground ambulance services under MIPPA

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008. In accordance with Section 146(a) of MIPPA, ambulance fee schedule amounts for ground ambulance services have increased.

The fee increases are effective for claims with dates of service on or after July 1, 2008, and before January 1, 2010. First Coast Service Options Inc. will identify and, to the extent possible, automatically reprocess any claims that were paid under the previous fee schedule rates and complete that reprocessing no later than September 30, 2008.

HCPCS Code	Urban/Rural	Locality 01/02	Locality 03	Locality 04
A0425	Urban	$6.55	$6.55	$6.55
A0425	Rural	$6.61	$6.61	$6.61
A0426	Urban	$233.62	$245.08	$254.49
A0426	Rural	$235.91	$247.48	$256.98
A0427	Urban	$369.90	$388.04	$402.94
A0427	Rural	$373.52	$391.85	$406.89
A0428	Urban	$194.68	$204.23	$212.07
A0428	Rural	$196.59	$206.24	$214.15
A0429	Urban	$311.49	$326.77	$339.32
A0429	Rural	$314.54	$329.98	$342.65
A0432	Urban	$340.69	$357.41	$371.13
A0432	Rural	$344.03	$360.91	$347.77
A0433	Urban	$535.38	$561.64	$583.21
A0433	Rural	$540.62	$567.15	$588.92
A0434	Urban	$632.72	$663.76	$689.24
A0434	Rural	$638.92	$670.27	$696.00

Source: CMS JSM 08429, July 24, 2008

AMBULATORY SURGICAL CENTER

New requirement for ordering/referring information on ambulatory surgical center claims for diagnostic services

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

Provider types affected

Ambulatory surgical centers (ASCs) submitting claims to Medicare administrative contractors (A/B MACs) or carriers for services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6129 which states that the Centers for Medicare & Medicaid Services (CMS) has determined that beginning January 1, 2009, the ordering/referring physician needs to be reported on claims for diagnostic radiology services submitted by ASCs, as it is for other Part B claims for diagnostic services (modifier TC). The name of the ordering/referring physician needs to be present in block 17 and the national provider identifier (NPI) of the physician needs to be present in block 17B of the CMS-1500 (or in Data Element Loops 2420E and 2310A of the 837P).

Key points of CR 6129

- Effective for dates of service on or after January 1, 2009, for allowed ASC claims, if modifier = TC, the ordering/referring physician name needs to be included in block 17 and ordering/physician NPI in block 17B of the CMS-1500 for paper claims.
- Effective for dates of service on or after January 1, 2009, for allowed ASC claims, if modifier = TC, the ordering physician name and NPI needs to be present in Loop 2420E NM1 (NM101=DK, NM102=1, NM103=provider's last name, NM104=provider's first name, NM108=XX, NM109=provider's NPI).
- Effective January 1, 2009, for allowed ASC claims, if modifier = TC, the referring physician name and NPI needs to be present in Loop 2310A/2420F NM1 (NM101=DN, NM102=1, NM103=provider's last name, NM104=provider's first name, NM108=XX, NM109=provider's NPI).
- Claims will be returned as unprocessable (using claim adjustment reason code 16- Claim/service lacks information which is needed for adjudication) for the above services without the ordering/referring physician name or NPI on the claim.
- When returning claims as unprocessable, your Medicare carrier or A/B MAC will use Remittance advice remark codes:
  - N264 - Missing/incomplete/invalid ordering provider name
  - N265 - Missing/incomplete/invalid ordering provider primary identifier
  - N285 - Missing/incomplete/invalid referring provider name, or
  - N286- Missing/incomplete/invalid referring provider primary identifier
- If the NPI of the ordering/referring provider cannot be obtained by the billing provider and it cannot be found on the NPI Registry, the billing provider (in X12N 837 transactions) or the service provider (in NCPDP 5.1 transactions) may be used in the ordering/referring field on a temporary basis and such use is subject to postpayment review.

Background

Prior to January 1, 2008, ASCs could not be paid for diagnostic radiology services since these services were not included on the list of ASC-approved procedures. Effective for services on or after January 1, 2008, several radiology codes were added to the list of payable ASC procedures. Since ASCs may now bill for these services with the TC modifier, claims from ASCs for these services must be in compliance with Section 1883 (q) of the Social Security Act, which requires that physician ordering/referring information be included on all claims for payable services when there had been a referral by a referring physician.

Additional information

To see the official instruction (CR 6129) issued to your Medicare carrier or AB/MAC, refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1572CP.pdf* on the CMS Web site. If you have questions, please contact your Medicare carrier or A/B MAC at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6129
Related Change Request (CR) #: 6129
Related CR Release Date: August 8, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1572CP
Implementation Date: January 5, 2009

CARDIAC SERVICES

Medicare coverage of artificial hearts

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

Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [A/B MACs]) for cardiac-related services and supplies to Medicare fee-for-service (FFS) beneficiaries and Medicare managed care plan beneficiaries.

What you need to know

Change request (CR) 6185, from which this article is taken, announces that Medicare has issued a national coverage determination (NCD) (effective on May 1, 2008), that establishes limited coverage for artificial hearts when implanted in patients enrolled in Medicare-approved clinical studies meeting all of the coverage with evidence development (CED) criteria.

Make sure that your billing staffs are aware of these artificial heart coverage and billing instructions in CR 6185. Details are presented in the *Background* section below.

Background

As determined by the May 19, 1986, the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD), Medicare did not cover the use of artificial hearts prior to May 1, 2008. CR 6185 announces that Medicare has issued an NCD that establishes limited coverage for artificial hearts as a **bridge-to-transplantation** and as **destination therapy** under CED.

This means that Medicare will cover artificial hearts when implanted in patients enrolled in Medicare-approved clinical studies that meet all of the CED criteria listed below.

For your reference, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies, which CMS has determined meet the standards, and address the research questions listed below. Clinical studies CMS has determined meet these requirements will be listed on the CMS Web site at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp*.

Coverage under CED will only apply to artificial hearts that are implanted in the context of one of these approved clinical studies.

To be approved, a clinical study must:

1. Address at least one of the following questions:
   - Were there unique circumstances (such as expertise available in a particular facility or an unusual combination of conditions in particular patients) that affected their outcomes?
   - What will be the average time to device failure when the device is made available to larger numbers of patients?
   - Do results adequately give a reasonable indication of the full range of outcomes (both positive and negative) that might be expected from more widespread use?

and

2. The clinical study must meet all of the following criteria:
   - It must be reviewed and approved by the Food and Drug Administration (FDA).
   - Its principal purpose is to test whether a particular intervention potentially improves the participants' health outcomes.
   - It is well supported by available scientific and medical information, or is intended to clarify or establish the health outcomes of interventions already in common clinical use.
   - It does not unjustifiably duplicate existing studies.
   - Its design is appropriate to answer the research question being asked in the study.
   - It is sponsored by an organization, or individual, capable of executing the proposed study successfully.
   - It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 CFR Part 46 (if a study is FDA-regulated it also must be in compliance with 21 CFR Parts 50 and 56).
   - All aspects are conducted according to appropriate standards of scientific integrity (see *http://www.icmje.org* on the Internet).
   - It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with study participation (CSP) or CED coverage.

Medicare coverage of artificial hearts (continued)

- It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. (Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options).
- It is registered at *http://clinicaltrials.gov/* on the clinical trials Web site by the principal sponsor/investigator as demonstrated by having a national clinical trial control number.
- The research protocol must:
  - Specify the method and timing of public release of all pre-specified outcomes to be measured, including release of outcomes if outcomes are negative or study is terminated early. (The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer- reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors, which can be found at *http://www.icmje.org* on the Internet. However a full report of the outcomes must be made public no later than three years after the end of data collection.)
  - Explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of these populations in the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, it must discuss why these criteria are necessary.
  - Explicitly discuss how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

Billing requirements

Claims related to the routine costs, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in the trial, and claims for managed care beneficiaries receiving services in an approved-clinical study for artificial hearts, should be sent to the appropriate FFS contractor and include the appropriate codes to ensure proper payment.

Institutional and physician/supplier claims for routine services provided in approved artificial heart studies should be billed and processed according to previously issued instructions for clinical trials.

Your Medicare contractor will hold your claims until CR 6185 is implemented and the claims can be correctly processed. Upon successful implementation of CR 6185, Medicare contractors will process the claims and pay interest (as appropriate) on held claims.

CMS has also determined that since coverage is only available under clinical studies, the billing and coding requirements will be the same as those currently used for other Medicare covered clinical trials as included in the NCD effective September 2000. This means that Medicare Advantage (MA) organizations will not be responsible for payment for the artificial heart, or for routine services related to the study, until a plan's capitated rate has been appropriately adjusted to include them.

Coding requirements

The following addresses the institutional and physician/supplier coding requirements for coverage of artificial hearts in clinical trials:

1. **Institutional claims**

   Effective for discharges on or after May 1, 2008, institutional claims for International Classification of Diseases, 9th edition (ICD-9) procedure code 37.52 are only payable when you include ICD-9 diagnosis code V70.7 (examination of participant in clinical research) and condition code 30 (qualifying clinical trial). In addition, value code D4, with an 8-digit national clinical trial number that matches an approved clinical trial on the CMS Web site provided above is also required.

   If your FI or A/B MAC rejects your claim with ICD-9 procedure code 37.52, because it does not meet all of these necessary billing criteria, they will use:

   - **Claim adjustment reason code (CARC) 16 – *Claim/service lacks information, which is needed for adjudication, when ICD-9 procedure code 37.52 is present on a claim without all the required ele*ments.**
   - The following remittance advice remark codes (RARCs), when applicable:

     MA97 – *Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number*, for a missing/incomplete/invalid clinical trial number when ICD-9 procedure code 37.52 is billed.

     M64 – *Missing/incomplete/invalid other diagnosis*, for a missing V70.7 diagnosis code when ICD-9 procedure code 37.52 is billed

     M44 – *Missing/incomplete/invalid condition code*, for a missing condition code 30 when ICD-9 procedure code 37.52 is billed.

Medicare coverage of artificial hearts (continued)

2. Physician/Supplier Claims

Effective for dates of service on or after May 1, 2008, physician/supplier claims for *Common Procedural Terminology (CPT)* code *0051T* must include ICD-9 diagnosis code V70.7 and Healthcare Common Procedure Coding System (HCPCS) modifier Q0 on the same claim line as *CPT* code *0051T*, and must also include the eight-digit clinical trial number that matches an approved clinical trial on the CMS Web site provided above.

If your carrier or A/B MAC returns your claim with *CPT* code *0051T* as unprocessable because it does not meet all of these necessary billing criteria, they will use:

CARC 16 – *Claim/service lacks information, which is needed for adjudication*, when CPT code 0051T is present on a claim without the required diagnosis code or 8-digit clinical trial number.

CARC 4 – *The procedure code is inconsistent with the modifier used or a required modifier is missing*, when there is no HCPCS modifier Q0 appended to *CPT* code *0051T*.

RARC MA 130 – (Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information), when there is no HCPCS modifier Q0 appended to *CPT* code *0051T*.

The following RARCs when applicable:

MA97 – *Missing/ incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number*, for a missing/incomplete/invalid clinical trial number when *CPT* code *0051T* is billed without the eight-digit clinical trial number.

M64 – *Missing/incomplete/invalid other diagnosis*, for a missing V70.7 diagnosis code when *CPT* code *0051T* is billed without the V70.7 diagnosis code.

3. Additional Inpatient and Outpatient Claims Instructions Related to Clinical Trial Patients

Inpatient Claims

Institutional providers billing clinical trial service(s) must report a diagnosis code V70.7 and a condition code 30 regardless of whether all services are related to the clinical trial or not.

Note: HCPCS codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

Outpatient claims

Institutional providers billing clinical trial claims that contain only clinical trial line item services do not have to report the routine modifiers QV or Q1. The presence of condition code 30, along with the absence of modifier QV or Q1 r, is the provider's attestation that **all** line item services on the claim are routine clinical trial services (with the exception of any investigational item on the claim that would be identified with modifier Q0 on or after January 1, 2008, or modifier QA before January 1, 2008.

Institutional providers billing clinical trial claims that contain both clinical trial line item services *and* nonclinical trial line item services, must bill the following elements:

Claims with dates of service **before** January 1, 2008:

- HCPCS modifier QV **only** on line items related to the clinical trial
- Diagnosis code V70.7 (Examination of participant in clinical trial) reported as the *secondary* diagnosis
- Condition code 30

Claims with dates of service **on or after** January 1, 2008:

- HCPCS modifier Q1 **only** on line items related to the clinical trial
- Diagnosis code V70.7 (Examination of participant in clinical trial) reported as the **secondary** diagnosis
- Condition Code 30

Message to principal investigator

Finally, if you are the principal investigator (PI) of an artificial heart clinical study seeking Medicare payment, you should submit the following documentation to CMS (who will notify you when the review is complete):

- The complete study protocol (must be dated or identified with a version number)
- The protocol summary
- A statement that the submitted protocol version has been agreed upon by the FDA
- A statement that the above study standards are met
- A statement that the study addresses at least one of the above questions related to artificial hearts

Medicare coverage of artificial hearts (continued)

- Complete contact information (phone number, email address, and mailing address)
- The Clinicaltrials.gov registration number.

The PI should send this information to:

Director, Coverage and Analysis Group
Centers for Medicare & Medicaid Services
Re: Artificial Heart
Mailstop C1-09-06
7500 Security Boulevard
Baltimore, MD 21244-1850

Additional information

CR 6185 was issued in two separate transmittals, one for conveying changes to the Medicare NCD Manual and one for changes to the *Medicare Claims Processing Manual*. These transmittals are available respectively, on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R95NCD.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1592CP.pdf*.

The revised portions of each manual are attached to the respective transmittals.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6185
Related Change Request (CR) Number: 6185
Related CR Release Date: September 10, 2008
Related CR Transmittal Number: R95BP and R1593CP
Effective Date: May 1, 2008
Implementation Date: December 1, 2008

Prothrombin time monitoring for home anticoagulation management

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

Provider types affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs] or Part A/B Medicare administrative contractors [A/B MACs]) for home prothrombin time (PT) and international normalized ratio (INR) anticoagulation management monitoring services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6138, and alerts providers that effective for claims with dates of service on and after March 19, 2008 the Centers for Medicare & Medicaid Services (CMS) revised its national coverage determination (NCD) limits and will expand the population eligible for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin. See the *Key points* section of this article for details.

Background

The PT test is an in-vitro test to assess coagulation. PT testing and its normalized correlate, the INR, are the standard measurements for therapeutic effectiveness of warfarin therapy. warfarin, Coumadin®, and others, are self-administered, oral anticoagulant, or blood thinner, medications that affect a person's vitamin K-dependent clotting factors.

Currently, Medicare's NCD at 190.11 of the *NCD Manual* limits coverage of home PT/INR monitoring to anticoagulation management for patients with mechanical heart valves who are on warfarin. The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See *http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410_32.pdf* on the CMS Web site.) and the following requirements must be met:

1. The patient must have been anticoagulated for at least three months prior to use of the home INR device.
2. The patient must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home.
3. Self-testing with the device should not occur more frequently than once a week.

CMS received a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. CR 6138 is a result of that request.

PT monitoring for home anticoagulation management (continued)

Key points of CR 6138

Effective for claims with dates of service on and after March 19, 2008, CMS revised its NCD to provide for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) and all of the following requirements must be met:

1. The patient must have been anticoagulated for at least three months prior to use of the home INR device
2. The patient must undergo a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home
3. The patient continues to correctly use the device in the context of the management of the anticoagulation therapy following the initiation of home monitoring, and
4. Self-testing with the device should not occur more frequently than once a week.

Note: Applicable HCPCS Codes G0248, G0249, and G0250 will continue to be used for claims processing purposes for PT/INR. With the July 2008 outpatient code editor (OCE) and Medicare physician fee schedule updates, the descriptors of these codes will change to reflect the revised coverage policy

The following revised descriptors reflect the expanded NCD criteria and are effective for services on or after March 19, 2008, as follows:

- **Long descriptor G0248**: Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing prior to its use.
- **Short descriptor G0248**: Demonstrate use home INR mon
- **Long descriptor G0249**: Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week
- **Short descriptor G0249**: Provide INR test mater/ equipm
- **Long descriptor G0250**: Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes face-to-face verification by the physician that the patient uses the device in the context of the management of the anticoagulation therapy following initiation of the home INR monitoring; not occurring more frequently than once a week.
- **Short descriptor G0250**: MD INR test revie inter mgmt

Note: Test materials continue to include four tests. Frequency of reporting requirements shall remain the same.

Note: Porcine valves are not included in this NCD, so Medicare will not make payment on home INR monitoring for patients with porcine valves unless covered by local Medicare contractors.

Note: This NCD is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17, of the *NCD Manua*l.

The following are applicable diagnosis codes to be used when submitting claims to Medicare contractors:

- For services furnished on or after March 19, 2008, the applicable ICD-9-CM diagnosis codes for this benefit are:
  - V43.3 (organ or tissue replaced by other means; heart valve)
  - 289.81 (primary hypercoagulable state)
  - 451.0-451.9 (phlebitis & thrombophlebitis)
  - 453.0-453.3 (other venous embolism & thrombosis)
  - 415.11-415.19 (pulmonary embolism & infarction), or
  - 427.31 (atrial fibrillation [established] [paroxysmal])

Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with CR 6138. Denied claims are subject to appeal. When denying such claims, your Medicare carrier, FI or A/B MAC will use the following codes:

- Remittance advice remark code N386, "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp* on the CMS Web site. If you do not have Web access, you may contact the contractor to request a copy of the NCD."
- Claim adjustment reason code 50 will be used: "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

Providers should be aware that your Medicare contractor will assign liability for the denied charges to you unless documentation of an advance beneficiary notice (ABN) is present on the claim. Also, your contractor will not search for claims but will adjust inappropriately denied claims with dates of service March 19, 2008, through the implementation date of CR 6138, that are brought to their attention.

Additional information

CR 6138 was issued in two transmittals, i.e., one for the *NCD Manual* and one for the Medicare *Claims Processing Manual*. These transmittals are available at

PT monitoring for home anticoagulation management (continued)

http://www.cms.hhs.gov/Transmittals/downloads/R90NCD.pdf and *http://www.cms.hhs.gov/Transmittals/downloads/R1562CP.pdf*, respectively, on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6138
Related Change Request (CR) #: 6138
Related CR Release Date: July 25, 2008
Effective Date: March 19, 2008
Related CR Transmittal #: R1562CP and R90NCD
Implementation Date: August 25, 2008

COMPETITIVE AQUISITION PROGRAM

Medicare Part B drug CAP postponed for 2009

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

Provider types affected

Physicians who are currently participating in the 2008 Competitive Acquisition Program (CAP) for Part B drugs and biologicals and physicians who are interested in participating in the program in 2009.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has postponed the CAP for 2009, which was to begin on January 1, 2009.

Caution – what you need to know

The contract with the current approved CAP vendor, BioScrip Inc., will remain in effect through December 31, 2008. Physicians who are currently participating in the CAP must transition back into the average sales price (ASP) method of acquiring part B drugs for services provided on or after January 1, 2009. Claims processing for the CAP will continue past January 1, 2009, for claims with dates of service through December 31, 2008. The physician election period for 2009,that was scheduled for October 1, to November 15, 2008 will not be held.

Go – what you need to do

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

Background

This article contains information about the Competitive Acquisition Program (CAP). The CAP is mandated by Section 303(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which requires the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Section 303(d) of the MMA may be viewed at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/303d.pdf* on the CMS Web site.

CAP is postponed for 2009

Earlier this year, CMS accepted bids for vendor contracts for the 2009-2011 CAP. While CMS received several qualified bids, contractual issues with the successful bidders resulted in CMS postponing the 2009 program. As a result, CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008, and the 2009 CAP physician election period scheduled for October 1, to November 15, 2008, will not be held. CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008.

Drug ordering

The contract with the current approved CAP vendor, BioScrip Inc., will remain in effect through December 31, 2008. Participating CAP physicians must continue to obtain CAP drugs from the approved CAP vendor if the drugs are to be administered on or before December 31, 2008. After January 1, 2009, physicians must obtain and bill for drugs through the ASP process, and physicians will also be responsible for collecting applicable deductible and coinsurance from Medicare beneficiaries. Physicians should be mindful of the anticipated date of a CAP drug's administration when ordering drugs for administration in December of 2008.

Unused CAP drugs that remain at a physician's office belong to the approved CAP vendor. They may be returned to the approved CAP vendor, if permissible by state law, or purchased from the approved CAP vendor for administration under the ASP methodology for dates of service after January 1, 2009. Unused CAP drugs cannot be given away to a physician. Participating CAP physicians should contact the approved CAP vendor as early as possible to determine whether buying or returning unused drugs is preferable, and take steps to minimize the amount of unused drugs at their offices. Contact information for the approved CAP vendor is available at *http://www.bioscrip.com/* on the Internet.

Medicare Part B drug CAP postponed for 2009 (continued)

Claims processing and billing

Participating CAP physicians must submit CAP claims to their local carrier or Medicare administrative contractor (MAC) within 30 days of CAP drug administration. After January 1, 2009, participating CAP physicians can continue to submit CAP claims for dates of service through December 31, 2008.

Drugs acquired through ASP for administration on or after January 1, 2009, must be billed through ASP, and physicians should not use any of the CAP modifiers (J1, J2, J3, M2) in these claims.

Post-payment review

The purpose of the CAP post-payment review process is to verify the administration of a CAP drug or biological in order to assure that CAP drug payments are being made appropriately. Participating CAP physicians may receive requests from the CAP designated carrier, Noridian Administrative Services (NAS), for documentation about specific claims to support the CAP post payment review process.

In 2009, this process will continue for claims with dates of service on or before December 31, 2008. NAS will continue to send post payment letters to physicians, and physicians must submit requested documentation within 30 days.

CAP training during the transition

This fall, CMS will provide guidance and training for participating CAP physicians on how to transition out of the program at the end of the year. This information will be posted at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp* on the CMS CAP 'Information for Physicians' Web site. Announcements will also be sent via the dedicated CAP listserv and the Medicare Physicians listserv. Listserv registration is available at *https://list.nih.gov/* on the Internet. Please search that Web site for CMS-CAP-PHYSICIANS-L and PHYSICIANS-L in order to subscribe to the listserv.

CMS also plans to seek feedback on the CAP from current and former participating CAP physicians, as well as other parties. CMS is interested in hearing from the public about a range of issues, including, but not limited to, the categories of drugs provided under the CAP, the distribution of areas that are served by the CAP, and procedural changes that may increase the program's flexibility and appeal to potential vendors and physicians.

Information about how to submit comments will be available at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/* on the CMS Web site.

Additional information

For original overview information on the CAP, please review CR 4064 at *http://www.cms.hhs.gov/Transmittals/downloads/R777CP.pdf* and its related article: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf* on the CMS Web site.

For original background information on the CAP, please review CR4309 at: *http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf* and its related article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf* on the CMS Web site. For the original background information on the CAP physician election process, please review CR 4404 at *http://www.cms.hhs.gov/transmittals/downloads/R932CP.pdf* and its related article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf* on the CMS Web site.

For background information on the CAP post payment review process, please review CR 5546 at *http://www.cms.hhs.gov/Transmittals/downloads/R1207CP.pdf* on the CMS Web site.

Further information about the CAP is available at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/* on the CMS CAP Web site.

Additional information about the approved CAP vendor is available on their Web site at *http://www.bioscrip.com/* and at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp* on the CMS CAP Web site. Additional information about the CAP designated carrier, NAS, is available at *http://www.noridianmedicare.com/cap_drug* on their Web site.

MLN Matters Number: SE0833
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

October 2008 Competitive Acquisition Program drug list update

The list of drugs available under the Competitive Acquisition Program (CAP) has been updated and is now available in the "Downloads"' section on the CMS CAP "Information for Physicians" page, which may be accessed at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp*.

The following drug has been added to the CAP effective October 1, 2008: Vivitrol® naltrexone (J2315).

Source: PERL 200809-07

2009 Competitive Acquisition Program postponement announcement

The Centers for Medicare & Medicaid Services (CMS) has announced the postponement of the 2009 Medicare Part B Competitive Acquisition Program (CAP). The program will continue through December 31, 2008.

Earlier this year, CMS accepted bids for vendor contracts for the 2009-11 CAP. While CMS received several qualified bids, contractual issues with the successful bidders resulted in CMS postponing the 2009 program. As a result, CAP physician election for participation in the CAP in 2009 will not be held, and CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008.

Later this fall, CMS will provide additional guidance for participating CAP physicians on how to transition out of the program. This information will be posted on the CMS CAP physician's page at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp*.

CMS also plans to seek feedback on the CAP from participating physicians, potential vendors, and other interested parties. CMS will assess the information and consider implementing changes to the CAP before proceeding with another bid solicitation. As part of the process, CMS is interested in hearing from the public about a range of issues, including, but not limited to, the categories of drugs provided under the CAP, the distribution of areas that are served by the CAP, and procedural changes that may increase the flexibility and appeal of the program to potential vendors and physicians.

Information about how to submit comments will be available at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/*.

Visit the Medicare Learning Network – it's free!

Source: PERL 200809-15

Revisions to the Competitive Acquisition Program for Part B drugs and biologicals

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

Provider types affected

Physicians and other providers who bill Medicare carriers and Medicare administrative contractors (A/B MAC) for Competitive Acquisition Program (CAP) claims for part B drugs and biologicals provided to Medicare beneficiaries.

What you need to know

CR 6124, effective with claims processed on or after January 5, 2009, revises Medicare systems to allow individual CAP claims with different prescription order numbers to not be denied as duplicate claims though they are for the same patient, contain the same date of service, and contain the same Healthcare Common Procedure Coding System (HCPCS) drug code. This will also apply to an individual CAP claim that contains multiple lines that appear to be duplicates except for different prescription order numbers.

Background

Because of a systems error, Medicare carriers and A/B MACs may be denying CAP claims that contain the same beneficiary, date of service, and HCPCS drug code, but have different prescription order numbers.

CR 6124, effective for claims processed on or after January 5, 2009, instructs Medicare carriers, A/B MACs, and the CAP designated carrier to revise duplicate claim edits to allow separate CAP claims with different prescription order numbers to be considered as non-duplicative claims even though they are for the same beneficiary, date of service, and HCPCS drug code. This will also apply to an individual claim that contains multiple lines that appear to be duplicates except for different prescription order numbers. If you have claims that were incorrectly denied prior to January 5, 2009, your contractor will adjust those claims if you bring them to their attention.

Additional information

You may view CR 6124 at *http://www.cms.hhs.gov/Transmittals/downloads/R1577CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6124
Related Change Request (CR) #: 6124
Related CR Release Date: August 15, 2008
Effective Date: Claims processed on or after January 5, 2009
Related CR Transmittal #: R1577CP
Implementation Date: January 5, 2009

Part B Drug Competitive Acquisition Program Quarterly Drug Update

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

Provider types affected

Physicians billing Medicare administrative contractors (A/B MAC) and carriers for Medicare Part B drugs, and approved Competitive Acquisition Program (CAP) vendors billing the CAP designated carrier.

What providers need to know

This article is based on change request (CR) 6158, which provides notice that there will be a Part B CAP Quarterly Drug List Update effective October 1, 2008. When available, the October 2008, list of drugs supplied under the CAP will be posted at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopofPage* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Section 303 (d), which may be found at *http://www.cms.hhs.gov/MMAUpdate* on the Centers for Medicare & Medicaid Services (CMS) Web site) required the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians were given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process.

Key points of CR 6158

- A quarterly update of the CAP drug list will become effective on October 1, 2008.
- Payment amounts for drugs added to the CAP drug list as a result of the update will be implemented for claims with dates of service beginning October 1, 2008 per the new file.

Additional information

To see the official instruction (CR 6158) issued to your Medicare A/B MACs and carriers visit *http://www.cms.hhs.gov/Transmittals/downloads/R1576CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

For more information about the Competitive Acquisition for Part B Drugs & Biologicals, refer to *http://www.cms.hhs.gov/CompetitiveAcquisforBios* on the CMS Web site.

