MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

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FIRST COAST SERVICE OPTIONS, INC.

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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:*

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

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## Medicare B Update!

**Vol. 6, No. 12**
**December 2008**

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

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



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# THE FCSO MEDICARE B UPDATE!

## About the FCSO *Medicare B Update!*

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

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

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education Web site, *http://www.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

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

# CLAIMS

## Health professional shortage area bonus payment policy changes

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

### Provider types affected

Physicians and providers submitting claims to Medicare carriers, Medicare administrative contractors (A/B MACs), and/or fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in areas designated as geographic HPSAs.

### Provider action needed

This article is based on change request (CR) 6106 and informs providers who are serving Medicare beneficiaries in areas that were eligible on December 31 of the prior year for the health professional shortage area (HPSA) bonus but not on the automated ZIP code list to use the modifier AQ to receive the HPSA bonus payment. Make sure billing staff are aware of the clarified criteria for proper use of the modifier AQ.

### Background

The Section 1833(m) of the Social Security Act provides for an additional ten percent bonus payment for physicians' services furnished to a covered individual in an area that is designated as a geographic HPSA prior to the beginning of the year in which the services were provided. Such HPSA areas are identified by the Secretary of the Department of Health and Human Services prior to the beginning of such year. The Centers for Medicare & Medicaid Services (CMS) posts a file annually of ZIP codes within which the HPSA bonus payment should be made automatically. Physicians furnishing services in areas that were eligible for the HPSA bonus prior to the beginning of the year but not on the automated list have been instructed to use the modifier AQ to receive the HPSA bonus payment.

### Key points

- Effective for claims with dates of service on or after January 1, 2009, only services furnished in areas that are designated as geographic HPSAs as of December 31 of the prior year are eligible for the HPSA bonus payment.
- Services furnished in areas that are designated at any time during the current year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31.
- If you are providing services to Medicare beneficiaries in areas that are designated on December 31 of the prior year but not included on the list of ZIP codes eligible for automated HPSA bonus payments make certain you use the modifier AQ to receive the HPSA bonus payment.
- Remember, your Medicare contractor will automatically make a HPSA bonus payment to physicians providing eligible services in a ZIP code included in the annual file.

### Additional information

If you have 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.

For complete details regarding this change request (CR) please see the official instruction (CR 6106) issued to your Medicare A/B MAC, carrier or FI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1639CP.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: MM6106
Related Change Request (CR) #: 6106
Related CR Release Date: November 21, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1639CP
Implementation Date: January 5, 2009

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# Quarterly update to Correct Coding Initiative edits

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

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 6290, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits.

## Background

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

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

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

The latest package of CCI edits, version 15.0, is effective January 1, 2009, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

Version 15.0 will be available via the CMS Data Center, and a test file will be available on or about November 2, 2008. The final file will be available on or about November 17, 2008.

## Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site. The official instruction (CR 6290) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1658CP.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: MM6290
Related Change Request (CR) #:6290
Related CR Release Date: December 31, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1658CP
Implementation Date: January 5, 2009

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# AMBULANCE

## Payment rate increase for covered ground 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 Medicare administrative contractors [MACs]) for ambulance services provided to Medicare beneficiaries.

### What you need to know

Change request (CR) 6206, from which this article is taken announces an increase in payment for ground ambulance transports. Effective July 1, 2008, through December 31, 2009, the ambulance fee schedule amounts for covered ground ambulance transports which originate in rural areas are increased by three percent, and for covered ground ambulance transports which originate non-rural areas, they are increased by two percent. You should ensure that your billing staffs are aware of these ambulance fee schedule increases.

### Background

Section 146(a) of Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) amends Section 1834(1)(13) of the Social Security Act to provide an increase in payment for ground transports, effective for claims with dates of service on or after July 1, 2008, and before January 1, 2010. It increases the ambulance fee schedule amounts for:

- Covered ground ambulance transports which originate in a rural area by three percent; and
- Covered ground ambulance transports which originate in a non-rural area by two percent.

Until the new fee schedule files have been tested and implemented, your carrier, FI, MAC will hold all of your ground ambulance claims affected by these changes and release them for processing when the files are implemented.

They will also identify ambulance claims (with dates of service on or after July 1, 2008) that were not paid at the rates that CR 6206 provides; and (to the extent possible) automatically reprocess them within 30 days of the release date of CR 6206. In addition, they will adjust claims that cannot be automatically identified and adjusted, if you bring such claims to their attention. Finally, you should be aware that your carrier, FI, or MAC will follow their normal processes for transmitting the adjusted claims to supplemental insurers, where appropriate.

### Additional information

The official instruction, CR 6206, issued to your carrier, FI, or MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R414OTN.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

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

MLN Matters number: MM6206
Related change request (CR) #: 6206
Related CR release date: December 12, 2008
Effective date: July 1, 2008
Related CR transmittal #: R414OTN
Implementation date: January 12, 2009

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# DURABLE MEDICAL EQUIPMENT

## 2008 jurisdiction list for DMEPOS HCPCS codes

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

**Note:** This article was revised on December 8, 2008, to reflect that change request (CR) 6062 was revised by the Centers for Medicare & Medicaid Services on December 5, 2008. CR 6062 was revised to reflect a revised 2008 jurisdiction list to clarify that HCPCS code A4559 (coupling gel) may only be billed to the local carrier. The CR release date, transmittal number, and Web address for accessing CR 6062 were also revised. All other information remains the same. The complete jurisdiction list may be found in the October 2008 *Medicare B Update!* (page 15) and at the end of CR 6062 (link provided in the *Additional* information section of this article.

### 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 DMEPOS services provided to Medicare beneficiaries.

### Impact on providers

This article is informational and is based on CR 6062 that notifies providers that the spreadsheet containing an updated list of the 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/R1644CP.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/R1644CP.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 *Revised*
Related CR #: 6062
Related CR Release Date: December 5, 2008
Effective Date: October 27, 2008, except December 12, 2008 for HCPCS code A4559
Related CR Transmittal #: R1644CP
Implementation Date: October 27, 2008, except December 12, 2008 for HCPCS code A4559

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# LABORATORY/PATHOLOGY

## Changes to the laboratory national coverage determination edit software

*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) 6304 which announces the changes that will be included in the January 2009 release of the edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in October 2008.

### 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.

***Changes to the laboratory national coverage determination edit software (continued)***

In accordance with the *Medicare Claims Processing Manual*, 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 6304 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for January 2009 as described below. These changes become effective for services furnished on or after January 1, 2009, and are as follows:

**For HIV testing**

Add ICD-9-CM code 482.42 to the list of ICD-9-CM codes covered by Medicare for the HIV testing (Diagnosis) (190.14) NCD.

**For partial thromboplastin time (PTT)**

Add ICD-9-CM code range 249.40-249.41 to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT (190.16) NCD.

**For prothrombin time (PT)**

- Add ICD-9-CM code range 249.40-249.41 and the ICD-9-CM codes 197.7, V15.21, V15.22, and V15.29 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Delete ICD-9-CM code V15.2 from the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.

**For serum iron studies**

Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91, 285.22, 285.29, V15.21, V15.22, and V15.29 to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.

**For blood glucose testing**

Add ICD-9-CM code 482.42 and the code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD.

**For glycated hemoglobin/glycated protein**

Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.

**For thyroid testing**

Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the thyroid testing (190.22) NCD.

**For lipid testing**

Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD.

**For gamma glutamyl transferase**

Add ICD-9-CM code 275.2 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

**For fecal occult blood test (FOBT)**

- Add ICD-9-CM codes 530.86 and 530.87 to the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (FOBT) (190.34 ) NCD.
- For All 23 NCDs (190.12-190.34):
- Add ICD-9-CM codes V16.52 and V73.81 to the list of denied ICD-9-CM codes for all 23 Lab NCDs.

## Additional information

The official instruction, CR 6304, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1645CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM6304
Related Change Request (CR) #: 6304
Related CR Release Date: December 9, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1645CP
Implementation Date: January 5, 2009

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# New waived tests

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

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 6287 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has listed the latest tests approved by the Food and Drug Administration as waived tests under Clinical Laboratory Improvement Amendments of 1988 (CLIA). The tests newly added to the waived tests are in the table under *Key points of CR 6287*. Be sure your billing staffs are aware of these changes.

## Background

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level. CMS identifies CLIA waived tests by providing an updated list of waived tests to the Medicare contractors on a quarterly basis via a recurring update notification. To be recognized as a waived test, some CLIA waived tests have unique HCPCS procedure codes and some must have a modifier QW included with the HCPCS code.

For a list of specific HCPCS codes subject to CLIA, see *http://www.cms.hhs.gov/CLIA/downloads/waivetbl.pdf* on the CMS Web site.

## Key points of CR 6287

- Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The *Current Procedural Terminology* (*CPT*) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page at *http://www.cms.hhs.gov/CLIA/downloads/waivetbl.pdf* (i.e., *CPT* codes: *81002*, *81025*, *82270*, *82272*, G0394, *82962*, *83026*, *84830*, *85013*, and *85651*) do not require a modifier QW to be recognized as a waived test.

| *CPT* Code | Effective Date | Description |
|---|---|---|
| *83036QW* | October 11, 2007 | Siemens Medical Diagnostics DCA vantage analyzer |
| *81003QW* | May 28, 2008 | Henry Schein onestepplus urine analyzer |
| *82274QW* G0328QW | July 1, 2008 | Germaine Laboratories compliance gold iFOB (immunological fecal occult blood) test |
| *82274QW* G0328QW | July 1, 2008 | Beckman Coulter hemoccult ICT (K080812) |
| *82274QW* G0328QW | July 22, 2008 | BTNX Inc. rapid response immunolgical fecal occult blood test (IFOBT) |
| *80101QW* | July 31, 2008 | Aventir Biotech LLC home check multiple drug cup test |
| *80101QW* | August 18, 2008 | American Bio medica rapid TOX |
| *83986QW* | September 18, 2008 | Common Sense Ltd. VA-SENSE kit |

- For 2009, the new *CPT* code *87905* was developed for infectious agent enzymatic activity other than virus (e.g., sialidase activity in vaginal fluid) testing. Therefore, the *CPT* code assigned to the Gryphus Diagnostics BVBlue test and the Genzyme Diagnostics OSOM BVBlue Test is changed to *87905QW* with an effective date of January 1, 2009.
- Providers please note that your contractor will not search their files to either retract payment or retroactively pay claims processed before CR 6287 is implemented. However, they will adjust such claims if you bring them to your contractor's attention.

## Additional information

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

The official instruction (CR 6287) issued to your Medicare A/B MAC, or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1652CP.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: MM6287
Related change request (CR) #: 6287
Related CR release date: December 19, 2008
Effective date: January 1, 2009
Related CR transmittal #: R1652CP
Implementation date: January 5, 2009

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# SURGERY

## Medicare proposes revised coverage policy for bariatric surgery

**The Center for Medicare & Medicaid Services (CMS) seeks comments from public on proposal to limit coverage to morbidly obese patients**

CMS announced a proposal to clarify its policies for Medicare coverage of bariatric surgery as a treatment for beneficiaries with type 2 (or non-insulin-dependent) diabetes.

Following an extensive evidence review, CMS proposes to revise its existing coverage policy for bariatric surgery. The proposed decision notes that type 2 diabetes is one of the co-morbidities CMS would consider in determining whether bariatric surgery would be covered for a Medicare beneficiary who is morbidly obese. An individual with a body-mass index (BMI) of at least 35 is considered morbidly obese.

To read the CMS press release issued November 7, 2008, click here: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

The proposed decision memorandum is available on CMS' Coverage Web site at *http://www.cms.hhs.gov/center/coverage.asp*.

Source: PERL 200811-33

## Thermal intradiscal procedures

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

### Provider types affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (MAC) for providing thermal intradiscal procedures (TIP) to Medicare beneficiaries.

### What you need to know

Change request (CR) 6291, from which this article is taken, communicates the findings of a new national coverage determination (NCD) regarding thermal intradiscal procedures (TIPs), including billing requirements.

Effective for services performed on or after September 29, 2008, the Centers for Medicare & Medicaid Services (CMS) has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Effective September 29, 2008, TIPs are noncovered for Medicare beneficiaries.

Specifically, CR 6291:

- Announces the relevant *Current Procedural Terminology (CPT)* codes that (effective September 29, 2008) will be denied when submitted, and also the codes that will be denied when identified as a TIP
- Instructs Medicare contractors to deny claims for radiologic or fluoroscopic guidance when performed in conjunction with a TIP, and
- Urges physicians, ambulatory surgical centers (ASC), and hospitals to provide appropriate liability notices to beneficiaries.

You should make sure that your billing staffs are aware of this NCD regarding TIPs, the details of which may be found in the *Background* section that follows.

### Background

Percutaneous thermal intradiscal procedures (TIPs) involve the insertion a catheter(s)/probe(s) into the spinal disc under fluoroscopic guidance in order to produce, or apply, heat and/or disruption within the disc to relieve low back pain.

On January 15, 2008, the CMS initiated a national coverage analysis (NCA) on TIPs. CR 6291 communicates the findings of this NCA, and the resultant NCD. Please note that this is the first NCD to address thermal intradiscal procedures (TIPs).

The NCA addressed the use of TIPs to: 1) treat symptomatic patients with annular disruption of a contained herniated disc, 2) to seal annular tears or fissures, or 3) to destroy nociceptors for the purpose of relieving pain. It included the use of percutaneous intradiscal techniques that utilize devices employing a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for coagulation and/or decompression of disc material. Further, it included techniques that use single or multiple probes/catheters which: 1) utilize a resistance coil or other thermal intradiscal technology; 2) are flexible or rigid; and 3) are placed within the nucleus, the nuclear-annular junction, or the annulus.

Although not meant to be a complete list, TIPs are commonly identified as:

- Intradiscal electrothermal therapy (IDET)
- Intradiscal thermal annuloplasty (IDTA)
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)
- Radiofrequency annuloplasty (RA)
- Intradiscal biacuplasty (IDB)
- Percutaneous (or plasma) disc decompression (PDD) or ablation, or
- Targeted disc decompression (TDD).

At times, TIPs are identified, or labeled, based on the name of the catheter(s)/probe(s) that are used (e.g.

