MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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

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

Third party Web sites:

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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.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

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

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

"GA" modifier and appeals

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

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

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

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

Sign up to our *eNews* electronic mailing list

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

AMBULANCE

Ambulance inflation factor for calendar year 2009

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

Provider types affected

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

What you need to know

Change request (CR) 6113, from which this article is taken, provides the ambulance inflation factor (AIF) for calendar year (CY) 2009. The AIF for CY 2009 is 5.0 percent.

Background

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

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).

CR 6113, from which this article is taken furnishes the CY 2009 AIF, which will be 5.0 percent. The following table displays the AIF for CY 2009 and for the previous six years.

Ambulance Inflation Factor by CY	
2009	5.0 percent
2008	2.7 percent
2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

The national fee schedule for ambulance services was phased in over a five-year transition period beginning April 1, 2002. Further, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) is subject to a "floor amount."

Payment will not be less than this "floor amount," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule.

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.

To read more about this temporary 25 percent "per mile" rate increase for ambulance trips of 51 miles or greater, you might want to read *MLN Matters* article MM3099 (MMA-Implementation of Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003) released on June 25, 2004. You may find this article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3099.pdf* on the Centers for Medicare & Medicaid (CMS) Web site.

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate. For CY 2009, this blend is 20 percent regional ground base rate and 80 percent national ground base rate. Part B coinsurance and deductible requirements apply.

Additional information

CR 6113, the official instruction issued to your Medicare contractor, is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1607CP.pdf* on the CMS Web site.

If you have any questions, please contact your Medicare 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: MM6113
Related Change Request (CR) #: 6113
Related CR Release Date: October 3, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1607CP
Implementation Date: January 5, 2009

Medicare payment for air ambulance services

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6214, which alerts providers to the fact that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.

Be aware that upon the implementation date of January 5, 2009, in addition to the successful installation of the revised calendar year (CY) 2008 ZIP code file, your Medicare contractor will mass-adjust all air ambulance claims with dates of service on or after July 1, 2008, through December 31, 2008, which were previously paid under an urban ZIP code that was considered rural on December 31, 2006. In addition, the revised ZIP code file will be used to process such claims that were not already processed.

Key points of CR 6214

Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) further amends the designation of rural areas for air ambulance services.

- The statute specifies that any area that was designated as a rural area, as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.
- Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently re-designated as urban, CMS has re-established the "rural" indicator on the ZIP code file for air ambulance services, effective July 1, 2008.
- Your Medicare contractor will process air ambulance transport and mileage claims (i.e., A0430, A0431, A0435, A0436), in accordance with these revised designations.

Background

The ambulance fee schedule was implemented in April 2002 based on a final rule published in the *Federal Register* (67 Fed. Reg. 9100 [February 27, 2002]). The elements of this final rule allowed for payment for various ground ambulance services and rotary and fixed wing air ambulance services under a fee schedule. The payment for these services is based on the type of service provided and on the geographical points of pick up. The final rule also establishes increased payment for services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance.

When the fee schedule was implemented, a rural area was defined as one that was outside any area defined by the Office of Management and Budget as a metropolitan statistical area, (MSA) or a New England county metropolitan area (NECMA). The definition of "rural" also included the Goldsmith modification. The Goldsmith modification was developed because of the need to identify small towns and rural areas within large metropolitan counties. Some of these communities were isolated from central areas with health services because of distance or other physical features. The urban and rural areas were identified for payment purposes by a nexus of the ZIP code file and the ambulance fee schedule. The ZIP code file is updated quarterly.

Another final rule published in the *Federal Register* (71 Fed. Reg. 69713 [December 1, 2006]), revised the geographic designations for urban and rural areas as set forth in OMB's core-based statistical areas (CBSAs) standard. It added the definition of ''urban area'' as defined by the Executive Office of Management and Budget (OMB). In addition, it removed the definition of "Goldsmith modification" and amended the definition of ''rural area'' to include areas determined to be rural under the most recent version of the Goldsmith modification. Updating the MSA definition to conform with OMB's CBSA-based geographic area designations, coupled with updating the Goldsmith modification (that is, using the current rural urban commuting areas (RUCAs) version, as discussed in Section III.B.1.b of the final rule), more accurately reflected the contemporary urban and rural nature of areas across the country for ambulance payment purposes and made ambulance fee schedule payments more accurate. These changes became effective January 1, 2007.

Additional information

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

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

To see the official instruction (CR 6214) issued to your Medicare carrier, FI or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R387OTN.pdf* on the CMS Web site.

MLN Matters Number: MM6214
Related Change Request (CR) #: 6214
Related CR Release Date: October 17, 2008
Effective Date: July 1, 2008
Related CR Transmittal #: R387OTN
Implementation Date: January 5, 2009

AMBULATORY SURGICAL CENTER

Physician payment amounts when physicians furnish excluded procedures in ambulatory surgical centers

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

Provider types affected

Physicians and ambulatory surgical centers (ASCs) submitting claims to Medicare contractors (carriers and/or Part A/B Medicare administrative contractors [A/B MACs]) for ASC services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6052 regarding payment amounts provided when physicians furnish excluded procedures in ambulatory surgical centers (ASCs).

Caution – what you need to know

Effective for dates of service on or after January 1, 2008, Medicare will pay physicians at the facility rate for furnishing procedures in ASCs that are excluded from the list of covered ASC procedures. CR 6052 implements this policy beginning January 5, 2009. In essence, the fee paid on all physician services performed in ASCs (place of service code of 24) will be the lower facility fee and not the non-facility fee.

Go – what you need to do

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

Background

Prior to January 1, 2008, physicians were paid for furnishing noncovered procedures in ambulatory surgical centers (ASCs) at the non-facility amount. Beginning January 1, 2008, Medicare revised this policy to require payment to physicians at the facility payment amount which is in agreement with both the policy under the hospital outpatient prospective payment system (OPPS) and the revised ASC payment policy related to the list of covered services. The revised ASC payment system is based on the ambulatory payment classification (APC) groups and payment weights of the OPPS.

The Centers for Medicare & Medicaid Services (CMS) believes ASC facilities are similar, insofar as the delivery of surgical and related nonsurgical services, to hospital outpatient departments. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services.

Under the revised ASC payment system, CMS adopted a policy that identifies, and excludes from ASC payment, only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay.

As such, CMS believes that it would be inconsistent with the revised ASC payment system policies to pay the typically higher non-facility rate to physicians who furnish excluded ASC procedures. Because the excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, CMS does not believe it would be appropriate to provide a payment based on the non-facility rate to physicians who furnish them in the ASC setting.

In addition, the proposed revision to the *Code of Federal Regulations* (42CFR414.22(b)(5)(i)(A) and (B); see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl* on the Internet) imposes beneficiary liability for facility costs associated with surgical procedures that are not Medicare covered surgical procedures when performed in ASCs.

Under the revised ASC payment system, CMS has determined that the only surgical procedures excluded from ASC payment are those that pose a significant safety risk to beneficiaries or are expected to require an overnight stay when furnished in ASCs. Therefore, CMS provides no payment to ASCs for these procedures.

Note: CMS does not expect that these unsafe services will be furnished to Medicare beneficiaries in ASCs, and CMS expects that physicians and ASCs will advise beneficiaries of all of the possible consequences (including no Medicare ASC payments with concomitant beneficiary liability and significant surgical risk) if surgical procedures excluded from ASC payment were to be provided in ASCs.

Additional information

The official instruction, CR 6052, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1604CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM6052
Related Change Request (CR) #: 6052
Related CR Release Date: September 26, 2008
Effective Date: January 1, 2008
Related CR Transmittal #: R1604CP
Implementation Date: January 5, 2009

October 2008 update to the ambulatory surgical center payment system

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

Provider types affected

Providers (ambulatory surgical centers [ASCs]) who submit claims to Medicare administrative contractors (A/B MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

Provider action needed

This article is based on change request (CR) 6205 which describes changes to, and billing instructions for, payment policies implemented in the October 2008 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II HCPCS codes for drugs and biologicals. Be sure billing staff is aware of these changes.

Key points of CR 6205

Billing for drugs and biologicals

The Centers for Medicare & Medicaid Services (CMS) strongly encourages ASCs to report charges for all separately payable drugs and biologicals, using the correct Healthcare Common Procedure Coding System (HCPCS) codes for the items used. ASCs billing for these products should make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

Remember that under the ASC payment system, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the noncompounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.

Drugs and biologicals with payment based on average sales price (ASP) effective October 1, 2008

Payments for separately payable drugs and biologicals based on the ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates for previous quarter(s) are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2008 release of the ASC drug file.

Your Medicare contractors will make available to the ASCs the list of any newly added codes and previous quarter payment rate changes as identified in CR 6205.

New HCPCS drugs and biologicals separately payable under the ASC payment system effective October 1, 2008

The three HCPCS codes that are newly payable in ASCs and their descriptors are listed in Table 1 below.

Table 1

HCPCS	Long descriptor	Payment indicator
C9243	Injection, bendamustine hcl, 1 mg	K2
C9244	Injection, regadenoson, 0.4 mg	K2
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5cc	K2

Updated payment rates for certain HCPCS codes effective January 1, 2008, through March 31, 2008

The payment rates for three HCPCS codes were incorrect in the January 2008 ASC DRUG file. The corrected payment rates are listed below in Table 2 and have been included in the revised January 2008 ASC DRUG file, effective for services furnished on January 1, 2008, through March 31, 2008. Your Medicare contractor will adjust claims affected by these corrections if you bring such claims to their attention.

Table 2

HCPCS	Short descriptor	Corrected payment rate	Payment indicator
J7324	Orthovisc inj per dose	$169.10	K2
J9015	Aldesleukin/single use vial	$757.34	K2
J9303	Panitumumab injection	$82.86	K2

October 2008 update to the ASC payment system (continued)

Updated payment rates for certain HCPCS codes effective April 1, 2008, through June 30, 2008

The payment rates for three HCPCS codes were incorrect in the April 2008 ASC DRUG file. The corrected payment rates are listed below in Table 3 and have been corrected in the revised April 2008 ASC DRUG file effective for services furnished on April 1, 2008, through June 30, 2008. Your Medicare contractor will adjust claims affected by these corrections if you bring such claims to their attention.

Table 3

HCPCS	Short descriptor	Corrected payment rate	Payment indicator
J7324	Orthovisc inj per dose	$174.63	K2
J9303	Panitumumab injection	$82.83	K2
Q4096	VWF complex, not Humate-P	$0.65	K2

Updated payment rates for certain HCPCS codes effective July 1, 2008, through September 30, 2008

The payment rate for one HCPCS code was incorrect in the July 2008 ASC DRUG file. The corrected payment rate is listed below and has been corrected in the July 2008 ASC DRUG file, effective for services furnished on July 1, 2008, through September 30, 2008. Your Medicare contractor will adjust claims affected by these corrections if you bring such claims to their attention.

Table 4

HCPCS	Short descriptor	Corrected payment rate	Payment indicator
J7324	Orthovisc inj per dose	$175.85	K2

Correct reporting of drugs and biologicals when used as implantable devices

ASCs are reminded that with the exception of drugs and biologicals with pass-through status under the outpatient prospective payment system (OPPS), ASCs are not to bill separately for drug and biological HCPCS codes when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures.

Correct reporting of units for drugs

ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

- For example, if the drug HCPCS code descriptor specifies 6 mg, and 6 mg of the drug were administered to the patient, the units billed should be one.
- As another example, if the drug HCPCS code descriptor specifies 50 mg, but 200 mg of the drug were administered to the patient, the units billed should be four.
- ASCs should not bill the units based on how the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 10 units should be reported on the bill, even though only one vial was administered.
- The HCPCS code short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Payment for office-based procedures and covered ancillary radiology services

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), which may be reviewed at *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3200* on the CMS Web site, requires that the Medicare physician fee schedule (MPFS) update originally applicable to dates of service January 1, 2008 through June 30, 2008 be extended through December 31, 2008. Consequently, ASC payments for some office-based procedures and covered ancillary radiology services, services for which payment is made at the lesser of the ASC rate or the MPFS non-facility practical expense relative value unit (RVU) amount, are affected.

