MEDICARE B Update!

A NEWSLETTER FOR FLORIDA MEDICARE PART B PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

- ☐ Physician/Provider
- ☐ Office manager
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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.

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

"GA" modifier and appeals

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

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

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

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

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative 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.

Ambulance

Clarification of date of service of ambulance services

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

Provider types affected

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

Impact on providers

Providers of ambulance services should note the clarifications made by CR 6372, as noted in this article. Specifically, CR 6372 clarifies the proper date of service to use on claims, especially in situations where the beneficiary dies.

Background

CR 6372 provides clarification of Centers for Medicare & Medicaid Services' (CMS) policy towards dates of service (DOS) for ambulance services, especially in regard to a beneficiary's date of death.

The clarifications for providers of ambulance services are listed as follows:

- The date of service of an ambulance service is the date that the loaded ambulance vehicle (ground or air) departs the point of pickup, except in cases where the beneficiary is pronounced dead as noted below.
- In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the DOS is considered to be the date of the ambulance vehicle's dispatch.
- In the case of an air transport, if the beneficiary is pronounced dead after the aircraft takes off to pick up the beneficiary, the DOS is considered to be the date of the ambulance vehicle's takeoff.

Failure to code dates of service correctly in these situations could result in the denial of the claim.

Additional information

The official instruction, CR 6372, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1682CP.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: MM6372
Related Change Request (CR) #: 6372
Related CR Release Date: February 13, 2009
Effective Date: March 13, 2009
Related CR Transmittal #: R1682CP
Implementation Date: March 13, 2009

Ambulatory Surgical Center

Implementation of an ambulatory surgical center payment indicator file

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

Provider types affected

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

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6184 which provides Medicare contractors with instructions for implementing an ASC healthcare common procedure coding system (HCPCS) payment indicator file.

Caution -- what you need to know

CR 6184 provides instructions to your Medicare contractor(s) to modify their systems to accept the new ASC HCPCS payment indicator file and ensure that it properly interfaces with the other ASC files in order to process ASC claims appropriately. This new file will enable your Medicare contactor(s) to enhance the their ability to (1) identify all separately payable and nonseparately payable (packaged) services, as well as nonpayable services, and (2) provide more precise messaging via remittance advice remark codes in the processing and disposition of ASC claims for all HCPCS codes submitted by ASCs.

Go -- what you need to do

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

Background

As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 626 of), the Centers for Medicare & Medicaid Services (CMS) implemented a revised ASC payment system January 1, 2008.

CMS provided in CR 5680 (Transmittal 1325, August 29, 2007; see related *MLN Matters* article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5680.pdf* on the CMS Web site) supporting ASC file record layouts of the ASC facility payment file (ASCFS) and ASC drug file to interface with the instructions issued to implement the revised ASC payment system. The ASCFS includes rates for all services that are eligible for payment under the revised ASC payment system, except separately paid drugs and biologicals, and the ASC drug file provides the rates for all drugs and biologicals that are eligible for separate payment under the revised ASC payment system.

Using defined "payment indicators" (72 FR 67189-67190; see *http://www.gpoaccess.gov/fr/retrieve.html* on the Internet), CMS identifies each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment.

For calendar year 2008, Medicare contractors did not have access to the ASC payment indicators for all services and, therefore, were unable to accurately determine the specific reason for nonpayment in all cases, though the payment decisions made on the claims were correct.

CR 6184 announces that CMS is providing a file of the ASC payment indicators that are assigned to each HCPCS code in order to enhance the ability of Medicare contractors to identify both separately payable and nonseparately payable (packaged) services, as well as nonpayable services. This information will enable contractors to provide detailed messaging in the processing and disposition of ASC claims for all HCPCS codes submitted by ASCs.

In addition to the ASCFS and ASC drug file(s), CMS is providing Medicare contractors with a more comprehensive list of HCPCS codes and the payment indicator assigned to each of the codes. Beginning January 1, 2009, Medicare contractors will be able to process ASC claims using the revised ASC HCPCS code payment indicator file and will provide messaging to ASCs and beneficiaries, in part, based on the "messaging " provided in CR 6184. The specific payment indicators are identified in an attachment to CR 6184.

Additional information

The official instruction, CR 6184, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1616CP.pdf* on the CMS Web site. Attachment B of CR 6184 contains the list of ASC payment indicators and their respective definitions.

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

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

MLN Matters Number: MM6184
Related Change Request (CR) #: 6184
Related CR Release Date: October 17, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1616CP
Implementation Date: January 5, 2009

Cardiology Services

Heartsbreath test for heart transplant rejection

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6366 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) determined that the Heartsbreath test is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act, and is noncovered for dates of service on or after December 8, 2008. See the *Background* and *Additional information* sections of this article for further details regarding this issue.

Background

On December 8, 2008, CMS issued a decision memorandum in response to a formal request for Menssana Research, Inc., to consider national coverage of the Heartsbreath test as an adjunct to the heart biopsy to detect grade 3 heart transplant rejection in patients who have had a heart transplant within the last year and an endomyocardial biopsy in the prior month. CMS determined that the evidence does not adequately define the technical characteristics of the test nor demonstrate that Heartsbreath testing to predict heart transplant rejection improves health outcomes in Medicare beneficiaries.

Key points

- Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath test used to predict heart transplant rejection is nationally noncovered. This coverage change to *Current Procedural Terminology (CPT)* code *0085T, breath test for heart transplant rejection*, will be effective with the April 1, 2009, quarterly update of the Medicare physician fee schedule database.
- Effective with the April 1, 2009, quarterly update of the integrated outpatient code editor, *CPT* code *0085T, breath test for heart transplant rejection*, is no longer payable by Medicare.
- When denying claims for *CPT* code *0085T*, Medicare contractors will use:

  Medicare summary notice (MSN) message 16.10: Medicare does not pay for this item or service

  Claim adjustment reason code 50: These are non-covered services because this is not deemed a medical necessity by the payer

  Claim adjustment remark code MA 51: Missing/ Incomplete/Invalid Procedure Code(s)

  N386: This decision was based on an 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, contact your Medicare contractor to request a copy of the NCD.)