***Thermal intradiscal procedures (continued)***

SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes); and each technique or device has its own protocol for application of the therapy.

**Note:** Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompressor procedure or laser procedure) are not within this NCD's scope.

**TIPs NCD requirements**

CR 6291 announces that CMS has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Therefore, effective September 29, 2008, TIPs are noncovered for Medicare beneficiaries; and for services on and after that date, your carriers, FIs, and MACs will deny any claims that you submit for TIPs.

The following table displays the CPT/HCPCS codes that are identified for TIPs procedures performed within the annulus of the intervertebral disc. On, or after, September 29, 2008, your Medicare contractors will deny claims that you submit for TIPs procedures with any of these noncovered codes.

| ***CPT*/HCPCS Code** | **Description** |
|---|---|
| *22526* | *Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level* |
| *22527* | *Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels* |
| *0062T* | *Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level* |
| *0063T* | *Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; one or more additional levels* |

**CPT codes identified for TIPs procedures performed within the annulus of the intervertebral disc***

*The change to add the noncovered indicator for these codes will be part of the January 2009 Medicare physician fee schedule update and the change to the status indicator to noncovered for the above HCPCS is part of the integrated outpatient code editor (IOCE) update for January 2009 .

Note that the following CPT codes, which can be used for TIPs procedures performed within the nucleus of the disc (e.g., PDD or TDD procedures), can also be used for procedures that are not within the scope of this NCD:

- *62287 (Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar)*
- *22899 (Unlisted procedure, spine)*, and
- *64999 (Unlisted procedure, nervous system)*

Please note that since codes *22899* or *64999* do suspend for review, when you submit them for TIPs procedures performed within the nucleus, you should submit a clear description of the procedure in the narrative section of the claim. Contractors may also be advising providers to submit intervertebral disc nucleus procedures that are considered TIPs under codes *22899* or *64999* in order to avoid improper payment for a TIP under code *62287*. Providers are also advised to submit the biacuplasty procedure under code *0062T* (currently some providers are submitting this procedure under code *64999*).

In addition, as all TIPs procedures are performed with radiologic or fluoroscopic guidance, this ancillary service would be directly related to a noncovered service and would itself, therefore, also be noncovered. CR 6291 instructs your carrier, FI, or A/B MAC to deny claims for the radiologic or fluorosocpic guidance when performed in conjunction with a TIP.

When denying your TIPs claims, Medicare contractors will use:

- Medicare summary notice (MSN) 21.11 - "This service was not covered by Medicare at the time you received it;"
- Claim adjustment reason code (CARC) 96 - "Non-covered charge(s)", and
- Remittance advise remark code N386, "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have access, you may contact the contractor to request a copy of the NCD."

**Note:** Carriers, FIs, and A/B MACs do not need to search their files to recoup payment for claims already paid, however they will adjust claims that are brought to their attention.

CR 6291 further advises physicians and hospitals to give beneficiaries, who choose to have this procedure, an advance beneficiary notice (ABN), consistent with the *Medicare Claims Processing Manual*, Chapter 30, (Financial Liability Protections). This ABN, which you must issue prior to the procedure, should indicate that, after an NCA, Medicare issued a national coverage determination (NCD) (*Medicare National Coverage Determinations (NCD) Manual*, Section 150.11 (Thermal Intradiscal Procedures [TIPs] [effective September 29, 2008]) which states that TIPs are not reasonable and necessary for Medicare beneficiaries. Therefore, Medicare never pays for this service and the beneficiary would be held financially responsible if they decide to have this procedure.

***Thermal intradiscal procedures (continued)***

You should be aware that unless the beneficiary was informed via the ABN prior to performance of the procedure that he/she would be financially responsible, you are liable for charges for TIPs.

You should also be aware that beginning March 1, 2009, the ABN-G will no longer be valid and you must issue the revised ABN (CMS-R-131).

## Additional information

You may find the official instruction, CR 6291,was issued to your carrier, FI or MAC in two transmittals. You will find revised *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2 (Sections 90 – 160.26) (Coverage Determinations), Section 150.11 (Thermal Intradiscal Procedures [TIPs] [Effective September 29, 2008] is a national coverage determination [NCD]) at *http://www.cms.hhs.gov/Transmittals/downloads/R97NCD.pdf* on the CMS Web site. The transmittal that revises the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 220 (Billing Requirements for Thermal Intradiscal Procedures [TIPs] Claims), 220.1 (General), 220.2 (Contractor A/B MAC), 220.3 (Medicare Summary Notice [MSN], Claim Adjustment Reason Code [CARC] and Remittance Advise Remark Code [RARC]), and 220.4 (Advance Beneficiary Notice [ABN]) is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1646CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM6291
Related Change Request (CR) #: 6291
Related CR Release Date: December 9, 2008
Effective Date: September 29, 2008
Related CR Transmittal #: R1646CP and R97NCD
Implementation Date: January 5, 2009

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# ELECTRONIC DATA INTERCHANGE

## Instructions for utilizing 837 professional claim adjustment segments for Medicare secondary payer Part B 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, DME Medicare administrative contractors [DME MACs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

### Provider action needed

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

This article is based on change request (CR) 6211 which informs Medicare contractors about the changes necessary to derive Medicare secondary payer (MSP) payment calculations from incoming 837 4010-A1 claims transactions.

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

CR 6211 is limited to providers billing Part B contractors (carriers and MACs) and DME/MACs.

***Go – what you need to do***

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

### Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health & Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions, and the implementation guides for each transaction are available at *http://www.wpc-edi.com* on the Internet.

This article is to remind you to include claim adjustment (CAS) segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6211 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements, and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.

Adjustments made by the payer are reported in the CAS segments on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices.

Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment. Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code contractual obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the *Medicare Secondary Payer Manual*, which is available at *http://www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS Web site and in the federal regulations at 42 CFR 411.32 and 411.33.

### Additional information

The official instruction, CR 6211, issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R62MSP.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, 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: MM6211
Related change request (CR) #: 6211
Related CR release date: December 12, 2008
Effective date: April 1, 2009
Related CR transmittal #: R62MSP
Implementation date: April 6, 2009

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# Remittance advice remark code and claim adjustment reason code update

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

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 6229 which updates remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs). If you use the Medicare Remit Easy Print software, note that Medicare will update that software as a result of implementing CR 6229. Be sure billing staff are aware of these updates.

## Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information are required in the remittance advice transaction.

**X12N 835 Health Care Remittance Advice Remark Codes**

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, are required to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS, as the X12 recognized maintainer of RARCs, receives requests from Medicare and non-Medicare payers for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare.

**Note:** The complete list of remark codes is available at *http://www.wpc-edi.com/codes* on the Internet.

Medicare contractors will use the latest approved and valid codes in the 835, corresponding standard paper remittance (SPR) advice, and coordination of benefits transactions.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of codes. At this site you can find some other information that is also available from the Washington Publishing Company (WPC) Web site. The Web site address is *http://www.cmsremarkcodes.info/* on the Internet.

**Note I:** This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

**Note II:** Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any CARC explaining a specific adjustment.

An example of an informational code:

**N369 Alert**: Although this claim has been processed, it is deficient according to state legislation/regulation.
The above information is sent per state regulation, but does not explain any adjustment.
These informational codes are used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with a CARC -16, 17, 96, 125, and A1.

**RARC changes**
**New codes**

| Code | Current Narrative | Medicare Initiated |
|---|---|---|
| N434 | Missing/Incomplete/Invalid Present on Admission indicator.<br>Start: 7/1/2008 | |
| N435 | Exceeds number/frequency approved /allowed within time period without support documentation.<br>Start: 7/1/2008 | |
| N436 | The injury claim has not been accepted and a mandatory medical reimbursement has been made.<br>Start: 7/1/2008 | |
| N437 | Alert: If the injury claim is accepted, these charges will be reconsidered.<br>Start: 7/1/2008 | |

***Remittance advice remark code and claim adjustment reason code update (continued)***

| Code | Current Narrative | Medicare Initiated |
|---|---|---|
| N438 | This jurisdiction only accepts paper claims.<br>Start: 7/1/2008 | |
| N439 | Missing anesthesia physical status report/indicators.<br>Start: 7/1/2008 | |
| N440 | Incomplete/invalid anesthesia physical status report/indicators.<br>Start: 7/1/2008 | |
| N441 | This missed appointment is not covered.<br>Start: 7/1/2008 | |
| N442 | Payment based on an alternate fee schedule.<br>Start: 7/1/2008 | |
| N443 | Missing/incomplete/invalid total time or begin/end time.<br>Start: 7/1/2008 | |
| N444 | Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.<br>Start: 7/1/2008 | |
| N445 | Missing document for actual cost or paid amount.<br>Start: 7/1/2008 | |
| N446 | Incomplete/invalid document for actual cost or paid amount.<br>Start: 7/1/2008 | |
| N447 | Payment is based on a generic equivalent as required documentation was not provided.<br>Start: 7/1/2008 | |
| N448 | This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.<br>Start: 7/1/2008 | |
| N449 | Payment based on a comparable drug/service/supply.<br>Start: 7/1/2008 | |
| N450 | Covered only when performed by the primary treating physician or the designee.<br>Start: 7/1/2008 | |
| N451 | Missing Admission Summary Report.<br>Start: 7/1/2008 | |
| N452 | Incomplete/invalid Admission Summary Report.<br>Start: 7/1/2008 | |
| N453 | Missing Consultation Report.<br>Start: 7/1/2008 | |
| N454 | Incomplete/invalid Consultation Report.<br>Start: 7/1/2008 | |
| N455 | Missing Physician Order.<br>Start: 7/1/2008 | |
| N456 | Incomplete/invalid Physician Order.<br>Start: 7/1/2008 | |
| N457 | Missing Diagnostic Report.<br>Start: 7/1/2008 | |
| N458 | Incomplete/invalid Diagnostic Report.<br>Start: 7/1/2008 | |
| N459 | Missing Discharge Summary.<br>Start: 7/1/2008 | |
| N460 | Incomplete/invalid Discharge Summary.<br>Start: 7/1/2008 | |
| N461 | Missing Nursing Notes.<br>Start: 7/1/2008 | |
| N462 | Incomplete/invalid Nursing Notes.<br>Start: 7/1/2008 | |
| N463 | Missing support data for claim.<br>Start: 7/1/2008 | |
| N464 | Incomplete/invalid support data for claim.<br>Start: 7/1/2008 | |
| N465 | Missing Physical Therapy Notes/Report.<br>Start: 7/1/2008 | |

***Remittance advice remark code and claim adjustment reason code update (continued)***

| Code | Current Narrative | Medicare Initiated |
|---|---|---|
| N466 | Incomplete/invalid Physical Therapy Notes/Report.<br>Start: 7/1/2008 | |
| N467 | Missing Report of Tests and Analysis Report.<br>Start: 7/1/2008 | |
| N468 | Incomplete/invalid Report of Tests and Analysis Report.<br>Start: 7/1/2008 | |
| N469 | Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).<br>Start: 7/1/2008 | YES |
| N470 | This payment will complete the mandatory medical reimbursement limit.<br>Start: 7/1/2008 | |
| N471 | Missing/incomplete/invalid HIPPS Rate Code.<br>Start: 7/1/2008 | |
| N472 | Payment for this service has been issued to another provider.<br>Start: 7/1/2008 | |
| N473 | Missing certification.<br>Start: 7/1/2008 | |
| N474 | Incomplete/invalid certification<br>Start: 7/1/2008 | |
| N475 | Missing completed referral form.<br>Start: 7/1/2008 | |
| N476 | Incomplete/invalid completed referral form<br>Start: 7/1/2008 | |
| N477 | Missing Dental Models.<br>Start: 7/1/2008 | |
| N478 | Incomplete/invalid Dental Models<br>Start: 7/1/2008 | |
| N479 | Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).<br>Start: 7/1/2008 | |
| N480 | Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).<br>Start: 7/1/2008 | |
| N481 | Missing Models.<br>Start: 7/1/2008 | |
| N482 | Incomplete/invalid Models<br>Start: 7/1/2008 | |
| N483 | Missing Periodontal Charts.<br>Start: 7/1/2008 | |
| N484 | Incomplete/invalid Periodontal Charts<br>Start: 7/1/2008 | |
| N485 | Missing Physical Therapy Certification.<br>Start: 7/1/2008 | |
| N486 | Incomplete/invalid Physical Therapy Certification.<br>Start: 7/1/2008 | |
| N487 | Missing Prosthetics or Orthotics Certification.<br>Start: 7/1/2008 | |
| N488 | Incomplete/invalid Prosthetics or Orthotics Certification<br>Start: 7/1/2008 | |
| N489 | Missing referral form.<br>Start: 7/1/2008 | |
| N490 | Incomplete/invalid referral form<br>Start: 7/1/2008 | |
| N491 | Missing/Incomplete/Invalid Exclusionary Rider Condition.<br>Start: 7/1/2008 | |
| N492 | Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.<br>Start: 7/1/2008 | |

***Remittance advice remark code and claim adjustment reason code update (continued)***

| Code | Current Narrative | Medicare Initiated |
|---|---|---|
| N493 | Missing Doctor First Report of Injury.<br>Start: 7/1/2008 | |
| N494 | Incomplete/invalid Doctor First Report of Injury.<br>Start: 7/1/2008 | |
| N495 | Missing Supplemental Medical Report.<br>Start: 7/1/2008 | |
| N496 | Incomplete/invalid Supplemental Medical Report.<br>Start: 7/1/2008 | |
| N497 | Missing Medical Permanent Impairment or Disability Report.<br>Start: 7/1/2008 | |
| N498 | Incomplete/invalid Medical Permanent Impairment or Disability Report.<br>Start: 7/1/2008 | |
| N499 | Missing Medical Legal Report.<br>Start: 7/1/2008 | |
| N500 | Incomplete/invalid Medical Legal Report.<br>Start: 7/1/2008 | |
| N501 | Missing Vocational Report.<br>Start: 7/1/2008 | |
| N502 | Incomplete/invalid Vocational Report.<br>Start: 7/1/2008 | |
| N503 | Missing Work Status Report.<br>Start: 7/1/2008 | |
| N504 | Incomplete/invalid Work Status Report.<br>Start: 7/1/2008 | |

**Modified codes**

| Code | Current Modified Narrative | Last Modified |
|---|---|---|
| M29 | Missing operative note/report. | 7/1/08 |
| N10 | Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. | 7/1/08 |
| N26 | Missing itemized bill/statement. | 7/1/08 |
| N40 | Missing radiology film(s)/image(s). | 7/1/08 |
| N130 | Alert: Consult plan benefit documents/guidelines for information about restrictions for this service. | 7/1/08 |
| N209 | Missing/incomplete/invalid taxpayer identification number (TIN). | 7/1/08 |
| N232 | Incomplete/invalid itemized bill/statement. | 7/1/08 |
| N233 | Incomplete/invalid operative note/report. | 7/1/08 |
| N242 | Incomplete/invalid radiology film(s)/image(s). | 7/1/08 |
| N350 | Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure. | 7/1/08 |
| N367 | Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account. | 7/1/08 |
| N390 | This service/report cannot be billed separately | 7/1/08 |
| N393 | Missing progress notes/report | 7/1/08 |
| N394 | Incomplete/invalid progress notes/report. | 7/1/08 |

**Deactivated codes**

There are no newly deactivated codes with CR 6229. Lists of all deactivated and scheduled to be deactivated RARCs are available at the WPC Web site at *http://www.wpc-edi.com/codes* on the Internet.

