

# MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

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**T**he *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:

- ☐ Physician/Provider
- ☐ Office manager
- ☐ Billing/Vendor
- ☐ Nursing Staff
- ☐ Other \_\_\_\_\_



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## Medicare B Update!

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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.

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# 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.fcsso.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-R131 form 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](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** (waiver 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.fcsoc.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

### 2009 ambulance fee schedule

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

Specifically, this section of the Act provides for a 2009 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF). change request (CR) 6113 furnished the calendar year 2009 AIF, which is 5.0 percent. The revised fees are effective for dates of service January 1, 2009 and after.

**Note:** For ground ambulance trips of over 50 miles that you furnish on or after July 1, 2004, and before January 1, 2009 (regardless of where the transportation originates); a 25 percent bonus “per mile” payment will be added to the existing “per mile” reimbursement rate for all miles above the initial 50 miles. This 25 percent increase in the “per mile” payment rate for trips of 51 miles or greater will stop on December 31, 2008; and effective for dates of service of January 1, 2009 and later, services paid under the ambulance fee schedule will not include this temporary increase.

You may obtain the complete *MLN Matters* article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6113.pdf>. The official issued instruction (CR 6113), is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1607CP.pdf>.

Code	Loc 01/02	Loc 03	Loc 04	
A0425	\$6.87	\$6.87	\$6.87	
A0425	\$6.94	\$6.94	\$6.94	*
A0426	\$245.65	\$259.84	\$269.01	
A0426	\$248.06	\$262.39	\$271.64	*
A0427	\$388.95	\$411.42	\$425.93	
A0427	\$392.77	\$415.45	\$430.10	*
A0428	\$204.71	\$216.54	\$224.17	
A0428	\$206.72	\$218.66	\$226.37	*
A0429	\$327.54	\$346.46	\$358.67	
A0429	\$330.75	\$349.86	\$362.19	*
A0430	\$2758.36	\$2870.75	\$2943.30	
A0430	\$4137.54	\$4306.12	\$4414.95	*

Code	Loc 01/02	Loc 03	Loc 04	
A0431	\$3207.00	\$3337.66	\$3422.01	
A0431	\$4810.50	\$5006.49	\$5133.02	*
A0432	\$358.25	\$378.94	\$392.30	
A0432	\$361.76	\$382.66	\$396.15	*
A0433	\$562.96	\$595.48	\$616.47	
A0433	\$568.48	\$601.32	\$622.52	*
A0434	\$665.31	\$703.75	\$728.56	
A0434	\$671.84	\$710.65	\$735.70	*
A0435	\$8.07	\$8.07	\$8.07	
A0435	\$12.11	\$12.11	\$12.11	*
A0436	\$21.53	\$21.53	\$21.53	
A0436	\$32.30	\$32.30	\$32.30	*

\* Rural rate

Source: Publication 100-04, transmittal 1607, CR 6113

## COMPETITIVE ACQUISITION PROGRAM

### September 18, 2008, ask the contractor teleconference PowerPoint presentation

On September 18, 2008, the Centers for Medicare & Medicaid Services (CMS) hosted an “Ask the Contractor” teleconference for Medicare Part B Drug Competitive Acquisition Program (CAP) physicians to discuss the postponement of the CAP for 2009 and to assist participating CAP physicians in planning for the transition out of the program. This event was moderated by Noridian Administrative Services LLC (NAS), the CAP designated carrier.

The PowerPoint slide presentation for this teleconference is available in the “Training and Events” section on the NAS Web site at: [https://www.noridianmedicare.com/cap\\_drug/train/act.html](https://www.noridianmedicare.com/cap_drug/train/act.html).

Additional information about the CAP and the 2009 CAP postponement is available on the CMS Web site at <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>.

Source: CMS PERL 200811-14

# CONSOLIDATED BILLING

## Annual update of healthcare common procedure coding system codes used for home health consolidated billing enforcement

*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], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries during an episode of home health care.

### Provider action needed

#### *Stop – impact to you*

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of healthcare common procedure codes system (HCPCS) codes subject to the consolidated billing provision of the home health prospective payment system (HH PPS).

#### *Caution -- what you need to know*

This article is based on change request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

#### *Go -- what you need to do*

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

### Background

The Social Security Act Section 1842(b)(6); (see [http://www.ssa.gov/OP\\_Home/ssact/title18/1842.htm](http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see [http://edocket.access.gpo.gov/cfr\\_2005/octqtr/42cfr409.100.htm](http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm) on the Internet) and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20.1), available at <http://www.cms.hhs.gov/manuals/TOM/list.asp> on the CMS Web site.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., 'K' codes) throughout the calendar year.

The following HCPCS code is added to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

The following HCPCS code is deleted from the home health consolidated billing supply code list, and this code is being removed because it is noncovered by Medicare statute.

Deleted HCPCS Code	Descriptor
A6413	Adhesive Bandage, First-Aid Type, any size, each

### Additional Information

The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.pdf> on the CMS Web site.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, 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: MM6262

Related Change Request (CR) #: 6262

Related CR Release Date: November 7, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1633CP

Implementation Date: January 5, 2009

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## DRUGS AND BIOLOGICALS

### Influenza vaccine and the pneumococcal vaccine payment allowances

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

#### Provider types affected

Physicians and providers submitting claims to Medicare 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

This article is based on change request (CR) 6153 which provides the updated payment allowances, effective as of September 1, 2008, for influenza and pneumococcal vaccines when payment is based on 95 percent of the average wholesale price (AWP).

#### Background

The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year. The payment allowances for pneumococcal vaccines are updated on a quarterly basis. CR 6153 provides the payment allowances for the following influenza virus vaccines: *Current Procedural Terminology (CPT)* codes 90655, 90656, 90657, 90658, and 90660 as well as the pneumococcal vaccines (*CPT* codes 90732 and 90669) when payment is based on 95 percent of the average wholesale price (AWP).

Effective September 1, 2008, these Medicare Part B payment allowances for influenza vaccines are as follows:

CPT Code	Allowance
90655	\$16.879
90656	\$18.198
90657	\$6.609
90658	\$13.218

*CPT* 90660 (FluMist, a nasal influenza vaccine) may be covered if the local Medicare claims processing contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for *CPT* 90660 is \$22.316 (effective September 1, 2008).

The Medicare Part B payment allowance for the pneumococcal vaccine *CPT* code 90732 is \$32.703, and for *CPT* code 90669 is \$78.803. These payment allowances were published as a part of the July 2008 Quarterly Average Sales Price (ASP) Drug Pricing Files, as specified in CR 6049. See <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6049.pdf> on the CMS Web site to view the article related to CR 6049.

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

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

Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 6153. However, they will adjust such claims that you bring to their attention.

#### Additional information

The official instruction, CR 6153, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1623CP.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: MM6153

Related Change Request (CR) #: 6153

Related CR Release Date: October 31, 2008

Effective Date: September 1, 2008

Related CR Transmittal #: R1623CP

Implementation Date: No later than December 1, 2008

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## Use of compendia as the authoritative sources for medically accepted indication

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 Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

### Provider action needed

#### Stop – impact to you

This article is based on change request (CR) 6191 which updates the list of compendia recognized as authoritative sources of information for the determination of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens.

#### Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) is recognizing the following as authoritative compendia and listing them in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5) for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service-Drug Information (AHFS-DI), (existing)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (effective June 5, 2008)
- Thomson Micromedex DrugDex, (effective June 10, 2008) and
- Clinical Pharmacology (effective July 2, 2008).

#### Go – what you need to do

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

### Background

In the past, the following three compendia were recognized as authoritative sources for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary of the Department of Health and Human Services determined that the use was not medically appropriate or the use was identified as not indicated in one or more such compendia):

1. American Medical Association Drug Evaluations (AMA-DE)
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

Because the AMA-DE and the USP-DI are no longer published (due to changes in the pharmaceutical reference industry), the AHFS-DI became the only remaining statutorily-named compendia available for the CMS to use as a reference. Consequently, CMS received requests from the stakeholder community for a process to revise the list of recognized authoritative compendia.

In the Medicare physician fee schedule final rule for calendar year 2008, CMS established:

- A process for revising the list of compendia. (Section 1861(t)(2) of the Social Security Act; [[http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)], and
- A definition for “compendium.” (72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], 72 FR 66303-66306 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiapreamble.pdf>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

A compendium is defined “as a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment.” (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>].

In addition, a compendium:

- (1) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; and,
- (2) Is indexed by drug or biological. (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>], 72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

During a public meeting on March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) generated a list of desirable characteristics to use when reviewing a compendium. Subsequently, the MedCAC advised CMS of their findings and recommendations regarding the desirable characteristics of compendia for use in the determination of medically-accepted indications of drugs and biologicals in anti-cancer therapy.

After CMS conducted a review of specific compendia and compared their characteristics with the MedCAC list of desirable characteristics, CMS determined the following are recognized as authoritative compendia and is listing them in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5) for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service - Drug Information (AHFS-DI)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Thomson Micromedex DrugDex, and
- Clinical Pharmacology.

The above listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as medically accepted if the:

- Indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

*Use of compendia as the authoritative sources for medically accepted indication (continued)*

A use is not medically accepted by a compendium if the:

- Indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- Narrative text in AHFS or Clinical Pharmacology is “not supportive.”

The complete absence of narrative text on a use is considered neither supportive nor nonsupportive.

Medicare contractors may also identify off-label uses that are supported by clinical research under the conditions identified in Section 50.4.5 of the *Medicare Benefits Policy Manual*, as amended by CR 6191. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.

In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, Medicare contractors will evaluate the evidence in published, peer-reviewed medical literature listed in the revised Section 50.4.5.C, which is attached to CR 6191. When evaluating this literature, Medicare contractors will consider (among other things) the following:

- Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- Whether the administered chemotherapy regimen is adequately represented in the published evidence.

- Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- Whether the study is appropriate to address the clinical question.

**Additional Information**

The official instruction, CR 6191, 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/R96BP.pdf> on the CMS Web site. The revised sections of the *Medicare Benefit Policy Manual* are attached to CR 6191.

If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at <http://www.cms.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: MM6191

Related Change Request (CR) #: 6191

Related CR Release Date: October 24, 2008

Effective Date: June 5, June 10, and July 2, 2008

Related CR Transmittal #: R96BP

Implementation Date: November 25, 2008

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

## DURABLE MEDICAL EQUIPMENT

### Fee schedule update for 2009 for durable medical equipment, prosthetics, orthotics, and supplies

*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, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for DMEPOS provided to Medicare beneficiaries.

**Provider action needed**

This article is based on change request (CR) 6270 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

**Background**

The update process for the DMEPOS fee schedule is contained in section 60, Chapter 23 of the *Medicare Claims Processing Manual*, which is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at

[http://www.cms.hhs.gov/DMEPOSFeeSched/01\\_overview.asp](http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp) on the CMS Web site. The key points of CR 6270 are as follows:

The following codes are being deleted from the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2009, and are therefore being removed from the DMEPOS fee schedule files:

**Fee schedule update for 2009 for DMEPOS (continued)**

L5993	L5994	L5995	L7611	L7612
L7613	L7614	L7621	L7622	

For gap-filling purposes, the 2008 deflation factors by payment category are:

0.500 for Oxygen	0.504 for Capped Rental	0.505 for Prosthetics and Orthotics	0.641 for Surgical Dressings	0.697 for Parental and Enteral Nutrition
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- The fee schedule amounts for HCPCS code K0672 (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) are added to the fee schedule file on January 1, 2009, and are effective for claims submitted with dates of service on or after January 1, 2009.
- HCPCS code E2295 (Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features) is added to the HCPCS file on January 1, 2009. Due to low claims volumes expected, your Medicare contractor will establish local fee schedule amounts to pay claims for E2295.
- Fee schedule amounts for L3905, L3806, and L3808 were revised in the July 2008 Quarterly Update. However, CMS has determined that the gap-filled fees originally established for these three codes were correct and the fee amounts will revert back to what was in place prior to the July update. Claims already processed for dates of service on or after July 1, 2008, through December 31, 2008, will not be adjusted.