- For beneficiaries who choose to have this procedure anyway, providers shall issue an advance beneficiary notice (ABN) indicating that Medicare issued an NCD at section 260.10 of the *NCD Manual* stating that the Heartsbreath test is not reasonable and necessary for Medicare beneficiaries. Medicare never pays for this test and the beneficiary would be held financially liable. (Beginning March 1, 2009, the ABN-G will no longer be valid and providers must issue the revised ABN (CMS-R-131.)
  - Medicare contractors will include the group code CO (contractor obligation) or PR (provider responsibility) depending on liability.
- For claims already processed with dates of service between December 8, 2008, and April 1, 2009, contractors will not search their files, but may go back and adjust claims that are brought to their attention.

Additional information

If you have questions, please contact your Medicare FI, carrier 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.

The official instruction (CR 6366) was issued to your Medicare FI, carrier or MAC via two transmittals. The first conveys the revised claims processing instructions and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1683CP.pdf* on the CMS Web site. The second transmittal conveys the change to the *National Coverage Determinations Manual* and that transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R99NCD.pdf* on the CMS Web site.

MLN Matters Number: MM6366
Related Change Request (CR) #: 6366
Related CR Release Date: February 13, 2009
Effective Date: December 8, 2008
Related CR Transmittal #: R1683CP and R99NCD
Implementation Date: April 6, 2009

Competitive Acquisition Program

Medicare Part B Drug Competitive Acquisition Program postponed for 2009

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

Note: This article was revised on February 6, 2009, to reflect the fact that the Competitive Acquisition Program (CAP) for 2009 is postponed and the impact of that postponement. This information was previously published in the September 2008 *Medicare B Update!* pages 15-16.

Provider types affected

Physicians who participated in the 2008 Medicare CAP for Part B drugs and biologicals.

Provider action needed

Stop -- impact to you

The Centers for Medicare & Medicaid Services (CMS) has postponed the CAP for 2009.

Caution -- what you need to know

The contract with the current approved CAP vendor, BioScrip Inc., expired December 31, 2008. Physicians who participated in the CAP must transition back into the average sales price (ASP) method of acquiring part B drugs for services provided on or after January 1, 2009. Emergency restocking requests for drugs used from office stock must be submitted to the approved CAP vendor by January 30, 2009. Claims processing for the CAP will continue past January 1, 2009, for claims with dates of service through December 31, 2008, and participating CAP physicians must submit their drug administration claims by January 30, 2009. The physician election period for 2009 that was scheduled for October 1 to November 15, 2008, will not be held. In 2009, beneficiaries whose physicians participated in the CAP will only receive a Medicare summary notice (MSN) from the CAP designated carrier if the corresponding claims for their Medicare drugs were from dates of service on or before December 31, 2008.

Go -- what you need to do

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

Background

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

CAP is postponed for 2009

In 2008, CMS accepted bids for vendor contracts for the 2009-11 CAP. While CMS received several qualified bids, contractual issues with the successful bidders resulted in CMS postponing the program as of January 1, 2009. As a result, CAP drugs will not be available from an approved CAP vendor for dates of service after December 31, 2008, and the 2009 CAP physician election period scheduled for October 1 to November 15, 2008, will not be held.

Drug ordering

The contract with the current approved CAP vendor, BioScrip Inc., will remain in effect for dates of service through December 31, 2008. Participating CAP physicians must continue to obtain CAP drugs from the approved CAP vendor if the drugs are to be administered on or before December 31, 2008. Beginning January 1, 2009, physicians must obtain and bill for drugs through the ASP process, and physicians will also be responsible for collecting applicable deductible and co-insurance from Medicare beneficiaries.

Unused CAP drugs that remain at a physician's office belong to the approved CAP vendor. They must be returned to the approved CAP vendor, if permissible by state law, by February 28, 2009, or purchased from the approved CAP vendor for administration under the ASP methodology for dates of service after January 1, 2009. Unused CAP drugs cannot be given away to a physician, and physicians will be liable for the cost of these drugs if they are not returned by February 28, 2009.

Participating CAP physicians should contact the approved CAP vendor as early as possible to determine whether buying or returning unused drugs is preferable, and take steps to minimize the amount of unused drugs at their offices. Contact information for the approved CAP vendor is available at *http://www.bioscrip.com/* on the Internet.

Emergency restocking

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

Medicare Part B Drug Competitive Acquisition Program postponed for 2009 (continued)

If a participating CAP physician administers a drug from office stock on or before December 31, 2008, and does not submit a prescription order and a request for replacement drugs, the physician will not be able to bill Medicare under the ASP system for the administered drug. The approved CAP vendor will not send replacement products under the CAP emergency restocking provision (modifier J2 claims) after February 28, 2009.

Claims processing and billing

Participating CAP physicians must submit CAP claims to their local carrier or Medicare administrative contractor (MAC) within 30 days of CAP drug administration. All CAP drug claims with dates of service through December 31, 2008, must be submitted on or before January 30, 2009. Any CAP claims with dates of service after December 31, 2008, will be denied.

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

Beneficiaries whose physicians participated in the CAP received separate MSNs from both: the CAP designated carrier, Noridian Administrative Services (NAS) and the local carrier/MAC that processes a beneficiary's claims. In 2009, beneficiaries will only receive MSNs from the CAP designated carrier if the corresponding claims for their Medicare drugs were from dates of service on or before December 31, 2008.

Post payment review

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

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

CAP training during the transition

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

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

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

Additional information

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

For original background information on the CAP, please review CR 4309 at: *http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf* and its related article at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf* on the CMS Web site.

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

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

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

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

MLN Matters Number: SE0833 *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

Reminder: Unused Competitive Acquisition Program drugs and emergency restocking

The following are reminders about the remaining Competitive Acquisition Program (CAP) deadlines:

- 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.
- The approved CAP vendor will not send replacement products under the CAP emergency restocking provision (J2 modifier claims) after February 28, 2009.
- CAP physicians who have not submitted a prescription order and a request for replacement drugs under the emergency restocking provision will not be able to bill Medicare under the average sales 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 & Medicaid Services Web site at: *http://www.cms.hhs.gov/CompetitiveAcquisforBios/01_overview.asp*.