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care CARCs. The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early November, March, and July.

The list is available at *http://www.wpc-edi.com/codes* on the Internet.

***Remittance advice remark code and claim adjustment reason code update (continued)***

**New codes**

| Code | Current Narrative | Implementation Date |
|---|---|---|
| 222 | Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Start Date: 6/1/2008 | 1/5/2009 |
| 223 | Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.<br>Start Date: 6/1/2008 | 1/5/2009 |
| 224 | Patient identification compromised by identity theft. Identity verification required for processing this and future claims.<br>Start Date: 6/1/2008 | 1/5/2009 |
| 225 | Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)<br>Start Date: 6/1/2008 | 1/5/2009 |

**Note**: Codes 223 and 224 are Medicare initiated

**Modified code**

| Code | Modified Narrative | Implementation Date |
|---|---|---|
| 60 | Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services. | 1/5/2009 |

**Deactivated code**

| Code | Current Narrative | Implementation Date |
|---|---|---|
| D22 | Reimbursement was adjusted for the reasons to be provided in separate correspondence. (**Note**: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code.<br>Start: 01/27/2008 Stop 01/01/2009 | 1/1/2009 |

**Note:** The Code Committee also reactivated CARC 207

## Additional information

The official instruction, CR 6229, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1634CP.pdf* on the CMS Web site.

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

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

MLN Matters number: MM6229
Related change request (CR) #: 6229
Related CR release date: November 14, 2008
Effective date: January 1, 2009
Related CR transmittal #: R1634CP
Implementation date: January 5, 2009

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

# GENERAL INFORMATION

## New workload numbers for the J9 Medicare administrative contractor

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

### Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and fiscal intermediaries [FIs]) for services provided to Medicare beneficiaries in the state of Florida and territories of Puerto Rico and the U.S. Virgin Islands.

### Provider action needed

This article is based on change request (CR) 6285 which announces that the Centers for Medicare & Medicaid Services (CMS) will issue new workload numbers to replace the existing contractor numbers for the Medicare administrative contractor (MAC) Jurisdiction 9 (J9) Part A and Part B workloads in the state of Florida and the territories of Puerto Rico and the U.S. Virgin Islands. These changes are being made because certain CMS claims systems rely on these numbers for processing purposes. Some provider systems may also rely on these numbers.

### Background

The workloads to be transitioned, effective dates and new numbers are indicated in the following tables:

| Part A | MAC Workload Number | Effective Date | Current Contractor Number |
|---|---|---|---|
| Florida | 09101 | 02/16/2009 | 00090 |
| Puerto Rico<br>U.S. Virgin Islands | 09201 | 03/02/2009 | 57400 and 00468 |

| Part B | MAC Workload Number | Effective Date | Current Contractor Number |
|---|---|---|---|
| Florida | 09102 | 02/02/2009 | 00590 |
| Puerto Rico | 09202 | 03/02/2009 | 00973 |
| U.S. Virgin Islands | 09302 | 03/02/2009 | 00974 |

The Florida Part A and Part B workloads are currently processed by:

First Coast Service Options Inc.
(Blue Cross and Blue Shield of Florida, Inc.)
532 Riverside Avenue
Jacksonville, Florida 32202

The Puerto Rico and U.S. Virgin Islands Part A workload is currently processed by:

Cooperativa de Seguros de Vida de Puerto Rico
GPO Box 363428
San Juan, Puerto Rico 00936-3428

The Puerto Rico/U.S. Virgin Islands Part B workload is currently processed by:

Triple-S, Inc.
Box 71391
San Juan, Puerto Rico 00936-1391

In the event the MAC transition needs to be delayed, CMS will provide as much notice as possible to affected Medicare contractors, but no less than five business days prior to the planned effective date.

Finally, CMS is studying how best to transition to the applicable MACs the workload covered by contractor workload number 52280, which was formerly processed by Mutual of Omaha and is currently processed by Wisconsin Physicians Service (WPS). CMS will notify all parties concerned as soon as its instructions are finalized for that transition.

### Additional information

The official instruction, CR 6285, issued to your carrier or FI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R423OTN.pdf* on the CMS Web site. If you have any questions, please contact your carrier or 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: MM6285
Related change request (CR) #: 6285
Related CR release date: December 24, 2008
Effective date: February 2, 2009
Related CR transmittal #: R423OTN
Implementation date: January 5, 2009

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## National Heritage Insurance Corporation awarded the jurisdiction 14 contract

**National Heritage Insurance Corporation (NHIC) will administer Medicare claim payments in Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont**

The Centers for Medicare & Medicaid Services (CMS) recently announced that National Heritage Insurance Corporation (NHIC) has been awarded a contract of up to five years for the combined administration of Part A and Part B Medicare claim payment in Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

NHIC will serve as the first point of contact for the processing and payment of Medicare fee-for-service claims from hospitals, skilled nursing facilities, physicians and other health care practitioners in this jurisdiction. The new Part A/Part B Medicare administrative contractor (A/B MAC) was selected using competitive procedures in accordance with federal procurement rules.

The new contractor will take claim payment work currently performed by three fiscal intermediaries and two carriers in this jurisdiction. The A/B MAC contract, which has an approximate value of $176 million over five years, will fulfill the requirements of the Medicare Modernization Act (MMA) contracting reform provisions.

As the A/B MAC contractor, NHIC will immediately begin implementation activities and will assume full responsibility for the claim processing work in its five-state jurisdiction no later than May 2009. NHIC will be reaching out to providers and state medical associations to provide education and information about the implementation. For more details, visit NHIC's Web site at *http://www.medicarenhic.com/*.

CMS awarded the first A/B MAC contract in July 2006 to Noridian Administrative Services, LLC, headquartered in Fargo, N.D. The list of new contractors and the states they cover, along with other information, may be found at *http://www.cms.hhs.gov/MedicareContractingReform/*.

To read the related CMS press release issued on November 19, 2008, click here: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200811-31

## Understanding workload and roll-up numbers for all Medicare administrative contractors

**Effective date:** January 1, 2006
**Implementation date:** December 29, 2008

Change request (CR) 6259 replaces previously issued CR 5651. The information outlined below provides details related to changes for providers and contractors as they move toward the Medicare administrative contractor (MAC) environment. Information includes:

- explanation of the numbering scheme of the MAC workload number
- explanation and use of the "roll-up numbers"
- chart outlining all numbers that may be utilized for all MAC jurisdictions

### Background

The Centers for Medicare & Medicaid Services (CMS) will assign new workload numbers for MAC Jurisdictions. Medicare contracting reform requires that CMS use competitive procedures to replace its current fiscal intermediaries and carriers with a uniform type of administrative entity, referred to as Medicare administrative contractor (MAC). As such, new numbers are required to identify the work being performed by the new MAC contractors. Previous instructions were issued in CR 5651. New numbers have been issued for the state of North Carolina Part A and Part B due to the previous numbers utilized by another CMS component. For ease of reference and to reduce duplication, CR 5651 has been withdrawn and its pertinent sections combined with CR 6259.

The numbering scheme allows for three tiers of MAC numbers to meet the current and future needs of CMS and its contractors.

**The bottom tier** is the workload number, which uniquely identifies each MAC workload by claim type and state as described below.

**The second tier** number is the Part A number, Part B number, durable medical equipment (DME) number, or home health and hospice (HHH) number. This number is the aggregate for each of the claim types processed within each MAC jurisdiction and is commonly referred to as the "roll-up" number.

**The top tier** consists of a single jurisdiction number, which uniquely identifies each MAC and includes all claim types processed by that jurisdiction.

As the MAC implementations move forward, it is imperative that all:

- CMS components and contractors understand the numbering convention and what it represents
- claim processing and financial system applications recognize/process the appropriate numbers, and
- components use the appropriate number that best meets their needs within the overall MAC numbering scheme as described below.

When each jurisdiction is awarded and cutover dates are finalized, a change request will be issued with the appropriate MAC numbers for that jurisdiction.

### Workload number

For Part A and Part B, there will be a unique workload number for each state within the 15 MAC jurisdictions. That number may be appended with a unique business segment identifier (BSI), which also represents the state and is used in certain applications and workload reporting. The following shows an example for the state of Kansas in jurisdiction 5.

***Understanding new numbers for all Medicare administrative contractor jurisdications (continued)***

**Workload Number** **Business Segment Identifier**
0 5 2 0 1 K S A

05 - jurisdiction indicator
2 -state indicator - by state alphabetical order within the jurisdiction
0 - for use in future to indicate a change of MAC contractor
1 - claim type*
KSA - business segment identifier

*Claim type designations: Part A = 1; Part B = 2; DME = 3; RHHI = 4

## Part A, Part B, DME, or HHH number (a.k.a. roll-up number)

This number is for components requiring a roll-up number for Part A and Part B for the 15 A/B MACs (e.g., financial reporting) or a DME or HHH number. There will be no BSI or state indicator for these numbers. The Part A and Part B examples are shown for the state of Kansas.

The four DME jurisdictions (jurisdictions A, B, C, and D) are identified for numbering purposes as jurisdictions 16, 17, 18, and 19 respectively.

Four A/B MACs (jurisdictions 6, 11, 14, and 15) will be responsible for processing HHH claims. Each of those MACs will process HHH claims for a designated HHH jurisdiction, configured in the same manner as the DME jurisdictions. The following four examples illustrate the application of the roll-up number for each of the different claim types.

**Part A (roll-up) number**
0 5 0 0 1*

**Part B (roll-up) number**
0 5 0 0 2*

**DME number**
1 8 0 0 3*

**HHH Number**
0 6 0 0 4*

First two numbers - jurisdiction indicator
Last number - claim type*

* Claim type designations: Part A = 1; Part B = 2; DME = 3; RHHI = 4

## Jurisdiction number

This would be the number representing the entire MAC jurisdiction. This would be used by an application desiring an all-inclusive jurisdiction number.

Jurisdiction number
0 5 0 0 0

The following chart shows all numbers that may be utilized for all MAC jurisdictions.

| Jurisdiction | Workload Type | Workload Number | State | Roll- up |
|---|---|---|---|---|
| 1 | A | 01101<br>01201<br>01301 | CA<br>HI<br>NV | 01001 |
| | B | 01192<br>01102<br>01202<br>01302 | CA S.<br>CA N.<br>HI<br>NV | 01002 |
| 2 | A | 02101<br>02201<br>02301<br>02401 | AK<br>ID<br>OR<br>WA | 02001 |
| | B | 02102<br>02202<br>02302<br>02402 | AK<br>ID<br>OR<br>WA | 02002 |
| 3 | A | 03101<br>03201<br>03301<br>03401<br>03501<br>03601 | AZ<br>MT<br>ND<br>SD<br>UT<br>WY | 03001 |
| | B | 03102<br>03202<br>03302<br>03402<br>03502<br>03602 | AZ<br>MT<br>ND<br>SD<br>UT<br>WY | 03002 |

***Understanding new numbers for all Medicare administrative contractor jurisdications (continued)***

| Jurisdiction | Workload Type | Workload Number | State | Roll- up |
|---|---|---|---|---|
| 4 | A | 04101<br>04201<br>04301<br>04401 | CO<br>NM<br>OK<br>TX | 04001 |
| | B | 04102<br>04202<br>04302<br>04402 | CO<br>NM<br>OK<br>TX | 04002 |
| 5 | A | 05101<br>05201<br>05301<br>05401 | IA<br>KS<br>MO<br>NE | 05001 |
| | B | 05102<br>05202<br>05302<br>05392<br>05402 | IA<br>KS<br>MO W.<br>MO E.<br>NE | 05002 |
| 6 | A | 06101<br>06201<br>06301 | IL<br>MN<br>WI | 06001 |
| | B | 06102<br>06202<br>06302 | IL<br>MN<br>WI | 06002 |
| 7 | A | 07101<br>07201<br>07301 | AR<br>LA<br>MS | 07001 |
| | B | 07102<br>07202<br>07302 | AR<br>LA<br>MS | 07002 |
| 8 | A | 08101<br>08201 | IN<br>MI | 08001 |
| | B | 08102<br>08202 | IN<br>MI | 08002 |
| 9 | A | 09101<br>09201 | FL<br>PR/VI | 09001 |
| | B | 09102<br>09202<br>09302 | FL<br>PR<br>VI | 09002 |
| 10 | A | 10101<br>10201<br>10301 | AL<br>GA<br>TN | 10001 |
| | B | 10102<br>10202<br>10302 | AL<br>GA<br>TN | 10002 |
| 11 | A | 11501<br>11201<br>11301<br>11401 | NC<br>SC<br>VA<br>WV | 11001 |
| | B | 11502<br>11202<br>11302<br>11402 | NC<br>SC<br>VA<br>WV | 11002 |

***Understanding new numbers for all Medicare administrative contractor jurisdications (continued)***

| Jurisdiction | Workload Type | Workload Number | State | Roll- up |
|---|---|---|---|---|
| 12 | A | 12101<br>12201<br>12301<br>12401<br>12501 | DE<br>DC<br>MD<br>NJ<br>PA | 12001 |
| | B | 12102<br>12202<br>12302<br>12402<br>12502 | DE<br>DC<br>MD<br>NJ<br>PA | 12002 |
| 13 | A | 13101<br>13201 | CT<br>NY | 13001 |
| | B | 13102<br>13292<br>13282<br>13202 | CT<br>NY (GHI<br>NY (HealthNow)<br>NY (Empire) | 13002 |
| 14 | A | 14101<br>14201<br>14301<br>14401<br>14501 | ME<br>MA<br>NH<br>RI<br>VT | 14001 |
| | B | 14102<br>14202<br>14302<br>14402<br>14502 | ME<br>MA<br>NH<br>RI<br>VT | 14002 |
| 15 | A | 15101<br>15201 | KY<br>OH | 15001 |
| | B | 15102<br>15202 | KY<br>OH | 15002 |
| DMAC A | | 16003 | RAD | 00811 |
| DMAC B | | 17003 | RBD | 00635 |
| DMAC C | | 18003 | RCD | 00885 |
| DMAC D | | 19003 | RDD | 05655 |
| **Home Health and Hospice** | | | | |
| 6 | HHH D | 06004 | AKR | |
| 11 | HHH C | 11004 | ALR | |
| 14 | HHH A | 14004 | CTR | |
| 15 | HHH B | 15004 | ILR | |

The following systems shall reflect the new contractor number: BESS, CAFM, CERT, CMIS, COBA, the CMS HDC, CROWD, CSAMS, CWF, DCS, ECRS, FISS, HCIS, HIGLAS, IRIS, LOLA, MPaRTS, MCS, National Claims History, NGD, the NPI crosswalk, OSCAR, PECOS, PIMR, PORS, PS&R, the PSC, PSOR, PULSE, REMAS, REMIS, STAR, and the Expert Claims Processing System or ECPS(which was formerly known as SuperOP).

