

MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

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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://medicare.fcso.com/>.

Routing Suggestions:

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



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Medicare B Update!

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

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

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THE FCSO MEDICARE B UPDATE!

About the FCSO Medicare B Update!

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

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

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

Who receives the Update?

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

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

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

We use the same mailing address for *all* correspondence, and cannot designate that the *Update!* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers

must keep their addresses current with the Medicare Provider Enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Update!* is arranged into distinct sections.

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

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

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131 form as part of the Beneficiary Notices Initiative (BNI). The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

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

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

ABN modifiers

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

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

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

"GA" modifier and appeals

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

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

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

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

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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://medicare.fcs.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

Ambulatory Surgical Center

January 2009 update of the ambulatory surgical center payment system

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

Provider types affected

ASCs that submit claims to Medicare administrative contractors (MACs) or carriers for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6323 and is a recurring update that describes changes to and billing instructions for various payment policies implemented in the January 2009 ambulatory surgical center (ASC) update. Make sure billing staff are aware of the changes.

Background

This notification includes updates to the Healthcare Common Procedure Coding System (HCPCS) for ASCs and updated payment rates for selected separately payable drugs and biologicals, long descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the calendar year (CY) 2009 ASC payment rates for covered surgical and ancillary services (ASCFS file).

Key points

Table 1 below shows updates to four core based statistical areas (CBSAs) recognized by the Centers for Medicare & Medicaid Services (CMS) for ASC claims with dates of service on and after January 1, 2009.

Table 1 - January 1, 2009 CBSA changes

County/state	FIPS code	2008 CBSA	2009 CBSA
Sarasota, Florida	12115	42260	14600
Chautauqua, New York	36013	27460	33
Garfield, Oklahoma	40047	21420	37
Stanly, North Carolina	37167	34	16740

Drugs and biologicals with payment based on average sales price (ASP) effective January 1, 2009

- In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for separately payable drugs and biologicals based on the ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.
- Effective January 1, 2009, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2009 outpatient prospective payment system/ambulatory surgical center (OPPS/ASC) final rule with comment period as a result of ASP calculations based on sales price submissions from the third quarter of CY 2008. In cases where the payment rates are different from those published in Addendum BB to the OPPS/ASC final rule with comment period in the *Federal Register*, the correct, updated payment rates have been incorporated into the January 2009 release of the ASC DRUG file. The updated payment rates effective January 1, 2009, for covered ancillary drugs and biologicals can be found in the January 2009 update of the ASC Addendum BB which may be viewed at <http://www.cms.hhs.gov/ASCPayment/ASCRN/ItemDetail.asp?ItemID=CMS1216691> on the CMS Web site.

New HCPCS codes for drugs and biologicals that are separately payable under the ASC payment system as of January 1, 2009.

- For CY 2009, new Level II HCPCS codes have been created for reporting specific drugs and biologicals for which no previous payable HCPCS code existed.
- Thirty of the new Level II HCPCS codes for reporting drugs and biologicals are separately payable to ASCs for dates of service on or after January 1, 2009. The new Level II HCPCS codes, their payment indicators, and long descriptors are displayed in Table 2 below. The CY 2009 ASC payment rates for the drugs and biologicals are in the January 2009 ASC DRUG file.

Table 2 - New level II HCPCS codes for drugs and biologicals separately payable under the ASC payment system for CY 2009

HCPCS code	CY 2009 payment indicator	Long descriptor
C9245	K2	Injection, romiplostim, 10 mcg
C9246	K2	Injection, gadoxetate disodium, per ml
C9248	K2	Injection, clevidipien butyrate, 1 mg

January 2009 update of the ambulatory surgical center payment system (continued)

HCPCS code	CY 2009 payment indicator	Long descriptor
J0641	K2	Injection, levoleucovorin calcium, 0.5 mg
J1267	K2	Injection, doripenem, 10 mg
J1453	K2	Injection, fosaprepitant, 1 mg
J1459	K2	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1750	K2	Injection, iron dextran, 50 mg
J1930	K2	Injection, lanreotide, 1 mg
J1953	K2	Injection, levetiracetam, 10 mg
J2785	K2	Injection, regadenoson, 0.1 mg
J3101	K2	Injection, tenecteplase, 1 mg
J7186	K2	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.
J8705	K2	Topotecan, oral, 0.25 mg
J9033	K2	Injection, bendamustine hcl, 1 mg
J9207	K2	Injection, ixabepilone, 1 mg
J9330	K2	Injection, temsirolimus, 1 mg
J0132	K2	Injection, acetylcysteine, 100 mg
J0470	K2	Injection, dimercaprol, per 100 mg
J0550	K2	Injection, penicillin g benzathine and penicillin g procaine, up to 2,400,000 units
J0630	K2	Injection, calcitonin salmon, up to 400 units
J1212	K2	Injection, dmsol, dimethyl sulfoxide, 50%, 50 ml
J1455	K2	Injection, foscarnet sodium, per 1000 mg
J2460	K2	Injection, oxytetracycline hcl, up to 50 mg
J2515	K2	Injection, pentobarbital sodium, per 50 mg
J2805	K2	Injection, sincalide, 5 micrograms
J3400	K2	Injection, triflupromazine hcl, up to 20 mg
J7191	K2	Factor viii (antihemophilic factor (porcine)), per i.u.
J7516	K2	Cyclosporin, parenteral, 250 mg
J9165	K2	Injection, diethylstilbestrol diphosphate, 250 mg
90296	K2	<i>Diphtheria antitoxin, equine, any route</i>
90378	K2	<i>Respiratory syncytial virus immune globulin (rsv-igim), for intramuscular use, 50 mg, each</i>
90665	K2	<i>Lyme disease vaccine, adult sodate, for intramuscular use</i>
90681	K2	<i>Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use</i>
90696	K2	<i>Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use</i>
90740	F4	<i>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use</i>
90743	F4	<i>Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use</i>
90744	F4	<i>Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use</i>
90746	F4	<i>Hepatitis B vaccine, adult dosage, for intramuscular use</i>
90747	F4	<i>Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use</i>
Q4101	K2	Skin substitute, apligraf, per square centimeter
Q4102	K2	Skin substitute, oasis wound matrix, per square centimeter
Q4103	K2	Skin substitute, oasis burn matrix, per square centimeter
Q4104	K2	Skin substitute, integra bilayer matrix wound dressing (bmwd), per square centimeter
Q4105	K2	Skin substitute, integra dermal regeneration template (drt), per square centimeter
Q4106	K2	Skin substitute, dermagraft, per square centimeter

January 2009 update of the ambulatory surgical center payment system (continued)

HCPCS code	CY 2009 payment indicator	Long descriptor
Q4107	K2	Skin substitute, graft jacket, per square centimeter
Q4108	K2	Skin substitute, integra matrix, per square centimeter
Q4110	K2	Skin substitute, primatrix, per square centimeter
Q4111	K2	Skin substitute, gammagraft, per square centimeter
Q4112	K2	Allograft, cymetra, injectable, 1cc
Q4113	K2	Allograft, graft jacket express, injectable, 1cc
Q4114	K2	Allograft, integra flowable wound matrix, injectable, 1cc

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

The payment rates for six drugs and biologicals (Table 3) were incorrect in the April 2008 ASC DRUG file. The corrected payment rates are listed below and have been corrected in the revised April 2008 ASC DRUG file. The corrected rates are effective for services furnished on April 1, 2008, through June 30, 2008. If your claims were processed with the incorrect rates and you make your carrier/MAC aware of such claims, the carrier/MAC will adjust the claims.

Table 3 - Updated payment rates for certain drugs and biologicals effective April 1, 2008, through June 30, 2008

HCPCS code	CY 2008 PI	Short descriptor	Corrected payment rate
J0150	K2	Injection adenosine 6 MG	\$12.71
J1626	K2	Granisetron HCl injection	\$5.99
J2405	K2	Ondansetron hcl injection	\$0.23
J2730	K2	Pralidoxime chloride inj	\$83.17
J9208	K2	Ifosfomide injection	\$36.77
J9209	K2	Mesna injection	\$7.81

Updated payment rates for certain drugs and biologicals effective July 1, 2008, through September 30, 2008

- The payment rates for nine drugs and biologicals (Table 4) were incorrect in the July 2008 ASC DRUG file. The corrected payment rates are listed below and have been corrected in the revised July 2008 ASC DRUG file.
- The corrected rates are effective for services furnished on July 1, 2008, through September 30, 2008. If your claims were processed with the incorrect rates and you make your carrier/MAC aware of such claims, the carrier/MAC will adjust the claims.

Table 4 - Updated payment rates for certain drugs and biologicals effective July 1, 2008, through September 30, 2008

CY 2008 HCPCS code	CY 2008 PI	Short descriptor	Corrected payment rate
J0150	K2	Injection adenosine 6 MG	\$11.57
J1566	K2	Immune globulin, powder	\$28.37
J1569	K2	Gammagard liquid injection	\$34.66
J2730	K2	Pralidoxime chloride inj	\$84.90
J7190	K2	Factor viii	\$0.85
J7192	K2	Factor viii recombinant	\$1.12
J7198	K2	Anti-inhibitor	\$1.47
J8510	K2	Oral busulfan	\$2.55
J9208	K2	Ifosfomide injection	\$34.04

Updated payment rates for certain drugs and biologicals effective October 1, 2008, through December 31, 2008

- The payment rates for two drugs and biologicals (Table 5) were incorrect in the October 2008 ASC DRUG file. The corrected payment rates are listed below and have been corrected in the revised October 2008 ASC DRUG file.
- The corrected rates are effective for services furnished on October 1, 2008, through December 31, 2008. If your claims were processed with the incorrect rates and you make your carrier/MAC aware of such claims, the carrier/MAC will adjust the claims.

Table 5 - Updated payment rates for certain drugs and biologicals effective October 1, 2008, through December 31, 2008

CY 2008 HCPCS code	CY 2008 PI	Short descriptor	Corrected payment rate
J1568	K2	Octagam injection	\$35.58
J2323	K2	Natalizumab injection	\$7.51

January 2009 update of the ambulatory surgical center payment system (continued)

Correct reporting of drugs and biologicals when used as implantable devices

- When billing for a biological for which the HCPCS code describes a product that is solely surgically implanted or inserted, and that is separately payable under the ASC payment system, the ASC should report the HCPCS code for the product.
- If the implanted biological is packaged, that is, not eligible for separate payment under the ASC payment system, the ASC should not report the biological product HCPCS code.
- When billing for a biological for which the HCPCS code describes a product that may be either surgically implanted or inserted or otherwise applied in the care of a patient, ASCs should not report the HCPCS code for the product when the biological is used as an implantable device (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures.
- Under the ASC payment system, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items. When using biologicals during surgical procedures as implantable devices, ASCs may include the charges for these items in their charges for the procedure.

Correct reporting of units for drugs

- ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the HCPCS long code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. If the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4.
- ASCs should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only one vial was administered.
- The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Attachment A to CR 6323 lists the surgical procedures that are newly payable in the ASC setting as of January 1, 2009. Those procedures are displayed here in Table 6 as follows.

Table 6 - Surgical procedures newly payable in the ASC setting effective January 1, 2009

HCPCS code	Short descriptor	HCPCS code	Short descriptor
0190T	Place intraoc radiation src	49325	Lap revision perm ip cath
0191T	Insert ant segment drain int	49326	Lap w/omentopexy add-on
0192T	Insert ant segment drain ext	49652	Lap vent/abd hernia repair
15170	Acell graft trunk/arms/legs	49653	Lap vent/abd hern proc comp
15171	Acell graft t/arm/leg add-on	49654	Lap inc hernia repair
15175	Acellular graft, f/n/hf/g	49655	Lap inc hern repair comp
15176	Acell graft, f/n/hf/g add-on	49656	Lap inc hernia repair recur
20696	Comp multiplane ext fixation	49657	Lap inc hern recur comp
20697	Comp ext fixate strut change	55706	Prostate saturation sampling
34490	Removal of vein clot	62267	Interdiscal perq aspir, dx
36455	Bl exchange/transfuse non-nb	64448	N block inj fem, cont inf
41530	Tongue base vol reduction	64449	N block inj, lumbar plexus
43273	Endoscopic pancreatoscopy	64455*	N block inj, plantar digit
46930*	Destroy internal hemorrhoids	64632*	N block inj, common digit
49324	Lap insertion perm ip cath	65756	Corneal trnspl, endothelial
77785	Hdr brachytx, 1 channel	77786	Hdr brachytx, 2-12 channel
77787	Hdr brachytx over 12 chan		

* Indicates that the office-based payment indicator assigned for CY 2009 is temporary.

Attachment B to CR 6323 lists the procedures to which the no cost/full credit and partial credit device adjustment policy applies. Those procedures are displayed here in Table 7 as follows.

Table 7 – CY 2009 list of procedures to which the no cost/full credit and partial credit device adjustment policy applies.

HCPCS code	Short descriptor	HCPCS code	Short descriptor
24361	Reconstruct elbow joint	54416	Remv/repl penis contain pros
24363	Replace elbow joint	55873	Cryoablate prostate
24366	Reconstruct head of radius	61885	Insrt/redo neurostim 1 array

January 2009 update of the ambulatory surgical center payment system (continued)

HCPCS code	Short descriptor	HCPCS code	Short descriptor
25441	Reconstruct wrist joint	61886	Implant neurostim arrays
25442	Reconstruct wrist joint	62361	Implant spine infusion pump
25446	Wrist replacement	62362	Implant spine infusion pump
27446	Revision of knee joint	63650	Implant neuroelectrodes
33206	Insertion of heart pacemaker	63655	Implant neuroelectrodes
33207	Insertion of heart pacemaker	63685	Insrt/redo spine n generator
33208	Insertion of heart pacemaker	64553	Implant neuroelectrodes
33212	Insertion of pulse generator	64555	Implant neuroelectrodes
33213	Insertion of pulse generator	64560	Implant neuroelectrodes
33214	Upgrade of pacemaker system	64561	Implant neuroelectrodes
33224	Insert pacing lead & connect	64565	Implant neuroelectrodes
33225	L ventric pacing lead add-on	64573	Implant neuroelectrodes
33240	Insert pulse generator	64575	Implant neuroelectrodes
33249	Eltrd/insert pace-defib	64577	Implant neuroelectrodes
33282	Implant pat-active ht record	64580	Implant neuroelectrodes
53440	Male sling procedure	64581	Implant neuroelectrodes
53444	Insert tandem cuff	64590	Insrt/redo pn/gastr stimul
53445	Insert uro/ves nck sphincter	65770	Revise cornea with implant
53447	Remove/replace ur sphincter	69714	Implant temple bone w/stimul
54400	Insert semi-rigid prosthesis	69715	Temple bne implnt w/stimulat
54401	Insert self-contd prosthesis	69717	Temple bone implant revision
54405	Insert multi-comp penis pros	69718	Revise temple bone implant
54410	Remove/replace penis prosth	69930	Implant cochlear device

Attachment C to CR 6323 lists the devices for which the modifier FB or FC must be reported with the procedure code when furnished at no cost or with full or partial credit. That list of devices is displayed here as Table 8.