Source: PERL 200902-15

Durable Medical Equipment

Payment for repair, maintenance and servicing of oxygen equipment

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

Provider types affected

Providers and suppliers submitting claims to Medicare durable medical equipment Medicare administrative contractors (DME MACs), and/or regional home health intermediaries (RHHIs) for repair, maintenance and servicing of oxygen equipment provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6296 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is providing instructions regarding repair, maintenance, and servicing of oxygen equipment resulting from implementation of Section 144(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The 36-month cap noted in MIPPA 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, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under HCPCS codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made every six months, beginning six months after the 36-month rental cap (as early as July 1, 2009, in some cases), and the allowed payment amount for each visit is equal to the 2009 fee for code E1340 (K0739 for dates of service on or after April 1, 2009) multiplied by two, for the state in which the in-home visit takes place.

Suppliers should use the HCPCS code for the equipment E1390, E1391, E1392, and/or K0738 along with the modifier MS in order to bill and receive payment for these maintenance and servicing visits. For example, if the supplier visits a beneficiary's home in Pennsylvania to perform the general maintenance and servicing on a portable concentrator, the supplier would enter E1392MS on the claim and the allowed payment amount would be equal to the lesser of the supplier's actual charge or two units of the allowed payment amount for K0739 in Pennsylvania. If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a stationary concentrator (E1390 or E1391) and a transfilling unit (K0738), payment can be made for maintenance and servicing of both units (E1390MS or E1391MS, and K0738MS). If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a portable concentrator (E1392), payment can only be made for maintenance and servicing of the one unit/HCPCS code (E1392MS).

CMS will issue further instructions in the future regarding continuation of these payments for dates of service on or after January 1, 2010.

Payment for repair, maintenance and servicing of oxygen equipment (continued)

Background

Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. Initial instructions related to implementation of these changes were issued as part of the January 2009 durable medical equipment prosthetics orthotics & supplies (DMEPOS) fee schedule update, CR 6297. The *MLN Matters* article related to CR 6297 may be viewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf* on the CMS Web site.

Key points

To distinguish between the repair or nonroutine service of beneficiary-owned DME and oxygen equipment, two new "K" codes are effective for claims with dates of service on or after April 1, 2009. Those "K" codes are:

- K0739 - Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes
- K0740 - Repair or nonroutine service for oxygen equipment requiring the skill of a technician, labor component, per 15 Minutes
- The new noncovered code K0740 should be used by suppliers to indicate the labor associated with the repair of stationary or portable oxygen equipment.
- The existing E1340 HCPCS code is invalid for Medicare claims, effective April 1, 2009. The revised 2009 labor payment rates, provided in CR 6297, map directly to the new K0739 code and will be used to pay claims for code K0739 with dates of service on or after April 1, 2009.

Note that the two new codes are not yet final and should not be used until effective on April 1, 2009.

DME MACs and RHHIs:

- Deny claims with dates of service on or after April 1, 2009, for HCPCS code K0740.
- Will deny claims with dates of service on or after January 1, 2009, for claims received on or after April 6, 2009, for replacement parts billed using a HCPCS code and the modifier RB when the part is replaced in conjunction with the repair of oxygen equipment identified by HCPCS codes E0424, E0431, E0434, E0439, E1390, E1391, E1392, E1405, E1406, or K0738.

Additional information

For complete details regarding this CR please see the official instruction (CR 6296) issued to your Medicare DME MAC, or RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R443OTN.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM6296
Related Change Request (CR) #: 6296
Related CR Release Date: February 13, 2009
Effective Date: April 1, 2009
Related CR Transmittal #: R443OTN
Implementation Date: April 6, 2009

Medicare DMEPOS Competitive Bidding Program announcement

The Centers for Medicare & Medicaid Services has delayed the effective date for the interim final rule with comment period that 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. The effective date was originally February 17, 2009, and now is April 18, 2009.

The original comment period on the interim final rule remains unchanged. The public has until March 17, 2009, to submit comments on the substantive policy issues discussed in the rule.

Visit the CMS Web site at *http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/* for additional information.

Source: PERL 200902-24

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative 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.

DMEPOS supplier accreditation -- get it now

Deadline is September 30, 2009

The Centers for Medicare & Medicaid Services (CMS) wants to remind suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B that they must obtain accreditation by September 30, 2009. In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary) must comply with Medicare's supplier and quality standards and become accredited. DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

DMEPOS suppliers who submitted a completed application to an accrediting organization, on or before January 31, 2009, will have an accreditation decision (either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.

DMEPOS suppliers submitting applications to an accrediting organization, on or after February 1, 2009, may or may not have their accreditation decision by the September 30, 2009, deadline.

The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine, and prosthetic devices, prosthetics, and orthotics. Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians, and athletic trainers must also meet the September 30, 2009, deadline for DMEPOS accreditation.

Certain eligible professionals and other persons as specified by the Secretary are exempt from the accreditation requirement.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at *http://www.cms.hhs.gov/medicareprovidersupenroll*.

Source: PERL 200902-29

General Coverage

Shipboard services billed to the carrier and not provided within the United States -- fully replaces CR 6217

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

Provider types affected

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

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6327 which clarifies payment for shipboard services billed to Medicare contractors and services not provided within the United States.

Caution -- what you need to know

CR 6327 revises the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* to clarify that Medicare contractors will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization, including emergency physician and ambulance services furnished during the time period immediately preceding the covered foreign hospitalization. CR 6327 rescinds and fully replaces CR 6217.

Go -- what you need to do

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

Background

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services (see the Social Security Act, Section 1814(f) at *http://www.ssa.gov/OP_Home/ssact/title18/1814.htm* and Section 1862(a)(4) at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Internet). The law specifies the following are exceptions to the "foreign" exclusion:

- 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:
  - The emergency arose within the U.S, or
  - The emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay, between Alaska and another State.
- 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

Shipboard services billed to the carrier and not provided within the United States -- fully replaces CR 6217 (continued)

- Physician and ambulance services in connection with a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Note: The term "United States" includes 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, the territorial waters adjoining the land areas of the United States.

The *Medicare Claims Processing Manual* (Chapter 1, Section 10.1.4.7; see *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site) 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
- The physician must be registered with the Coast Guard in order for Medicare to make payment.

However, that manual language is not consistent with Medicare law. Therefore, because Section 10.1.4.7 is not consistent with Medicare law, CMS is clarifying Section 10.1.4.7 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 Chapter 1, Sections 10.1.4, and 10.1.4.1 and Chapter 3, Section 110.1 of the *Medicare Claims Processing Manual* and Chapter 16, Section 60 of the *Medicare Benefit Policy Manual* to show that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered. The term "and during a period of" covered foreign hospitalization 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.