**2009 fee schedule updates following the Enactment of the Medicare Improvements for Patients and Providers Act (MIPPA)**

- MIPPA of 2008 mandates a fee schedule covered item update of -9.5 percent for 2009 for items included in round one of the DMEPOS Competitive Bidding Program. The reduction applies to items furnished on or after January 1, 2009, in any geographical area.
- Items selected for competitive bidding in 2008 will receive a -9.5 percent update for 2009 with the exception of HCPCS codes E1392, K0738, E0441, E0442, E0443 and E0444. These six oxygen generating portable equipment (OGPE) and oxygen contents codes will receive a 0 percent update for 2009 as the fees for these items are not adjusted by the covered item update specified in 1834(a)(14), and are not reduced by the -9.5 percent, even though they are competitive bid items.
- Non-competitive bid items will receive a 5.0 percent covered item update for 2009.

**New modifier KE and the modifier KL**

A new HCPCS modifier was added to the HCPCS on January 1, 2009, and is effective for claims with dates of service on or after January 1, 2009. The new modifier is KE (Bid Under Round One of the DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment).

To accommodate the fee schedule updates required per the MIPPA, CMS is adding the modifier KE to the fee schedule for all power mobility device (PMD) accessory items selected for competitive bidding in 2008 as part of this update. The modifier KE is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. For example, HCPCS code E0981 Wheelchair Accessory, Seat Upholstery, Replacement Only, Each can be used with both competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898).

All fee schedules for PMD accessory codes with the modifier KE will receive a 5 percent covered item update for 2009, whereas the fee schedules for the PMD accessory codes without the modifier KE will receive the MIPPA-required 9.5 percent reduction for 2009. Suppliers need to know that if a competitively bid PMD accessory code is used with a competitively bid standard PMD base code (K0813 thru K0829) or complex rehabilitative PMD base code (K0835 thru K0864), claims for the PMD accessory code should be submitted without the modifier KE. If such claims are submitted with the modifier KE, they will be rejected with message M78 (Missing/incomplete/invalid HCPCS modifier) and 125 (Submission/billing error (s)).

Suppliers should bill the accessory code with the modifier KE when the accessory is used in conjunction with a non-competitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). In the case of the complex rehabilitative only PMD accessory code E2373 KC, suppliers should bill for the replacement only of E2373 without the modifier KE, but with the modifier KC when the accessory is used with a competitively bid complex rehabilitative PMD base code (K0835 thru K0864). When the replacement only code E2373 is used with a non-competitively bid manual or miscellaneous wheelchair, suppliers should bill code E2373 without the modifier KC, but with the modifier KE.

For the aforementioned reasons, CMS is also adding the modifier KE to the fee schedule for the following competitively bid HCPCS codes: A4636, A4637, A7000, and E0776. If codes A4636 and A4637 are used in conjunction with a competitively bid walker code (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, and E0149), claims for the replacement handgrip (A4636) or tip (A4637) should be submitted without the modifier KE. Suppliers should bill codes A4636 and A4637 with the modifier KE when the codes are used with non-competitively bid cane or crutch codes. Likewise, suppliers should bill the disposable canister code A7000 without the modifier KE when this code is used in conjunction with the competitively bid negative pressure wound therapy pump code E2402. When code A7000 is used with a non-competitively bid respiratory or gastric suction pump, suppliers should bill code A7000 with the modifier KE. Similarly when an IV pole (E0776) is used in conjunction with competitively bid enteral nutrient codes (B4149, B4150, and B4152 thru B4155), suppliers should bill code E0776 with the modifier BA, but without the modifier KE. When code E0776 is used with non-competitively bid parenteral nutrient codes, suppliers should bill code E0776 without the modifier BA, but with the modifier KE.



**Fee schedule update for 2009 for DMEPOS (continued)**

Further instruction on the use of the modifier KE with codes competitively bid in 2008 is available in Attachment B of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Web site.

**Note: Suppliers should not use the modifier KE on any claims for payment for items that were included under Round 1 such as an accessory for a standard power wheelchair.**

With CR 6270, CMS is also adding the KL modifier to the fee schedule for the following diabetic supply HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259. As indicated in CR 5641 (July Quarterly Update for 2007 DMEPOS Fee Schedule, discussed in *MLN Matters* article MM5641 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf>), suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258 and A4259) furnished via mail order on or after July 1, 2007. Effective January 1, 2009, the modifier KL has been changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers must use the modifier KL on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The modifier KL is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier store fronts.

**Note:** Inappropriate use of a competitive bidding modifier on a competitive bidding claim is in violation of the law and may lead to claims denial and/or other corrective actions. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

**Competitive bidding items from 2008 impacted by 2009 pricing**

The following product lists of the HCPCS codes that were selected for competitive bidding in 2008 are subject to the -9.5 percent covered item update for 2009. The detailed descriptions of the listed HCPCS codes (for product categories 1-10) are not repeated in this article, but are available in Attachment A of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Web site.

**Product Category 1 -- Oxygen, supplies and equipment (for the detailed product description of each HCPCS code see Attachment A)**

E1390	E1391	E0424	E0439	E0431
E0434	A4608	A4615	A4616	A4617
A4620	E0560	E0580	E1353	E1355

As part of this update, CMS is implementing the 2009 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2009. CMS is revising the fee schedule file to include the new national 2009 monthly payment rate of \$175.79 for stationary oxygen equipment. This revised 2009 monthly payment rate of \$175.79 is reduced by 11.8 percent from the 2008 monthly payment rate. This reduction includes the 9.5 percent covered item reduction ascribed to items selected for competitive bidding in 2008 as required by section 154(a)(2)(A) of MIPPA and the 2.53 percent budget neutrality reduction as required by section 1834(a)(9)(D)(ii) of the Social Security Act and discussed in a final rule published in the *Federal Register* on November 9, 2006. The previously announced payment amount for 2009 of \$193.21 did not include the 9.5 percent reduction and assumed a higher shift to oxygen generating portable equipment (OGPE).

As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

**Product Category 2—Standard power wheelchairs, scooters, and related accessories (for the detailed product description of each HCPCS code see Attachment A)**

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1016	E1020	E1028
E2208	E2209	E2210	E2361	E2363	E2365	E2366	E2367
E2368	E2369	E2370	E2371	E2381	E2382	E2383	E2384
E2385	E2386	E2387	E2388	E2389	E2390	E2391	E2392
E2394	E2395	E2396	E2601	E2602	E2603	E2604	E2605
E2606	E2607	E2608	E2611	E2612	E2613	E2614	E2615
E2616	E2619	E2620	E2621	K0015	K0017	K0018	K0019
K0020	K0037	K0038	K0039	K0040	K0041	K0042	K0043
K0044	K0045	K0046	K0047	K0050	K0051	K0052	K0053
K0098	K0195	K0733	K0734	K0735	K0736	K0737	K0800
K0801	K0802	K0806	K0807	K0808	K0813	K0814	K0815
K0816	K0820	K0821	K0822	K0823	K0824	K0825	K0826
K0827	K0828	K0829					

**Fee schedule update for 2009 for DMEPOS (continued)**

**Product category 3 -- complex rehabilitative power wheelchairs and related accessories (for the detailed product description of each HCPCS code see Attachment A)**

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1002	E1003	E1004
E1005	E1006	E1007	E1008	E1010	E1016	E1020	E1028
E1029	E1030	E2208	E2209	E2210	E2310	E2311	E2321
E2322	E2323	E2324	E2325	E2326	E2327	E2328	E2329
E2330	E2351	E2361	E2363	E2365	E2366	E2367	E2368
E2369	E2370	E2371	E2373 KC	E2374	E2375	E2376	E2377
E2381	E2382	E2383	E2384	E2385	E2386	E2387	E2388
E2389	E2390	E2391	E2392	E2394	E2395	E2396	E2601
E2602	E2603	E2604	E2605	E2606	E2607	E2608	E2611
E2612	E2613	E2614	E2615	E2616	E2619	E2620	E2621
K0015	K0017	K0018	K0019	K0020	K0037	K0038	K0039
K0040	K0041	K0042	K0043	K0044	K0045	K0046	K0047
K0050	K0051	K0052	K0053	K0098	K0195	K0733	K0734
K0735	K0736	K0737	K0835	K0836	K0837	K0838	K0839
K0840	K0841	K0842	K0843	K0848	K0849	K0850	K0851
K0852	K0853	K0854	K0855	K0856	K0857	K0858	K0859
K0860	K0861	K0862	K0863	K0864			

**Product category 4 -- mail-order diabetic supplies (for the detailed product description of each HCPCS code see Attachment A)**

A4233 KL	A4234 KL	A4235 KL	A4236 KL	A4253 KL	A4256 KL	A4258 KL	A4259 KL
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**Product category 5 -- enteral nutrients, equipment, and supplies (for the detailed product description of each HCPCS code see Attachment A)**

B4034	B4035	B4036	B4081	B4082	B4083	B4087	B4088	B4149
B4150	B4152	B4153	B4154	B4155	B9000	B9002	E0776	

**Product category 6 -- continuous positive airway pressure devices, respiratory assist devices, and related supplies and accessories (for the detailed product description of each HCPCS code see Attachment A)**

A4604	A7030	A7031	A7032	A7033	A7034	A7035	A7036
A7037	A7038	A7039	A7044	A7045	A7046	E0470	E0471
E0472	E0561	E0562	E0601				

**Product category 7 -- hospital beds and related supplies (for the detailed product description of each HCPCS code see Attachment A)**

E0250	E0251	E0255	E0256	E0260	E0261	E0265	E0266
E0271	E0272	E0280	E0290	E0291	E0292	E0293	E0294
E0295	E0296	E0297	E0300	E0301	E0302	E0303	E0304
E0305	E0310	E0316	E0910	E0911	E0912	E0940	

**Product category 8 -- negative pressure wound therapy pumps and related supplies and accessories (for the detailed product description of each HCPCS code see Attachment A)**

A6550	A7000	E2402
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**Product category 9 -- walkers and related supplies (for the detailed product description of each HCPCS code see Attachment A)**

A4636	A4637	E0130	E0135	E0140	E0141	E0143	E0144	E0147
E0148	E0149	E0154	E0155	E0156	E0157	E0158	E0159	

**Product category 10 -- support surfaces (for the detailed product description of each HCPCS code see Attachment A)**

E0193	E0277	E0371	E0372	E0373
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**Billing instructions for power wheelchair harness (HCPCS code E2313)**

The April quarterly update for the 2007 DMEPOS fee schedule included instructions for suppliers to submit claims for the electronics necessary to upgrade from a non-expandable controller to an expandable controller at initial issue using



**Fee schedule update for 2009 for DMEPOS (continued)**

HCPCS code E2399. This instruction was intended as a temporary measure until a new code could be added to describe the electronics/cables/junction boxes used when upgrading from a non-expandable controller at initial issue.

- HCPCS code E2313 (Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each) was added to the HCPCS effective January 1, 2008, for use in paying claims for the electronics furnished when upgrading from a non-expandable controller at initial issue.
- Suppliers may submit claims for the electronics provided at initial issue using HCPCS code E2313 for dates of service on or after January 1, 2008, and must no longer use code E2399 for submission of such items.
- Claims submitted for the electronics necessary to upgrade from a non-expandable controller to an expandable controller using HCPCS code E2399 are invalid and will be denied as contractor/supplier responsibility. When such claims are denied, CMS will use message codes of M20 (Missing/incomplete/invalid HCPCS), 189 (Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.), N211 (Alert: You may not appeal this decision.), and MA13 (You may be subject to penalties if you bill the patient for amount not reported with the PR (patient responsibility) group code.). These denials are made as CO-Contractual obligation denials.