Payment for brachytherapy sources

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at hospital charges adjusted to costs. As a result of the legislative amendment, there is no prospective rate under the OPPS for that period. Contrary to the payment policy, payment indicators and payment rates included in previous guidance, including Addendum BB to the November 27, 2007 OPPS/ASC final rule, for dates of service July 1, 2008 through December 31, 2009, payment for brachytherapy sources will be made at contractor-priced amounts, consistent with payment policy for the revised ASC payment system when no OPPS rate is available.

The HCPCS codes for separately paid brachytherapy sources, long descriptors and payment indicators are listed in Table 5.

October 2008 update to the ASC payment system (continued)

Table 5

HCPCS	Long descriptor	Payment indicator
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H7
C1716	Brachytherapy source, nonstranded, gold-198, per source	H7
C1717	Brachytherapy source, nonstranded, high dose rate iridium-192, per source	H7
C1719	Brachytherapy source, nonstranded, non-high dose rate iridium-192, per source	H7
C2616	Brachytherapy source, nonstranded, yttrium-90, per source	H7
C2634	Brachytherapy source, nonstranded, high activity, iodine-125, greater than 1.01 mCi (NIST), per source	H7
C2635	Brachytherapy source, nonstranded, high activity, palladium-103, greater than 2.2 mCi (NIST), per source	H7
C2636	Brachytherapy linear source, nonstranded, palladium-103, per 1MM	H7
C2638	Brachytherapy source, stranded, iodine-125, per source	H7
C2639	Brachytherapy source, nonstranded, iodine-125, per source	H7
C2640	Brachytherapy source, stranded, palladium-103, per source	H7
C2641	Brachytherapy source, nonstranded, palladium-103, per source	H7
C2642	Brachytherapy source, stranded, cesium-131, per source	H7
C2643	Brachytherapy source, nonstranded, cesium-131, per source	H7
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H7
C2699	Brachytherapy source, nonstranded, not otherwise specified, per source	H7

Additional information

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

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

To see the official instruction (CR 6205) issued to your Medicare carrier or MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1611CP.pdf* on the CMS Web site. Your Medicare contractor will make the October 2008 ASC fee schedule data for their localities.

MLN Matters Number: MM6205
Related Change Request (CR) #: 6205
Related CR Release Date: October 3, 2008
Effective Date: October 1, 2008
Related CR Transmittal #: R1611CP
Implementation Date: October 6, 2008

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.

COMPETITIVE AQUISITION PROGRAM

Competitive Acquisition Program update

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 and/or Medicare administrative contractors [MACs]) for Part B drugs and biologicals paid under the Competitive Acquisition Program (CAP).

Provider action needed

This article is based on change request (CR) 6210, which updates instructions regarding vendor identification number (VIN) Q103 in CAP claims processing and other related processes. The CR also updates procedures pertaining to CAP physician election and addresses the procedure for paying CAP claims for iron dextran products.

Background

CR 6210 updates instructions about end-dating VIN Q103, which corresponds to the 2006-2008 approved CAP vendor. The current contract with the 2006-2008 approved CAP vendor will remain in effect through December 31, 2008. Additional information about the CAP program is available on the CMS Web site at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp*.

The Healthcare Common Procedure Coding System (HCPCS) codes for two iron dextran products (J1751 [Injection, iron dextran 165, 50mg]; and J1752 [Injection, iron dextran 267, 50mg]) were changed to Q4098 (Injection, iron dextran, 50mg) effective April 1, 2008. When submitting CAP claims for these codes, physicians should bill under the existing CAP not otherwise classified (NOC) code Q4082. HCPCS code Q4098 will not be added into the CAP. Though these drugs are now under one code, the payment amounts for these products when they are furnished under the CAP remain unchanged. Iron dextran supplied under the CAP is paid at the approved CAP vendor contract's existing payment amounts for J1751 and J1752.

CR 6210 also includes instructions related to the CAP physician election process. Unless a physician is submitting an election form within the first 90 days of joining Medicare, Medicare contractors are instructed to return election forms that are submitted outside of a regularly scheduled physician election period.

Additional information

The official instruction, CR 6210, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R381OTN.pdf* on the CMS Web site. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

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

MLN Matters Number: MM6210
Related Change Request (CR) #: 6210
Related CR Release Date: October 3, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R381OTN
Implementation Date: January 5, 2009

Upcoming training for the Medicare Part B drugs Competitive Acquisition Program

Noridian Administrative Services (NAS), the designated carrier for the Competitive Acquisition Program (CAP), offers interactive, online workshops about the CAP for Part B drugs and biologicals. These workshops train CAP vendors and elected physicians on a variety of CAP topics, including how to transition out of the CAP at the end of 2008 due to the postponement of the program for 2009. NAS staff will also be available to answer questions. Interested parties may view additional information about and register for these workshops on the Noridian Web site at: *https://www.noridianmedicare.com/cap_drug/train/schedule.html*.

Upcoming workshop will be held on:

November 24, 2008 at 2:00 p.m. CST

Additional information about the CAP and the 2009 postponement is available at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp*.

Source: PERL 200810-23

CMS releases special edition article on the 2009 CAP postponement

A *Medicare Learning Network* (*MLN*) *Matters* special edition article on the 2009 competitive acquisition program (CAP) postponement is now available on the CMS Web site. This article contains billing, drug ordering, claims processing, and other information for participating CAP physicians on the transition from CAP to the average sales price (ASP) "buy and bill" methodology for 2009. This article is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0833.pdf*.

Additional information on the CAP and the postponement of the program for 2009 is available on the CMS CAP Web site at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp*.

If you no longer wish to receive e-mails related to CMS Open Door Forums, you may go to the following Web site to unsubscribe from the Listservs: *https://list.nih.gov/LISTSERV_WEB/signoff.htm*.

Source: PERL 200810-04

CONSOLIDATED BILLING

2009 Annual update of codes for skilled nursing facility consolidated billing

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 who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6220 which provides the 2009 annual update of healthcare common procedure coding system (HCPCS) codes for skilled nursing facility consolidated billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

Caution – what you need to know

Physicians and providers are advised that, by the first week in December 2008, new code files will be posted at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the Centers for Medicare & Medicaid Services (CMS) Web site. Institutional providers note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the *General Explanation of the Major Categories* PDF file located at the bottom of the FI update for each year listed at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS Web site in order to understand the major categories including additional exclusions not driven by HCPCS codes.

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 claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs). (This manual is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site.) These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional information

The official instruction, CR 6220, 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/R1608CP.pdf* on the CMS Web site. 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: MM6220
Related Change Request (CR) #: 6220
Related CR Release Date: October 3, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1608CP
Implementation Date: January 5, 2009

DURABLE MEDICAL EQUIPMENT

Claim jurisdiction and enrollment procedures for suppliers of certain prosthetics, durable medical equipment and replacement parts, accessories and supplies

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

Provider types affected

Suppliers, including manufacturers, billing Medicare carriers and Medicare administrative contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 5917 to alert suppliers, including manufacturers, enrolled with the national supplier clearinghouse (NSC) as a durable medical equipment prosthetic, orthotics, and supplies (DMEPOS) supplier, that they may now enroll with and bill the Medicare carrier or A/B MAC for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME items that are not required to be billed to the Medicare fiscal intermediary.

Caution – what you need to know

Such suppliers may bill the carrier/MAC for these items only, unless the entity separately qualified as a supplier for items and/or services in another benefit category.

Go – what you need to do

Make certain that you use your national provider identifier (NPI) and do not include your NSC number on claims submitted to carriers/MACs for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME.

Key points

- CR 5917 reinstates the Part B carrier/MAC jurisdiction for suppliers of replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME only, including manufacturers of such items.
- Suppliers that wish to bill the carrier/MAC for these items must enroll with the NSC as a DMEPOS supplier prior to enrolling with, and billing these items to, the Part B carrier/MAC.
- All suppliers must meet the enrollment standards of the NSC and qualify as a DMEPOS supplier. (A DMEPOS supplier must meet certain requirements and enroll with the NSC as described in Chapter 10 of the *Program Integrity Manual*, which may be reviewed at *http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf* on the CMS Web site.
- When submitting claims to the carrier or A/B MAC, be sure to use your NPI, rather than the NSC number.

Additional Information

CR 5917 contains the list of HCPCS codes that may be billed to the carrier/MAC as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME. That list is attachment A of CR 5917 and it is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1603CP.pdf* on the CMS Web site. Also, the full 2008 jurisdiction list of DMEPOS HCPCS is attached to CR 6062, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R1605CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM5917
Related Change Request (CR) #: 5917
Related CR Release Date: September 26, 2008
Effective Date: October 27, 2008
Related CR Transmittal #: R1603CP
Implementation Date: October 27, 2008

2008 jurisdiction list for DMEPOS HCPCS codes

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], and Part A/B Medicare administrative contractors [A/B MACs]) for durable medical equipment prosthetics, orthotics, and supply (DMEPOS) services provided to Medicare beneficiaries.

Impact on providers

This article is informational and is based on change request (CR) 6062 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for DME MAC and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2008 Jurisdiction List is attached to CR 6062 at *http://www.cms.hhs.gov/Transmittals/downloads/R1605CP.pdf* on the CMS Web site.

Additional information

To see the official instruction (CR 6062) issued to your Medicare DME MAC, carrier, or A/B MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1605CP.pdf* on the CMS Web site.

If you have questions, please contact your Medicare DME MAC, carrier or A/B MACs 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: MM6062
Related Change Request (CR) #: 6062
Related CR Release Date: September 26, 2008
Effective Date: October 27, 2008
Related CR Transmittal #: R1605CP
Implementation Date: October 27, 2008

2008 jurisdiction list for DMEPOS HCPCS codes

HCPCS	Description	Jurisdiction
A0021 - A0999	Ambulance services	Local carrier
A4206 - A4209	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4210	Needle free injection device	DME MAC
A4211	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4212	Noncoring needle or stylet with or without catheter	Local carrier
A4213 - A4215	Medical , surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4216 - A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4220	Refill kit for implantable pump	Local carrier
A4221 - A4250	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4252 - A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Local carrier
A4262 - A4263	Lacrimal duct implants	Local carrier

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4266 - A4269	Contraceptives	Local carrier
A4270	Endoscope sheath	Local carrier
A4280	Accessory for breast prosthesis	DME MAC
A4281 - A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Local carrier
A4300 - A4301	Implantable catheter	Local carrier
A4305 - A4306	Disposable drug delivery system	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4310 - A4358	Incontinence supplies/urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4359 (deleted 12/31/06)	Incontinence supplies/urinary supplies	See description above.
A4361 - A4434	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450 - A4455	Tape adhesive remover	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4458	Enema bag	DME MAC
A4461-A4463	Surgical dressing holders	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4465	Nonelastic binder for extremity	DME MAC
A4470	Gravlee jet washer	Local carrier
A4480	Vabra aspirator	Local carrier
A4481	Tracheostomy supply	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4483	Moisture exchanger	DME MAC
A4490 - A4510	Surgical stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical trays	Local carrier
A4554	Disposable underpads	DME MAC
A4556 - A4558	Electrodes; lead-wires; conductive paste	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling gel	Local carrier if incident to a physician's (not separately payable).
A4561 - A4562	Pessary	Local carrier