You can find the revised chapters of two manuals referenced above as attachments to CR 6327.

Additional information

The official instruction, CR 6327, was issued to your carrier, FI, and MAC via two transmittals. The first modifies the *Medicare Claims Processing Manual* and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1677CP.pdf* and the second modifies the *Medicare Benefit Policy Manual* and that transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R102BP.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: MM6327
Related Change Request (CR) #: 6327
Related CR Release Date: February 13, 2009
Effective Date: March 13, 2009
Related CR Transmittal #: R1677CP and R102BP
Implementation Date: March 13, 2009

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

Note: This article was rescinded on February 17, 2009, because the Centers for Medicare & Medicaid Services (CMS) rescinded related change request (CR) 6217. That CR was replaced by CR 6327, which CMS issued on February 13, 2009. The article based on CR 6327 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6327.pdf* on the CMS Web site. This information was previously published in the January 2009 Medicare B Update! pages 37-38.

MLN Matters Number: MM6217 *Revised*
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

Electronic Data Interchange

Medicare remit easy print software codes update

Medicare fee-for-service professional providers and suppliers

The latest claim adjustment reason codes and remittance advice remark codes are available in the codes.ini file for the Medicare remit easy print (MREP) software. You may access this file in the zipped folder for "Medicare Remit Easy Print - Version 2.5" at *http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Source: PERL 200902-16

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General Information

Standard system change to allow claims processing contractors flexibility with 9-digit ZIP codes

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

Provider types affected

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

Provider action needed

This article is informational and is based on change request (CR) 6293 which makes revisions to Medicare systems to allow Medicare contractors to add new and valid 4-digit ZIP code extensions to the file they use for jurisdictional pricing, thus enabling claims requiring use of the 9-digit ZIP code to process faster when new ZIP codes are established.

If a physician, provider, or supplier has received a claim denial informing them that the 4-digit ZIP code extension they submitted was invalid, but they have verified validity through the United States Postal Service, they should contact their carrier or MAC so that the ZIP code can be added to the file and the claim processed appropriately.

Background

CR 6293 will allow Medicare contractors to add new, valid 4-digit ZIP code extensions more quickly to the 9-digit ZIP code file that contractors receive quarterly from the Centers for Medicare & Medicaid Services (CMS) thus avoiding any delays in processing claims. These changes are effective for claims processed on or after July 6, 2009.

Note: CR 6293 makes no change to the policy of jurisdictional payment for claims paid under the physician fee schedule and anesthesia claims.

Additional information

The official instruction, CR 6293, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1675CP.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM6293
Related Change Request (CR) #: 6293
Related CR Release Date: January 30, 2009
Effective Date: claims processed on or after July 6, 2009
Related CR Transmittal #: R1675CP
Implementation Date: July 6, 2009

Change in the amount in controversy for administrative law judge hearings and federal district court appeals

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) 6295, which notifies Medicare contractors of the amount in controversy (AIC) required to sustain administrative law judge (ALJ) and federal district court appeal rights beginning January 1, 2009.

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2009, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2009, is $120.

For federal district court review, the amount remaining in controversy goes from $1,180 for requests on or after January 1, 2008, to $1,220 for requests on or after January 1, 2009.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6295 modifies the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or judicial court review.

Additional information

The official instruction (CR 6295) issued to your Medicare carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1676CP.pdf* on the CMS Web site.

Change in the amount in controversy for administrative law judge hearings and federal district court appeals (continued)

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: MM6295
Related Change Request (CR) #: 6295
Related CR Release Date: January 30, 2009
Effective Date: May 4, 2009
Related CR Transmittal #: R1676CP
Implementation Date: May 4, 2009

Physician signature requirements for diagnostic tests

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

Note: This article was revised on February 6, 2009, to remove a parenthetical statement under the *What you need to know* section of this article. All other information remains the same.

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MAC]) for diagnostic laboratory services provided to Medicare beneficiaries.

What you need to know

CR 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (Definitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional information

You may find more information about physician signature requirements for diagnostic tests by going to CR 6100, located at *http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. You will find the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (Definitions) as an attachment to CR 6100.

If you have 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: MM6100 *Revised*
Related Change Request (CR) #: 6100
Related CR Release Date: August 29, 2008
Effective Date: January 1, 2003
Related CR Transmittal #: R94BP
Implementation Date: September 30, 2008

Implementation of new provider authentication requirements for Medicare contractor provider telephone and written inquiries

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

Note: This article was revised on February 26, 2009, revising the change request (CR) release date, transmittal number, and the Web address of the CR. All other information remains the same. This information was previously published in the September 2008 *Medicare B Update!* pages 62-63.

Provider types affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], or durable medical equipment Medicare administrative contractors [DME MACs]). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to interactive voice response (IVR) systems.

What you need to know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a customer service representative (CSR).

Effective April 6, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication:

1) national provider identifier (NPI)

2) provider transaction access number (PTAN)

3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last 5-digits of your TIN.

As a result of CR 6139, the Disclosure Desk Reference for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

Authentication of providers with No NPI

Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

Beneficiary authentication

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

1) Last name

2) First name or initial

3) Health insurance claim number (HICN), and

4) Either date of birth (eligibility, next eligible date, durable medical equipment Medicare administrative contractor information form (DIF pre-claim) or date of service claim status, [CMN/DIF post-claim]).

Written inquiries

In general, three data elements (NPI, PTAN, and last 5-digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, e-mail, pre-formatted inquiry forms or inquiries written on remittance advice [RAs] or Medicare summary notices [MSNs]).

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice

Implementation of new provider authentication requirements for . . . . . (continued)

location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match the NPI, the PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

Overlapping claims

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional information

You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at *http://www.cms.hhs.gov/Transmittals/downloads/R24COM.pdf* on the CMS Web site.

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

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

MLN Matters Number: MM6139 *Revised*
Related Change Request (CR) #: 6139
Related CR Release Date: February 25, 2009
Effective Date: April 6, 2009
Related CR Transmittal #: R24COM
Implementation Date: April 6, 2009 for providers

Internet-based enrollment available in all states and the District of Columbia

It's fast, secure, and easy

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

The Centers for Medicare & Medicaid Services (CMS) will make Internet-based PECOS to all organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers) later this year.

