MEDICARE B Update!

A NEWSLETTER FOR MAC J9 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
- ❑ Billing/Vendor
- ❑ Nursing Staff
- ❑ Other _____

TABLE OF CONTENTS

Medicare B Update!

Vol. 7, No. 3
March 2009

Publications staff

Terri Drury
Millie C. Pérez
Mark Willett
Robert Petty

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.

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

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

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, Puerto Rico, and U.S. Virgin Islands.

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 FCSO 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, 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 **local coverage determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- 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**, and
- **Addresses,** and **phone numbers**, and **Web sites** for Florida and the U.S. Virgin Islands.

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. Refer to the Address, Phone Numbers, and Web sites section of this publication for the address in which to send written appeals requests.

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.

Introducing FCSO's monthly Part B publications

First Coast Service Options Inc. (FCSO) is pleased to introduce its monthly Part B publication to providers in Puerto Rico and the U.S. Virgin Islands. Florida providers have long benefited from this informative publication, and FCSO is pleased to offer the same advantage to the newest members of its provider community.

Now more than ever, it is essential for providers and their representatives to be aware of changes to the Medicare program and to have immediate access to accurate as well as current information. To ensure providers throughout jurisdiction 9 (J9) remain informed, FCSO not only electronically publishes a new, comprehensive issue monthly instead of quarterly, it also offers English and Spanish editions to serve the jurisdiction's diverse provider community more effectively.

As a special welcome to providers in Puerto Rico and the U.S. Virgin Islands, FCSO is offering the March 2009 Part B publication, your premier issue, as a free printed edition. Although this is the only complementary issue that will be automatically mailed to your office, all subsequent issues will be available electronically on *medicare.fcso.com* (English edition) and *medicareespanol.fcso.com* (Spanish edition) during the first week of each month.

FCSO's monthly Part B publication is available in hardcopy for those providers who can substantiate the need, due to extensive technology limitations or other barriers. To qualify for this free service, providers are required to complete and fax the required registration form (located within this publication and online at *http://medicare.fcso.com/Publications/145989.pdf*.

Please note: Registration forms must be received by April 30, 2009, and must be approved by FCSO. Paid annual subscriptions are also available; please check the back this publication for a subscription form.

Stay informed with free electronic editions of our monthly publication

FCSO offers its monthly publications electronically not only to minimize printing and postage costs but also to benefit its providers. Instead of waiting to receive a printed copy in the mail, providers can access the latest edition the same day it is published. Subscribe to eNews, FCSO's free electronic mailing list to be promptly notified when the current edition becomes available.

Each edition is posted on FCSO's provider Web sites in PDF format, so you can save it to your computer, print it for distribution within your office, or just view it online at your convenience. In addition, each online publication is searchable: You can quickly find specific topics, terms, or phrases related to your practice, and print only what you need.

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.

Annual Medicare Part B hardcopy/CD-ROM registration form

To receive free editions of the Part B publication in hardcopy, CD-ROM, or e-mail format, you must complete this registration form. To receive a hardcopy or CD-ROM of future issues of the Part B publication, your form must be faxed to the number below by April 30, 2009. Providers currently receiving hardcopy publications must renew by using this form. Providers who do not renew by the April 30 deadline will no longer receive free hardcopy versions after that date. The publication cycle begins every year on October 1 and concludes September 30. Back issues will be provided for registrations started after October 1.

If you miss the registration deadline, you still have the ability to receive a hard copy or CD-ROM through subscription. The annual cost for a hardcopy subscription is $33; however, the annual cost for a CD-ROM subscription is $55. Back issues will be provided for subscriptions started after October 1.

Please note that you are not obligated to complete this form to access information contained in the Part B publication. Issues dating back to 1997 are available free on First Coast Service Options' provider Web site: *http://medicare.fcso.com/Landing/135985.asp*. Click the "more" link in the publications information box for a listing of current and past issues.

Provider/Facility Name: _____

Medicare Provider Identification Number (PIN): _____

Address: _____

City, State, ZIP Code: _____

Contact Person/Title: _____

Telephone Number: _____ Fax Number: _____ Email Address: _____

Rationale for needing a hardcopy:

Does your office have Internet access?	YES ❑	NO ❑
Do you have a PC with a CD-ROM drive?	YES ❑	NO ❑
Will you accept publications via e-mail?	YES ❑	NO ❑

Other technical barrier or reason for needing publications hardcopy or on CD-ROM: _____

Registration type: NEW ❑ RENEWAL ❑

Language preference: English ❑ Spanish ❑

Note: Providers who qualify will receive one copy of each monthly publication.

Fax your completed form to:

Medicare Publications

1-904-361-0723

Please share your questions and/or concerns regarding this initiative with us.

Additional questions or concerns may be submitted via the Medicare provider education Web site at *http://medicare.fcso.com/Contacts/137656.asp*. You also may fax your questions or comments to 1-904-361-0723. **Our Provider Contact Center will not be able to respond to inquiries about this form.**

CLAIMS

Quarterly update to Correct Coding Initiative edits

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6388, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in January 2009.