Finally, CMS is studying how and when to transition to the applicable MACs the workload covered by contractor workload number 52280, which was formerly processed by Mutual of Omaha and is currently processed by Wisconsin Physicians Service(WPS) in its capacity as a legacy Title XVIII fiscal intermediary. CMS will notify all parties as soon as its instructions are final.

Source: Publication 100-20, transmittal 405, change request 6259

# Online provider enrollment now available

Internet-based Medicare enrollment is available for Medicare physicians and nonphysician practitioners (NPPs) in 44 states and the District of Columbia. It's fast, secure, and easy.

Now there's a better way for physicians and NPPs to enroll or make a change in their Medicare enrollment information. The Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) will allow physicians and NPPs to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on the status of a Medicare enrollment application via the Internet.

Previously, the Centers for Medicare & Medicaid Services (CMS) announced that Internet-based PECOS is available to physicians and NPPs in the District of Columbia and the following states:

| | | | | |
|---|---|---|---|---|
| Alaska | Kansas | New York | Washington | Arizona |
| Kentucky | North Carolina | West Virginia | Connecticut | Maryland |
| North Dakota | Wisconsin | Delaware | Michigan | Ohio |
| Wyoming | Florida | Minnesota | Oregon | Hawaii |
| Missouri | Pennsylvania | Idaho | Montana | South Carolina. |

CMS has announced the expansion of Internet-based PECOS for physicians and NPPs in the following states:

| | | | | |
|---|---|---|---|---|
| Alabama | Louisiana | Mississippi | Vermont | Arkansas |
| Massachusetts | New Hampshire | Georgia | Maine | Rhode Island. |

Physicians and NPPs (located in the District of Columbia and in the states shown above) who wish to access Internet-based PECOS, may go to *https://pecos.cms.hhs.gov*.

CMS will expand the availability of Internet-based PECOS for physicians and NPPs to all states over the next two months. In addition, CMS will make Internet-based PECOS available next year to all providers and suppliers (except those who supply durable medical equipment, prosthetics, orthotics, and supplies).

## Fast

By submitting the initial Medicare enrollment application through Internet-based PECOS, a physician or NPP's enrollment application can be processed as much as 50 percent faster than by paper.

This means that it will take less time to enroll.

Physicians and NPPs are required by regulation to report certain changes in their enrollment information within specified timeframes. Internet-based PECOS will allow them to update, make corrections, and check on the status of their Medicare enrollment applications as much as 50 percent faster than by paper. Changes include a change in practice location, ownership, or final adverse action (medical license suspension or revocation). For additional information about the types of changes that must be reported, go to the download section of *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

## Secure

Internet-based PECOS meets all required Government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only authorized individuals can enter enrollment information into PECOS or view PECOS data from the Internet.

Authorized individuals include physicians and NPPs. Their user IDs and passwords protect the access to their enrollment information. After physicians or NPPs create user IDs and passwords (or change their passwords), they should keep this information secure and not share it with anyone. By safeguarding their user IDs and passwords, they are taking an important step in protecting their enrollment information. CMS does not disclose Medicare enrollment information to anyone except when authorized or required to do so by law.

## Easy

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and NPPs complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record. In contrast to the information collected on the CMS-855I, physicians and NPPs will no longer see questions that are not applicable to their enrollment scenarios when using Internet-based PECOS.

**Note:** Physicians and NPPs are still required to sign and date the certification statement and to mail the certification statement and all supporting paper documentation to the Medicare contractor.

A Medicare contractor will not process an Internet enrollment application without the signed and dated certification statement and the required supporting documentation. In addition, the effective date of filing an enrollment application is the date the Medicare contractor receives the signed certification statement that is associated with the Internet submission.

## Additional information

For information about Internet-based PECOS, including important information that physicians and NPPs should know before submitting a Medicare enrollment application via Internet-based PECOS, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Source: PERL 200812-13, 200812-25, 200812-34, 200812-45

## Medicare publishes new information on quality of care at dialysis facilities

### Changes to Web site will help consumers compare care and make informed health care choices

The Centers for Medicare & Medicaid Services (CMS) recently announced important additions to the Dialysis Facility Compare consumer Web site (*http://www.medicare.gov/dialysis/*) that will give consumers even better insight into the quality of care provided by their local dialysis patient facilities. The improvements include two new quality measures that demonstrate how well dialysis patients are treated for anemia (low red blood cell count) as well as updated information that will help patients better understand survival rates by facility.

Dialysis Facility Compare links consumers with detailed information about the 4,700 dialysis facilities certified by Medicare and allows users to compare facilities in a geographic region. Users can review information about the size of the facility, the types of dialysis offered, the facilities' ownership, and whether the facility offers evening treatment shifts. Consumers can also compare dialysis facilities based on three key quality measures:

- How well patients at a facility have their anemia under control
- How well patients at a facility have waste removed from their blood during dialysis
- Whether the patients treated at a facility generally live as long as expected.

Dialysis Facility Compare also links users to resources that support family members and specialized groups of kidney patients.

"Dialysis Facility Compare is yet another tool that equips consumers with the tools they need to seek better, value-based health care," said CMS Acting Administrator Kerry Weems. "Adding more information on the Dialysis Facility Compare Web site about anemia – a condition that affects many dialysis patients – and patient survival will help us all learn more about how well the country's dialysis facilities are serving Medicare beneficiaries and the entire healthcare system."

Dialysis Facility Compare has featured information about anemia control since the Web site was launched in 2001. Historically, the Web site has shown the percentage of patients in a facility whose hematocrit levels were at 33 percent or more (or hemoglobin levels of 11 g/dL or more), based on clinical practice guidelines at the time. However, recent evidence about increased risk of certain adverse events associated with the use of erythropoiesis stimulating agents (ESAs), which are used to treat anemia, has raised concerns about patients whose hemoglobin levels are too high as well as patients whose hemoglobin levels are too low. The Food and Drug Administration has responded by requiring manufacturers to develop a Medication Guide and to ensure that this information is provided to patients. As a result, Dialysis Facility Compare will now feature two anemia measures – one measure will show the percentage of patients whose hemoglobin levels are considered too low (i.e., below 10 g/dL) and a second measure will show the percentage of patients whose hemoglobin levels are considered too high (i.e., above 12 g/dL).

"These two new measures better reflect recent medical evidence about the challenges of managing anemia," said CMS Chief Medical Officer and Director of the agency's Office of Clinical Standards & Quality, Barry Straube, M.D. "Our new measures will help patients and health care providers to better understand how a facility's patients are treated for anemia, a condition for which studies have shown that over and under-treatment may affect patients' health status and quality of life."

In addition to adding new information about anemia treatment, CMS has also updated the way it reports patient survival rates on Dialysis Facility Compare. Since 2001, CMS has reported survival rates by comparing a facility's expected patient survival rate to its actual patient survival rate. (The expected survival rate takes into account the patients' personal characteristics, health, and dialysis history. The actual survival rate is the rate each facility reports to CMS about how many patients have survived in a given timeframe.) Facilities' survival rates were then rated as belonging to one of three categories:

- Better than expected (by 20 percent or more)
- As expected
- Worse than expected (by 20 percent or more).

This method of calculating patient survival resulted in a finding of "as expected" for 94 percent of dialysis facilities nationwide, with only three percent in the "better" or "worse" categories, respectively.

To help consumers make better distinctions among facilities' survival rates, CMS updated the statistical method it used to classify facilities in the three categories. While consumers will continue to see facilities placed into one of these categories, they will find fewer facilities in the "as expected" category and more facilities in the "better" or "worse" categories.

These enhancements are only one part of CMS' plans to improve the quality of care in America's dialysis facilities. Earlier this year, CMS revised its conditions for coverage regulations for the first time in over 30 years, which updated the health and safety standards that dialysis facilities must meet to receive Medicare coverage. A key element of this regulation was the development of a new Web-based data entry framework for dialysis facilities nationwide, which will eventually provide substantially more detailed information for consumers as part of Dialysis Facility Compare. CMS is also working to implement a value-based purchasing program to pay for dialysis services, which will reward facilities for providing high-quality, efficient, and effective care.

The Dialysis Facility Compare Web site may be viewed at *http://www.medicare.gov/dialysis*.

Other provider compare Web sites are available through *http://www.medicare.gov/* or directly at *http://www.medicare.gov/HHCompare* for information about home health agencies and nursing homes. For information on hospitals, visit *http://www.hospitalcompare.hhs.gov* .

CMS also provides links to comparative resources about Medicare Advantage and Medicare prescription drug plans at (*http://www.medicare.gov/*).

Source: PERL 200811-34

## Dialysis Facility Compare Web site: Updated survival and anemia management measures

The Centers for Medicare & Medicaid Services (CMS) has announced important additions to the Dialysis Facility Compare consumer Web site (*http://www.medicare.gov/Dialysis*) that will give consumers even better insight into the quality of care provided by their local dialysis patient facilities.

The improvements include two new quality measures that demonstrate how well dialysis patients are treated for anemia (low red blood cell count) as well as updated information that will help patients better understand survival rates by facility.

To view the entire press release, please see: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200811-37

## Electronic mailbox for submitting requests to add or delete telehealth services

The Centers for Medicare & Medicaid Services (CMS) makes any additions or deletions to the services defined as Medicare telehealth services effective on a January 1st basis. Any interested parties from either the public or private sectors may submit requests for adding services to the list of Medicare telehealth services.

Requests for adding services to the list of Medicare telehealth services may be submitted on an ongoing basis. Requests must be submitted and received no later than December 31 of each calendar year to be considered for the following year proposed rule (i.e., requests must be received by December 31, 2008, to be considered during the 2009 rulemaking cycle that establishes physician fee schedule rates for 2010).
Requests to add or delete services may be mailed to:

Attention: Telehealth Review Process
Division of Practitioner Services
Mail Stop: C4-03-06
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

As an alternative to regular mail, requests may be submitted electronically to the telehealth requests resource mailbox *CMS Telehealth_Review_Process@cms.hhs.gov*.

For information on submitting a request to add or delete telehealth services, visit the CMS Web site at *http://www.cms.hhs.gov/telehealth/*.

Source: CMS PERL 200812-15

## Medicare Part B Drug Competitive Acquisition Program post-payment review in 2009

After January 1, 2009, the CAP post-payment review process will continue for 2008 claims. The post-payment review process for the CAP is conducted to verify drug administration for Medicare claims submitted by an approved CAP vendor. For this process, a small sample of physician and vendor claims and other documentation is examined in order to establish that drugs billed by an approved CAP vendor were administered and were medically necessary.

To support this review, participating CAP physicians may receive a request for copies of medical records from the CAP designated carrier, Noridian Administrative Services (NAS). Medicare requirements require participating CAP physicians to submit all information necessary to support the services billed on claims.

Participating CAP physicians must submit medical records to NAS within the requested timeframe. This submission should include the patient's drug administration record and all other records supporting medical necessity for the drug. If CAP post-payment review activity cannot establish that a drug was administered, then the vendor's drug claim will be denied. The associated physician drug administration claim will also be referred to the physician's local carrier for review and recoupment as necessary.

For additional information on the post-payment review process, please visit NAS's CAP Web site at: *https://www.noridianmedicare.com/cap_drug/index.html*.

Also, please remember that CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008.

Additional information about the 2009 CAP postponement claims submission deadlines and instructions about what to do with unused CAP drug is available on the CMS CAP Web site at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp*.

Source: PERL 200812-09

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

## Competitive Acquisition Program claim submission deadlines and unused drugs

In preparation for the 2009 Competitive Acquisition Program (CAP) postponement, the following is a reminder about upcoming CAP deadlines. It is very important that participating CAP physicians understand and comply with these deadlines because failure to do so will affect physicians' ability to be reimbursed.

**CAP drugs administered during 2008**

- All CAP drug claims must have a date of service on or before December 31, 2008, and physicians' corresponding CAP drug administration claims must be submitted on or before January 30, 2009.
- CAP drug claims for dates of service after December 31, 2008, will be denied.
- CAP drugs that have not been administered by December 31, 2008, are the property of the approved CAP vendor.

**CAP drugs NOT administered by December 31, 2008**

- CAP physicians must return any unused CAP drugs to the approved CAP vendor by February 28, 2009.
- CAP drugs are the property of the approved CAP vendor. Therefore, physicians who have not returned these drugs to the approved CAP vendor on or before February 28, 2009, will be liable for the cost of drugs.
- Please note that CAP physicians may contact the approved CAP vendor to discuss the option of purchasing unused CAP drugs.