**Additional Information**

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.

For complete details regarding this CR please see the official instruction (CR 6270) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.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.

Code	Fee
A4561	\$21.62
A4562	\$53.74
A7040	\$42.71
A7041	\$80.25
A7042	\$190.66
A7043	\$30.37
E0749	\$253.80
E0782	\$4508.08
E0783	\$8596.26
E0785	\$496.13
E0786	\$8385.13
L8600	\$563.24
L8603	\$395.57
L8606	\$207.65
L8609	\$5943.03
L8610	\$577.75
L8612	\$609.36
L8613	\$272.82
L8614	\$17268.34
L8615	\$411.39
L8616	\$95.82
L8617	\$83.70
L8618	\$23.90
L8619	\$7407.48

Code	Fee
L8621	\$0.56
L8622	\$0.30
L8623	\$59.01
L8624	\$147.06
L8630	\$303.88
L8631	\$2039.39
L8641	\$329.82
L8642	\$270.73
L8658	\$282.94
L8659	\$1760.14
L8670	\$502.09
L8680	\$418.98
L8681	\$1030.25
L8682	\$5437.91
L8683	\$4786.58
L8684	\$628.58
L8685	\$11927.92
L8686	\$7610.99
L8687	\$15522.99
L8688	\$9904.93
L8689	\$1573.38
L8690	\$4339.22
L8691	\$2432.27
L8695	\$15.20

Code	Fee
Q0480	\$82151.87
Q0481	\$13254.26
Q0482	\$4151.48
Q0483	\$17102.23
Q0484	\$3321.20
Q0485	\$320.66
Q0486	\$266.88
Q0487	\$311.37
Q0489	\$14826.70
Q0490	\$641.33
Q0491	\$1008.22
Q0492	\$81.25
Q0493	\$231.27
Q0494	\$195.71
Q0495	\$3810.12
Q0496	\$1367.52
Q0497	\$427.01
Q0498	\$468.53
Q0499	\$152.22
Q0500	\$27.85
Q0501	\$465.83
Q0502	\$593.05
Q0503	\$1186.13
Q0504	\$625.88

MLN Matters Number: MM6270  
 Related Change Request (CR) #: 6270  
 Related CR Release Date: November 7, 2008  
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 Related CR Transmittal #: R1630CP  
 Implementation Date: January 5, 2009

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# MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

## New 2008 Medicare physician fee schedule payment rates

*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], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries and paid under the MPFS.

### Provider action needed

#### **Stop -- impact to you**

This article is based on change request (CR) 6212, which announces the new 2008 MPFS payment rates effective for dates of service July 1, 2008, through December 31, 2008. Please note that Medicare contractors have already implemented the actions annotated in this article.

#### **Caution -- what you need to know**

The Centers for Medicare & Medicaid Services (CMS) directed Medicare contractors to revert back to the 0.5 percent payment rates that were previously in place until June 30, 2008, and to use those rates through December 31, 2008. In addition, carriers/Part B MACs are using the same rates as used for January 1 through June 30, 2008, to make payments, where appropriate, to ambulatory surgical centers (ASCs) for services rendered from July 1 through December 31, 2008. This reflects a continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services. CMS also provided revised fees for selected mental health codes that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008.

#### **Go -- what you need to do**

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

### Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. The -10.6 percent Medicare physician fee schedule (MPFS) that took effect on July 1, 2008, was changed back to the January-June 2008 rates, which reflect an update of 0.5 percent. CMS directed Medicare contractors to revert back to the 0.5 percent payment files that were previously in place until June 30, 2008. The new MPFS rates are retroactive to July 1, 2008.

Consistent with the new legislation, carriers/Part B MACs are using the same fees as used for January 1 through June 30, 2008, to make payments to ambulatory surgical centers (ASCs) for July 1 through December 31, 2008. Those fees reflect the continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services.

FIs/Part A MACs also have reverted back to the fees that were in effect from January 1, 2008, through June 30, 2008.

In addition, based on the new legislation, CMS provided Medicare contractors with new revised fees for selected mental health codes that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008, and Medicare contractors are currently paying the new fees.

After Medicare contractors began paying claims at the new rates, they began to identify any MPFS claims that were paid at the -10.6 percent rate for dates of service on and after July 1, 2008. Contractors are in the process of automatically adjusting those claims, and must complete the adjustments no later than September 30, 2008.

There may be some claims that cannot be automatically adjusted. Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1, 2008, and later billed with a submitted charge at least at the level of the January 1 through June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount requires providers to contact their local contractor for direction on obtaining adjustments. Nonparticipating physicians who submitted unassigned claims at the reduced non-participation amount also will need to request an adjustment.

Contractors are following the normal process for transmitting the adjusted claims to supplemental insurers, where appropriate. Contractors disclosed the new MPFS rates on their Web sites by July 23, 2008.

### Additional Information

The official instruction, CR 6212, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R389OTN.pdf> on the CMS Web site.

If you have any questions, please contact your carrier, FI, A/B MAC, or RHHI 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: MM6212

Related Change Request (CR) #: 6212

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## PREVENTIVE SERVICES

### Update to the initial preventive physical examination benefit

*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 fiscal intermediaries (FIs), carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for the initial preventive physical examination (IPPE) provided to Medicare beneficiaries.

#### What you need to know

This article is based on change request (CR) 6223, which announces that, effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) is expanding coverage for the IPPE benefit.

This expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, no later than 12 months (rather than six months as previously required) after the date the individual's first coverage period begins under Medicare Part B. However, this expanded coverage only applies if the IPPE is performed on or after January 1, 2009.

The IPPE has been expanded to include measurement of an individual's body mass index, and end-of-life planning as mandatory services (upon an individual's consent). The screening electrocardiogram (EKG) is no longer a mandatory part of the IPPE, but it may be performed as an optional one-time service as a result of a referral arising out of the IPPE. Be sure your billing staff is aware of these changes.

#### Background

Pursuant to Section 101 (b) of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), CMS is amending section 410.16 and related regulation provisions of the Code of Federal Regulations. Effective January 1, 2009, this expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, also known as the "Welcome to Medicare Visit", not later than 12 months after the date the individual's first coverage period begins under Medicare Part B.

#### Changes to IPPE

##### The initial preventive physical examination

Effective for services performed on or after January 1, 2009, MIPPA changes the IPPE as follows:

- Waives the deductible for the IPPE.
- Adds the measurement of body mass index as part of the IPPE,
- Adds end-of-life planning to the IPPE (upon an individual's consent), and
- Removes the mandatory requirement of the screening electrocardiogram (EKG). The screening EKG is optional and is permitted as a one-time screening service as a result of a referral arising out of the IPPE.

##### Eligibility

- Effective January 1, 2009, the MIPPA of 2008 extends the eligibility period from six months after Part B enrollment to 12 months after enrollment.
- Effective for IPPEs performed on or after January 1, 2009, a beneficiary is eligible for the extended IPPE benefits of MIPPA when he/she first enrolls in Medicare Part B and receives the IPPE benefit within the first 12 months of the effective date of the initial Part B coverage period.
- For IPPEs performed on or after January 1, 2009, the Medicare deductible does not apply to the IPPE.
- The waived deductible is applicable to the IPPE (code G0402) only, but the coinsurance still applies. Prior to January 1, 2009, the deductible was not waived.

#### Billing requirements

##### Codes used to bill the IPPE

- Effective January 1, 2005, the physician or qualified non-physician practitioner will bill for IPPEs performed on or before December 31, 2008, using HCPCS code G0344 with one of the following HCPCS codes for the mandatory EKG: G0366, G0367, or G0368.
- Effective January 1, 2009, the screening EKG is billable with HCPCS code(s) G0403, G0404, or G0405, when it is a result of a referral from an IPPE.
- For an IPPE performed during the global period of surgery refer to Section 30.6.6, Chapter 12 of the *Medicare Claims Processing Manual* for reporting instructions at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> on the CMS Web site.

The following HCPCS codes have been developed for the IPPE benefit effective January 1, 2009:

*Update to the initial preventive physical examination benefit (continued)*

HCPCS Code	Short Descriptor
G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	Initial Preventive Exam
G0403: Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report	EKG for initial prevent exam
G0404: Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination	EKG tracing for initial prev
G0405: Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	EKG interpret & report preve

**Professional claims processed by carriers/MACs**

- The type of service (TOS) for each of the new codes is as follows:  
G0402: TOS = 1  
G0403: TOS = 5  
G0404: TOS = 5  
G0405: TOS = 5
- The HCPCS codes for an IPPE and screening EKG are paid under the Medicare physician fee schedule (MPFS). The appropriate deductible and coinsurance applies to codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405.
- The deductible is waived for code G0402 after January 1, 2009, but the coinsurance still applies.

**Institutional claims processed by FIs/MACs**

- FIs/MACs will pay for code G0402 for the IPPE and code G0404 for the screening EKG, tracing only when those services are submitted on a TOB 12c or 13c for hospitals subject to the outpatient prospective payment system (OPPS). Codes G0403 and G0405 are not payable under the OPPS. Hospitals not subject to OPPS will be paid under current methodologies.
- For inpatient or outpatient services in hospitals in Maryland, payment is made according to the state cost containment System.
- For services performed on a 12x, Indian Health Services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.
- For services performed on a 13x, IHS hospitals, payment is made based on the all-inclusive rate (AIR).
- For services performed on an 85x, IHS critical access hospitals (CAHs), payment is made based on an all inclusive facility specific per visit rate. For other CAHs billing on the 85x, payment is based on reasonable cost.
- For services billed by skilled nursing facilities (SNFs) on the 22x, payment for the technical component of the EKG is based on the MPFS.

**Note:** HCPC code G0405 is a professional component and is only allowable on 71x, 73x and 85x (CAH method II) TOBs. In addition, G0404 is a technical component HCPCS code that can only be submitted on 12x, 13x, 22x, OR 85x (method I and II) TOBs.

**Rural health clinics/federally qualified health centers (RHCs/FQHCs)****Special billing instructions**

Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit.

**OPPS hospital billing**

Hospitals subject to OPPS (TOBs 12x and 13x) must use modifier 25 when billing the IPPE G0344 along with technical component of the EKG, G0367, on the same claim. The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404.

**Reporting a medically necessary evaluation and management (E&M) at same IPPE visit**

When the physician or qualified nonphysician practitioners (Web sites) provides a medically necessary E&M service in the same visit as the IPPE, CPT codes 99201-99215 may be used depending on the clinical appropriateness of the circumstances. CPT modifier 25 will be appended to the medically necessary E&M service identifying this service as a significant, separately identifiable service from the IPPE code reported (G0344 or G0402, whichever applies based on the date of service).

**Documentation**

Physicians and qualified Web sites are required to use the 1995 and 1997 E&M documentation guidelines to document the medical record with the appropriate clinical information. The guidelines may be reviewed at [http://www.cms.hhs.gov/MLNedWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNedWebGuide/25_EMDOC.asp) on the CMS Web site.

**Medicare notices and messages****Remittance advice remark codes and claim adjustment reason codes**

- Your Medicare contractors will use the appropriate remittance advice remark code, i.e., N117 (This service is paid only once in a patient's lifetime) when denying additional claims for an IPPE and/or a screening EKG.
- Your Medicare contractors will use the appropriate claim adjustment reason code, i.e., 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for an IPPE and/or a screening EKG.



*Update to the initial preventive physical examination benefit (continued)***Advance beneficiary notice as applied to the IPPE**

- Effective for beneficiaries whose IPPE is provided on January 1, 2005, through December 31, 2008, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory six-month period has lapsed.
- Effective for IPPEs performed on or after January 1, 2009, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed since based on Social Security Act Section 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period under the MIPPA of 2008.