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A4565	Sling	Local carrier
A4570	Splint	Local carrier
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580 - A4590	Casting supplies & material	Local carrier
A4595	TENS Supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
A4601	Lithium ion battery for nonprosthetic use	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611 - A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615 - A4629	Oxygen and tracheostomy supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630 - A4640	DME supplies	DME MAC
A4641 - A4642	Imaging agent; contrast material	Local carrier
A4648	Tissue marker, implanted	Local carrier
A4649	Miscellaneous surgical supplies	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable radiation dosimeter	Local carrier
A4651 - A4932	Supplies for ESRD	DME MAC
A5051 - A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A5102 - A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A5500 - A5513	Therapeutic shoes	DME MAC
A6000	Noncontact wound warming cover	DME MAC

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A6010-A6024	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone gel sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154 - A6411	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441 - A6512	Surgical dressings	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6513	Compression burn mask	DME MAC
A6530 - A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000 - A7002	Accessories for suction pumps	DME MAC
A7003 - A7039	Accessories for nebulizers, aspirators and ventilators	DME MAC
A7040 - A7041	Chest drainage supplies	Local carrier
A7042 - A7043	Pleural catheter	Local carrier
A7044 - A7046	Respiratory accessories	DME MAC
A7501-A7527	Tracheostomy supplies	DME MAC
A8000-A8004	Protective helmets	DME MAC
A9150	Non-prescription drugs	Local carrier
A9152 - A9153	Vitamins	Local carrier
A9155	Artificial saliva	Local carrier
A9180	Lice infestation treatment	Local carrier
A9270	Noncovered items or services	DME MAC
A9274 - A9278	Glucose monitoring	DME MAC
A9279	Monitoring feature/device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC
A9282	Wig	DME MAC
A9283	Foot off loading device	DME MAC

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
A9300	Exercise equipment	DME MAC
A9500 - A9700	Supplies for radiology procedures	Local carrier
A9900	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034 - B9999	Enteral and parenteral therapy	DME MAC
D0120 - D9999	Dental procedures	Local carrier
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus care equipment	DME MAC
E0200 - E0239	Heat/cold applications	DME MAC
E0240 - E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250 - E0304	Hospital beds	DME MAC
E0305 - E0326	Hospital bed accessories	DME MAC
E0328 - E0329	Pediatric hospital beds	DME MAC
E0350 - E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC
E0371 - E0373	Decubitus care equipment	DME MAC
E0424 - E0484	Oxygen and related respiratory equipment	DME MAC
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC
E0500	IPPB Machine	DME MAC
E0550 - E0585	Compressors/Nebulizers	DME MAC
E0600	Suction Pump	DME MAC
E0601	CPAP Device	DME MAC
E0602 - E0604	Breast Pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage Board	DME MAC
E0607	Home Blood Glucose Monitor	DME MAC
E0610 - E0615	Pacemaker Monitor	DME MAC
E0616	Implantable cardiac event recorder	Local carrier

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
E0617	External defibrillator	DME MAC
E0618 - E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621 - E0636	Patient lifts	DME MAC
E0637 - E0642	Standing devices/lifts	DME MAC
E0650 - E0676	Pneumatic compressor and appliances	DME MAC
E0691 - E0694	Ultraviolet light therapy systems	DME MAC
E0700	Safety equipment	DME MAC
E0701 (deleted 12/31/06)	Protective helmet	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Local carrier
E0747 - E0748	Osteogenic stimulators	DME MAC
E0749	Implantable osteogenic stimulators	Local carrier
E0755	Reflex stimulator	DME MAC
E0760	Ultrasonic osteogenic stimulator	DME MAC
E0761	Electromagnetic treatment device	DME MAC
E0762	Electrical joint stimulation device	DME MAC
E0764	Functional neuromuscular stimulator	DME MAC
E0765	Nerve stimulator	DME MAC
E0769	Electrical wound treatment device	DME MAC
E0776	IV pole	DME MAC
E0779 - E0780	External infusion pumps	DME MAC
E0781	Ambulatory infusion pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion pumps, implantable	Local carrier
E0784	Infusion pumps, insulin	DME MAC
E0785 - E0786	Implantable infusion pump catheter	Local carrier
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840 - E0900	Traction equipment	DME MAC

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
E0910 - E0930	Trapeze/fracture frame	DME MAC
E0935 - E0936	Passive motion exercise device	DME MAC
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942 - E0945	Orthopedic devices	DME MAC
E0946 - E0948	Fracture frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC
E1300 - E1310	Whirlpool equipment	DME MAC
E1340	Repair or nonroutine service	Local carrier if repair of implanted DME. If other, DME MAC.
E1353 - E1392	Additional oxygen related equipment	DME MAC
E1399	Miscellaneous DME	Local carrier if implanted DME if other, DME regional carrier.
E1405 - E1406	Additional oxygen equipment	DME MAC
E1500 - E1699	Artificial kidney machines and accessories	DME MAC
E1700 - E1702	TMJ device and supplies	DME MAC
E1800 - E1841	Dynamic flexion devices	DME MAC
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100 - E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201 - E2399	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC
E2500 - E2599	Speech generating device	DME MAC
E2601 - E2621	Wheelchair cushions	DME MAC
E8000 - E8002	Gate trainers	DME MAC
G0008 - G0332	Misc. professional services	Local carrier
G0333	Dispensing fee	DME MAC
G0337 - G0368	Misc. professional services	Local carrier
G0372	Misc. professional services	Local carrier
G0375 - G0376	Misc. professional services	Local carrier
G0378 - G9140	Misc. professional services	Local carrier
J0120 - J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologics	Local carrier

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
J7030 - J7130	Miscellaneous drugs and solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7187 - J7195	Antihemophilic factor	Local carrier
J7197	Antithrombin III	Local carrier
J7198	Anti-inhibitor; per I.U.	Local carrier
J7199	Other hemophilia clotting factors	Local carrier
J7300 - J7307	Intrauterine copper contraceptive	Local carrier
J7308	Aminolevulinic acid HCL	Local carrier
J7310	Ganciclovir, long-acting implant	Local carrier
J7311	Fluocinolone acetonide, intravitrea implant	Local carrier
J7317 (deleted 12/31/06)	Sodium hyaluronate	Local carrier
J7319 (deleted 12/31/07)	Hyaluronan	Local carrier
J7320 (deleted 12/31/06)	Hylan	Local carrier
J7321 - J7324	Hyaluronan	Local carrier
J7330	Autologous cultured chondrocytes implant	Local carrier
J7340 - J7349	Dermal and epidermal tissue	Local carrier
J7350 (deleted 12/31/06)	Dermal and epidermal tissue	Local carrier
J7500 - J7599	Immunosuppressive drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7602 - J7699	Inhalation solutions	Local carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, other than inhalation drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501 - J8999	Oral anti-cancer drugs	DME MAC
J9000 - J9999	Chemotherapy drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552	External infusion pump supplies	DME MAC
K0553 - K0555 (deleted 12/31/07)	Accessories for CPAP and ventilators	DME MAC

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
K0601 - K0605	External infusion pump batteries	DME MAC
K0606 - K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC
K0734 - K0737	Power wheelchair seat cushions	DME MAC
K0738	Oxygen equipment	DME MAC
K0800 - K0899	Power mobility devices	DME MAC
L0100 (deleted 12/31/06)	Orthotics	DME MAC
L0110 (deleted 12/31/06)	Orthotics	DME MAC
L0112 - L2090	Orthotics	DME MAC
L2106 - L2116	Orthotics	DME MAC
L2126 - L4398	Orthotics	DME MAC
L5000 - L5999	Lower limb prosthetics	DME MAC
L6000 - L7499	Upper limb prosthetics	DME MAC
L7500 - L7520	Repair of prosthetic device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic donning sleeve	DME MAC
L7611 - L7622	Prosthetic terminal devices	DME MAC
L7900	Vacuum erection system	DME MAC
L8000 - L8485	Prosthetics	DME MAC
L8499	Unlisted procedure for miscellaneous prosthetic services	Local carrier if implanted prosthetic device. If other, DME MAC.
L8500 - L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507 - L8515	Voice prosthesis	DME MAC
L8600 - L8699	Prosthetic implants	Local carrier
L9900	Miscellaneous orthotic or prosthetic component or accessory	Local carrier if used with implanted prosthetic device. If other, DME MAC.
M0064 - M0301	Medical services	Local carrier
P2028 - P9615	Laboratory tests	Local carrier
Q0035	Influenza vaccine; cardiokymography	Local carrier
Q0081	Infusion therapy	Local carrier
Q0083 - Q0085	Chemotherapy administration	Local carrier

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
Q0091	Smear preparation	Local carrier
Q0092	Portable X-ray setup	Local carrier
Q0111 - Q0115	Miscellaneous lab services	Local carrier
Q0144	Azithromycin dihydrate	Local carrier if incident to a physician's service. If other, DME MAC.
Q0163 - Q0181	Anti-emetic	DME MAC
Q0480 - Q0505	Ventricular assist devices	Local carrier
Q0510 - Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Local carrier
Q1003 - Q1005	New technology IOL	Local carrier
Q2004	Irrigation solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier
Q3001	Radio elements for brachytherapy	Local carrier
Q3014	Telehealth originating site facility fee	Local carrier
Q3025 - Q3026	Vaccines	Local carrier
Q3031	Collagen skin test	Local carrier
Q4001 - Q4051	Splints and Casts	Local carrier
Q4080	Inhalation drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, local carrier.
Q4082	Drug subject to competitive acquisition program	Local carrier
Q4083 - Q4086 (deleted 12/31/07)	Hyaluronan	Local carrier
Q4087 - Q4092 (deleted 12/31/07)	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4093 - Q4094 (deleted 12/31/07)	Inhalation solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4095 (deleted 12/31/07)	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other DME MAC.
Q4096 - Q4098	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump.
Q4099	Inhalation solutions	DME MAC
Q5001 - Q5009	Hospice services	Local carrier
Q9945 - Q9950 (deleted 12/31/07)	Imaging agents	Local carrier
Q9951 - Q9954	Imaging agents	Local carrier

2008 jurisdiction list for DMEPOS HCPCS codes (continued)

HCPCS	Description	Jurisdiction
Q9955 - Q9957	Microspheres	Local carrier
Q9958 - Q9967	Imaging agents	Local carrier
R0070 - R0076	Diagnostic radiology services	Local carrier
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic contact lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530 - V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600 - V2615	Low vision aids	DME MAC
V2623 - V2629	Prosthetic eyes	DME MAC
V2630 - V2632	Intraocular lenses	Local carrier
V2700 - V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing corneal tissue	Local carrier
V2786	Lense	DME MAC
V2787 - V2788	Intraocular lenses	Local carrier
V2790	Amniotic membrane	Local carrier
V2797	Vision supply	DME MAC
V2799	Miscellaneous vision service	DME MAC
V5008 - V5299	Hearing services	Local carrier
V5336	Repair/modification of augmentative communicative system or device	DME MAC
V5362 - V5364	Speech screening	Local carrier

Note: Deleted codes are valid for dates of service on or before the date of deletion.

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Reasonable charge update for 2009 for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses

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

Provider types affected

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

What you need to know

Change request (CR) 6221, from which this article is taken, instructs your carriers, FIs, MACs, and DME MACs how to calculate reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2009. CR 6221 also announces that the 2009 inflation-indexed charge (IIC) update factor is 5.0 percent.

Background

Payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 CFR 405.501.

For calendar year 2009, Medicare will continue to pay for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses on a reasonable charge basis.

In addition, please note that:

1) Payment for intraocular lenses is only made on a reasonable charge basis for lenses implanted in a physician's office.
2) You should use the Q-codes for splints and casts, when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

The 2009 payment limits for splints and casts will be based on the 2008 limits that were announced in CR 5740 last year, increased by 5.0 percent (the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2008). (The *MLN Matters* article related to CR 5740 may be viewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5740.pdf* on the CMS Web site.)

CR 6221 instructs your carrier or MAC to:

1) Compute 2009 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular lenses implanted in a physician's office) using actual charge data from July 1, 2007, through June 30, 2008.
2) Compute 2009 IIC amounts for these codes that were not paid using gap-filled payment amounts in 2008.