Table 8 – CY 2009 list of devices for which the modifier FB or FC must be reported with the procedure code when furnished at no cost or with full or partial credit.

Device HCPCS code	Short descriptor	Device HCPCS code	Short descriptor
C1721	AICD, dual chamber	C1881	Dialysis access system
C1722	AICD, single chamber	C1882	AICD, other than sing/dual
C1764	Event recorder, cardiac	C1891	Infusion pump, non-prog, perm
C1767	Generator, neurostim, imp	C1897	Lead, neurostim, test kit
C1771	Rep dev, urinary, w/sling	C1898	Lead, pmkr, other than trans
C1772	Infusion pump, programmable	C1900	Lead coronary venous
C1776	Joint device (implantable)	C2619	Pmkr, dual, non rate- resp
C1778	Lead, neurostimulator	C2620	Pmkr, single, non rate- resp
C1779	Lead, pmkr, transvenous VDD	C2621	Pmkr, other than sing/dual
C1785	Pmkr, dual, rate- resp	C2622	Prosthesis, penile, non- inf
C1786	Pmkr, single, rate- resp	C2626	Infusion pump, non-prog, temp
C1813	Prosthesis, penile, inflatab	C2631	Rep dev, urinary, w/o sling
C1815	Pros, urinary sph, imp	L8614	Cochlear device/system
C1820	Generator, neuro rechg bat sys	L8690	Aud osseo dev, int/ext comp

Additional information

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

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

The official instruction CR 6323 issued to your MAC or carrier is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1669CP.pdf> on the CMS Web site.

January 2009 update of the ambulatory surgical center payment system (continued)

For the special edition *MLN Matters* article that provides an overview of the ASC payment system, see <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Web site.

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Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. CPT codes, descriptions and other data only are copyrighted 2008 American Medical Association (or other such date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply.

Consolidated Billing

Skilled nursing facility consolidated billing as it relates to ambulance services

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

Note: This article was revised on January 29, 2009, to add the note under “Roundtrip to a physician’s office” regarding transportation between a skilled nursing facility (SNF) and a physician’s office. All other information remains the same. This information was previously published in the November 2007 *Medicare B Update!* pages 18-20.

Provider types affected

Skilled nursing facilities (SNFs), physicians, ambulance suppliers, and providers.

Provider action needed

This special edition article describes SNF consolidated billing (CB) as it applies to ambulance services for SNF residents.

Clarification: The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources may include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their durable medical equipment Medicare administrative contractor [DME MAC]).

Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See *MLN Matters* article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf> on the CMS Web site.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations, i.e. based on the reason the ambulance service is needed. This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983. Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary’s SNF “resident” status. The events are as follows:

Skilled nursing facility consolidated billing as it relates to ambulance services (continued)

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.)
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care
- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below), or
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance trips to receive excluded outpatient hospital services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in program memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization
- Computerized axial tomography imaging (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite)
- Emergency room services
- Radiation therapy
- Angiography, and
- Lymphatic and venous procedures.

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other ambulance trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers between two SNFs

A beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)). Thus, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, the ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under §411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, when an individual leaves an SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply.

Roundtrip to a physician's office

If an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 *Federal Register* 41674-75) clarifies that the scope of the required service bundle

Skilled nursing facility consolidated billing as it relates to ambulance services (continued)

furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance under the conditions described above, rather than more general coverage of other forms of transportation.

Note: Confusion sometimes arises over the issue of an ambulance roundtrip that transports an SNF resident to the physician's office, as the separate Part B ambulance benefit does not normally cover transportation to this particular setting. However, the regulations at 42 CFR 409.27(c), which describe the Part A SNF benefit's scope of coverage for ambulance transportation, incorporate by reference only the Part B ambulance benefit's general medical necessity requirement at 42 CFR 410.40(d)(1) (i.e., that transportation by any other means would be medically contraindicated), and not any of the more detailed coverage restrictions that apply under the separate Part B benefit, such as the limitation of coverage to only certain specified destinations (42 CFR 410.40(e)). Thus, if an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance, that ambulance roundtrip would be the responsibility of the SNF.

Noncoverage of transportation by any means other than ambulance

In contrast to the ambulance coverage described previously, Medicare simply does not provide any coverage at all under Part A or Part B for any non-ambulance forms of transportation, such as ambulette, wheelchair van, or litter van. Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be medically necessary--that is, that the patient's condition is such that transportation by any other means would be medically contraindicated.

This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance--for example, via wheelchair van--the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance also would not be covered (because the use of an ambulance in such a situation would not be medically necessary). As with any noncovered service for which a resident may be financially liable, the SNF must provide appropriate notification to the resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to ". . . inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate."

Additional information

See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0431.pdf> on the CMS Web site.

The Centers for Medicare & Medicaid Services (CMS) *MLN* Consolidated Billing Web site is at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS Web site.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a non-covered stay, and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Web site may be found at http://www.cms.hhs.gov/SNFPSPS/05_ConsolidatedBilling.asp on the CMS Web site.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles, and
- Links to publications (including transmittals and *Federal Register* notices).

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Drugs and Biologicals

January 2009 update and previous revisions to the quarterly average sale price Medicare Part B drug pricing file updates

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

Provider types affected

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

What you need to know

CR 6288, from which this article is taken, instructs Medicare contractors to download and implement the January 2009 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2008, July 2008, April 2008, and January 2008 files. They will use the January 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2009 with dates of service January 1, 2009, through March 31, 2009.

Background

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

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

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

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

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

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned

to facilitate separate payment. Separate payment may be operationalized through use of NOC HCPCS codes.

ASP methodology

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

- End-stage renal disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities); and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPSS.
- Beginning January 1, 2008, under the OPSS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5 percent. Beginning January 1, 2009, under the OPSS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4 percent. Drugs and biologicals with pass-through status under the OPSS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are determined in the same manner that the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPSS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. The payment allowance limits were not updated in 2008. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP

January 2009 update and previous revisions to the quarterly ASP Medicare Part B drug pricing file updates (continued)

unless the drug is compounded or the drug is furnished incident to a professional service.

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department. When furnished in a hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPSS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP; but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of \$0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2009, the blood clotting furnishing factor of \$0.164 per I.U. is added.

Note: At their discretion, Medicare contractors may contact CMS to obtain payment limits for drugs and biologicals that are not included in the quarterly ASP or NOC files, or otherwise made available on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPSS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. In the case of radiopharmaceuticals furnished in other than the hospital outpatient department, Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

Quarterly payment files

On or after December 16, 2008, the January 2009 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after December 16, 2008, the January 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR 6288 for the dates of service noted in the following table:

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

Drugs furnished during filling or refilling an implantable pump or reservoir

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

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

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

Payment allowance limit revision date	Applicable dates of service
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008

January 2009 update and previous revisions to the quarterly ASP Medicare Part B drug pricing file updates (continued)

Payment allowance limit revision date	Applicable dates of service
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008

Additional information

You may find the official instruction, CR 6288, issued to your carrier, FI, RHHI, MAC, or DME MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1650CP.pdf> on the CMS Web site.

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

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

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Annual clotting factor furnishing fee update

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

Provider types affected

Providers billing Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MAC), or regional home health intermediaries (RHHI) for services related to the administration of blood clotting factors to Medicare beneficiaries.

What you need to know

CR 6277, from which this article is taken, announces that for calendar year 2009, the blood clotting furnishing factor of \$0.164 per international unit (I.U.) is added to the payment limit for a blood clotting factor that is not included on the average sales price (ASP) or not otherwise classified (NOC) files.

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) Section 303(e)(1) added section 1842(o)(5)(C) to the Social Security Act (the Act) which requires that, beginning January 1, 2005, a furnishing fee be paid for items and services associated with the administration of blood clotting factors. It further specifies that for CY 2006 (and subsequent years) this furnishing fee will be equal to the fee for the previous year, increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year.

CMS includes the clotting factor furnishing fee in the published payment limits for blood clotting factor billing codes included on the Medicare Part B drug ASP pricing file or NOC pricing file. Your Medicare contractor will make separate payment for the blood clotting factor furnishing fee when a separate payment for the blood clotting factor is allowed, and the payment limit for the blood clotting factor is not included on the Medicare Part B drug ASP or NOC pricing files. The blood clotting furnishing factors for years 2005-2009 are displayed in the following table:

Blood clotting factor furnishing fee*	
Furnishing fee	Calendar year
\$0.164 per I.U.	2009
\$0.158 per I.U.	2008
\$0.152 per I.U.	2007
\$0.146 per I.U.	2006
\$0.140 per I.U.	2005

*When the blood clotting factor is not included on the Medicare Part B drug ASP or NOC pricing files

Additional information

You may find more information about the blood clotting furnishing factor by going to CR 6277, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1653CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

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

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Competitive Acquisition Program claims submission deadlines and unused CAP drugs

The following is a reminder about upcoming Competitive Acquisition Program (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

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

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 provision, 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 was on or before December 31, 2008, and the corresponding drug administration claim submitted on or before January 30, 2009.
- Physicians were required to request replacement drugs by January 30, 2009.
- The approved CAP vendor will not send replacement products under the CAP emergency restocking provision (modifier J2 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 average sale price (ASP) system for the CAP drugs that they administered on or before December 31, 2008, from their private stock.

For more information

Physicians who participated 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 200901-14 & 200901-39

Upcoming training for the Medicare Part B Drugs Competitive Acquisition Program

Noridian Administrative Services (NAS), the designated carrier for the Competitive Acquisition Program (CAP), offers interactive, online workshops about the CAP for Part B drugs and biologicals. During the 2009 CAP postponement, a limited number of workshops are being held to assist 2008 CAP physicians with transitioning out of the CAP. NAS staff will be available to answer questions during the session. Interested parties may view additional information about and register for the remaining workshop on the Noridian Web site at: https://www.noridianmedicare.com/cap_drug/train/schedule.html. The workshop will be held February 12, 2009, at 2:00 p.m. CST

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

Source: PERL 200901-34

Durable Medical Equipment

Changes in payment for oxygen equipment and additional instructions regarding payment for durable medical equipment prosthetics orthotics and supplies

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

Provider types affected

Physicians, providers and suppliers submitting claims to Medicare carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B MACs (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) 6297 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) terminates all round I supplier contracts awarded under the DMEPOS Competitive Bidding Program, as a result of Section 154 of the MIPPA which delays the program. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts. This article also provides guidance on the changes in payment for oxygen and oxygen equipment as a result of section 144(b) of the MIPPA of 2008, as well as, additional claims processing and payment instructions for DMEPOS items. See the *Key points* of this article for specific instructions that impact you.

Background

Oxygen and oxygen equipment are paid on a fee schedule basis in accordance with section 1834(a)(5) of the Social Security Act. The Deficit Reduction Act of 2005 (DRA) limited monthly payments for oxygen and oxygen equipment to 36 months of continuous use, after which the equipment title transferred to the beneficiary. As part of the DRA rulemaking effort, CMS established beneficiary safeguards to ensure that suppliers would continue to maintain and service beneficiary-owned oxygen equipment after the 36-month cap. The safeguards included payment for periodic (every six months) general maintenance and servicing of beneficiary-owned oxygen equipment, payment for pickup of beneficiary-owned oxygen tanks that are no longer needed, and rules for furnishing or replacing oxygen equipment during the 36-month payment period.

MIPPA was enacted on July 15, 2008. Section 144(b) of the MIPPA repeals the transfer of ownership provision established by the DRA for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. This one-time update provides guidance on the changes in payment for oxygen and oxygen equipment resulting from Section 144(b) of the MIPPA. CR 6297 also contains additional claims processing and payment instructions for DMEPOS. Specific instructions related to the implementation of these changes will be issued in a separate CR (CR 6296). Once CR 6296 is released, a related *MLN Matters* article will be available

at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf> on the CMS Web site.

Key points

Payment policies for oxygen and oxygen equipment and capped rental following the enactment of the MIPPA of 2008

- Section 154 of the MIPPA delays the Durable Medical Equipment, Prosthetic, Orthotics & Supplies (DMEPOS) Competitive Bidding Program and terminates all round I supplier contracts. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts.
- Medicare will pay no more than 13 continuous rental months for capped rental items and 36 continuous monthly payment amounts for oxygen and oxygen equipment.
- The competitive bidding policy that would have provided an additional 13 months of rental payments in situations where beneficiaries transitioned from noncontract suppliers to contract suppliers in the middle of the 13-month rental period for capped rental items is no longer valid. Therefore, for capped rental items, the supplier who received payment for the 13th continuous rental month must transfer title of the equipment to the beneficiary.
- The competitive bidding policy that would have provided a minimum of 10 monthly payments to contract suppliers in situations where beneficiaries transitioned from noncontract suppliers to contract suppliers in the middle of the 36-month rental period for oxygen and oxygen equipment is no longer valid. Therefore, for oxygen and oxygen equipment, the supplier who receives payment for the 36th continuous rental month must continue to furnish the oxygen and oxygen equipment until the reasonable useful lifetime of the oxygen equipment expires.
- Beneficiaries residing in the 10 competitive bidding areas for Round I may obtain oxygen and oxygen equipment and capped rental items and supplies from any Medicare-enrolled supplier and are not required to return to the supplier they were using before July 1, 2008.

New HCPCS modifiers for repair and replacement

- The following two modifiers are being added to the HCPCS on January 1, 2009, and are effective for claims with dates of service on or after January 1, 2009:

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

RA – Replacement of a DME item

RB - Replacement of a part of DME furnished as part of a repair

- The existing modifier RP will be deleted from the HCPCS, effective December 31, 2008.
- Suppliers should use the new modifier RA on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. In contrast, the new modifier RB should be used on a DMEPOS claim to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).
- Medicare contractors will accept modifier “RA” rather than “RP” for replacement of beneficiary-owned DMEPOS due to loss, irreparable damage, or when the item has been stolen.
- Medicare contractors will accept modifier “RB” rather than “RP” for replacement parts furnished in order to repair beneficiary-owned DMEPOS.