**Emergency restocking of CAP drugs for dates of services on or before December 31, 2008**

When permitted under the emergency restocking provisions, physicians may submit a prescription order for a CAP drug to replace what they used from their own stock (the emergency restocking provision). Physicians may request replacement drugs **only** if the date of service is on or before December 31, 2008, AND the corresponding drug administration claim has been submitted on or before January 30, 2009.

**Physicians must request replacement drugs by January 30, 2009.**

The approved CAP vendor will not send replacement products under the CAP emergency restocking provision (J2 modifier claims) after February 28, 2009.

CAP physicians who have not submitted a prescription order and a request for replacement drugs under the emergency restocking provision as described above will not be able to bill Medicare under the ASP system for the CAP drugs that they administered on or before December 31, 2008, from their private stock.

**What should you do to prepare?**

Physicians who are participating in the CAP during 2008 are encouraged to contact the approved CAP vendor and reconcile their inventories as soon as possible. Contact information for the approved CAP vendor, BioScrip, is available on their Web site at *http://www.bioscrip.com/*.

Additional information on the 2009 CAP postponement is available on the Centers for Medicare and Medicaid Services Web site at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp*.

Source: PERL 200812-08

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## Advanced practice nursing and physician assistants Web page

The *Medicare Learning Network (MLN)* is pleased to announce the availability of the *Advanced Practice Nursing/Physician Assistants (APN/PA)* Web page. This dedicated Web page is for Medicare fee-for-service (FFS) advanced practice nurses and physician assistants who provide services to Medicare beneficiaries.

From this Web page, you will be able to access and peruse the Medicare FFS program topics in order to keep abreast of policy and operational updates specific to advanced practice nurses and physician assistants.

One of the educational resources featured on this Web page is the *Advanced Practice Nurse/Physician Assistant Web-based Training Program*.

This interactive Web-based training program:

- provides definitions of the advanced practice nursing/physician assistant provider types
- outlines the qualifications of the advanced practice nursing/physician assistant provider types
- describes collaboration/supervision requirements for advanced practice nursing/physician assistant Medicare reimbursements
- lists the Medicare billing requirements for advanced practice nursing and physician assistants
- identifies links to Medicare manuals and other resources.

This Web page is updated on a regular basis, so check it often for timely and reliable information from the *MLN*.

For more information, visit the Web page on the CMS site at *http://www.cms.hhs.gov/MLNProducts/70_APNPA.asp#TopOfPage*.

Source: PERL 200812-24

## News on the ICD-10-CM/PCS initiative

### Transcript from the national provider conference call for physicians now available

The transcript of the Centers for Medicare & Medicaid Services (CMS) International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) national provider conference call for physicians that was held on November 17, 2008, is now available at *http://www.cms.hhs.gov/ICD10/Downloads/November17calltranscript.pdf*.

### ICD-10 2009 files

CMS has updated the ICD-10 download files by posting the 2009 version of the following documents at *http://www.cms.hhs.gov/ICD10/01m_2009_ICD-10-PCS.asp#TopOfPage*:

- ICD-10 General equivalence mappings (these refer to procedure codes)
- Reimbursement mappings and guides for the use of the mappings
- 2009 version of ICD-10-procedure coding system (PCS)
- ICD-10 version of the digestive Medicare severity-diagnosis related groups (MS-DRG)

The 2009 ICD-10-CM (diagnosis codes) general equivalence mappings have been posted at *http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp*.

The 2009 version of ICD-10-Clinical Modifications (CM), diagnoses, will be posted by the end of December 2008 on the following sites:

- *http://www.cdc.gov/nchs/icd9.htm*
- *http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp*

Source: PERL 200812-38

## 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-9CM and ICD-10-CM/PCS, and implementation planning recommendations, is available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp*, scroll down to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

Source: PERL 200812-06

## ICD-10 national conference call for other Part A and Part B providers transcript

The transcript of the Centers for Medicare & Medicaid Services ICD-10-CM/PCS national provider conference call for other Part A and Part B providers that was held on November 12, 2008, is now available at *http://www.cms.hhs.gov/icd10/Downloads/Nov12calltranscript.pdf*.

Source: PERL 200812-14

## Written clarification on the DMEPOS accreditation deadline

Medicare for Patients and Providers Act of 2008 (MIPPA) section 154(b) added a new subparagraph (F) to section 1834(a)(20) of the Social Security Act. This subparagraph states that eligible professionals and other persons are exempt from meeting the September 30, 2009, accreditation deadline that generally applies to other DMEPOS suppliers unless the Centers for Medicare & Medicaid Services (CMS) determines that the quality standards are specifically designed to apply to such professionals and persons.

The eligible professionals to whom this exemption applies are set out at sections 1848(k)(3)(B) and 1861(r) of the Act, and include physicians, physical therapists, occupational therapists, qualified speech-language pathologists, physician assistants, and nurse practitioners.

Additionally, section 154(b) of MIPPA allows the Secretary to specify "other persons" that, like the eligible professionals described above, are exempt from meeting the accreditation requirements unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, we are defining "such other persons" as orthotists, prosthetists, opticians, and audiologists.

CMS will define how the quality standards apply to these eligible professionals and other persons by rulemaking in 2009.

Individuals not included in this exemption list, such as pedorthotists, mastectomy fitters, orthopedic fitters/technicians or athletic trainers applying for Medicare enrollment in order to bill for Medicare Part B services are not exempt from meeting the September 30, 2009, deadline for DMEPOS accreditation.

Source: PERL 200812-27

## E-prescribing incentive program update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the specifications for the e-prescribing measure, which will be used to determine whether an eligible professional is a successful e-prescriber and may qualify for a two percent incentive payment for the 2009 reporting period, has been posted to the CMS Web site. The measure specifications may be found in the *Downloads* section of the E-Prescribing Incentive Program Web page at *http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage* on the CMS Web site.

An eligible professional does not have to enroll to participate in the e-Prescribing incentive program. Furthermore, an eligible professional does not need to participate in PQRI to participate in this incentive program.

Beginning January 1, 2009, eligible professionals may participate in the e-Prescribing incentive program by submitting information required by the e-prescribing measure on their Medicare Part B claims.

Detailed information on the implementation of the e-Prescribing incentive program for 2009 may be found in the final 2009 Medicare physician fee schedule final rule with comment period that was published in the *Federal Register* on November 19, 2008. A copy of the final rule with comment period is on display at the *Federal Register* and may be viewed at *http://www.cms.hhs.gov/center/physician.asp* on the CMS Web site.

Source: PERL 200812-01

## Medicare's Practical Guide to the e-prescribing incentive program

The guide explains the e-prescribing incentive program, how eligible professionals can participate, and how to choose a qualified e-prescribing system. To read or print the guide, visit *http://www.cms.hhs.gov/partnerships/downloads/11399.pdf*.

By adopting e-prescribing through Medicare's program, eligible professionals can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care, while earning incentives from Medicare.

### Continuing Education credits available

On October 6–7, 2008, CMS and 34 partner organizations hosted the national e-prescribing conference to promote and explain the potential of e-prescribing to improve health care in the United States. Sessions included the e-prescribing incentive payment program; strategies and tools for integrating e-prescribing with current health care delivery practices; and privacy, security, and risk management implications.

The Massachusetts Medical Society and the American Pharmacists Association will provide continuing education for selected presentations from the conference through an online education portal. Available credits are a maximum of 22.5 AMA PRA Category 1 Credits™, and Continuing Education for pharmacists (up to 13.25 hours of continuing education credit [1.325 CEUs]). To view or listen to the presentations, and complete an online test on each segment, go to *http://www.massmed.org/cme/CMS_eprescribing*.

### Additional information

For additional information about e-prescribing, you may also visit *http:// www.cms.hhs.gov/PQRI*. Select *E-prescribing Incentive Program*; *http://www.cms.hhs.gov/eprescribing* for information on Part D e-prescribing standards that will be effective April 1, 2009; and *http://www.ehealthinitiative.org* to download *A Clinician's Guide to Electronic Prescribing*.

Additional information is available on the National E-Prescribing Conference site at *http://www.epsilonregistration.com/er/EventHomePage/CustomPage.jsp?ActivityID=378&ItemID=1117*.

The Centers for Medicare & Medicaid Services looks forward to working with you on the adoption of e-prescribing and implementation of the incentive program.

Source: PERL 200811-35

## Steps for eligible professionals to access their Physician Quality Reporting Initiative feedback reports

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

**Note:** This article was revised on November 25, 2008, to provide clarification of some of the steps involved in registration and to clarify who can register as individual practitioners. This information was previously published in the September *2008 Medicare B Update!* pages 48-49.

### Provider types affected

This document is directed to individual eligible professionals who reported Physician Quality Reporting Initiative (PQRI) quality measures data to Medicare and will access their reports. If you are enrolled in Medicare as a sole proprietorship business, this is your only option for accessing PQRI feedback reports via the Internet.

Eligible professionals described above cannot have staff or others register to access your PQRI feedback reports.

**Note:** This article does not apply to (1) professionals who have reassigned all of their Medicare benefits to one or more group practices, or (2) to group practices that are limited liability companies or corporations, including those that are solely owned. Group practices that are limited liability companies or corporations, even those that are solely owned, must register in IACS as organizations. Registering as an organization follows a delegated authority model that begins with registration by a security official that represents the organization (the group practice) and requires submission of IRS documents. For details on registering as an IACS organization, see *MLN Matters* article SE0831at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf* on the CMS Web site.

***Steps for eligible professionals to access their PQRI feedback reports (continued)***

## Provider action needed

PQRI feedback reports are available on a secure Web site to those eligible professionals who reported PQRI quality measures in a given year. The following are the steps eligible professionals need to take to access their PQRI feedback reports. For access to certain CMS provider Internet applications, including PQRI feedback reports, you must first register in the CMS security system known as the Individuals Authorized Access to CMS Computer Services (IACS). IACS registration provides you with a user ID and password that may be used to access CMS applications such as the PQRI feedback reports. You only register in IACS once. As a result of that single registration, you are able to access certain other CMS Internet applications in addition to the PQRI feedback reports.

Your IACS user ID and password permit you access to confidential or sensitive Medicare information. Safeguard your IACS user ID and password once you receive them. They were assigned to you, based on information you furnished to IACS. Do not share them with others or give others permission to use them. Do not write your user ID and password on papers or documents that others may see. As a security measure, you are required to change your IACS password after you receive it, and do so every sixty days thereafter. (user IDs cannot be changed.)

A five-step process to access PQRI feedback reports

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

Registering in IACS as an individual practitioner for purposes of accessing the PQRI application means that you are enrolled in Medicare with a private practice that is a sole proprietorship business, with or without employees, and you are paid directly by Medicare.

**Step two: Confirm your Medicare provider enrollment.**

CMS will match your IACS registration information with the Medicare provider enrollment data before allowing you to use your IACS user ID and password to access the PQRI application. Therefore, update your Medicare enrollment information if necessary before attempting to register in IACS.

1. If you have not submitted a Medicare enrollment application (CMS-855) since November 2003, you will need to do so before registering in IACS. See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* for more information about the Medicare enrollment process. To facilitate your enrollment into the Medicare program or to update your enrollment with Medicare, you should review the following downloadable file at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollment tips.pdf* before submitting an enrollment application to a Medicare administrative contractor (MAC) or your Medicare carrier.
2. If you submitted an enrollment application since November 2003, proceed to Step three.
3. If you are unsure when the enrollment application was submitted, you may wish to contact your Medicare carrier or MAC.

**Note:** There are avoidable mistakes that can lead to an inability to match IACS data with provider enrollment data. When registering in IACS, always enter information as it was entered in your Medicare enrollment form (855).

Common reasons for mismatched data:

- Use of first name initial instead of first name
- Use of nicknames, e.g. Ken vs. Kenneth
- Use of different first names, e.g. Randal vs. David
- Middle names included as part of the first name
- Misspellings in names, e.g. Ray vs. Roy and Smythe vs. Smyth
- Special characters in the last name, .e.g. dashes or apostrophes
- Generational and/or certification/degree information in last name field, and
- Inclusion or exclusion of hyphen in name fields.

**Step three: Proceed to register as an individual practitioner in IACS.**

Go *to https://applications.cms.hhs.gov* on the CMS Web site.

The IACS registration process confirms your identity by checking the data you enter against Social Security Administration records. Once your identity information is confirmed and you complete the registration process, you will receive an IACS user ID and password, each in a separate e-mail. You will, however, be in a "pending status" until your Medicare enrollment has been confirmed.

In confirming Medicare enrollment, CMS will match your IACS registration information against Medicare enrollment data available after November of 2003. Confirmation occurs within one business day of receipt of your IACS user ID and password.

If your Medicare enrollment is confirmed you will receive a third e-mail from CMS that states: "You are currently registered in IACS as an Individual Practitioner. IACS has confirmed your Medicare enrollment. Additional provider applications may now be available to you. Pease sign into your IACS account and review the options available to you under *Modify Profile* for more information".

**Note:** If your Medicare enrollment is confirmed, the IACS registration process will only take 24 hours.

If, within one business day of receiving your IACS user ID and password, you do not get an e-mail confirming your Medicare enrollment, take the following actions:

- If you have not submitted an enrollment application since November of 2003, update your Medicare 855 enrollment form. Follow the instructions in Step 2. In addition, if you are not receiving Medicare payments via Electronic Funds Transfer, you will also need to complete a CMS-588 "Electronic Funds Transfer (EFT) Authorization Agreement."
- If you have been approved to participate in Medicare since November 2003, have been billing the Medicare program, and have an active enrollment with Medicare, contact your carrier or MAC.

***Steps for eligible professionals to access their PQRI feedback reports (continued)***

For additional information on registering in IACS, the Individual Practitioner New user Registration Quick Reference Guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

**Step four: Following receipt of your IACS user ID and password and a third e-mail confirming your Medicare enrollment, request a PQRI user role.**

Once you receive the enrollment confirmation e-mail referenced in Step three, go to the IACS site at *https://applications.cms.hhs.gov* on the CMS Web site.