MLN Matters Number: MM6158
Related Change Request (CR) #: 6158
Related CR Release Date: August 15, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1576CP
Implementation Date: October 6, 2008

DIAGNOSTIC SERVICES

Indicator for the technical component of purchased diagnostic services

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

Provider types affected

Physicians and suppliers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare administrative contractors [A/B MACs]) for diagnostic services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6122 which provides instructions to your carrier or AB MAC on how to process claims for diagnostic services when there is no entry (either an indication in block 20 of the CMS-1500 or a claim or line level PS1 segment on the 837P X12 4010A1 electronic format) on the claim to indicate that whether the diagnostic services were purchased.

Caution – what you need to know

Carriers and AB MACs will adjudicate a claim lacking an entry for the "Yes/No" indicator or lacking the PS1 segment for a diagnostic service as if it were not a purchased service.

Go – what you need to do

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

Background

Medicare carrier jurisdictional rules for purchased diagnostic tests/interpretations were changed in April 2005 to allow suppliers to bill their local carriers for diagnostic test/interpretation services (and receive the correct payment amount) regardless of the location where the services were performed. In addition, because all purchased diagnostic services are paid under the Medicare Physician Fee Schedule (MPFS), the diagnostic services are subject to the same payment rules as all other services paid under the MPFS, as well as to the jurisdictional rules for that fee schedule.

Only laboratories, physicians, and independent diagnostic testing facilities (IDTF) may bill for purchased tests and interpretations.

A claim development issue sometimes arises when there is no indication whether the service was purchased,

Indicator for the TC of purchased diagnostic services (continued)

and the Centers for Medicare & Medicaid Services (CMS) has found that claims have been returned as unprocessable needlessly due to the fact that the biller did not indicate whether the TC of a diagnostic service had been purchased. CMS has also found over time that if there was no indication in Block 20 on the CMS-1500 form or claim or line level PS1 segment on the electronic claim, it was likely that the service had not been purchased. Therefore, CMS is issuing CR 6122 to decrease the volume of claims returned to physicians and suppliers.

CR 6122 instructs carriers and AB MACs to assume that a diagnostic service is not purchased if there is no entry in either Block 20 on the CMS-1500 form or there is no PS1 segment on the 837P X12 4010A1 electronic format. Carriers and A/B MACs will adjudicate such a claim for a diagnostic service as if it were not a purchased service.

Please note that if there is no indication that the service was purchased and CMS later finds that, indeed, the service had been purchased, this could result in finding of a false claim. Also note that a professional component (PC) service is not relevant for this policy. The purchase price of the PC portion is not, and should not be, a part of the adjudicative process of the technical component.

Additional information

The official instruction, CR 6122, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1589CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6122
Related Change Request (CR) #: 6122
Related CR Release Date: September 8, 2008
Effective Date: December 8, 2008
Related CR Transmittal #: R1589CP
Implementation Date: December 8, 2008

DRUGS AND BIOLOGICALS

October 2008 average sales price Medicare Part B drug pricing files and revisions to prior quarterly pricing files

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

Provider types affected

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6175, from which this article is taken, instructs Medicare contractors to download and implement the October 2008 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2008, April 2008, January 2008, and October 2007 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

The ASP methodol*ogy* is based on quarterly data that drug manufacturers submit to CMS, which CMS then provides (quarterly) to Medicare contractors (carriers, *DME* MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs. Please note that payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under Section 1847A.

October 2008 ASP Medicare Part B drug pricing revisions (continued)

For the purpose of identifying "single source drugs" and "biological products" subject to payment under Section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

- The Food and Drug Administration (FDA) approval
- Therapeutic equivalents as determined by the FDA
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are **not** two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of not otherwise classified (NOC) HCPCS codes.

Average sales price methodology

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for:

- End-stage renal disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities)
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are determined in the same manner that the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits are not being updated in 2008**. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When furnished in a hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP; but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood-clotting factor when the blood-clotting factor is not included on the ASP file.**

  Note: At their discretion, Medicare contractors may contact CMS to obtain payment limits for drugs and biologicals that are not included in the quarterly ASP or NOC files, or otherwise made available on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the

October 2008 ASP Medicare Part B drug pricing revisions (continued)

payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.

- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.
- On or after September 16, 2008, the October 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after September 16, 2008, the October 2008 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR 6049 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
October 2008 ASP and NOC files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim makes these determinations.

Drugs furnished during filling or refilling an implantable pump or reservoir

Physicians (or a practitioner described in Section 1842(b) (18) (C) of the Social Security Act) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

Please be aware that your contractors will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional Information

You may find the official instruction, CR 6175, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1595CP.pdf* on the CMS Web site

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6175
Related Change Request (CR) Number: 6175
Related CR Release Date: September 12, 2008
Related CR Transmittal Number: R1595CP
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

EVALUATION AND MANAGEMENT

Medicare payments for Part B mental health services

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

Provider types affected

Physicians, providers and suppliers submitting claims to Medicare carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for mental health services provided to Medicare beneficiaries.

Provider action needed

As recommended by the Office of Inspector General's (OIG's) April 2007 report, this special edition article is being provided to explain Medicare's guidelines for payment of Part B mental health services including: qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E&M) services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment. It is important that providers of mental health services to Medicare beneficiaries know the policies guiding the provision of and payment for such services. While instructions on these various topics related to mental health services furnished to Medicare beneficiaries have already been provided under several Medicare manuals, this special article consolidates and summarizes these manual instruction policy guidelines.

Background

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) as recommended by the Office of Inspector General's (OIGs) April 2007 Report titled: "Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity, Documentation and Coding." You may review a copy of this report at *http://www.oig.hhs.gov/oei/reports/oei-09-04-00220.pdf* on the Internet.

In that report the OIG's study found that forty-seven percent of the mental health services allowed by Medicare in 2003 did not meet program requirements, resulting in approximately $718 million in improper payments. Medicare allowed approximately $2.14 billion in 2003 for Part B mental health services; 47 percent of these services did not meet Medicare requirements. Miscoded and undocumented services accounted for 26 and 19 percent of all mental health services in 2003, respectively. Medically unnecessary services and services that violated the "incident to" rule each accounted for 4 percent of all mental health services in 2003. Psychiatrists typically billed for procedures involving evaluation and management (E&M) services, while psychologists and clinical social workers were more likely to bill for individual and group psychotherapy.

Eliminating error rates has been a goal of CMS. Each year, CMS measures Medicare's national fee-for-service paid claims error rates in addition to more specific error rates based on Medicare contractor jurisdictions, services, and provider specialties. A key part of the CMS effort for reducing/eliminating improper payments has been to increase the level of detail of the error rate information to highlight the areas in need of improvement in the case of mental health services, such as medical necessity, documentation, and coding.

This special edition article explains Medicare's guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for E&M services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.

Medicare coverage for Part B mental health services

General provisions of the Social Security Act (sometimes referred to as the Act) govern Medicare reimbursement of all services, including mental health services. The Social Security Act (Section 1862(a)(1)(A); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the internet) states that no payment may be made for services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." The Social Security Act (Section 1833(e); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the internet) requires that providers furnish "such information as may be necessary to determine the amounts due" to receive Medicare payment. Related regulations at 42 CFR subsection 411.15(k)(1) and 424.5(a)(6) implement these provisions of the Medicare law.

Medicare Part B covers physicians' services, outpatient care, and other services not covered by Medicare's Hospital Insurance (Part A). In general, beneficiaries are responsible for coinsurance of 20 percent of the approved amount for most Part B services; however, the Act limits payments to 62.5 percent of the expenses (Medicare-approved amount) for mental health services (Social Security Act, Section 1833(c); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the internet). Specifically, the law limits payments for incurred expenses in connection with the treatment of "mental, psychoneurotic, and personality disorders."

The Social Security Act (Section 1848(a)(1); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet) established the Medicare physician fee schedule (MPFS) as the basis for Medicare reimbursement for all physician services beginning in January 1992. The Social Security Act (Section 1848(c)(5); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the internet) required the Secretary of the Department of Health and Human Services to develop a uniform coding system for all physician services. The American Medical Association's (AMA) "*Cur-*

Medicare payments for Part B mental health services (continued)

rent Procedural Terminology" (*CPT*) maintains a numeric coding system for physicians' services, including mental health services. In 1983, the CMS adopted *CPT* as part of Medicare's Healthcare Common Procedure Coding System (HCPCS) and mandated that providers use HCPCS to report physicians' services to Medicare. This was reaffirmed in the Medicare physician fee schedule final rule, dated November 25, 1991, Vol. 56, No. 227, p. 59527.

Qualification requirements for mental health providers

Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered, mental health professionals must be working within their state scope of practice act and licensed or certified to perform mental health services by the state in which the services are performed. Qualification requirements for mental health professionals are listed below.

A qualified physician must:

- Be legally authorized to practice medicine and surgery by the state in which he/she performs his/her services, and
- Perform his/her services within the scope of his/her license as defined by state law.

Also, see the Medicare General Information, Eligibility and Entitlement Manual (Pub. 100-01), Chapter 5, Section 70 at *http://www.cms.hhs.gov/manuals/downloads/ge101c05.pdf* on the CMS Web site for the definition of a physician, and see the *Medicare Benefits Policy Manual*, Chapter 15, Section 30 at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site for the covered services of a physician.

A clinical psychologist (CP) must:

- Hold a doctoral degree in psychology; and
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Effective July 1, 1990, the diagnostic and therapeutic services of CPs and services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. However, the CP must be legally authorized to perform the services under applicable licensure laws of the state in which they are furnished.

Clinical psychologist services that may be covered are:

- Diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with state law and/or regulation.

Medicare carriers and MACs pay all qualified CPs based on the MPFS for the diagnostic and therapeutic services. (Psychological tests by practitioners who do not meet the requirements for a CP may be covered under the provisions for diagnostic psychological and neuropsychological tests as described in the *Medicare Benefits Policy Manual*, Chapter 15, Section 80.2 (see *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site).

Services and supplies furnished incident to a CP's services are covered in the same manner and under the same requirements that apply to services incident to a physician's services, as described in the Medicare *Benefits Policy Manual*, Chapter 15, Section 60. These services must be:

- Mental health services that are commonly furnished in CPs' offices
- An integral, although incidental, part of professional services performed by the CP
- Performed under the direct personal supervision of the CP; i.e., the CP must be physically present and immediately available
- Furnished without charge or included in the CP's bill, and
- Furnished by an employee of the CP (or an employee of the legal entity that employs or contracts with the supervising CP).

The services of CPs are not covered if the service is otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by state law to perform them. For example, the Social Security Act (Section 1862(a)(1)(A)); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the internet) excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, even though the services are authorized by state law, the services of a CP that are determined to be not reasonable and necessary are not covered. Additionally, any therapeutic services that are billed by CPs under *CPT* psychotherapy codes that include medical evaluation and management services are not covered.

Refer to the *Medicare Benefits Policy Manual*, Chapter 15, Section 170 at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site for the covered services of a clinical psychologist.

A clinical social worker (CSW) must:

- Possess a master's or doctor's degree in social work, and
- Have performed at least two years of supervised clinical social work, and
- Be licensed or certified as a clinical social worker by the state in which the services are performed, or
- In the case of an individual in a state that does not provide for licensure or certification, the individual must be licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed; and the CSW must have completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, SNF, or clinic.

The Social Security Act (Section 1861(hh)(2); see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the internet) defines "clinical social worker services" as those services that the CSW is legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses. Services furnished to an inpatient of a hospital or an inpatient of a

Medicare payments for Part B mental health services (continued)

SNF that the SNF is required to provide as a requirement for participation are not included. The services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service.

Refer the *Medicare Benefits Policy Manual*, Chapter 15, Section 170 at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site for the covered services of a clinical social worker. Also see the Social Security Act (Section 1861(hh)) at *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet.

A nurse practitioner (NP) must:

- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law; and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or
- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

NPs who applied to be a Medicare billing supplier for the first time on or after January 1, 2001, and prior to January 1, 2003, must meet the requirements as follows:

- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

NPs applying to be a Medicare billing provider for the first time on or after January 1, 2003, must meet the requirements as follows:

- Possess a master's degree in nursing
- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, and
- Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

Refer to the *Medicare Benefits Policy Manual*, Chapter 15, Section 200 at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site for the covered services of a nurse practitioner.

A clinical nurse specialist (CNS) must:

- Be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law
- Have a master's degree in a defined clinical area of nursing from an accredited educational institution, and
- Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for a CNS.

Refer to the *Medicare Benefits Policy Manual*, Chapter 15, Section 210 at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site for the covered services of a clinical nurse specialist.

A physician assistant (PA) must:

- Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA), or
- Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA), and
- Be licensed by the state to practice as a physician assistant.

Refer to the *Medicare Benefits Policy Manual*, Chapter 15, Section 190 at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site for the covered services of a physician assistant.

Outpatient mental health treatment limitation

Regardless of the actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for these services. The limitation is called the outpatient mental health treatment limitation.

Expenses for diagnostic services (e.g., psychological and neuropsychological testing and evaluation to diagnose the patient's illness) are not subject to this limitation. This limitation applies only to therapeutic services and to diagnostic psychological and neuropsychological tests performed to evaluate the progress of a course of treatment for a diagnosed condition.

Incident to services

Incident to a physician's professional services for outpatient services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Charges for such services and supplies must be included in the physicians' bills. Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct supervision by a physician or those nonphysician practitioners (NPPs) who may bill for incident to services.

There are statutory exceptions to the requirement that services follow the rules of their own benefit category when one exists. Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists have specific benefits enumerated under the Social Security Act. Those physicians/NPPs are allowed to: 1) bill directly for services they personally perform, or 2) have their services billed incident to the services of another physician/NPP, or 3) bill for the services of staff provided incident to their own services. The services provided as professional services incident to the services of another physician/NPP must represent the service covered under their statutory benefit and also comply with all the requirements for services incident to the services of a physician/NPP. Where the policies of the two benefit categories conflict and are not resolved in Medicare manuals, Medicare

Medicare payments for Part B mental health services (continued)

contractors will apply the policies that, in the judgment of the contractor, best serve the beneficiary.

The benefit differs for therapists and clinical social workers. Due to statutory provisions, physical therapists, occupational therapists, and clinical social workers may 1) bill directly for services they personally perform, or, 2) have their services billed incident to the services of a physician/NPP. However, the benefit for their services does not allow them to bill for the services of staff furnished as an incident to the services that they personally provide.

Speech-language pathologists may have their services billed incident to the services of a physician/NPP, but the benefit for their services does not allow them to bill for the services of staff as incident to the services they personally provide.

All of the requirements for services incident to must be followed before payment is appropriate. For more details on "incident to" services, see the *Medicare Benefit Policy Manual*, Chapter 15, Section 60 at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* on the CMS Web site.

Auxiliary personnel as it relates to "incident to" services means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide when the service(s) is (are) performed. However, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the time the aide is performing service(s).

Reasonable and necessary services

The Social Security Act (Section 1862(a)(1)(A); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the internet) states that all Medicare Part B services, including mental health services, must be "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service.

Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient psychiatric care. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

Reasonable expectation of improvement

Services must be for the purpose of diagnostic study or be reasonably expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that a patient's condition would deteriorate, relapse further, or require hospitalization if treatment services are withdrawn, this criterion would be met.

General principles of medical record documentation

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time
- Communication and continuity of care among providers involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations, and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible
- Documentation of each patient encounter should include:
    - Reason for encounter and relevant history
    - Physical examination findings and prior diagnostic test results
    - Assessment, clinical impression, and diagnosis
    - Plan for care, and
    - Date and legible identity of observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible for treating and/or consulting physician
- Appropriate health risk factors should be identified
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented, and
- *CPT* and ICD-9-CM codes reported on the health insurance claim should be supported by documentation in the medical record.

Coding errors can occur from 'upcoding', 'downcoding', or miscoding. Upcoded services are billed at a level higher than the actual level of the service performed. For example, a 20- to 30-minute individual psychotherapy service billed as a 45- to 50-minute service is an upcoded service. Conversely, a downcoded service is billed at a lower level than the actual level of the service performed.

The OIG's report found that the majority of miscoded individual psychotherapy claims lacked documentation to

Medicare payments for Part B mental health services (continued)

justify the time billed. Individual psychotherapy can be billed as one of three time periods: 20 to 30 minutes, 45 to 50 minutes, or 75 to 80 minutes. Because reimbursement of psychotherapy services is based on face-to-face time spent with the patient, practitioners are required to document in the medical record the time spent with the patient. Providers must note that Section 1833(e) of the Act requires that providers furnish "such information as may be necessary to determine the amounts due" to receive Medicare payment."

One of the principal causes of miscoded services occurs because no time is documented. When this happens, the services should be billed at the lowest possible time period. Miscoding for psychotherapy services also occurs when documentation in the medical record indicates that the actual services were not psychotherapy but totally different services, such as E&M services, medication management, psychological evaluation, and group psychotherapy. Medication management may be billed under one of two codes: *90862* (psychiatric pharmacologic management) or M0064 (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders).

Evaluation & management (E&M) services – coding and documentation guidelines

Practitioners who provide E&M services in conjunction with psychotherapy need to document the E&M services and psychotherapy in the medical record. If only psychotherapy is documented, the practitioners should use codes for services solely for psychotherapy. Providers should thoroughly familiarize themselves with documentation guidelines for E&M services. These guidelines are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp#TopOfPage* on the CMS Web site.

Miscoding for E&M services can occur when the E&M services are billed at a higher level than the medical record documentation supports. E&M services levels vary based on:

- The extent of the patient history obtained
- The extent of the examination performed, and
- The complexity of the medical decisionmaking.

Additional causes of E&M coding errors reported in the OIG report included billing E&M services:

- For an initial visit when the services were rendered during a subsequent visit. Reimbursement rates for subsequent E&M visits are typically less than those for initial visits.
- When the services should have been billed as psychiatric diagnostic interview examinations, consultations, or psychotherapy, which are reimbursed at a lower rate.
- Where the place of service (e.g., inpatient) does not match the place of service indicated in the medical record (e.g., outpatient).

Psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment

Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (*CPT* codes *90801 – 90802*, *90804 – 90899* under the Psychiatry section), overview and definitions for central nervous system assessment (*CPT* codes *96100 – 96117*), and health and behavior assessment (*CPT* codes *96150 – 96155*) as described in the Physicians' *Current Procedural Terminology*, which is an annual publication developed by the American Medical Association (AMA) and available from the AMA at *http://www.ama-assn.org/ama/pub/category/3113.html* on the Internet.

Additional information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

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Critical care visits and neonatal intensive care

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the August 2008 Medicare B Update! pages 12-17.

Note: This article was revised on July 23, 2008, to reflect additional changes made to change request (CR) 5993 on July 9. CR 5993 was revised to correctly state the payment policy regarding emergency department visits on the same day as critical care services for the same patient by the same physician, to clarify reporting of services supplied to neonates, infants, and children by referring providers to consult the *American Medical Association's Current Procedural Terminology*, and to correct the information on how to calculate critical care time from the paragraph before Table 1 of this article. There are additional minor clarifications.

Provider types affected

Physicians and qualified nonphysician practitioners (NPP) who bill Medicare carriers and Medicare administrative contractors (A/B MAC) for critical care services provided to Medicare beneficiaries.

What you need to know

CR 5993, from which this article is taken, revises the *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care [Codes *99291 - 99292*]), replacing all previous critical care payment policy language in the Section and adding general Medicare evaluation and management (E/M) payment policies that impact payment for critical care services.

Specifically, CR 5993:

- Explains the definition of, and how to bill for, critical care services, and includes the *American Medical Association* (*AMA*) *Current Procedural Terminology* (*CPT*) definitions of critical care and critical care services.
- Adds a new *CPT* code for 2008 (*36591*) which replaces code *36540*. Code *36591* identifies a bundled vascular access procedure when performed with a critical care service.

Make sure that your billing staffs are aware of these revisions.

Background

CR 5993, from which this article is taken, explains the definition of critical care services and how to correctly bill for these services. It discusses medically necessary services, full physician attention, counting the hours of critical care billing, performance of other evaluation and management (E/M) services on the same day as critical care services, group practice issues, services by a qualified nonphysician practitioner (NPP), bundled procedures, global surgery issues, ventilation management, teaching physician issues, physician services off the unit/floor, split/shared services, unbundled procedures, and inappropriate use of time and family counseling and discussions.

The following summarizes the information contained in CR 5993 and in *Medicare Claims Processing Manual* Chapter 12, Section 30.6.12, which is an attachment to CR 5993.

Use of critical care codes (*CPT* codes *99291-99292*)

Critical care is defined as a physician's (or physicians') direct delivery of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single, or multiple, vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include (but are not limited to):

- Central nervous system failure
- Circulatory failure
- Shock
- Renal, hepatic, metabolic, and/or respiratory failure.

Although it typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

You should remember that providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. While critical care is usually given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services that you provide in any location as long as this care meets the critical care definition.

When all these criteria are met, Medicare contractors (carriers and A/B MACs) will pay for critical care and critical care services that you report with *CPT* codes *99291* and *99292* (described below).

Critical care services and medical necessity

Critical care services must be reasonable and medically necessary. As explained above, critical care services encompass both the treatment of "vital organ failure" and "prevention of further life threatening deterioration in the patient's condition." Therefore, delivering critical care in a moment of crisis, or upon being called to the patient's bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient's condition, in the threat of imminent deterioration; while not necessarily emergent, is required.

In this context, examples of patients whose medical conditions may warrant critical care services would include:

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm reSection. Two days after surgery he requires fluids and vasopressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67 year old female patient is three days status post mitral valve repair. She develops petechiae, hypotension, and hypoxia requiring respiratory and circulatory support.
3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of chronic obstructive pulmonary disease (COPD) becomes hypoxic and hypotensive two days after admission.

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4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

You should not consider that the provision of care to a critically ill patient is automatically a critical care service just because the patient is critically ill or injured. To this point, each physician providing critical care services to a patient during the critical care episode of an illness or injury must be managing one or more of the critical illness(es) or injury(ies) in whole, or in part.

In this context, examples of scenarios in which a patient's medical condition may not warrant critical care services would include:

1. A dermatologist evaluating and treating a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist.
2. Daily management of a patient on chronic ventilator therapy unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.
3. Management of dialysis or care related to dialysis for a patient receiving end-stage renal disease (ESRD) hemodialysis, unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence (Refer to *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 160.4 (Requirements for Payment).

Note: When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed it may be billed as critical care, if critical care requirements are met. Modifier 25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) should be appended to the critical care code when applicable in this situation.

Similarly, examples of patients who may not satisfy Medicare medical necessity criteria for critical care payment would include:

- Patients admitted to a critical care unit because no other hospital beds were available
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose)
- Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

You should consult the AMA *CPT Manual* for the applicable codes and guidance for critical care services provided to neonates, infants and children.

Critical care services and full attention of the physician

The duration of critical care services that physicians should report is the time you actually spend evaluating, managing, and providing the critically ill, or injured, patient's care. Be aware that during this time, you cannot provide services to any other patient, but rather must devote your full attention to this particular critically ill patient.

This time must be spent at the patient's immediate bedside or elsewhere on the floor, or unit, so long as you are immediately available to the patient. For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even when it does not occur at the bedside; if this time represents your full attention to the management of the critically ill/injured patient.

Note: Time spent off the unit or floor where the critically ill/injured patient is located (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) floor may not be reported as critical care time because the physician is not immediately available to the patient. This time is regarded as pre- and post-service work bundled in evaluation and management services.

Critical care services and qualified NPPs

Qualified NPPs may provide critical care services (and report for payment under their national provider identifier [NPI]), when these services meet the above critical care services definition and requirements.

Notes

1) The critical care services that NPPs provide must be within the scope of practice and licensure requirements for the state in which they practice and provide the services.

2) NPPs must meet the collaboration, physician supervision requirements, and billing requirements; and physician assistants (PA) must meet the general physician supervision requirements.

Critical care services and physician time

Critical care is a time- based service. Payment for critical care services is not restricted to a fixed number of hours, days, or physicians (on a per-patient basis) when such services meet medical necessity; and time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments (e.g. 50 minutes of continuous clock time or five ten minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient. For each medical encounter, the physician's progress notes must document the total time that critical care services are provided.

For Medicare Part B physician services, paid under the physician fee schedule, critical care is not a service that is paid on a "shift" basis or a "per day" basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include:

- Claims from several physicians submitting multiple units of critical care for a single patient
- Submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date.

Physicians assigned to a critical care unit (e.g., hospitalist, intensivist etc.) may not report critical care for patients based on a 'per shift" basis. You should use *CPT*

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code *99291* (evaluation and management of the critically ill or critically injured patient, first 30-74 minutes) to report the first 30-74 minutes of critical care on a given calendar date of service. You can only use this code once per calendar date to bill for care provided for a particular patient by the same physician or physician group of the same specialty.

CPT code *99292* (critical care, each additional 30 minutes) is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care. Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

Table 1 (below) illustrates the correct reporting of critical care services, followed by a clinical example.

Table 1
Reporting of Critical Care Services

Total Duration of Critical Care	**Appropriate *CPT* Codes**
Less than 30 minutes	*99232* or *99233* or other appropriate E/M code
30 - 74 minutes	*99291* x 1
75 - 104 minutes	*99291* x 1 and *99292* x 1
105 - 134 minutes	*99291* x1 and *99292* x 2
135 - 164 minutes	*99291* x 1 and *99292* x 3
165 - 194 minutes	*99291* x 1 and *99292* x 4
194 minutes or longer	*99291* – *99292* as appropriate (per the above illustrations)

Clinical example of correct billing of time

A patient arrives in the emergency department (ED) in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (*CPT* code *99291*) and not also codes for emergency department services. Using *CPT* code *99291*, the cardiologist may also report the 35 minutes of critical care services provided in the ED. Additional critical care services by the cardiologist in the CCU (on the same calendar date) using *99292* or another appropriate E/M code depending on the clock time involved.

Other critical care issues

There are some specific rules about physician services and time that you should know:

1. Only one physician can bill for critical care during any one single period of time. Unlike other E/M services, critical care services reflect one physician's (or qualified NPP's) care and management of a critically ill or critically injured patient for the specified reportable period of time. You cannot report a split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) as a critical care service. The critical care service reported should reflect the evaluation, treatment and management of the patient by the individual physician or qualified NPP and not representative of a combined service between a physician and a qualified NPP.
   When *CPT* code requirements for time and critical care requirements are met for a medically necessary visit by an individual clinician the service shall be reported using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.
   Please note that medically necessary service(s) that do not meet critical care criteria may be reported as subsequent hospital care services.
   In denying a claim for a critical care service that is a split/shared service, carriers and A/B MACS will use the following messages:

   Claims adjustment reason code
   150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

   Remittance advice reason code
   N180 – This item or service does not meet the criteria for the category under which it was billed.

   Medicare summary notice
   17.11 – This item or service cannot be paid as billed.

   For unassigned claims, Medicare contractors will use add-on message 16.34 – You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the "you may be billed" column; or

   For assigned claims, Medicare contractors will use add-on message 16.35 – You do not have to pay this amount.

2. When performed on the day a physician bills for critical care, the following services are included in the critical care service, and should not be reported separately:

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- the interpretation of cardiac output measurements (*CPT 93561, 93562*)
- chest x-rays, professional component (*CPT 71010, 71015, 71020*)
- blood draw for specimen (*CPT 36415*)
- blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data [*CPT 99090*])
- gastric intubation (*CPT 43752, 91105*)
- pulse oximetry (*CPT 94760, 94761, 94762*)
- temporary transcutaneous pacing (*CPT 92953*)
- ventilator management (*CPT 94002 – 94004, 94660, 94662*)
- vascular access procedures (*CPT 36000, 36410, 36415, 36591, 36600*)

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

2. Concurrent care by more than one physician (generally representing different physician specialties) is payable if the services all meet critical care requirements, are medically necessary, and are not duplicative. Refer to *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services) for concurrent care policy discussion).
   Critically ill or injured patients may require the care of more than one physician medical specialty, but keep in mind that the critical care services provided by each physician must be medically necessary. Medicare will pay for non-duplicative, medically necessary critical care services provided by 1) physicians from the same group practice; or 2) from different group practices to the same patient.

Note: Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the Medicare contractor who adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative the critical care services may be reported by each regardless of their group practice relationship.

Your medical record documentation must support that the critical care services each physician provided were necessary for treating and managing the patient's critical illness(es) or critical injury(ies). Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to *Medicare Claims Processing Manual*, Chapter 12 [Physicians/Nonphysician Practitioners], and Section 40 [Surgeons and Global Surgery]; and *Medicare Benefit Policy Manual*, Chapter 15 [Covered Medical and Other Health Services], and Section 30 [Physician Services]).
You will need to follow these specific coding requirements.