Fast

By submitting the initial Medicare enrollment application through Internet-based PECOS, a physician or NPPs enrollment application can be processed as much as 50 percent faster than by paper. This means that it will take less time to enroll or make a change in an existing enrollment record. For additional information about the types of changes that must be reported, go to the *Download* section of *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Secure

Internet-based PECOS meets all required government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only authorized individuals can enter enrollment information into PECOS or view PECOS data from the Internet. Authorized individuals include physicians and NPPs. Their user IDs and passwords protect the access to their enrollment information. After physicians or NPPs create user IDs and passwords or change their passwords, they should keep this information secure and not share it with anyone. By safeguarding their user IDs and passwords, they are taking an important step in protecting their enrollment information. CMS does not disclose Medicare enrollment information to anyone except when we are authorized or required to do so by law.

Easy

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and NPPs complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record.

There are three basic steps to completing an enrollment action using Internet-based PECOS. Physicians and NPPs must:

1. Have a National Plan and Provider Enumeration System (NPPES) user ID and password to use Internet-based PECOS.

   For security reasons, physicians and NPPs should change passwords periodically, at least once a year. For information on how to change a password, go to the NPPES help page available at *https://nppes.cms.hhs.gov/NPPES/Welcome.do* and select the *Reset Password Page*.

2. Go to Internet-based PECOS at *https://pecos.cms.hhs.gov* and complete, review, and submit the electronic enrollment application via Internet-based PECOS.
3. Print, sign and date the certification statement (blue ink recommended) and mail the certification statement and all supporting paper documentation to the Medicare contractor.

Internet-based enrollment available in all states and the District of Columbia (continued)

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

Additional information

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

Source: PERL 200901-43

Steps for completing Internet-based Medicare enrollment

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

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and NPPs complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record.

There are three basic steps to completing an enrollment action using Internet-based PECOS. Physicians and NPPs must:

1. Have an NPPES User ID and password to use Internet-based PECOS.
   - For security reasons, physicians and NPPs should change passwords periodically, at least once a year. For information on how to change a password, go to the NPPES application help page available at *https://nppes.cms.hhs.gov/NPPES/Help.do?topic=* and select the *Reset Password Page*.
2. Access the Internet-based PECOS at *https://pecos.cms.hhs.gov* and complete, review, and submit the electronic enrollment application.
3. Print, sign and date the two-page certification statement and mail along with all supporting paper documentation to the Medicare contractor within seven days of electronic submission.

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

While the Centers for Medicare & Medicaid Services (CMS) encourages physicians and NPPs to print and retain a copy of the enrollment record for their records, physicians and NPPs should only mail the two-page certification statement to the designated contractor.

Additional information

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

CMS will make Internet-based PECOS to all organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers) later this year.

Source: PERL 200902-25

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 CMS-contracted Medicare administrative 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.

Providers serving Medicare beneficiaries enrolled in private fee-for-service plans

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

Provider types affected

All Medicare physicians, providers, and suppliers who provide services to Medicare patients enrolled in a Medicare Advantage (MA) private fee-for-service organizations (PFFS).

What you need to know

The Centers for Medicare & Medicaid Services (CMS) has announced a new process for handling payment disputes raised by providers who serve Medicare patients enrolled in MA PFFS plans. Such disputes arise when the billing provider is not satisfied with the MA PFFS organizations payment and the provider has exhausted the dispute resolution process with that organization. Effective January 1, 2009, CMS has delegated the adjudication of PFFS provider payment disputes to an independent review entity, i.e., First Coast Service Options, Inc. (FCSO). Therefore, as of January 1, 2009, after having exhausted the appeals process with the PFFS plan; providers should begin submitting payment dispute decision requests directly to FCSO. This process applies to providers treating such patients, where the provider has not contracted with the MA PFFS organization. Providers rendering such services without contracting with the MA PFFS plan are "deemed" providers for that plan. Please see the *Background* section for more detail.

Background

Prior to January 1, 2009, CMS central and regional office staff adjudicated payment disputes between deemed and noncontracted PFFS providers and MA organizations offering PFFS plans. However, beginning January 1, 2009, after an MA PFFS plan informs a provider or supplier in writing that a payment dispute has been denied through the MA PFFS plan provider payment dispute process; those who disagree with the pricing decision have the right to request the decision be reviewed by an independent review entity under contract with CMS.

Further, on November 25, 2008, CMS released a Health Plan Management System (HPMS) memorandum (Instructions for Model Private Fee-For-Service Terms and Conditions of Payment) announcing (effective January 1, 2009) that FCSO would be the independent review entity to which the adjudication of PFFS provider payment disputes would be delegated. In this role, FCSO directly adjudicates payment disputes between deemed and noncontracted private fee-for-service (PFFS) providers and MA organizations offering PFFS plans.

What decisions are subject to the payment dispute process?

Provider payment disputes include any decisions in which there is a dispute that the payment amount made by the MA PFFS plan to deemed providers is less than the payment amount that would have been paid under the MA PFFS Plan's terms and conditions, or the amount paid to noncontracted providers is less than would have been paid under original Medicare (including balance billing).

Note: A deemed provider is one who was aware that the patient was a private fee for service member at the time of service, and therefore had the ability to view the plan's terms and conditions of payment. A noncontracting provider is one that was not aware the patient was a private fee for service member at the time of service, e.g., an emergency situation.

Which decisions are not subject to the PFFS provider payment dispute process?

- Services denied for coverage issues such as local coverage determinations (LCDs)
- National coverage determinations (NCDs)
- Appeals of medical necessity determinations by the plan should first be sent through the appeals process of the MA PFFS plan and that process should be on the plan's Web site along with the plan's terms and conditions of payment, and
- Disputes between a contracted network PFFS provider and the MA PFFS plan are also not reviewed by the IRE or CMS.

How do you file a request for independent review (payment dispute decision [PDD])?

If you have exhausted the PFFS organization's dispute resolution process and wish to escalate review, you must file a PDD request directly with FCSO within 180 days of written notice from the MA PFFS plan (all requests must be received within 180 days of the MA PFFS plan written decision).