- Read the contents of the *CMS Applications Portal Warning/Reminder* screen. Enter the CMS Applications Portal by clicking the *Enter CMS Applications Portal* button at the bottom of the screen.
- On the *CMS Applications Portal Introduction* page, click on the *Account Management* tab at the top of the screen.
- On the Account Management page, click the *My Profile* link.
- Login using your IACS user ID and password.
- On the *My Profile* page, click the *Modify Account Profile* link.
- On the *Modify Account Profile* page under *Access Request*, select *Modify Provider Profile* from the *Select Action* list box if this is your first time requesting access to an application via IACS. If your profile is already associated to other applications that use IACS, select *Add Application* from the *Select Action* list box.
- Select the *PQRI user* role.

The *Request Access to CMS Application Quick Reference Guide* provides instructions for requesting an application role. It may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

**Step five: Enter PQRI application**

If you have reported PQRI quality measures, have an IACS account and an established PQRI user role, you may access your PQRI feedback report by going to *http://www.qualitynet.org/pqri* using your IACS user ID and password. This site also contains a user guide for the PQRI system, and instructions for interpreting your 2007 PQRI feedback report.

### Additional help for IACS

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

### Additional help for PQRI

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

For questions concerning the status of PQRI incentive payments and any offset applied, contact your carrier or MAC provider call center. The Provider Call Center Toll Free Numbers Directory, which offers information on how to contact the appropriate provider call center, is available for download at *http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp* on the CMS Web site.

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

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

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## Steps for IACS defined organizations to access their Physician Quality Reporting Initiative feedback reports

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

**Note:** This article was revised on November 25, 2008, to provide clarification of some of the steps involved in registering to access the reports and to clarify who should register as organizations. This information was previously published in the September 2008 *Medicare B Update!* pages 49-51.

### Provider types affected

This article is directed to group practices that are corporations or limited liability companies in which at least one eligible professional reported Physician Quality Reporting Initiative (PQRI) quality measures data to Medicare.

### Provider action needed

PQRI feedback reports are available on a secure Web site to IACS-defined organizations that reported PQRI quality measures in a given year. For access to certain CMS provider Internet applications, including PQRI, an organization must first register in the CMS security system known as the Individuals Authorized Access to CMS Computer Services (IACS). IACS registration provides a user ID and password that may be used to access CMS applications such as the "PQRI Feedback Report" application. You only register in IACS once. As a result of that single registration, you are able to access certain other CMS Internet applications in addition to the PQRI feedback report application.

***Steps for IACS defined organizations to access their PQRI feedback reports (continued)***

**Note:** Do not register as an organization in IACS if you are a private practice that is a sole proprietorship with or without employees that is paid directly by Medicare. Those practices must register as individual practitioners and access their PQRI feedback reports personally because they may not have the requisite Internal Revenue Service (IRS) documents described in this article. Refer to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf* for information about how to register in IACS as an individual practitioner and access PQRI feedback reports.

**I. Registering in IACS as an organization.**

This process will take roughly ten business days following submission of IRS documents.

To access your PQRI feedback report, register in IACS as an organization if you are:

- A group practice as described at the beginning of this document which receives Medicare payments on behalf of its members, or
- An individual practitioner who has reassigned benefits to a group practice and is directed by that group practice to register in IACS to access the PQRI feedback reports of that group practice. Professionals who have reassigned Medicare benefits to a group practice should otherwise **not** register in IACS to view the group practice's PQRI feedback reports.
- IACS-defined organization registration requires entry of a legal business name (LBN) and a taxpayer identification number (TIN) (the employer identification number [EIN]). CMS will verify that information against IRS documents submitted by the security official (SO) for the organization.
- One PQRI feedback report will be prepared for each TIN to which Medicare payments are sent.
- The group practice will be responsible for sharing national provider identifier (NPI) level PQRI information with the appropriate professionals in the group practice.
- Up to 10 individuals can be approved as end users to access the PQRI feedback report for each organization registered in IACS.

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

**Step 1: The organization SO must register and be approved in IACS.**

If your organization already has an SO approved in IACS, do not register another SO.

IACS employs a delegated-approval model. The SO for the organization is the first person in that organization to register in IACS. The SO is the person who registers the organization in IACS and updates the organization's profile information in IACS. There can be only one SO for an organization. The SO is trusted by the organization to approve subsequent registration requests of backup SO(s) and user group administrators (UGAs) and can approve the application (e.g., the PQRI Feedback Report Application) access requests of UGAs and end users.

Because of these approval roles, the SO is not permitted to access any applications, including the PQRI feedback report application.

It is strongly suggested a backup SO be designated as well. This will avoid delays and confusion in the event an SO leaves the organization or is otherwise unavailable.

- Go to *https://applications.cms.hhs.gov* on the CMS Web site and register as an SO. The SO should then receive an e-mail from CMS' End User Services (EUS) Help Desk requesting IRS documentation and the e-mail will include the address to which the documentation should be sent.
- Submit IRS documentation containing IRS letterhead, a typed LBN and a typed TIN (EIN) to the EUS Help Desk. Examples include photocopies of an IRS CP-575 form, IRS 147C letter, or a federal tax deposit coupon. The LBN and TIN used to register in IACS must match the LBN and TIN that are shown on the IRS documents.
- Within about ten business days and once the IACS registration information has been verified by the EUS help desk, the SO will receive an IACS user ID and password via two separate e-mails.

**Step 2: The organization's UGA must register in IACS and be approved by the SO.**

A UGA registers the user group within an IACS-defined organization and updates the user group profile information in IACS. The SO or UGA is trusted to approve the access requests of end users for that user group.

- Go to *https://applications.cms.hhs.gov* on the CMS Web site and register as a UGA for an organization.
- IACS will send an e-mail to the SO for approval.
- If approved, the UGA will receive an IACS user ID and password via two separate e-mails.

In rare cases where there will be only one user in a user group, that user must register as a UGA. The UGA may be approved to access the 2007 PQRI feedback report negating the need for end users to register.

**Step 2a: Organization end users must register in IACS and be approved by the UGA.**

**Note:** This step is optional if the UGA will access the PQRI feedback report application as described above in Step 2.

An end user is usually a staff member who is trusted to perform Medicare business for the organization.

- Go to *https://applications.cms.hhs.gov* on the CMS Web site and register as an end user in an organization user group.
- IACS will send an email to the UGA for approval.
- If approved, the end user will receive an IACS user ID and password via two separate emails.

**Step 3: Request a PQRI feedback report application role**

- Both UGAs and end users have the ability to request PQRI roles.
- Go to the IACS site at *https://applications.cms.hhs.gov* on the CMS Web site.

***Steps for IACS defined organizations to access their PQRI feedback reports (continued)***

- Read the contents of the *CMS Applications Portal Warning/Reminder* screen. Enter the CMS Applications Portal by clicking the *Enter CMS Applications Portal* button at the bottom of the screen.
- On the *CMS Applications Portal Introduction* page, click on the *Account Management* tab at the top of the screen.
- On the Account Management page, click the *My Profile* link.
- Login using your IACS user ID and password.
- On the *My Profile* page, click the *Modify Account Profile* link.
- On the *Modify Account Profile* page under *Access Request*, select *Modify Provider Profile* from the Select Action list box if this is your first time requesting access to an application via IACS. If your profile is already associated to other applications that use IACS, select *Add Application* from the *Select Action* list box.
- Select the *PQRI Use*" role.

You will be presented the option to choose one of two PQRI roles: *PQRI approver* or *PQRI user*. In most cases PQRI user is the proper selection. Do not select PQRI approver unless someone other than the SO will be designated to approve PQRI user requests. The assumption is that the SO will approve PQRI users.

**Step 4: Enter PQRI feedback report application**

Go to *http://www.qualitynet.org/pqri* and use your IACS user ID and password to gain access to your PQRI feedback report.

This site also contains a user guide for the PQRI system, and instructions for interpreting your 2007 PQRI feedback report.

**III. IACS quick reference guides**

More information on registering for the SO, BSO, UGA or End User role can be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Quick reference guides address:

- Registering as an SO, UGA, end user
- Request access to CMS application (request PQRI user role)
- Approvers
  - Click on *General User Guides and Resources* in the left column for approver guide, which provides steps to approve registration requests (SO approves UGA, UGA approves end user), and for the SO to approve PQRI user role requests from UGA and/or end user.

**IV. Additional help for IACS**

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

**V. Additional help for PQRI**

More information about accessing PQRI participant feedback reports is posted on *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

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

For questions concerning the status of PQRI incentive payments and any offset applied, contact your carrier or Medicare administrative contractor (MAC) provider call center. The Provider Call Center Toll Free Numbers Directory, which offers information on how to contact the appropriate provider call center, is available for download at *http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp* on the CMS Web site.

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

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

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# New 2007 Physician Quality Reporting Initiative report

## Reporting experience for the 2007 Physician Quality Reporting Initiative

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the release of a new report titled *Physician Quality Reporting Initiative (PQRI): 2007 Reporting Experience*. The report provides a detailed analysis of the 2007 PQRI reporting experience and outlines some of the challenges and successes of the 2007 program, as well as some of the business reasons that may explain why these challenges occurred.

Specifically, the report describes several issues identified for 2007 and CMS' plans for modifications to the analytics for the 2008 PQRI. In addition, CMS will apply these modifications to the 2007 PQRI data and rerun the data. Based on these efforts, CMS expects that additional eligible professionals will qualify for an incentive payment for both 2007 and 2008. It is anticipated that these activities will be completed by the fall of 2009.

The report is available online at *http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportExperience.pdf* on the CMS Web site.

This report was also discussed on the PQRI national provider call held on Tuesday, December 16, 2008, from 3:30 p.m. EST to 5 p.m. EST.

To learn more about PQRI, visit *http://www.cms.hhs.gov/pqri* on the CMS Web site.

Source: PERL 200812-18

# 2009 Physician Quality Reporting Initiative program updates

## 2009 Physician Quality Reporting Initiative measures specifications are now available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the release of the detailed specifications for the 2009 Physician Quality Reporting Initiative (PQRI) measures and the 2009 PQRI measures groups. The following resources have been posted to the PQRI Web page on the CMS Web site:

**2009 PQRI Quality Measures Specifications Manual and Release Notes**: Contains the detailed specifications (including codes and reporting instructions) for the 153 2009 PQRI quality measures for claims or registry-based reporting and a summary of the changes from the 2008 PQRI measure specifications (in the form of release notes delineated by measure number).

**2009 PQRI Implementation Guide**: Provides guidance about how to implement 2009 PQRI claims-based reporting of measures to facilitate satisfactory reporting of quality data codes by eligible professionals for the 2009 PQRI.

**2009 PQRI Measures Group Specifications Manual and Release Notes**: Contains the detailed specifications and instructions for the seven 2009 PQRI measures groups and a summary of the changes from the 2008 PQRI measures groups specifications (in the form of release notes).

**Getting Started with 2009 PQRI Reporting of Measures Groups**: Provides guidance about implementing the 2009 PQRI measures groups.

To access the 2009 PQRI Measures Specifications Manual and Release Notes, the 2009 PQRI Implementation Guide, the 2009 PQRI Measures Group Specifications Manual and Release Notes, or the Getting Started with 2009 PQRI Reporting of Measures Groups, visit *http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage* on the CMS Web site. Once on the *Measure/Codes* page, scroll down to the *Downloads* section, and click on the appropriate link.

Source: CMS PERL 200812-39

Please note that the 2009 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality measure used in 2008. Therefore, specifications for all 2009 PQRI quality measures, whether or not included in the 2008 PQRI program, must be obtained from the 2009 PQRI Quality Measures Specifications Manual.

In addition, measures group specifications are different from the specifications for individually reported measures that form the group. Therefore, the specifications and reporting instructions for the 2009 PQRI measures groups must be obtained from the 2009 PQRI Measures Group Specifications Manual.

Reporting for the 2009 PQRI begins January 1, 2009. Please note there is no need to sign up or pre-register in order to participate.

## New section page on the Physician Quality Reporting Initiative Web page

CMS is pleased to announce a new section page on the Physician Quality Reporting Initiative Web page. The *Spotlight* section page may be accessed on PQRI Web page at *http://www.cms.hhs.gov/pqri/* on the CMS Web site. Once on the PQRI Web page, select *Spotlight* from the side menu. The *Spotlight* page is updated frequently and was created to alert eligible professionals to the newest program information available on the PQRI Web page.

Detailed information on the 2009 PQRI may be found in the 2009 Medicare physician fee schedule final rule with comment period (73 FR 69817 through 69847) that was published in the *Federal Register* on November 19, 2008. The final rule with comment period can be found in the *Related Links Outside of CMS* section of the Physician Quality Reporting Initiative on the CMS Web site at *http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf*.

Reporting for the 2009 PQRI begins January 1, 2009. Please note there is no need to sign up or pre-register in order to participate.

# CMS posts Physician Quality Reporting Initiative information on Web site

Beginning December 19, 2008, the names of physicians and other health care professionals who reported quality information under the Physician Quality Reporting Initiative (PQRI) in 2007 are available at *http://www.medicare.gov/Physician*, the physician and other health care professional directory located on *www.medicare.gov*. This information includes all eligible professionals identified by their national provider identifier (NPI) who submitted at least one quality data code on their Medicare claims for services furnished between July 1, 2007, and December 31, 2007.

The PQRI is a voluntary reporting program. A physician or other health care professional may choose whether to report quality information to Medicare under the PQRI program. Reporting quality information by professionals is an important means to promote improved quality of care to Medicare beneficiaries. There are, however, numerous reasons why physicians or other health care professionals, who are committed to providing high quality care to their patients, may have chosen not to report quality information under the PQRI program, which began in 2007.

For more information on the PQRI and the instructions for reporting and requirements for satisfactory reporting, go to *http://www.cms.hhs.gov/pqri*.

Detailed information on the 2009 PQRI may be found in the 2009 Medicare physician fee schedule final rule with comment period (73 FR 69817 through 69847) that was published in the *Federal Register* on November 19, 2008. The final rule with comment period may be found in the *Related Links Outside of CMS* section of the Physician Quality Reporting Initiative on the CMS Web site at *http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf*.