The 2009 IIC update factor is 5.0 percent.

For codes identified in the following four tables, CR 6221 instructs DME MACs to compute 2009 customary and prevailing charges using actual charge data from July 1, 2007 through June 30, 2008; and will compute 2009 IIC amounts for the codes that were not paid using gap-filled amounts in 2008.

Table 1
Dialysis supplies billed with modifier AX

A4215	A4216	A4217	A4244	A4245	A4246
A4247	A4248	A4450	A4452	A4651	A4652
A4657	A4660	A4663	A4670	A4927	A4928
A4930	A4931	A6216	A6250	A6260	A6402

Table 2
Dialysis supplies billed without modifier AX

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Reasonable charge update for 2009 for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses (continued)

Table 3
Dialysis equipment billed with modifier AX

E0210NU	E1632	E1637	E1639

Table 4
Dialysis equipment billed without modifier AX

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Your contractors will make payment for splints and casts furnished in 2009 based on the lower of the actual charge or the payment limits established for these codes. They will use the 2009 reasonable charges or the attached 2009 splints and casts payment limits to pay claims for items furnished from January 1, 2009, through December 31, 2009. Please refer to Attachment A, at the end of this article for a detailed list of the applicable HCPCS codes and 2009 payment limits.

Additional information

Detailed instructions for calculating:

- Reasonable charges are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments).
- Customary and prevailing charges are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge).
- The IIC are located in Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

The *Medicare Claims Processing Manual* is available at *http://www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS Web site.

MLN Matters Number: MM6221
Related Change Request (CR) #: 6221
Related CR Release Date: October 3, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1613CP
Implementation Date: January 5, 2009

LABORATORY/PATHOLOGY

Laboratory national coverage determination edit software for October 2008

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 6213 which announces the changes that will be included in the October 2008 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in July 2008. CR 6213 incorporates all changes from July 2008 to the present.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Section 120.2 (see *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6213 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for October 2008 as described below. These changes become effective for services furnished on or after October 1, 2008.

Bacterial urine culture

- Add ICD-9-CM codes 038.12, 599.70, 599.71, 599.72, 780.60, 780.61, 780.62, 780.63, 780.64, 780.65, 788.91, and 788.99 to the list of ICD-9-CM codes covered by Medicare for the urine culture, bacterial (190.12) NCD.
- Delete ICD-9-CM codes 599.7, 780.6, and 788.9 from the list of ICD-9-CM codes covered by Medicare for the urine culture, bacterial (190.12) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Urine Culture, Bacterial (190.12) NCD.

HIV Testing

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the HIV testing (prognosis including monitoring [190.13]) NCD.
- Add ICD-9-CM codes 078.12, 136.21, 136.29, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM codes covered by Medicare for the HIV testing (diagnosis) (190.14) NCD.
- Delete ICD-9-CM codes 136.2 and 780.6 from the list of ICD-9-CM codes covered by Medicare for the HIV testing (diagnosis) (190.14) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the HIV testing (diagnosis) (190.14) NCD.

Blood counts

- Add ICD-9-CM codes 078.12, V45.11, V45.12, V49.83, V51.0, V51.8, V61.01, V61.02, V61.03, V61.04, V61.05, V61.06, V61.09, V62.21, V62.22, V62.29 and V72.42 to the list of ICD-9-CM codes that do not support medical necessity for the blood counts (190.15) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the blood counts (190.15) NCD.
- Delete ICD-9-CM codes V45.1, V51, V61.0, and V62.2 from the list of ICD-9-CM Codes that do not support medical necessity for the blood counts (190.15) NCD

Partial thromboplastin time (PTT)

- Add ICD-9-CM codes 275.5, 238.77, 571.42, 599.70, 599.71, 599.72, and 611.89 to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes 599.7 and 611.8 from the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.

Prothrombin time (PT)

- Add ICD-9-CM codes 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 511.81, 511.89, 571.42, 599.70, 599.71, 599.72, 611.89, and 999.89 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Delete ICD-9-CM codes 511.8, 599.7, 611.8, and 999.8 from the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the prothrombin time (PT) (190.17) NCD.

Serum iron studies

- Add ICD-9-CM codes 199.2, 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.60, 209.61, 209.62, 209.63, 209.64,

Laboratory national coverage determination edit software for October 2008 (continued)

209.65, 209.66, 209.67, 209.69, 209.30, 238.77, 571.42, 999.89, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.

- Delete ICD-9-CM codes 999.8 and V15.2 from the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the serum iron studies (190.18) NCD.

Collagen crosslinks
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the collagen crosslinks, any method (190.19) NCD.

Blood glucose testing
- Add ICD-9-CM codes 038.12, 707.20, 707.21, 707.22, 707.23, 707.24, 707.25, 780.72, V23.85, and V23.86 to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the blood glucose testing (190.20) NCD.

Glycated hemoglobin/glycated protein
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.

Thyroid Testing
- Add ICD-9-CM codes 275.5, 780.72, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM code 780.6 from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM codes V28.8.and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Thyroid Testing (190.22) NCD.

Lipid Testing
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Lipids Testing (190.23) NCD.

Digoxin Therapeutic Drug Assay
- Add ICD-9-CM codes 275.5, 339.3, and 780.72 to the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.

Alpha-Fetoprotein
- Add ICD-9-CM codes 571.42, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the Alpha-Fetoprotein (190.25) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the alpha-fetoprotein (190.25) NCD.

Carcinoembryonic antigen
- Add ICD-9-CM codes 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the carcinoembryonic antigen (190.26) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the carcinoembryonic antigen (190.26) NCD.

Human chorionic gonadotropin
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the human chorionic gonadotropin (190.27) NCD.

Tumor antigen by immunoassay-CA125
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the tumor antigen by immunoassay-CA125 (190.28) NCD.

Tumor antigen by immunoassay-CA15-3/CA27.29
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the tumor antigen by immunoassay-CA15-3/CA27.29 (190.29) NCD.

Tumor antigen by immunoassay-CA19-9
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the tumor antigen by immunoassay-CA19-9 (190.30) NCD

Prostate specific antigen (PSA)
- Add ICD-9-CM codes 599.70, 599.71, and 599.72 to the list of ICD-9-CM codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM code 599.7 from the list of codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the (PSA) (190.31) NCD.

Gamma Glutamyl Transferase
- Add ICD-9-CM codes 275.5, 038.12, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 558.41, 558.42, and 571.42 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

Hepatitis Panel/Acute Hepatitis Panel
- Add ICD-9-CM code 780.72 to the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/ Acute Hepatitis Panel (190.33) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

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Fecal occult blood test (FOBT)

- Add ICD-9-CM codes 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 530.13, 558.41, 558.42, 569.44, 571.42, and 780.72 to the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (FOBT) (190.34) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the FOBT (190.34) NCD.

All 23 NCDs (190.12-190.34)

- Add ICD-9-CM codes V28.81, V28.82, V28.89, V68.01, and V68.09 to the list of denied ICD-9-CM codes for all 23 lab NCDs.

Additional information

The official instruction, CR 6213, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1606CP.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.

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MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

2009 Medicare physician fee schedule payment rates

The 2009 Medicare physician fee schedule (MPFS) payment rates will be posted to the Florida Medicare Web site after publication of the MPFS final rule in the *Federal Register*. This publication usually occurs in mid-November.

Source: Publication 100-04, Chapter 1, Section 30.3.12.1(B)

Availability of an interim study of alternative MPFS payment localities

Medicare is statutorily required to adjust payments for Medicare physician fee schedule (MPFS) services, to account for differences in costs due to geographic location. There are currently 89 localities that have not been revised since 1997. In the calendar year 2009 physician fee schedule notice of proposed rulemaking released on June 30, 2008, the Centers for Medicare & Medicaid Services (CMS) indicated they would post a preliminary study of several options for revising the payment localities on its Web site. The report titled, Review of Alternative GPCI Payment Locality Structures, produced by Acumen LLC under contract to CMS, may be found at *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/ReviewOfAltGPCIs.pdf*.

CMS' study of possible alternative payment locality configurations is in the early stages of development. At this time, CMS is not proposing to make any changes to the payment localities. CMS encourages interested parties to submit comments on the options presented in the report, as well as suggestions for other options. These comments will be considered in the development of possible future notice and comment rulemaking. When CMS is ready to propose any changes to the locality configuration, they will provide extensive opportunities for public comment (for example, a town hall meeting or open door forum) on specific proposals, before implementing any change.

Source: PERL 200810-22

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THERAPEUTIC SERVICES

Continuous positive airway pressure therapy for obstructive sleep apnea

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

Note: This article was revised on October 16, 2008, to reflect changes to change request (CR) 6048, which CMS revised on October 15, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6048 were revised. In addition, some language in item 3 of Key points was clarified. All other information remains the same. This information previously published in the September 2008 *Medicare B Update!* (pages 41-42).

Provider types affected

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

Impact on providers

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

Background

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

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

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

Key points of CR 6048

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

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

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
   - Polysomnography (PSG) performed in a sleep laboratory, or
   - Unattended home sleep monitoring device of Type II, or
   - Unattended home sleep monitoring device of Type III, or
   - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

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

3. A positive test for OSA is established if either of the following criteria using the apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) are met:
   - AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
   - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour of sleep or continuous monitoring with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

As previously stated, the AHI is equal to the average number of episodes of apnea and hypopnea per hour of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring. However, there is variability in the published medical literature about the definition of the events that constitute a respiratory disturbance. The technology assessment that supported this NCD recognized this variability and defined RDI in the

Continuous positive airway pressure therapy for obstructive sleep apnea (continued)

context of the specific sleep test technology under review. For the purposes of this NCD, a respiratory disturbance is defined in the context of the sleep test technology of interest and does not require direct measurement of airflow. Local contractors will, as needed, determine, based on their review of the published, peer-reviewed medical literature, the equivalent test result criteria corresponding to the required AHI or RDI for Type IV devices measuring 3 or more channels that do not measure AHI or RDI directly.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a two-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR 6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at Section 310.1 of the *NCD Manual* and Chapter 32 and Sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available at *http://www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS Web site.

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

Code	Descriptor
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
G0398	Short Descriptor: Home sleep test/type 2 Porta
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
G0399	Short Descriptor: Home sleep test/type 3 Porta
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels
G0400	Short Descriptor: Home sleep test/type 4 Porta

Additional information

To see the official instruction (CR 6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R96NCD.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM6048 *Revised*
Related Change Request (CR) #: 6048
Related CR Release Date: October 15, 2008
Effective Date: March 13, 2008
Related CR Transmittal #: R96NCD
Implementation Date: August 4, 2008

GENERAL COVERAGE

The ICD-10-Clinical Modification/Procedure Coding System (CM/PCS) -- the next generation of coding

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

Provider types affected

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

Provider action needed

This special edition article (SE0832) outlines general information for providers detailing the International Classification of Diseases, 10th Edition (ICD-10) clinical system. Compared to the current ICD-9 coding system, ICD-10 offers more detailed information and the ability to expand specificity and clinical information in order to capture advancements in clinical medicine. Providers may want to become familiar with the new coding system.

The system is not yet implemented in Medicare's fee-for-service (FFS) claim processes so no action is needed at this time.

Background

All of the following countries already use ICD-10:

- United Kingdom (1995)
- France (1997)
- Australia (1998)
- Germany (2000)
- Canada (2001)

ICD-10-CM/PCS consists of two parts:
ICD-10- CM (Clinical Modification)

The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in all United States of America health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM).

ICD-10- PCS (Procedure Coding System)

The procedure classification system was developed by CMS for use in the U.S. for inpatient hospital settings **only**. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

ICD-10-CM/PCS

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services
  - Increased sensitivity when refining grouping and reimbursement methodologies
  - Enhanced ability to conduct public health surveillance, and
  - Decreased need to include supporting documentation with claims.
- Includes updated medical terminology and classification of diseases.
- Provides codes to allow comparison of mortality and morbidity data.
- Provides better data for:
  - Measuring care furnished to patients
  - Designing payment systems
  - Processing claims
  - Making clinical decisions
  - Tracking public health
  - Identifying fraud and abuse, and
  - Conducting research.