**Medicare summary notices (MSNs)**

- When denying additional claims for G0402, Medicare contractors will use MSN message 20.91 - This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.
- When denying additional claims for screening EKG codes G0403, G0404 and G0405, contractors will use

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MSN message 20.12 - This service was denied because Medicare only covers this service once a lifetime.

**Additional information**

The official instruction (CR 6223) issued to Medicare carriers, FIs and A/B MACs regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1615CP.pdf> on the CMS Web site. If you have any questions, please contact your Medicare contractor (carrier, FI, or 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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## PSYCHIATRIC SERVICES

**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.*

**Note:** This article was revised on November 14, 2008, to show that the "Reasonable Expectation of Improvement" discussion only applies to mental health services furnished under partial hospitalization programs. This information was previously published in the September 2008 *Medicare B Update!* pages 22-26.

**Provider types affected**

Physicians, providers and suppliers submitting claims to Medicare contractors (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 (OIG's) 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



**Medicare payments for Part B mental health services (continued)**

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 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](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](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 section 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](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](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](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) “*Current 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).

**Medicare payments for Part B mental health services (continued)**

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](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
- 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 two 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](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 SNF that the SNF is required to provide as a requirement for participation are not included. Services furnished to patients of partial hospitalization programs are also 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](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.

**Medicare payments for Part B mental health services (continued)**

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 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 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](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.



*Medicare payments for Part B mental health services (continued)***Reasonable expectation of improvement for mental health services furnished under partial hospitalization programs**

Services furnished under partial hospitalization programs 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. The overall intent of the partial hospitalization program admission is to treat the serious presenting psychiatric symptoms. Continued treatment in order to maintain a stable psychiatric condition or functional level requires evidence that less intensive treatment options (e.g. intensive outpatient, psychosocial, day treatment, and/or other community supports) cannot provide the level of support necessary to maintain the patient and to prevent hospitalization.

**General principles of medical record documentation for individual mental health services**

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.

According to section 424.24(e) of the *Code of Federal Regulations*, additional medical record documentation requirements exist for partial hospitalization programs. (See [http://edocket.access.gpo.gov/cfr\\_2007/octqtr/pdf/42cfr424.24.pdf](http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr424.24.pdf) on the Internet.)

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 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).

**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](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.

**Medicare payments for Part B mental health services (continued)**

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.

MLN Matters Number: SE0816 *Revised*

Related Change Request (CR) #: N/A

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## THERAPY SERVICES

**2009 annual update to the therapy code list**

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

**Provider types affected**

Physicians, therapists, and providers of therapy services billing Medicare carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) or Part A/B Medicare administrative contractors (A/B MACs) for outpatient rehabilitation therapy services.

**What providers need to know**

This article is based on change request (CR) 6254 and alerts providers to updates to Medicare's therapy code list with two "sometimes" therapy codes for calendar year (CY) 2009. Note that these codes always represent therapy services and require the use of a therapy modifier when performed by therapists. The two codes added are:

95992     *Standard Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day.*

0183T     *Low frequency, non-contact, non-thermal ultrasound, including topical applications(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.*

**Note:** If billed by a hospital subject to outpatient prospective payment system (OPPS) for an outpatient service, CPT code 0183T will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. In addition, no Medicare physician fee schedule (MPFS) amount exists for this code. Since the local carrier (or A/B MAC) determines the coverage and pricing for this code, the FI or A/B MAC contacts the local contractor to obtain the appropriate fee schedule amount.

**Background**

This instruction updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2008 and 2009 HCPCS/CPT-4.

Therapy services, including "always therapy" services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Chapter 5 which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site and the *Medicare Benefit Policy Manual*, Chapter 12, which is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c12.pdf> on the CMS Web site.

**Additional information**

The official instruction (CR 6254) issued to your Medicare FI, A/B MAC, carrier or RHHI, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1625CP.pdf> on the CMS Web site.



**2009 annual update to the therapy code list (continued)**

If you have questions, please contact your Medicare FI, A/B MAC, carrier or RHHI 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: MM6254

Related Change Request (CR) #: 6254

Related CR Release Date: October 31, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1625CP

Implementation Date: January 5, 2009

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## GENERAL COVERAGE

### Release of the 2009 HCPCS annual update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the CMS HCPCS Web site at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage>.

Included are changes to the Current Dental Terminology (CDT) codes contributed by the American Dental Association (ADA) with their scheduled update.

In addition, the following changes have been made:

E0764 – Language revised

E0770 – Coverage indicator changed

Q4114 – Language revised

All changes are effective January 1, 2009, unless otherwise indicated in the effective date column.

Source: CMS PERL 200811-04 & 200811-23

### HCPCS coding decision for skin substitute products

The 2009 HCPCS annual update includes a new code range, Q4100-Q4115, effective January 1, 2009, to identify skin substitute products. HCPCS codes J7340, J7341, J7342, J7343, J7344, J7346, J7347, J7348, J7349 and C9357 are discontinued effective December 31, 2008. For specific code language, please refer to the 2009 HCPCS annual update posted on CMS HCPCS Web site at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS>.

The coding decision was made based on programmatic reasons and to facilitate accurate coding of these products. Medicare Part B is not changing the way the payment amounts are determined for the products in the new codes. To the extent that single source drugs or biologicals were within the same billing and payment code as of October 1, 2003, Medicare Part B will continue to treat them as multiple source drugs for payment purposes as required by Section 1847A(c)(6)(C)(ii) of the Social Security Act.

Source: CMS PERL 200811-04

#### 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.

## GENERAL INFORMATION

### Update to Medicare deductible, coinsurance and premium rates for 2009

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

#### Impact on providers

This article is based on change request (CR) 6258, which provides the Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2009.

#### 2009 Part A – hospital insurance

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode. When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

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

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during an illness episode. The 2009 deductible and coinsurance amounts are in the following table.

**Table 1 – 2009 Part A – Hospital insurance**

Deductible	\$1,068.00		
Coinsurance	Hospital		Skilled nursing facility
	Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
	\$267.00	\$534.00	\$133.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) benefits without a premium payment. In addition, the Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium.

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2009 Part A premiums are listed in table 2.

**Table 2 – 2009 Part A premiums**

Voluntary enrollees Part A premium schedule	
Base premium (BP)	\$443.00 per month
Base premium with 10 percent surcharge	\$487.30 per month
Base premium with 45 percent reduction	\$244.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	\$268.40 per month

#### 2009 Part B – supplementary medical insurance

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

For 2009, the standard premium for SMI services is \$96.40 a month; the deductible is \$135.00 a year; and the coinsurance is 20 percent. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6258, which is available on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R56GI.pdf>.

*Update to Medicare deductible, coinsurance and premium rates for 2009 (continued)***Additional Information**

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: MM6258

Related Change Request (CR) Number: 6258

Related CR Release Date: November 17, 2008

Related CR Transmittal Number: R56GI

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

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**Preparing for a transition from an FI/carrier to a Medicare administrative contractor**

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

**Provider types affected**

This article is relevant to all fee-for-service physicians, providers, and suppliers that submit claims to fiscal intermediaries (FIs), carriers or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries. Providers already billing Medicare administrative contractors (MACs) have already transitioned and need not review this article.

**Impact on providers**

This article is intended to assist all providers that will be affected by Medicare administrative contractor (MAC) implementations. The Centers for Medicare & Medicaid Services (CMS) is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business.

**Background**

Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B Fee For Service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new Medicare administrative contractor authority. Medicare Contracting Reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare fee-for-service program.

When completed there will be 15 new MACs processing Part A and Part B claims. Each MAC will handle roughly the same volume of work. Because of this, the MACs will vary in geographic size but not necessarily in the amount of work they handle. This should result in greater consistency in the interpretation of Medicare policies.

**MAC implementation milestones definitions**

There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action, relative to the milestones defined as follows:

**Award** – this is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

**Cutover** – This is the date on which carrier or FI work ceases and MAC work begins. Cutover is often done in phases by state-level jurisdictions.

**Pre - award**

If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare contracting reform by visiting <http://www.cms.hhs.gov/medicarecontractingreform/> on the CMS Web site.

**Post- award**

Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

- **Pay attention** to the mail you receive from your outgoing Medicare contractor and your new MAC--you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic fund transfers, etc.
- **Sign up for your new MAC's listserv.** While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC that may not always be the case. Getting on the MAC listserv distribution will ensure that you receive news as it happens concerning the implementation.
- **Access and bookmark the MAC's Web site and visit it regularly.** The MAC will have a new Web site that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.
- **Review the Frequently-Asked Questions (FAQs) on the MAC's Web site.**
- **Participate in the MAC's advisory groups and "Ask the Contractor" meetings.** Every MAC will

*Preparing for a transition from an FI/carrier to a MAC (continued)*

be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC.

- **Review the MAC's local coverage determinations (LCDs)** as they may be different from the outgoing contractor LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and Web site for information regarding potential changes to the LCDs.

**One Month Prior to Cutover**

- **Complete and return your Electronic Funds Transfer (EFT) agreements.** CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC. (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and get it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. Contact your MAC with any questions concerning the agreement.
  - The CMS-588 form can be found at <http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf> on the CMS Web site.
  - You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's Web site. Your contractor may also provide instructions on its Web site on accurately completing the form.
- Your new MAC may also request you to execute a new Electronic Data Interchange (EDI) Trading Partner Agreement as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available at <http://www.cms.hhs.gov/EducationMaterials/downloads/TradingPartner-8.pdf> on the CMS Web site.
- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their Web site for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC Electronic Data Interchange (EDI) staff will send these Submitter IDs and passwords to you in hardcopy or electronically. You don't need to do anything to get the new IDs, however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different Electronic Data Interchange (EDI) Platform, it is critical to consider testing to minimize any disruption to your business at cutover.
- Contact your claims processing vendor and clearinghouse to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using

the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"

- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.
- Be aware that some MACs may offer participation in an "early boarding" process for electronic claims submission and/or electronic remittance advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password -- watch for and document them for use after cutover to the MAC.

**Cutover weekend**

- Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend. Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two-week period.
- Be aware that providers may also experience system "dark days" around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to Fiscal Intermediary Standard System (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.
- Be aware that some Interactive Voice Response (IVR) functionality may also be unavailable during a dark day.

**Post-cutover**

- The first 1-2 weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll free number for use.
- Be prepared that you may experience longer than normal wait times for customer service representatives and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Learn how to use the MAC's IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If



**Preparing for a transition from an FI/carrier to a MAC (continued)**

users are unfamiliar and resort to calling the Contact Center Representative (CSR) line, the result is a spike in volume of calls to (CSRs) that are difficult to accommodate.

- Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's Web sites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.
- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that you may experience changes in remittance advice (RA) coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

**CMS post-cutover monitoring**

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

**Attachment A****Timeline and checklist for preparing for MAC implementation**

Checklist item	Input
Scheduled Award Date:	
Actual Award Date:	
MAC Contractor:	
MAC Contractor Number:	
MAC Mailing Address:	
MAC Scheduled Dark Days	
MAC Web site:	
MAC Contact Center Number: 1-800-	
MAC EDI Mailing Address:	

**90 days before cutover**

1. Visit MAC Web site and bookmark for future use
2. Join the MAC Listserv
3. **Monitor:**
  - LCDs Published by the new MAC; compare current LCD's that affect your practice's services.
4. **Review:**
  - Provider enrollment status for all providers, update as needed.
  - Pay-to address information for practice/providers, update as needed.
5. **Contact:**
  - Your Practice Management/Billing software vendor to determine if your system will be able to send & receive data to/from the new MAC.

**Additional Assistance**

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A is a summary of what you need to do and information you will need
- Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation, and
- Attachment C may be used to assist you in tracking major MAC milestones.

**Additional information**

The following *MLN Matters* article provides additional information about the MAC implementation process:

- MM5979: "Assignment of Providers to Medicare Administrative Contractors" located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5979.pdf> on the CMS Web site.

If you have questions, please contact your Medicare carrier, FI, A/B MAC, and/or RHHI, 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.