Additional instructions for implementation of MIPPA 144(b) -- oxygen equipment

- Section 144(b) of the MIPPA eliminates the requirement for suppliers to transfer title to oxygen equipment to the beneficiary following the 36th continuous month during which payment is made for the equipment. The requirement for suppliers to transfer title to the beneficiary for capped rental equipment following the 13th continuous month during which payment is made for the equipment remains in effect. As noted above, section 144(b) of MIPPA repealed the Deficit Reduction Act (DRA) transfer of title provision for oxygen equipment and allows suppliers to retain ownership of the oxygen equipment following the 36-month rental cap.
- The supplier who furnished the stationary and/or portable oxygen equipment during the 36-month rental period is required to continue furnishing the stationary and/or portable equipment following the 36-month rental period for any period of medical need for the remainder of the equipment’s reasonable useful lifetime.
- The supplier who receives payment for furnishing the equipment during month 36 of continuous use is responsible for furnishing the oxygen equipment at any time after the 36-month rental period and before the expiration of the reasonable useful lifetime of the oxygen equipment if the beneficiary has a medical need for oxygen and oxygen equipment furnished under Medicare Part B. This requirement includes situations where there is a temporary break in need or break in use of the equipment of any duration after the 36-month rental cap. In such situations, the supplier remains responsible for furnishing the oxygen equipment after the break in need for the remainder of the reasonable useful lifetime during which the medical need for oxygen and oxygen equipment continues.
- Following the 36-month cap, the supplier is responsible for furnishing all of the same necessary services associated with furnishing oxygen equipment that

were furnished during the 36-month rental period. For example, as required by the Medicare quality standards for respiratory equipment, supplies, and services established in accordance with 1834(a)(20) of the Social Security Act, the supplier shall provide services 24 hours a day, 7 days a week as needed by the beneficiary. Suppliers may not bill beneficiaries separately for these services.

- Medicare oxygen equipment rental payments continue to be limited to 36 months and under no circumstances will a new rental period start following the completion of the 36-month rental period unless the equipment is replaced because it is lost, stolen, irreparably damaged, or is replaced after the reasonable useful lifetime expires.
- As indicated in section 30.6 of Chapter 20 of the *Medicare Claims Processing Manual* (Pub. 100-04), the monthly payment amount for oxygen and oxygen equipment covers equipment, contents, supplies and accessories. Section 144(b) of MIPPA caps the all inclusive oxygen and oxygen equipment monthly payments at 36 months and does not provide for payment of replacement oxygen supplies and accessories following the 36-month cap. The supplier who received payment for furnishing the oxygen and oxygen equipment during the 36-month rental period is responsible for continuing to furnish any accessories and supplies necessary for the effective use of the equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Therefore, separate payment shall not be made for replacement of supplies and accessories for use with oxygen equipment that are furnished on or after January 1, 2009. This applies to any supply or accessory billed under a miscellaneous HCPCS code, any codes added to the HCPCS in the future, or under the following current HCPCS codes:

HCPCS code	Descriptor
A4608	Transtracheal oxygen catheter, each
A4615	Cannula, nasal
A4616	Tubing (oxygen), per foot
A4617	Mouth piece
A4619	Face tent
A4620	Variable concentration mask
A7525	Tracheostomy mask, each
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353	Regulator

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

HCPCS code	Descriptor
E1354	Wheeled cart for portable cylinder or concentrator (Added to HCPCS effective January 1, 2009)
E1355	Stand/Rack
E1356	Battery pack/cartridge for portable concentrator (Added to HCPCS effective January 1, 2009)
E1357	Battery charger for portable concentrator (Added to HCPCS effective January 1, 2009)
E1358	DC Power adapter for portable concentrator (Added to HCPCS effective January 1, 2009)

- Instructions regarding claims for oxygen accessory or supply codes will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional instructions for implementation of MIPPA 144(b) -- oxygen contents

- Section 144(b) of MIPPA also mandates that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment.
- Monthly payment for oxygen contents for beneficiary-owned liquid or gaseous oxygen equipment (stationary or portable) shall continue to be made in accordance with existing program instructions in section 30.6.3 of Chapter 20 of the *Medicare Claims Processing Manual*, which is available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Web site. Suppliers should continue to use HCPCS codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents.
- Separate payment shall not be made under any circumstances for the pick up and disposal of liquid or gaseous oxygen equipment (i.e., tanks).
- Instructions regarding claims for oxygen contents will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional instructions for implementation of MIPPA 144(b) -- maintenance and servicing of oxygen equipment

Section 144(b) of MIPPA mandates payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap. The 36-month cap applies to stationary and portable oxygen equipment furnished on or after January 1, 2006; therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006. CMS has determined that under no circumstances would it be reasonable and necessary to pay

for any maintenance and servicing or repair of supplier-owned oxygen equipment, with the exception of an in-home visit by suppliers to inspect oxygen concentrators and transfilling equipment and provide general maintenance and servicing six months after the 36-month rental cap.

Additional claims processing and payment instructions regarding these maintenance and servicing visits will be furnished in a separate CR.

- In the case of all oxygen equipment furnished after the 36-month rental cap, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment that is necessary to ensure that the equipment is in good working order for the remainder of the reasonable useful lifetime of the equipment. This includes parts that must be replaced in order for the supplier-owned equipment to continue to function appropriately.
- Payment shall not be made for any repairs or maintenance and servicing, other than the maintenance and servicing payments described above. In no case shall payment be made for any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment.
- Payment shall not be made for loaner equipment furnished during periods when these repairs or maintenance and servicing services are performed.

Payment for capped rental equipment following the enactment of MIPPA

As noted above, MIPPA of 2008 did not eliminate or amend the provisions of the DRA of 2005 that apply to capped rental DME. All previously issued Medicare instructions relating to these provisions remain in effect, including the requirement for suppliers to transfer title of the equipment on the first day after the 13th continuous month of use during which payment is made for the equipment.

MIPPA remittance advice messages

Although Section 144(b) of the MIPAA takes effect on January 1, 2009, the new remittance advice (RA) and Medicare summary notice (MSN) messages associated with this provision are not yet available. Therefore, in the interim, for claims with dates of service of January 1, 2009 and later, the following non-specific RA message will be used when paying the 36th month oxygen equipment claim:

Reason code 223: Adjustment code for mandated federal, state or local law/legislation that is not already covered by another code and is mandated before a new code can be created.

Additional instructions related to the implementation of this provision of the MIPPA will be provided in the near future.

Revisions to the labor payment rates associated with repairing DMEPOS items

- As part of this update, CMS is revising the labor payment rates for HCPCS code(s) E1340, L4205, and L7520. The current rates were established based on historic supplier charges; however, annual inflation adjustments were not applied consistently from state

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

to state. In addition, the rates differ dramatically among the states in the continental United States (e.g., from \$9.51 to \$23.53 in the case of E1340). To reduce this span and correct the disparity in payments for codes E1340, L4205, and L7520, CMS is revising the fees to apply inflation updates in years where it determined that these updates were not provided. Secondly, state payment amounts below the median state payment amount are being increased to the median state payment amount for each code. These changes are effective for claims with dates of service on or after January 1, 2009.

- Attachment A (see *Additional information* section of this article) contains the revised 2009 payment amounts for HCPCS codes E1340, L4205, and L7520. The payment rates include all costs (other than replacement of parts) associated with repairing DMEPOS items.
- Suppliers should only bill in 15 minutes for the time spent repairing the item and cannot bill for the time spent traveling to the beneficiary’s home.
- The rates established for codes E1340, L4205, and L7520 are based on 25 percent of the previous hourly repair rates for codes E1350, L4200, and L7500, respectively. The supplier’s travel costs are assumed to have been taken into account by suppliers in setting the prices they charged for these services under these codes. As such, these costs have already been accounted for in the calculation of the rates for codes E1340, L4205, and L7520. Therefore, separate payment shall not be made for travel costs associated with repairing DMEPOS items. In addition, suppliers may not bill beneficiaries directly for travel charges.
- DME MACs, RHHIs and Medicare carriers and/or MACs will use the 2009 allowed payment amounts for code E1340 under Attachment A (see *Additional information* section of this article) to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned DME with dates of service from January 1, 2009, through December 31, 2009.
- DME MACs, FIs, Medicare carriers and/or MACs will use the 2009 allowed payment amounts for codes L4205 and L7520 under Attachment A to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned orthotics, prosthetics, and prosthetic devices with dates of service from January 1, 2009, through December 31, 2009.

Medicare coverage of elastic support garments

CMS has received questions regarding coverage of elastic support garments such as leg, arm, back, or neck braces (orthotics). The definition of a brace in section 130 of Chapter 15 of the *Medicare Benefit Policy Manual* specifies that:

A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace.

Elastic garments or devices in general do not meet the definition of a brace because they are not rigid or semi-rigid devices. This includes devices that include stays that do not provide sufficient pressure to restrict or eliminate motion in the body part. While elastic devices may provide compression or warmth to a leg, arm, back, or neck, if they do not restrict or eliminate motion in a diseased or injured part of the body, then they may not be covered as braces. When a Medicare contractor identifies an elastic device that does not meet the Medicare definition of a brace, they shall not cover claims submitted for these devices and they shall not classify such devices under a HCPCS code that describes items that do meet the Medicare definition of a brace.

Additional information

For complete details regarding this CR please see the official instruction (CR 6297) issued to your Medicare FI, RHHI, DME/MAC, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R421OTN.pdf> on the CMS Web site.

For more information on CR 5461, you may go to <http://www.cms.hhs.gov/Transmittals/downloads/R1177CP.pdf> on the CMS Web site. The related *MLN Matters* article may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5461.pdf> on the CMS Web site.

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

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

Attachment A

2009 repair and service fees, 15 minute unit

State	E1340	L4205	L7520		E1340	L4205	L7520
AK	23.59	28.79	33.88	NC	13.41	19.99	27.14
AL	24.71	19.99	27.14	ND	13.41	28.73	33.88
AR	24.71	19.99	27.14	NE	13.41	19.97	37.84
AZ	22.40	19.97	33.39	NH	13.41	19.97	27.14
CA	22.40	32.83	38.26	NJ	15.99	19.97	27.14
CO	22.40	19.99	27.14	NM	14.00	19.99	27.14

Changes in payment for oxygen equipment and additional instructions regarding payment for DMEPOS (continued)

State	E1340	L4205	L7520		E1340	L4205	L7520
CT	19.95	20.45	27.14	NV	14.40	19.97	36.99
DC	19.95	19.97	27.14	NY	14.40	19.99	27.14
DE	19.22	9.97	27.14	OH	14.40	19.97	27.14
FL	17.46	19.99	27.14	OK	13.41	19.99	27.14
GA	18.10	19.99	27.14	OR	13.41	19.97	39.03
HI	15.61	28.79	33.88	PA	13.41	20.56	27.14
IA	15.49	19.97	32.49	PR	13.41	19.99	27.14
ID	15.49	19.97	27.14	RI	13.41	20.58	27.14
IL	13.41	19.97	27.14	SC	13.41	19.99	27.14
IN	13.41	19.97	27.14	SD	13.41	19.97	36.28
KS	13.41	19.97	33.88	TN	13.41	19.99	27.14
KY	13.41	25.60	34.71	TX	13.41	19.99	27.14
LA	13.41	19.99	27.14	UT	13.41	19.97	42.27
MA	15.32	19.97	27.14	VA	13.41	19.97	27.14
MD	13.41	19.97	27.14	VI	13.41	19.99	27.14
ME	13.41	19.97	27.14	VT	13.41	19.97	27.14
MI	13.41	19.97	27.14	WA	13.41	29.30	34.80
MN	13.41	19.97	27.14	WI	13.41	19.97	27.14
MO	13.41	19.97	27.14	WV	13.41	19.97	27.14
MS	13.41	19.99	27.14	WY	13.41	26.65	37.84
MT	13.41	19.97	33.88				

MLN Matters Number: MM6297
 Related Change Request (CR) #: 6297
 Related CR Release Date: December 23, 2008
 Effective Date: January 1, 2009
 Related CR Transmittal #: R421OTN
 Implementation Date: January 6, 2009

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End-Stage Renal Disease

End-stage renal dialysis Medicare Claims Processing Manual clarification

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

Provider types affected

Providers and laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for end-stage renal dialysis (ESRD) services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6245 which clarifies existing policies related to laboratory billing procedures for laboratory services furnished to hospital-based and independent dialysis facility patients. Be sure billing staff is aware of these clarifications.

Key points

CR 6245 clarifies existing policy located in the *Medicare Claims Processing Manual*, Chapters 8 and 16 regarding billing for ESRD related laboratory services. The

clarified policy chapters are attached to CR 6245 at <http://www.cms.hhs.gov/Transmittals/downloads/R1655CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site. The revisions are summarized as follows:

- Hospital-based laboratories providing separately billable laboratory services to dialysis patients of the hospital's dialysis facility or another dialysis facility bill and are paid in accordance with the hospital outpatient laboratory provisions in Chapter 16, section 40.3. This may be reviewed at <http://www.cms.hhs.gov/manuals/Downloads/clm104c16.pdf> on the Center for Medicare and Medicaid Services (CMS) Web site.
- If the ESRD patient also receives other hospital outpatient services on the same day as a specimen collection and/or laboratory test, then the patient is considered to be a registered hospital outpatient and

ESRD Medicare Claims Processing Manual clarification (continued)

cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. When the patient does not also receive hospital outpatient services on the same day as the specimen collection and/or laboratory test, then the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14x bill type.

- Independent laboratories and independent dialysis facilities with the appropriate clinical laboratory certification in accordance with the Clinical Laboratory Improvement Act (CLIA) may be paid for ESRD clinical laboratory tests that are separately billable. The laboratories and independent dialysis facilities are paid for separately billable clinical laboratory tests according to the Medicare laboratory fee schedule for independent laboratories. (See Chapter 16, Section 40.3 [as referenced above] for details on Part B hospital billing rules for laboratory services.)
- When a hospital laboratory is billing for laboratory services ordered by an ESRD facility and the patient (beneficiary) is a skilled nursing facility (SNF) resident under a Part A stay, the hospital laboratory must use the modifier CB for those services excluded from consolidated billing.
- Beneficiaries in a SNF Part A stay are eligible for a broad range of diagnostic services as part of the SNF Part A benefit. Physicians ordering medically necessary diagnostic tests that are not directly related to the beneficiary's ESRD are subject to the SNF consolidated billing requirements. Physicians may bill the contractor for the professional component of these diagnostic tests.

In most cases, however, the technical component of diagnostic tests is included in the SNF PPS rate and is not separately billable to the contractor.

- If you have claims that may not have been paid correctly based on the above clarifications, note that your Medicare contractor will not search its files to adjust the claims. However, they will adjust claims that you bring to their attention.

Additional information

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

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

The official instruction, CR 6245, issued to your Medicare MAC, carrier or FI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1655CP.pdf> on the CMS Web site.