- The initial critical care time (billed as *CPT* code *99291*) must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical examination performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.
- Subsequent critical care visits performed on the same calendar date are reported using *CPT* code *99292*. The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for *CPT* code *99292*. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.
- Physicians in the same group practice who have the same specialty may not each report *CPT* initial critical care code *99291* for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners.)
- Physicians in the same group practice, with different specialties, who provide critical care to a critically ill or critically injured patient may not always each report the initial critical care code (*CPT 99291*) on the same date. When these physicians are providing care that is unique to his/her individual medical specialty, and are managing at least one of the patient's critical illness(es) or critical injury(ies); then the initial critical care service may be payable to each. However, if a physician (or qualified NPP) within a group provides "staff coverage" or "follow-up" for each other after another group physician provided the first hour of critical care services on that same calendar date but has left the case; the second group physician (or qualified NPP) should report the *CPT* critical care add-on code *99292*, or another appropriate E/M code.

Clinical examples of critical care services

a) Two pulmonary specialists, who share a group practice, each provide critical care services (at different times during the same day) to a patient who has multiple organ dysfunction (including cerebral hematoma, flail chest and pulmonary contusion), is comatose, and has been in the intensive care unit for four days following a motor vehicle accident. Both physicians may report medically necessary critical care services provided at the different time periods. One physician would report *CPT* code *99291* for the initial visit and the second, as part of the same group practice, would report *CPT* code *99292* on the same calendar date if the appropriate time requirements are met.

b) A 79 year old male comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates him and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits him to the observation

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unit for monitoring, and diagnostic and laboratory tests; during which time he has a cardiac arrest. His primary care physician provides 50 minutes of critical care services, and admits him to the intensive care unit. On the same calendar day his condition deteriorates and he requires intermittent critical care services. In this scenario, the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

4. When a patient requires critical care services upon presentation to a hospital emergency department, you may only report critical care codes *99291-99292*. You may not also report an ED visit code.
   However, when critical care services are provided on a day during which an inpatient hospital, or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient. Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other evaluation and management services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

5. Critical care services will not be paid on the same calendar date that the physician also reports a procedure code with a global surgical period, unless the critical care is billed with *CPT* modifier *25* to indicate that the critical care is a significant, separately identifiable, evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.
   Services such as endotracheal intubation (*CPT* code *31500*) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (*CPT* code *93503*) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier 25. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, should be excluded from the determination of the time spent providing critical care.
   This policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (CPR -- *CPT* code *92950*). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care maybe billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier *25*. The time spent performing CPR should be excluded from the determination of the time spent providing critical care. In this instance the physician who performs the resuscitation must bill for this service. Members of a code team cannot each bill Medicare Part B for this service.
   When a physician, other than the surgeon, provides postoperative critical care services (for procedures with a global surgical period); no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, both the surgeon and intensivist, who are submitting claim, must use *CPT* modifiers *54* (surgical care only) and *55* (postoperative management only). Critical care services must meet all the conditions previously described, and the medical record documentation of the surgeon and physician who assumes a transfer (e.g., intensivist's), must both support claims for services when *CPT* modifiers *54* and *55* are used indicating the transfer of care from the surgeon to the intensivist.

6. In addition to a global fee, critical care services provided during the preoperative portion and postoperative portions of the global period of procedures with 90-day global period in trauma and burn cases may be paid if the patient is critically ill and requires the full attention of the physician; and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed.
   Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition. Preoperatively, in order for these services to be paid, two reporting requirements must be met. Codes *99291 - 99292* and modifier *25* (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.
   Postoperatively, in order for these services to be paid, two reporting requirements must also be met. Codes *99291-99292* and modifier *24* (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.
   An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

   Note: Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

7. Critical care *CPT* codes *99291* and *99292* include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service.
   However, time involved with family members or other surrogate decision makers, whether to obtain a history

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or to discuss treatment options (as described in *CPT*), may be counted toward critical care time when these specific criteria are met:

- The patient is unable or incompetent to participate in giving a history and/or making treatment decisions.
- The discussion is necessary for determining treatment decisions.

For such family discussions, the physician should document:

- The medically necessary treatment decisions for which the discussion was needed.
- That the patient is unable or incompetent to participate in giving history and/or making treatment decisions.
- The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family."
- A summary in the medical record that supports this medical necessity.

Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, only if they meet the same criteria as described in the aforementioned paragraph. Further, no other family discussions (no matter how lengthy) may be additionally counted towards critical care.

8. A teaching physician, to bill for critical care services, must meet the requirements for critical care described above. For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.4 (Time-Based Codes).
Time spent teaching may not be counted towards critical care time. Nor, can the teaching physician bill, as critical care or other time-based services, for time spent by the resident (in the teaching physician's absence). Only time that the teaching physician spends alone with the patient (and that he/she and the resident spend together with the patient), can be counted toward critical care time.
A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment.

   However, the teaching physician medical record documentation must provide substantive information including:

   - Time the teaching physician spent providing critical care
   - That the patient was critically ill during the time the teaching physician saw the patient
   - What made the patient critically ill
   - The nature of the treatment and management provided by the teaching physician.

   The medical review criteria are the same for the teaching physician as for all physicians. (See *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.1 (Evaluation and Management (E/M) Services) for teaching physician documentation guidance).
   The following is an example of acceptable teaching physician documentation: "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care." Conversely, the following is an example of unacceptable documentation from a teaching physician: "I came and saw (the patient) and agree with (the resident)".

9. Medicare recognizes ventilator codes (*CPT* codes *94002-94004*, *94660* and *94662*) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an E/M service (e.g., critical care services, *CPT* codes *99291-99292*) on the same day for the patient even when the E/M service is billed with *CPT* modifier 25. Physicians should consult the *CPT* manual for the applicable codes and guidance for critical care services provided to neonates, infants and children. Critical care services provided in the outpatient setting (e.g., emergency department or office) for neonates and pediatric patients up through 24 months of age, use the hourly critical care codes *99291* and *99292*. For all other inpatient neonatal and pediatric critical care, refer to *CPT* for guidance on the correct use of codes.

Additional information

You may find more information about critical care visits and neonatal intensive care (codes *99291-99292*) by going to CR 5993, located at *http://www.cms.hhs.gov/Transmittals/downloads/*R1548CP.*pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. Updated *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291-99292) is an attachment to that CR.

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

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LABORATORY/PATHOLOGY

Clinical laboratory fee schedule—Medicare travel allowance fees for collection of specimens

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

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6195, which revises and clarifies payment of travel allowances that are based on either a per mileage basis (P9603) or on a flat rate basis (P9604) for calendar year (CY) 2008. The new rates are $1.035 per mile (P9603) and $9.55 per flat-rate trip (P9604).

Caution – what you need to know

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

Go – what you need to do

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

Background

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act and payment is made based on the clinical laboratory fee schedule. (See Section 1833(h)(3) of the Social Security Act at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the Internet.) Furthermore, the travel codes allow for payment of the travel allowance either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604), and payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover estimated travel costs of collecting the specimen (including the laboratory technician's salary and travel expenses), and Medicare contractors have the discretion to choose:

- Either a flat rate or a mileage basis, and
- How to set each type of allowance.

The per flat rate trip basis travel allowance (P9604) is $9.55, and the per mile travel allowance (P9603) is $1.035 cents per mile and is used in situations where the average trip to the patients' homes is:

- Longer than 20 miles round trip, and
- To be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip.

As of August 1, 2008, the per mile allowance rate of $1.035 cents per mile was computed using the Federal mileage rate of $0.585 cents per mile for automobile expenses plus an additional $0.45 cents per mile to cover the technician's time and travel costs. Medicare contractors have the option of establishing a higher per mile rate in excess of the minimum of $1.035 cents per mile if local conditions warrant it.

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

The following are examples to further clarify the new allowances:

Example 1: On August 2, 2008, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $62.10 (60 miles x 1.035 cents a mile), plus the specimen collection fee.

Example 2: On August 2, 2008, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or $41.40 (40 x 1.035), plus the specimen collection fee.

Note: Some Medicare contractors have established local policy to pay based on a flat rate basis only.

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x $9.55 for a total trip reimbursement of $19.10, plus the specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $9.55 = $57.30). Each of the claims submitted would be for $11.46 ($57.30 /5 = $11.46). Since one of the patients is non-Medicare, four claims would be submitted for $11.46 each, plus the specimen collection fee for each.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $9.55 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $9.55 = $19.10) and then divided by five (1/5 of $19.10 = $3.82). Since one of the patients is non-Medicare,

Medicare travel allowance fees for collection of specimens (continued)

four claims would be submitted for $3.82 each, plus the specimen collection fee.

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

Additional information

To see the official instruction (CR 6195) issued to your Medicare A/B MACs and carriers visit *http://www.cms.hhs.gov/Transmittals/downloads/R1584CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6195
Related Change Request (CR) #: 6195
Related CR Release Date: September 5, 2008
Effective Date: July 1, 2008
Related CR Transmittal #: R1584CP
Implementation Date: October 6, 2008

Independent laboratory billing for the technical component of physician pathology services

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

Provider types affected

Independent laboratories billing Medicare carriers or Medicare administrative contractors (MACs) for services rendered to hospitalized Medicare beneficiaries.

Impact on providers

Qualifying independent laboratories may continue to bill Medicare directly for the technical component (TC) of certain physician pathology services provided to patients as part of a covered hospital inpatient stay or outpatient hospital service, through December 31, 2009 regardless of the beneficiary's hospitalization status, in accordance with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Change request (CR) 6042 also instructs the carriers/MACs not to implement the business requirements of CR 5347 with respect to action for physician pathology services (See *MLN Matters* article, MM5347, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. (CR 5347 prevents payment by a carrier for a TC of a pathology service rendered during an inpatient stay or for the same date of service (DOS) as an outpatient service. CR 6042 negates that directive to carriers/MACs.)

Background

As a result of MIPPA, CR 6042 instructs the carriers/MACs to notify the independent laboratories that those that qualify to bill under the section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA)/Section 732 of the Medicare Modernization Act (MMA)/ section 104 of the Tax Relief and Health Care Act of 2006 (TRHCA)/ section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) for the TC of the physician pathology services may continue to do so effective with DOS July 1, 2008, through December 31, 2009. This is an additional eighteen (18) months beyond the expiration date in the MMSEA.

Additional Information

To see the official instruction (CR 6042) issued to your Medicare carrier or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1561CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6042
Related Change Request (CR) #: 6042
Related CR Release Date: July 25, 2008
Effective Date: July 1, 2008
Related CR Transmittal #: R1561CP
Implementation Date: August 25, 2008

New waived tests

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

Provider types affected

Clinical laboratories and providers that submit claims to Medicare carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What you need to know

CR 6179, from which this article is taken, informs providers, Medicare carriers, and A/B MACs of new waived tests approved by the Food and Drug Administration (FDA) under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Make sure that your billing staffs are aware of these newly waived tests, which you can find listed in the table below.

Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Centers for Medicare & Medicaid Services (CMS) only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

New waived tests are approved by the FDA on a flow basis, and the tests are valid as soon as they are approved. The new waived tests announced by CR 6179 (and their effective dates) are in the following table:

CPT* Code	**Effective Date**	**Description**
87880QW	June 28, 2007	PSS World Medical Select Diagnostics Strep A Twist
87880QW	March 19, 2008	Jant Pharmacal Accutest Integrated Strep A Rapid Test Device
87880QW	March 19, 2008	Inverness Medical Biostar Acceava Strep A Twist
87880QW	April 8, 2008	Diagnostic Test Group Clarity Strep A Rapid Test Strips
80061QW, 82465QW, 83718QW, 84478QW	April 14, 2008	Abaxis, Piccolo xpress Chemistry Analyzer {Lipid Panel Reagent Disc} (Whole Blood)
82465QW, 82947QW, 82950QW, 82951QW, 82952QW, 83718QW, 84478QW, 84450QW, 84460QW	April 14, 2008	Abaxis Piccolo xpress Chemistry Analyzer {Lipid Panel Plus Reagent Disc} (Whole Blood)}
82042QW, 82150QW, 82247QW, 82977QW, 84157QW, 84075QW, 84450QW, 84460QW	April 14, 2008	Abaxis Piccolo xpress Chemistry Analyzer {Liver Panel Plus} (Whole Blood)
89300QW	June 12, 2008	SpermCheck Vasectomy
83520QW	June 13, 2008	HemoCue Albumin 201 System

*These new tests must have the modifier QW to be recognized as a waived test.

CR 6179 also announces that:

- The new waived *CPT*/HCPCS code *87809* has been assigned to the infectious agent antigen detection by immunoassay with direct optical observation; adenovirus. The HCPCS code assigned to the rapid pathogen screening PRS adeno detector test has been changed to *87809QW* with an effective date of January 1, 2008.
- The new waived *CPT* code, *83520QW* has been assigned for the albumin test performed using the A HemoCue Albumin 201 System with an effective date of June 13, 2008.
- As of May 1, 2008, the following test systems are either discontinued or are no longer manufactured, and their names have been removed from the list of tests granted waived status under CLIA:

  Metrika A1c now for prescription home use (K020234)
  Metrika A1c now for professional use (K000887)
  Metrika A1c now for professional use (K020235)
  Metrika DRx® HbA1c (professional use test system)
  Bayer DCA 2000 – glycosylated hemoglobin (Hgb A1c)
  Bayer DCA 2000+ - glycosylated hemoglobin (Hgb A1c)
- The Bayer A1c now+ {for professional use} was granted waived complexity categorization because of its home (over the counter) use. Effective May 1, 2008, the *CPT* code for Bayer A1c now+ {for professional use} test system has been changed from *83036QW* to *83037QW* on the list of tests granted waived status under CLIA.
- The attachment to CR 6179 includes the list of tests granted waived status under CLIA. Please note that the tests mentioned on the first page of the attachment (i.e., *CPT* codes: *81002*, *81025*, *82270*, *82272*, G0394, *82962*, *83026*, *84830*, *85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

New waived tests (continued)

Please note that your Medicare carrier or MAC will not automatically adjust claims processed prior to the implementation of these changes; however they will adjust claims that you bring to their attention.

Additional information

For complete details, please see the official instruction, CR 6719, issued to your carrier or A/B MAC regarding this change. That instruction may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1594CP.pdf* on the CMS Web site.

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6179
Related Change Request (CR) #: 6179
Related CR Release Date: September 12, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1594CP
Implementation Date: October 6, 2008

MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

October update to the 2008 Medicare physician fee schedule database

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

Provider types affected

Physicians and providers who submit claims to Medicare carriers or Part A/B Medicare administrative contractors (A/B MACs) for services rendered to Medicare beneficiaries paid based on the Medicare physician fee schedule database (MPFSDB).

Key points of change request 6180

Changes in the October update to the 2008 MPFSDB are as follows:

CPT/HCPCS Codes	Action
15878 and 15879	Bilateral indicator = 1
92557 and 92567	PC/TC Indicator = 9
93660—26	Multiple Procedure Indicator = 2
G0398, G0399, and G0400	PC/TC Indicator = 1

- Attachment 1 of CR 6180 describes changes **effective March 13, 2008,** for:
  G0398–TC G0398–26 G0399-TC
  G0399-26 G0400-TC G0400-26
- An editorial change was made to the long descriptor of G0250 as noted in Attachment 1 of CR6180.

Make certain your billing staffs are aware of these changes. Your Medicare contractor will retroactively adjust claims if you bring such claims to their attention.

Background

This article is based on CR 6180, which states that payment files were issued to contractors based upon the 2008 MPFS final rule. CR 6180 amends those payment files.

Additional information

You may see the official instruction (CR 6180) issued to your Medicare carrier or A/B MAC, by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1580CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6180
Related Change Request (CR) Number: 6180
Related CR Release Date: August 22, 2008
Effective Date: January 1, 2008
Related CR Transmittal Number: R1580CP
Implementation Date: October 6, 2008

PREVENTIVE SERVICES

2008 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6121 which reminds the Medicare physician community of the requirements to correctly enroll in order to conduct mass immunization roster billing and centralized billing of Medicare for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for mass immunizer roster billers.

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing CR 6121 as a reminder for mass immunization roster billing and centralized billing for influenza and pneumococcal vaccinations.

Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals, and they must be properly licensed in the states in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors processing claims. Individuals and entities must be properly licensed in the States in which they plan to operate influenza (flu) and/or pneumococcal clinics.

Providers who only offer influenza services:

- May enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a centralized biller, and
- Must meet the guidelines for being either a mass immunizer or centralized biller.

Suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Mass immunization roster billers and centralized billers must enroll in the Medicare program even if mass influenza and/or pneumococcal immunizations are the only service being provided. They must:

- Accept assignment on both the vaccine and its administration
- Bill only for influenza and/or pneumococcal vaccinations, and
- Submit claims using the roster billing process.

Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1, to request participation for the upcoming year. Claims for centralized billers are processed by one Medicare specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Providers and suppliers must enroll using the appropriate CMS-855 provider enrollment form (See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp* on the CMS Web site). Applications are available from the local contractors. Refer to the *Medicare Claims Processing Manual*, Chapter 18, Section 10-10.5 at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf* on the CMS Web site for more information on billing requirements.

Note: Medicare Part B pays 100 percent for pneumococcal vaccines, influenza virus vaccines, and their administration. The Part B deductible and coinsurance do not apply for influenza virus and pneumococcal vaccine.

Remember the following regarding the influenza vaccine:

- Medicare allows one influenza (flu) vaccination per year
- Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the influenza vaccine and its administration, and
- The beneficiary may receive the influenza vaccine upon request without a physician's order and without physician supervision.

Remember the following with regard to the pneumococcal vaccine, effective for services furnished on or after July 1, 2000:

- Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration, and
- The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, the pneumococcal vaccine is administered once in a lifetime. Claims for pneumococcal vaccines are paid for beneficiaries who:

- Are at high risk of pneumococcal disease, and
- Have not received a pneumococcal vaccine within the last five years, or
- Are revaccinated because they are unsure of their vaccination status.

2008 reminder for roster billing and centralized billing for flu and PPV (continued)

Additional information

CMS offers a number of free educational products on its *Medicare Learning Network* (*MLN*). These products are available on the *MLN* Preventive Services Educational Products Web page located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage* on the CMS Web site.

The official instruction, CR 6121, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R366OTN.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6121
Related Change Request (CR) #: 6121
Related CR Release Date: August 15, 2008
Effective Date: September 15, 2008
Related CR Transmittal #: R366OTN
Implementation Date: September 15, 2008

Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines

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

Provider types affected

Physicians and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]) for services to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6079 and notifies providers that the Centers for Medicare & Medicaid Services (CMS) revised CMS-1500 to accommodate the reporting of the national provider identifier (NPI). The current CMS 1500 (08-05) does not require reporting the NPI for influenza virus and pneumococcal vaccine claims submitted as roster bills. Therefore your Medicare contractor **should not return claims as unprocessable** to the supplier/provider of service when the rendering provider does not enter his/her NPI into 24J of the CMS-1500 for influenza virus and pneumococcal vaccine claims submitted as roster bills.

Key point of CR 6079

The requirement of an NPI for the rendering provider does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills.

Additional information

To see the official instruction (CR 6079) issued to your Medicare FI, carrier, or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1586CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6079
Related Change Request (CR) Number: 6079
Related CR Release Date: September 5, 2008
Related CR Transmittal Number: R1586CP
Effective Date: October 6, 2008
Implementation Date: October 6, 2008

Screening DNA stool test for colorectal cancer

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

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6145 which announces the Centers for Medicare & Medicaid Services (CMS) decision regarding a request for reconsideration of the current national coverage determination (NCD) for colorectal cancer screening.

Caution – what you need to know

CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA (deoxyribonucleic acid) stool test; because the Food and Drug Administration (FDA) determines that this test requires pre-market review and approval. A subsequent request for reconsideration will be considered once FDA-approval is obtained.

Go – what you need to do

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

Background

Congress specifically authorized coverage of certain screening tests under Part B of the Medicare program and made necessary conforming changes in order to ensure that payments are made. As a result, CMS currently covers colorectal cancer screening for average-risk individuals ages

Screening DNA stool test for colorectal cancer (continued)

50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema.

Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under the *Code of Federal Regulations* (42 CFR 410.37(a)(1)(v)) at *http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html* and the Social Security Act (Section 1861(pp)(1)(D)) *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

Following a request for reconsideration of the current NCD at Section 210.3 of the *Medicare National Coverage Determinations Manual* for colorectal cancer screening, CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy.

The FDA determined that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA-determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test. Therefore, CMS does not believe that identification of stool DNA mutations is an appropriate colorectal cancer-screening test at this time.

Additional Information

The official instruction, CR 6145, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change, is reflected in two transmittals, one for the *Medicare Benefit Policy Manual* and one for the *National Coverage Determinations Manual*. These two transmittals are on the CMS Web site respectively at *http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R92NCD.pdf*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6145
Related Change Request (CR) Number: 6145
Related CR Release Date: July 25, 2008
Related CR Transmittal Number: R93BP and R92NCD
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

RADIOLOGY

Fluorodeoxyglucose positron emission tomography imaging for infection and inflammation

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

Provider types affected

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

Impact on providers

This article is based on change request (CR) 6099 instructing that the Centers for Medicare & Medicaid Services (CMS) is continuing its national noncoverage policy for the off-label indications of fluorodeoxyglucose (FDG) positron emission tomography (PET) imaging for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Background

CMS was asked to reconsider the current, de facto noncoverage for FDG PET imaging in the *Medicare National Coverage Determinations (NCD) Manual* (Section 220.6), for the following off-label uses (instead of bone, leukocyte, and/or gallium scintigraphy):

1. Suspected chronic osteomyelitis in patients with:
   - previously documented osteomyelitis with suspected recurrence, or
   - symptoms of osteomyelitis for more than 6 weeks (including diabetic foot ulcers)
2. Investigation of patients with suspected infection of hip prosthesis
3. Fever of unknown origin in patients with:
   - a febrile illness of >3 weeks duration,
   - a temperature of >38.3 degrees centigrade on at least two occasions, and
   - uncertain diagnosis after a thorough history, physical examination, and 1 week of proper investigation.

Fluorodeoxyglucose PET imaging for infection and inflammation (continued)

Based upon its review, CMS determined that the evidence is inadequate to conclude that FDG PET for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin improves health outcomes in the Medicare populations, and therefore is not reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A). (See that provision on the Internet at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm*.)

Additionally, CMS determined that this request for coverage is not appropriate for the Coverage with Evidence Development (CED) paradigm.

Additional information

The official instruction, CR 6099, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R84NCD.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6099
Related Change Request (CR) Number: 6099
Related CR Release Date: June 27, 2008
Related CR Transmittal Number R84NCD
Effective Date: March 19, 2008
Implementation Date: July 28, 2008

Note on payment for imaging services

The Deficit Reduction Act of 2005 capped the Medicare physician fee schedule (MPFS) payment for the technical component (TC) of most imaging services at the outpatient prospective payment system (OPPS) payment rate. The cap applies to both TC-only and the TC of global services. Where the payment is capped, the MPFS files may disclose only the capped payment amount. Several providers have requested disclosure of both the capped and uncapped amounts. Such information may be found at *http://www.cms.hhs.gov/PFSlookup/02_PFSSearch.asp#TopOfPage*.

Source: CMS PERL 200809-38

SKILLED NURSING FACILITY

Revision to skilled nursing facility Common Working File editing

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

Provider types affected

Therapy professionals and providers submitting claims to Medicare contractors (carriers and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6128 which revises the action taken by CR 5757 to eliminate the negative impact on therapy professionals. CR 6128 applies to claims processed on or after January 5, 2009. Be sure your billing staff is aware of this issue.

Background

CR 5757 (transmittal 1365) implemented revised the Medicare Common Working File (CWF) editing for skilled nursing facility (SNF) consolidated billing. It has come to the attention of the Centers for Medicare & Medicaid Services (CMS) that the editing changes implemented by CR 5757 negatively impacted therapy professionals. (You may review the MLN Matters article related to CR 5757 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5757.pdf* on the CMS Web site.)

The editing from CR 5757 will no longer be applied. Medicare contractors will reopen and re-process claims incorrectly denied when you bring such claims to their attention.

Additional information

The official instruction, CR 6128, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1554CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6128
Related Change Request (CR) #: 6128
Related CR Release Date: July 18, 2008
Effective Date: Claims processed on or after January 5, 2009
Related CR Transmittal #: R1554CP
Implementation Date: January 5, 2009

THERAPUETIC SERVICES

Continuous positive airway pressure therapy for obstructive sleep apnea

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

Note: CMS has revised this MLN Matters article on September 2, 2008, to reflect revisions to change request (CR) 6048, which CMS revised on August 28, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6048 were revised. In addition, some language in item 3 was clarified. All other information remains the same. The *MLN Matters* article MM6048 was published in the August 2008 Medicare B Update! (pages 24-25).

Provider types affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or durable medical equipment [DME] MACs) for obstructive sleep apnea (OSA)-related services provided to Medicare beneficiaries.

Impact on providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of continuous positive airway pressure (CPAP) therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR 6048.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 national coverage determination (NCD) for CPAP therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with Section 240.4 of the Medicare NCD Manual (see the *Additional Information* section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR 6048. (Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, Chapter 20, Section 30.5, which is available on the CMS Web site at *http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf*.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four percent oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key points of change request 6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

Note: DME prosthetics, orthotics, and supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively [42 CFR 424.57(c)(12)]. Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges [(42 CFR 424.57(d)].

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:

   - Polysomnography (PSG) performed in a sleep laboratory.
   - Unattended home sleep monitoring device of type II.
   - Unattended home sleep monitoring device of type III.
   - Unattended home sleep monitoring device of type IV, measuring at least three channels.

Note: In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the apnea-hypopnea index (AHI) or respiratory distress index (RDI) are met:

   - AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
   - AHI or RDI greater than or equal to five and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

   Note: The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a two-hour period.

CPAP therapy for obstructive sleep apnea (continued)

5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or type II, type III, or a type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the *NCD Manual* revision attached to CR 6048. Medicare will process claims according to coverage with evidence development (CED)/clinical trials criteria at Section 310.1 of the *NCD Manual* and Chapter 32 and Sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available on the CMS Web site at *http://www.cms.hhs.gov/manuals/IOM/list.asp*.

Note: The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at Section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.

G0398 Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.
Short Descriptor: Home sleep test/type 2 Porta

G0399 Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
Short Descriptor: Home sleep test/type 3 Porta

G0400 Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels
Short Descriptor: Home sleep test/type 4 Porta

Additional information

To see the official instruction (CR 6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R94NCD.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6048
Related Change Request (CR) Number: 6048
Related CR Release Date: August 29, 2008
Related CR Transmittal Number: R94NCD
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

ELECTRONIC DATA INTERCHANGE

Remittance advice remark code and claim adjustment reason code update

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

Provider types affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Part A/B Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for services.

Impact on providers

CR 6109, from which this article is taken, announces the latest update of remittance advice remark codes (RARC) used in electronic and paper remittance advice, and claim adjustment reason codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008.

Be sure that your billing staffs are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year and are posted on the Washington Publishing Company (WPC) Web site *at http://www.wpc-edi.com/Codes* on the Internet. The tables at the end of this article (right after the *Additional Information* section) summarize the latest changes to these lists, as announced in CR 6109.

CMS has also developed a tool to help you search for a specific category of RARC code and that tool is available at *http://www.cmsremarkcodes.info* on the Internet. Note that this Web site does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional information

To see the official instruction (CR 6109) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf* on the CMS Web site.