Structural differences between the two coding systems
1. Diagnoses codes

ICD-9-CM diagnoses codes are 3 – 5 digits in length with the first digit being alpha (E or V) or numeric and digits 2 - 5 being numeric. For example:

496	Chronic airway obstruction not elsewhere classified (NEC)
511.9	Unspecified pleural effusion, and
V02.61	Hepatitis B carrier.

ICD-10-CM diagnoses are 3 – 7 digits in length with the first digit being alpha, digits 2 and 3 being numeric and digits 4 – 7 are alpha or numeric. The alpha digits are not case sensitive. For example:

A66	Yaws
A69.21	Meningitis due to Lyme disease, and
S52.131a	Displaced fracture of neck of right radius, initial encounter for closed fracture.

2. Procedure codes

ICD-9-CM procedures are 3 – 4 digits in length and all digits are numeric. For example:

43.5	Partial gastrectomy with anastomosis to esophagus, and
44.42	Suture of duodenal ulcer site.

ICD-10-PCS procedures are 7 digits in length with each of the 7 digits being either alpha or numeric. The alpha digits are not case sensitive. Letters O and I are not used to avoid confusion with the numbers 0 and 1. For example:

0FB03ZX	Excision of Liver, Percutaneous Approach, Diagnostic, and
0DQ107Z	Repair, esophagus, upper, open with autograft.

Note that ICD-10-CM/PCS would not affect physicians, outpatient facilities, and hospital outpatient departments' usage of *Current Procedural Terminology* (*CPT*) codes on Medicare FFS claims as *CPT* use would continue.

The ICD-10-CM/PCS -- the next generation of coding (continued)

Additional information

The Centers for Medicare & Medicaid Services (CMS) has developed a dedicated webpage for ICD-10 information. That page is at *http://www.cms.hhs.gov/ICD10* on the CMS Web site.

Details on the ICD-10-PCS coding system, mappings, and a related training manual may be found at *http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp#TopOfPage* on the CMS Web site.

The ICD-10 notice of proposed rulemaking is available at *http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf* on the Internet.

Details on the ICD-10-CM coding system, mappings, and guidelines may be found at *http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm* on the Internet and also at *http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp#TopOfPage* on the CMS Web site.

Many private sector professional organizations and businesses have resources available that may help with ICD-10-CM/PCS implementation planning.

Please note that the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act (HIPAA) standard. The dedicated CMS ICD-10 page also has links to these resources in the *Related Links Outside of CMS* at the bottom of the page.

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Related Change Request (CR) #: N/A
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Implementation Date: N/A

Medicare publishes billing edits to reduce payment errors

The Centers for Medicare & Medicaid Services (CMS) recently announced that beginning October 1, 2008, it will publish most of the edits utilized in its medically unlikely edit (MUE) program to improve the accuracy of claims payments.

"It is always our aim to ensure that CMS pays for appropriate services, at the same time protecting the Medicare trust funds and the American taxpayer," said CMS Acting Administrator Kerry Weems. "This program is going to help us dramatically reduce costly payment errors."

CMS established the MUE program to reduce payment errors for Medicare Part B claims.

Claims processing contractors utilize these edits to assure that providers and suppliers do not report excessive services. The edits are applied during the electronic processing of all claims.

These edits check the number of times a service is reported by a provider or supplier for the same patient on the same date of service. Providers and suppliers report services on claims using HCPCS/*CPT* codes along with the number of times (i.e., units of service) that the service is provided.

Prior studies, including one by the U.S Department of Health and Human Services' Office of the Inspector General in May 2006, identified significant Medicare overpayments because provider or supplier claims sometimes report services with too many units of service. These errors may be caused by numerous factors, including clerical errors and coding errors.

CMS first implemented the MUE program January 1, 2007, with edits for about 2,600 HCPCS/*CPT* codes. There have been quarterly updates adding additional codes. The October 1, 2008, version of MUE will contain edits for about 9,700 HCPCS/*CPT* codes that have been assigned unit values for MUEs. MUEs are cumulative for each quarter. However, CMS did not publish all MUEs on October 1, 2008. CMS has not yet determined if there have been any savings in the MUE program since it was implemented.

The edits were developed by CMS with the cooperation and participation of national health care organizations representing physicians, hospitals, nonphysician practitioners, laboratories, and durable medical equipment suppliers. CMS also utilized claims data in its analysis of MUE.

The edits may be found on the CMS Web site at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage*.

At the start of each calendar quarter, CMS publishes most MUEs active for that quarter.

Although the October 1, 2008, publication contains most MUEs, additional ones will be published on January 1, 2009. CMS is not able to publish all active MUEs because some are primarily designed to detect and deter questionable payments, rather than billing errors.

Publishing those MUEs would diminish their effectiveness.

Source: PERL 200810-08

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Clarification of Medicare payment for routine costs in a clinical trial

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

Provider types affected

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

Provider action needed

This special edition article provides clarification regarding Medicare payment of routine costs associated with clinical trials. Be sure your billing staff is aware of this information.

Background

The Centers for Medicare & Medicaid Services (CMS) reminds providers that the policies for payment of the routine costs of the clinical trial are outlined in Chapter 16, Section 40 of the *Medicare Benefit Policy Manual*. The policy in the manual states:

> **40 No Legal Obligation to Pay for or Provide Services**
>
> Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free x-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

Key points of SE0822

There are three concerns addressed in this article regarding "Payment for Routine Costs in a Clinical Trial" and they are addressed in the following questions and answers:

Question: If a research sponsor says in writing that they will pay for routine costs if there is no reimbursement from any insurance company (including Medicare), does that fall into the "free of charge" category?

Answer: If the routine costs of the clinical trial are furnished gratuitously (i.e., without regard to the beneficiary's ability to pay and without expectation of payment from any other source), then Medicare payment cannot be made and the beneficiary cannot be charged. If private insurers deny the routine costs and the provider of services does not pursue the non-Medicare patients for payment after the denials (even though the non-Medicare patient has the ability to pay), Medicare payment cannot be made and the beneficiary cannot be charged for the routine costs.

Question: If the research sponsor pays for the routine costs provided to an indigent non-Medicare patient (the provider has determined that the patient is indigent due to a valid financial hardship) may Medicare payment be made for Medicare beneficiaries?

Answer: If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts. As noted at *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf*, "nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations or program instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance.

Thus, the provider of services should bill the beneficiary for co-payments and deductible, but may waive that payment for beneficiaries who have a valid financial hardship.

Question: May a research sponsor pay Medicare copays for beneficiaries in a clinical trial.

Answer: If a research sponsor offers to pay cost-sharing amounts owed by the beneficiary, this could be a fraud and abuse problem. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a federal health care program.

Clarification of Medicare payment for routine costs in a clinical trial (continued)

The citations include 42 U.S.C. 1320a-7(a)(i)(6); OIG Special Advisory Bulletin on Offering Gifts to Beneficiaries (*http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf*) and OIG Special Fraud Alert on Routine Waivers of Copayments and Deductibles (*http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html*).

Additional information

Chapter 16, Section 40 of the *Medicare Benefit Policy Manual* is available at *http://www.cms.hhs.gov/manuals/Downloads/bp102c16.pdf* on the CMS Web site.

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

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

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Implementation Date: N/A

ELECTRONIC DATA INTERCHANGE

Health care provider taxonomy code update effective October 1, 2008

Effective October 1, 2008, the Health care Provider Taxonomy Codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of the HPTC is available from the Washington Publishing Company Web site at *http://www.wpc-edi.com/codes/taxonomy*. If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level rejection may occur.

To ensure you do not receive a claim or file level rejection, it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system, please contact your software support vendor.

Source: Publication 100-04, transmittal 1614, change request 6190

Medicare Remit Easy Print update

New version of Medicare Remit Easy Print software is available

Version 2.5 of the Medicare Remit Easy Print (MREP) software is available for download at *http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp* on the CMS Web site. For a description of the changes in this version, see the What's New section (page 7) of the MREP User Guide – Version 2.5 at *http://www.cms.hhs.gov/AccesstoDataApplication/Downloads/EasyPrintUserGuide.pdf*.

Note: The latest *Codes.ini* file is now available. This file is necessary when the MREP software is distributed.

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

Source: PERL 200810-26

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GENERAL INFORMATION

Nonacceptance of legacy provider numbers on incoming Medicare claims

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

Provider types affected

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

Provider action needed

With the implementation of the national provider identifier (NPI) on May 23, 2008, Medicare ceased accepting legacy provider numbers, qualified by 1C and 1G within the secondary provider REF segments, on incoming Medicare American National Standards Institute (ANSI) X12N 837 4010A1 claims. Effective October 6, 2008, providers should note that, with one qualified exception, as highlighted below, Medicare will reject all incoming Medicare X12N 837 4010A1 claims that contain legacy identifiers. The following qualifiers within the secondary provider REF loops are acceptable:

- For 837 institutional claims, the employer identification number (EIN)/Federal tax ID, qualified by "EI" or "TJ," will be accepted, and
- For 837 professional claims, the provider's EIN/tax ID, qualified by "EI" or "TJ," or social security number, as qualified by "SY," will be accepted.

The secondary provider REF loops encompass all of the following loops within the HIPAA ANSI X12N 837 4010A1 institutional or professional format: 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2310E, 2330D, 2330E, 2330F, 2330G, 2330H, 2420A, 2420B, 2420C, 2420D, 2420E and 2420F.

Therefore, providers that bill Medicare should only be including the above referenced values within the indicated secondary provider REF loops as appropriate for the line of business submitted. In addition, providers should only use values qualified by "EI," "TJ," and "SY" when valid for the loop submitted.

Exception: Providers that bill Veterans Administration (VA) demonstration claims to TrailBlazer Health Enterprises, LLC, are permitted to include Medicare legacy provider numbers, qualified by 1C and 1G, within the secondary REF fields highlighted above. In addition, Medicare does not require NPI qualifiers and values within the NM108 and NM109 segments of the above referenced loops for incoming VA demonstration code claims (also known as the VA Medicare Remittance Advice [VA MRA] project claims).

Providers and suppliers that have questions regarding these loops and/or qualifiers should contact their software vendor for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the NPI as the primary provider identifier to be used on Medicare claims effective May 23, 2008. Through the systematic actions that CMS is implementing on October 6, 2008, CMS will ensure that its objective of not accepting legacy provider numbers will be realized.

Additional information

If you have any questions, please contact your intermediary, carrier, A/B MAC, or DME MAC at its toll-free number 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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Implementation Date: N/A

NPI registry update

The national provider identifier (NPI) registry option to search by Doing Business As (DBA) name has been temporarily removed from the NPI registry search page while CMS makes enhancements to the system. The DBA search option was expected to be available by Friday, October 10, 2008.

For more information

Providers may apply for an NPI online at *https://nppes.cms.hhs.gov* or may call the NPI enumerator to request a paper application at 1-800-465-3203.

Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information.

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

Source: CMS PERL 200809-41

NPPES -- keeping it safe and keeping it updated

This message is for health care providers, particularly physicians and other practitioners, who have obtained national provider identifiers (NPIs) and have records in the National Plan and Provider Enumeration System (NPPES). CMS recommends that each health care provider, including individual physicians, and nonphysician practitioners (NPPs) do all the following:

Know and maintain their NPPES user IDs and passwords

Reset their NPPES passwords at least once a year. See the *NPPES Application Help* page regarding the *Change Password* rules, located at *https://nppes.cms.hhs.gov/NPPES/Help.do?topic=ChangePassword*. Those rules indicate the length, format, content and requirements of NPPES passwords.

Review their NPPES records in order to ensure that the information reflects current and correct information.