MLN Matters Number: MM6245

Related Change Request (CR) #: 6245

Related CR Release Date: December 31, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1655CP

Implementation Date: February 2, 2009

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Evaluation and Management

Expansion of Medicare telehealth services

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

Provider types affected

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

Provider action needed

In the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC), the Centers for Medicare & Medicaid Services (CMS) added three codes to the list of Medicare distant site health services for follow-up inpatient telehealth consultations. This article highlights the related policy instructions. Be sure your billing staff is aware of these changes.

Background

CMS added three follow-up inpatient telehealth consultations to the list of Medicare distant site health services as noted in the calendar year 2009 physician fee schedule final rule with comment period (CMS-1403-FC). CMS created these new Healthcare Common Procedure Coding System (HCPCS) codes specific to the telehealth delivery of follow up inpatient consultations to re-establish the ability for practitioners to provide and bill for follow up inpatient consultations delivered via telehealth. These procedure codes are for follow-up inpatient telehealth consultations effective January 1, 2009. These new codes are intended for use by practitioners serving beneficiaries located at qualifying originating sites requiring the consultative input of physicians who are not available for a face-to-face encounter. These HCPCS codes are not intended to include the ongoing evaluation and management (E/M) services of a hospital inpatient.

Expansion of Medicare telehealth services (continued)

The new HCPCS codes are listed in the following table:

HCPCS Code	Descriptor
G0406	Follow-up inpatient telehealth consultation, limited
G0407	Follow-up inpatient telehealth consultation, intermediate
G0408	Follow-up inpatient telehealth consultation, complex

Follow-up inpatient telehealth consultations are consultative visits furnished via telehealth to complete an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in person or via telehealth.

Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient’s status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies would be included as well, consistent with the nature of the problem(s) and the patient’s needs.

The physician or practitioner who furnishes the inpatient follow up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by a physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient’s ongoing care management, such care would not be included in the definition of a follow up inpatient consultation and is not appropriate for delivery via telehealth. Follow-up inpatient telehealth consultations are subject to the criteria for consultation services, as described in Chapter 12, Section 30.6.10 of the *Medicare Claims Processing Manual*. Medicare manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Web site.

Payment for follow up telehealth inpatient consultations would include all consultation related services furnished before, during, and after communicating with the patient via telehealth. Pre-service activities would include, but would not be limited to, reviewing patient data (for example, diagnostic and imaging studies, interim lab work) and communicating with other professionals or family members. Post-service activities would include, but would not be limited to, completing medical records or other documentation and communicating results of the consultation and further care plans to other health care professionals. No additional E/M service could be billed for work related to a follow up inpatient telehealth consultation.

Follow up inpatient telehealth consultations could be provided at various levels of complexity:

- Practitioners taking a problem focused interval history, conducting a problem focused examination, and engaging in medical decision making that is straightforward or of low complexity, would bill a limited service, using HCPCS G0406 (Follow-up inpatient telehealth consultation, limited). At this level of service, practitioners would typically spend 15 minutes communicating with the patient via telehealth.

- Practitioners taking an expanded focused interval history, conducting an expanded problem focused examination, and engaging in medical decision making that is of moderate complexity, would bill an intermediate service using HCPCS G0407 (Follow-up inpatient telehealth consultation, intermediate). At this level of service, practitioners would typically spend 25 minutes communicating with the patient via telehealth.
- Practitioners taking a detailed interval history, conducting a detailed examination, and engaging in medical decision making that is of high complexity, would bill a complex service, using HCPCS G0408 (Follow-up inpatient telehealth consultation, complex). At this level of service, practitioners would typically spend 35 minutes or more communicating with the patient via telehealth.

Although follow-up inpatient telehealth consultations are specific to telehealth, these services must be billed with either the “GT” or “GQ” modifier to identify the telehealth technology used to provide the service. (See Chapter 12, Section 190.6 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> for more information on the use of these modifiers.)

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 270) at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf> on the CMS Web site, and the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 12, Section 190) at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> on the CMS Web site.

Additional information

The official instruction, CR 6130, was issued in two transmittals to your carrier, FI, and A/B MAC. The first transmittal revises the *Medicare Benefit Policy Manual* and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R99BP.pdf> and the second transmittal, which modifies the *Medicare Claims Processing Manual*, is at <http://www.cms.hhs.gov/Transmittals/downloads/R1654CP.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: MM6130
 Related Change Request (CR) #: 6130
 Related CR Release Date: December 24, 2008
 Effective Date: January 1, 2009
 Related CR Transmittal #: R1654CP and R99BP
 Implementation Date: January 5, 2009

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Laboratory/Pathology

Calendar year 2009 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

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

Provider types affected

Clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Impact on providers

This article is based on change request (CR) 6070 which provides instructions for the calendar year (CY) 2009 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

Background

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet), as amended by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 (Section 628), the annual update to the local clinical laboratory fee schedule for CY 2009 is 4.5 percent. Payments made on a reasonable charge basis for all other laboratory services is updated by 5.0 percent. The Social Security Act (Section 1833(a)(1)(D)) provides that payment for a clinical laboratory test is the lesser of the following:

- The actual charge billed for the test
- The local fee, or
- The national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

Note: The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National minimum payment amounts

For a cervical or vaginal smear test (pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2009 national minimum payment amount is \$15.42 (\$14.76 plus 4.5 percent update for CY 2009). The affected CPT/HCPCS codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150	88152
88153	88154	88164	88165	88166	88167
88174	88175	G0123	G0143	G0144	G0145
G0147	G0148	P3000			

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with the Social Security Act (Section 1833(h)(4)(B)(viii)).

Access to data file

Internet access to the CY 2009 clinical laboratory fee schedule data file is available after November 17, 2008, at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS Web site. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2009 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 14, 2008, CMS hosted a public meeting to solicit input on the payment relationship between CY 2008 codes and new CY 2009 *Current Procedural Terminology (CPT)* codes. Notice of the meeting was published in the *Federal Register* on May 23, 2008, and on the CMS Web site on June 16, 2008. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS Web site. Additional written comments from the public will be accepted until October 10, 2008. CMS will post a summary of the public comments and the rationale for their final payment determinations on the CMS Web site also.

Pricing information

The CY 2009 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (CPT/HCPCS codes 36415, P9612, and P9615).

For dates of service from January 1, 2009, through December 31, 2009, the fee for clinical laboratory travel code P9603 is \$1.035 per mile (rounded to \$1.04 if necessary) and the fee for clinical laboratory travel code P9604 is \$10.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2009, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2009 clinical laboratory fee schedule also includes codes that have a modifier QW to both identify codes and determine payment for tests performed by a

Calendar year 2009 annual update for clinical laboratory fee schedule and laboratory services ... (continued)

laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the CY 2009 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping information

- New code 83876 is priced at the same rate as code 83520.
- New code 83951 is priced by adding the rates for code 83950.
- New code 85397 is priced at the same rate as code 85245.
- New code 87905 is priced by subtracting the rate for code 87176 from the rate for code 82657.
- New code 88720 is priced at the same rate as code 88400.
- New code 88740 is priced at the same rate as code 88400.
- New code 88741 is priced at the same rate as code 88400.
- Code 88400 is deleted beginning CY 2009.
- Healthcare Common Procedure Coding System (HCPCS) Code G0394 is deleted beginning CY 2009.
- For CY 2009, there are no new test codes to be gap filled.

Laboratory costs subject to reasonable charge payment in CY 2009

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 through 42 CFR 405.508 (see http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html on the Internet), the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by the Social Security Act (Section 1842(b)(3); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) and 42 CFR 405.509(b)(1) (see http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html on the Internet). Further, Section 145 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) adjusted the inflation-indexed update by -0.5 percent. As a result, the inflation-indexed update for CY 2009 is 4.5 percent.

Manual instructions for determining the reasonable charge payment can be found in Publication 100-04, *Medicare Claims Processing Manual* (Chapter 23, Section 80 through 80.8; see <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS Web site). If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual* (Chapter 8, Section 60.3; see <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS Web site) instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood products					
P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual* (Chapter 3, Section 20.5 through 20.54; see <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS Web site) (formerly *Medicare Carriers Manual* (MCM) 2455):

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on the Social Security Act (Section 1842(o)). The payment limits based on that provision, including the payment limits for codes P9041, P9043, P9045, P9046, P9047, P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine					
86850	86860	86870	86880	86885	86886
86890	86891	86900	86901	86903	86904
86905	86906	86920	86921	86922	86923
86927	86930	86931	86932	86945	86950
86960	86965	86970	86971	86972	86975
86976	86977	86978	86985	G0267	

Reproductive medicine procedures					
89250	89251	89253	89254	89255	89257
89258	89259	89260	89261	89264	89268
89272	89280	89281	89290	89291	89335
89342	89343	89344	89346	89352	89353
89354	89356				

Additional information

The official instruction, CR 6070, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1660CP.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.

Calendar year 2009 annual update for clinical laboratory fee schedule and laboratory services ... (continued)

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 Implementation Date: January 5, 2009

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Correction to prothrombin time monitoring for home anticoagulation management

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

Provider types affected

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

Impact on providers

This article is based on change request (CR) 6313, which corrects CR 6138 (Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management, released on July 25, 2008) by adding particular ICD-9-CM codes (451.11, 451.19, 451.2, 451.80-451.84, 451.89, 453.40-453.49 and 415.12) that CR 6138 omitted. It contains no other changes; however its content is repeated in this article for your convenience as a reference document.

CR 6313 alerts providers that effective for claims with dates of service on and after March 19, 2008, the Centers for Medicare & Medicaid Services (CMS) revised its national coverage determination (NCD) on PT/INR monitoring for home anticoagulation management to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. Effective March 19, 2008, Medicare now covers the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with 1) mechanical heart valves, 2) chronic atrial fibrillation and 3) venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

Background

Warfarin, Coumadin®, and others, are self-administered, oral anticoagulant medications that affect a person’s Vitamin K-dependent clotting factors. The PT test (an in-vitro test to assess coagulation); and its normalized correlate, the INR, are the standard measurements for therapeutic effectiveness of warfarin therapy.

In response to a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin, the Centers for Medicare & Medicaid Services (CMS) revised its NCD on PT/INR monitoring for home anticoagulation management.

Effective for claims with dates of service on and after March 19, 2008, Medicare will cover the use of home PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

This coverage includes the following ICD-9-CM codes.

ICD-9-CM Code	Descriptor
V43.3	Organ or tissue replaced by other means; heart valve
289.81	Primary hypercoagulable state
451.0	Phlebitis and thrombophlebitis: of superficial vessels of lower extremities: saphenous vein (greater) (lesser)
451.11	Phlebitis and thrombophlebitis: of deep vessels of lower extremities: femoral vein (deep) (superficial)
451.19	Phlebitis and thrombophlebitis: of deep vessels of lower extremities: other (femoropopliteal vein popliteal vein tibial vein)
451.2	Phlebitis and thrombophlebitis: of deep vessels of lower extremities: other (femoropopliteal vein, popliteal vein, tibial vein)
451.80	Phlebitis and thrombophlebitis: of other sites
451.81	Phlebitis and thrombophlebitis: of other sites: iliac vein

Correction to prothrombin time monitoring for home anticoagulation management (continued)

ICD-9-CM Code	Descriptor
451.82	Phlebitis and thrombophlebitis: of other sites: of superficial veins of upper extremities (antecubital vein, basilic vein, cephalic vein)
451.83	Phlebitis and thrombophlebitis: of other sites: of deep veins of upper extremities (brachial vein, radial vein, ulnar vein)
451.84	Phlebitis and thrombophlebitis: of other sites: of upper extremities, unspecified
451.89	Phlebitis and thrombophlebitis: of other sites: other
451.9	Phlebitis and thrombophlebitis: of other sites: of unspecified site
453.0	Other venous embolism and thrombosis: Budd-Chiari Syndrome (hepatic vein thrombosis)
453.1	Other venous embolism and thrombosis: thrombophlebitis migrans
453.2	Other venous embolism and thrombosis: of vena cava
453.3	Other venous embolism and thrombosis: of renal vein
453.40	Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of unspecified vessels of lower extremity (deep vein thrombosis NOS, DVT NOS)
453.41	Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of deep vessels of proximal lower extremity (femoral, iliac, popliteal; thigh, upper leg NOS)
453.42	Venous embolism and thrombosis of deep vessels of lower extremity: venous embolism and thrombosis of deep vessels of distal lower extremity (calf, lower leg NOS; peroneal, tibial)
453.8	Venous embolism and thrombosis of deep vessels of lower extremity: of other specified veins
453.9	Venous embolism and thrombosis of deep vessels of lower extremity: of unspecified site
415.11	Pulmonary embolism and infarction: iatrogenic pulmonary embolism and infarction
415.12	Pulmonary embolism and infarction: septic pulmonary embolism
415.19	Pulmonary embolism and infarction: other
427.31	Atrial fibrillation (established) (paroxysmal)

You should keep in mind that the monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410_32.pdf on the CMS Web site.) and all of the following requirements must be met:

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

Note: Applicable HCPCS Codes G0248, G0249, and G0250 will continue to be used for claims processing purposes for PT/INR. With the July 2008 Outpatient Code Editor (OCE) and Medicare Physician Fee Schedule updates, the descriptors of these codes will change to reflect the revised coverage policy.

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

Long descriptor G0248: Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous

thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing prior to its use.

Short descriptor G0248: Demonstrate use home INR mon.

Long descriptor G0249: Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week.

Short descriptor G0249: Provide INR test mater/equipm.

Long descriptor G0250: Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes face-to-face verification by the physician that the patient uses the device in the context of the management of the anticoagulation therapy following initiation of the home INR monitoring; not occurring more frequently than once a week.

Short descriptor G0250: MD INR test revie inter mgmt.

Notes:

1. Test materials continue to include 4 tests. Frequency of reporting requirements shall remain the same.

Correction to prothrombin time monitoring for home anticoagulation management (continued)

2. Porcine valves are not included in this NCD, so Medicare will not make payment on Home INR Monitoring for patients with porcine valves unless covered by local Medicare contractors.
3. This NCD is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17, of the *NCD Manual*.

Your Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with this CR; however denied claims are subject to appeal, and medical review override of denials for appeal purposes will be allowed. When denying such claims, your Medicare carrier, FI or MAC will use the following codes:

- Medicare summary notice 15.20, “The following policies (NCD 190.11) were used when we made this decision.”
- Remittance advice remark Code N386, “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp> on the CMS Web site. If you do not have Web access, you may contact the contractor to request a copy of the NCD.”
- Claim adjustment reason code 50, “These are noncovered services because this is not deemed a ‘medical necessity’ by the payer.”