Reporting for the 2009 PQRI begins January 1, 2009. Please note there is no need to sign up or pre-register in order to participate.

Source: PERL 200812-43

## New Physician Quality Reporting Initiative educational resources

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that two new educational resources on the 2009 Physician Quality Reporting Initiative (PQRI) have been posted to the PQRI Web page on the CMS Web site.

### 2009 PQRI quality measures list

This reference list outlines the 153 quality measures which were published in the in the Medicare physician fee schedule (MPFS) 2009 final rule on November 19, 2008. To access the *2009 PQRI Quality Measures List*, visit *http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage* on the CMS Web site. Once on the *Measures/Codes* page, scroll down to the *Downloads* section and click on the *2009 PQRI Quality Measures List* link.

The detailed measure specifications will be available on this Web page on or before December 31, 2008.

### Registry requirements for submission of 2009 PQRI data on behalf of eligible professionals

This document describes the high-level requirements for a registry to qualify to submit under the registry-based reporting alternatives for 2009. This document also outlines how a registry can become qualified for 2009 data submission. To access the R*egistry Requirements for Submission of 2009 PQRI Data on Behalf of Eligible Professionals* document, visit *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage* on the CMS Web site. Once on the Reporting page, scroll down to the *Downloads* section and click on the *Registry Requirements* for *Submission of 2009 PQRI Data on Behalf of Eligible Professionals* link.

To qualify to submit data on behalf of eligible professionals seeking incentive payments for 2009, registries are required to go through a self-nomination and vetting process if they are new to PQRI registry reporting or to notify CMS of their desire to continue PQRI data submission in 2009 if they were qualified in 2008. Selected registries must meet certain technical and other requirements specified by CMS.

Detailed information on the 2009 PQRI, including the 2009 registry requirements, may be found in the 2009 MPFS final rule with comment period (73 FR 69817 through 69847) that was published in the *Federal Register* on November 19, 2008. The final rule with comment period may be found in the Related Links Outside of CMS section of the Physician Quality Reporting Initiative on the CMS Web site at: *http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf*.

Source: PERL 200812-18

## 2008 Physician Quality Reporting Initiative claims-based reporting of measures groups -- change request and article rescinded

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

Since the Center for Medicare & Medicaid Services rescinded related change request (CR) 6187, this article has been rescinded also. CR 6187 will not be replaced at this time. A new CR will be prepared for the 2009 Physician Quality Reporting Initiative. This information was previously published in the November 2008 *Medicare B Update!* pages 34-37.

MLN Matters number: MM6187 *Rescinded*
Related change request (CR) #: 6187
Related CR release date: November 14, 2008
Effective date: July 1, 2008
Related CR transmittal #: R401OTN
Implementation date: December 15, 2008

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## A CMS quick reference information resource for flu season

**Flu season is here!** Medicare provides coverage of the flu vaccine without any out-of-pocket costs to Medicare patients. No deductible or copayment/coinsurance applies. For quick information to assist with filing claims for the influenza vaccine and its administration, the Centers for Medicare & Medicaid Services (CMS) has prepared the *Quick Reference Information: Medicare Part B Immunization Billing chart (Feb. 2008)*. This two-sided laminated reference chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to coding and billing information. To view, download, and print the quick reference chart, go to the CMS Web site *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

To order a copy, free of charge, go to the MLN Products Ordering Web page at *http://cms.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs*.

**Get your flu shot – not the flu.**

Source: PERL 200811-41

# Influenza pandemic emergency -- the Medicare program prepares

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

**Note:** This article was revised on December 8, 2008, to include a Web link to change request (CR) 6209, which was recently issued by the Centers for Medicare & Medicaid Services (CMS). All other information remains the same. This information was previously published in the October 2008 *Medicare B Update!* page 43.

## 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 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; and
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; and
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* on the CMS Web site. 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 6146, which may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf* on the CMS Web site
- CR 6164, which may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf* on the CMS Web site
- CR 6174, which may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf* on the CMS Web site, and
- CR 6209, which is available at *http://cms.hhs.gov/Transmittals/downloads/R411OTN.pdf* on the CMS Web site.

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

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

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

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# The Adult Immunizations brochure now available for ordering

The October 2008 version of the Adult Immunizations tri-fold brochure, which provides fee-for-service health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration, is now available for ordering from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* (*MLN*). To place your order, *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp*, scroll down to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

Source: PERL 200812-37

## National Influenza Vaccination Week

The Centers for Disease Control and Prevention (CDC) has announced the week of December 8-14, 2008, as National Influenza Vaccination Week. This week-long event is designed to raise awareness of the importance of continuing influenza (flu) vaccination, as well as foster greater use of flu vaccine in December, January, and beyond. Since flu activity typically does not peak until February or later, December and January still provide good opportunities to offer flu shots.

This year, Thursday, December 11, is designated as Seniors' Vaccination Day. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare get their flu shots. Please use this week-long event as an opportunity to place greater emphasis on flu prevention. If you have Medicare patients who have not yet received their annual flu shots, we ask that you encourage these patients to protect themselves from the seasonal flu and serious complications arising from the flu virus by recommending that they take advantage of the flu shot benefit covered by Medicare.

**Remember**: Health care professionals and their staff are also at risk for contracting and spreading the flu virus, so don't forget to immunize yourself and your staff. Protect yourself, patients, family and friends.

**Get your flu shot -- not the flu!**

**Note**: Influenza vaccine plus its administration are covered Part B benefits. Influenza vaccine is not a Part D covered drug.

### For more information

Learn more about Medicare's coverage of the flu vaccine and other Medicare Part B covered vaccines and related provider education resources created by CMS, by reviewing special edition *MLN Matters* article SE0838 located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf* on the CMS Web site.

For more information about National Influenza Vaccination Week, please visit the Centers for Disease Control and Prevention's Web site at *http://www.cdc.gov/flu/nivw/*.

Source: PERL 200812-19

## Flu shot reminder

It's not too late to get the flu shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. Re-vaccination is necessary each year because flu viruses change each year. So please encourage your Medicare patients who haven't already done so to get their annual flu shot. Medicare patients give many reasons for not getting their annual flu shot, including:

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

The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting an annual flu shot.

Also, don't forget to immunize yourself and your staff. Protect yourself, your patients, your family and friends.

**Get your flu shot – not the flu!**

**Remember:** Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug.

### Educational resources

Health care professionals and their staff may learn more about Medicare's coverage of the influenza vaccine and its administration, and other Medicare Part B covered vaccines and related provider education resources created by the CMS *Medicare Learning Network* (*MLN*), by reviewing special edition *MLN Matters* article SE0838 on the CMS Web site *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf*.

Additional information is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf*.

To download the Medicare Part B Immunization Billing quick reference chart, go to the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*. A copy of this quick reference chart may be ordered at no charge by going to the *MLN Products* Web page and clicking on *MLN Product Ordering Page* in the *Related Links Inside CMS* section of the Web page.

Source: PERL 200811-36, 200812-02, 200812-47

## CMS issues press release on improper payment rates for Medicare, Medicaid, and SCHIP

The Center for Medicare & Medicaid Services has reported it protected roughly $400 million of taxpayer dollars. Improper payments for Medicare fee-for-service (FFS) decreased from 3.9 percent in fiscal year (FY) 2007 to 3.6 percent (or $10.4 billion) in FY 2008. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) improper payment rates are issued annually as part of the U.S. Department of Health & Human Services (HHS) agency financial report.

In addition to improved Medicare FFS payments for FY 2008, CMS reports its first Medicare Advantage improper payment rate of 10.6 percent (or $6.8 billion) in payments made in calendar year 2006. Also being reported for the first time are the FY 2007 national composite error rates for Medicaid and SCHIP. The Medicaid composite error rate is 10.5 percent (or $32.7 billion) of which the federal share is $18.6 billion. The SCHIP composite error rate is 14.7 percent (or $1.2 billion) with a federal share of $0.8 billion.

To read the complete CMS press release issued November 7, 2008, click here: *http://www.cms.hhs.gov/apps/media/press_releases.asp*.

Source: PERL 200811-32

## What's new for Medicare fee-for-service providers on the CMS Web site

The Centers for Medicare & Medicaid Services (CMS) is continually updating and improving the fee-for-service (FFS) provider Web pages to make it easier for FFS providers to find important information on the CMS Web site. CMS notifies interested parties via the FFS provider listserv periodically when those revisions are made. Most of the Medicare FFS provider Web pages may be found on the Medicare page at *http://www.cms.hhs.gov/home/medicare.asp*. The following Medicare FFS provider Web pages are a sample of what's been updated:

- These sections have been improved by adding dynamic lists for provider specific regulations and notices and transmittals for inpatient psychiatric facilities (*http://www.cms.hhs.gov/InpatientPsychFacilPPS/*) and hospice (*http://www.cms.hhs.gov/Hospice/*) providers.
- The Educational Resources section of the Hospital-Acquired Conditions (HAC) & Present on Admission (POA) Indicator Reporting Web page (*http://www.cms.hhs.gov/HospitalAcqCond/*) has recently been updated to include the agenda for the hospital-acquired conditions and hospital outpatient healthcare-associated conditions listening session scheduled for Thursday, December 18, 2008.
- Effective for dates of service on or after January 1, 2009, the National Correct Coding Initiative (NCCI) edits will not categorically exclude any types of services. For more information, go to the Hospital Outpatient PPS and Therapy NCCI Web page at (*http://www.cms.hhs.gov/NationalCorrectCodInitEd/02_hoppscciedits.asp*). These institutional NCCI edits will be available on or about January 1, 2009 at: (*http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp*). To review the types of NCCI edits that were previously excluded from the institutional version but are currently included in the physician version for these categories, refer to the NCCI files on the following page *http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp*.
- See the updates to the Competitive Acquisition for Part B Drugs & Biologicals (*http://www.cms.hhs.gov/CompetitiveAcquisforBios/*) Web pages which reflect the major changes to this program.

Check out what's new for you.

Source: PERL 200812-31

## Guide for residents, practicing physicians, and other health care professionals

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (October 2008)*, which offers general information about the Medicare program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare trust fund, inquiries, overpayments, and appeals, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp*, scroll down to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

Source: PERL 200812-33 & 200812-38

## Medicare Part B drugs average sales price files -- January 2009

The Centers for Medicare & Medicaid Services (CMS) has made available the Medicare Part B drug and biological average sales price (ASP) payment amounts for January 1, 2009, to March 31, 2009, on the CMS Web site at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2009aspfiles.asp#TopOfPage*. The files are located in the *Downloads* section of this Web page.

Source: PERL 200812-35

## Listening session transcript for Medicare value-based purchasing initiative

The Centers for Medicare & Medicaid Services (CMS) has posted the transcript and audio download for the December 9, 2008, listening session on the issues paper regarding development of a plan to transition to Medicare value-based purchasing for physician and other health professional services. The plan was mandated by the Medicare Improvements for Patients and Providers Act of 2008. The transcript and audio download, along with the agenda, PowerPoint slides, and issues paper from the listening session are posted on the CMS Web site Physician Center Spotlights at: *http://www.cms.hhs.gov/center/physician.asp*.

Source: PERL 200812-32

## Facilitator's Guide: Companion to Medicare Physician Guide

The revised Facilitator's Guide – Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (October 2008) is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*.

This publication includes all the following information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program:

- instructions for facilitators
- customization guide
- PowerPoint presentation with speaker notes
- pre- and post-assessments
- master assessment answer keys, and
- evaluation tools.

Source: PERL 200812-10

# LOCAL COVERAGE DETERMINATIONS

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

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

## Effective and Notice Dates

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

## Electronic Notification

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

## More Information

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

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

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## Advance beneficiary notice

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

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

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

# RETIRED LCDS

## 95250: Continuous glucose monitoring system -- LCD retired
**LCD ID number: L6179**

The local coverage determination (LCD) for continuous glucose monitoring system (CGMS) was last revised on January 1, 2006. Since that time, it has been determined that this LCD should be retired. Based on First Coast Service Options Inc. (FCSOs) annual review of active LCDs it was determined that the LCD for continuous glucose monitoring system is inconsistent with documentation from the Centers for Medicare & Medicaid Services (CMS) resulting from a Medicare Evidence Development and Coverage Advisory Committee (MedCAC) meeting of August 30, 2006. Until further documentation to support the appropriateness of CGMS in relation to type II diabetes is published, this LCD will be retired.

### Effective date
This revision is effective for services rendered on or after February 2, 2009. The full text of this retired LCD is available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

## 97802: Medical nutrition therapy -- LCD retired
**LCD ID number: L5931**

The local coverage determination (LCD) for medical nutrition therapy (MNT) was last revised on October 1, 2005. Since that time, it has been determined that this LCD should be retired based on national coverage determination (NCD) 180.1.

### Effective date
This revision is effective for services rendered on or after February 2, 2009. The full text of this retired LCD is available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

# REVISION TO THE LCD

## THERSVCS: Therapy and rehabilitation services -- revision to the coding guidelines
**LCD ID Number: L6196**

The coding guidelines attachment for therapy and rehabilitation services was last revised on July 1, 2008. Since that time, the coding guidelines attachment has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 6254, transmittal 1625, dated October 31, 2008, Annual Update to the Therapy Code List.
The following language has been added effective January 1, 2009:

- *CPT 95992* -- Standard Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day -- is considered a “sometimes therapy” code. This is a bundled procedure and therefore will not be paid separately. This service is considered included into other services performed on the same day. If providers do bill this procedure code on a claim the appropriate therapy modifier must be attached, however separate payment will not be made.
- *CPT 0183T* -- low-frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment and instruction(s) for ongoing care, per day -- is considered a “sometimes therapy” code. *0183T* is currently in the list of Medicare noncovered services local coverage determination (LCD) as an investigational procedure. Therefore, this service is not payable by Medicare and will be denied as such when billed.

### Effective date
This revision to the Coding Guidelines attachment is effective for claims processed on or after January 5, 2009, for services rendered on or after January 1, 2009. First Coast Service Options Inc., LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting *LCD Attachments* in the *Jump to Section* dropdown menu at the top of the LCD page.

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# ADDITIONAL INFORMATION

## Clarification on correct administration of Neupogen® and Neulasta™

Providers continue to inappropriately administer Neupogen® (J1440 and J1441) and Neulasta™ (J2505) to patients who are receiving a chemotherapeutic agent.