- Claims Clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.

**75 days before cutover**

1. Continue to check the MAC's Web site and/or Listserv for outreach programs, educational and informational events, and conference calls.
2. Check your state's Medical Society or local provider organization Web site for MAC transition information, MAC Coordinators.

**60 days before cutover**

1. If needed, submit CMS Form 588 – EDI form(s) to the new MAC
2. Consider registering for electronic remittance advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample remittance advice (RA). RA codes are standard but use of codes may vary across contractors.



*Preparing for a transition from an FI/carrier to a MAC (continued)***45 days before cutover**

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

**30 days before cutover**

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI Submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of e-mail from the MAC Listserv.

**15 days before cutover**

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational.
3. Collect and record all MAC telephone and fax numbers for: General Inquiry Customer Service, Provider Enrollment, Provider Relations, EDI and ERA.
4. Place test calls and become familiar with the MAC IVR query system.
5. Continue daily monitoring of the MAC Listserv.

**10 days before cutover**

1. Address any existing open items.
2. Continue daily monitoring of the MAC Listserv.

**5-10 days after cutover**

1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of the MAC listserv.
3. Monitor and follow up on the MAC Open Item list.

**30 days after cutover**

1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

**Attachment B****Schedule of MAC contractor training classes**

Scheduled date	Title of class	Attendee(s)

**Schedule of MAC conferences**

Scheduled date	Conference subject	Attendee(s)

*Preparing for a transition from an FI/carrier to a MAC (continued)***Attachment C****Important MAC implementation dates**

<b>Event</b>	<b>Date</b>
MAC dark days	
Cutoff date for claims submissions	
Last date for outgoing contractor will make payment	
Last date outgoing contractor will have telephone/customer service	
Last day outgoing contractor will send file to bank	
Date MAC will accept electronic claims	
Date MAC will accept paper claims	
Date bill/claim cycle begins	
First anticipated MAC payment date	
Date MAC begins customer service	

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

**CMS announces MCPSS to begin December 2008**

The Centers for Medicare & Medicaid Services (CMS) has announced that data collection for the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) will begin in December 2008 and conclude in April 2009. The purpose of the annual MCPSS is to objectively measure (through the collection and analysis of quantifiable data) provider satisfaction levels with regard to the performance of the fee-for-service (FFS) contractors responsible for the processing and payment of more than \$280 billion in Medicare claims each year. All fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, Medicare administrative contractors (MACs), and durable medical equipment (DME) MACs will be included in the national administration of this important survey.

**Goals of the MCPSS**

1. Provide feedback from providers to contractors so they may implement process improvement initiatives.
2. Establish a uniform measurement of provider satisfaction with contractor performance.
3. Satisfy the requirements of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) to measure provider satisfaction levels.

**Contractor performance rated on seven key business functions**

Of the 1.2 million Medicare providers (physicians, health care practitioners, and facilities) who provide service for Medicare beneficiaries, approximately 30,000 will be invited to participate in the 2009 MCPSS; the goal is to obtain approximately 400 completed surveys per contractor sample. Those surveyed will be asked to rate their FFS contractor(s) using a scale of one to six on each of the business functions listed below, with "one" representing "not at all satisfied" and "six" representing "completely satisfied."

**The MCPSS offers randomly selected providers and suppliers the opportunity to rate their contractor(s) on the following seven key business functions of the provider-contractor relationship:**

1. Provider outreach and education
2. Provider inquiries
3. Claim processing
4. Appeals
5. Medical review
6. Provider enrollment
7. Provider audit and reimbursement (for Part A providers).

**Provider participation essential to success of MCPSS**

CMS uses the findings of the annual MCPSS as a benchmark for monitoring future trends and to improve the oversight of contractor performance as well as the efficiency of Medicare program administration. Providers chosen to participate in the MCPSS also represent other organizations similar in size, practice type, and geographical location; therefore, the views of every respondent are critical to the success of this important study.

Medicare providers are strongly encouraged to complete and return their surveys promptly. Responses may be submitted via a secure Internet site, a telephone interview, or via mail or fax (if a paper copy of the survey instrument is requested) and will be kept strictly confidential.

**How to obtain additional information and MCPSS updates**

Data collection reports and study updates will be available beginning January 16, 2009, and the final results of the 2009 MCPSS will be accessible via an online reporting system in July of 2009. For further information about the survey, please visit

<http://www.cms.hhs.gov/MCPSS/> on the MCPSS Web site.

The MCPSS home study page may be accessed at <https://www.mcpsstudy.org/>.

Source: CMS JSM 09015, October 10, 2008

## 2008-2009 influenza season resources for health care professionals

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

### Provider types affected

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

### Provider action needed

- Keep this special edition *MLN Matters* article and refer to it throughout the 2008-2009 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff – Get the Flu Shot – Not the Flu!

### Introduction

Historically the flu vaccine has been an underutilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get flu and pneumococcal immunizations. 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.

### Prevention is key to public health!

While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. Get Your Flu Shot – Not the Flu!

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

### Educational products for health care professionals

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

#### 1. MLN Matters articles

- MM6153: Influenza Vaccine and the Pneumococcal Vaccine Payment Allowances Based on 95 Percent of the Average Wholesale Price (AWP) on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6153.pdf>.
- MM6121: 2008 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6121.pdf>.
- MM6079: Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6079.pdf>.
- MM5511: Update to *Medicare Claims Processing Manual*, Chapter 18, Section 10 for Part B Influenza Billing on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf>.
- MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf>.
- MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of *Current Procedural Terminology (CPT) Code 90660* for the Reporting of the Influenza Virus Vaccine on the CMS Web site at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf>.

#### 2. MLN influenza related products for health care professionals

- Quick Reference Information: Medicare Part B Immunization Billing – This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/gr\\_immun\\_bill.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/gr_immun_bill.pdf).
- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition – This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers,

**2008-2009 influenza season resources for health care professionals (continued)**

and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/mps\\_guide\\_web-061305.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf).

- Medicare Preventive Services Adult Immunizations Brochure – This two-sided tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/Adult\\_Immunization.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf).
- Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course – This WBT course contains four modules that include information about Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. To register, free of charge, to take this course go to the MLN Products Web page <http://www.cms.hhs.gov/MLNProducts/> and select “Web-Based Training Modules” from Related Links Inside CMS at the bottom of the Web page.
- Quick Reference Information: Medicare Preventive Services – This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare’s preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file on the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf).
- Medicare Preventive Services Bookmark – This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder for health care professionals of the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file on the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcsbkmrk.pdf>.
- MLN Preventive Services Educational Products Web Page – This *Medicare Learning Network (MLN)* Web page provides descriptions of all MLN preventive services related educational products

and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This Web page is updated as new product information becomes available. Bookmark this page for easy access ([http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)).

**3. Other CMS resources**

- CMS Adult Immunizations Web Page is on the CMS Web site at <http://www.cms.hhs.gov/AdultImmunizations/>.
- CMS Frequently Asked Questions are available on the CMS Web site at [http://questions.cms.hhs.gov/cgi-bin/cms\\_hhs.cfg/php/enduser/std\\_alp.php?p\\_sid=I3ALEDhi](http://questions.cms.hhs.gov/cgi-bin/cms_hhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi).
- Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations available on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf>.
- *Medicare Claims Processing Manual* – Chapter 18, Preventive and Screening Services available on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>.
- Medicare Part B Drug Average Sales Price Payment Amounts Influenza and Pneumococcal Vaccines Pricing found on the CMS Web site at [http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01\\_overview.asp](http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp).

**4. Other resources**

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2008 – 2009 flu season:

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

Other sites with helpful information include:

- Centers for Disease Control and Prevention – <http://www.cdc.gov/flu>
- Food and Drug Administration – <http://www.fda.gov/>
- Immunization Action Coalition – <http://www.immunize.org>
- Immunization: Supporting a Healthy Life Throughout the Lifespan – <http://www.nfid.org/pdf/publications/naiaw08.pdf>



**2008-2009 influenza season resources for health care professionals (continued)**

- Indian Health Services – <http://www.ihs.gov/>
- Medicare Quality Improvement Community – <http://www.QualityNet.org/MedQIC>
- National Alliance for Hispanic Health – <http://www.hispanichealth.org/>
- The National Center for Immunization and Respiratory Diseases (NCIRD) – <http://www.cdc.gov/ncird/default.htm>
- National Foundation For Infectious Diseases – <http://www.nfid.org/influenza>
- National Library of Medicine and NIH Medline Plus – <http://www.nlm.nih.gov/medlineplus/immunization.html>
- National Network for Immunization Information – <http://www.immunizationinfo.org>
- National Vaccine Program – <http://www.hhs.gov/nvpo>
- Office of Disease Prevention and Promotion – <http://odphp.osophs.dhhs.gov>
- Partnership for Prevention – <http://www.prevent.org>
- World Health Organization – <http://www.who.int/en/ on the Internet>.

**Beneficiary information**

For information to share with your Medicare patients, please visit the Internet at <http://www.medicare.gov>.

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**November flu shot reminder**

The flu season is here. The following are some of the many reasons Medicare patients give for not getting their annual flu shot:

- It causes the flu
- I don't need it
- It has side effects
- It's not effective
- I didn't think about it
- I don't like needles

Every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting an annual flu shot. Also, don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends.

**Get the 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 professionals and their staff, please go to the CMS Web site at [http://www.cms.hhs.gov/MLNProducts/Downloads/flu\\_products.pdf](http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf).

To download the Medicare Part B immunization billing quick reference chart, go to the CMS Web site [http://www.cms.hhs.gov/MLNProducts/downloads/qr\\_immun\\_bill.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf).

A copy of this chart can be ordered, free of charge, by going to the MLN Products Web page and clicking on MLN Product Ordering Page in the "Related Links Inside" CMS section of the Web page.

Visit the Medicare Learning Network – it's free!

Source: CMS PERL 200811-05

## 2008 Physician Quality Reporting Initiative claims-based reporting of measures groups

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

### Provider types affected

Physicians and practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI).

### What you need to know

Change request (CR) 6187, from which this article is taken, announces that the 2008 PQRI claims-based measures groups reporting alternative is available for the six-month reporting period from July 1 through December 31, 2008. If you successfully report under this method; you may, on that basis, receive an incentive payment equal to 1.5 percent of the total allowed Medicare physician fee schedule (MPFS) charges for covered professionals during this period.

### Background

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) authorized CMS to establish alternative methods to report 2008 PQRI quality data, including the option of reporting on a group of clinically-related measures. Four measures groups have been established for 2008 PQRI: 1) diabetes mellitus, 2) end-stage renal disease (ESRD), 3) chronic kidney disease (CKD), and 4) preventive care. These four groups, which combined include a total of 22 measures, may be reported through either claims-based or registry-based submission.

CR 6187, from which this article is taken, announces that the 2008 PQRI claims-based measures groups reporting alternative is available for the six-month reporting period from July 1 through December 31, 2008.

You may choose to report through more than one 2008 PQRI reporting option. Professionals, who successfully report under more than one reporting option, will receive a maximum of one incentive payment, which will be equivalent to 1.5 percent of MPFS allowed charges for all covered professional services that you furnish to patients enrolled in Medicare Part B fee-for-service (FFS) during the July through December, 2008 reporting period.

**Note:** Medicare Part C (e.g., Medicare Advantage) claims will not be utilized for 2008 PQRI analysis.

In order to identify your intent to report a measures group, you should submit a measures group-specific G-code on a claim for covered professional services furnished to a patient enrolled in Medicare Part B FFS:

G8485: I intend to report the diabetes measure grouping

G8488: I intend to report the ESRD measure grouping

G8487: I intend to report the CKD measure grouping

G8486: I intend to report the preventive care measure grouping.