Your Medicare contractor will adjust claims already processed and inappropriately denied prior to the implementation of CR 6313, but only if you bring such claims to the attention of the contractor.

Additional information

You may find more information about PT/INR monitoring for home anticoagulation management by going to CR 6313, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1663CP.pdf> on the CMS Web site. The revised *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 60 (Coverage and Billing for Home Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management), Subsections 4.1 (Allowable Covered Diagnosis Codes) and 5.2 (Applicable Diagnosis Codes for Carriers) can be found as an attachment to that CR.

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: MM6313
 Related Change Request (CR) #: 6313
 Related CR Release Date: January 8, 2009
 Effective Date: March 19, 2008
 Related CR Transmittal #: R1663CP
 Implementation Date: February 9, 2009

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Prothrombin time monitoring for home anticoagulation management

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

Note: This article is superseded by MM6313 as change request (CR) 6313 replaced CR 6138, on which this article had been based. CR 6313 reflects additional ICD-9-CM codes involved with this issue. Those codes were inadvertently omitted from CR 6138. Please see *MLN Matters* article MM6313, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6313.pdf> on the CMS Web site. This information was previously published in the September 2008 *Medicare B Update!* pages 13-15.

MLN Matters Number: MM6138 *Revised*
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 Related CR Release Date: July 25, 2008
 Effective Date: March 19, 2008
 Related CR Transmittal #: R1562CP and R90NCD
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Medicare Physician Fee Schedule

Emergency update to the 2009 Medicare physician fee schedule database

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

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [A/B MACs])for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 6351 which amends payment files that were issued to contractors based upon the 2009 MPFS final rule. Be sure billing staff are aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

Specific changes included in the Emergency Update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6351. That CR is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1661CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Web site. Key changes, however, are summarized as follows:

Key changes

Noncovered services

Due to the national coverage determination for thermal intradiscal procedures (TIPs), effective September 29, 2008, current procedural terminology (CPT) codes 22526, 22527, 0962T, and 0963T became noncovered services on or after September 29, 2008, for Medicare purposes.

Descriptor changes

The long and/or short descriptors have been revised for the following codes:

CPT code	Revised long descriptor	Revised short descriptor
4275F	Hepatitis B vaccine injection administered or previously received (HIV)	Hep b vac inj admin/ rcvd
D0486	Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	N/A
D1203	Topical application of fluoride - child	Topical app fluoride child
D1204	Topical application of fluoride – adult	Topical app fluoride adult
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	End thxpy, anterior tooth
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	End thxpy, bicuspid tooth
D3330	Endodontic therapy, molar (excluding final restoration)	End thxpy, molar
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	N/A
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	N/A
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	N/A
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	N/A
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	N/A
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	N/A
Q4114	Integra flowable wound matrix, injectable, 1 cc	N/A

Emergency update to the 2009 Medicare physician fee schedule database (continued)

New dental codes for 2009

Code	Long descriptor	Short descriptor
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Collect & prep saliva sample
D0418	Analysis of saliva sample	Analysis of saliva sample
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	Part pulp for apexogenesis
D5991	Topical medicament carrier	Topical medicament carrier

Fee revisions

Code	Participating			Nonparticipating			Limiting charge			Note
	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99	
37205	\$4207.63	\$4420.88	\$3896.64	\$3997.25	\$4199.84	\$3701.81	\$4596.84	\$4829.82	\$4257.08	
37206	\$2533.11	\$2661.56	\$2344.13	\$2406.45	\$2528.48	\$2226.92	\$2767.42	\$2907.75	\$2560.96	
47525	\$522.18	\$555.13	\$481.78	\$496.07	\$527.37	\$457.69	\$570.48	\$606.48	\$526.34	
47525	\$131.89	\$145.29	\$121.78	\$125.30	\$138.03	\$115.69	\$144.10	\$158.73	\$133.04	*

* This amount applies when service is performed in a facility setting.

Additional information

The official instruction, CR 6351, issued to your carrier, FI, or MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1661CP.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: MM6351

Related Change Request (CR) #: 6351

Related CR Release Date: January 2, 2009

Effective Date: January 1, 2009

Related CR Transmittal #: R1661CP

Implementation Date: January 5, 2009

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Summary of policies in the 2009 Medicare physician fee schedule and the telehealth originating site facility fee

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

Provider types affected

Physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries and paid under the MPFS.

Provider action needed

This article is based on change request (CR) 6349 which provides a summary of the policies in the 2009 MPFS and announces the telehealth originating site facility fee payment amount. Be sure billing staff are aware of these Medicare changes.

Background

The Social Security Act (Section 1848(b)(1) at http://www.ssa.gov/OP_Home/ssact/title18/1848.htm requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2009.

Summary of policies in the 2009 MPFS and the telehealth originating site facility fee (continued)

The Social Security Act (Section 1834(m) at http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002 at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) as defined in §1842(i)(3) of the Act. The MEI increase for CY 2009 is 1.6 percent. The telehealth originating site facility fee for 2009 is 80 percent of the lesser of the actual charge or \$23.72.

Summary of key changes

A complete summary of significant issues discussed in CMS-1403-FC, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is attached to CR 6349, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R419OTN.pdf> on the CMS Web site. The following further summarizes the key points of that attachment to CR 6349.

MPFS issues

Payment for preadministration-related services for intravenous infusion of immune globulin (IVIG) Payment is no longer made under the physician fee schedule for G0332, for preadministration related services for IVIG infusion, effective January 1, 2009. This code has been deleted from the MPFS database and is no longer recognized for services furnished after December 31, 2008.

Multiple procedure payment reduction (MPPR) for diagnostic imaging

CMS added several additional procedures to the MPPR list. Six procedures represent codes newly created since the MPPR list was established. Four additional procedures were identified as similar to procedures currently subject to the MPPR. CMS also removed CPT code 76778, a deleted code, from the list.

Proposed HCPCS code for prostate saturation biopsies

Prostate saturation biopsy is a technique that was previously described by category III CPT code 0137T, *Biopsy, prostate, needle, saturation sampling for prostate mapping*. Typically, this service entails 40-80 core samples taken from the prostate under general anesthesia. Currently, the biopsies are reviewed by a pathologist and this service is captured under CPT code 88305, *Surgical pathology, gross and microscopic examination*, which is separately billed by the physician for each core sample taken. CPT code 88305 has a physician work value of 0.75 and a total nonfacility payment rate of \$102.83. CMS added four G codes to more accurately represent the pathologic evaluation, interpretation, and report for this service. In the final rule with comment period, CMS finalized its proposal, but provided assigned values to the four new G codes based upon assumption of the number of cancerous cells.

New and revised codes

CMS received work relative value unit (RVU) recommendations for 128 new and revised CPT codes from the American Medical Association (AMA) Relative Update Committee (RUC) this year. Of the recommendations received, CMS accepted 114 and disagreed with 14.

The CPT editorial panel created 20 CPT codes to replace the G codes for monthly and per diem end-stage renal disease (ESRD) services. CMS accepted the AMA RUC recommendations for these services. The new CPT codes are listed in the following table:

Deleted G code	New CPT code	Short descriptor
G0308	90951	Esrd serv, 4 visits p mo, <2
G0309	90952	Esrd serv, 2-3 vsts p mo, <2
G0310	90953	Esrd serv, 1 visit p mo, <2
G0311	90954	Esrd serv, 4 vsts p mo, 2-11
G0312	90955	Esrd srv 2-3 vsts p mo, 2-11
G0313	90956	Esrd srv, 1 visit p mo, 2-11
G0314	90957	Esrd srv, 4 vsts p mo, 12-19
G0315	90958	Esrd srv 2-3 vsts p mo 12-19
G0316	90959	Esrd serv, 1 vst p mo, 12-19
G0317	90960	Esrd srv, 4 visits p mo, 20+
G0318	90961	Esrd srv, 2-3 vsts p mo, 20+
G0319	90962	Esrd serv, 1 visit p mo, 20+
G0320	90963	Esrd home pt, serv p mo, <2
G0321	90964	Esrd home pt serv p mo, 2-11
G0322	90965	Esrd home pt serv p mo 12-19
G0323	90966	Esrd home pt, serv p mo, 20+
G0324	90967	Esrd home pt serv p day, <2
G0325	90968	Esrd home pt srv p day, 2-11
G0326	90969	Esrd home pt srv p day 12-19
G0327	90970	Esrd home pt serv p day, 20+

Renumbered CPT codes

Effective for CY 2009, the following CPT codes have been renumbered:

Deleted CPT code	New CPT code	Short descriptor
90760	96360	Hydration iv infusion, init
90761	96361	Hydrate iv infusion, add-on
90765	96365	Ther/proph/diag iv inf, init
90766	96366	Ther/proph/diag iv inf addon
90767	96367	Tx/proph/dg addl seq iv inf
90768	96368	Ther/diag concurrent inf
90769	96369	Sc ther infusion, up to 1 hr
90770	96370	Sc ther infusion, addl hr
90771	96371	Sc ther infusion, reset pump
90772	96372	Ther/proph/diag inj, sc/im
90773	96373	Ther/proph/diag inj, ia
90774	96374	Ther/proph/diag inj, iv push
90775	96375	Tx/pro/dx inj new drug addon
90776	96376	Tx/pro/dx inj new drug adon
90779	96379	Ther/prop/diag inj/inf proc

Summary of policies in the 2009 MPFS and the telehealth originating site facility fee (continued)

Deleted CPT code	New CPT code	Short descriptor
99289	99466	<i>Ped crit care transport</i>
99290	99467	<i>Ped crit care transport addl</i>
99293	99471	<i>Ped critical care, initial</i>
99294	99472	<i>Ped critical care, subsq</i>
99295	99468	<i>Neonate crit care, initial</i>
99296	99469	<i>Neonate crit care, subsq</i>
99298	99478	<i>Ic, lbw inf < 1500 gm subsq</i>
99299	99479	<i>Ic lbw inf 1500-2500 g subsq</i>
99300	99480	<i>Ic inf pbw 2501-5000 g subsq</i>
99431	99460	<i>Init nb em per day, hosp</i>
99432	99461	<i>Init nb em per day, non-fac</i>
99433	99462	<i>Sbsq nb em per day, hosp</i>
99435	99463	<i>Same day nb discharge</i>
99436	99464	<i>Attendance at delivery</i>
99440	99465	<i>Nb resuscitation</i>

Medicare telehealth services

CMS has added HCPCS codes specific to follow-up inpatient consultation delivered via telehealth and clarified that the criteria for these services will be consistent with Medicare policy for consultation services.

For 2009, Medicare contractors will pay for the Medicare telehealth originating site facility fee as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014 at 80 percent of the lesser of the actual charge or \$23.72. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Part B drug issues

In the 2009 MPFS final rule, CMS announces it will adopt three regulatory changes affecting payment of Part B drugs under the average sales price (ASP) methodology, i.e.:

- CMS will update its regulations to comport with the new volume-weighting ASP calculation methodology established in section 112(a) of the Medicare and Medicaid SCHIP Extension Act (MMSEA) of 2008.
- CMS will make conforming changes to its regulations to address the special payment rule for certain single source drugs or biologicals that are treated as multiple source drugs because of the application of the grandfathering provisions of section 1847A of the Act.
- Section 1847A(d)(1) of the Act allows the Secretary to disregard the ASP for a Part B drug or biological that exceeds the WAMP or the AMP for such drug by an applicable threshold percentage. For CY 2009, CMS will maintain the threshold at 5 percent, absent of data that suggests a change is appropriate.

Application of health professional shortage area (HPSA) bonus payment

CMS makes minor policy revisions to clarify that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of ZIP codes for automated HPSA bonus payments should use the modifier AQ to receive the HPSA bonus payment.

Independent diagnostic testing facilities (IDTF)

CMS is requiring all mobile units providing diagnostic testing services to Medicare beneficiaries to enroll in the Medicare program. In addition, all mobile units furnishing diagnostic testing services will be required to bill for services unless the service is furnished under arrangement with a hospital. When services are furnished under arrangement, the hospital will continue to bill for the diagnostic testing services.

Physician and nonphysician enrollment safeguards

The following is a summary of the enrollment provisions in the MPFS final rule for 2009:

1. Limit retrospective payments to physicians and nonphysician practitioners (NPPs) and physician and NPP organizations.

CMS has established that the effective date of billing for physicians and NPPs and physician or NPP organizations as the later of: (1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or NPP first started rendering services at a new practice location. This provision permits physicians and NPPs to retrospectively bill for services furnished up to 30 days prior to the effective date of enrollment if the physician or NPP meets all program requirements, even if the initial enrollment application is rejected or denied as long as the application is ultimately approved. In addition, physicians and nonphysician practitioners will be permitted to retrospectively bill for services furnished up to 90 days prior to the effective date if the physician or NPP meets all program requirements and there is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Section 5121-5206 (Stafford Act).

2. Prohibit physicians and NPPs, as well as owners, authorized officials, and delegated officials of a physician or nonphysician practitioner organization from obtaining additional billing privileges if their current billing privileges are suspended or an overpayment is pending.
3. Require all providers and suppliers, including individual practitioners, to maintain ordering and referring documentation for seven years from the date of service.
4. Require physician and nonphysician organizations, physicians and NPPs, and IDTFs to submit all outstanding claims within 60 days of the revocation date.
5. Require physicians and NPPs and physician and NPP organizations to notify their Medicare contractor of a change of ownership, final adverse action, or change of location that impacts a payment amount within 30 days. Failure to notify the designated contractor of these changes may result in an overpayment from the date of the reportable change.

*Summary of policies in the 2009 MPFS and the telehealth originating site facility fee (continued)***Educational requirements for nurse practitioners (NPs) and clinical nurse specialists (CNSs)**

In the 2009 MPFS final rule, CMS finalizes its proposal to recognize the doctor of nursing practice (DNP) degree and also states that it will continue to study the evolution of the DNP degree to ensure that it continues to be consistent with our program requirements. In addition, CMS finalized a proposed technical correction to the NP regulatory qualifications that will clarify that the requirement for a master's degree in nursing is the minimum educational level for newly enrolled NPs and CNSs independently treating Medicare beneficiaries.

Provisions from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)**Section 101: Improvements to Coverage of Preventive Services Payment for the IPPE**

The MMA provided for one IPPE per beneficiary per lifetime. A beneficiary is eligible when first enrolling in Medicare Part B on or after January 1, 2005, and receives the IPPE benefit within the first 6 months of the effective date of the initial Part B coverage period. If the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate existing HCPCS G code(s). MIPPA made several changes to the IPPE including expanding the IPPE benefit period to not later than 12 months after an individual's first coverage period begins under Medicare Part B. (Other changes to this benefit were included in segment 1 of the rule.) The following is a summary of the payment changes resulting from section 101 of the MIPPA:

The deductible change with MIPPA

The Medicare deductible does not apply to the IPPE if performed on or after January 1, 2009 within the beneficiary's 12-month initial enrollment period of Medicare Part B. The waived deductible is applicable to the IPPE service only. Medicare will pay for one IPPE per beneficiary per lifetime. The Medicare deductible for the IPPE performed before January 1, 2009 (G0344) applies. Co-insurance applies irrespective of codes or date of the IPPE. The waived deductible for the IPPE, effective January 1, 2009, does not apply to the screening EKG.