Neupogen® is a class II hematopoietic growth factor that acts on progenitor cells. Because Neupogen® acts only on progenitor cells that are already committed to one pathway, it increases only the neutrophil count. The local coverage determination (LCD) for Neupogen® outlines the Food and Drug Administration (FDA)-approved indications as well as the off-label indications FCSO will cover when the medical necessity criteria are met. Under the "Limitations" section of the G-CSF (Filgrastim, Neupogen®) LCD, it is outlined that Neupogen® should not be given within 24 hours before or 24 hours after a dose of a chemotherapeutic agent, as rapidly dividing myeloid cells are potentially sensitive to these agents. This instruction follows the FDA-approved label. This rule applies to any indication in the LCD that requires the administration of a chemotherapeutic agent.

Neulasta™ is a colony stimulating factor (CSF) that acts on hematopoietic cells by binding to specific cell surface receptors thereby, stimulating proliferation, differentiation, commitment, and end cell functional activation. The LCD for Neulasta™ outlines the FDA-approved indications as well as the off-label indication FCSO will cover when the medical necessity criteria are met. Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the Pegfilgrastim (Neulasta™) LCD, it is outlined that Neulasta™ administration should not occur within 14 days before and 24 hours after administration of cytotoxic chemotherapy.

The continued practice of inappropriate administration of Neupogen® and Neulasta™ may prompt medical review of documentation to ensure the appropriate FDA-labeling is followed.

FCSO strongly encourages providers to review the current LCDs for Neupogen® and Neulasta™ to ensure their patients meet the coverage criteria outlined for each indication and that all other documentation and utilization requirements are met. LCDs may be located through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Questions regarding coverage or the appropriate administration of Neupogen® or Neulasta™ can be forwarded to *medical.policy@fcso.com*. FCSO also has a process in place that providers can follow when they feel LCD reconsideration may be appropriate. The LCD reconsideration process is outlined at *http://www.floridamedicare.com/Part_B/Local_Medical_Coverage/108779.asp*. For reconsideration of this issue, then the appropriate clinical literature supporting administration outside the FDA-approved indications must be submitted to the medical policy department for review and consideration. If you find that your facility has been reimbursed for services that are outside Medicare coverage guidelines, you may find information regarding an overpayment refund at *http://www.floridamedicare.com/Part_B/Forms/105650.pdf*.

## Intravenous Emend® (Fosaprepitant)

Emend® (aprepitant) capsules for oral (po) administration and Emend® (fosaprepitant dimeglumine) for injection, when given in combination with other antiemetic agents is indicated for:

- the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy including high-dose cisplastin, and
- the prevention of nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy.

Emend®, administered orally, is a covered benefit for a three dose oral pack as outlined in the Centers for Medicare & Medicaid Services (CMS) Pub. 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Section 110.18. The three dose oral regimen is covered and paid by the durable medical equipment Medicare administrative contractor (DMEMAC). There is also a Part D or similar coverage in certain circumstances. For Medicare Part B to cover the intravenous (IV) product, the IV route of administration must meet the criteria for what is considered "reasonable and necessary" as outlined in the CMS Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.3, which indicates medication given by injection is not covered if standard medical practice indicates that the oral administration of the medication is effective and is an accepted or preferred method of administration.

If the patient tolerates the subsequent oral doses of aprepitant, the medical necessity for the IV route of administration on the initial dose is uncertain. Regardless of whether the initial IV dose is covered under Medicare Part B, the subsequent oral doses may be covered under the patient's Medicare Part D plan. When the initial dose is administered intravenously, none of the doses are covered through the DME benefit.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), First Coast Service Options Inc. (FCSO) is currently reviewing claims in which Emend® is administered intravenously to determine if the IV administration of Emend® meets the medical necessity criteria as outlined in the *Medicare Benefit Policy Manual*.

## J0881: Erythropoiesis Stimulating Agents -- clarification

### LCD ID number: L5984

Providers are applying the incorrect modifiers when billing erythropoiesis stimulating agents (ESAs) J0881 (Injection, darbepoetin alfa, 1 mcg (non-ESRD use) and J0885 (Injection, epoetin alfa, (for non-ESRD use), 1000 units. This article serves to outline the appropriate use of the modifiers for non-ESRD ESA administration and the appropriate ICD-9 CM diagnosis codes for each modifier.

Effective January 1, 2008 all claims reporting non-ESRD ESAs J0881 and J0885 are required to report one of the following modifiers:

EA: ESA, anemia, chemo induced
EB: ESA anemia, radio-induced
EC: ESA anemia, non-chemo/radio

The modifier EA should only be reported when the ESA is being given for anemia resulting from myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. The corresponding covered ICD-9 CM codes that would apply to the modifier EA are as follows: 140.0-149.9, 150.0-159.9, 160.0-165.9, 170.0-176.9, 179-189.9, 190.0-199.1, 200.0-200.88, 201.00-201.98, 202.00-202.98, 203.00-203.81, 204.00-204.91, 230.0-234.9, 235.0-235.9, 236.0-236.99, 237.0-237.9, 238.0, 238.1, 238.2, 2383, 238.4, 238.5, 238.6, 238.8, 238.9, 239.0-239.9, 273.3. The corresponding anemia code must also be billed. The dual diagnosis rule is outlined in the LCD. Any other covered diagnosis code listed in the LCD for J0881 or J0885 will be denied if billed with the modifier EA.

The modifier EC should only be reported for those covered indications outlined in the LCD for J0881 and J0885 where the anemia being treated is non-chemo/radio induced. FSCO has discovered that providers are billing the modifier EC for one of the covered cancer diagnosis codes listed above under the modifier EA instructions. By appending the modifier EC to a cancer diagnosis code, the provider is stating that the anemia for that cancer condition is not related to chemotherapy. Anemia of cancer not related to cancer treatment is a nationally noncovered condition per the NCD issued by CMS for non-ESRD ESA use. The following are the appropriate ICD-9 CM diagnosis codes that would apply when billing the modifier EC:

**For J0881** -- 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 273.3, 585.1, 585.2, 585.3, 585.4, 585.5, 585.9

**For J0885** -- 042, 070.54, 070.70, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 273.3, 585.1, 585.2, 585.3, 585.4, 585.5, 585.9, 714.0, V07.8

The corresponding anemia code must also be billed. The dual diagnosis rule is outlined in the LCD. The modifier EB is noncovered. If billed with an ESA the claim will be denied. All other conditions of coverage are outlined in the LCD and corresponding coding guideline. FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. If providers have questions regarding coverage of ESAs, please send correspondence to *medical.policy@fcso.com*.

## 2009 HCPCS local coverage determination changes

Florida Medicare has revised local coverage determinations (LCDs) impacted by the 2009 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

| LCD title | Changes |
|---|---|
| ALEFACEPT Alefacept **(Coding Guidelines only)** | Deleted *CPT* code *90772*<br>Added *CPT* code *96372* |
| APBI Accelerated Partial Breast Irradiation (APBI) | Descriptor change for *CPT* codes *19296* and *19297*<br>Retired "Coding Guidelines" attachment |
| IDTF Independent Diagnostic Testing Facility **(Coding Guidelines only)** | Deleted *CPT* codes *93727*, *93731*, *93732*, *93733*, *93734*, *93735*, *93736*, *93741*, *93742*, *93743*, and *93744*<br>Added *CPT* codes *93228*, *93229*, *93279*, *93280*, *93281*, *93282*, *93283*, *93284*, *93285*, *93286*, *93287*, *93288*, *93289*, *93290*, *93291*, *93292*, *93293*, *93294*, *93295*, *93296*, *93297*, *93298*, *93299*, *93306*, *93351*, and *93352* |
| J1561 Intravenous Immune Globulin | Descriptor change for HCPCS code J1572<br>Deleted HCPCS code Q4097<br>Added HCPCS code J1459<br>Deleted HCPCS code G0332 from the "Coding Guidelines" attachment<br>Changed Contractor's Determination Number to J1459 |
| J2792 Rho (D) Immune Globulin Intravenous | Descriptor change for HCPCS codes J2788 and J2790 |
| J9000 Doxorubicin HCl | Descriptor change for HCPCS code J9000 |
| J9001 Doxorubicin, Liposomal (Doxil) | Descriptor change for HCPCS code J9001 |
| J9010 Alemtuzumab (Campath®) | Descriptor change for HCPCS code J9010 |

***2009 HCPCS local coverage determination changes (continued)***

| LCD title | Changes |
|---|---|
| J9015 Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2) | Descriptor change for HCPCS code J9015 |
| J9045 Carboplatin (Paraplatin®, Paraplatin-AQ®) | Descriptor change for HCPCS code J9045 |
| J9160 Denileukin Diftitox (Ontak®) | Descriptor change for HCPCS code J9160 |
| J9170 Docetaxel (Taxotere®) | Descriptor change for HCPCS code J9170 |
| J9181 Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) | Descriptor change for HCPCS code J9181<br>Deleted HCPCS code J9182 |
| J9185 Fludarabine (Fludara®) | Descriptor change for HCPCS code J9185 |
| J9200 Floxuridine (FUDR) | Descriptor change for HCPCS code J9200 |
| J9201 Gemcitabine (Gemzar®) | Descriptor change for HCPCS code J9201 |
| J9206 Irinotecan (Camptosar®) | Descriptor change for HCPCS code J9206 |
| J9212 Interferon | Descriptor change for HCPCS codes J9212, J9214, J9215, and J9216 |
| J9213 Interferon, alfa-2a (Roferon®-A) | Descriptor change for HCPCS code J9213 |
| J9265 Paclitaxel (Taxol®) | Descriptor change for HCPCS code J9265 |
| J9300 Gemtuzumab Ozogamicin (Mylotarg™) | Descriptor change for HCPCS code J9300 |
| J9310 Rituximab (Rituxan®) | Descriptor change for HCPCS code J9310 |
| J9350 Topotecan Hydrochloride (Hycamtin®) | Descriptor change for HCPCS code J9350 |
| J9355 Trastuzumab (Herceptin®) | Descriptor change for HCPCS code J9355 |
| J9390 Vinorelbine Tartrate (Navelbine®) | Descriptor change for HCPCS code J9390 |
| J9600 Porfimer (Photofrin®) | Descriptor change for HCPCS code J9600 |
| NCSVCS The List of Medicare Non-covered Services | Descriptor change for *CPT* codes *0092T*, 0095T*, 0098T*, 0124T*, 0163T*, 0164T*, 0165T*, 20985*, 22857*, 22862*, 22865*, and 34806* (* investigational)*<br>Changed *CPT* code *53899* (RENESSA system)* to *CPT* code *0193T**<br>Deleted *CPT codes 0026T, 0028T*, 0029T*, 0031T, 0032T, 0058T, 0059T, 0088T*, 0089T*, 0090T*, 0093T*, 0096T*, 0162T*, 20986*, and 20987**<br>Added *CPT* codes *0054T*, 0055T*, 0194T*, 0195T*, 0196T*, 0198T*, 22856*, 22861*, 22864*, 41530*, 53899* (Treatment(s) for incontinence, pulsed magnetic neuromodualtion, per day), 76499* (Dual energy x-ray absorptiometry [DEXA] body composition study, one or more sites), 95803*, 95980*, 95981*, and 95982** to the "Local Noncoverage Decisions" section of the LCD<br>Added *CPT* codes *58999 (Speculoscopy), 84999 (Lipoprotein, direct measurement, intermediate density lipoproteins [IDL], [remnant lipoprotein]), 89240, 90650* and *90681* to the "Local Noncoverage Decisions" section of the LCD |
| SKINSUB Skin Substitutes | Deleted HCPCS codes J7340, J7341, J7342, J7343, and J7344<br>Added HCPCS codes Q4100, Q4101, Q4102, Q4105, and Q4106<br>Added modifiers JC and JD to the "Coding Guidelines" attachment |
| 11000 Debridement Services | Descriptor change for *CPT* code *11001* |
| 64400 Peripheral Nerve Blocks | Descriptor change for *CPT* codes *64416, 64446, 64448, and 64449* |
| 64561 Sacral Neuromodulation **(Coding Guidelines only)** | Descriptor change for HCPCS code L8689 |

***2009 HCPCS local coverage determination changes (continued)***

| LCD title | Changes |
|---|---|
| 64640 Destruction by neurolytic agent; interdigital nerve of the foot-Morton's Neuroma | Added *CPT* code *64632* |
| 78460 Cardiovascular Nuclear Imaging Studies **(Coding Guidelines only)** | Descriptor change for HCPCS code A9502 |
| 92025 Computerized Corneal Topography **(Coding Guidelines only)** | Added *CPT* code *65756* |
| 93224 Electrocardiographic Monitoring for 24 Hours (Holter Monitoring) | Descriptor change for *CPT* codes *93224, 93225, 93226, 93227, 93230, 93231, 93232, 93233, 93235, 93236, and 93237* |
| 93268 Patient Demand Single or Multiple Event Monitor | Descriptor change for *CPT* codes *93268, 93270, 93271, and 93272* |
| 93303 Transthoracic Echocardiography (TTE) | Descriptor change for *CPT* codes *93307* and *93308*<br>Added *CPT* code *93306* |
| 93350 Stress Echocardiography | Descriptor change for *CPT* code *93350*<br>Added *CPT* codes *93351* and *93352* |
| 95004 Allergy Skin Tests | Descriptor change for *CPT* codes *95010* and *95015* |
| 95250 Continuous Glucose Monitoring System (CGMS) | Descriptor change for *CPT* codes *95250* and *95251* |

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**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.

# EDUCATIONAL RESOURCES

## Upcoming provider outreach and education events

### January - February 2009

### Evaluation and Management (E/M) webcast

Topic: To be determined
When: January 20, 2009
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

### Ask-the-contractor webcast

Topic: Understanding and resolving duplicate claims
When: January 21, 2009
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

### Ask-the-contractor webcast

Topic: Understanding and resolving duplicate claims
When: January 22, 2009
Time: 1:00 p.m. – 2:30 p.m.
Type of Event: Teleconference

### Ask-the-contractor webcast

Topic: To be determined
When: February 10, 2009
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*

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