You must submit the request in writing; preferably on a standard PDD form available at the FCSO's PFFS Web site. A written request that is not made on the standard PDD form will be accepted if it contains all the required elements, as follows:

- Provider or supplier contact information including name and address
- Pricing information, including the national provider identifier (NPI) of the provider (and CMS certification number (CCN) or OSCAR number for institutional providers), ZIP where services were rendered, physician specialty, the name of the MA PFFS plan that made the redetermination including the specific PFFS plan name, and whether the provider/supplier is deemed or noncontracted
- The reason for dispute; a description of the specific issue
- A copy of the provider's submitted claim with disputed portion identified
- A copy of the PFFS plan's original pricing determination
- A copy of the PFFS plan's redetermination (dispute) pricing decision
- A copy of the relevant portion of terms and conditions (which are on the plan's Web site and that Web site address should be listed on the beneficiary's membership card for the plan) or contract and any supporting documentation and correspondence that support the provider's position that the plan's reimbursement is not correct (this may include interim rate letters where appropriate)
- An appointment of provider or supplier representative authorization statement, if applicable, and

Important information for providers serving Medicare beneficiaries enrolled in private fee-for-service plans (continued)

- The name and signature of the party or the representative of the party.

Mail your requests to:

First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44017
Jacksonville, Florida 32231-4017

Alternatively, if the submission and associated documents do not contain any personally identifiable health information (PHI) (or any PHI has been redacted), you may submit the payment dispute decision request to a dedicated e-mail box at *IREPFFS@FCSO.com*. FCSO can also receive PDD requests (including associated documents such as claims forms that may contain PHI) via fax at 1-904-361-0551.

What is the timeframe for making a PDD?

Once you have requested a PDD, FCSO may request documentation from the MAPFFS plan that processed the redetermination. When that plan receives FCSO's request for the case file, they must send it within seven calendar days so that FCSO receives it on or before the eighth day. PFFS plans that do not respond timely to IRE requests will be considered out of compliance with their CMS contract and subject to compliance processes.

FCSO will issue a decision within 60 days after receiving a provider payment dispute appeal unless it grants itself an exception to the 60-day timeframe. In the issued payment dispute decision letter, FCSO will notify all parties of either its decision, or that it has dismissed the PDD request. The PDD letter will also include the facts of the appeal, arguments made for and against additional reimbursement, the adjudicator's decision and rationale, and notification to the parties of their right to request a debriefing. Finally, when the IRE renders a decision on a case and notifies all parties of its decision, it considers the case closed. Please note again, however, that both parties have the right to request a debriefing.

If you have questions regarding the adjudication process or individual disputes being reviewed by the IRE, you can contact FCSO at 1-904-791-6430. You will be able to leave messages at this number and should expect a return call within 48 hours of receipt. Additionally, you can mail correspondence associated with a dispute request to:

First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44035
Jacksonville, Florida 32231-4035

Additional information

The standard PDD form and other information regarding this independent review process are available on the FCSO Web site at *http://www.fcso.com/whatwedo/QIC/139297.asp*.

MLN Matters Number: SE0902
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

Managing your Physician Quality Reporting Initiative e-mail updates

Effective immediately, Physician Quality Reporting Initiative (PQRI) messages will only be sent out through the *Medicare physician mailing list*. Previously, PQRI messages regarding recent news, policy changes, and updates were disseminated through all Medicare provider mailing lists.

If you are not currently subscribed to the *Medicare physician mailing list*, you may sign up by visiting *https://list.nih.gov/archives/physicians-l.html* on the Internet. Click on the link *join or leave the list, update options*. After completing the required information, click on *Join the list*.

For more information

New information is continually added to the most reliable source of information about PQRI on the CMS Web site: *http://www.cms.hhs.gov/PQRI*. This page contains the latest information on the 2009 PQRI, new and revised frequently asked questions (FAQ), updates on issues related to both the 2007 and 2008 PQRI, new educational products, and access to the latest information you need to successfully participate in PQRI.

Note: If you have a problem accessing the URLs embedded in the message, cut and paste the URLs into your Internet browser.

Source: PERL 200902-22

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 CMS-contracted Medicare administrative 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.

Availability of Five-Star Preview Reports

The Five-Star Preview Reports will be available beginning February 19. Please visit your Quality Improvement Evaluation System (QIES) mailbox (available through your electronic connection to the state servers) for submission of Minimum Data Set (MDS) data to review your results. To access these reports, select the *Certification and Survey Provider Enhanced Reports (CASPER) Reporting* link located at the bottom of the login page.

Once in the CASPER reporting system, click on the *Folders* 'button and access the five star report in your "st LTC facid" folder. The "st" is the 2-digit postal code of the state in which your facility is located, and "facid" is the state-assigned facility identifier of your facility.

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 accessible on the Five-Star Quality Rating System Web page at *http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp*.

Source: PERL 200902-26

The Expanded Benefits Brochure is now available for ordering

Now available for order: The *Expanded Benefits Brochure* (January 2009). 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 this brochure, please go to the *Medicare Learning Network* (*MLN*) at *http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf*. To order free of charge, visit *http://www.cms.hhs.gov/MLNProducts/*, scroll down to *Related Links Inside CMS*, and select *MLN Product Ordering Page*.

Source: PERL 200901-50

New 2009 Physician Quality Reporting Initiative educational products

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

The following items are now available for download on the PQRI Educational Resources Web page:

What's New for the 2009 Physician Quality Reporting Initiative (PQRI) - This fact sheet provides an overview of the 2009 PQRI and highlights the changes from the 2008 PQRI program.

2009 PQRI Made Simple – Reporting the Preventive Care Measures Group - This tip sheet provides quick, easy to understand instructions on how to satisfactorily participate in the 2009 PQRI for those who wish to report quality data using claims for the Preventive Care Measures Group.

To access these available educational resources, visit *http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage* on the CMS Web site and click on the *2009 PQRI Fact Sheet: What's New for the 2009 PQRI* and the *2009 PQRI Made Simple- Reporting the Preventive Care Measures Group* links.

Source: PERL 200901-51

New 2009 e-Prescribing incentive program educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new educational resource has been posted to the e-Prescribing incentive program section on the CMS Web site.

The following item is available for download:

2009 electronic prescribing incentive program made simple - This fact sheet provides detailed information on how to participate in the 2009 e-Prescribing incentive program by reporting the e-Prescribing measure.