You do not need to submit the measures group-specific G-code on more than one claim. In fact, if you submit the G-code for a given group multiple times during the reporting period, only the submission with the earliest date of service will be included in the PQRI analyses; and subsequent submissions of that code will be ignored.

Remember that there are two reporting methods for claims-based submission of measures groups:

- **Consecutive patient sample method.** You must report on all applicable measures within the selected measures group on claims for 15 consecutive Medicare Part B FFS patients who meet patient sample criteria for the measures group, beginning with the first date of service for which the measures group-specific G-code is submitted. For example, you can indicate intent to begin reporting the diabetes mellitus measures group by submitting G8485 on the first patient claim in the series of consecutive diabetic patients. You must report all the applicable measures within the group at least once for each patient within the sample population seen during the reporting period.
- **80 percent patient sample method.** You must report on all applicable measures within the selected measures group on claims for at least 80 percent of all Medicare Part B FFS patients seen during the entire reporting period (July 1 – December 31, 2008) who meet the measures group patient sample criteria. For this method, you must submit the measures group-specific G-code once during the reporting period to indicate your selection of the measures group. You must report all applicable measures within the group at least once for each patient within the sample population seen during the reporting period.

The patient samples for both the consecutive patient sample and 80 percent patient sample methods are determined by diagnosis and/or encounter parameters common to all measures within a selected measures group. You must report all applicable measures within a group for each patient within the sample that meets the criteria (age, gender, or additional diagnosis) required in accordance with the 2008 Physician Quality Reporting Initiative Claims-Based Measures Groups Handbook located at [http://www.cms.hhs.gov/PQRI/01\\_Overview.asp](http://www.cms.hhs.gov/PQRI/01_Overview.asp) as a downloadable file under the PQRI Tool Kit link.

For example, if you are reporting on the preventive measures group, the screening or therapy for osteoporosis measure would only need to be reported on women within the patient sample. Denominator coding has been modified from the original measure as specified by the measure developer to allow for implementation as a measures group.

CR 6187 also includes a step-by-step strategy (including clinical examples) to facilitate your successful reporting through this claims-based reporting alternative (for completeness, some of the above information is repeated in this strategy section).

**2008 PQRI claims-based reporting of measures groups (continued)****Additional information**

You may find more information about using the claims-based reporting of measures groups option for reporting 2008 PQRI data by going to CR 6187, located at <http://www.cms.hhs.gov/Transmittals/downloads/R401OTN.pdf> on the CMS Web site.

You might also want to review *MLN Matters* article MM6104, 2008 Physician Quality Reporting Initiative (PQRI) Establishment of Alternative Reporting Periods and Reporting Criteria, released on June 13, 2008, to learn more about the 2008 PQRI Program. You may find that article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6104.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.

**You might find it of value to circulate the following portion of this article to your office staffs.**

**Measure groups participation strategy**

- Plan and implement processes within your practice to ensure successful reporting of measures groups.
- Determine your patient sample based on the patient sample criteria, which is used for both the consecutive patient sample and the 80 percent patient sample methods. The following table contains patient sample criteria (common codes) that will qualify a Medicare Part B patient's professional services claim for inclusion in the measures group analysis. Claims must contain a specific line-item ICD-9-CM diagnosis code (where applicable) accompanied by a specific CPT patient encounter code.

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9 Diagnosis Codes
Diabetes Mellitus 18–75 years	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04
End-Stage Renal Disease (ESRD) 18 years and older	90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319	585.6
Chronic Kidney Disease (CKD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	585.4, 585.5
Preventive Care 50 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	

Indicate your intention to begin reporting a measures group by submitting a measures group-specific G-code (G8485, G8488, G8487, or G8486) as noted above.

- Measures group-specific G-code line items on the claim must be complete, including accurate coding, date of service and diagnosis pointer. The diagnosis pointer field on the claim links one or more patient diagnoses to the service line. A G-code specific to a condition-specific measures group (e.g. diabetes mellitus measures group) should be linked to the diagnosis for the condition to which it pertains; a G-code for the preventive care measures group may be linked to any diagnosis on the claim.
- Measures group-specific G-code line items should be submitted with a charge of zero dollars (\$0.00). Measures group-specific G-code line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. You should check your remittance advice (explanation of benefits or EOB) for a denial code (e.g., N365) for the measures-group-specific G-code, confirming that the code passed through your local carrier to the national claims history file. The N365 denial indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of measures group-specific G-codes.
- For patients for who measures groups apply, report all applicable individual measures for the measure group. Report quality-data codes (QDCs) as instructed in the 2008 PQRI Claims-Based Measures Groups Handbook located at [http://www.cms.hhs.gov/PQRI/01\\_Overview.asp](http://www.cms.hhs.gov/PQRI/01_Overview.asp) on all applicable measures within the measures group for each patient included in the sample population. You may choose to submit QDCs either on a current claim or on a claim representing a subsequent visit, particularly if the quality action has changed. For example, a new laboratory value may be available at a subsequent visit. Only one instance of reporting for each patient included in the sample population will be used when calculating reporting and performance rates for each measure within a group. You are only required to report QDCs on those individual measures in the measures group that meet the criteria (age, gender, or additional diagnosis) according to the 2008 PQRI Measures Groups Handbook. For example, if you are reporting the Preventive Care Measures Group

**2008 PQRI claims-based reporting of measures groups (continued)**

for a 52 year old female patient, only five measures out of nine apply. See the following Preventive Measures Group Demographic Criteria table.

<b>Preventive Measures Group Demographic Criteria</b>		
<b>Age</b>	<b>Measures for Male Patients</b>	<b>Measures for Female Patients</b>
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 114, 115	110, 112, 113, 114, 115
65-69 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 112, 113, 114, 115, 128
70-80 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 113, 114, 115, 128
≥81 years	110, 111, 114, 115, 128	39, 48, 110, 111, 114, 115, 128

Another example would be: if you are reporting on the CKD Measures Group, you would not be expected to report measure 120 (ACE inhibitor or angiotensin receptor blocker (ARB) therapy in patients with CKD) for a CKD patient who does not also have hypertension and proteinuria.

There are two types of patients that can be reported in the ESRD measures group; those that have ESRD and are undergoing hemodialysis, and those that have ESRD and are undergoing peritoneal dialysis. If you choose to report this measures group you should report the appropriate quality-data code for all four measures if the patient is receiving hemodialysis. However, if the patient is receiving peritoneal dialysis, only measures #79 and #80 should be reported as these two measures do not apply to patients undergoing peritoneal dialysis.

**Reporting measures groups - common clinical scenarios**

The following clinical scenarios are offered as examples describing the quality data that should be reported on claims using a measures group's method:

**Diabetes mellitus example**

Primary care office visit for a new patient with newly diagnosed diabetes mellitus: A1c = lab drawn, result unknown, prior result not available (3046F-8P); LDL-C=110 (3049F); today's BP = 140/80 (3077F, 3079F); referred to ophthalmologist for dilated eye exam (2022F-8P); urine protein screening performed = negative (3061F)

Dx 1: 250.00

<b>Measure No.</b>	<b>Date of Service</b>	<b>CPT/HCPCS</b>	<b>Modifier</b>	<b>Diagnosis Pointer</b>	<b>Charges</b>	<b>NPI</b>
	07/01/2008	99201		1	\$60.00	0123456789
	07/01/2008	G8485		1	\$0.00	0123456789
	07/01/2008	83036		1	\$15.00	0123456789
	07/01/2008	81000		1	\$6.00	0123456789
1	07/01/2008	3046F	8P	1	\$0.00	0123456789
2	07/01/2008	3049F		1	\$0.00	0123456789
3	07/01/2008	3077F		1	\$0.00	0123456789
3	07/01/2008	3079F		1	\$0.00	0123456789
117	07/01/2008	2022F	8P	1	\$0.00	0123456789
119	07/01/2008	3061F		1	\$0.00	0123456789

The above is an example of successful reporting in PQRI. In this example, the eligible professional has chosen to report measures 1 and 117 with an 8P modifier indicating that performance of the measure was not met on this visit. An eligible professional may choose whether to report these two measures on the current claim or wait to report them on a claim for a subsequent visit during the reporting period after the results of the test/exam are available.

**ESRD example**

Hemodialysis visit for a patient with ESRD: AV Fistula = functioning (4052F); documentation of flu vaccination received on January 1, 2008 (4037F); Hgb = 10 with a plan of care documented (3281F, 0516F); Ktv = 1.3 (3083F)

Dx 1: 585.6

<b>Measure No.</b>	<b>Date of Service</b>	<b>CPT/HCPCS</b>	<b>Modifier</b>	<b>Diagnosis Pointer</b>	<b>Charges</b>	<b>NPI</b>
	07/01/2008	90935		1	\$500.00	0123456789
	07/01/2008	G8488		1	\$0.00	0123456789
78	07/01/2008	4052F		1	\$0.00	0123456789
79	07/01/2008	4037F		1	\$0.00	0123456789
80	07/01/2008	3281F		1	\$0.00	0123456789
80	07/01/2008	0516F		1	\$0.00	0123456789
81	07/01/2008	3083F		1	\$0.00	0123456789



**2008 PQRI claims-based reporting of measures groups (continued)****CKD Example**

Stage 5 CKD patient, not receiving RRT, office visit: known hypertensive with documented plan of care for hypertension (G8477, 0513F); urinalysis indicates proteinuria, documentation of current prescription for ACE inhibitor (G8479); lab tests ordered on last visit and results documented in the chart (3278F); Hgb = 14 and patient is receiving ESA and has a plan of care documented for elevated hemoglobin level (3279F, 0514F, 4171F)

Dx 1: 585.5; Dx 2: 401.0; Dx 3: 791.0

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	99213		1	\$50.00	0123456789
	07/01/2008	G8487		1	\$0.00	0123456789
120	07/01/2008	G8479		1	\$0.00	0123456789
121	07/01/2008	3278F		1	\$0.00	0123456789
122	07/01/2008	G8477		1	\$0.00	0123456789
122	07/01/2008	0513F		1	\$0.00	0123456789
123	07/01/2008	3279F		1	\$0.00	0123456789
123	07/01/2008	0514F		1	\$0.00	0123456789
123	07/01/2008	4171F		1	\$0.00	0123456789

**Preventive care example**

Primary care office visit for a 67 year old female, established patient. Presents with mild cold symptoms. Record indicates patient had a DXA done at age 62, with results documented as within normal limits (G8399); denies urinary incontinence (1090F); record indicates influenza vaccination at a previous visit in January of this year (G8482); pneumonia vaccination administered last year (4040F); results of last month's mammogram (3014F) and last week's FOBT (3017F) reviewed with patient; denies tobacco use (1000F, 1036F, G8457); today's BMI measurement = 24 (G8420)

Dx 1: Use any visit-specific diagnosis for the measures in this group

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	99212		1	\$45.00	0123456789
	07/01/2008	G8486		1	\$0.00	0123456789
39	07/01/2008	G8399		1	\$0.00	0123456789
48	07/01/2008	1090F		1	\$0.00	0123456789
110	07/01/2008	G8482		1	\$0.00	0123456789
111	07/01/2008	4040F		1	\$0.00	0123456789
112	07/01/2008	3014F		1	\$0.00	0123456789
113	07/01/2008	3017F		1	\$0.00	0123456789
114	07/01/2008	1000F		1	\$0.00	0123456789
114	07/01/2008	1036F		1	\$0.00	0123456789
115	07/01/2008	G8457		1	\$0.00	0123456789
128	07/01/2008	G8420		1	\$0.00	0123456789

MLN Matters Number: MM6187

Related Change Request (CR) #: 6187

Related CR Release Date: November 14, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R401OTN

Implementation Date: December 15, 2008

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## 2009 final rule implements new electronic prescribing incentive program Physicians may earn pay boost of up to 5.1 percent from MIPPA update plus e-prescribing and PQRI incentives

The Centers for Medicare & Medicaid Services (CMS) announced a new initiative for physicians to trade in their prescription pads and improve efficiency and safety, when ordering drugs for patients with Medicare. The initiative is included in the Medicare physician fee schedule (MPFS) final rule for calendar year 2009.