New G codes needed with MIPPA implementation

CMS revised the G codes for the IPPE and EKG to reflect the changes in the legislation. The EKG codes will reflect a once-in-a-lifetime screening with a referral from an IPPE.

Section 132: Incentives for Electronic Prescribing

Eligible professionals who are successful electronic prescribers shall be paid 2 percent incentive of estimated allowable charges submitted not later than 2 months after the end of the reporting period for 2009 successful electronic prescribing.

A "successful electronic prescriber" is defined under section 1848(m)(3)(B)(ii) of the Social Security Act as an eligible professional who reports the e-prescribing measure in at least 50 percent of the cases in which the measure is reportable by the professional. Although the Secretary is given authority to assess successful electronic prescribing

using either data reported by eligible professionals using electronic prescribing quality measures or using Part D prescription data, CMS will use the former for 2009. CMS will set forth the statutory criteria for successful electronic prescriber as reporting the measure in 50 percent of applicable cases.

There is also a limitation of the applicability of the e-prescribing incentive. For CY 2009, in order to be considered an eligible professional for purposes of the e-prescribing incentive, the e-prescribing measure denominator codes must apply to at least 10 percent of the total of allowed charges for all such covered services furnished by the eligible professional.

Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth

Currently, telehealth may substitute for a face-to-face, "hands on" encounter for professional consultations, office visits, office psychiatry services, and a limited number of other PFS services that CMS has determined to be appropriate for telehealth. Medicare will make a fixed payment to the originating site as well as a PFS payment to the physician. The originating site must be located in a non-metropolitan statistical area (non-MSA) county or rural HPSA. To date, originating sites have been limited to: the office of a physician or practitioner; a hospital; a critical access hospital (CAH); a rural health clinic (RHC); and a federally qualified health center (FQHC).

The MIPPA recognizes the following additional originating sites, effective for services furnished on or after January 1, 2009: a hospital-based or CAH-based renal dialysis center (including satellites); a skilled nursing facility (SNF); and a community mental health center (CMHC).

Additional information

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

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

The official instruction, CR 6349, issued to your Medicare A/B MAC, carrier or FI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R419OTN.pdf> on the CMS Web site.

MLN Matters Number: MM6349

Related Change Request (CR) #: 6349

Related CR Release Date: December 19, 2008

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Psychiatric Services

Adjustment for Medicare mental health services

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

Provider types affected

Physicians, clinical psychologists (CPs), clinical social workers (CSWs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and physician assistants (PAs) who submit claims to Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), or carriers, for mental health services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6208 that identifies the CPT psychiatry procedure codes that represent mental health services that have already been increased in payment by 5 percent effective for these “specified services” provided on or after July 1, 2008, through December 31, 2009. Be sure your billing staff is aware of this list of CPT codes that represent “specified services”.

Key points of CR 6208

Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 defines “specified services” as CPT procedure codes consisting of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital, or residential care facility settings under the subcategories of services that are insight oriented, behavior modifying, or supportive psychotherapy or, interactive psychotherapy. This list of CPT codes for specified services provides contractors with a way to link the already increased payment amounts for specified services to a particular CPT code. Accordingly, the specific psychiatry CPT codes affected by the 5 percent increase are as follows:

Insight oriented, behavior modifying and/or supportive psychotherapy - CPT codes 90804, 90805, 90806, 90807, 90808, and 90809

Interactive psychotherapy - CPT codes 90810, 90811, 90812, 90813, 90814, and 90815

Inpatient hospital, partial hospital or residential care facility (insight oriented, behavior modifying and/or supportive psychotherapy) - CPT codes 90816, 90817, 90818, 90819, 90821, 90822

Interactive psychotherapy - CPT codes 90823, 90824, 90826, 90827, 90828, and 90829

Background

Medicare contractors were previously sent the payment rates that include the 5 percent increase for certain mental health services under the RV3D file for the 2008 Medicare physician fee schedule. Accordingly, Medicare contractors should have loaded the already increased payment rates that are effective from July 1, 2008, through December 31, 2009. While contractors do not have to increase payment for these codes, they will now be able to link a CPT code with the appropriate payment amount for the code. The notification under CR 6208 provides contractors with the list of CPT codes that represent the specified services under the MIPPA provision that corresponds with the increased payment amounts already in place.

Additional information

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

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

To see the official instruction (CR 6208) issued to your Medicare carrier, FI or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R426OTN.pdf> on the CMS Web site.

MLN Matters Number: MM6208

Related Change Request (CR) #: 6208

Related CR Release Date: December 31, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R426OTN

Implementation Date: February 2, 2009

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Change request 6208 -- clarification

Change request (CR) 6208 is a clarification of the mental health codes that received a 0.5 percent increase in the fee schedule payment rates for claims with dates of service on/after July 1, 2008, through December 31, 2008, under joint signature memorandum (JSM) 08410.

The increased fee schedule for these mental health codes was implemented on July 17, 2008. Contractors were instructed at that time to automatically reprocess any claims that processed under the old payment rates, for dates of service on/after July 1, 2008, with the new payment rates. FCSO has already adjusted all impacted claims with these mental health codes for dates of service on/after July 1, 2008.

Source: Publication 100-20, transmittal 426, CR 6208

Surgery

Three national coverage determinations issued to protect patients from preventable surgical errors

The Centers for Medicare & Medicaid Services (CMS) recently announced three national coverage determinations (NCDs) to establish uniform national policies that will prevent Medicare from paying for certain serious, preventable errors in medical care. The following errors, called “never events,” specified in these NCDs are identified in the National Quality Forum’s (NQF) list of serious reportable events:

- Wrong surgical or other invasive procedures performed on a patient
- Surgical or other invasive procedures performed on the wrong body part, and
- Surgical or other invasive procedures performed on the wrong patient.

In addition, consistent with current policy for noncovered services, Medicare does not cover any services related to these noncovered services.

In 2002, prompted in part by the release of the 1999 Institute of Medicine report titled, *To Err is Human: Building a Safer Health System*, the NQF created a list of 27 never events, which was expanded to 28 events in 2006. As part of the ongoing implementation of Section 5001(c) of the Deficit Reduction Act (DRA) of 2005, CMS has addressed some of the NQF list of never events through the hospital-acquired conditions (HACs) provisions in the inpatient prospective payment system (IPPS) final rule for fiscal years (FY) 2008 and 2009.

For discharges occurring on or after Oct. 1, 2008, Medicare will no longer pay a hospital at a higher rate for an inpatient hospital stay if the sole reason for the enhanced payment is one of the selected HACs, and the condition was acquired during the hospital stay. CMS is exploring the feasibility of adapting this policy to its other payment systems.

In the IPPS FY 2008 final rule, CMS selected eight categories of conditions for the HAC list, a number of which were among the 28 never events listed by the NQF and include retained foreign object after surgery, air embolism, blood incompatibility, stage III & IV pressure ulcers, and injuries related to falls and traumatic events such as electric shock and burns.

In the IPPS FY 2009 final rule, CMS added manifestations of poor glycemic control, including hypoglycemic coma, to the list. Hypoglycemic coma is closely related to NQF’s listing of death or serious disability associated with hypoglycemia.

CMS determined that not all conditions included on the NQF list of never events should be addressed by the HAC payment provision and therefore determined that the NCD process was appropriate to address coverage for the three types of surgical errors cited above. Unlike the HAC provisions, which affect only payments to hospitals for inpatient stays, these NCDs may affect payment to hospitals, physicians, and any other health care providers and suppliers involved in the erroneous surgeries.

These NCDs are effective immediately; however, implementation instructions for processing such claims will occur at a later date. To view the NCDs, visit:

Wrong body part: <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=222>

Wrong patient: <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=221>

Wrong surgery performed on a patient: <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=223&>

Source: PERL 200901-28

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Therapeutic Services

Negative pressure wound therapy devices

The Centers for Medicare and Medicaid Services (CMS) have partnered with the Agency for Healthcare Research and Quality (AHRQ) to commission a review of negative pressure wound therapy (NPWT) devices. The purpose of this review is to provide information to CMS for consideration in Healthcare Common Procedure Coding System (HCPCS) coding decisions. Section 154(c) (3) of the Medicare Improvements for Patient and Providers Act of 2008 (MIPPA) calls for the Secretary of Health and Human Services to perform an evaluation of the HCPCS codes for NPWT devices.

The HCPCS Level II coding system is a comprehensive, standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing.

Devices are classified based on similarities in function and whether one product exhibits significant therapeutic distinctions from other products. This review will facilitate CMS' evaluation of HCPCS coding for NPWT by providing CMS with relevant studies and information for use in consideration of coding changes, as required by the MIPPA legislation. CMS will use this review in its assessment of whether existing HCPCS codes adequately represent the technology and comparative benefits of NPWT devices.

This review is one of several that are being conducted for the AHRQ Technology Assessment Program. It will include a review of all available literature on the topic and a solicitation from all interested stakeholders including healthcare professionals, scientific researchers, wound care organizations, biotech industry, and the patient wound care community for studies and other compelling clinical evidence regarding clinical outcomes associated with NPWT devices. We are particularly interested in those well-conducted clinical trials that describe the comparative benefits of these devices.

The solicitation for studies and evidence was made available to industry stakeholders on December 30, 2008, and requested stakeholders provide this information to AHRQ by February 06, 2009. Stakeholders who would like to provide information about studies or other compelling evidence related to comparative benefits and outcomes of NPWT devices should refer to

<http://www.ahrq.gov/clinic/ta/npwtrequest.htm>.

The full HCPCS Web page is located at <http://www.cms.hhs.gov/medhcpcsgeninfo/> on the CMS Web site.

Source: PERL 200901-14

General Coverage

Shipboard services billed to the carrier and not provided within the United States

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6217 which announces that the Centers for Medicare & Medicaid Services (CMS) wants providers to know that the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* are being revised. Chapter 1, Section 10.1.4.7 of the *Medicare Claims Processing Manual* currently states that services furnished by a physician or supplier in U.S. territorial waters must be furnished on board vessels of American registry and that the physician must be registered with the Coast Guard in order for Medicare to make payment. However, Section 10.1.4.7 of the manual is not consistent with Medicare law. Therefore, because Section 10.1.4.7 of the manual is not consistent with Medicare law,

CMS is clarifying that manual section in order to make it consistent with current Medicare law by removing the language that states the vessels must be of American registry and the physician must be registered with the Coast Guard. CMS is also clarifying in the manual that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered. CMS removed the term "and during a period of" covered foreign hospitalization since it implies that only physician and ambulance services that are furnished during the period of the covered foreign hospitalization are covered (i.e., the period after the beneficiary has been admitted to the foreign hospital), when, in fact, the emergency physician and ambulance services are covered both during the time period immediately before the beneficiary is actually admitted to the foreign hospital and during the covered foreign hospitalization itself. In other words, if the foreign hospitalization is covered by Medicare, then the emergency physician and ambulance services that are furnished during the time period that immediately precedes the covered foreign hospitalization are also covered. Be sure your billing staff is aware of these changes.

*Shipboard services billed to the carrier and not provided within the United States (continued)***Key points of CR 6217**

The following services furnished aboard a vessel are covered:

- Emergency and nonemergency services furnished by a physician or supplier aboard a vessel are covered when the ship is within the territorial waters of the United States. If the emergency or nonemergency services were furnished within the territorial waters of the United States and the physician or supplier refuses to submit the claim on the beneficiary's behalf (or enroll in Medicare, if applicable), then the contractor must follow the compliance monitoring instructions outlined in the *Medicare Claims Processing Manual*, chapter 1, section 70.8.8.6B because these claims are not processed as foreign claims. Chapter 1 of the *Medicare Claims Processing Manual* may be reviewed at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> on the CMS Web site.
- Emergency services furnished by a physician or supplier aboard a vessel are covered when the services are rendered while the ship is within the territorial waters of Canada (while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another state) and the emergency services are furnished in connection with a covered foreign hospitalization in Canada. The compliance monitoring instructions outlined in the *Medicare Claims Processing Manual*, Chapter 1, Section 70.8.8.6B do not apply to these claims because they are processed as foreign claims.
- See Chapter 1 Section 10.1.4 of the *Medicare Claims Processing Manual* for the definitions of "territorial waters" and "United States."
- Your Medicare contractors/carriers will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization.

Background

Medicare law (i.e., Section 1862(a)(4) of the Social Security Act) prohibits payment for items and services furnished outside the United States except for certain limited services (see Section 1814(f) of the Act). The term "United States" means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States.

The law specifies the following exceptions to the "foreign" exclusion:

1. Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
 - a. the emergency arose within the U.S.; or
 - b. the emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another state.
2. Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists.
3. Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Additional information

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

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

To see the official instruction (CR 6217) was issued to your Medicare FI, carrier or A/B MAC via two transmittals. The first transmittal which covers changes to the *Medicare Claims Processing Manual* is at <http://www.cms.hhs.gov/Transmittals/downloads/R1609CP.pdf> on the CMS Web site. The second transmittal, covering the revisions to the *Medicare Benefit Policy Manual*, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R95BP.pdf> on the CMS Web site.

MLN Matters Number: MM6217

Related Change Request (CR) #: 6217

Related CR Release Date: October 3, 2008

Effective Date: January 5, 2009

Related CR Transmittal #: R1609CP & R95BP

Implementation Date: January 5, 2009

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Clarification of Medicare payment for routine costs in a clinical trial

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

Note: This article was revised on January 7, 2009, to delete the first question and answer. All other information remains the same. This information was previously published in the October 2008 *Medicare B Update!* pages 35-36.

Provider types affected

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

*Clarification of Medicare payment for routine costs in a clinical trial (continued)***Provider action needed**

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

Background

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

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

Key points

There are two concerns addressed in this article regarding payment for routine costs in a clinical trial and they are addressed in the following questions and answers:

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

Answer: If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts. As noted at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf, “nothing in the Centers for Medicare & Medicaid Services’ (CMS’) regulations or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital’s indigency policy. By “indigency policy” we mean a policy developed and utilized by a hospital to determine patients’ financial ability to pay for services. By “medically indigent,”

we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS’ policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program – a highly unlikely circumstance. Thus, the provider of services should bill the beneficiary for co-payments and deductible, but may waive that payment for beneficiaries who have a valid financial hardship.