Maintaining NPPES account information for safety and accessibility

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

Viewing NPPES information

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

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

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

2. By accessing the NPI Registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*. The NPI Registry gives the health care provider an online view of Freedom of Information Act (FOIA)-disclosable NPPES data. The health care provider can search for its information using the name or NPI as the criterion.

Updating NPPES information

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

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

Additional information

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

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

Source: PERL 200810-26

National provider identifier for secondary providers

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

Note: This article was revised on October 19, 2008, to reflect changes to change request (CR) 6093, which CMS revised on October 15, 2008, to include the Fiscal Intermediary Standard System (FISS) in the business requirements. The FISS implementation date was also added. The CR release date, transmittal number, and the Web address for accessing CR 6093 were also revised. All other information remains the same. This information was previously published in the September 2008 *Medicare B Update!* pages 47-48.

Provider types affected

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

Provider action needed

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

Background

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

National provider identifier for secondary providers (continued)

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

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

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

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

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

Key points of CR 6093

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

Additional information

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

For complete details regarding this Change Request (CR) please see the official instruction (CR6093) issued to your Medicare Carrier, DME MAC, MAC or FI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R270PI.pdf on the CMS Web site.

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

MLN Matters Number: MM6093 *Revised*
Related Change Request (CR) #: 6093
Related CR Release Date: October 15, 2008
Effective Date: May 23, 2008
Related CR Transmittal #: R270PI
Implementation Date: September 26, 2008
(FISS implementation date is November 3, 2008)

Incorporation of recent regulatory revisions into Chapter 10 of the Program Integrity Manual

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6178 which incorporates recent regulatory changes into the *Medicare Program Integrity Manual* (PIM), Chapter 10 (Healthcare Provider/Supplier Enrollment).

Background

The *Medicare PIM* (Chapter 10) specifies the resources and procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program.

CR 6178 revises Chapter 10 (Healthcare Provider/Supplier Enrollment) of the *Medicare PIM* and incorporates non-appeals related provisions contained in "Appeals of CMS or CMS Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges (CMS 6003-F)" which was published in the *Federal Register* on June 27, 2008. This CR instructs contractors to:

- Establish an enrollment bar for those providers and suppliers whose billing privileges are revoked. The enrollment bar will require that providers and suppliers whose billing privileges are revoked to wait from one to three years before reapplying to participate in the Medicare program.
- Require providers and supplier to receive payments by electronic funds transfer (EFT) when enrolling, making a change to their enrollment information, or during a revalidation process. In addition, providers or suppliers must continue to receive payment via EFT when Medicare contractor transition occurs and the provider or supplier was previously receiving payment via EFT.
- Allow Medicare contractors to reject an enrollment application when a provider or supplier fails to provide missing information/documentation within 30 days of a contractor's request for additional information (The previous standard was 60 days.).
- Establish a new revocation reason for services that could not be provided (e.g., physician billing for services within in the United States when the physician was living outside of the country.)

Additional information

The official instruction, CR 6178, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R269PI.pdf* on the CMS Web site. The revised Chapter 10 of the *PIM* is attached to CR 6178.

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

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

MLN Matters Number: MM6178
Related Change Request (CR) #: 6178
Related CR Release Date: September 19, 2008
Effective Date: October 20, 2008
Related CR Transmittal #: R269PI
Implementation Date: October 20, 2008

October flu shot reminder

Flu season is upon us. Begin now to take advantage of each office visit as an opportunity to encourage your patients to get a flu shot. It's still their best defense against combating the flu this season. Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies. And don't forget, health care personnel can spread the highly contagious flu virus to patients. Protect yourself and don't get the flu. Get your flu shot.

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, please go to *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf* on the CMS Web site.

Source: PERL 200810-03 & PERL 200810-13

ICD-10-CM/PCS national provider conference call for Part A and Part B providers

Medicare Part A providers (except hospitals) and Part B providers may now register for the Centers for Medicare & Medicaid Services ICD-10-CM/PCS national provider conference call that will be conducted on November 12, 2008, from 12:30 p.m.-2:30 p.m. EST.

To register for this call, go to *http://www.cms.hhs.gov/icd10/Downloads/ICD10_otherproviders.pdf*.

To find additional information about this conference call and to access the ICD-10 overview presentation that will be discussed during the call, go to *http://www.cms.hhs.gov/ICD10/07_Sponsored_Calls.asp*.

Source: PERL 200810-27

ICD-10-clinical modification/procedure coding system fact sheet

The ICD-10-Clinical Modification/Procedure Coding System Fact Sheet, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2008.pdf*.

Source: CMS PERL 200810-27

ICD-10-clinical modification/procedure coding system bookmark

The ICD-10 clinical modification/procedure coding system (CM/PCS) bookmark is now available from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*. This bookmark explains the ICD-10-CM and ICD-10-PSC, including the benefits of adopting the system, recommended steps to be taken in order to plan and prepare for implementation of the system, and where additional information about the system may be found.

To place your order, visit *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp*, scroll down to Related Links Inside CMS and select MLN Product Ordering Page. If you have problems accessing this hyperlink, please copy and paste the URL into your Internet browser.

Source: PERL 200810-19

Physician Quality Reporting Initiative self-serve look-up tool is now available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new self-service look-up tool is now available on the PQRI portal at *http://www.qualitynet.org/pqri*. This useful tool allows an eligible professional, at the tax identification number (TIN) level, to see if their report is available. Once on the site, go to the "Verify TIN Report Portlet," located at the bottom left of the page. Enter the TIN, and a message will appear indicating whether a report is or is not available.

This self-service look-up tool does not allow the eligible professional to view their report. The availability of the report is helpful for the eligible professional to know, because it enables them to decide whether they need to register for an Individuals Authorized Access to the CMS Computer Services (IACS) account, which would allow them to log into the PQRI portal and view their report. Additional information may be found in *MLN Matters* special edition articles SE0830 – Steps for Individual Eligible Professionals to Access Their 2007 Physician Quality Reporting Initiative (PQRI) Feedback Reports Personally (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf*) and SE0831 – Steps for Organizations to Access Their 2007 Physician Quality Reporting Initiative (PQRI) Feedback Reports (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf*).

In addition, the eligible professional can call the QualityNet Help Desk to determine whether a 2007 PQRI Feedback Report is available. The representatives at the QualityNet Help Desk can only inform the provider if a 2007 PQRI Feedback Report is available; they are unable to disclose the information in the 2007 PQRI Feedback Report. The QualityNet Help Desk may be reached via telephone at 1-866-288-8912 (from the hours of 7am-7pm CST) or via e-mail at mailto: *Qnetsupport@ifmc.sdps.org*.

Note: The TIN must be the one used by the eligible professional to submit Medicare claims and valid PQRI quality data codes for dates of service July 1–December 31, 2007.

Source: PERL 200810-02

CMS announces updates to the Physician Quality Reporting Initiative Web page

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce a new E-Prescribing Incentive Program section on the Physician Quality Reporting Initiative (PQRI) Web page at *http://www.cms.hhs.gov/pqri/03_EPrescribingIncentiveProgram.asp#TopOfPage* on the CMS Web site. This new section will provide information about the new e-prescribing incentive program that was authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Included on this page in the *Downloads* section is a fact sheet titled *Electronic Prescribing Incentive Fact Sheet* that describes the MIPPA provisions for the e-prescribing incentive program. Additional information about the e-prescribing incentive program and how to qualify for the e-prescribing incentive for the 2009 reporting year will be posted in early November.

Information is continually being added, so please visit the Physician Quality Reporting Initiative Web page at *https://www.cms.hhs.gov/PQRI* on the CMS Web site often.

Source: PERL 200810-25

Influenza pandemic emergency—the Medicare program prepares

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

Provider types affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], durable medical equipment Medicare administrative contractors [DME MACs], carriers or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Impact on providers

This article is informational only and is alerting providers that the Centers for Medicare & Medicaid Services (CMS) has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background

As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that **may** be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act.
2. The Secretary of the Department of Health and Human Services declares – under Section 319 of the Public Health Service Act – that a public health emergency exists.
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to Section 1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

Dedicated CMS Web page now available

Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at *http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp*.

That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional information

Additional CMS influenza pandemic policy documents include:

- CR 6164 may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R379OTN.pdf* on the CMS Web site.
- CR 6174, which may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R390OTN.pdf* on the CMS Web site.

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

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

MLN Matters Number: SE0836	Related Change Request (CR) Number: N/A
Related CR Release Date: N/A	Related CR Transmittal Number N/A
Effective Date: N/A	Implementation Date: N/A

Community pan-flu preparedness -- a checklist of key legal issues for providers

The Centers for Medicare & Medicaid Services (CMS) wants to alert providers to a valuable resource in the preparation for a potential pandemic influenza.

Community Pan-Flu Preparedness: A Checklist of Key Legal Issues for Healthcare Providers is a scalable tool designed to assist providers along the continuum of care, as well as the broader health care and public health communities, in taking concrete steps to prepare for a pandemic influenza. The Checklist was informed by a public interest dialogue session convened by the American Health Lawyers Association (AHLA), the Office of Inspector General of the U.S. Department of Health & Human Services, and the U.S. Centers for Disease Control and Prevention.

Participants from federal and state agencies, the provider and payer communities, academia, and other stakeholders discussed the role of the health care sector in community pan-flu preparedness. They also shared their best thinking regarding the challenges to pan-flu preparedness and practical solutions to such challenges. These ideas and recommendations were incorporated into the Checklist in order to make the resource as practical and relevant as possible.

CMS encourages hospitals and other health care providers to review the Checklist as they consider the legal impediments and implementation challenges to community pan-flu preparedness and practical solutions to such challenges.

This publication may be found at *http://www.healthlawyers.org/panfluchecklist*.

On October 22, 2008, AHLA also sponsored a teleconference entitled "The Sneeze Heard Round the World: Pandemic Influenza Preparedness Strategies to Adopt Now." The teleconference focused on the considerations unique to preparedness planning for pandemic influenzas, including protection of employees and maintaining operations, implementation of altered clinical pathways, and strategies for successful public health and provider coordination that need to be addressed at the present time to ensure an adequate level of preparedness. One of the country's leading experts, Dr. Michael T. Osterholm, and three experts in the emerging specialty of emergency preparedness law will discuss practical preparedness steps that health care entities, providers and payers can implement now. To learn more about the teleconference, go to *http://www.healthlawyers.org/Template.cfm?Section=Past_Teleconferences1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=13&ContentID=45270*.

Source: CMS PERL 200810-24

Influenza pandemic emergency -- policies concerning the Medicare program

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

Note: This article was rescinded on October 20, 2008. It was replaced by special edition article SE0836, which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0836.pdf* on the CMS Web site.

MLN Matters Number: MM6164 *Rescinded*
Related Change Request (CR) #: 6164
Related CR Release Date: September 26, 2008
Effective Date: October 27, 2008 (for preparedness)
Related CR Transmittal #: R379OTN
Implementation Date: October 27, 2008 (for preparedness)

CMS enhances program integrity efforts to fight Medicare fraud, waste and abuse

The Centers for Medicare & Medicaid Services (CMS) recently announced aggressive new steps to find and prevent waste, fraud and abuse in Medicare. CMS is working closer with beneficiaries and providers, consolidating its fraud detection efforts, strengthening its oversight of medical equipment suppliers, and home health agencies, and launching the national recovery audit contractor (RAC) program.

The new national RACs may be found at *http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf*.

For more information, visit the CMS RAC Web site at: *http://www.cms.hhs.gov/RAC/*.

You may also access either the CMS Press Release or RAC fact sheet, both of which are also available at *http://www.cms.hhs.gov/RAC/* in the Related Links Inside CMS section.

Source: PERL 200810-20

Hospital outpatient department payment data for value-driven health care updated

To support the delivery of high-quality, efficient health care and enable consumers to make more informed health care decisions, President Bush directed the U.S. Department of Health & Human Services to make cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2006 and 2007 about the payments it made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

Earlier this year, Medicare updated the hospital information and moved it to the Hospital Compare Web site where it may be viewed along with hospital quality information. The Hospital Compare Web site may be found at www.medicare.gov.