To access this new educational resource, visit *http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage* on the CMS Web site and click on the *2009 Electronic Prescribing Incentive Program Made Simple* link.

Source: PERL 200901-52

Ambulance Fee Schedule Fact Sheet

The revised *Ambulance Fee Schedule Fact Sheet (January 2009)*, which provides general information about the ambulance fee schedule, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508-09.pdf*.

Source: PERL 200902-02

Ambulatory Surgical Center Fee Schedule Fact Sheet

The revised *Ambulatory Surgical Center Fee Schedule Fact Sheet (January 2009)*, which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf*.

Source: PERL 200902-02

Revised Payment System Fact Sheets

The following revised Payment System Fact Sheets are now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

Medicare physician fee schedule (January 2009): Provides general information about the Medicare physician fee schedule. This fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.

Hospital outpatient prospective payment system (January 2009): Provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set. This fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf*.

Hospice payment system (January 2009): Provides general information about the Medicare hospice benefit including coverage of hospice services, certification requirements, election periods, and how payment rates are set. This fact sheet may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*.

Note: If you are unable to access any of the hyperlinks in this message, please copy and paste the URLs into your Internet browser.

Source: PERL 200902-07

Skilled nursing facility consolidated billing Web-based training course

The revised skilled nursing facility consolidated billing (SNF CB) Web-based training (WBT) course (October 2008), which provides general information about SNFs, SNF consolidated billing, and under "arrangement agreements" between SNFs and other providers or suppliers, is now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To access this course, visit *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp* and select the "Web-based Training Modules" link from the "Related Links Inside CMS" section located at the bottom of the Web page.

Source: PERL 200902-08

A guide to assist with understanding the remittance advice

The *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* (October 2008) guide is now available to download from the CMS *Medicare Learning Network* (*MLN*). This publication is designed to help fee-for-service Medicare providers understand the remittance advice (RA), its applicable uses, and how to interpret RA fields and codes communicated by Medicare contractors. To view, download and print this guide, please go to the CMS *Medicare Learning Network* (*MLN*) at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

Note: Print copies will be available in approximately 4 to 6 weeks.

Source: PERL 200902-10

Revised Clinical Laboratory Fee Schedule Fact Sheet

The revised *Clinical Laboratory Fee Schedule Fact Sheet (February 2009)*, which provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set, is now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network* in downloadable format at *http://www.cms.hhs.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf*.

Source: PERL 200902-27

Revised Medicare Learning Network publications

The following revised publications are now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place an order for these publications, visit *http://www.cms.hhs.gov/MLNGenInfo/* scroll down to "Related Links Inside CMS" and select "*MLN* Product Ordering Page."

- Facilitators, trainers, educators, and physicians: Medicare Resident, Practicing Physician, and Other Health Care Professional Training Facilitator's Kit (October 2008) provides all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program including instructions for facilitators, customization guide, a PowerPoint presentation with speaker notes, pre- and post-assessments, master assessment answer keys, and evaluation tools. The Facilitator's Kit contains the following materials:
  - Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals
  - Facilitator's Guide
  - Medicare Resident, Practicing Physician, and Other Health Care Professional
  - Training: An introduction video.
- Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Bookmark (November 2008) provides information about the Medicare resident, practicing physician, and other health care professional training program.
- Rural Health Bookmark (November 2008) offers Medicare providers, suppliers, and physicians information about rural educational resources.

Source: PERL 200902-18

Medicare fee-for-service provider/supplier Web pages bookmark

A bookmark is available for all Medicare fee-for-service (FFS) providers and suppliers and their staff to use as a one-stop resource for the Medicare FFS provider and supplier Web pages available on the CMS Web site. This bookmark tells you how to get to the Web page with the download that allows you to access and peruse all the Medicare FFS Web pages available. You can stay abreast of policy and operational updates to FFS initiatives from the CMS Web site.
This bookmark is available at the MLN Product Ordering page. To order free of charge, visit *http://www.cms.hhs.gov/MLNProducts/80_FFS_Provider_Web_Pages.asp*, scroll down to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

Source: PERL 200902-20

Rural Health Bookmark available in print

The *Rural Health Bookmark* (November 2008), which offers Medicare providers, suppliers, and physicians information about rural educational resources, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

Source: PERL 200902-21

February is American Heart Month

In recognition of American Heart Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of cardiovascular screening blood tests and smoking and tobacco-use cessation counseling for eligible Medicare beneficiaries.

Quick facts

- Although heart disease is sometimes thought of as a "man's disease," it is the leading cause of death for both women and men in the United States, and women account for 52.8 percent of the total heart disease deaths.
- Heart disease is the leading cause of death among women aged 65 years and older.
- Major risk factors for heart disease include high blood pressure, high blood cholesterol, tobacco use, diabetes, physical inactivity, and poor nutrition.
- The average age of a first heart attack for men is 66 years.
- Smoking causes coronary heart disease, the leading cause of death in the United States. Cigarette smokers are 2-4 times more likely to develop coronary heart disease than nonsmokers.
- Cigarette smoking approximately doubles a person's risk for stroke.
- Cigarette smoking causes reduced circulation by narrowing the blood vessels (arteries). Smokers are more than 10 times as likely as nonsmokers to develop peripheral vascular disease.

Cardiovascular screening blood tests

Medicare provides coverage of the following cardiovascular screening blood tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke:

- Total cholesterol test
- Cholesterol test for high-density lipoproteins
- Triglycerides test

February is American Heart Month (continued)

Coverage of cardiovascular screening blood tests is provided as a Medicare Part B benefit. The beneficiary will pay nothing for blood tests; there is no coinsurance or copayment and no deductible for this benefit.

Important note: The cardiovascular screening benefit covered by Medicare is a stand alone billable service separate from the initial preventive physical examination or "Welcome to Medicare Visit" and does not have to be obtained within the first six months of a beneficiary's Medicare Part B coverage.

Smoking and tobacco-use cessation counseling

Medicare provides coverage of smoking and tobacco-use cessation counseling for people with Medicare who meet one of the following criteria:

- Use tobacco and have a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or
- Are taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on Food and Drug Administration-approved information.

Eligible beneficiaries are covered under Medicare Part B when certain conditions of coverage are met, subject to certain frequency and other limitations.