For additional information about remittance advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf* on the CMS Web site.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site. The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

The changes that are effective on October 1, 2008 are as follows:

Remittance advice remark code changes

New codes

Code	Current narrative	Medicare initiated
N433	Resubmit this claim using only your national provider identifier (NPI)	Y

Modified codes

Code	Current modified narrative	Last modified
MA97	Missing/incomplete/invalid Medicare managed care demonstration contract number or clinical trial registry number.	2/29/08
N175	Missing review organization approval.	2/29/08
N241	Incomplete/invalid review organization approval.	2/29/08
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/08

RARC and CARC update, continued

Deactivated codes

None

Health care claim adjustment reason codes

New codes

Code	Current narrative	Effective date (per WPC Web site)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (**Note**: To be used for Workers' Compensation only)	1/27/2008
215	Based on subrogation of a third party settlement	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (**Note**: To be used for Workers' Compensation only)	1/27/2008
218	Based on entitlement to benefits (**Note**: To be used for Workers' Compensation only)	1/27/2008
219	Based on extent of injury (**Note**: To be used for Workers' Compensation only)	1/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (**Note**: To be used for Workers' Compensation only)	1/27/2008
221	Workers' Compensation claim is under investigation. (**Note**: To be used for Workers' Compensation only. Claim pending final resolution)	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (**Note**: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 1/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/27/2008

Modified Codes

Code	Modified Narrative	Effective Date (per WPC Web site.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1/27/2008

Deactivated Codes

Code	Current Narrative	Effective Date (per WPC Web site)
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (**Note**: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/1/2009

MLN Matters Number: MM6109
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1563CP
Related Change Request (CR) #: 6109
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Implementation of new claim adjustment reason code 213

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

Provider types affected

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

What you need to know

Change request (CR) 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new claim adjustment reason code (CARC) 213 when denying claims based on non-compliance with the physician self-referral prohibition.

Make sure that your billing staffs are aware of this new CARC code.

Background

Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound)
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Orthotics, prosthetics, and prosthetic devices
- Parenteral and enteral nutrients, equipment and supplies
- Physical therapy, occupational therapy, speech-language pathology services
- Outpatient prescription drugs
- Home health services and supplies
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.

Prior to the publication of the new CARC 213 ("Non-compliance with the physician self-referral prohibition legislation or payer policy"), there was no specific code to describe claims that are denied based on "Stark" (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition. Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

Exceptions

Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You may read these exceptions in Section 1877 of the Social Security Act, which you may find on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf*; and in 42 C.F.R. Part 411, subpart J.) (42 U.S.C. Section 1395nn).

Additional information

You may find more information about CARC 213 by going to CR 6131, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf* on the CMS Web site.

You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General billing requirements Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition) as an attachment to that CR.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6131
Related Change Request (CR) Number: 6131
Related CR Release Date: August 15, 2008
Related CR Transmittal Number: R1578CP
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

FCSO selected to administer Medicare in Florida, Puerto Rico, and Virgin Islands

The Centers for Medicare & Medicaid Services (CMS) recently announced that First Coast Service Options Inc. (FCSO) has been awarded a contract of up to five years for the combined administration of Medicare Part A and Part B claim payment in Florida, Puerto Rico, and the US Virgin Islands.

"With this award, CMS continues its progress in reengineering the way in which the government contracts for claim administration for the largest part of the Medicare program. CMS is seeking the best value, from a cost and technical perspective for this critical function," said acting CMS Administrator Kerry Weems. "This is another step toward improving services to beneficiaries and providers who are in the Medicare fee-for-service benefit plan."

FCSO will serve as the first point of contact for the processing and payment of Medicare fee-for-service claims from hospitals, skilled nursing facilities, physicians and other health care practitioners in Florida, Puerto Rico, and the US Virgin Islands. The new Part A/Part B Medicare administrative contractor (A/B MAC) was selected using competitive procedures in accordance with federal procurement rules. The entire press release may be viewed at *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200809-41

NATIONAL PROVIDER IDENTIFIER

NPPES -- keeping it safe and keeping it updated

This message is for health care providers, particularly physicians and other practitioners, who have obtained national provider identifiers (NPIs) and have records in the national plan and provider enumeration system (NPPES). The Centers for Medicare & Medicaid Services (CMS) recommends that each health care provider, including individual physicians and nonphysician practitioners:

- Know and maintain their NPPES user IDs and passwords.
- Reset their NPPES passwords at least once a year. See the NPPES Application Help page regarding the 'Reset Password' rules. Those rules indicate the length, format, content and requirements of NPPES passwords.
- Review their NPPES records in order to ensure that the information reflects current and correct information.

Maintaining NPPES account information for safety and accessibility

Health care providers, including physicians and nonphysician practitioners, should maintain their own NPPES account information (i.e., user ID, password, and secret question/answer) for safety and accessibility purposes.

Viewing NPPES information

Health care providers, including physicians and nonphysician practitioners, can view their NPPES information in one of two ways:

1. By accessing the NPPES record at *https://nppes.cms.hhs.gov/NPPES/Welcome.do* and following the NPI hyperlink and selecting Login. The user will be prompted to enter the user ID and password that he/she previously created.

   Note: If the health care provider has forgotten the password, enter the user ID and click the "Reset Forgotten Password" button to navigate to the Reset Password Page. If the health care provider enters an incorrect user ID and password combination three times, the user ID will be disabled. Please contact the NPI enumerator at 1-800-465-3203 if the account is disabled or if the health care provider has forgotten the user ID.

2. By accessing the NPI registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*. The NPI registry gives the health care provider an online view of Freedom of Information Act (FOIA)-disclosable NPPES data.

The health care provider can search for its information using the name or NPI as the criterion.

Updating NPPES information

Health care providers, including physicians and nonphysician practitioners, can correct, add, or delete information in their NPPES records by accessing their NPPES records at *https://nppes.cms.hhs.gov/NPPES/Welcome.do* and following the NPI hyperlink and selecting Login. The user will be prompted to enter the user ID and password that he/she previously created.

Please note: Required information cannot be deleted from an NPPES record; however, required information can be changed/updated to ensure that NPPES captures the correct information. Certain information is inaccessible via the Web, thus requiring the change/update to be made via paper application. The paper NPI application/update form may be downloaded and printed at *http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf*.

Need more information?

Providers can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the *https://www.cms.hhs.gov/NationalProvIdentStand* CMS Web page.

Source: PERL 200809-16

Rescinding instructions for reporting service facility provider information

As a result of a recent clarification from the Centers for Medicare & Medicaid Services (CMS), the billing instructions addressing reporting service facility provider information have been rescinded.

This notification was posted on the provider educational Web site on July 25, 2008, and published in the August 2008 Medicare B Update! (page 36).

Source: Publication 100-08, Change Request 6093

National provider identifier for secondary providers

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

Provider types affected

All Medicare providers who submit claims to Medicare carriers, Medicare administrative contractors (MACs), durable medical equipment Medicare administrative contractors (DME/MACs) and/or fiscal intermediaries (FIs) in which a secondary provider must be identified.

Provider action needed

This article is based on change request (CR) 6093 and outlines the need to use national provider identifiers (NPIs) to identify secondary providers in Medicare claims beginning May 23, 2008.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The NPI final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers and entities covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS- 0045-F).

Effective May 23, 2008, paper and electronic Medicare claims must contain NPIs to identify health care providers in their role as health care providers. (NPIs do not replace taxpayer identification numbers, which identify health care providers in their role as taxpayers.)

Medicare claims always identify primary providers. Primary providers are the billing and pay-to providers and, for non-institutional and non-pharmacy claims, the rendering provider.

Some Medicare claims also need to identify one or more secondary providers. A secondary provider could be a health care provider who ordered services for a Medicare patient or who referred a Medicare patient to another health care provider (ordering/referring providers); an attending, operating, supervising, purchased service, other, or service facility provider; or a prescriber (the latter only in retail pharmacy drug claims).

Prior to May 23, 2008, health care providers who ordered/referred were identified by unique physician identification numbers (UPINs). UPINs were assigned to physicians as defined in section 1861(r) of the Social Security Act, and to nurse practitioners, clinical nurse specialists, physician assistants, licensed clinical social workers, clinical psychologists, and certified nurse midwives—the only practitioners who are permitted by law to order/refer in the Medicare program. Medicare ceased assigning UPINs in June 2007 as part of the implementation of the NPI.

Note: CR 6093 does not alter existing requirements for capturing the name and address, when required, of secondary providers or instructions that address the specific practitioner types that must be reported in certain referral and "incident to" situations. CR 6093 instruction addresses only the reporting of the identifier for secondary providers, when required.

Key points of CR 6093

- When an identifier is reported on a paper or electronically submitted claim for a secondary provider (ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]), that identifier must be an NPI.
- If the secondary provider (the ordering, referring, attending, operating, supervising, purchased service, other, or service facility provider [in the X12N 837 claims transactions] or for prescriber [in the NCPDP 5.1 retail drug claim transactions]) does not furnish its NPI at the time of the order/, referral, purchase, prescription, or time of service, **you** as the billing provider need to know that NPI in order to use it in your claim.
- You may use the NPI Registry or you may need to contact the ordering, referring, attending, operating, supervising, purchased service, other, service facility, or prescriber in order to obtain that NPI. While the implementation guides for the X12N claims transactions permit the reporting of the social security number (SSN) for some secondary providers if there is no NPI, the Centers for Medicare & Medicaid Services (CMS) does not believe you will be successful in having secondary providers disclose their SSNs.
- If you are unable to obtain the NPI of the entity to be identified as the service facility provider, or if that entity has not obtained an NPI, **no** identifier is to be reported in that loop.
- If you are unable to obtain the NPI of the ordering, referring, attending, operating, supervising, purchased service, other, or prescriber, you (the billing provider) must use **your NPI** as the identifier for that secondary provider.
- Claims will not be paid if the secondary providers (with the exception of the service facility provider) are not identified by NPIs. No NPI is necessary for the service facility provider.

Additional information

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

For complete details regarding this CR please see the official instruction (CR 6093) issued to your Medicare carrier, DME/MAC, MAC or FI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R267PI.pdf* on the CMS Web site.

National provider identifier for secondary providers (continued)

MLN Matters Number: MM6093
Related Change Request (CR) #: 6093
Related CR Release Date: September 12, 2008
Effective Date: May 23, 2008
Related CR Transmittal #: R267PI
Implementation Date: September 26, 2008

PROVIDER QUALITY REPORTING INITIATIVE

Steps for individual eligible professionals to access their 2007 PQRI feedback reports personally

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

Provider types affected

This document is directed to individual eligible professionals who reported 2007 Physician Quality Reporting Initiative (PQRI) quality measures data to Medicare and will access their reports personally.

Note: Solo practitioners who wish to use employees to access their reports and group practices must register in IACS as organizations. For information regarding registration as an organization, see *MLN Matters* article SE0831, which is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf* on the CMS Web site.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that 2007 PQRI final feedback reports are available on a secure Web site. This document provides the steps professionals need to take to access their feedback reports personally. You must register for access through a CMS security system known as the Individuals Authorized Access to CMS Computer Services (IACS).

Do not register if you did not report quality measures in 2007.

A five step process to access PQRI feedback reports

Step one: determine if you should register under the "individual practitioner" role in IACS to access your 2007 PQRI feedback report.

For purposes of IACS registration, an individual practitioner is:

1. A solo eligible professional without employees who is paid directly by Medicare, or
2. A solo eligible professional with one or more employees who is paid directly by Medicare and wants to access their PQRI feedback report personally. (If you want to use employees to access your report, register as an organization. Refer to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf* for information on how to register as an organization and access your 2007 PQRI feedback report.)

If you meet the requirements above and are already registered in IACS as an individual practitioner, do not register again. Proceed to step four.

Professionals who reassigned Medicare payments to a group practice should **not** register in IACS unless they are one of the two or three users designated to do so by the group practice. One 2007 PQRI feedback report will be prepared for each taxpayer identification number (TIN). The group practice will be responsible for sharing NPI level information with the appropriate professionals in the practice.

If you meet the definition of individual practitioner above, you may access your 2007 PQRI feedback report personally by following the steps below.

Step two: confirm your enrollment data in Medicare after 2003.

CMS will match your IACS registration information with Medicare provider enrollment data before allowing you to access the PQRI application. Therefore, we encourage you to update your enrollment information if necessary before registering in IACS.

Individual professionals who have not submitted a Medicare enrollment application (CMS-855) since November 2003 will need to do so. See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* for more information about the Medicare enrollment process. To facilitate your enrollment into the Medicare program or updating your enrollment with Medicare, you should review the following downloadable file at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollmenttips.pdf* before submitting an enrollment application to a Medicare contractor:

If you submitted an enrollment application since November 2003, or are unsure when the enrollment application was submitted, proceed to step three.

Step three: online registration for individual practitioners as defined in step one

The IACS registration process confirms your identity. Upon successful completion, you will receive a User ID and Password for IACS, each in separate e-mail.

Remember to register as an individual practitioner. The Individual Practitioner New User Registration Quick

Access 2007 PQRI feedback reports personally (continued)

Reference Guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

To register in IACS go to https://applications.cms.hhs.gov on the CMS Web site.

Step four: request a PQRI user role (wait at least one business day after receiving your IACS ID and password)

Once your IACS registration is approved, CMS will match your registration information against Medicare enrollment data available after November of 2003. Your IACS registration information and CMS provider enrollment data must match for you to be approved to access the PQRI feedback report application. You will receive a 3rd e-mail from CMS if your Medicare enrollment has been confirmed. This should occur within one business day of IACS registration if your enrollment data is in our database.

Once you receive the enrollment confirmation e-mail, you can re-enter IACS at https://applications.cms.hhs.gov to enter the CMS Applications Portal, click on "Account Management" and then "My Profile". Then, using your newly provided User ID and Password to login, you may request access to the PQRI feedback report application by selecting the "PQRI User" role. The "Request Access to CMS Application Quick Reference Guide" provides instructions for requesting an application role. It may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Note: If you request the "PQRI User" role prior to confirmation of enrollment data, you will get an error message that IACS cannot confirm your Medicare enrollment status.

If you do not get an e-mail confirming your Medicare enrollment, or get an error message that your enrollment cannot be confirmed:

- Update your Medicare enrollment information if you have not submitted an enrollment application since November of 2003 (follow the instructions in Step two).
- If you have submitted an enrollment application since November 2003, contact your carrier/ Medicare administrative contractor.

Step five: enter PQRI application

If you have reported PQRI quality measures for 2007 and been approved in IACS for the PQRI User role, you may access your 2007 report at *http://www.qualitynet.org/pqri* using your IACS user ID and password. This site also contains a user guide for the PQRI system, and instructions for interpreting your 2007 PQRI feedback report.

Additional help for IACS

CMS has established the External User Services (EUS) Help Desk to support provider access to IACS. The EUS Help Desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759. Hours of operation are Monday through Friday 7AM to 7PM EST.

Additional help for PQRI

For help accessing the PQRI system and questions on your feedback report, contact the Report Delivery System Help Desk on 866-288-8912 or *qnetsupport@ifmc.sdps.org*.

For questions concerning the status of PQRI incentive payments and any offset applied, contact your carrier or A/B Medicare administrative contractor (MAC) provider call center.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: SE0830
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Steps for organizations to access their 2007 Physician Quality Reporting Initiative feedback reports

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

Provider types affected

This document is directed to:

- Group practices under which at least one eligible professional reported 2007 PQRI quality measures data to Medicare; and
- Individual eligible professionals who reported 2007 Physician Quality Reporting (PQRI) quality measures data to Medicare and wish to have employees access their 2007 PQRI feedback reports.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that 2007 PQRI final feedback reports are available on a secure Web site. This document provides the steps organizations need to take to access their feedback reports. Access requires registration through a CMS security system known as the Individuals Authorized Access to CMS Computer Services (IACS).

Note: If you are a solo professional without employees, you must register in IACS as an individual practitioner. For information regarding registration as an individual practitioner, see MLN Matters article SE0830, which is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf* on the CMS Web site.

Organizations accessing their 2007 PQRI feedback reports (continued)

Do not register if you did not report quality measures in 2007.

I. Determine if you should register in IACS as an "organization."

Register in IACS as an organization if you are:

- A group practice which receives Medicare payments on behalf of its members, or
- A solo eligible professional who will use one or more employee(s) to access PQRI.
- Organizations must enter a Legal Business Name and Taxpayer Identification Number (TIN)/Employer Identification Number (EIN) in IACS which CMS will verify against Internal Revenue Service documents such as the CP-575.

Up to two individuals will be able to access the 2007 PQRI feedback report for each organization registered in IACS. One report will be prepared for each TIN. The group practice will be responsible for sharing NPI level information with the appropriate professionals in the practice.

Note: Professionals who reassigned Medicare payments to a group practice should NOT register in IACS unless they are one of the individuals designated to do so by the group practice.

Do not register as an organization in IACS (register as an Individual Practitioner instead) if you are:

- A solo eligible professional without employees who is paid directly by Medicare, or
- A solo eligible professional with one or more employees who is paid directly by Medicare and wants to access your PQRI feedback report personally.

Note that registration information for those registering as individual practitioners will be matched against Medicare enrollment data. Refer to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf* for information about how to register in IACS as an individual practitioner and access your 2007 PQRI feedback report.

II. Steps for organizations to access their 2007 PQRI feedback reports

Step 1. register and be approved in IACS

IACS online registration confirms your identity. Upon successful completion, approved users will receive a User ID and Password for IACS via email.

IACS employs a delegated approval model. The Security Official for the organization is the first person to register in IACS and is approved by CMS. If your organization already has a SO approved in IACS, do not register another SO. To register in IACS go to https://applications.cms.hhs.gov on the CMS Web site.

1. a. A security official (SO) must register in IACS, but cannot access PQRI data.

The SO is the person who registers the organization in IACS and updates the organization profile information in IACS. There can be only one Security Official for an organization. The SO is trusted to approve the registrations requests of Backup security official(s) and user group administrators and can approve the application (e.g. the PQRI Feedback Report Application) access requests of user group administrators and end users. Because of these approval roles, the SO is not permitted to access applications, including the PQRI feedback report application.

After registering in IACS, the Security Official must submit IRS documentation to the External User Services (EUS) Help Desk as described below:

Documentation prepared by the IRS containing:

- IRS letterhead
- Typed legal business name
- Typed TIN/EIN

Examples: CP-575 hard copy form, IRS 147C letter, Copy of Federal Tax Deposit Coupon

1. b. Once the SO is approved, a User Group Administrator (UGA) must register in IACS and be approved by the SO.

A UGA registers the user hroup within an organization in IACS and updates the user group profile information in IACS. If there will be only one user in a group, that user must register as a UGA. The UGA is trusted to approve the access requests of end users for that user group. In step two, the UGA may be approved to access the 2007 PQRI feedback report negating the need for end users to register. unless there is desire to have a second person with access to the report.

1. c. End users: (optional if the UGA will access the application personally):

Once the UGA is approved, an end user may register in IACS and be approved by the UGA. An end user is a staff member who is trusted to perform Medicare business for the organization. In step two, the end user may be approved to access the 2007 PQRI feedback report.

Step two: request a PQRI application user role and be approved by the SO.

Following IACS registration, registrants need to request specific application user roles. You will be presented the option to choose one of two PQRI roles:

1. PQRI approver
2. PQRI user

In most cases PQRI user is the proper selection. Do not select PQRI approver unless someone other than the SO will be designated to approve PQRI user requests.

Organizations accessing their 2007 PQRI feedback reports (continued)

Up to 2 users approved for the user group administrator and/or end user IACS roles may request access to the PQRI feedback report application by requesting the PQRI User role. Each request must be approved by the SO.

Step three: enter PQRI feedback report application

If you have been approved in IACS for the PQRI User role, your IACS ID and password can be used to gain access to your 2007 PQRI feedback report at *http://www.qualitynet.org/pqri*. This site also contains a user guide for the PQRI system, and instructions for interpreting your 2007 PQRI feedback report.

III. IACS Quick Reference Guides

The following IACS Quick Reference Guides may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

- Separate Guides for registering as an SO, UGA, End User
- Request Access to CMS Application (request PQRI User role)
- Approver Quick Reference Guide:
  - Click on "General User Guides and Resources" in the left column for approver guide, which provides steps to approve registration requests (SO approves UGA, UGA approves end user), and for the SO to approve PQRI User role requests from UGA and/or end user.

IV. Additional help for IACS

CMS has established the External User Services (EUS) help desk to support provider access to IACS. The EUS help desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759. Hours of operation are Monday through Friday 7AM to 7PM EST.

V. Additional help for PQRI

More information about accessing 2007 PQRI Participant feedback reports will soon be posted on *http://www.cms.hhs.gov/PQRI* on the Internet.

For help accessing the PQRI system and questions on your feedback report, contact the Report Delivery System Help Desk on 866-288-8912 or by sending an e-mail to *qnetsupport@ifmc.sdps.org*.

For questions concerning the status of PQRI incentive payments and any offset applied, contact your carrier or A/B Medicare administrative contractor (MAC) provider call center.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: SE0831
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Updates to the Physician Quality Reporting Initiative Web page

The Center for Medicare & Medicaid Services (CMS) is pleased to announce that several section pages on the Physician Quality Reporting Initiative (PQRI) Web page have been updated to include the following:

- The Overview page has been updated to announce the posting of the registries that qualified for 2008 PQRI and information about the availability of the 2007 feedback reports.
- The Reporting page has been updated to add the list of registries that qualified for 2008 PQRI as a new downloadable file under the "Downloads" section.
- On the CMS Sponsored Calls page, the updated slides from the July 9 National Provider Call has been posted as a downloadable file under the "Downloads" section.
- The Educational Resources page has been updated to add the "2008 Errata Sheet: Getting Started with Claims-Based Reporting of Measures Groups" as a new downloadable file under the "Downloads" section.
- The 2007 PQRI Educational Resources page has been updated to add the two new special edition *MLN Matters* articles on accessing the 2007 feedback reports (by individuals and by organizations) as new downloadable files under the "Downloads" section.

All publicly available information on the CMS PQRI may be found at *http://www.cms.hhs.gov/PQRI*, on the CMS Web site.

Source: PERL 200808-37

PQRI 2007 incentive payment and feedback reports

The Centers for Medicare & Medicaid Services (CMS) has revised the Physician Quality Reporting Initiative (PQRI) 2007 incentive payment and feedback reports. The revised report is available at *http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA080608.pdf*. The minor changes include:

- Addition of TTY numbers and e-mail addresses for the external user service help desk and QualityNet help desk
- Two additional frequently asked questions (FAQs). (The new FAQs will also be visible on the CMS/PQRI Web site next week.)

Source: PERL 200808-36

Information for eligible professionals who participated in the 2007 PQRI

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that 2007 Physician Quality Reporting Initiative (PQRI) final feedback reports are available on a secure Web site. Two MLN Matters articles on accessing the reports are now available that can assist individual eligible professionals and group practices that reported valid 2007 PQRI quality measures data to Medicare. The reports are organized by tax identification number (TIN). For eligible professionals reporting measures for 2007 PQRI under a group practice TIN, the group practice determines who can access the feedback report for the group practice or organization.

The first article, "Steps for Individual Eligible Professionals to Access Their 2007 PQRI Feedback Reports Personally", MM SE0830, may be accessed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf*.

The second article, "Steps for Organizations to Access Their 2007 PQRI Feedback Reports", is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf*.

Once you are registered in the Individuals Authorized Access to CMS Computer Services (IACS) system and have access to the PQRI feedback report application, any questions about the feedback report should be directed to the Report Delivery System Help Desk referenced at the end of the end of the *MLN Matters* articles. Additional educational resources and information about the PQRI program is available at, *http://www.cms.hhs.gov/PQRI*.

Source: PERL 200808-28

2007 PQRI final feedback reports

The Centers for Medicare & Medicaid Services (CMS) has announced that 2007 PQRI final feedback reports are available on a secure Web site.

The first step is to register for access through a CMS security system known as the Individuals Authorized Access to CMS Computer Services (IACS). Do not register if you did not report PQRI quality measures in 2007.

There are two categories of user types in IACS: individual practitioner and organization. The CMS approval process differs depending on the type of user you are; therefore, it is important to register correctly.

2007 PQRI final feedback reports (continued)

Follow these instructions if you are a professional paid by Medicare directly (you have not reassigned Medicare payments to a group practice):

If you do not have employees, the CMS approval process requires you to register as an individual practitioner and access the PQRI 2007 feedback report personally. Some solo professionals have incorrectly registered in IACS as organizations, and have had to re-register as individual practitioners.

If you have employees and therefore are an organization for tax purposes, you may select one of two options:

Option 1: Register in IACS as an organization if you will use one or more employees to access IACS and/or your PQRI feedback reports

Option 2: Register in IACS through the Individual Practitioner role if you will access the PQRI report personally.

If you are a professional who has reassigned Medicare payments to a group practice:

Do NOT register in IACS unless you are one of the individuals designated to do so by the group practice.

Group practices will register in IACS as organizations. Up to two individuals will be able to access the 2007 PQRI feedback report for each organization that registers in IACS. One 2007 PQRI feedback report will be prepared for each taxpayer identification number (TIN). The group practice will be responsible for sharing national provider identifier (NPI) level information with the appropriate professionals within the group practice.

For more information

IACS quick reference guides may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp* on the CMS Web site. Summary information about accessing the 2007 PQRI feedback reports for those registering as organizations and individual practitioners will soon be posted on *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

Source: PERL 200808-01

Transcript posted for July 15 special PQRI open door forum

The transcript for the July 15 Special ODF: PQRI – Participation by the American College of Physicians has been posted on the Special ODF Web site at *http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp#TopOfPag* under the *Downloads* section. During the call, as transcribed on page 30, Dr. Hornback inadvertently stated 15 percent instead of 1.5 percent in his presentation regarding incentive payment. Please make note of the correct percentage rate 1.5 percent when reading the transcript.

Source: PERL 200807-30

GENERAL INFORMATION

Medicare awards contracts for quality improvement organizations

Nationwide network of contractors to work with providers on improving quality and safety of health care for Medicare beneficiaries

The Centers for Medicare & Medicaid Services (CMS) has awarded contracts for the 9th statement of work (SOW) for the 53 contractors participating in the Medicare quality improvement organization (QIO) program. The 9th SOW focuses on improving the quality and safety of health care services to Medicare beneficiaries. The QIO contracts extend from August 1, 2008, through July 31, 2011, and mark a new direction for the QIO program.

The QIO program 9th SOW aims to improve the quality of care and protect Medicare beneficiaries through three national themes, to be implemented by each of the 53 QIO contractors nationwide throughout the contract period:

- Beneficiary protection
- Patient safety (also known as the "CMS National Patient Safety Initiative")
- Prevention

In addition to these national themes, QIOs in select states will focus on health disparities reduction, care transitions, and chronic kidney disease work.

For more information about the QIO 9th statement of work, including a list of all 53 QIOs and the states/jurisdictions selected for sub-national work, view the fact sheet at *http://www.cms.hhs.gov/QualityImprovementOrgs/downloads/9thSOWAnnouncement080508.pdf*.

For more information, please visit *http://www.cms.hhs.gov/QualityImprovementOrgs*.

Source: PERL 200808-17

CMS announces Medicare premiums and deductibles for 2009

The standard Medicare Part B monthly premium will be $96.40 in 2009, the same as the Part B premium for 2008. This is the first year since 2000 that there was no increase in the standard premium over the prior year.

The 2009 Part B premium of $96.40 is the same as the amount projected in the 2008 Medicare Trustees Report issued in March. This monthly premium paid by beneficiaries enrolled in Medicare Part B covers a portion of the cost of physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

By law, the standard premium is set to cover approximately one fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. The income to the program from premiums and general revenues are paid into the Part B account of the Supplementary Medical Insurance trust fund, and Part B expenditures are drawn from this account.

To view this fact sheet in its entirety go to *http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3272&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date* to view this fact sheet in its entirety.

Source: PERL 200809-41

Beneficiary submitted claims

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

Provider types affected

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

Provider action needed

Change request (CR) 5683 updates the procedures for processing claims submitted by Medicare beneficiaries to carriers and/or A/B MACs and serves as a reminder to providers and suppliers that they are required by law to submit claims to Medicare for services they render to Medicare beneficiaries. These updates do not apply to beneficiary claims submitted to durable medical equipment (DME) MACs.

Background

All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, the Social Security Act (section 1848 [g][4][A] *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) requires all providers and suppliers to submit claims for services rendered to Medicare beneficiaries. The current manual requirement instructs Medicare contractors to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided. Medicare contractors are also instructed to process beneficiary submitted claims for services that:

Beneficiary submitted claims (continued)

(1) Are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc., in accordance with its normal processing procedures; see 42 CFR 411.15 at *http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf* for details), and

(2) Are covered by Medicare when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S*; http://www.cms.hhs.gov/CMSForms/CMSForms/*) and all supporting documentation associated with the claim, including an itemized bill with the following information:

- Date of service
- Place of service
- Description of illness or injury
- Description of each surgical or medical service or supply furnished
- Charge for each service
- The doctor's or supplier's name, address
- The provider or supplier's national provider identifier (NPI).