On October 17, 2008, Medicare posted an update to the hospital outpatient department data. ASC and physician payment data were updated earlier this year. The information is being displayed in the same format as in previous years, updated with calendar year (CY) 2007 data. The posting updates may be found at *http://www.cms.hhs.gov/HealthCareConInit/*.

Source: PERL 200810-26

Notice of interest rate for Medicare overpayments and underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the current value of funds rate (five percent for calendar year 2008) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health & Human Services that the PCR has been changed to 11.375 percent, effective October 22, 2008. The PCR will remain in effect until a new rate change is published. The following table lists previous interest rates.

Period	Interest Rate
July 24, 2008 – October 21, 2008	11.125%
April 18, 2008 – July 23, 2008	11.375%
January 18, 2008 – April 17, 2008	12.125%
October 19, 2007 – January 17, 2008	12.5%
July 20, 2007 – October 18, 2007	12.625%
April 20, 2007 – July 19, 2007	12.375%

Source: CMS Pub. 100-06, Transmittal 142, CR 6238

CMS issues new resources on ESRD conditions for coverage

Frequently asked questions

Thank you to all providers in the renal care community who submitted questions to the Centers for Medicare & Medicaid Services (CMS) about the recently released end-stage renal disease (ESRD) conditions for coverage final rule. In response to these inquiries, CMS has already provided many providers with individual responses to your questions; however, to share the benefit of these questions with the entire community, CMS has developed a "Frequently Asked Questions" (FAQ) document that condenses many of the questions received from providers. The FAQs are available online at *http://www.cms.hhs.gov/center/esrd.asp* on the CMS Web site. To view them, go to *http://www.cms.hhs.gov/CFCsAndCoPs/downloads/FAQsESRDRolloutFINAL082808.pdf*.

Crosswalk: Former conditions versus revised conditions

As another tool to help you understand the new conditions for coverage, CMS has developed a crosswalk that compares the former conditions to the final revised conditions, which were issued in the *Federal Register* on April 15, 2008. The crosswalk will help you navigate the new organization structure of the condition as well as some revised provisions of the conditions themselves. To access the crosswalk, go to *http://www.cms.hhs.gov/CFCsAndCoPs/downloads/ESRDConditionsCrosswalkFINAL080408.pdf*.

We hope you find these tools helpful as you work to implement the revised conditions. For more information, please visit the CMS Web site at *http://www.cms.hhs.gov/CFCsAndCoPs/13_ESRD.asp*.

Source: PERL 200810-12

Medicare solicits nominees for advisory panel

The Centers for Medicare & Medicaid Services (CMS) is soliciting nominations for individuals to serve on the Program Advisory and Oversight Committee (PAOC) that advises CMS on various issues relating to the competitive bidding program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

The PAOC was initially established in 2004, as required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), to advise CMS on the design and implementation of a competitive bidding program for DMEPOS that would build on the successes of two pilot projects that had shown that competitive bidding could reduce prices of DMEPOS, without adversely affecting beneficiary access or compromising quality.

Because the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) delayed implementation of and made certain changes to the competitive bidding program, and extended the PAOC for two years through December 31, 2011, CMS is ending the term of service for current PAOC members.

The PAOC will be comprised of 10 and 12 members from the following broad categories:

- Beneficiary/consumer representatives
- Physicians and other practitioners
- Suppliers
- Professional standards organizations
- Financial standards specialists (that is, economist/certified public accountant)
- Association representatives

CMS may consider nominees for additional categories if it finds that their expertise will help to ensure the successful implementation of the program nominations are due to CMS by November 3, 2008. For more information, please see the CMS Web site at: *http://www.cms.hhs.gov/center/dme.asp*.

To read the CMS press release issued on October 1, 2008, click here *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200810-07

CMS provides guidance on DMEPOS accreditation for pharmacy suppliers

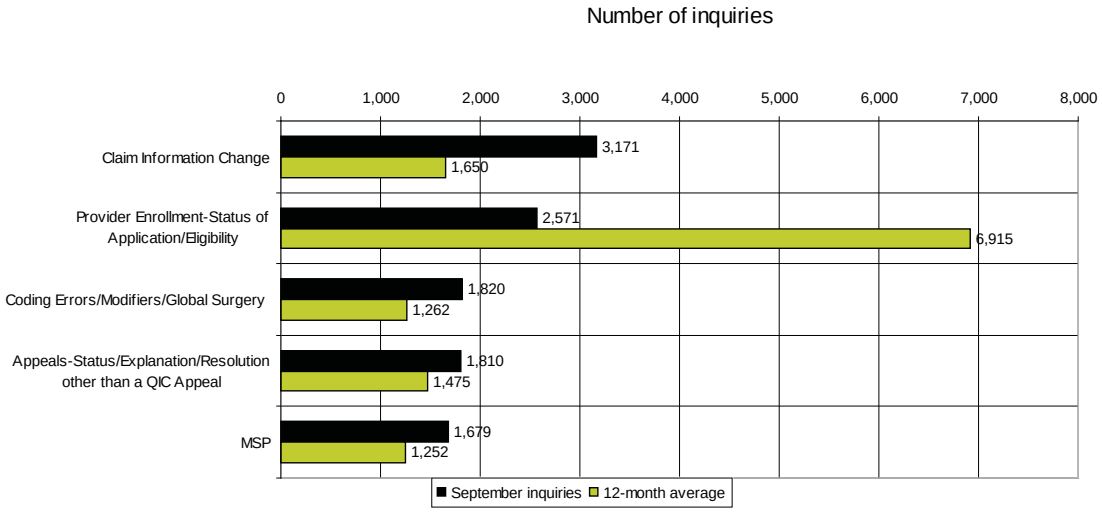
On September 3, 2008, the Centers for Medicare & Medicaid Services (CMS) announced a list of providers that were exempt from meeting the quality standards for durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) accreditation. CMS would like to clarify that pharmacists and pharmacies were not included in this provider exemption; therefore, they do need to obtain accreditation. For example, if a pharmacy is providing DMEPOS supplies to Medicare beneficiaries, such as diabetic supplies and enteral/parenteral nutrition, they would need to be accredited by the September 30, 2009 deadline. For more information about DMEPOS accreditation, please visit the Web page at *http://www.cms.hhs.gov/medicareprovidersupenroll/*.

Source: PERL 200810-10

Top inquiries for September 2008

This chart demonstrates how September's inquiries compare to the preceding 12 months. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our Web site at *http://www.floridamedicare.com/Reference/Inquiries_and_Denials/index.asp*.

The five inquiry topics received most frequently by the Part B provider contact center during September 2008 are:



FRAUD AND ABUSE

CMS enhances program integrity efforts to fight fraud, waste and abuse in Medicare

The Centers for Medicare & Medicaid Services (CMS) today announced aggressive new steps to find and prevent waste, fraud and abuse in Medicare. CMS is working closer with beneficiaries and providers; consolidating its fraud detection efforts; strengthening its oversight of medical equipment suppliers and home health agencies; and launching the national recovery audit contractor (RAC) program.

"Because Medicare pays for medical services and items without looking behind every claim, the potential for waste, fraud and abuse is high," said CMS Acting Administrator Kerry Weems. "By enhancing our oversight efforts we can better ensure that Medicare dollars are being used to pay for equipment or services that beneficiaries actually received while protecting them and the Medicare trust fund from unscrupulous providers and suppliers."

As part of these enhanced efforts, CMS is consolidating its efforts with new program integrity contractors that will look at billing trends and patterns across Medicare. They will focus on companies and individuals whose billings for Medicare services are higher than the majority of providers and suppliers in the community. CMS is also shifting its traditional approach to fighting fraud by working directly with beneficiaries by ensuring they received the durable medical equipment or home health services for which Medicare was billed and that the items or services were medically necessary.

Furthermore, CMS will be taking additional steps to fight fraud and abuse in home health agencies in Florida and suppliers of durable medical equipment, prosthetics and orthotics (DMEPOS) in Florida, California, Texas, Illinois, Michigan, North Carolina and New York. Those additional steps include:

- Conducting more stringent reviews of new DMEPOS suppliers' applications including background checks to ensure that a principal, owner or managing owner has not been suspended by Medicare.
- Making unannounced site visits to double check that suppliers and home health agencies are actually in business.
- Implementing extensive pre- and post-payment review of claims submitted by suppliers, home health agencies and ordering or referring physicians.
- Validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians.
- Verifying the relationship between physicians who order a large volume of DMEPOS equipment or supplies or home health visits and the beneficiaries for whom they ordered these services.
- Identifying and visiting high risk beneficiaries to ensure they are appropriately receiving the items and services for which Medicare is being billed.

The additional reviews that will be focused on DMEPOS equipment and supplies with high expenditures and high growth rates expect to identify items such as oxygen supplies and equipment, power mobility devices or power wheelchairs, and diabetic test strips.

For those claims not reviewed before payment is made, CMS is implementing further medical review of submitted DMEPOS claims by one of the new RACs. The RACs review paid claims for all Medicare Part A and B providers to ensure their claims meet Medicare statutory, regulatory and policy requirements and regulations. If the RACs find that any Medicare claim was paid improperly it will then request repayment from the provider if an overpayment was found or request that the provider is repaid if the claim was underpaid. The new national RACs can be found at www.cms.hhs.gov/RAC.

The new RACs were selected under a full and open competition and will begin to educate and inform providers later in October and November about the program. The RACs will be paid on a contingency fee basis on both the overpayments and underpayments they find. The selection of these new contractors was based on a best value determination that included a sound technical approach for the level and quality of claim analysis and detail to exceptional customer service, conflict of interest reviews and lowest contingency fee. The three-year RAC demonstration program in California, Florida, New York, Massachusetts, South Carolina and Arizona collected over $900 million in overpayments and nearly $38 million in underpayments returned to health care providers.

Finally, CMS is consolidating the work of Medicare's program safeguard contractors (PSCs), and the Medicare drug integrity contractors (MEDICs) with new zone program integrity contractors (ZPICs). The new contractors will eventually be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi). The first two ZPIC contracts were awarded to Health Integrity, LLC for Zone 4 which encompasses Texas, New Mexico, Colorado and Oklahoma and SafeGuard Services LLC for Zone 7 which encompasses Florida, Puerto Rico and US Virgin Islands.

"We are continuing to build on our fraud fighting and program integrity efforts by identifying high risk areas and trends to better focus our limited funds and resources," said Weems.

CMS enhances program integrity efforts to fight fraud, waste and abuse in Medicare (continued)

Medicare is required by law to pay claims to health care providers for services provided to beneficiaries within 30 days after the claim is submitted, as long as the claim meets Medicare's rules. After the claim is paid, CMS or its contractors can review the claim to ensure that the items or services were actually provided or the services were medically necessary. If the claim was not submitted under Medicare's rules, CMS checks to see if the claim was submitted in error or may be potentially fraudulent. Those claims that could be fraudulent are referred to law enforcement for further investigation.
For more information about CMS RAC Web site, please visit
http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf.

To read the CMS Press release issued on October 6, 2008, access this link
http://www.cms.hhs.gov/apps/media/press_releases.asp.

Source: CMS Press Release, October 6, 2008

OIG publishes voluntary supplemental compliance program guidance for nursing facilities

New voluntary guidance will help nursing facilities develop compliance programs that address major Medicare and Medicaid fraud and abuse problems related to poor quality of care, billing Federal health care programs, and kickbacks. The Office of Inspector General (OIG) of the U.S. Department of Health & Human Services announces that the supplemental compliance program guidance (CPG) for nursing facilities appears in the September 30 *Federal Register*.

The new CPG responds to developments in the nursing facility industry, including significant changes in the way nursing facilities deliver and receive reimbursement for health care services, evolving business practices, and changes in the federal enforcement environment.