To view the press release, go to the Web page at [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp).

A copy of the final rule (CMS-1403-FC) is available at: <http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1216674&intNumPerP>.

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

Source: CMS PERL 200810-30

## E-prescribing information on the Medicare summary notice

The Centers for Medicare & Medicaid Services (CMS) has directed Medicare contractors to begin including messages regarding electronic prescribing and new services for caregivers on all Medicare summary notices (MSNs) generated and sent to Medicare beneficiaries on or after October 14, 2008, through February 28, 2009. Specifically, the MSN messages include the following statements:

- Electronic prescribing can save you time at the pharmacy, reduce the chance of getting the wrong medication or dose, and save money. When you go to the doctor, ask “Do you e-Prescribe?”
- Caring for someone with Medicare? We know it’s not easy. Visit “Ask Medicare” at <http://www.medicare.gov/Caregivers/> for up-to-the-minute information, resources, and tips on making the most of Medicare.

You may find additional information on the e-prescribing initiative on the CMS Web site at <http://www.cms.hhs.gov/EPrescribing/> and [http://www.cms.hhs.gov/PQRI/03\\_EPrescribingIncentiveProgram.asp](http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp).

Source: CMS PERL 200810-39

## Reporting national provider identifiers for purchased out-of-jurisdiction mammography services

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

### Provider types affected

Physicians and other Part B providers/suppliers who submit bills to Medicare carriers and Medicare administrative contractors (A/B MAC) for mammography services provided to Medicare beneficiaries.

### What you need to know

CR 6237, from which this article is taken provides billing instructions for using the NPI on paper, or electronically-submitted, Medicare claims for purchased mammography screening and diagnostic services when the service is performed outside of the carrier’s or A/B MAC’s claims processing jurisdiction. In this situation, billing providers should report their own NPI as the performing provider and also provide the name, address, and zip code of the performing physician/supplier.

You should be aware that carriers and AB MACs will return your out-of-jurisdiction, purchased mammography screening or diagnostic service claims as unprocessable if you submit them without the billing provider’s NPI; and the name, address, and ZIP code of the performing physician/supplier.

### Additional Information

You may find more information about the reporting of the NPI on claims for out-of-jurisdiction purchased mammography preventive screening and diagnostic services by going to CR 6237, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1624CP.pdf> on the Centers for Medicare & Medicaid (CMS) Web site.

For claims processing instructions on the CMS-1500 and electronic form ANSI X12 837P you can refer to the *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 10.1.1.1. (Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004). That manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Web site. To learn more about the NPI in general, visit <http://www.cms.hhs.gov/NationalProviderStand> 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: MM6237  
Related Change Request (CR) #: 6237  
Related CR Release Date: October 31, 2008  
Effective Date: December 1, 2008  
Related CR Transmittal #: R1624CP  
Implementation Date: December 1, 2008

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## Call for public comment to CMS on preliminary imaging efficiency measures

The Centers for Medicare & Medicaid Services (CMS) through The Lewin Group and its subcontractors, the National Imaging Associates Inc., (NIA) and Dobson/DaVanzo & Associates, LLC, is developing a preliminary set of outpatient imaging efficiency measures.

CMS would like to invite you to review and comment on these measures during the 30-day public comment period that begins on November 15, 2008, and will run through December 14, 2008. Please note that while the team will make every effort to consider and incorporate all comments, CMS will be making any and all determinations on the final measure set, including if or how they will be used in CMS program activities.

To review the measures and submit comments, please go to <http://www.imagingmeasures.com>.

CMS would also like to encourage you to forward this message and link to any colleagues or organizations you believe would be interested in reviewing and commenting on the measures.

Thank you in advance for your interest and contributions as CMS works to improve this preliminary measure set.

CMS is looking forward to hearing from you.

Source: CMS PERL 200811-22

## The Medicare Learning Network

The *Medicare Learning Network* (MLN) is the brand name for the official Centers for Medicare & Medicaid Services (CMS) national fee-for-service (FFS) health care professional education products. The *MLN* is designed to promote national consistency of Medicare information developed for CMS initiatives. Most importantly, it is available to help you.

Each quarter the *MLN* will send out information on the latest products available to order. Please be on the lookout for those updates.

For more information on the *Medicare Learning Network*, please visit on the Internet <http://www.cms.hhs.gov/MLNGenInfo>.

### Revised Medicare Physician Guide

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2008), which offers general information about the Medicare program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare trust fund, inquiries, overpayments, and appeals, is now to download from the CMS *Medicare Learning Network* at <http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf>.

### The MLN product catalog

The *MLN* products catalog is now an interactive downloadable document that lists all *MLN* products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All products indicate the available formats as follows:

- Title product and downloadable -- will link you to the online version of the product.
- Hard copy and CD-ROM -- will automatically link you to the *MLN* product ordering page.

The catalog is updated quarterly and the latest version is now available for download on the CMS Web site at <http://www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf>.

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

Source: CMS PERL 200810-29

## Revised Medicare Physician Guide available

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2008), which includes information about the following items, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at <http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf>:

- General information about the Medicare program
- Becoming a Medicare provider or supplier
- Medicare reimbursement
- Medicare payment policies
- Evaluation and management services
- Protecting the Medicare Trust Fund
- Inquiries
- Overpayments
- Appeals

Source: CMS PERL 200810-35

## Adult immunizations brochure for health care providers now available

The *Adult Immunizations* (October 2008) brochure for health care providers has been updated and is now available in downloadable portable document format (PDF) from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. This brochure provides an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. To view, download, and print, please go to the CMS Web site [http://www.cms.hhs.gov/MLNProducts/downloads/Adult\\_Immunization.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf).

Source: CMS PERL 200811-27

## Medicare billing information for rural providers, suppliers, and physicians

The revised publication titled *Medicare Billing Information for Rural Providers, Suppliers, and Physicians* (October 2008), which consists of charts that provide Medicare billing information for rural health clinics, federally qualified health centers, skilled nursing facilities, home health agencies, critical access hospitals, and swing beds, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf>.

Source: CMS PERL 200811-29

## Guidelines for teaching physicians, interns, and residents booklet now available

The revised publication, *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 print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit [http://www.cms.hhs.gov/MLNProducts/01\\_Overview.asp](http://www.cms.hhs.gov/MLNProducts/01_Overview.asp), scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: CMS PERL 200811-18 and 200811-24

## November is American Diabetes Month\*

The American Diabetes Association (ADA) has designated American Diabetes Month\* as a time to communicate the seriousness of diabetes and the importance of proper diabetes control. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations, and premature death. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes. Medicare also provides coverage for services to help beneficiaries effectively manage their diabetes. Coverage of these services is subject to certain eligibility and other limitations.

### Diabetes screening tests

Medicare provides coverage of the following diabetes screening tests for eligible beneficiaries:

- A fasting blood glucose test
- A post-glucose challenge test (not limited to an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults)
- A two-hour post-glucose challenge test alone.

For beneficiaries diagnosed with diabetes, Medicare provides coverage of diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services to help beneficiaries learn to effectively manage their condition.

### Diabetes self-management training

DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. Medicare provides coverage of DSMT services for beneficiaries who have been recently diagnosed with diabetes, determined

to be at risk for complications from diabetes, or were previously diagnosed with diabetes before meeting Medicare eligibility requirements and have since become eligible for coverage under the Medicare program. Eligible Medicare beneficiaries must receive a referral from a physician or qualified nonphysician practitioner certifying that DSMT services are needed to treat their diabetic condition.

### Medical nutrition therapy

MNT provided by a registered dietitian or a qualified nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression. Medicare provides coverage of MNT services for beneficiaries diagnosed with diabetes or renal disease (except for those receiving dialysis). Eligible beneficiaries must receive a referral from the treating physician, the primary care physician, or specialist coordinating care for the beneficiary with diabetes or renal disease. Qualified nonphysician practitioners cannot make referrals for MNT.

**Note:** MNT is a separate billable benefit from DSMT services. Eligible beneficiaries may receive referrals for both services, but both services cannot be received on the same day.

### Your help is needed

Your help is needed to ensure people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes and that those who are eligible take advantage of the diabetes screening tests. And, when appropriate, you can provide referrals for DSMT and MNT. These services can help beneficiaries learn to manage their disease and may help lower the risk of serious complications.



**November is American Diabetes Month® (continued)****For more information**

- For more information about Medicare's coverage of diabetes screening services, DSMT, and MNT services (including coverage, coding, billing, and reimbursement guidelines), please visit the CMS Medicare Learning Network (MLN) Preventive Services Educational Products Web page [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp).
- For literature to share with your Medicare patients, please visit <http://www.medicare.gov>.
- To locate recognized diabetes education programs in

your local area, please visit the ADA Web site <http://www.diabetes.org/education/edustate2.asp>.

- To locate registered dietitians or qualified nutrition professionals in your local area, please visit the ADA Web site at <http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/index.html>.
- For more information about American Diabetes Month®, please visit the ADA Web site <http://www.diabetes.org/communityprograms-and-localevents/americanmonth.jsp>.

Source: CMS PERL 200811-06

**Gustav and Ike waivers expire**

In September 2008, the Centers for Medicare & Medicaid Services (CMS) issued guidance that discussed the statutory requirement under the Medicare skilled nursing facility (SNF) benefit for a three-day prior hospital stay and the inability of beneficiaries, who were evacuated or transferred as a result of Hurricanes Gustav and Ike, to meet this requirement. This guidance provided temporary emergency coverage of SNF services that are not post-hospital SNF services under our authority in Section 1812(f) of the Social Security Act (the Act), for those beneficiaries who are evacuated, transferred, or otherwise dislocated as a result of the hurricanes.

In addition, for beneficiaries who (prior to the hurricanes) had been recently discharged from an SNF after utilizing some or all of their available SNF benefits, this guidance addressed the inability to meet the requirement to end an existing Medicare benefit period (or “spell of illness”) before renewing SNF benefits.

Under the authority of Section 1812(f) of the Act, this policy enabled such beneficiaries to receive up to an additional 100 days of SNF Part A benefits for care needed as a result of the hurricanes, without first having to end a spell of illness by being discharged to custodial or noninstitutional care for a 60-day period.

Unlike the general waivers issued in response to the hurricanes under the authority of Section 1135 of the Act, these two SNF-related policies were not limited to states designated as emergency areas. Rather, they would apply to all beneficiaries who were evacuated from an emergency area as a result of the hurricanes, regardless of where the “host” SNF providing post-hurricane care was located. In addition, these two SNF-related policies would remain in effect until such time as CMS issued a notification that normal procedures would resume.

We hereby announce the termination of these SNF-related policies concurrently with the 90-day expiration of the public health emergencies (PHEs) declared for Hurricanes Gustav and Ike. The waivers and modifications granted under the Section 1135 waiver authority also terminate concurrently with the expiration of the PHEs.

The expiration dates for the PHEs are shown below. Accordingly, effective with SNF admissions occurring on or after the termination dates listed below, the Internet-Only Manual instructions for determining compliance with the SNF benefit's prior hospitalization and benefit period requirements shall apply.

Finally, all program policies and questions and answers that implemented modifications to program requirements under the Section 1135 waiver authority for Hurricanes Gustav and Ike are no longer applicable on and after the dates stated below. Therefore, claims with dates of service on or after the termination dates cited below will follow all normal program requirements.

Hurricane(s)	State(s)	Section 1812(f)/1135 Waiver Termination Dates
Gustav	Mississippi, Alabama	November 29, 2008
Gustav and Ike	Texas	December 10, 2008
Gustav and Ike	Louisiana	December 12, 2008

Source: CMS PERL 200811-25

**Unsolicited/voluntary refunds**

All Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open accounts receivable). Intermediaries generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds. The Centers for Medicare & Medicaid Services reminds providers that:

“The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.”