If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. The Centers for Medicare & Medicaid Services (CMS) will be providing suggested language for that letter in a later transmittal. In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims when the beneficiary used a CMS-1500 with instructions on how to complete and return the CMS-1490S for processing.

Note: CMS will be providing suggested language for the above mentioned letter in a later transmittal.

When manually returning a beneficiary submitted claim (CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:

- The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and
- In order to submit the claim, the provider must enroll in the Medicare program.

Medicare contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare.

(2) Submit a complete CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the beneficiary's claim Form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

Contractors will maintain:

(1) Documentation of beneficiary complaints involving violations of the mandatory claims submission policy

(2) A list of the top 50 violators (by state) of the mandatory claim submission policy.

The instructions provided in CR 5683 do not apply to foreign claims, and they do not apply to beneficiary claims submitted to DME MACs (for durable medical equipment, prosthetics, orthotics and supplies). The processing of foreign claims will remain unchanged, and DME MACs should continue to follow procedures that are currently in place.

Additional information

The official instruction, CR 5683, issued to your carrier, A/B MAC, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1588CP.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007 (FL) or 1-888-760-6950 (CT).

MLN Matters Number: MM5683
Related Change Request (CR) #: 5683
Related CR Release Date: September 5, 2008
Effective Date: Claims received on or after August 18, 2008
Related CR Transmittal #: R1588CP
Implementation Date: August 18, 2008

New CMS initiative helps to identify and assist Medicare beneficiary caregivers

Ask Medicare provides online information, tools, and materials for caregivers

The Centers for Medicare & Medicaid Services (CMS) recently launched Ask Medicare, a new initiative to help family caregivers -- those who are family members or friends who help people with Medicare access and use valuable health care information, services, and resources.

According to a recent report by AARP, more than 44 million Americans (more than one in five adults), provide care valued in economic terms of $350 billion annually, to a loved one, friend, or neighbor.

The new initiative will provide a one-stop Web page for caregivers *http://www.medicare.gov/caregivers* that provides easy access to useful information about Medicare and other essential resources to help with caregiving. Most caregivers do not think of or identify themselves as caregivers; however, many of the resources available to them use that term.

The Ask Medicare Web site will provide links to key partner organizations that assist caregivers and beneficiaries, and present personal stories from caregivers in the community. Support information and tools to help caregivers address common problems will also be available. As part of the initiative, CMS will launch an e-newsletter for caregivers that will deliver information into the subscribers' e-mail boxes.

For more information about Medicare's new caregiver initiative, please visit *http://www.medicare.gov/caregivers*.

To read the CMS press release issued on September 18, 2008, click here *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200809-41

Limitation on recoupment of section 935 for provider, physicians and suppliers overpayments

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

Provider types affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit claims to Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], carriers, Medicare administrative contractors (A/B/MAC), or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided or supplied to Medicare beneficiaries.

What you need to know

Change request (CR) 6183, from which this article is taken, announces changes to the physician, provider, and supplier overpayment recoupment process, as required by Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which amended Title XVIII of the Social Security Act to add to Section 1893 a new paragraph (f) addressing this process. The important points of interest for providers are as follows:

- For overpayments subject to this limitation on recoupment, Medicare will not begin overpayment collection of debts (or will cease collections that have started) when it receives notice that the provider has requested a Medicare contractor redetermination (first level of appeal) or a reconsideration by a qualified independent contractor (QIC).
- As appropriate, Medicare will resume overpayment recoveries with interest if the Medicare overpayment decision is upheld in the appeals process.
- If the administrative law judge (ALJ) level process reverses the Medicare overpayment determination, Medicare will refund both principal and interest collected, and also pay Section 935 interest on any recouped funds that Medicare took from ongoing Medicare payments. (If a provider has any other outstanding overpayments, Medicare will apply the amount *collected* first to those overpayments and any excess monies will then be refunded back to the provider.)
- Payment of Section 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions. Interest is only payable on the principal amount recouped.
- Providers must note that when Medicare sends a demand letter notifying a provider of Medicare's intent to collect an overpayment, the provider may submit a letter of rebuttal that disputes the debt. The rebuttal letter will not necessarily stop Medicare from beginning the process of recouping that debt. Only a provider's timely and valid request for a redetermination or reconsideration will halt the recoupment.

This article provides more detail on these general points and clarifies which overpayments are subject to this limitation on recoupment and which types of overpayments are not subject to this limitation. Make sure that your billing staffs are aware of these changes as described below.

Background

Before the MMA was enacted, a provider electing to appeal an overpayment determination did not affect Medicare's prerogative to recover the debt. However, through an amendment of Title XVIII of the Social Security Act (the Act), MMA Section 935 changed this process, by adding a new paragraph (f) to Section 1893 of the Act.

This amendment requires the Centers for Medicare & Medicaid Services (CMS) to change: 1) the way it recoups certain overpayments to providers, physicians and suppliers; and 2) how it pays interest to a provider, physician or supplier whose overpayment is reversed at subsequent ALJ or judicial levels of appeal.

CR 6183 describes these changes to the providers, physicians and suppliers overpayment recoupment process. Specifically, Section 1893 (f)(2)(a) of the Social Security Act protects providers, physicians, and suppliers during the initial stages of the appeal process (both first level appeal – contractor redetermination, and second level appeal – QIC reconsideration) by limiting the recoupment process for Medicare overpayments while the appeals process is underway.

Limitation on recoupment of section 935 for overpayments (continued)

It requires that when a valid first or second level appeal is received from a provider on an overpayment, subject to certain limitations (see below), CMS and its Medicare contractors may not recoup the overpayment until the decision on the redetermination and/or reconsideration has been rendered.

Overpayments that are subject to limitation on recoupment

- Determined post-pay denial of claims for benefits under Medicare Part A for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of the medical record, claim, or billing records is subject to this provision).
- Determined post-pay denial of claims for benefits under Medicare Part B for which a written demand letter was issued.
- Medicare Secondary Payer (MSP) recovery where the provider or supplier received a duplicate primary payment and for which a written demand letter was issued (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision), or
- MSP recovery based on the provider's or supplier's failure to file a proper claim with the third party payer plan, program, or insurer for payment for Part A or B (a letter informing the provider of the overpayment determination as a result of a post payment review of claim or billing records is subject to this provision).
- The final claims associated with a home health agency (HHA) request for anticipated payment (RAP) under the home health prospective payment system (HH PPS), but not the RAP itself (see table 2).

Overpayments that are not subject to limitation on recoupment

- All other MSP recoveries except those identified in the preceding section of this article.
- Beneficiary overpayments
- Overpayments that arise from a cost report determination.
- Overpayments that are appealed under the provider reimbursement payment (PRB) process of 42 CFR parts 405 subpart R-Provider/Reimbursement Determinations and Appeals.
- HHA requests for anticipated payment (RAP) under home health prospective payment system (HH PPS).

  Note: While a RAP is not considered a claim for purposes of Medicare appeal regulations, it is submitted using the same format as Medicare claims. RAPs under the HH PPS do not have appeal rights during: 1) the 120 days from the start of the episode; or 2) 60 days from the payment date of the RAP to submit the final claim. Rather, appeals rights are tied to the claims that represent all services delivered for the entire HH PPS episode. (Refer to the *Medicare Claims Processing Manual*, Chapter 10 (Home Health Agency Billing), Sections 10.1.10 (Provider Billing Process Under HH PPS), 10.1.11 (Payment, Claim Adjustments and Cancellations), 10.1.12 (Request for Anticipated Payment (RAP)), 40.1 (Request for Anticipated Payment [RAP]), and 50 (Beneficiary-Driven Demand Billing Under HH PPS). This manual is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.**)**

- Hospice caps calculations
- Provider initiated adjustments
- Accelerated/advanced payments
- Certain claims adjustments at the contractors' discretion that will not be subject to Section 935 (this requires approval by CMS).

The rebuttal process

Here is how the rebuttal process with the limitation on recoupment works.

You are given an opportunity to **rebut** any proposed recoupment action submitting a statement within 15 days of the notice of an impending recoupment action. **These rebuttal procedures occur prior to the appeals process and are separate from the requirements of the limitation on recoupment.**

The rebuttal process gives you a vehicle to indicate why the proposed recoupment should not take place; but you should remember that, as opposed to the limitations that CR 6183 describes, your Medicare contractor may (based on the rebuttal statement) determine to either stop, or proceed with, recoupment.

Step one – overpayments

Part A

As a result of post-pay reviews or MSP recoveries and during the Part A claim adjustment process (including Part B of A claims), Medicare FIs, RHHIs, and/or MACs, will determine if the limitations apply to the claim and annotate the system of the MMA Section 935 adjustment. If the adjustment results in a refund to the provider, they will follow existing underpayment policies; however, if the adjustment is deemed an overpayment and the Section 935 rules apply, they will mark the claim as being available for the limitation on recoupment protections.

Part B

As a result of post-pay reviews or MSP recoveries and during the Part B claim adjustment process, Medicare carriers and MACs, including DME MACs, will adjust claims in the normal manner.

Limitation on recoupment of section 935 for overpayments (continued)

Step two – demand letter

These adjustments will trigger the creation of the first demand letter (unless previously issued), which (in addition to the requirements listed in the *Medicare Financial Management Manual*, Chapter 3 [Overpayments], and Chapter 4 [Debt Collection]) will:

- States that the provider may submit a rebuttal statement (which is not an appeal request) to any proposed recoupment action and the Medicare contractor will review it and consider whether to proceed or stop the offset (remember that they may elect to continue recoupment).
- States that in order to stop recoupment under the provisions of Section 935 of the MMA; providers must request a valid appeal (redetermination) of the overpayment within 30 days from the date of the demand letter.
- Explains how the overpayment arose, the amount of the overpayment, how the overpayment was calculated, and why the original payment was not correct.
- Explains why the provider knew or should have known the items or services would not be covered, as well as the regulatory and statutory references for the 1879 determination, **or** (when appropriate) why the provider was not found to be without fault in causing the overpayment.
- Explains that recoupment will begin on the 41st day from the date of the first demand letter if:

  1) payment is not received in full, or
  2) an acceptable request for an extended repayment schedule, or 3) a valid request for a contractor redetermination is not date stamped in the Medicare contractor's mailroom by day 30 from the date of the demand letter.

  However, if the appeal is filed later than 30 days, the contractor will also stop recoupment at whatever point that an appeal is received and validated, but Medicare may not refund any recoupment already taken.

Notes:

1. Timeliness of this request is important because if you don't send this request within 30 days, Medicare can begin to recoup on the 41st day from the date of the Medicare demand letter.
2. In addition, during this appeal process, while the Medicare contractor cannot recoup or demand the debt, it continues to age (its interest continues to accrue); and, once both levels of appeal are completed, if the appeal decision results in an affirmation of the overpayment decision, collection activities may resume within the designated timeframes.
3. If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. You should immediately notify your Medicare contractor about this bankruptcy so that they can coordinate with both CMS and the Department of Justice to assure that your particular situation is handled properly.

Step three – how to stop recoupment

First level appeal (redetermination)

Recoupment can proceed on day 41 from the first demand letter unless you submit a request for a redetermination by the 30th day following the date of the first demand letter, in which case recoupment will stop.
Table 1 below displays the time frame for the recoupment process after the first demand letter.

Time frame	Medicare contractor	Provider
Day 1	Date of demand letter (date demand letter mailed).	Provider receives notification by first class mail of overpayment determination.
Day 1-15	Day 15 deadline for rebuttal request. No recoupment occurs.	Provider must submit a statement within 15 days from the date of demand letter.
Day 1-40	No recoupment occurs.	Provider can appeal and potentially limit recoupment from occurring.
Day 41	Recoupment begins.	Provider can appeal and potentially stop recoupment.

Redetermination or reconsideration (appeals) requests

Upon receiving your valid request for a redetermination of an overpayment, your Medicare contractor will take the following actions:

- Cease recoupment of the overpayment that is the subject of the appeal, or will not initiate recoupment if it has not yet started.
- Retain any amounts recouped, if they had already recouped funds before receiving the request for redetermination, and apply them first to interest and then to principal.
- Will continue to collect any other debts that you might owe, but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

Limitation on recoupment of section 935 for overpayments (continued)

A redetermination can have three possible outcomes:

1. Full reversal of the overpayment decision.
   In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (they may apply these funds to any other debt that you might owe and then release any excess to you).
2. Partial reversal (partially favorable) of the overpayment decision.
   In this instance (in which the debt is reduced below the initial stated amount) Medicare contractors will recalculate the correct amounts of both the underpayment and the overpayment, make appropriate payments to you if due; or, if necessary, issue a revised demand letter for the newly calculated overpayment amount. This letter will state that the contractor can begin recoupment no earlier than the 61st day from the date of the revised overpayment determination if they have not been notified by the QIC that you have requested a reconsideration. It will also state that in order to stop recoupment under the provisions of Section 935 of the MMA, you must request a valid appeal (reconsideration) of the overpayment within 60 days from the date of the notice. It will also remind you that you have an opportunity to rebut the proposed recoupment action (but keep in mind that a rebuttal does not mandate that recoupment will stop).
3. Full affirmation of the overpayment decision.
   With this "unfavorable" decision that upholds the overpayment determination, the Medicare contractor will issue the second or third demand letter (as appropriate), which will state that they can begin to recoup no earlier than 61st calendar day from the Medicare redetermination notice, it they have not been notified by the QIC that you have requested a reconsideration.

Table 2 below displays the time frame for the recoupment process after redetermination.

Time frame	Medicare contractor	Provider
Day 60 following revised notice of overpayment following redetermination	Date reconsideration request is stamped in mailroom, or payment received from the revised overpayment notice	Provider must pay overpayment or must have submitted request for 2nd level appeal
Day 61 – 75	Recoupment could begin on the 61st day	Provider appeals or pays
Day 76	Recoupment begins or resumes	Provider can still appeal. Recoupment stops on date receipt of appeal

Second level appeal (reconsideration)

You can also stop Medicare from recouping any payments at a second point in the recoupment process by filing a valid request for reconsideration with the QIC within 60 days of the appropriate notice/letter.

When your Medicare contractor receives notification from the QIC of your valid and timely request for a reconsideration, they will:

- Cease recoupment of the overpayment, or not initiate recoupment if it has not yet begun.
- Retain the amount recouped, and apply it first to interest and then to principal (if the recoupment process had begun before the reconsideration request was received).
- Will continue to collect other debts that you might owe, if an overpayment is appealed and recoupment stopped; but will not withhold or place in suspense any monies related to this debt, while it is in the appeal status.

A QIC reconsideration can have three possible outcomes:

1. Full reversal
In this instance, Medicare contractors may need to adjust the overpayment and amount of interest charged (the amount held may be applied to any other debt that you might owe and any excess refunded to you).

2. Partial reversal
In this instance, this reduces the overpayment. Medicare contractors effectuate the redetermination decision and if necessary issue a revised demand letter to the provider of the revised overpayment amount or make appropriate payments if due of the underpayment amount. Medicare contractors may apply the excess to any other debt (including interest) that you might owe before releasing payment to you.
They will issue you a notice of the revised overpayment amount, which will also state that they can begin to recoup on the 30th day, from the date of notice of the revised overpayment. This is to give you an opportunity to make payment arrangements or to rebut the recoupment as described above.

3. Affirmation
If the QIC reconsideration results in an "unfavorable" overpayment decision, recoupment may be resumed on the 30th calendar day after the date of the notice of the reconsideration. This gives you time to make payment or to request a repayment plan.

Note: Medicare contractors can initiate (or resume) recoupment immediately upon receipt the QIC's decision or dismissal notice of a physician's, provider's, or supplier's request for reconsideration, regardless of a subsequent appeal to the ALJ (third appeal level) and all further levels of appeal (see the following).

Third level of appeal (administrative law judge)

Whether or not the provider, physician or supplier subsequently appeals the overpayment to the ALJ, the Medicare Appeals Council, or federal court, the Medicare contractor will continue to recoup until the debt is satisfied in full.

Additional details of CR 6183

CR 6183 also provides some additional specific payment details, i.e.:

Limitation on recoupment of section 935 for overpayments (continued)

1. If you have been granted an extended repayment schedule (ERS) and have submitted a valid and timely request for a redetermination or reconsideration to the Medicare contractor, you will not be considered in default if your payments were not made. The appeal would supersede the ERS agreement.
   Further, payments that you make under an ERS are **not** recoupment for the limitation provision and are not subject to Section 935 interest, if reversed at the ALJ appeal or above. However, if you default on the ERS schedule and recoupment begins before a valid and timely request has been received, those recoupment **are** subject to payment of interest under the Section 935 interest requirements.
2. Suspended funds involving providers who have been put on payment suspension are **not** a "recoupment" for purposes of the limitation on recoupment. Medicare is not restricted from applying suspended funds to reduce or dispose of an overpayment. However, if the suspended payments are insufficient to fully eliminate any overpayment, and the provider or supplier meets the requirements of 42 CFR, Section 405.379 "Limitation on Recoupment" provision under Section 1893(f)(2) of the Social Security Act, Section 935 of the MMA Act will be applicable to any remaining balance still owed to CMS.
3. Payments made by a provider in response to a demand are **not** recoupments. Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. Therefore, payments made in response to a demand are **not** subject to Section 935 interest.
4. Lastly, CR 6183 amends the way interest is to be paid to a provider or supplier whose overpayment determination is overturned in administrative or judicial appeals subsequent to the second level of appeal (QIC reconsideration). This is called Section 935 interest, which is payable on an underpayment when the reversal occurs at the ALJ level or subsequent levels of administrative appeal, when that decision results in a full or partial reversal of the prior decision and contractors retained recouped funds (based on the period that Medicare recouped the provider's or supplier's funds). Payment of Section 935 interest is only applicable to overpayments recovered under the limitation on recoupment provisions, and is only payable on the principal amount recouped. In these instances, Medicare will pay simple interest rather than compound interest, and ***will not pay interest on interest; (mirroring the manner in which interest against providers is assessed).*** Monies recouped and applied to interest would be refunded and **not** included in the "amount recouped" for purposes of calculating any interest due the provider.

The periods of recoupment will be calculated in full 30-day periods; and interest **will not** be payable for any periods of less than 30 days in which Medicare had possession of the recouped funds; and will be calculated for each 30-day period using the interest rate in effect on the ALJ decision date or the revised written final determination date.

Finally, please be aware that CR 6183 does not change the rebuttal process for this recovery, nor the appeal process including the appeal levels, the time a provider or supplier has to file a request for appeal, or the decision making time frames.

Additional information

You may find the official instruction, CR 6183, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting the CMS Web site *http://www.cms.hhs.gov/Transmittals/downloads/R141FM.pdf*.

You will find the updated *Medicare Financial Management Manual*, Chapter 3 (Overpayments), as an attachment to CR 6183.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6183
Related Change Request (CR) Number: 6183
Related CR Release Date: September 12, 2008
Effective Date: September 29, 2008
Related CR Transmittal Number: R141FM
Implementation Date: September 29, 2008

Medicare issues new rules to enforce marketing requirements

The two regulations issued today include prohibitions on telemarketing and other unsolicited sales contacts. The new rules also prohibit financial incentives that could encourage agents and brokers to maximize commissions by inappropriately moving, or churning, beneficiaries from one plan to another each year. Plans must be in compliance with these provisions when they begin their marketing activities on October 1, 2008.

The final rule implementing MIPPA marketing requirements may be viewed at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/2008-21674_PI.pdf*.

The interim final rule dealing with agent commissions and other MIPPA provisions may be viewed at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/2008-21686_PI.pdf*.

Comments are due at 5:00 p.m. Eastern time on November 15, 2008.

Guidance for MA plans under Part C and PDPs under Part D plans may be viewed at *http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/MIPPA_Imp_memo091208Final.pdf*.

Fact sheets with more information on each rule may be viewed at *http://www.cms.hhs.gov/apps/media/fact_sheets.asp*.

To read more of the CMS press release issued September 15, 2008, click here: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200809-41

Reporting withholding due to IRS federal payment levy program on the remittance advice

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

Provider types affected

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

Provider action needed

Stop – impact to you

Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe.

Caution – what you need to know

The Taxpayer Relief Act of 1997, Section 1024, requires the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of "WU" in the PLB03-1 data field.

Go – what you need to do

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

Background

In July 2000, the Treasury Department's Financial Management Service and the IRS started the Federal Payment Levy Program (FPLP), which is authorized by the Internal Revenue Code Section 6331 (h), as prescribed by Section 1024 of the Taxpayer Relief Act of 1997. Through this program, collection of overdue taxes through a continuous levy on certain federal payments is authorized. This includes federal payments made to contractors and vendors, including Medicare providers, doing business with the government.

IRS may reduce federal payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, the Financial Management Service will send a letter of explanation, including information on which federal payment was levied, and advice on who to contact for resolution.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of "WU" in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field. **Should this happen to you, note that under current privacy rules and regulations, only the IRS may discuss the tax issue with you. Thus, if you have questions, contact the IRS at the toll-free number just mentioned, instead of contacting your Medicare contractor.**

Additional information

To view the official instruction (CR 6125) issued to your Medicare contractor on this issue, visit on the Centers for Medicare & Medicaid Services Web site *http://www.cms.hhs.gov/Transmittals/downloads/R367OTN.pdf*.

MLN Matters Number: MM6125
Related Change Request (CR) Number: 6125
Related CR Release Date: August 15, 2008
Related CR Transmittal Number: R367OTN
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Physician signature requirements for diagnostic tests

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MAC]) for diagnostic laboratory services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (Definitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests (including X-ray, laboratory, and other diagnostic tests) that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional information

You may find more information about physician signature requirements for diagnostic tests by going to CR 6100, located at *http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

You will find the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (Definitions) as an attachment to CR 6100.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6100
Related Change Request (CR) Number: 6100
Related CR Release Date: August 29, 2008
Related CR Transmittal Number: R94BP
Effective Date: January 1, 2003
Implementation Date: September 30, 2008

Signature requirements CR 5971 clarification

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries, regional home health intermediaries, Part A/B Medicare administrative contractors, including durable medical equipment Medicare administrative contractors) for care provided to Medicare beneficiaries.

What you need to know

The purpose of this notice is to provide guidance to providers/suppliers and Medicare contractors on the use of stamped signatures. Note that stamped signatures are not acceptable on any medical record.

Background

The Centers for Medicare & Medicaid Services (CMS) has taken this step to ensure accurate application of Medicare's program requirements throughout the nation. CMS has identified problems of noncompliance with existing statutes, regulations, rules, and other systematic problems relating to standards of practice for a valid physician's signature on medical orders and related medical documents.

CR 5971 (transmittal #248) was issued to prohibit the use of stamped signatures. These requirements are intended to apply all providers/suppliers. *Stamped signatures are not acceptable on any medical record.* Medicare will accept hand written, electronic signatures or facsimiles of original written or electronic signatures..

In addition, the Medicare Conditions of Participation (CoP) are requirements for ensuring health and safety. The CoPs define specific quality standards that providers must meet to participate in the Medicare program. A provider's compliance with the CoPs is ultimately determined by the CMS regional office based on the State survey agency recommendation (per the *Medicare Program Integrity Manual*, Publication 100-8, Chapter 3, Section 3.4.2.1, which is available at *http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf* on the CMS Web site). Compliance with the CoPs and any related policies does not necessarily ensure that certain requirements for payment are being met.

Additional information

The official instruction, CR 5971, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf* on the CMS Web site.

Signature requirements CR 5971 clarification (continued)

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: SE0829
Related Change Request (CR) #: 5971
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Implementation of new provider authentication requirements for Medicare contractor provider telephone and written inquiries

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

Provider types affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], or durable medical equipment Medicare administrative contractors [DME MACs]). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to interactive voice response (IVR) systems.

What you need to know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a customer service representative (CSR).

Effective March 1, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide all three of the following data elements for authentication:

1) Your national provider identifier (NPI)
2) Your provider transaction access number (PTAN)
3) The last five digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last five digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last five digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last five digits of your TIN.

As a result of CR 6139, the Disclosure Desk Reference for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

Authentication of providers with no NPI

Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

Beneficiary authentication

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

1. last name
2. first name or initial, health insurance claim number (HICN)
3. either:

Implementation of new provider authentication requirements (continued)

- date of birth (eligibility, next eligible date) and Durable Medical Equipment Medicare Administrative Contractor Information Form [DIF] [pre-claim]
- date of service (claim status, CMN/DIF [post-claim])

Written inquiries

In general, three data elements (NPI, PTAN, and last five digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, preformatted inquiry forms or inquiries written on remittance advice (RAs) or Medicare summary notices [MSNs]).

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either, the NPI, PTAN, or last five digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last five digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

Overlapping claims

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last five digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional information

You may find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at *http://www.cms.hhs.gov/Transmittals/downloads/R22COM.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6139
Related Change Request (CR) #: 6139
Related CR Release Date: August 8, 2008
Effective Date: March 1, 2009
Related CR Transmittal #: R22COM
Implementation Date: January 5, 2009

Revised form CMS-R-131 advance beneficiary notice of noncoverage

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

Provider types affected

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

What you need to know

Change request (CR) 6136, from which this article is taken announces that, effective March 3, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented use of the revised advance beneficiary notice (ABN) of noncoverage; which combines the general advance beneficiary notice (ABN-G) and laboratory advance beneficiary notice (ABN-L) into a single form, with form number CMS-R-131.

You should be aware that beginning March 3, 2008, and prior to March 1, 2009, your contractors will accept either the current ABN-G, and ABN-L or the revised ABN as valid notification. **However, beginning March 1, 2009, Medicare contractors will accept only a properly executed revised ABN (CMS-R-131) as valid notification**.

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

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious nonmedical health care institutions paid under Part A; were instructed to use the general ABN-G or ABN-L to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised ABN of noncoverage. This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS-R-131).

The *Medicare Claims Processing Manual* chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. 85 subsections have been deleted from this chapter, and 47 are either new or have been revised. Attached to CR 6136 is the updated chapter 30 and the Web address for viewing CR 6136 is contained in the "*Additional Information*" Section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare fee-for-service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious nonmedical health care institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).

Revised CMS-R-131 ABN of noncoverage (continued)

2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and notice of exclusion from Medicare benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

   Note: Once the revised skilled nursing facility (SNF) ABN is implemented, SNFs must use the revised SNF ABN for all items and services billed to Part A and Part B.

3. The following situations require by statute that an ABN be issued:
   - Care is not reasonable and necessary
   - There was a violation of the prohibition on unsolicited telephone contacts
   - Medical equipment and supplies supplier number requirements not met
   - Medical equipment and/or supplies denied in advance
   - Custodial care
   - A hospice patient who is not terminally ill.

4. In the following situations ABN use is voluntary ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).
   Additionally, the ABN may also be issued voluntarily in place of the NEMB for care that is never covered such as:
   - Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act.
   - Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
     - Services for which there is no legal obligation to pay
     - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles)
     - Services required as a result of war
     - Personal comfort items
     - Routine physicals (except the initial preventive physical or "Welcome to Medicare" physical examination) and most screening tests
     - Routine eye care
     - Dental care
     - Routine foot care

5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as "**notifiers**". Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.

   Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three "**triggering events**" during a course of treatment (initiation, reduction, and termination).
   Notifiers must give an ABN to "**recipients**" (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers' inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient's record and undisputed by the beneficiary.

Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN preparation requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DME-POS), hospice, and comprehensive outpatient rehabilitation facility (CORF).

Additional information

You may find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf* on the CMS Web site.

There you will find the updated *Medicare Claims Processing Manual* chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

Revised CMS-R-131 ABN of noncoverage (continued)

Additional information on the revised ABN and other limitation of liability notices may be found on the Beneficiary Notice Initiatives Web site at *http://www.cms.hhs.gov/bni*. Questions regarding the revised ABN may be e-mailed to *RevisedABN_ODF@cms.hhs.gov*.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6136
Related Change Request (CR) Number: 6136
Related CR Release Date: September 5, 2008
Related CR Transmittal Number: R1587CP
Effective Date: March 3, 2008
Implementation Date: March 1, 2009

Medicare contractor annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

Provider types affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DMACs], and fiscal intermediaries [FIs] including regional home health intermediaries [RHHIs]).