"The new guidance reflects OIG's increased focus on quality of care for nursing home residents, as well as our long-standing commitment to safeguarding Medicare and Medicaid program funds and beneficiaries through fraud and abuse prevention efforts," said Inspector General Daniel R. Levinson. "The guidance should serve as a valuable resource for the long term care industry."

Since 1998, OIG has issued a series of CPGs directed at various health care industry sectors. Each provides comprehensive guidance to promote compliance with Medicare and other federal health care program rules and regulations. OIG originally published a CPG for nursing facilities in 2000. The new CPG reflects input from public comments received on a draft document published in the *Federal Register* in April 2008 and provides a roadmap for developing, implementing, and evaluating nursing facility compliance programs.

According to the new CPG, "A successful compliance program addresses the public and private sectors' common goals of reducing fraud and abuse, enhancing health care providers' operations, improving quality of health care services, and reducing their overall cost. Meeting these goals benefits the nursing facility industry, the Government, and residents alike."

A significant goal of the new CPG is fostering quality of care in nursing facilities. The new CPG will help compliance professionals address areas such as staffing, resident care plans, medication management, appropriate use of psychotropic medications, and resident safety. The new CPG emphasizes the importance of submitting accurate claims and discusses issues related to reporting resident case-mix data, therapy services, screening for excluded individuals and entities, and restorative and personal care services. The guidance also urges nursing facilities to consider the risks of improper kickback payments associated with their business arrangements including those involving free goods and services, as well as those with physicians and suppliers.

The guidance, "OIG Supplemental Compliance Program Guidance for Nursing Facilities," appears in the *Federal Register* on September 30, 2008. It is also available on the OIG Web site at
http://oig.hhs.gov/fraud/docs/complianceguidance/nhg_fr.pdf.

Source: OIG News, September 30, 2008

LOCAL COVERAGE DETERMINATIONS

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), carriers no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text LCDs on our provider education Web sites, *http://www.fcso.com*. Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part B Medical Policy section.

Effective and Notice Dates

Effective dates are provided in each LCD, and are based on the date of service (unless otherwise noted in the LCD). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the Web site is considered the notice date.

Electronic Notification

To receive quick, automatic notification when new LCDs are posted to the Web site, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our Web site *http://www.fcso.com*, select Florida Providers, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the prompts.

More Information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Local Coverage Determinations—Table of Contents

Advance Beneficiary Notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

REVISIONS TO THE LCDS

J0881: Erythropoiesis stimulating agents – revision to the LCD

LCD ID: L5984

The local coverage determination (LCD) for erythropoiesis stimulating agents (ESAs) was last revised on October 1, 2008. Since that time, the LCD has been revised. A request was received to clarify the language surrounding the dosage and administration of ESAs as it relates to chronic kidney disease (CKD) and to include the entire black box warning found on the product labeling for epoetin alfa and darbepoetin alfa, so the warnings for CKD and cancer indications are better defined. As a result of this request, the LCD has been revised to include the entire black box warning for ESAs, which clearly define the CKD warnings from the cancer warnings. In addition, the language surrounding the dosage and administration for CKD for ESAs was revised to read per the current approved Food and Drug Administration label. This revision to the LCD is effective for services rendered on or after October 7, 2008

To better identify the dual diagnosis requirements for each HCPCS code in the LCD, the notations found under each list of ICD-9-CM codes have been moved to the top of each list of ICD-9-CM codes. The asterisks have been removed from diagnoses 285.21, 285.29 and 285.9 to lessen the confusion over which diagnosis codes require a dual diagnosis. As previously published, every claim submitted with HCPCS codes J0881, J0882, J0885 or J0886 require dual diagnoses. These notations at the top of the ICD-9-CM code lists group the appropriate anemia codes with the appropriate covered indication.

Effective Date

This revision to the LCD is effective for services rendered on or after April 7, 2008.

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

SKINSUB: Skin Substitutes - revision to the LCD

LCD ID: L13832

The local coverage determination (LCD) for skin substitutes was last updated on January 1, 2007. Since that time, a reconsideration request was evaluated and the following revisions were made to the LCD:

- Under the *Indications and Limitations of Coverage and/or Medical Necessity* section of the LCD for Apligraf®, removed the statement "The safe and effective use of Apligraf® has not been determined when used for treating diabetic foot ulcers that are less than 0.4cm² or greater than 16.0cm²."
- Added *Dermal Regeneration Template (DRT)* to the product description of Integra® throughout the LCD where indicated.
- Under the *ICD-9 Codes that Support Medical Necessity* section of the LCD, the following diagnosis codes were added: For Apligraf® (J7340) and Oasis® Wound Matrix (J7341), ICD-9-CM codes 707.10, 707.11, 707.19, and 707.8 were added to the LCD. For Xenograft (J7343), ICD-9-CM codes 707.11, 707.19, and 707.8 were added to the LCD.
- In addition, the *Sources of Information and Basis for Decision* section was updated.

Effective Date

This revision to the LCD is effective for services rendered on or after October 17, 2008. First Coast Service Option, Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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.

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

LCD ID: L13835

The local coverage determination (LCD) for ibritumomab tiuxetan (Zevalin™) therapy was last revised on October 1, 2007. Since that time, the LCD has been revised based on a reconsideration request. The list of *CPT*/HCPCS codes that support medical necessity has been revised to now include *CPT* code *78802* (Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agents(s); whole body, single day imaging). Following the injection of In-111, a scan is performed to assess bio-distribution. This only requires one day of imaging, and can be done over two or more days. The LCD will now allow for the one day of imaging or two or more days of imaging.

Effective Date

This revision to the LCD is effective for services rendered on or after October 7, 2008. First Coast Service Option, Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

ADDITIONAL INFORMATION

Billing laboratory tests for dialysis patients

An article was published in the March 2008 *Medicare B Update!* (page 45) regarding the billing of laboratory tests for dialysis patients. In the second paragraph of the article, First Coast Service Options Inc (FCSO) mistakenly indicated that laboratory tests exceeding established frequencies required dual diagnoses. FCSO is not requiring dual diagnoses. However, in order for the laboratory service to be allowed, claims must include a diagnosis code (ICD-9-CM) other than 585.6 (end-stage renal disease). The code should represent the nature of the illness or injury requiring the additional test(s).

Clarification of coverage for cardiac catheterization performed in an IDTF

Effective for services rendered on or after January 12, 2006, the Centers for Medicare & Medicaid Services (CMS) repealed Section 20.25, titled *Cardiac Catheterization in Other than a Hospital Setting* of Publication 100-03 (*Medicare National Coverage Determinations [NCD]* Manual). Therefore, determinations of coverage for cardiac catheterization when performed outside the hospital setting are at the discretion of the local Medicare carrier.

Effective Date

The local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was effective for services rendered on or after February 29, 2008. This LCD did not include the procedure codes for cardiac catheterization. However, First Coast Service Options Inc. (FCSO) will continue to provide coverage for medically reasonable and necessary cardiac catheterizations performed in an IDTF place of service, for facilities that were approved based on equipment and personnel requirements and were performing these services on or before November 1, 2006. Additional information will be provided in future revisions to the LCD.

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

Final/active LCD list sorted by FCSO LCD number pages retired

The "Final/active LCD list sorted by FCSO LCD number" articles previously located on the Part B local coverage determination (LCD) page on the *floridamedicare.com* Web site was retired effective September 15, 2008. This document was replaced with links to pre-defined searches of the Medicare coverage database (MCD) on the Centers for Medicare & Medicaid Services (CMS) Web site.

For First Coast Service Options Inc. (FCSO) final/active Part B LCDs, from the *floridamedicare.com* site, select the Part B tab; from the *Local Medical Coverage* section, select "Final LCDs," and choose the link entitled "Final/Active LCD List sorted by LCD Title." Or, go directly to the CMS Web site at *http://www.cms.hhs.gov/mcd/results_index.asp?from2=results_index.asp&contractor=11&from='lmrpcontractor'&retired=&name=First%20Coast%20Service%20Options,%20Inc.%20(00590,%20Carrier)&letter_range=4&*.

A how-to guide for effectively locating LCDs on the CMS site, including other features available in the MCD, may also be found on the Part B Final LCDs Web page as well as the *Help* section at the top right of each page on the *floridamedicare.com* site.

EDUCATIONAL RESOURCES

Upcoming provider outreach and education events
November 2008

Hot Topics: Medicare updates
Medicare updates, medical policies, and what you need to know to avoid denials and return as unprocessable claims
When: November 13, 2008
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Evaluation and Management (E/M) webcast
Topic: Emergency Department Servicesl
When: November 25, 2008
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Two easy ways To register

Online – Simply log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event. **First Time user?** Please set up an account using the instructions located at *www.floridamedicare.com/Education/108651.asp* in order to register for a class and obtain materials.

Fax – Providers without Internet access can leave a message on our Registration Hotline at 904-791-8103 requesting a fax registration form. Class materials will be faxed to you the day of the event.

Tips for using the FCSO provider training Web site

The best way to search and register for Florida events on *www.fcsomedicaretraining.com* is by clicking on the following links in this order:

- "Course Catalog" from top navigation bar
- "Catalog" in the middle of the page
- "Browse Catalog" on the right of the search box
- "FL – Part B or FL – Part A" from list in the middle of the page.

Select the specific session you're interested in, click the "Preview Schedule" button at the bottom of the page. On the Instructor-Led Training (ILT) Schedule page, locate the line that has the course you are interested in and click the "Register" link in the Options column.

If you need assistance, please contact our FCSO Medicare training help desk by calling 1-866-756-9160 or sending an e-mail to *fcsohelp@geolearning.com*.

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to 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.fcso.com* , or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

Mail directory

Claims Submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of information act
Freedom of information act requests
Post office box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

EMC claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request:
Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education
For educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
For processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

For refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options, Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007
Interactive Voice Response (IVR):
1-877-847-4992
E-mail Address: *AskFloridaB@fcso.com*
FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

For Education Event Registration (not toll-free):
1-904-791-8103

EMC
Format issues & testing:
1-904-354-5977 option 4

Start-up & front-end edits/rejects:
1-904-791-8767 option 1

Electronic funds transfer
1-904-791-8016

Electronic remittance advice, electronic claim status, & electronic eligibility:
1-904-791-6895

PC-ACE support:
1-904-355-0313

Marketing:
1-904-791-8767 option 1

New installations:
(new electronic senders; change of address or phone number for senders):
1-904-791-8608

Help desk:
(confirmation/transmission):
1-904-905-8880 option 1

DME, orthotic or prosthetic claims
Cigna Government Services
1-866-270-4909

Medicare Part A
Toll-Free:
1-866-270-4909

Medicare Web sites

Provider
Florida Medicare contractor
www.floridamedicare.com

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

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

Order Form -- 2009 Part B Materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO with the designated account number indicated below.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	**Account Number**	**Cost per Item**	Quantity	Total
***Medicare B Update!* Subscription** – The *Medicare B Update!* is available free of charge online at *http://www.fcso.com*. Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2008 through September 2009.	40300260	Hardcopy $33.00		
		CD-ROM $55.00		
2009 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2009, through December 31, 2009, is available free of charge online at *http://www.fcso.com*. Additional copies or a CD-ROM is available for purchase. The fee schedule contains calendar year 2009 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note also that revisions to fees may occur; these revisions will be published in future editions of the *Medicare Part B Update!* Nonprovider entities or providers who need additional copies at other office locations may purchase additional copies.	40300270	Hardcopy: $12.00		
		CD-ROM: $6.00		
Please write legibly			Subtotal	$
			Tax (**add % for your area**)	
			Total	

Mail this form with payment to:

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

Contact Name:_____

Provider/Office Name:_____

Phone: _____

Mailing Address:_____

City:_____State: _____ZIP:_____

Please make check/money order payable to: FCSO Account # (fill in from above)
(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