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

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

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

Additional information

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

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

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

MLN Matters Number: SE0822 *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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Electronic Data Interchange

January 2009 claim status category code and claim status code update

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

Provider types affected

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

Provider action needed

Change request (CR) 6328, from which this article is taken, reminds providers of the periodic updates to the claim status codes and claim status category codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background

The claim category and claim status codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national code maintenance committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response transactions.

The national code maintenance committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6328 updates the changes in the claim status codes and claim status category codes from the June, 2008 committee meeting. These updates were posted at <http://www.wpc-edi.com/content/view/180/223/> on June 30, 2008.

Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by January 5, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

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 Centers for Medicare & Medicaid Services (CMS) Web site.

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

The official instruction (CR 6328) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1656CP.pdf> on the CMS Web site.

MLN Matters Number: MM6328

Related Change Request (CR) #: 6328

Related CR Release Date: December 31, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1656CP

Implementation Date: January 5, 2009

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April 2009 claim status category code and claim status code update

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

Provider types affected

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

Provider action needed

Change request (CR) 6325, from which this article is taken, reminds providers of the periodic updates to the claim category and claim status codes that Medicare contractors use with the health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background

The claim category and claim status codes explain the status of submitted claims. The Health Insurance Portability

and Accountability Act (HIPAA) requires all health care benefit payers to use only national code maintenance committee-approved codes in the X12 276/277 Health Care Claim Status Request and response transactions.

The national code maintenance committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6325 updates the changes in the claim status codes and claim status category codes from the September, 2008 committee meeting. These updates were posted at <http://www.wpc-edi.com/content/view/180/223/> on November 1, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by April 6, 2009. On

April 2009 claim status category code and claim status code update (continued)

and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

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 Centers for Medicare & Medicaid Services (CMS) Web site.

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

The official instruction (CR 6325) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1670CP.pdf> on the CMS Web site.

MLN Matters Number: MM6325

Related Change Request (CR) #: 6325

Related CR Release Date: January 16, 2009

Effective Date: April 1, 2009

Related CR Transmittal #: R1670CP

Implementation Date: April 6, 2009

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Final ICD-10 code sets and updated electronic transaction standards rules

The U.S. Department of Health and Human Services (HHS) recently released two final rules that will facilitate the United States' ongoing transition to an electronic health care environment through adoption of a new generation of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.

The first final rule, with a compliance date of October 1, 2013, replaces the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets. The second final rule adopts an updated X12 standard, version 5010, for certain electronic health care transactions, an updated version of the National Council for Prescription Drug Programs (NCPDP) standard, version D.0, for electronic pharmacy-related transactions, and a standard for Medicaid pharmacy subrogation transactions. Version 5010 includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Version 5010 also accommodates the use of the ICD-10 code sets, which are not supported by version 4010/4010A1, the current X12 standard.

"These regulations will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology," HHS Secretary Mike Leavitt said. "The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, bio-surveillance, and other critical activities. The updated X12 transaction standards, version 5010, provide the framework needed to support the ICD-10 codes."

The ICD-10 rule titled HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS is available in text format at <http://edocket.access.gpo.gov/2009/E9-743.htm> and in pdf format at <http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf>.

The updated X12 transaction standards, version 5010, rule titled Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards is available in text format at <http://edocket.access.gpo.gov/2009/E9-740.htm> and in pdf format at <http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf>.

The fact sheet describing both rules is available at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp>

Source: PERL 200901-30

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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 contractor. 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://medicare.fcs.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

General Information

New common working file Medicare secondary payer type for Workers' Compensation Medicare set-aside arrangements to stop conditional payments

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

Provider types affected

Physician, providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], including regional home health intermediaries [RHHIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services related to Workers' Compensation liability claims.

What you need to know

In order to prevent Medicare's paying primarily for future medical expenses that should be covered by Workers' Compensation Medicare set-aside arrangements (WCMSA), CR 5371, from which this article is taken, provides your Medicare contractors with instructions on the creation of a new Medicare secondary payer (MSP) code in Medicare's claim processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) will have the capability to discontinue conditional payments for diagnosis codes related to such settlements.

Background

A Workers' Compensation Medicare set-aside arrangement (WCMSA) is an allocation of funds from a Workers' Compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare. The CMS has a review process for proposed WCMSA amounts and updates its common working file (CWF) system in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit <http://www.cms.hhs.gov/WorkersCompAgencyServices> on the CMS Web site.

The CMS has determined that establishing a new MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist Medicare contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code specifically

associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

When denying a claim because of these edits, your Medicare contractor will notify the beneficiary using Medicare summary notice (MSN) message 29.33 - Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies).

In addition, Medicare will use reason code 201, group code PR, and remark code MA01, on outbound claims and/or remittance advice transactions when Medicare denies claims based on the WCMSA presence. Also, on 271 inquiry reply transactions, Medicare will reflect the WCMSA on the 271 response with "EB" followed by the qualifier WC.

Additional information

You may find the official instruction, CR 5371, issued to your Medicare contractor at <http://www.cms.hhs.gov/Transmittals/downloads/R1665CP.pdf> on the CMS Web site.

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

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

MLN Matters Number: MM5371
Related Change Request (CR) #: 5371
Related CR Release Date: January 9, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1665CP
Implementation Date: July 6, 2009

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Medicare physician fee schedule -- carrier specific pricing files New for calendar year (CY) 2009

The Centers for Medicare & Medicaid Services (CMS) has condensed all 56 physician fee schedule (PFS) carrier specific pricing files into one zip file. This file is found in the list on the CMS Web page at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp>. It is labeled as "All States" in the *State* field, and "2009" in the *Calendar Year* field. Because the list is ordered by state name, "All States" appears after the Alaska files. If you sort by most recent calendar year, the file will appear at the top of the list.

Source: PERL 200901-38

Update to the e-Prescribing incentive program

Beginning January 1, 2009, eligible professionals can participate in the e-Prescribing incentive program by reporting on their adoption and use of an e-prescribing system by submitting information on one e-prescribing measure on their Medicare Part B claims. For the 2009 e-prescribing reporting year, to be a successful e-prescriber and to qualify to receive an incentive payment, an eligible professional must report one e-prescribing measure in at least 50 percent of the cases in which the measure is reportable by the eligible professional during 2009. There is no sign-up or pre-registration to participate in the e-Prescribing incentive program. For more information, visit <http://www.cms.hhs.gov/PQRI> and select *e-Prescribing Incentive Program* in the left-hand column.

In October 2008, the Centers for Medicare & Medicaid Services (CMS) and 34 partner organizations hosted a meeting about the mechanics of implementing an e-prescribing program in a practice. Audiotapes and slides are now archived online for continuing education credit. The Massachusetts Medical Society and the American Pharmacist Association are pleased to provide continuing medical education (a maximum of 22.5 AMA PRA Category 1 Credits™, [risk management study for MA physicians] and continuing education for pharmacists (up to 13.25 hours of continuing education credit [1.325 CEUs]). Simply go to http://www.massmed.org/cme/CMS_eprescribing to view the presentations and hear the audiotapes of the program. There are no registration or certificate fees.

Source: PERL 200901-27

Revised form CMS-R-131 advance beneficiary notice of noncoverage

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals. This information was previously published in the September 2008 Medicare B Update! pages 63-65.

Provider types affected

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

What you need to know

Change request (CR) 6136, from which this article is taken announces that, effective March 3, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented use of the revised advance beneficiary notice (ABN) of noncoverage; which combines the general advance beneficiary notice (ABN-G) and laboratory advance beneficiary notice (ABN-L) into a single form, with form number (CMS R-131).

You should be aware that beginning March 3, 2008, and prior to March 1, 2009, your contractors will accept either the current ABN-G, and ABN-L or the revised ABN as valid notification. **However, beginning March 1, 2009, Medicare contractors will accept only a properly executed revised ABN (CMS R-131) as valid notification.**

Make sure that your billing staffs are aware of these ABN form changes.

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious nonmedical health care institutions paid under Part A; were instructed to use the general ABN-G or ABN-L to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised ABN of noncoverage. This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

The *Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections)*, Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. 85 subsections

have been deleted from this Chapter, and 47 are either new or have been revised. Attached to CR 6136 is the updated Chapter 30 and the Web address for viewing CR 6136 is contained in the *Additional Information* Section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare fee-for-service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious nonmedical health care institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).
2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and notice of exclusion from Medicare benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

Note: Once the revised skilled nursing facility (SNF) ABN is implemented, SNFs must use the revised SNF ABN for all items and services billed to Part A and Part B.

3. The following situations require by statute that an ABN be issued:
 - Care is not reasonable and necessary
 - There was a violation of the prohibition on unsolicited telephone contacts
 - Medical equipment and supplies supplier number requirements not met
 - Medical equipment and/or supplies denied in advance
 - Custodial care
 - A hospice patient who is not terminally ill.

Revised form CMS-R-131 advance beneficiary notice of noncoverage (continued)

4. In the following situations ABN use is voluntary. ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification). Additionally, the ABN may also be issued voluntarily in place of the NEMB for care that is never covered such as:
- Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act.
 - Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
 - ♦ Services for which there is no legal obligation to pay
 - ♦ Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles)
 - ♦ Services required as a result of war
 - ♦ Personal comfort items
 - ♦ Routine physicals (except the initial preventive physical or “Welcome to Medicare” physical examination) and most screening tests
 - ♦ Routine eye care
 - ♦ Dental care
 - ♦ Routine foot care
5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as “**notifiers**”. Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.
- Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three “**triggering events**” during a course of treatment (initiation, reduction, and termination). Notifiers must give an ABN to “**recipients**” (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers’ inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient’s record and undisputed by the beneficiary.

Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN preparation requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and comprehensive outpatient rehabilitation facility (CORF).

Additional information

You may find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf> on the CMS Web site.

There you will find the updated *Medicare Claims Processing Manual* chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

Additional information on the revised ABN and other limitation of liability notices may be found on the Beneficiary Notice Initiatives Web site at <http://www.cms.hhs.gov/bni>. Questions regarding the revised ABN may be e-mailed to RevisedABN_ODF@cms.hhs.gov.

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

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

MLN Matters Number: MM6136
 Related Change Request (CR) Number: 6136
 Related CR Release Date: September 5, 2008
 Related CR Transmittal Number: R1587CP
 Effective Date: March 3, 2008
 Implementation Date: March 1, 2009

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New contractor numbers for the J9 Medicare administrative contractor workload

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

Note: This article was revised on January 20, 2009, to clarify the provider types affected section, by referencing the A/B MACs. All other information is unchanged. This information was previously published in the December 2008 *Medicare B Update!* page 21.

Provider types affected

Physicians, providers, and suppliers in the state of Florida and territories of Puerto Rico and the Virgin Islands submitting claims to 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) 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 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 workload

Location	MAC workload no.	Effective date	Current contractor no.
Florida	09101	February 16, 2009	00090
Puerto Rico Virgin Islands	09201	March 2, 2009	57400 and 00468

Part B workload

Location	MAC workload no.	Effective date	Current contractor no.
Florida	09102	February 2, 2009	00590
Puerto Rico	09202	March 2, 2009	00973
Virgin Islands	09302	March 2, 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 United States 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/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 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 *Revised*
Related CR Release Date: December 24, 2008
Related CR Transmittal #: R423OTN

Related Change Request (CR) #: 6285
Effective Date: February 2, 2009
Implementation Date: January 5, 2009

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Reporting withholding due to IRS Federal Payment Levy Program on the remittance advice

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

Note: This article was revised on January 8, 2009, to add information regarding requirements for provider representatives who contact IRS and to make other minor clarifications. This information was previously published in the September 2008 *Medicare B Update!* page 60.

Provider types affected

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

Provider action needed

Stop – impact to You

You Medicare payments could be reduced if the Centers for Medicare & Medicaid Services (CMS) needs to collect overdue taxes that you owe to the Internal Revenue Service (IRS).

Caution – what you need to know

The Taxpayer Relief Act of 1997, Section 1024, authorizes CMS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of “WU” in the PLB03-1 data field. Such payments may be reduced by 15 percent or the amount of the tax owed if it is less than 15 percent of the payment.

Go – what you need to do

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

Background

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

CMS may reduce your Medicare payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, CMS will notify the payee in the remittance advice which federal payment was levied, the amount withheld, and the toll free IRS/Treasury telephone number the payee should contact for resolution. If the amount of the withholding through FPLP exceeds the total debt owed by the payee, the IRS/Treasury is responsible for refunding the overpayment to the payee.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of “WU” in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field and the amount of the withholding will be inserted in the PLB04 field. Please note that under current privacy rules and regulations, only the IRS/Treasury may discuss the tax issue with you. Thus, if you have questions, contact the IRS at the toll-free number just mentioned, instead of contacting your Medicare contractor.

The person contacting the IRS must be authorized to represent the provider/physician regarding tax matters, otherwise the IRS will not discuss the issue. The caller must also have the taxpayer identification number (TIN) of the provider/physician from whom the recovery was made. The person calling the IRS should also state that the recovery was from a Medicare payment.

Please be advised that it can take several days for the amount offset from the Medicare payment to be posted to the IRS records.

If you use Medicare Remit Easy Print (MREP) software supplied by your Medicare contractor, you will need to obtain an updated version of the software, on or after October 6, 2008, in order to view these changes on your printed remittances.

Additional information

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

MLN Matters Number: MM6125 *Revised*

Related Change Request (CR) #: 6125

Related CR Release Date: August 15, 2008

Effective Date: October 1, 2008

Related CR Transmittal #: R367OTN

Implementation Date: October 6, 2008

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Providers urged to participate in annual Medicare contractor satisfaction survey

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

Provider types affected

Medicare physicians, providers, and suppliers selected to participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS).

Provider action needed

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) will distribute its annual MCPSS to a new sample of Medicare providers. CMS is sending the 2009 survey, designed to be completed in about 20 minutes, to approximately 30,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. CMS will begin to notify providers selected to participate in the survey in December 2008. Providers are urged to submit their responses via a secure Web site, mail, fax, or over the telephone.

Background

The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. All Medicare administrative contractors (MACs) will be measured against performance targets on the 2009 MCPSS as part of their contract requirements.

The 2008 survey results revealed that, for the second consecutive year, the top indicator of satisfaction among providers was how Medicare contractors handled provider inquiries. As in the two previous years, claims processing also remained a strong indicator in 2008 of provider satisfaction across all contractor types. The shift from claims processing as the top predictor in 2006 to provider inquiries as the top predictor of satisfaction in 2008 is an example of the type of trend data the MCPSS will reveal. Contractors are able to factor such insights into how they prioritize their provider-focused efforts.