Impact on providers

This article is based on change request (CR) 6107 and reminds the Medicare contractors and providers that the annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) will be effective for dates of service on and after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008). You may see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage*, or at the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm* in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6107 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs), and for all institutional claims; but is not required for ambulance supplier claims.

Additional information

The official instruction (CR 6107) issued to your Medicare contractor is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1566CP.pdf* on the CMS Web site.

As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage* on the CMS Web site or at the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm*, in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6107
Related Change Request (CR) #: 6107
Related CR Release Date: July 29, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1566CP
Implementation Date: October 6, 2008

HHS proposes adoption of ICD-10 code sets and updated electronic transaction standards

Proposed changes would improve disease tracking and speed transition to an electronic health care environment

The Department of Health and Human Services (HHS) announced Friday a long-awaited proposed regulation that would replace the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets, effective October 1, 2011. In a separate proposed regulation, HHS has proposed adopting the updated X12 standard, Version 5010, and the National Council for Prescription Drug Programs standard, Version D.0, for electronic transactions, such as health care claims. Version 5010 is essential to use of the ICD-10 codes.

In 2000, under authority provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the ICD-9-CM code sets were adopted for use in the administrative transactions by both the public and private sectors to report diagnoses and inpatient hospital procedures. Covered entities required to use the ICD-9-CM code sets include health plans, health care clearinghouses, and health care providers who transmit any electronic health information in connection with a transaction for which a standard has been adopted by HHS.

Developed almost 30 years ago, ICD-9 is now widely viewed as outdated because of its limited ability to accommodate new procedures and diagnoses. ICD-9 contains only 17,000 codes and is expected to start running out of available codes next year. By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures. The additional codes will help to enable the implementation of electronic health records because they will provide more detail in the electronic transactions.

Comments on the both the ICD-10 code sets proposed rule and the updated transaction proposed standards are due by 5:00 p.m. Eastern time on October 21, 2008.

Both regulations may be viewed at *www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSets-Regulations.asp#TopOfPage*.

To read the HHS press release issued please click here or see attached: *http://www.hhs.gov/news/press/2008pres/2008.html*.

Fact sheets describing both proposed rules will be forthcoming at *http://www.cms.hhs.gov/apps/media/fact_sheets.asp*.

Visit the Medicare Learning Network – it's free

Source: PERL 200808-23

Flu shot reminder

Flu season is coming! It's not too early to start vaccinating as soon as you receive vaccine. Encourage your patients to get a flu shot as it is still their best defense against the influenza virus. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don't forget, health care workers also need to protect themselves. Get your flu shot – not the flu.

Remember: Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug.

For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professions and their staff, please go to *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf* on the CMS Web site. To order, free of charge, a quick reference chart on Medicare Part B Immunization Billing go to *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5* on the CMS Web site.

Source: PERL 200809-19

August is national immunization awareness month

The goal of the national immunization awareness month (NIAM) is to increase awareness about immunizations across the life span, from infants to the elderly. Getting immunized is a lifelong effort regardless of age, sex, race, ethnic background or country of origin. As parents prepare their children for school, students enter college and healthcare workers prepare for the upcoming flu season, the month of August and NIAM present an excellent opportunity to remind individuals that they can help protect themselves, their families, friends and their communities from serious, life-threatening infections by staying up-to-date with their immunizations.

Medicare helps beneficiaries with the cost of adult immunizations by providing coverage for pneumococcal, influenza and hepatitis B vaccines. Medicare covers the cost of pneumococcal and influenza vaccines and their administration by recognized providers. No beneficiary co-insurance or co-payment applies and a beneficiary does not have to meet his or her deductible to receive an influenza or pneumococcal immunization. Medicare also covers hepatitis B vaccination for persons at high or intermediate risk. The coinsurance or co-payment applies for hepatitis B vaccination after the yearly deductible has been met.

How can you help?

As a health care professional, you play an important role in helping your Medicare patients and others understand the importance of disease prevention through immunizations. Your recommendation is one the most important factors in increasing immunization rates among people with Medicare. Be aware of the recommended vaccines for adults of all ages and particularly seniors. Encourage your Medicare patients to stay up-to-date on recommended vaccines including those adult immunizations covered by Medicare (an annual influenza vaccination, a pneumococcal vaccination and the hepatitis B vaccination

August is national immunization awareness month (continued)

(for beneficiaries at high to intermediate risk) by encouraging utilization of these benefits as appropriate.

For more information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of provider education and outreach resources to help providers and suppliers to learn more about Medicare's coverage, coding, billing and reimbursement of influenza, pneumococcal, and hepatitis B immunizations. Resources include:

- The Guide to Preventive Services for Providers, Physicians, Suppliers and Other Health Care Professionals *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- Quick Reference Information: Medicare Part B Immunization Billing Chart *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*
- Adult Immunizations Brochure *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*
- The MLN Preventive Services Educational Products Web Page *www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*

For information to share with your Medicare patients, please visit *www.medicare.gov* on the Web.

To learn more about National Immunization Awareness Month, please visit *http://www.cdc.gov/vaccines/events/niam/default.htm#add* on the Web.

Thank you for supporting the effort to increase awareness and promote utilization of vaccines that can prevent infectious disease and save lives.

Visit the Medicare Learning Network – it's free!

Source: PERL 200808-03

September 21-27, 2008, is national adult immunization awareness week

This annual health observance is a great opportunity to promote the importance of adult immunizations. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers who accept the Medicare-approved payment amount for influenza, pneumococcal, and hepatitis B vaccines and their administration. All adults 65 and older should get influenza and pneumococcal shots. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a flu shot. People at medium to high risk for hepatitis B should get hepatitis B shots. CMS needs your help to ensure that people with Medicare take full advantage of these vital preventive benefits. You can help by talking with your Medicare patients about their risk for these vaccine-preventable diseases covered by Medicare and the steps they can take to help reduce their risk of contracting these diseases, including getting vaccinated. With flu season approaching, remember to start vaccinating as soon as you receive the vaccine. And remember to continue to vaccinate as long as you have vaccine available, even after the new year. And finally, don't forget, health care workers also need to protect themselves. Get Your Flu Shot – Not the Flu.

For more information about Medicare's coverage of adult immunizations and a list of related educational resources, please visit CMS' Medicare Learning Network Preventive Services Educational Products on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.
For information about the national adult immunization awareness week, please visit the National Foundation for Infectious Diseases at *http://www.nfid.org/* on the Web.

Source: PERL 200809-40

Physician groups earn performance payments for improving quality of care

Demonstration shows great promise for redesigning physician payment system.

The Centers for Medicare & Medicaid Services (CMS) announced today that all physician groups participating in the Physician Group Practice (PGP) Demonstration improved the quality of care delivered to patients with congestive heart failure, coronary artery disease, and diabetes mellitus during performance year two of the demonstration.

As a result, the 10 groups earned $16.7 million in incentive payments under the demonstration that rewards health care providers for improving health outcomes and coordinating the overall health care needs of Medicare patients assigned to the groups.

"We are paying for better outcomes and we are getting higher quality and more value for the Medicare dollar," said Kerry Weems, acting administrator of CMS. "And these results show that by working in collaboration with the physician groups on new and innovative ways to reimburse for high quality care, we are on the right track to find a better way to pay physicians."

All 10 of the participating physician groups achieved benchmark or target performance on at least 25 out of 27 quality markers for patients with diabetes, coronary artery disease and congestive heart failure.

The groups are:

- Billings Clinic, Billings, MO
- Dartmouth-Hitchcock Clinic, Bedford, NH
- The Everett Clinic, Everett, WA
- Forsyth Medical Group, Winston-Salem, NC
- Geisinger Clinic, Danville, PA
- Marshfield Clinic, Marshfield, WI
- Middlesex Health System, Middletown, CT
- Park Nicollet Health Services, St. Louis Park, MN
- St. John's Health System, Springfield, MO
- University of Michigan Faculty Group Practice, Ann Arbor, MI

Five of the physician groups – Forsyth Medical Group, Geisinger Clinic, Marshfield Clinic, St. John's Health System, and the University of Michigan Faculty Group Practice – achieved benchmark quality performance on all 27 quality measures.

Physician groups earn performance payments for improving quality of care (continued)

This demonstration is one of CMS value-based purchasing (VBP) initiatives.

The goal of VBP is to tie Medicare payments to performance on health care cost and quality measures. VBP is part of CMS' drive to transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care.

A related CMS physician VBP effort is the Physician Quality Reporting Initiative (PQRI), which uses a pay-for-reporting approach. Under the PQRI, physicians and other health care professionals can earn incentive payments for reporting measurement data about the quality of care they provide to Medicare patients CMS is also starting development of a physician VBP plan for moving from the PQRI pay-for-reporting approach to a performance-based approach for Medicare physician payments. The experience that CMS has gained from the PGP demonstration will be considered in developing the performance-based payment plan.

The 10 physician groups participating in the PGP demonstration agreed to place their PQRI incentive payments at risk for performance on the 27 quality measures reported under the demonstration. All physician groups received at least 96 percent of their PQRI incentive payments, with five groups earning 100 percent of their incentive payments. A total of $2.9 million in PQRI incentive payments was paid out to the 10 groups under the demonstration.

The groups also improved the quality of care delivered to Medicare beneficiaries on the chronic conditions measured. Physician groups increased their quality scores an average of nine percentage points across the diabetes mellitus measures, 11 percentage points across the heart failure measures, and five percentage points across the coronary artery disease measures.

These groups achieved outstanding levels of performance by having clinical champions (physicians or nurses who are in charge of quality reporting for the practice) at the practice, redesigning clinical care processes, and investing in health information technology. The enhancements to their electronic health records and patient registries allow practices to more easily identify gaps in care, alert physicians to these gaps during patient visits, and provide interim feedback on performance.

In addition to achieving benchmark performance for quality, several physician groups also experienced favorable financial performance under the demonstration's performance payment methodology. For patients with diabetes or coronary artery disease, Medicare expenditures grew more slowly for beneficiaries assigned to the physician groups than for beneficiaries in the comparison group with the same conditions.

This lower expenditure growth for chronic conditions as well as complex patients treated in the ambulatory and hospital settings contributed to four physician groups sharing in savings for improving the overall efficiency of care they furnish their patients.

The four physician groups – Dartmouth-Hitchcock Clinic, The Everett Clinic, Marshfield Clinic, and the University of Michigan Faculty Group Practice – earned $13.8 million in performance payments for improving the quality and cost efficiency of care as their share of a total of $17.4 million in Medicare savings. This compares to two physician groups that earned $7.3 million in performance payments under the first year of the demonstration.

The results are for the second performance year of the demonstration, which covered April 1, 2006, through March 31, 2007. The initial three-year demonstration was extended for a fourth performance year, which runs through March 2009.

More information about the PGP demonstration may be found at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1198992&intNumPerPage=10*.

To learn more about the PQRI please visit *http://www.cms.hhs.gov/PQRI*.

Source: PERL 200808-19

Reporting changes to Medicare enrollment information

Information for physicians, nonphysician practitioners (NPPs) and group practices

The Centers for Medicare & Medicaid Services (CMS) has posted three new fact sheets on the Medicare Provider Enrollment page, *http://www.cms.hhs.gov/MedicareProviderSupEnroll/*, on the CMS Web site.

These fact sheets list the types of changes that enrolled physicians, NPPs, and group practices are required to report to Medicare within specific times of occurrence. Non-reporting of changes may adversely affect claims processing, claims payment amounts, and the eligibility of the physician, NPP, or group practice to participate in Medicare. The fact sheets indicate the Medicare provider enrollment forms that must be used to report the changes, and include information on where to go for assistance.

Links to each fact sheet are provided below:

Reporting Responsibilities for Individual Physicians Enrolled in the Medicare Program
http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/PhysicianReportingResponsibilities.pdf.

Reporting Responsibilities for Individual Non-Physician Practitioners Enrolled in the Medicare Program
http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/Non-PhysicianReportingResponsibilities.pdf.

Reporting Responsibilities for Physician Group Practices Enrolled in the Medicare Program
http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/GroupPracticeReportingResponsibilities.pdf.

Source: PERL 200809-32

Availability of an interim study of alternative payment localities

Localities under the Medicare physician fee schedule

Medicare is statutorily required to adjust payments for physician fee schedule services to account for differences in costs due to geographic location. There are currently 89 different localities that have not been revised since 1997. In the calendar year (CY) 2009 physician fee schedule notice of proposed rulemaking, which was released on June 30, 2008, CMS indicated that it would post on the CMS Web site a preliminary study of several options for revising the payment localities. The report entitled: "Review of Alternative GPCI Payment Locality Structures," which was produced by Acumen, LLC under contract to CMS, may currently be found at the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/ReviewOfAltGPCIs.pdf*.

CMS' study of possible alternative payment locality configurations is in the early stages of development. At this time, CMS is not proposing to make any changes to the payment localities. CMS encourages interested parties to submit comments on the options presented in the report as well as suggestions for other options. These comments will be considered in the development of possible future notice and comment rulemaking. When CMS is ready to propose any changes to the locality configuration, it will provide extensive opportunities for public comment (for example, a town hall meeting or open door forum) on specific proposals before implementing any change.

Electronic comments on the interim report may be submitted to *CMS MPFS@cms.hhs.gov* until October 20, 2008.

Source: PERL 200808-25, 200809-06

Incorporation of recent regulatory revisions into Chapter 10 of the Program Integrity Manual

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6178 which incorporates recent regulatory changes into the *Medicare Program Integrity Manual* (*PIM*) (Chapter 10 [Healthcare Provider/Supplier Enrollment]).

Background

The *Medicare PIM* (Chapter 10) specifies the resources and procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program.

CR 6178 revises Chapter 10 (Healthcare Provider/Supplier Enrollment) of the *Medicare PIM* and incorporates non-appeals related provisions contained in "Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges (CMS 6003-F)" which was published in the *Federal Register* on June 27, 2008. This CR instructs contractors to:

- Establish an enrollment bar for those providers and suppliers whose billing privileges are revoked. The enrollment bar will require that providers and suppliers whose billing privileges are revoked to wait from one to three years before reapplying to participate in the Medicare program.
- Require providers and supplier to receive payments by electronic funds transfer (EFT) when enrolling, making a change to their enrollment information, or during a revalidation process. In addition, providers or suppliers must continue to receive payment via EFT when Medicare contractor transition occurs and the provider or supplier was previously receiving payment via EFT.
- Allow Medicare contractors to reject an enrollment application when a provider or supplier fails to provide missing information/documentation within 30 days of a contractor's request for additional information. (The previous standard was 60 days.)
- Establish a new revocation reason for services that could not be provided (e.g., physician billing for services within in the United States when the physician was living outside of the country.)

Additional information

The official instruction, CR 6178, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R269PI.pdf* on the CMS Web site. The revised Chapter 10 of the *Medicare PIM* is attached to CR 6178.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6178
Related Change Request (CR) #: 6178
Related CR Release Date: September 19, 2008
Effective Date: October 20, 2008
Related CR Transmittal #: R269PI
Implementation Date: October 20, 2008

Revisions to the Chapter 14 of the Medicare Program Integrity Manual

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

Provider types affected

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

Provider action needed

This article is informational only and is based on change request (CR) 6036 which reminds providers that the Centers for Medicare & Medicaid Services (CMS) no longer issues, updates, or uses the unique physician identification number (UPIN) in claims processing. CR 6036 also provides information on how to access the National Plan and Provider Enumeration System (NPPES) and UPIN data.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. CMS published the national provider identifier (NPI) final rule, which established the NPI as this standard.

CR 6036 updates *Medicare's Program Integrity Manual*, Chapter 14, Sections 14.1 -14.4 by removing information related to the issuance and maintenance of UPINs and replacing this information with information about obtaining NPI and UPIN data. CR 6036 includes the updated Chapter 14 as an attachment.

Information about the NPI may be found on the NPI Standard webpage at

http://www.cms.hhs.gov/NationalProvIdentStand/

on the CMS Web site.

Since the UPIN Registry is no longer available, a copy of the UPIN file may be obtained by writing to:

CMS Public Use Files
7500 Security Boulevard, N1-15-03
Baltimore, MD 21244-1850

The following information is releasable for physicians and nonphysician practitioners:

- Full name
- Credentials (e.g., MD)
- UPIN
- State
- ZIP code
- Specialty code

Additional information

The official instruction, CR 6036, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed *at http://www.cms.hhs.gov/Transmittals/downloads/R263PI.pdf* on the CMS Web site.

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

The toll-free number for First Coast Service Options, Inc. Medicare Part B Customer Service Center is 1-866-454-9007.

MLN Matters Number: MM6036
Related Change Request (CR) #: 6036
Related CR Release Date: July 25, 2008
Effective Date: May 23, 2008
Related CR Transmittal #: R263PI
Implementation Date: August 8, 2008

Delayed implementation of change request 5772

This information was previously published in the March 2008 Medicare B Update! pages 27-31.

Change request 5772 – Medicare Clinical Laboratory Services Competitive Bidding Project, issued on February 1, 2008, was scheduled for implementation on July 7, 2008. However, due to a preliminary injunction issued in San Diego, implementation has been delayed.

Source: JSM 08347, dated June 9, 2008

Release of out-of-pocket limits for Medigap plans K & L for calendar year 2009

The Centers for Medicare & Medicaid Services (CMS) released the 2009 out-of-pocket (OOP) limits for Medigap plans K & L; the limits are $4,620 and $2,310, respectively. The OOP limits for Medigap plans K and L are updated each year and are based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program published by CMS. The full text of the announcement is available on the CMS Web site at: *http://www.cms.hhs.gov/Medigap/*.

Source: PERL 200808-09

Medicare providers remain satisfied with fee-for-service contractors

The Centers for Medicare & Medicaid Services (CMS) reports that Medicare health care providers continue to be satisfied with services provided by Medicare fee-for-service (FFS) contractors, showing a relatively smooth transition to the new Medicare administrative contractors (MACs). The average score based on a satisfaction survey across all contractors was 4.51 on a scale of 1 to 6. This year's average score was comparable to last year's average score of 4.56.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), conducted by CMS for the third year, is designed to gather and report objective, quantifiable data on provider satisfaction with the FFS contractors who process and pay Medicare claims. In 2007, more than one billion claims were processed and paid to approximately one million health care providers who provided medically necessary items and services to 44 million beneficiaries.

The survey is mandated by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. Specifically, the law calls for CMS to develop contract performance requirements, including measuring provider satisfaction with Medicare contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to Medicare.

The summary report of the survey findings is available on the CMS Web site in the MCPSS section at *www.cms.hhs.gov/MCPSS*.

The CMS press release issued today may be viewed at: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200808-30

Lower Medicare part D costs than expected in 2009

Beneficiary satisfaction remains high

The Centers for Medicare & Medicare Services (CMS) recently announced that as Medicare's Part D prescription drug program enters its fourth year, beneficiary satisfaction rates remain high, program costs remain lower than originally expected, and Medicare prescription drug plan bids reflect nationwide drug price trends. Based on the bids submitted by Part D plans, CMS estimates that the average monthly premium beneficiaries will pay for standard Part D coverage in 2009 will be $28. This is about 37 percent lower than originally projected when the benefit was established in 2003.

The estimated average monthly premium for 2009 of roughly $28 for basic coverage is far below the original estimate for 2009 of $44.12, which was made at the time the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was enacted in 2003. The average expected premium for basic coverage in 2009 is about $3 higher than the actual average for 2008. The $3 premium increase is due to general trends in drug costs, the phase-out of a CMS demonstration project, and higher plan estimates for catastrophic coverage based on prior experience.

In addition to average premiums for 2009, CMS has announced the:

- 2009 national average monthly bid
- base beneficiary premium
- regional low-income subsidy premium amounts for 2009, and
- 2009 Medicare Advantage regional preferred provider organization benchmarks.

This data may be found at: *http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp*.

To read the CMS press release issued on August 14, 2008, go to: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200808-22

Medicare Learning Network fact sheets

The following fact sheets are now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "*MLN* Product Ordering Page."

- Federally Qualified Health Center Fact Sheet (revised April 2008) which provides information about federally qualified health center (FQHC) designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC payments; and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- Medicare Disproportionate Share Hospital Fact Sheet (revised April 2008) which provides information about methods to qualify for the Medicare disproportionate share hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005; number of beds in hospital determination; and Medicare DSH payment adjustment formulas.
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet (revised May 2008) which provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2009 update to the IPF PPS.

Source: PERL 200807-31

CMS end-stage renal disease network external stakeholder meetings

Proposed changes would improve disease tracking and speed transition to an electronic health care environment

The Centers for Medicare & Medicaid Services (CMS) hosted a series of end-stage renal disease (ESRD) stakeholder meetings to discuss the ESRD network (NW) program. The purpose of these meetings is to provide an opportunity for interested stakeholders to provide vital input and recommendations on the program moving forward.

The office of clinical standards and quality (OCSQ), is currently conducting an evaluation of the ESRD NW program. The results and recommendations developed from the evaluation will provide the steps to improving the program. OCSQ recognizes this assessment is essential to moving the program forward to meet the present needs and demands of Medicare beneficiaries in the rapidly growing field of ESRD. As well as, transitioning the program to achieve even greater strength in the following areas:

- Value
- Attribution
- Oversight
- Improved outcomes

Since 2006, OCSQ has been engaged in redesigning the quality improvement organization (QIO) program. The redesign efforts have been essential in developing the framework for the new contract period. These changes are captured in the recently released 9th scope of work (SOW) request for proposal (RFP). The changes are not limited to only the RFP documents. Change extends to several other areas as well, including the principles under which the SOW is developed, fundamental methods of contracting, (including methods of contract awards), and, especially, contract evaluation and monitoring. CMS' goal is to apply these concepts to the ESRD NW program. CMS welcomes your feedback during the stakeholder meetings to discuss how these changes can be applied to the program.

These meetings occurred during the months of August and September 2008. CMS conducted five separate meetings targeted for the following groups:

Stakeholder	Date	Location
CMS ESRD NW Contractors	August 28, 2008	CMS Quality-Net Conference
ESRD Advocates /Patients	September 4, 2008	Centers for Medicare & Medicaid Services
CMS ESRD NW Contractors	September 16, 2008	Web-Ex Conference
ESRD Providers /Facilities	September 11, 2008	Centers for Medicare & Medicaid Services
ESRD Researchers • Manufacturers • Pharmaceutical companies • Academic Institutions	September 19, 2008	Centers for Medicare & Medicaid Services

Each meeting was a participatory dialogue focused on key questions. CMS encouraged you to review the materials in advance of each meeting and come prepared to share your feedback and recommendations during the dialogue session at the meeting. To assist you in determining the appropriate representatives, the agendas and questions for each stakeholder session was posted at *http://esrdncc.org*, under the section titled "Events."

CMS looked forward to these meetings and working collectively in improving the quality of care for Medicare beneficiaries. If you have questions regarding these meetings, please contact Cheryl Bodden at (410) 786-6875, *Cheryl.Bodden@cms.hhs.gov*.

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

Source: PERL 200808-24

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the prompts.

Evaluation & management services guide now available

The July 2008 version of the evaluation & management services guide is now available on the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf*.

This guide provides:

- Evaluation and management services information about medical record documentation
- International Classification of Diseases and *Current Procedural Terminology* codes
- Key elements required for each service.

Source: PERL 200808-18

Guidelines for teaching physicians, interns, and residents

The revised Guidelines for Teaching Physicians, Interns, and Residents (July 2008), which provides information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf*.

Source: PERL 200809-42

April 2008 rural health clinic fact sheet

The April 2008 version of the rural health clinic fact sheet, which provides information about rural health clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." To download a copy, visit the "*MLN* Publications" page at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*, and search for the booklet title.

Source: PERL 200808-09

Beneficiary pilot program

The Centers for Medicare & Medicaid Services (CMS) today announced a pilot program to test options for beneficiaries with Original Medicare to maintain their health records electronically. Under this pilot in Arizona and Utah, a beneficiary may choose one of the selected commercial personal health record (PHR) tools, and Medicare will transfer up to two years of the individual's claims data into the individual's PHR.

Beneficiaries who select one of the participating PHR vendors can also add other personal health information if they choose. Depending on the specific product, they may be able to authorize links to other personal electronic information such as pharmacy data. PHRs can offer links to tools that help consumers manage their health such as wellness programs for tracking diet and exercise, medical devices, health education information, and applications to detect potential medication interactions.

Beneficiaries can elect to allow family members to have access to their PHR. They can also provide access to the PHR to their health care providers.

If PHR vendors want more information about this pilot, they can visit *http://www.NoridianMedicare.com/phr/* or they can send an e-mail to *solicitation@medicarephr.org*.

To read the entire CMS press release issued August 8, 2008, click here: *http://www.cms.hhs.gov/center/press.asp*.

Source: PERL 200808-09

Guide to Medicare coverage of kidney dialysis and transplant services

An updated version of The Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services booklet is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. This booklet explains how Medicare helps pay for kidney dialysis and kidney transplant services in the Original Medicare Plan, also known as "fee-for-service." To download a copy, visit the "*MLN* Publications" page at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*, and search for the booklet title.

Source: PERL 200808-09

CMS seeks cosponsors for conference on e-prescribing Incentive Payment Program

The Centers for Medicare & Medicaid Services (CMS) held a conference to educate physicians and other stakeholders about a newly enacted federal program of incentive payments to encourage the use of electronic prescribing. CMS requested interested public and private sector organizations to join the agency as cosponsors of the conference, which was held October 6–7, 2008, in Boston.

"The new incentive program will help spread adoption of e-prescribing throughout the health care community," said CMS Acting Administrator Kerry Weems. "E-prescribing has many benefits for patients, providers, health plans, and pharmacies. Not only is e-prescribing more efficient than paper prescriptions, it is also safer. E-prescribing can help reduce the number of adverse drug events, which for Medicare beneficiaries alone is estimated at 530,000 (events) a year."

The many benefits of e-prescribing include:

- Physicians have electronic access to each patient's prescription history, helping them avoid prescribing drugs that may result in harmful drug interactions
- e-prescribing eliminates the possibility of medication errors caused by illegible prescribing clinician handwriting
- e-prescribing reduces confusion and miscommunication, resulting in fewer phone calls and faxes between the physician's office and the pharmacy
- With access to a patient's insurance and formulary information at the point of care, physicians can prescribe a drug that is both covered and affordable, resulting in fewer trips to the pharmacy

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) established a five-year program of incentive payments to eligible professionals who are "successful electronic prescribers." Successful prescribers are those who either report applicable electronic prescribing measures established under the Physician Quality Reporting Initiative (PQRI) or who electronically submit prescriptions under Medicare Part D at a level determined by CMS. The incentive payment program begins on January 1, 2009. The conference will serve to educate affected constituencies on the MIPPA program and CMS' plans for implementation.

The notice invites interested parties to submit proposals detailing how they could support CMS, in a nonfiduciary relationship, by developing conference content, identifying speakers, and implementing outreach activities to educate affected provider, business, and consumer stakeholders about this new program. Interested organizations may include:

- Physician and provider organizations (including those representing primary care, specialty care, surgical, and medicine-based specialties)
- Organizations representing health care professionals
- Organizations representing pharmacy industry stakeholders, including retail and community pharmacies
- Organizations representing state and local officials
- Organizations representing a broad range of beneficiary interests

The educational conference did:

- Equip health care professionals and other stakeholders with the knowledge and the tools to integrate e-prescribing into their business model
- Educate health care professionals about the structure and implementation of the incentive payment structure with respect to e-prescribing and PQRI
- Generate discussion about the use of e-prescribing and other e-health initiatives to increase patient compliance and overall health outcomes
- Identify and promote opportunities to overcome barriers to adoption of this new technology
- Address constituent concerns about privacy, security, and risk management with respect to implementation of the e-prescribing incentive payment program

Selection criteria outlined in the notice includes an applicant's:

- Identity as a non-profit, financially disinterested entity that represents constituencies affected by e-prescribing
- Demonstrated interest in e-prescribing technology and implementation and knowledge of current e-prescribing standards for Medicare Part D
- Presentation of activities and connections that likely will further the public health benefits of e-prescribing
- Willingness to work collaboratively with other public and private sector organizations to achieve the goals of e-prescribing and other e-health initiatives.

CMS will invite selected organizations that meet the evaluation criteria to enter into formal, nonfiduciary cosponsor agreements to consult on the conference program content, speaker selection, and outreach strategies, in addition to other tasks as described in individual cosponsor agreements. Potential cosponsors must understand that cosponsor agreements will clearly indicate that there will be no Federal endorsement of the cosponsor or endorsement of any policies, activities, products, or services resulting from cosponsorship of the conference.