Source: CMS Pub 100-6 Transmittal 50, CR 3274

# 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

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## 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 LCD

### NCSVCS: The list of Medicare noncovered services -- revision to the LCD LCD ID: L5780

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised effective September 30, 2008. Since that time, the LCD has been revised. Procedure code 0051T (*Implantation of a total replacement heart system [artificial heart] with recipient cardiectomy*), was removed from the *National Noncoverage Decisions/Devices* section of the LCD, based on the Centers for Medicare & Medicaid Services' (CMS) change request 6185 (transmittal 95, dated September 10, 2008).

Medicare issued a national coverage determination (NCD), establishing coverage for artificial hearts when implanted under Coverage with Evidence Development (CED). Medicare will cover artificial hearts when implanted in patients enrolled in clinical studies that have been approved by Medicare to meet all of the CED criteria.

#### Effective date

This revision to the LCD is effective for services processed **on or after December 1, 2008**, for services rendered **on or after May 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>.

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## ADDITIONAL INFORMATION

### Hemophilia clotting factors billing clarification

Providers billing for hemophilia clotting factors may be experiencing problems with submitting and receiving the correct reimbursement for these services. The problems identified deal with the number of units administered and/or the billed dollar amounts both exceeding the number of allowable digits for the field/block/segment where this information is entered for billing purposes.

**Example:** The patient is administered 201,600 units of von Willebrand Factor complex (Humate-P), per IU vWF:RCO (HCPCS code J7187), with a billed amount of \$250,500.00.

In the example above the patient was administered 201,600 units of the hemophilia clotting factor. The Medicare claim processing system, as well as many claims software systems, will only allow up to three digits (or 999 units) to be entered. Additionally, for the line item billed amounts as well as the total claim billed amount there is a limit of seven digits (or \$99,999.99) that may be billed. These situations require separate and distinct billing instructions, along with manual intervention at the claims processing level.

The purpose of this article is to remind providers how to correctly bill in these situations in order to receive proper reimbursement. First Coast Service Option Inc. (FCSO) has published several articles advising of such.

- When the number of units exceed the allowed digits, providers must enter a "1" in the units field, and then include the actual number of units administered in the narrative field/(NTE segment).
- When the line item dollar amount exceeds the allowed digits, providers must enter the dollar amount as 99999.99, in the charge field and include the actual billed dollar amount in the narrative field (NTE segment).
- When the total claim billed amount exceeds the allowed number of digits due to multiple line items totaling more than the allowed number of digits providers must simply submit the services on two separate claims.

#### Narrative example:

201,601 units

Billed \$250,500.00

In situations where these claims have not processed correctly, do not resubmit; always request an appeal to have the claims corrected. Please remember that the appeals time limit is 120 days from the very first claim that processed.

**J2357: Xolair and administration code 96401 -- clarification of correct billing**

There has been recent discussion between First Coast Service Options Inc. (FCSO) and providers regarding omalizumab (Xolair®) and chemotherapy administration CPT code 96401 (*Chemotherapy administration, subcutaneous or intramuscular; nonhormonal*). Xolair® is indicated for adults and adolescents (12 years of age and above) with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. Xolair® is administered subcutaneously. For administrations of Xolair® where the dose is greater than 150 mg, the dose should be divided among more than one injection site to limit injections to not more than 150 mg per site. Because Xolair is a monoclonal antibody, the use of CPT code 96401 is permitted. The intent of the RVU weighting of CPT code 96401 was for the patient risk for the “single dose” not the syringes used to deliver a split dose. Providers are paid extra for chemotherapy administration (as opposed to other drug administration) given the risk and side effects associated with these drugs and the associated overhead to monitor. The additional cost for the syringe and nurse work is not a major factor since the code is weighted three times a therapeutic injection. Therefore, FCSO would not expect to see more than 1 unit of CPT code 96401 billed for the administration of Xolair®.

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**J3490: Triesence™ (triamcinolone acetonide injectable suspension)**

Triesence™ (triamcinolone acetonide injectable suspension), a synthetic corticosteroid, received approval from the Food and Drug Administration (FDA) on November 29, 2007, for intraocular (intravitreal) use in the conditions listed below. First Coast Service Options Inc. (FCSO) will consider Triesence™ medically reasonable and necessary for services rendered on or after the FDA-approval date for the following FDA-approved conditions:

- Sympathetic ophthalmia (diagnosis code 360.11)
- Temporal arteritis (diagnosis code 446.5)
- Uveitis (diagnosis codes include 360.11, 363.20, 364.00 and 364.3)
- Ocular inflammatory conditions unresponsive to topical corticosteroids (many diagnosis codes would apply to this condition)
- Visualization during a vitrectomy procedure

Triesence™ should be reported with HCPCS Code J3490 (unclassified drugs) and CPT code 67028 (*Intravitreal injection of a pharmacologic agent (separate procedure)*).

The administration for the intravitreal injection of Triesence™ must be billed on the same claim as the drug, with CPT code 67028 (*intravitreal injection of a pharmacologic agent*). When performing an injection on both eyes, modifier 50 should be used and modifier RT or LT should be used for unilateral services.

The initial recommended dose of Triesence™ for the treatment of ophthalmic diseases is 4 mg (100 microliters of 40 mg/mL suspension) with subsequent dosage as needed over the course of treatment.

The recommended dose of Triesence™ for visualization during vitrectomy is 1 to 4 mg (25 to 100 microliters of 40 mg/mL suspension) administered intravitreally.

Triesence™ is supplied in a single-use 1 mL vial containing 40 mg/mL of sterile triamcinolone acetonide suspension.

**Note:** The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that

they can use drugs or biologicals most efficiently, in a clinically appropriate manner. However, if a physician, hospital or other provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label (CMS Manual System, Pub 100-04, *Medicare Claims Processing Manual*, Chapter 17, Section 40).

Medical record documentation maintained by the performing provider should be available upon request, and must include the following:

- The clinical indication/medical necessity for the Triesence™ injection
- Name of the drug administered
- Dosage of drug administered
- Route of administration
- Topical corticosteroid(s) given to patient for ocular inflammatory condition prior to treating with Triesence™

**Note:** HCPCS code J3301 (Injection, triamcinolone acetonide, per 10 mg) is used to report Kenalog-10, Kenalog-40, Tri-Kort, Kenaject-40, Cenacort A-40, Triam-A or Triolog and the drugs represented by this HCPCS code have different indications, pricing, dosages, routes, etc than Triesence™. Therefore, claim processing methods used (e.g., indications, pricing, etc.) for the drugs represented by HCPCS code J3301 would NOT apply to Triesence™ (triamcinolone acetonide injectable suspension).

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## Percutaneous tibial nerve stimulation (PTNS) for voiding dysfunction

Voiding dysfunction includes urinary frequency, urgency, incontinence, and non-obstructive retention. Common causes of voiding dysfunction are pelvic floor dysfunction, inflammation, medication, obesity, psychogenic factors and disease. Altering the function of the posterior tibial nerve with PTNS is believed to improve voiding function and control. While the posterior tibial nerve is located near the ankle, it is derived from the lumbar-sacral nerves (L4-S3), which control the bladder detrusor and perineal floor. PTNS is a minimally invasive, office-based treatment for patients with overactive bladder (OAB) that is refractory to behavioral and/or pharmacologic therapies.

The Urgent® PC Neuromodulator (UPC) device used to deliver PTNS is a combination of electrode and generator components, including a small 34-gauge needle electrode, surface electrode, lead wires and hand-held electrical generator. The device produces an adjustable electrical impulse that travels to the sacral nerve plexus via the tibial nerve. In general, up to twelve once-weekly 30-minute treatments with PTNS are recommended for symptomatic patients for whom other forms of treatment have failed. However, if the patient is not responding to the new treatment, it should be discontinued much sooner.

### Provider billing

Providers must code to specificity and certain unique *CPT* codes have been used inappropriately to describe this service. PTNS is a new technology without a unique HCPCS level II or I / *CPT* code and should be coded as an unlisted procedure code, *CPT* code 64999 (unlisted procedure, nervous system) in item 24d of the claim form. Since unlisted codes are not unique to a service, Medicare contractors exercise discretion in first addressing denial vs. coverage. The narrative description of “PTNS” or “Urgent PC” should be entered in item 19 of the claim form. No documentation should be submitted with the claim. First Coast Service Options Inc. (FCSO) will request information by means of an additional documentation request (ADR). Once this information is received, it will be reviewed and a determination will be made as to coverage or denial of the claim.

### Denial vs. coverage

Since there is no national coverage determination (NCD) or local coverage determination (LCD) in Florida for PTNS, each claim is reviewed on an individual consideration basis. These case-by-case determinations allow the contractor to learn more about the efficacy and utilization of this service in the Medicare population. Also, given that there is no coverage statement at this time, this procedure may be denied or limited in the future based on the review of evidenced based literature during the LCD development process.

Any time there is a question whether Medicare’s medical reasonableness and necessary criteria would be met, it is recommended the use of an advance beneficiary notice (ABN) of noncoverage and appending modifier GA to the *CPT* code. For further details about CMS’ Beneficiary Notices Initiative (BNI), please access the following link: <http://www.cms.hhs.gov/BNI/>.

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## 93268: Patient demand single or multiple event recorder -- correct billing clarification

### LCD ID: L6150

The family of *CPT* codes 93268, 93270, 93271 and 93272 describes the service that utilizes a pre-symptom memory loop. *CPT* code 93268 is the complete service. *CPT* codes 93270, 93271 and 93272 describe the components of the service.

The family of *CPT* codes 93012 and 93014 describes the service using post-symptom rhythm strip(s). *CPT* code 93012 is coded for the telephonic transmission, tracing only. *CPT* code 93014 is billed for the interpretation and report only.

Services should be reported with either “pre-symptom” or “post symptom” codes, not both. Equipment with pre-symptom memory loop capabilities includes post-symptom capabilities or the equipment has post symptom memory capabilities only. Services are either “attended” or “non-attended” and therefore, codes from different groups should not be reported together.

The full text of the local coverage determination (LCD) for Patient Demand Single or Multiple Event Recorder (L6150) is available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>.

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# EDUCATIONAL RESOURCES

## Upcoming provider outreach and education events December 2008 - January 2009

### Ask-the-contractor webcast

Topic: Jurisdiction 9 - important transition updates  
When: December 17, 2008  
Time: 3:00 p.m. – 4:30 p.m.  
Type of Event: Teleconference

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Topic: Jurisdiction 9 - important transition updates  
When: December 17, 2008  
Time: 3:00 p.m. – 4:30 p.m.  
Type of Event: Teleconference

### Hot Topics: Medicare updates

Medicare updates, medical policies, and what you need to know to avoid denials and return as unprocessable claims  
When: January 13, 2009  
Time: 11:30 a.m. – 12:30 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](http://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](http://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](http://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 1-866-756-9160 or sending an e-mail to [fcsohelp@geolearning.com](mailto: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 1-904-361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, 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.fcsso.com](http://www.fcsso.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/prevaling 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](mailto: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](http://www.floridamedicare.com)

### Centers for Medicare & Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)

### Beneficiaries

### Centers for Medicare & Medicaid Services

[www.medicare.gov](http://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
<b>Medicare B Update! Subscription</b> – The <i>Medicare B Update!</i> is available free of charge online at <a href="http://www.fcsso.com">http://www.fcsso.com</a> . 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		
<b>2009 Fee Schedule</b> – 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 <a href="http://www.fcsso.com">http://www.fcsso.com</a> . 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 <i>Medicare Part B Update!</i> Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	40300270	Hardcopy: \$12.00		
		CD-ROM: \$6.00		
<i>Please write legibly</i>			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

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***MEDICARE B Update!***

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

◆ **ATTENTION BILLING MANAGER** ◆