Feedback captured through MCPSS is important, and CMS urges all Medicare providers who are selected to participate in the MCPSS to complete and return their surveys upon receipt. CMS plans to analyze the 2009 MCPSS data and release a summary report at <http://www.cms.hhs.gov/MCPSS> on the CMS Web site in July 2009.

Key points

- Survey questions focus on seven business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.
- Respondents are asked to rate their contractors using the 1 to 6 scale on each of the business functions with "1" representing "not at all satisfied" and "6" representing "completely satisfied." Contractors receive an overall composite score as well as a score on each business function.

- Results from previous surveys have enabled CMS to set performance standards for MAC's.
- Performance standards give contractors a benchmark to use to compare themselves to other contractors, as well as an individual standard to improve upon year after year.
- The contractor's MCPSS score is based on the average survey score from all surveyed Medicare providers in the contractor's jurisdiction. To meet the performance standard, the MAC's score for the 2009 MCPSS must fall within a specified range of the 2008 national mean score. The average 2008 MCPSS for all contractors, released last August, was 4.51 on a scale of 1 to 6. This score was comparable to the 2007 average MCPSS score of 4.56. CMS plans to utilize MCPSS results to help structure future contract incentives.

The MCPSS is required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Specifically, the law calls for CMS to develop contract performance requirements, including measuring health care provider satisfaction with Medicare contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to the Medicare fee-for-service program.

Additional information

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

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

MLN Matters Number: SE0843
 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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Signature and date stamps for DME supplies-certificates of medical necessity and DME MAC information forms

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

Provider types affected

Providers and suppliers submitting claims, CMNs, or DIFs 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]) related to durable medical equipment, prosthetic, and orthotic supplies (DMPEOS) provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6261 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. Signature and date stamps are not acceptable for use on CMNs and DIFs. Be sure your billing staffs are aware of this change. Your Medicare contractors will accept only hand written, facsimiles of original written and electronic signatures and dates on medical record documentation for medical review purposes on CMNs and DIFs.

Background

CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for durable medical equipment, prosthetic, and orthotic supplies (DMPEOS) have been met. The *Program Integrity Manual (PIM)*, Chapter 3, section 3.4.1.1, which may be reviewed at <http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf> on the CMS Web site, states that Medicare requires a legible identifier for services provided/ordered. The method used should be hand written including facsimiles of original written or an electronic signature in accordance with Chapter 3, Section 3.4.1.1 to sign an order or other medical record documentation for medical review purposes. Signature and date stamps are not acceptable for use on CMNs and DIFs.

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

For complete details regarding this change request (CR) please see the official instruction (CR 6261) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R281PI.pdf> on the CMS Web site.

MLN Matters Number: MM6261

Related Change Request (CR) #: 6261

Related CR Release Date: December 31, 2008

Effective Date: February 2, 2009

Related CR Transmittal #: R281PI

Implementation Date: February 2, 2009

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Medicare DMEPOS competitive bidding program announcements

The Centers for Medicare & Medicaid Services (CMS) has announced that an interim final rule with comment period, which implements certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the Round 1 rebid of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive acquisition program, is on display at the *Federal Register*.

CMS has also announced the appointment of new members to serve on the Program Advisory and Oversight Committee (PAOC) for the DMEPOS competitive bidding program.

Visit the CMS Web site at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/> to view the list of PAOC members and for the latest information on the DMEPOS competitive bidding program.

To view the press release, please click at http://www.cms.hhs.gov/apps/media/press_releases.asp.

Source: CMS PERL 200901-23

2009 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD for Florida is available on the FCSO Medicare Web site at:

<http://medicare.fcso.com/MEDPARD/>.

Source: Pub 100-04, transmittal 1627, change request 6235

Efforts strengthened to reduce Medicare waste, fraud, and abuse Medicare issues final rule requiring surety bonds for DMEPOS suppliers and takes next step in fighting home health fraud

The Centers for Medicare & Medicaid Services (CMS) announced it is requiring certain durable medical equipment suppliers to post a surety bond. In addition, CMS announced that it has revoked the billing privileges of more than 1,100 medical equipment suppliers in south Florida and southern California and is suspending payments to Florida home health agencies in the Miami-Dade area. To view the entire press release dated December 29, 2008, go to the following link on the CMS Web site: http://www.cms.hhs.gov/apps/media/press_releases.asp.

Source: PERL 200901-03

Informational message on the Medicare summary notice

Beginning January 9, 2009, through September 30, 2009, First Coast Service Options Inc. began printing the general message #24.15 on all Medicare summary notices (MSNs) issued to beneficiaries in Florida. This message is printed on the first page in the fraud section:

English version

Report items and services that you did not receive to Medicare's Fraud Hotline at 1-866-417-2078.

Spanish version

Reporte los servicios y artículos que no recibió a la línea gratuita para Fraude de Medicare al 1-866-417-2078.

Source: JSM 09111

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

Get your flu shot -- not the flu!

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

Health care professionals and their staff can learn more about Medicare's coverage of the influenza vaccine 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

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf> on the CMS Web site.

Source: PERL 200901-05

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 contractor. 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://medicare.fcso.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

January is National Glaucoma Awareness Month

In recognition of National Glaucoma Awareness Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of a comprehensive annual glaucoma screening exam for seniors and others with Medicare at high risk for developing glaucoma.

Glaucoma is a leading cause of blindness in the United States and while anyone can develop glaucoma, the risk of glaucoma increases with age. Early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

Medicare coverage

Medicare beneficiaries who belong to one of the following high risk groups are eligible for an annual glaucoma screening covered by Medicare:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older.

A covered glaucoma screening includes:

- A dilated eye examination with an intraocular pressure (IOP) measurement and
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

What you can do

As a health care professional who provides care to seniors and others with Medicare, you can help protect the vision of your Medicare patients who may be at high risk for glaucoma by educating them about their risk factors and reminding them of the importance of getting an annual glaucoma screening exam covered by Medicare. Your reminder and referral for a glaucoma screening exam can help provide eligible Medicare beneficiaries with peace of mind and safeguard their vision.

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their staff learn more about coverage, coding, billing, and reimbursement for preventive services and screenings covered by Medicare.

The MLN Preventive Services Educational Products Web Page -- provides descriptions and ordering information for all provider-specific educational products related to preventive services.

The Web page is located at http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp on the CMS Web site.

Glaucoma Screening Brochure -- this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of glaucoma screening services. To view online go to <http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf> on the CMS Web site. To order copies of the brochure, go to the CMS Medicare Learning Network (MLN) Product Ordering System located at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.

The CMS Web site -- provides information for preventive services covered by Medicare. Go to <http://www.cms.hhs.gov>, select "Medicare", and scroll down to the "Prevention" section.

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

For more information about glaucoma, visit The National Eye Institute <http://www.nei.nih.gov/index.asp>.

For more information about National Glaucoma Awareness Month, please visit <http://www.preventblindness.org/>.

Thank you for joining CMS in the effort to educate beneficiaries about glaucoma and the importance of early detection by encouraging them to take advantage of the annual glaucoma screening benefit covered by Medicare. You are helping CMS protect the vision of Medicare beneficiaries who are at higher risk for glaucoma.

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

Source: PERL 200901-07

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 contractor. 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://medicare.fcso.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

Products on preventive services available from the Medicare Learning Network

Products on preventive services are now available for ordering free-of-charge from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN).

The *ABCs of Providing the Initial Preventive Physical Examination Quick Reference* Information chart (January 2009) is a resource tool that is now available as either a two-sided laminated chart or as a tear-off pad. It may be used by Medicare fee-for-service physicians and qualified nonphysician practitioners as a guide when providing the initial preventive physical examination (IPPE), which is also known as the “Welcome to Medicare” physical exam or the “Welcome to Medicare” visit. This reference guide identifies the components and elements of the IPPE; provides eligibility requirements and procedure codes to use when filing claims, FAQs, and suggestions for preparing patients for the IPPE; and lists references for additional information. To view, download, and print this resource, please go to the CMS MLN at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf. To order the laminated chart or tear-off pad free-of-charge, visit <http://www.cms.hhs.gov/MLNProducts/>, scroll down to *Related Links Inside CMS*, and select *MLN Product Ordering Page*.

The *Medicare Preventive Services Quick Reference Information* chart (January 2009) is a two-sided laminated chart that gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare preventive services. To view, download, and print this resource, please go to the CMS MLN at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.

To order these two products free-of-charge, 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 200901-35 & PERL 200901-49

Reporting responsibilities for physicians, nonphysicians and group practices

The Centers for Medicare & Medicaid Services has revised the physician, nonphysician practitioner (NPP) and group practice reporting responsibility fact sheets and the physicians, NPP and other health care supplier brochures found on the Medicare Provider Enrollment Web page.

These fact sheets list the types of changes that enrolled physicians, NPPs, and group practices are required to report to Medicare. By reporting changes as soon as possible, physicians, NPPs, and group practices will help to ensure that their claims are processed correctly.

Links to the following educational materials are provided below:

Reporting Responsibilities for Individual Physicians Enrolled in the Medicare Program

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/PhysicianReportingResponsibilities.pdf>.

Reporting Responsibilities for Individual Non-Physician Practitioners Enrolled in the Medicare Program

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/Non-PhysicianReportingResponsibilities.pdf>.

Reporting Responsibilities for Physician Group Practices Enrolled in the Medicare Program

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/GroupPracticeReportingResponsibilities.pdf>.

Medicare Enrollment for Physicians, Non-Physician Practitioners and Other Health Care Suppliers

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/suppliers.pdf>.

Source: PERL 200901-21

The Expanded Benefits Brochure available

The *Expanded Benefits Brochure* (January 2009) is now available in downloadable format. This tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of three preventive services: the initial preventive physical examination (IPPE) (also known as the Welcome to Medicare Physical exam or the Welcome to Medicare visit), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. To view, download, and print the brochure please go to the CMS Medicare Learning Network (MLN) at http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf.

Source: PERL 200901-08

Printed copy of Medicare billing information publication now available for order

The Centers for Medicare & Medicaid Services (CMS) publication *Medicare Billing Information for Rural Providers, Suppliers, and Physicians* (revised October 2008) is comprised of charts that provide Medicare billing information for rural health clinics, federally qualified health centers, skilled nursing facilities, home health agencies, critical access hospitals, and swing beds. A printed copy of this publication is now available from the CMS *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 200901-13

Update to the Five-Star Quality Rating Technical Users' Guide

A new version of the *Five-Star Quality Rating Technical Users' Guide* and an accompanying *Summary of Updates to the Technical Users' Guide* document are available on the *Five-Star Quality Rating System* Web page. For the latest version of the manual, see http://www.cms.hhs.gov/CertificationandCompliance/13_FSQRS.asp#TopOfPage.

Source: CMS PERL 200901-37

Notice of interest rate for Medicare overpayments and underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the current value of funds rate (three percent for calendar year 2009) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health & Human Services that the PCR will remain at 11.375 percent, effective January 23, 2009. The PCR will remain in effect until a new rate change is published. The following table lists previous interest rates.

Period	Interest Rate
October 22, 2008 – January 22, 2009	11.375%
July 24, 2008 – October 21, 2008	11.125%
April 18, 2008 – July 23, 2008	11.375%
January 18, 2008 – April 17, 2008	12.125%
October 19, 2007 – January 17, 2008	12.5%
July 20, 2007 – October 18, 2007	12.625%

Source: CMS Pub. 100-06, Transmittal 146, CR 6239

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 contractor. 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 new and improved Web site, <http://medicare.fcs.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

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 of final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>.

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://medicare.fcso.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

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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Revision to the LCD

NCSVCS: The list of Medicare noncovered services -- revision to the LCD..... 54

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.

LCD Revision

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

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised on January 1, 2009. Since that time the LCD has been revised. Change request 6291, dated December 9, 2008, states that thermal intradiscal procedures (TIPs) are nationally noncovered. This instruction is outlined in national coverage determination (NCD) 150.11. With the issuance of this NCD, *CPT* codes 0062T, 0063T, 22526 and 22527 have been removed from the LCD.

Effective date

This revision is effective for claims processed on or after January 5, 2009, for services rendered on or after September 29, 2008. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/overview.asp>.

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology*. *CPT* codes, descriptions and other data only are copyrighted 2008 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.

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 contractor. 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://medicare.fcso.com>, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

Educational Resources

Upcoming provider outreach and education events February - March 2009

Ask-the-contractor webcast

Topic: National Correct Coding Initiative (NCCI) edits
When: February 10, 2009
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Evaluation and management (E/M) webcast

Topic: Inpatient hospital services
When: February 17, 2009
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Ask-the-contractor webcast

Topic: Jurisdiction 9 -- important transition updates
When: February 25, 2009
Time: 11:00 a.m. - 12:30 p.m.
Type of Event: Teleconference

Evaluation and management (E/M) webcast

Topic: Hospital observation services
When: March 3, 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.

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, http://medicare.fcsso.com/Education_resources/, or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

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!

Mail directory

Claims Submissions

Routine paper claims

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

Participating providers

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

Chiropractic claims

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

Ambulance claims

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

Medicare secondary payer

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

ESRD claims

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

Communication

Redetermination requests

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

Fair hearing requests

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

Freedom of information act

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

Administrative law judge hearing

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

Status/general inquiries

Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments

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

Durable medical equipment (DME)

DME, orthotic or prosthetic claims

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

Electronic media claims (EMC)

EMC claims, agreements and inquiries

Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

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

**Over 40 days of initial request:
Submit the charge(s) in question, including
information requested, as you would a new
claim, to:**

Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

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

Provider change of address:

Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and

Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

**For educational purposes and review of
customary/prevaling charges or fee schedule:**

Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

For education event registration:

Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:

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

For refund verification:

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

Medicare claims for Railroad retirees:

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

Fraud and abuse

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

Phone numbers

Providers

Toll-Free

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

Beneficiary

Toll-Free:

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

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

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

EMC

Format issues & testing:

1-904-354-5977 option 4

Start-up & front-end edits/rejects:

1-904-791-8767 option 1

Electronic funds transfer

1-904-791-8016

**Electronic remittance advice, electronic claim
status, & electronic eligibility:**

1-904-791-6895

PC-ACE support:

1-904-355-0313

Marketing:

1-904-791-8767 option 1

New installations:

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

Help desk:

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

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Medicare Web sites

Provider

Florida Medicare contractor
www.floridamedicare.com

**Centers for Medicare & Medicaid
Services**

www.cms.hhs.gov

Beneficiaries

**Centers for Medicare & Medicaid
Services**

www.medicare.gov

Order Form -- 2009 Part B Materials

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

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

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

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

◆ ATTENTION BILLING MANAGER ◆