The notice may be viewed at *http://federalregister.gov/page2.aspx*. Proposals to cosponsor the educational conference were due by 5:00 p.m. Eastern time on August 15, 2008.

Public and private-sector organizations considering becoming co-sponsors for the two day conference with CMS can access the notice in the *Federal Register* at: *http://federalregister.gov/OFRUpload/OFRData/2008-18678_PI.pdf*.

Proposals were to be sent electronically to the following: *e.prescribing@cms.hhs.gov*.

To read the entire CMS press release issued August 8, 2008, click here: *http://www.cms.hhs.gov/center/press.asp*.

Source: PERL 200808-08 & 200808-12

HHS takes new steps to accelerate adoption of electronic prescribing

Medicare payments for successful electronic prescribers, reporting quality data are important steps toward a value-driven health care system

Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be available beginning in 2009 for physicians who meet the requirements of the program. The initiative is part of the administration's broader efforts to accelerate the adoption of health IT and the establishment of a health care system based on value.

Beginning in 2009, and during the next four years, Medicare will provide incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals will receive a two percent incentive payment in 2009 and 2010; a 1 percent incentive payment in 2011 and 2012; and a one half percent incentive payment in 2013.

Beginning in 2012, eligible professionals who are not successful electronic prescribers will receive a reduction in payment.

Eligible professionals may be exempted from the reduction in payment, on a case-by-case basis, if it is determined that compliance with requirement for being a successful prescriber would result in significant hardship.

To read more, see the HHS Fact Sheet at *http://www.hhs.gov/news/facts/eprescribing.html*.

Source: PERL 200807-30

Individuals authorized access to CMS computer services—provider community

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the December 2007 Medicare B Update! pages 35-38.

Note: This article was revised on July 30, 2008, to reflect current processes and provide the Web address for the new IACS Web site which contains user reference guides. Please note that CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice.

The first in a series of articles

These articles will help providers to register for access to CMS online computer services when directed to do so by CMS. This article contains:

- Eleven questions and answers to get you started
- Overview of the registration process for IACS-PC defined provider/supplier organization users.

Provider types affected

Medicare physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS -PC at this time. DMEPOS suppliers may want to review question # 11 below.

What providers need to know

The Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access in the CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS-PC).

Provider action needed

CMS will notify providers as Internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are informed by CMS or one of its contractors to do so and only if you meet the criteria in the notice. This article and other articles in the IACS-PC series will help you navigate this process when directed to do so by CMS. The other articles currently available are:

- SE0753 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf* on the CMS Web site
- SE0754 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf* on the CMS Web site.

11 Questions and answers to get you started

1. What is IACS-PC?

IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (See question # 7), and their staff, as well as individual practitioners, will be able to access new CMS applications. Through IACS, provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

Note: IACS-PC is not applicable to FI/carrier/MAC internet applications or the DME Competitive Bidding System (DBidS) application.

2. Who can use this system?

Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, DBidS has a dedicated version of IACS outside of IACS-PC. (See question # 11)

3. When should I register?

CMS will notify providers as Web-based applications become available and provide clear instructions that specify which providers should register in IACS.

Do not register unless you fit the criteria in the CMS notice. For example, DMEPOS suppliers interested in

IACS-PC, The First in a Series (continued)

becoming a contract supplier under the Medicare Competitive Bidding Program will receive explicit instructions on how and when to register for access to bid software.

4. How long is my password valid?

Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

5. How do I register as an IACS-PC user?

IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

Note: User guides for the IACS-PC community may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by email *at EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. When would I register as an individual practitioner?

An individual practitioner (IP) is defined by IACS-PC as a solo physician or nonphysician practitioner (NPP); who has not reassigned Medicare payments to a group practice. This designation is intended for practitioners who will be conducting transactions with online applications personally and have no staff who will be accessing the applications on their behalf. If you will have staff or other practitioners who will need to access CMS applications, you should register as a provider organization (not as an individual practitioner). Please see #7.

CMS will match your IACS registration with Medicare enrollment data before allowing you to access a CMS application. Those registering as individual practitioners who have not submitted a Medicare enrollment application (CMS-855) since November 2003 will need to update their CMS-855.

Note: See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* for more information about the Medicare enrollment process. To facilitate your enrollment into the Medicare program or updating your enrollment with Medicare, you should review the following downloadable file at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollmenttips.pdf* before submitting an enrollment application to a Medicare contractor.

If you enrolled in Medicare after November 2003, or have updated your enrollment since then, register as an individual practitioner following the steps in the Individual Practitioner Registration - Quick Reference Guide, which may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

7. When would I register as an IACS-PC provider organization?

The term "organization", as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the NPI.

For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), independent diagnostic testing facilities (IDTFs), ambulance companies, ambulatory surgical centers (ASCs) and physician group practices.

It also includes individual physicians and NPP who want to delegate staff to conduct transactions on their behalf (office staff, administration support etc.). In this case, for IACS-PC registration purposes, registration must be as an organization.

IACS-PC provider organizations require security officials (SO) (see question # 9 that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the provider organization security official.

8. What should I have in hand before I register as an individual practitioner (IP)?

An IP (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) will need to know their:

- social security number
- correspondence information

9. What should I have in hand before I register as a security official of a provider organization?

For an IACS-PC provider organization, the SO of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- taxpayer identification number (TIN)
- legal business name
- corporate address
- Internal Revenue Service (IRS) Issued CP-575 hard copy form.

If the SO does not have the CP-575, a copy of other official IRS documentation may be submitted. An official IRS document should have the following information:

Required:

- IRS letterhead
- legal business name (not handwritten)

IACS-PC, The First in a Series (continued)

- TIN/employee identification number (EIN) (not handwritten)

Examples of acceptable IRS documents include, but are not limited to:

- copy of IRS CP-575
- copy of IRS 147C letter
- copy of federal tax deposit coupon
- All documents received must be legible

10. How do I register my IACS-PC provider organization?

IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization's IRS documentation, CMS will verify the SO's role in the organization, the TIN and the legal business name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the Overview section, which follows question #11.

Once you understand IACS-PC user roles, and have designated an SO, the SO should register using the instructions in the Security Official Registration - Quick Reference Guide, which is available at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

The next *MLN Matters* article in this series of articles provides instructions for additional users to register in IACS-PC.

11. Why are you excluding DMEPOS suppliers from IACS-PC?

DMEPOS suppliers should not register in IACS-PC because we do not have new online applications at this time. DMEPOS suppliers interested in DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which would be released closer to the bid window.

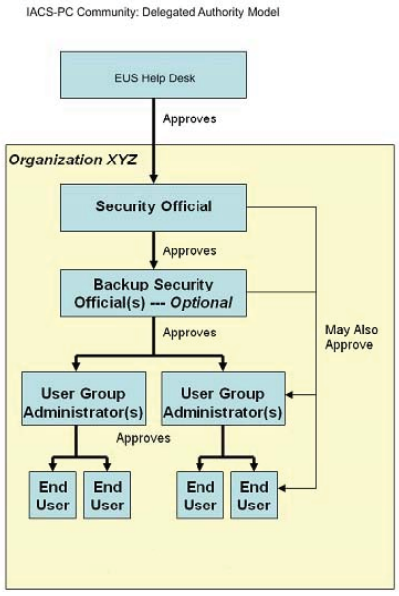
Overview: registering in IACS-PC as a provider organization or a provider organization user

For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, HHAs, SNFs, IDTFs, ambulance companies, ASCs, and physician group practices. It also includes individual physicians and NPPs who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process

IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least two users, one of whom will be able to access IACS-PC applications.

The "delegated authority model" previously described is shown below. The EUS help desk will be responsible for approving the organization's SO. Then the SO may approve the backup SO(s) etc.



IACS-PC, The First in a Series (continued)

II. Registration roles

1. The first person to register must be the SO.

The SO is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There can be only one SO for an organization. The SO is trusted to approve the access request of backup SO(s) and can approve the access requests of user group administrators. The SO will be approved by CMS through its EUS help desk. The SO is held accountable by CMS for the behavior of those approved in the organization, including end users. The Security Official Registration - Quick Reference Guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS Help Desk.

2. An organization may choose to have one or more backup SOs. (optional)

This is an optional role. You need not have a backup SO. The backup SO is approved by the SO. A backup SO performs the same functions as a SO in an organization, with the exception of approving other backup SOs. There can be one or more backup SOs in an organization. The backup SO can approve the access requests of user group administrators and may aid the SO with the administration of user groups and user group administrators' (UGA) accounts.

3. The next registrant must be a UGA.

The UGA is approved by the SO or backup SO. The UGA is trusted to approve the access requests of end users for that user group.

A UGA registers the user group within an organization in IACS-PC and updates the user group profile information in IACS-PC. There can be multiple UGAs for the same user group within an organization.

If the UGA is a surrogate user (not part of the organization, but rather a contractor company working on behalf of the organization), they should select to create a "Surrogate User Group"- See Section III.

4. The next registrants are end users.

An end user is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An end user is part of a user group within the provider organization. An end user may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An end user may belong to multiple groups in one or more organizations. The end user is approved by the UGA.

Note: End user requests cannot be approved until after the UGA has been approved.

III. Surrogate user groups

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a surrogate user group. Examples include clearinghouses, credentialing departments, independent contractors. A surrogate user group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A surrogate user group may be associated with multiple provider organizations.

1. The first contractor employee to register in a surrogate user group must be the UGA.

If there will be only one user in a surrogate group, that user must register as a UGA. The UGA for the surrogate user group will register the surrogate user group and update the user group profile information in IACS-PC. There can be multiple UGAs within the same surrogate user group. The UGA is trusted to approve the access requests of end users for their user group.

The UGA of the surrogate user group must be approved by the SO or backup SO in the provider organization on whose behalf it performs work. Once approved, the UGA of a surrogate group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an end user.

An end user is approved to perform Medicare business for a surrogate or provider user group by their UGA. An end user may belong to multiple groups in one or more organizations.

Additional help

The EUS help desk will support this process for IACS-PC. It may be reached by email at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

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Implementation Date: N/A

Individuals authorized access to CMS computer services—provider community

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the February 2008 Medicare B Update! pages 54-57.

Note: This article was revised on July 30, 2008, to reflect current processes and provide the Web address for the new IACS Web site which contains user reference guides. Please note that CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice.

The second in a series of articles

This article contains:

- three questions and answers about the registration process for provider organizations (See Note)
- links to the quick reference guides for completing the registration process for provider organizations. (See Note)

Note: For purposes of the IACS-PC, "Provider Organizations" include individual practitioners who will delegate IACS-PC work to staff as well as their staff using IACS-PC.

Provider types affected

Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]). Special Note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in this new series on IACS-PC, which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Provider action needed

CMS will inform providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice. This article and other articles in the IACS-PC series will help you navigate this process when directed to do so by CMS.

What providers need to know

The CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

Registering in IACS-PC

IACS protects and allows access to CMS enterprise applications. Communities (e.g., the IACS provider/supplier community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (For example, providers need access to provider-related CMS applications). The next community which will become available is the FI/Carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FI's, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, Medicare providers should select the "Provider/Supplier Community".

The first *MLN Matters* article in this series provided an overview of the IACS-PC registration process as well as registration instructions for security officials (SOs) of provider organizations and individual practitioners using IACS-PC personally. This article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

Three questions and answers about the provider organization registration process

1. How can I get registered in IACS-PC? Can I just figure it out by myself?

We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS-PC, go to *https://applications.cms.hhs.gov* and then click on Enter CMS Applications Portal.

2. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?

No, only register once. Each user will receive only one IACS-PC User ID and password. Once you receive approval and your user ID and password, you can add additional roles to your account.

Instructions for modifying your IACS profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the *Additional Help* section.

3. My organization is too small to fill all these roles. What should I do?

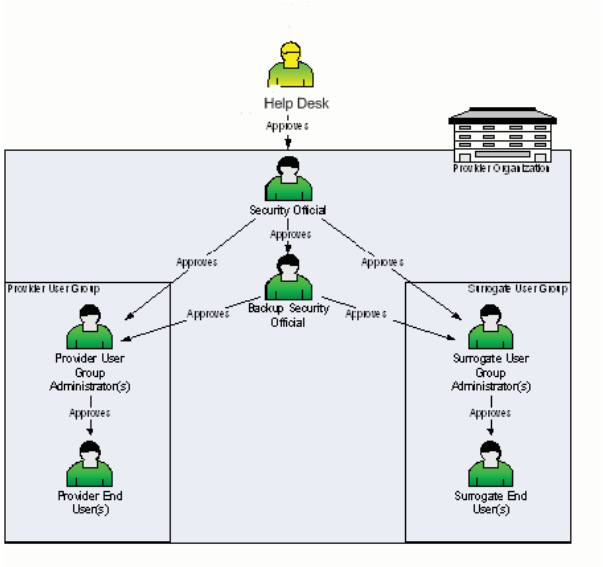
As few as two staff can be registered in IACS-PC for a provider organization to access CMS enterprise applications. The first person must register as a SO, the second registers as a user group administrator (UGA). The UGA may access CMS applications as approved by the SO.

IACS-PC, The Second in a Series (continued)

The backup security official (BSO) is an optional role. End users are only required for provider organizations with 10 or more IACS-PC users.

If you are an individual professional who will be using IACS-PC personally, you may register for the single role of individual practitioner. Please refer to the first *MLN Matter* article which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

Quick Reference Guides for Completing the Provider Organization Registration Process



IACS-PC registration approval process

1. Backup Security Official (BSO) Guide

BSOs will request access to an organization using the BSO Registration Quick Reference Guide at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

2. UGA guide

UGAs are the first user type able to request access to CMS web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS-PC and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, so they should know everyone in their user group.

The UGA Registration Quick Reference Guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Special note for UGAs of surrogate user groups

A surrogate user group is established by individuals or a company outside of the provider organization which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: Surrogate billing company ABC will work on behalf of provider organization XYZ. Once the provider organization XYZ is approved in IACS-PC, the surrogate billing company ABC can register in IACS-PC and request to create a surrogate user group under the provider organization XYZ. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of 3 different provider organizations, the UGA for the surrogate user group will need to make 3 different requests to create 3 different surrogate user groups, one for each provider with which the UGA needs to associate. If a provider organization does not appear in IACS-PC, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider appears in IACS-PC.

If the provider organization does appear in IACS-PC, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS-PC.

IACS-PC, The Second in a Series (continued)

In the future, CMS will explore options for simplifying this process for contractors which perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS-PC.

3. End User Registration Quick Reference Guide

An End User Registration Quick Reference Guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

4. Approver Quick Reference Guide

The Approver Quick Reference Guide provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS-PC. The Approver Quick Reference Guide may be found by selecting General User Guides and Resources on the left column of the following *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Next steps in accessing a CMS enterprise application

A third *MLN Matters* article discussing the final steps for using IACS to access CMS enterprise applications may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf* on the CMS Web site.

Additional help

The CMS has established an External User Services (EUS) Help Desk to assist with your access to IACS-PC. The EUS Help Desk may be reached by E-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you may find an informative reference chart outlining the steps for accessing CMS enterprise applications at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf* on the CMS Web site.

MLN Matters Number: SE0753 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Individuals authorized access to CMS computer services – provider community

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

Note: This article was revised on July 30, 2008, to reflect current processes and provide the Web address for the new IACS Web site which contains user reference guides. Please note that CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS-PC. Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice. This information was previously published in the February 2008 *Medicare B Update!* pages 57-59.

The third in a series of articles

This article describes the 3 steps providers must take to access a CMS Enterprise Provider Application including how to request a provider application role in IACS-PC (See step 2).

Provider types affected

Physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special Note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS -PC at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in a new series on IACS-PC which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf*.

Provider action needed

CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS-PC). Do not register until you are notified by CMS or one of its contractors to do so and only if you meet the criteria in the notice.

What providers need to know

The CMS will announce new online enterprise applications that will allow Medicare fee-for-service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include Internet applications offered by FIs/carriers/MACs. Details of these provider applications will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access through the CMS security system known as the Individuals Authorized Access to CMS Computer Services – Provider/Supplier Community (IACS-PC).

The first article in this series provided an overview of the IACS-PC registration process as well as registration instructions for security officials (SOs) and individual practitioners. This may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

IACS-PC, The Third in a Series (continued)

Note: Individual practitioners must register differently depending on whether they will have employees use IACS-PC and/or the CMS application on their behalf. Those using employees must register in IACS-PC as an "Organization". See the MLN Matters SE0747 for more information.

The second article in this series addressed common questions and gave remaining instructions for registering provider organizations including registration as backup security officials (BSOs), user group administrators (UGAs), and end users (EUs). It also provided instructions SOs, BSOs, and UGAs can use to approve user registration requests. This article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf* on the CMS Web site.

The 3 steps to access a CMS enterprise application

Provider IACS-PC users must take three steps to access a CMS enterprise application:

Step 1 Be approved for an IACS-PC role.

The first two *MLN Matters Articles* in this series discussed how to register in IACS-PC.

The purpose of the IACS-PC registration process is to:

- Confirm the identity of the person requesting registration.
- Assure registrants have a legitimate business need to access CMS provider systems.
- Provide the registrant an IACS-PC role (e.g., SO, BSO, UGA, or EU) that defines their responsibilities (if any) for approving the registration requests of others in their organization.
- Provide the registrant a User ID and Password for IACS-PC.

Step 2; Be approved for an application role.

After receiving approval for an IACS-PC role, a registered user in a Provider Organization may then request access to CMS provider Applications. This requires specifying a role for specific applications. For example, the role may be an "application approver" or an "application user." (**Note**: Because individual practitioners do work in the application themselves, they do not require "application approver" roles).

This role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization.
- What CMS enterprise applications (if any) they have a legitimate need to access.
- The appropriate level of access to each application for their job function (which application "role" they require).

Users who received approval in IACS-PC in Step 1 can then request access to specific CMS enterprise applications using their IACS-PC account.

This requires requesting either an "application approver" or an "application user" role for each application needed to perform Medicare-related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example, some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS.

Note: Each user must request a specific application role in IACS-PC for each CMS enterprise provider application they wish to use. Roles will be specific to each application.

The "Request Access to CMS Application Quick Reference Guide" provides instructions for requesting an application role. It may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Application approvers

Organizations must have designated persons that approve each user's request for an application role. The person who performs this task is an "application approver" and as such cannot personally access applications for which they serve in this role.

Though the UGA may frequently be the appropriate person to have this role, organizations have discretion in how they designate the application approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an EU may be approved for this role by the SO or BSO for the user group with which they are associated.

Note: If a user group does not have an application approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.

Application approver key points

- An application approver must be a member of the user group(s) for which they serve as an application approver (this does not apply if the SOs/BSOs is the application approver).
- Providers have flexibility in assigning the application approver role.
- The UGA does not have to be the application approver within the user group.
- An end user within a user group may serve in the role of the application approver.
- A different person may serve as an application approver in a user group for each application.
- The same person can be the application approver for multiple applications in a user group.
- The same person can be the application approver for multiple user groups (though they must be a member of each group).
- There may be multiple application approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an application approver for one application, and an application user for a different application, just not for the same one.
- If an application approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.

IACS-PC, The Third in a Series (continued)

- Organizations with a large number of IACS-PC users are encouraged to have application approvers in each user group for each application (may be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

Note: System security requires a "separation of duties" – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in application approver roles will not have access to the application for which they are an approver. SOs and BSOs, by definition, can never access any applications as they serve as the default application approvers as noted above.

Instructions for approving application role requests are the same as for approving IACS-PC registration requests. The Approver Quick Reference Guide may be found by selecting General User Guides and Resources in the left column of the page at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Step 3: Enter the application when it becomes available.

You will be notified as CMS enterprise applications become available. After you have been approved in steps 1 and 2, you will be able to access available CMS enterprise applications in accordance with approved application specific roles via the CMS or application Web site.

Additional CMS partner and customer communities will use IACS

IACS protects and allows access to CMS enterprise applications. IACS communities (e.g., the IACS - Provider/Supplier Community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications. For example, the next community will be the FI/carrier/MAC community. It will be comprised of users who work within Medicare contracting organizations (FIs, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider/Supplier Community".

Additional help

CMS has established the End User Services (EUS) Help Desk to support access to IACS-PC. The EUS Help Desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you may find an informative reference chart outlining the steps for organizations to access CMS enterprise applications at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf* on the CMS Web site.

Coming soon

- CMS enterprise applications to be made available via the Web include those related to the Physician Quality Reporting Initiative (PQRI) and the Provider Statistical and Reimbursement Report (PS&R).
- Instructions for modifying your user profile.
- What to do if you forget your user ID or password.
- Tools for SOs, BSOs and UGAs to manage user accounts.

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FRAUD AND ABUSE

OIG reports more than $2 billion in recoveries from fighting fraud, waste, and abuse for first-half fiscal year 2008

The Department of Health & Human Services (HHS) Office of Inspector General (OIG) "Semiannual Report to Congress" announced expected recoveries of $2.2 billion for the first half of fiscal year (FY) 2008 from efforts to reduce fraud, waste, and abuse in HHS programs.

Specifically, OIG's $2.2 billion in expected recoveries encompasses $1.1 billion in audit-related recoveries and another $1.1 billion in investigative-related recoveries. Additional savings from implemented recommendations are calculated annually and will be reported in the final FY 2008 Semiannual Report.

"OIG's accomplishments reflect a robust oversight agenda implemented through audits, evaluations, and compliance and enforcement activities," said Inspector General Daniel R. Levinson. "It is through a combination of vigilant oversight, outreach to the health care community, and partnership with government agencies at all levels that we are able to fulfill our mission to protect the integrity of HHS programs and beneficiaries."

Also for this period, OIG reported exclusions of 1,291 individuals and organizations for fraud or abuse of federal health care programs; 293 criminal actions against individuals or organizations that engaged in crimes against HHS programs; and 142 civil actions, which include False Claims Act (FCA) and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters.

OIG accomplishments for this first-half of FY 2008 include:

Medicare Part D sponsors: estimated reconciliation amounts for 2006

In our analysis of the Centers for Medicare & Medicaid Services' (CMS) Medicare Part D preliminary reconciliation data estimates (as of August 2007) and data from 16 sponsors with high enrollments, we estimated that Part D sponsors owed Medicare a net total of $4.4 billion for the 2006 program year. Eighty percent of the sponsors owed CMS money and 20 percent were due money. We also found that CMS had no mechanism to collect funds or adjust prospective payments prior to the reconciliation that is conducted after the close of the plan year. As a result, sponsors had the use of billions of dollars for a significant length of time. In response to our recommendations, CMS agreed to use data collected from 2006 and subsequent plan years in reviewing future bids, acknowledged its authority to change certain payment methodologies, and agreed to examine related options. CMS did not agree to implement an interim process or to seek legislation delaying changes to risk corridors.

Bristol-Myers Squibb Co. pays more than $499 million to resolve allegations of illegal drug marketing and pricing

As part of a civil settlement, the Bristol-Myers Squibb Co. (BMS) and its wholly owned subsidiary, Apothecon, Inc., agreed to pay $499 million plus interest to resolve allegations relating to a variety of federal and state claims. The Government alleged that BMS fraudulently set and maintained inflated prices for a wide assortment of oncology and generic drug products, paid various forms of illegal kickbacks to physicians and pharmacies, promoted off-label uses of the antipsychotic drug Abilify, and knowingly misreported its best price for the antidepression drug Serzone. BMS entered into a 5-year corporate integrity agreement (CIA) with OIG as part of the resolution of this FCA case.

National Institutes of Health: conflicts of interest in extramural research

In our review of financial conflicts of interest reported by grantee institutions to the National Institutes of Health (NIH), we found that the agency needed to improve its oversight of such conflicts. For FYs 2004-2006, NIH could not provide an accurate count of the financial conflict-of-interest reports that it received from grantees; of 438 financial conflict-of-interest reports received from grantee institutions in 2006, at least 89 percent did not state the nature of the conflicts or the way in which they would be managed; regarding oversight, NIH's institutes most often relied on grantees' assurances that financial conflict-of-interest regulations were being followed. NIH agreed with our recommendations to increase oversight of grantee compliance with regulations, require Institutes to forward grantee conflict-of-interest reports, and ensure that all of the reports are included in its database. NIH did not agree with our recommendation to require grantees to provide details about financial conflicts of interest.

Artificial-joint makers pay $310 million to settle kickback case

Medical device makers Zimmer Holdings, Inc.; DePuy Orthopaedics, Inc. (a unit of Johnson & Johnson); Smith & Nephew, Inc.; and Biomet, Inc., agreed to pay a total of approximately $310 million to resolve allegations of anti-kickback statute and FCA violations.

The four companies allegedly used consulting deals with orthopedic surgeons to induce the purchase of their respective artificial hip and knee products. As part of the settlement, the companies entered into five-year CIAs with OIG.

Medicare Part D payments to local community pharmacies

In our review of the relationship between Medicare Part D payments to local community pharmacies and the pharmacies' drug acquisition costs, we found that in September 2006 pharmacies almost always (97 percent of the time) acquired drugs for less than the reimbursement amounts. We performed this review at the request of 33 senators who raised concerns

OIG reports more than $2 billion in recoveries from fighting fraud, waste, and abuse for first-half fiscal year 2008 (continued)

about the sufficiency of reimbursement to local community pharmacies. We estimated that, excluding dispensing fees and including rebates that drug wholesalers paid to pharmacies, Medicare Part D payments to local, community pharmacies exceeded the pharmacies' drug acquisition costs by 18.1 percent. We recommended that Congress and CMS consider the results of the review in deliberations regarding Medicare Part D reimbursement, and CMS agreed.

Dermatologist sentenced for upcoding surgical procedures

A Michigan dermatologist was sentenced to 10 years and 6 months in prison and ordered to pay approximately $1.3 million in restitution and a $175,000 fine for upcoding surgical procedures, billing for medically unnecessary procedures, and improperly billing for follow-up office visits. The dermatologist falsely informed patients that they had cancer when, in fact, laboratory results indicated that their tissue specimens were benign. He then performed surgeries based on these false diagnoses.

Temporary assistance for needy families improper payment pilot reviews

In our pilot reviews of Temporary Assistance for Needy Families (TANF) basic assistance payments during a six-month period in 2005, we found that three States—Michigan, New York, and Pennsylvania—collectively claimed an estimated $95 million in improper payments. The estimated error rates ranged from 11.5 percent to 40 percent of the federal dollars expended. Our recommendations focused on state compliance with requirements, enrollee eligibility, and recalculating improperly paid benefits. Michigan disagreed, New York did not address the recommendations, and Pennsylvania agreed.

Payments for outpatient services in skilled nursing facility stays

We found that Medicare Part B made a total of $106.9 million in potential overpayments to suppliers of outpatient services on behalf of beneficiaries in Part A-covered skilled nursing facilities (SNF) during calendar years (CYs) 2001 and 2002. These potential overpayments occurred because CMS did not have system edits in place during most of this period. For CY 2003, when the edits were fully implemented, potential overpayments were reduced to $22.7 million. CMS agreed with our recommendations about reviewing overpayments, testing and refining edits, and establishing recovery controls.

To read the full semiannual report go to *http://oig.hhs.gov/publications/docs/semiannual/2008/semiannual_spring2008.pdf*.

Source: OIG semiannual report to Congress, June 12, 2008

OIG policy regarding providers waiving retroactive beneficiary cost-sharing amounts attributable to increased payment rates under the Medicare Improvements for Patients and Providers Act of 2008

The purpose of this policy statement is to assure providers, practitioners, and suppliers (collectively, "Providers")[1] affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)[2] that they will not be subject to Office of Inspector General (OIG) administrative sanctions if they waive retroactive beneficiary liability (as defined below), subject to the conditions noted in this policy statement.