For more information

CMS has developed a variety of educational products and resources to help fee-for-service health care professionals 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 the *Medicare Learning Network* (*MLN*) preventive services education products and resources for fee-for-service health care professionals. The Web page is located at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS Web site.

Expanded Benefits Brochure: This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the initial preventive physical exam (IPPE), ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. To view online go to *http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf* on the CMS Web site.

Smoking and Tobacco-Use Cessation Counseling Services: This tri-fold brochure provides health care professionals with and overview of Medicare's smoking and tobacco-use counseling service benefit. To view online, go to *http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf* on the CMS Web site.

To order copies of these brochures, free of charge, visit the CMS *MLN* at *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to *Related Links Inside CMS*, and select *MLN Product Ordering Page*.

The CMS Web site provides information for preventive service 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 information about American Heart Month, please visit the American Heart Association's Web site at *http://www.americanheart.org/presenter.jhtml?identifier=3063135* and the Centers for Disease Control and Prevention's Web site at *http://www.cdc.gov/dhdsp/announcements/american_heart_month.htm*.

Source: PERL 200902-05

January 2009 Medicare Fraud and Abuse Fact Sheet

The *January 2009 Medicare Fraud and Abuse Fact Sheet* is now available at *http://www.cms.hhs.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf* on the *Medicare Learning Network (MLN)*. The Centers for Medicare & Medicaid Services (CMS) works with other government agencies and law enforcement organizations to protect the Medicare program from fraud and abuse. Together with CMS, providers can help identify and prevent fraud and abuse; the first step for providers to protect themselves is to understand the legal definitions and be able to identify fraudulent and abusive practices. This fact sheet provides information on many available resources to help you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse.

Source: PERL 200902-30

Flu shot reminder

It's not too late to give and get the flu shot!

In the US, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot.

Don't get the flu. Don't give the flu.

Remember: Influenza and pneumococcal vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are **not** Part D covered drugs.

Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing special edition *MLN Matters* article SE0838 located at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf* on the CMS Web site.

Source: PERL 200901-55

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), contractors 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

Local Coverage Determinations -- Table of Contents

Additional Information

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.

Additional Information

The Urgent® PC neuromodulator for percutaneous tibial nerve stimulation for voiding dysfunction

No local coverage statement but certain claims paid on individual consideration

The Urgent® PC neuromodulator device used to deliver percutaneous tibial nerve stimulation (PTNS) is a combination of electrode and generator components, including a small 34-gauge needle electrode, surface electrode, lead wires and hand-held electrical generator. The device produces an adjustable electrical impulse that travels to the sacral nerve plexus via the tibial nerve.

PTNS is a minimally invasive office-based procedure used to treat voiding dysfunction including urinary frequency, urgency, incontinence, and nonobstructive retention that have not responded to pharmacologic and behavioral interventions. In general, up to twelve once-weekly 30-minute treatments with PTNS are recommended for symptomatic patients who have failed other forms of treatment, though the treatment should be discontinued much sooner if the patient is not responding.

Since there is no national coverage determination (NCD) or local coverage determination (LCD) in Florida for Urgent PC for PTNS, and because there is minimal literature that supports PTNS, First Coast Service Options Inc. (FCSO) is reviewing claims on an individual consideration basis. PTNS is a new technology without a unique *CPT* level II or I code, and should be coded with the unlisted *CPT* code *64999* (*unlisted procedure, nervous system*) in item 24d of the claim form. Since unlisted codes are not unique to a service, Medicare contractors exercise discretion in first addressing denial vs. coverage. The narrative description of "PTNS" or "Urgent PC" should be entered in item 19 of the claim form. No documentation should be submitted with the claim. FCSO will request information by means of an additional documentation request (ADR).

Currently, in order to qualify for individual consideration of a claim for PTNS, the documentation must show **all** of the following:

- The beneficiary has experienced urge incontinence for at least 12 months and the condition has resulted in significant disability (e.g., the frequency and/or severity of leakages are limiting the beneficiary's ability to participate in daily activities), and
- The beneficiary has failed to improve with pharmacologic treatment that includes one of the following:
  - At least 2 different anti-cholinergic medications for a minimum of 4 weeks, or
  - A combination of an anti-cholinergic and a tricyclic drug for a minimum of 6 weeks, or
  - The beneficiary was allergic or unable to tolerate the above types of drugs, and
- The beneficiary has tried behavioral treatments (e.g., pelvic floor exercise, biofeedback, timed voids, and/or fluid management) without improvement in symptoms.

Once the documentation is received, it will be reviewed and a determination will be made as to coverage or denial of the claim. These case-by-case determinations allow the contractor to learn more about the efficacy and utilization of this service in the Medicare population. Also, given that there is no coverage statement at this time, this procedure may be denied or limited in the future based on the review of evidenced based literature during the LCD development process.

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

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 CMS-contracted Medicare administrative 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
March - April 2009 (All times ET)

Hot Topics
Topic: What you need to know to avoid denials and RUCs
When: March 10, 2009
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Introduction to the Provider Data Summary report webcast
When: March 10, 2009
Time: 12:30 p.m. – 1:30 p.m.
Type of Event: Teleconference

Provider enrollment for new physicians, residents, and interns
When: March 12, 2009
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

Evaluation and management (E/M) webcast
Topic: Consultations
When: March 24, 2009
Time: 11:30 a.m. - 1:00 p.m.
Type of Event: Teleconference

Evaluation and management (E/M) webcast
Topic: Incident to
When: April 21, 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.

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

Tips for using the FCSO provider training Web site

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

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

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

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

Fax – If you would like to participate in any of these events, please complete the registration section, circle your selection(s) and fax to 1-904-361-0407. Keep listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and new scheduled events!

Please note:
- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to event advertisement.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

More educational events (teleconferences, webcasts, etc.) are being planned to help providers with hot issues. Keep checking our Web site, *http://medicare.fcso.com/Education_resources/*, or listening to information on the FCSO Provider Education Registration Hotline, 1-904-791-8103, for details and newly scheduled events.

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

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

Miscellaneous

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

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

Provider education

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

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

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

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

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

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

Phone numbers

Providers

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

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic Data Interchange

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

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

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

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

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Order Form -- 2009 Part B Materials

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

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

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

Mail this form with payment to:

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

Contact Name:_____

Provider/Office Name:_____

Phone: _____

Mailing Address:_____

City:_____State: _____ZIP:_____

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