MIPPA, enacted by Congress on July 15, 2008,[3] includes increased payment rates for certain items and services related to:

- the physician fee schedule[4]
- durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) (in the ten competitive bidding areas for the specific items for which competitive bidding was temporarily implemented)[5]
- brachytherapy sources and therapeutic radiopharmaceuticals under the outpatient prospective payment system[6]
- the ambulance fee schedule.[7]

Under MIPPA, these payment rate increases apply retroactively to July 1, 2008. We have been informed by the Centers for Medicare & Medicaid Services (CMS) that, as a result, beneficiary liability for cost-sharing amounts for the affected items and services also increased on a retroactive basis. Thus, beneficiaries who already paid, or were billed for, cost-sharing amounts based on lower payment rates temporarily in effect since July I, 2008, are liable for additional cost-sharing amounts under the increased MIPPA payment rates (the "retroactive beneficiary liability").[8]

We have been asked whether providers affected by the MIFPA payment rate increases are required to bill for or collect the retroactive beneficiary liability in order to comply with the OIG's fraud and abuse authorities. Ordinarily, routine waivers of Medicare cost-sharing amounts potentially implicate the federal anti-kickback statute,[9] the civil monetary penalty and exclusion laws related to kickbacks,[10] and the civil monetary penalty law prohibiting inducements to beneficiaries.[11] Notwithstanding, in these limited circumstances, providers will not be subject to OIG administrative sanctions if they waive retroactive beneficiary liability, subject to the conditions noted below.

- This policy statement applies to waivers of retroactive beneficiary liability owed by beneficiaries only for the period from July 1, 2008, until the date on which CMS (or the relevant carrier or intermediary) implements the increased payment rates applicable to the particular provider.[12] Once new payment rates are implemented, providers are expected to calculate cost-sharing amounts based on the new payment rates.
- This policy statement applies only to retroactive beneficiary liability, which is the increase in the beneficiary's cost-sharing obligation attributable to the increase in payment rates under MIFPA. This policy does not apply to waivers of beneficiary cost-sharing amounts that were calculated using the lower payment rates temporarily in effect since July 1, 2008.

OIG policy regarding providers waiving retroactive beneficiary cost-sharing amounts attributable to increased payment rates under the MIPPA 2008 (continued)

- This policy statement does not apply to waivers of retroactive beneficiary liability if the waivers are conditioned in any manner on the provision of future items, supplies, or services.

Nothing in this policy statement requires providers to waive retroactive beneficiary liability.

Importantly, nothing in this policy statement affects the ability of a provider to waive any cost-sharing amounts on the basis of a good faith, individualized determination of a beneficiary's financial need.[13]

Source: Daniel R. Levinson, Inspector General, July 23, 2008

[1] This policy statement applies only to providers that are impacted by the increased MIPPA payment rates. Specifically, with respect to DMEPOS suppliers, this policy statement only applies to those DMEPOS suppliers in the ten regions that were designated for competitive bidding, and then only to beneficiary liability related to the specific items to which competitive bidding would have applied.
[2] M1PPA, P.L. No. 110-275.
[3] Id.
[4] See id. at § 131(a).
[5] See id. at § 154.
[6] See id. at § 142.
[7] See id. at § 146.
[8] Generally speaking, the retroactive beneficiary liability will be 20 percent of the payment rate increase.
[9] Section 1128B(b) of the Social Security Act (the "Act"), 42 U.S.C. § 1320a-7b(b).
[10] Sections 1128(b)(7), 1128A(a)(7) of the Act, 42 U.S.C. §§ 1320a-7(b)(7), 1320a-7a(a)(7).
[11] Section 1128A(a)(5) ofthe Act, 42 U.S.c. § 1320a-7a(a)(5).
[12] Although MIPPA was enacted on July 15, 2008, as a practical matter, the revised payment rates will take time to be implemented by CMS (or the relevant contractors and intermediaries). We are informed by CMS that the exact implementation dates may vary by benefit, contractor, and intermediary. Until such time as the new payment rates are implemented, some providers may continue to calculate beneficiary cost-sharing obligations based on the prior, temporary payment rates, and the beneficiaries may pay, or be billed for, a lower amount than they actually owe under MIPPA.
[13] There is an important exception to the general prohibition against waiving Medicare cost-sharing amounts for financial hardship situations. Specifically, under the fraud and abuse laws, Medicare cost-sharing amounts may be waived as long as: (i) the waiver is not offered as part of any advertisement or solicitation; (ii) the party offering the waiver does not routinely waive cost-sharing amounts; and (iii) the party waives the cost-sharing amounts after determining in good faith that the beneficiary is in financial need or reasonable collection efforts have failed. Section 1128A(i)(6)(A) of the Act, 42 U.S.C. § 1320a-7a(i)(6)(A).

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LOCAL COVERAGE DETERMINATIONS

This section of the *Medicare B Update!* 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 that the carrier's LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education Web sites, *http://www.fcso.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each LCD, and are based on the date of service (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 Web site is considered the notice date.

Electronic Notification

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

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Local Coverage Determinations—Table of Contents

Advance Beneficiary Notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when 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 must append the billed service with modifier GA or GZ.

REVISIONS TO THE LCDS

IDTF: Independent Diagnostic Testing Facility—coding guideline revision

LCD ID: L26304

The local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was effective for services rendered on or after February 29, 2008. The credentialing matrix in the "Coding Guidelines" attachment was last revised July 8, 2008. Since that time, the credentialing has been revised in conjunction with CMS change request 6180, "October Update to the 2008 MPFSDB," dated August 22, 2008, as follows:

HCPCS codes	Level of supervision	Supervising physician qualification/ proficiency requirements	Technician qualification requirements
G0398	1	Board Certified (ABMS) Physician Certified by the American Board of Sleep Medicine (ABSM)	Credentialed by BRPT: RPSGT or ABRET: R. EEG T. (Polysomnography)
G0399	1	Board Certified (ABMS) Physician Certified by the American Board of Sleep Medicine (ABSM)	Credentialed by BRPT: RPSGT or ABRET: R. EEG T. (Polysomnography)
G0400	1	Board Certified (ABMS) Physician Certified by the American Board of Sleep Medicine (ABSM)	Credentialed by BRPT: RPSGT or ABRET: R. EEG T. (Polysomnography)

Effective date

This revision to the "Coding Guidelines" attachment is effective for claims processed on or after October 6, 2008, for services rendered on or after March 13, 2008. First Coast Service Options, Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page.

As a reminder, Medicare may reimburse IDTFs only for procedure codes for which they are approved, based on equipment and personnel requirements, IDTFs are required to submit a list of all procedure codes performed by the facility to Medicare provider enrollment. The codes and equipment should be listed on Attachment 2, Section 1 of Enrollment Application CMS-855B.

J9041: Bortezomib (Velcade®)—revision to the LCD

LCD ID: L21643

The local coverage determination (LCD) for bortezomib (Velcade®) was last updated on October 1, 2007. Since that time, a revision was made based on the new Food and Drug Administration (FDA)-approved indication for multiple myeloma without prior therapy for bortezomib – J9041.

A revision for the above FDA-approved indication was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD deleting the requirement for at least one prior therapy for treatment of patients with multiple myeloma.

In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective Date

This revision to the LCD is effective for services rendered on or after June 20, 2008. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

THERSVCS: Therapy and Rehabilitation Services—revision to the LCD

LCD ID: L6196

The therapy and rehabilitation services local coverage determination (LCD) was last revised on January 1, 2008. Since that time, it has been revised. Change request 5871, dated January 10, 2008, imposed a limitation on the therapy cap exception process which instructed providers that they could bill for services that qualified for the therapy cap exception process through June 30, 2008. On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 was enacted with a provision that extended the therapy cap exception process through December 31, 2009. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD and the "coding guidelines" attachment have been revised to reflect this new date for therapy cap exceptions.

Effective Date

This revision to the LCD and the coding guidelines attachment is effective for services rendered on or after July 1, 2008. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

31525: Diagnostic Laryngoscopy—revision to the LCD

LCD ID: L14598

The diagnostic laryngoscopy local coverage determination (LCD) was last revised on October 1, 2007. Since that time, it has been revised. The language related to place of service (POS) for *CPT* code *31525* (*Laryngoscopy direct, with or without tracheoscopy; diagnostic, except newborn*), under the"Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, does not include POS 11 (office). It has been determined that language in the *Federal Register* supports direct laryngoscopy performed in an office setting.

Additionally, the Medicare physician fee schedule database (MPFSDB) includes a site of service differential for direct laryngoscopy in the office setting. Based on this information, the language indicating POS in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been deleted.

Effective Date

This LCD revision is effective for services rendered on or after August 26, 2008. First Coast Service Option, Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

2009 ICD-9-CM changes

The 2009 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2008. Updated diagnosis codes must be used for all services billed on or after October 1, 2008. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. Florida Medicare has reviewed all local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2009 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2009 ICD-9-CM update:

LCD title	2009 changes
0145T Computed Tomographic Angiography of the Chest, Heart, and Coronary Arteries	Added diagnosis 414.3 for procedure codes *0145T, 0146T, 0147T, 0148T, 0149T, 0150T*, and *0151T*.
11000 Debridement Services	Changed descriptor for diagnosis range 998.31-998.32 for procedure codes *11000, 11001, 11004, 11005, 11006, 11008, 11040, 11041, 11042, 11043, 11044, 97597*, and *97598*. Added diagnoses 998.30 and 998.33 for procedure codes *11000, 11001, 11004, 11005, 11006, 11008, 11040, 11041, 11042, 11043, 11044, 97597*, and *97598*.
19318 Reduction Mammaplasty	Removed diagnosis V51 for procedure code *19318*. Added diagnosis V51.8 for procedure code *19318*.
22520 Percutaneous Vertebroplasty	Added diagnosis 203.02 for procedure codes *22520, 22521, 22522, 72291*, and *72292*.
22523 Kyphoplasty	Added diagnosis 203.02 for procedure codes *22523, 22524, 22525, 72291*, and *72292*.
29540 Strapping	Changed descriptor for diagnosis range 707.10-707.19 for procedure code *29580*.
31231 Diagnostic Nasal Endoscopy	Removed diagnosis 780.6 for procedure codes *31231, 31233, 31235*, and *92511*. Added diagnoses 780.60 and 780.61 for procedure codes *31231, 31233, 31235*, and *92511*.
31525 Diagnostic Laryngoscopy	Added diagnosis 530.13 for procedure codes *31525* and *31575*.
43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy	Added diagnoses 535.70, 535.71, and 571.42 for procedure codes *43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255*, and *43258*.
44388 Diagnostic Colonoscopy	Added diagnoses 199.2 and 569.44 for procedure codes *44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391*, and *45392*.

2009 ICD-9-CM changes (continued)

LCD title	2009 changes
51798 Post-Voiding Residual Ultrasound	Removed diagnosis 788.9 for procedure code *51798*. Added diagnoses 788.91 and 788.99 for procedure code *51798*.
62310 Epidural	Added diagnoses 199.2, 208.92, and 209.00-209.69 for procedure codes *62310*, *62311*, *64479*, *64480*, *64483*, and *64484*.
64400 Peripheral Nerve Blocks	Added diagnoses 199.2, 208.92, and 209.00-209.69 for procedure codes *64400*, *64402*, *64405*, *64412*, *64413*, *64415*, *64416*, *64417*, *64418*, *64420*, *64421*, *64425*, *64430*, *64445*, *64446*, *64447*, *64448*, *64449*, and *64450*.
70551 Magnetic Resonance Imaging of the Brain	Changed descriptor for diagnosis range 046.0-046.9 for procedure codes *70551*, *70552*, and *70553*. Removed diagnosis 780.6 for procedure codes *70551*, *70552*, and *70553*. Added diagnoses 349.31, 349.39, 780.60, 780.61, and 780.62 for procedure codes *70551*, *70552*, and *70553*.
72141 Magnetic Resonance Imaging of the Spine	Removed diagnosis 337.0 and changed range to 337.00-337.9 for procedure codes *72141*, *72142*, *72146*, *72147*, *72148*, *72149*, *72156*, *72157*, and *72158*. Added diagnosis 208.92 for procedure codes *72141*, *72142*, *72146*, *72147*, *72148*, *72149*, *72156*, *72157*, and *72158*.
73218 Magnetic Resonance Imaging of Upper Extremity	Changed descriptor for diagnosis 208.90 for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*. Added diagnoses 203.82 and 208.92 for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*.
76510 B-Scan	Removed new diagnoses 362.20, 362.22-362.27 from diagnosis range 362.01-362.89 for procedure codes *76510*, *76512*, and *76513*, as they are not appropriate.
78459 Myocardial Imaging, Positron Emission Tomography (PET) Scan	Added diagnosis 414.3 for procedure codes *78459*, *78491*, and *78492*.
78460 Cardiovascular Nuclear Imaging Studies	Added diagnosis 414.3 for procedure codes *78460*, *78461*, *78464*, *78465*, *78472*, *78473*, *78478*, *78480*, *78481*, *78483*, *78494*, and *78496*.
82310 Total Calcium	Added diagnoses 208.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, and 209.30 for procedure code *82310*.
82330 Ionized Calcium	Removed diagnoses 780.6 and V45.1 for procedure code *82330*. Added diagnoses 780.60, 780.61, 780.62, 780.63, and V45.11 for procedure code *82330*.
84100 Serum Phosphorus	Added diagnosis 203.02 for procedure code *84100*.
86706 Hepatitis B Surface Antibody and Surface Antigen	Removed diagnoses 780.6 and V45.1 for procedure code *87340*. Removed diagnosis V45.1 for procedure code *86706*. Added diagnoses 780.60, 780.61, and 780.63 for procedure code *87340*. Added diagnosis V45.11 for procedure codes *86706* and *87340*.
87181 Susceptibility Studies (Coding Guidelines only)	Removed diagnoses 599.7, 780.6, and 788.9 for procedure codes *87181*, *87184*, *87185*, *87186*, *87187*, *87188*, and *87190*. Added diagnoses 599.70, 599.71, 599.72, 780.60, 780.61, 788.91, and 788.99 for procedure codes *87181*, *87184*, *87185*, *87186*, *87187*, *87188*, and *87190*.

2009 ICD-9-CM changes (continued)

LCD title	2009 changes
92081 Visual Field Examinations	Removed new diagnoses 362.22-362.27 from diagnosis range 362.21-362.29 for procedure codes *92081*, *92082*, and *92083*, as they are not appropriate. Added diagnoses 346.92 and 346.93 for procedure codes *92081*, *92082*, and *92083*.
93000 Electrocardiography	Removed diagnoses 337.0 and 997.3 for procedure codes *93000*, *93005*, and *93010*. Added diagnoses 337.00, 337.01, 337.09, and 997.39 for procedure codes *93000*, *93005*, and *93010*.
93303 Transthoracic Echocardiography (TTE)	Changed descriptor for diagnosis 038.11 for procedure codes *93307* and *93308*. Removed diagnosis 780.6 for procedure codes *93307* and *93308*. Added diagnoses 038.12, 780.60, 780.61, and 780.62 for procedure codes *93307* and *93308*.
93922 Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries	Changed descriptor for diagnosis range 707.10-707.19 for procedure code *93922*, *93923*, and *93924*.
93975 Duplex Scanning	Removed diagnosis 599.7 for procedure codes *93975* and *93976*. Added diagnoses 599.70, 599.71, and 599.72 for procedure codes *93975* and *93976*.
95860 Electromyography and Nerve Conduction Studies	Removed diagnosis 337.0 for procedure codes *95860*, *95861*, *95863*, *95864*, *95867*, *95868*, *95869*, *95870*, *95872*, *95900*, *95903*, *95904*, *95934*, *95936*, and *95937*. Added diagnoses 337.00, 337.01, and 337.09 for procedure codes *95860*, *95861*, *95863*, *95864*, *95867*, *95868*, *95869*, *95870*, *95872*, *95900*, *95903*, *95904*, *95934*, *95936*, and *95937*.
98940 Chiropractic Services	Added diagnoses 346.92 and 346.93 for procedure codes *98940*, *98941*, and *98942*.
J0637 Caspofungin acetate (Cancidas®)	Removed diagnosis 780.6 for procedure code J0637. Added diagnosis 780.61 for procedure code J0637.
J0640 Leucovorin (Wellcovorin®)	Added diagnosis 199.2 for procedure code J0640.
J0881 Erythropoiesis Stimulating Agents	Added diagnosis 199.2, 203.82, 204.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, and 209.30 for procedure code J0881 and J0885.
J1440 G-CSF (Filgrastim, Neupogen®)	Added diagnosis 238.77 for procedure codes J1440 and J1441.
J1561 Intravenous Immune Globulin	Changed descriptor for diagnosis 204.10 for procedure codes J1561, J1566, J1568, J1569, J1572, and Q4097. Added diagnosis 204.12 for procedure codes J1561, J1566, J1568, J1569, J1572, and Q4097.
J2355 Oprelvekin (Neumega®)	Added diagnoses 199.2, 203.82, and 204.92 for procedure code J2355.
J2430 Pamidronate (Aredia®, APD)	Added diagnosis 203.02 for procedure code J2430.
J2505 Pegfilgrastim (Neulasta™)	Added diagnoses 199.2, 203.82, 204.02, 204.12, 204.22, and 204.82 for procedure code J2505.
J2820 Sargramostim (GM-CSF, Leukine®)	Added diagnosis 205.92 for procedure code J2820.
J3487 Zoledronic Acid	Added diagnosis 203.02 for procedure code J3487.
J9000 Doxorubicin HCl	Added diagnoses 203.02, 204.02, 204.12, 205.92, 206.02, and 207.02 for procedure code J9000.

2009 ICD-9-CM changes (continued)

LCD title	2009 changes
J9001 Doxorubicin, Liposomal (Doxil)	Added diagnosis 203.02 for procedure code J9001.
J9010 Alemtuzumab (Campath®)	Added diagnosis 204.12 for procedure code J9010.
J9015 Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2)	Added diagnoses 205.02 and 205.12 for procedure code J9015.
J9041 Bortezomib (Velcade®)	Changed descriptor for diagnosis 203.00 for procedure code J9041.
J9045 Carboplatin (Paraplatin®, Paraplatin-AQ®)	Added diagnosis 199.2 for procedure code J9045.
J9181 Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16)	Added diagnoses 199.2, 203.02, 204.02, 205.02, 205.12, 206.02, and 207.02 for procedure codes J9181 and J9182. Removed new diagnosis 238.77 from diagnosis range 238.71-238.79 for procedure codes J9181 and J9182, as it is not appropriate.
J9185 Fludarabine (Fludara®)	Added diagnoses 204.12, 204.92, 205.02, 206.02, and 207.02 for procedure code J9185.
J9212 Interferon	Changed descriptor for diagnosis 204.10 for procedure code J9214. Changed descriptor for diagnosis 205.10 for procedure codes J9214 and J9215. Added diagnosis 204.12 for procedure code J9214. Added diagnoses 203.82 and 205.12 for procedure codes J9214 and J9215.
J9213 Interferon, alfa-2a (Roferon®-A)	Changed descriptor for diagnosis 205.10 for procedure code J9213. Added diagnosis 205.12 for procedure code J9213.
J9265 Paclitaxel (Taxol®)	Added diagnosis 199.2 for procedure code J9265.
J9280 Mitomycin (Mutamycin®, Mitomycin-C)	Added diagnosis 205.12 for procedure code J9280, J9290, and J9291.
J9293 Mitoxantrone Hydrochloride	Added diagnosis 204.02, 205.02, 206.02, and 207.02 for procedure code J9293.
J9300 Gemtuzumab Ozogamicin (Mylotarg™)	Added diagnosis 205.02 for procedure code J9300.
J9310 Rituximab (Rituxan®)	Added diagnosis 204.12 for procedure code J9310.
J9350 Topotecan Hydrochloride (Hycamtin®)	Added diagnosis 205.12 for procedure code J9350. Removed new diagnosis 238.77 from diagnosis range 238.71-238.79 for procedure code J9350, as it is not appropriate.
THERSVCS Therapy and Rehabilitation Services	Changed descriptor for diagnosis range 998.31-998.32 for procedure code *97026*.

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare carrier. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education Web site. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the prompts.

ADDITIONAL INFORMATION

NCSVCS: The List of Medicare Noncovered Services

LCD ID: L5780

99199 pulsatile intravenous insulin therapy (PIVIT) – article clarification

The following information was previously published in the Second Quarter 2003 *Medicare B Update!* (pg. 54). First Coast Service Options Inc. (FCSO) considers pulsatile intravenous insulin therapy (PIVIT), also known as chronic intermittent intravenous insulin therapy (CIIIT), metabolic activation therapy (MAT) and hepatic activation therapy (HAT) a noncovered service. This service was added to the "*CPT*/HCPCS Codes" section under the Local Noncoverage Decision – Procedures subsection. Effective for services rendered on or after March 24, 2003, PIVIT is coded using *CPT* code *99199* (*unlisted special service, procedure or report*), since a unique *CPT* code does not currently exist describing this service,. However, services rendered prior to that date also do not meet medical necessity for coverage.

PIVIT, CIIIT, MAT and HAT involves delivering insulin intravenously over a six to seven hour period, in a pulsatile fashion using a specialized pump controlled by a computerized program that adjusts the insulin dosages based on frequent blood glucose monitoring. The pulses are designed to deliver a higher, more physiologic concentration of insulin to the liver than is delivered by traditional subcutaneous injections.

This higher level of insulin is thought to more closely mimic the body's natural levels of insulin as they are delivered to the liver. It is hoped that improved glucose control can be achieved through improved hepatic function. PIVIT is typically delivered once weekly as an outpatient therapy combined with daily intensive subcutaneous insulin therapy. PIVIT is intended to improve glycemic control while decreasing the incidence of hypoglycemic events, improve hypertension, and slow the progression of overt diabetic nephropathy while reversing some manifestations of diabetic neuropathy. The exact physiological mechanism of PIVIT is unclear.

Claims submitted to FCSO for this service will be denied as not being reasonable and necessary because this service/procedure is not scientifically proven to be effective, and is not within accepted standards of medical practice for the treatment of patients with diabetes. There is inadequate published scientific literature to permit conclusions regarding the effect of PIVIT on health outcomes.

These services should continue to be billed using *CPT* code *99199*. Documentation must be available to Medicare upon request. However, providers should not submit any medical record documentation with the claim. FCSO will request this by means of an additional documentation request (ADR) letter. Requested documentation should include a description of services rendered, patient's history and physical, office/progress notes, and test results. This documentation must also support the medical necessity of the procedure performed. Please note, the assignment of an unlisted code does not guarantee Medicare coverage or payment for services billed.

A drug which is self-administered by more than 50 percent of the Medicare beneficiaries is excluded from coverage in the outpatient setting (CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.2). For drugs, such as insulin, which have multiple indications and routes of administration FCSO Medicare has determined that insulin is usually a self-administered drug and, therefore noncovered incident to in a physician's office/clinic.

The services associated with this therapy are also noncovered (i.e., physician directed infusions, blood glucose monitoring, oxygen uptake, expired gas analysis tests), as they are intrinsic to the service that is noncovered. Also, multiple units of expired gas analysis testing are never covered since it is not medically necessary or reasonable in any episode of care for a patient. All components associated with this therapy should be billed under *CPT* code *99199*. This service should be reported with a GA modifier (not reasonable and necessary - waiver of liability on file). The beneficiary must sign an advance beneficiary notice (ABN) for each date of service. One ABN document may cover all of the services supplied on a single day. The provider must keep the ABN on file and supply a copy to the contractor upon request. Medicare will deny the service as not reasonable and necessary. The beneficiary will be liable for payment.

If the beneficiary does not sign an ABN, this service should be reported with a GZ modifier (not reasonable and necessary - no waiver of liability of file). FCSO Medicare will deny the service as not reasonable and necessary and will inform the beneficiary he/she is not responsible for payment.

Certain providers recognizing the local noncoverage of this service have submitted claims to FCSO for services under the routine cost in clinical trials assuming that they have met the requirements of deemed clinical trials. CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations* (NCD) *Manual*, Chapter 1, Section 310.1 outlines this coverage. Services associated with PIVIT (e.g., oxygen uptake, multiple expired gas analysis tests /*CPT* codes *94681*, *90765*, *90766*, etc.) are noncovered in clinical trials for PIVIT, as these services are never covered incident to in a physician's office for the infusion of insulin for patients with diabetes. These services should not be unbundled and billed to Medicare and the patient should have no liability. Also, the patient should be informed of the Medicare noncoverage of this service based on the LCD of 2003.

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

0192T: Aqueous Drainage Device for the Treatment of Glaucoma

Glaucoma filtering surgery is indicated when glaucomatous damage progresses despite pharmacological and/or surgical treatment. Trabeculectomy is the most widely used form of filtering surgical treatment for primary open-angle glaucoma. Glaucoma drainage implants designed to shunt the aqueous fluid posteriorly represent an alternative method for lowering intraocular pressure in glaucomatous patients and are commonly used in refractory glaucoma or after failure of filtration surgery.

Since the first mini shunt device was approved by the Food and Drug Administration (FDA) for marketing in March 2002, over 14,000 implantations have been performed. However, there has been disagreement in the ophthalmology community regarding the correct coding for this procedure. The majority of ophthalmologists billed *Current Procedural Terminology* (*CPT*) code *66180* (*Aqueous shunt to extraocular reservoir [eg, Molteno, Schocket, Denver-Krupin]*), with some using *66172* (*Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma [includes injection of antifibrotic agents]*) or *66999* (*Unlisted procedure, anterior segment of eye*). Because of this disagreement, the American Medical Association (AMA) *CPT* Panel developed a new Category III *CPT* code, *0192T* (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach), effective for services rendered on or after July 1, 2008. The appropriate ICD-9-CM codes are 365.10 - 365.15 (open-angle glaucoma). The device used must be FDA-approved, such as the Ex-PRESS™ mini shunt (Optonol).

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EDUCATIONAL RESOURCES

Upcoming provider outreach and education events
October 2008

Evaluation and management (E/M): how to choose the proper code level

Topic: Determining the proper E/M code level
When: October 14, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Evaluation and management (E/M): how to choose the proper code level

Topic: Determining the proper E/M code level
When: October 22, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Two easy ways To register

Online – Simply log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event. **First Time user?** Please set up an account using the instructions located at *www.floridamedicare.com/Education/108651.asp* in order to register for a class and obtain materials.

Fax – Providers without Internet access can leave a message on our Registration Hotline at 904-791-8103 requesting a fax registration form. Class materials will be faxed to you the day of the event.

Tips for using the FCSO provider training Web site

The best way to search and register for Florida events on *www.fcsomedicaretraining.com* is by clicking on the following links in this order:

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

Select the specific session you're interested in, click the "Preview Schedule" button at the bottom of the page. On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the "Register" link in the Options column.

If you need assistance, please contact our FCSO Medicare training help desk by calling 866-756-9160 or sending an e-mail to *fcsohelp@geolearning.com*.

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to (904) 361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, (904) 791-8103, for details and new scheduled events!

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

More educational events (teleconferences, webcasts, etc.) are being planned to help providers with hot issues. Keep checking our Web site, *www.fcso.com* , or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

Mail directory

Claims Submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of information act
Freedom of information act requests
Post office box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

EMC claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request:
Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education
For educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
For processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options, Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992
E-mail Address: *AskFloridaB@fcso.com*
FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

For Education Event Registration (not toll-free):
1-904-791-8103

EMC
Format issues & testing:
1-904-354-5977 option 4

Start-up & front-end edits/rejects:
1-904-791-8767 option 1

Electronic funds transfer
1-904-791-8016

Electronic remittance advice, electronic claim status, & electronic eligibility:
1-904-791-6895

PC-ACE support:
1-904-355-0313

Marketing:
1-904-791-8767 option 1

New installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608

Help desk:
(confirmation/transmission):
1-904-905-8880 option 1

DME, orthotic or prosthetic claims
Cigna Government Services
1-866-270-4909

Medicare Part A
Toll-Free:
1-866-270-4909

Medicare Web sites

Provider
Florida Medicare contractor
www.floridamedicare.com

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

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

Order Form—2009 Part B Materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO with the designated account number indicated below.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	**Account Number**	**Cost per Item**	Quantity	Total
***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.fcso.com*. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2008 through September 2009.	40300260	Hardcopy $33.00		
		CD-ROM $55.00		
2009 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2009 through December 31, 2009, is available free of charge online at *http://www.fcso.com*. Additional copies or a CD-ROM is available for purchase. The Fee Schedule contains calendar year 2009 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare Part B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	40300270	Hardcopy: $12.00		
		CD-ROM: $6.00		
Please write legibly			Subtotal	$
			Tax (**add % for your area**)	
			Total	

Mail this form with payment to:

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

Contact Name:_____

Provider/Office Name:_____

Phone: _____

Mailing Address:_____

City:_____State: _____ZIP:_____

Please make check/money order payable to: FCSO Account # (fill in from above)
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