Background

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

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

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

The latest package of CCI edits, version 15.1, is effective April 1, 2009, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

Additional information about CCI, including the current CCI and MEC edits, is available at *http://www.cms.hhs.gov/NationalCorrectCodInitEd* on the CMS Web site.

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site. The official instruction (CR 6388) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1699CP.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.

MLN Matters Number: MM6388
Related Change Request (CR) #: 6388
Related CR Release Date: March 13, 2009
Effective Date: April 1, 2009
Related CR Transmittal #: R1699CP
Implementation Date: April 6, 2009

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

Updates to the *Medicare Claims Processing Manual* for 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.

Provider action needed

This article is based on CR 6347 which implements significant changes to the Internet Only Manual Publication 100-04, Chapter 15. Most of the changes in CR 6347 have already been communicated via prior change requests and related *MLN Matters* articles. The key purpose of CR 6347 is to eliminate references to the reasonable charge payment methodology and the transition to the ambulance fee schedule, which took place from April 2002 until December 2006, in the actual Medicare manual. Please make sure your staff is familiar with these changes.

Background

Medicare has revised the ambulance section of the *Medicare Claims Processing Manual*, Chapter 15. Some sections have been added and other sections have been renumbered. Most of the added information has been conveyed in prior *MLN Matters* articles related to ambulance services.

Key points

The most important changes for providers of ambulance services outlined below.

References to statues and regulations

Section 1861(s) (7) of the Social Security Act (Act) establishes an ambulance service as a Medicare Part B service. Payment for ambulance services is addressed at Section 1834(l) of the Act. Coverage rules are addressed at 42 *Code of Federal Regulations* (CFR), Section 410.40. Additional rules, including rules regarding vehicular and staffing requirements, are specified at 42 CFR 410.41. Payment rules under the fee schedule established in 2002 are specified at 42 CFR Part 414, Subpart H (414.601 et seq.). Payment rules for ambulance services furnished by a critical access hospital (CAH) or by an entity owned and operated by a CAH are specified at 42 CFR 413.70(b) (5). Other general Medicare provisions apply to ambulance services. See Title XVIII of the Act and 42 CFR Parts 400 to 429 to determine applicability.

References to Centers for Medicare & Medicaid Services (CMS) manual instructions for ambulance providers

Coverage: Manual instructions regarding coverage of ambulance services, including specifications for vehicular and staffing requirements, are specified in the *Medicare Benefit Policy Manual*, Chapter 10, which is available at *http://www.cms.hhs.gov/manuals/downloads/bp102c10.pdf* on the CMS Web site.

Medical Review: Manual instructions regarding medical review for ambulance services are specified in the *Medicare Program Integrity Manual*, Chapter 6 at *http://www.cms.hhs.gov/manuals/downloads/pim83c06.pdf* on the CMS Web site.

Summary of the ambulance services benefit

Ambulance services are covered under Medicare Part B. However, a Part B payment for an ambulance service furnished to a Medicare beneficiary is available only if the following, fundamental conditions are met:

- Actual transportation of the beneficiary occurs.
- The beneficiary is transported to an appropriate destination.
- The transportation by ambulance must be medically necessary, i.e., the beneficiary's medical condition is such that other forms of transportation are medically contraindicated.
- The ambulance provider/supplier meets all applicable vehicle, staffing, billing, and reporting requirements.
- The transportation is not part of a Part A service.

Other requirements specified in CR 6347 or in the above-cited CMS manuals may also apply to the provider/supplier or to a particular transport or billing.

New and revised definitions related to ambulance claims processing

A/MAC – For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term refers to those Medicare contractors that process claims for institutionally-based ambulance providers billed on CMS-1450 (UB-04) and/or a Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant ANSI X12N 837I electronic transaction.

B/MAC – For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term refers to those Medicare contractors that process claims for ambulance suppliers billed on a CMS-1500 and/or a HIPAA compliant ANSI X12N 837P electronic transaction.

Date of service – The date of service (DOS) of an ambulance service is the date that the loaded ambulance vehicle departs the point of pickup (POP). 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 the date of the vehicle 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 the date of the vehicle takeoff.

Provider – For the purposes of this Chapter 15 of the *Medicare Claims Processing Manual* only, the term "provider" is used to reference a hospital-based ambulance provider which is owned and/or operated by a hospital, critical access hospital, skilled nursing facility,

Updates to the Medicare Claims Processing Manual for ambulance services (continued)

comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e) of the Act, a fund.

Supplier – For the purposes of Chapter 15 of the *Medicare Claims Processing Manual* only, the term supplier is defined as any ambulance service that is not institutionally based. A supplier can be an independently owned and operated ambulance service company, a volunteer fire and/or ambulance company, a local government run firehouse based ambulance, etc., that provides Part B Medicare-covered ambulance services and is enrolled as an independent ambulance supplier.

Claims jurisdiction

Claims jurisdiction for suppliers is considered to be where the ambulance vehicle is garaged or hangared. Claims jurisdiction for institutional based providers is based on the primary location of the institution.

Payment is based on the level of service provided, not on the vehicle used. Occasionally, local jurisdictions require the dispatch of an ambulance that is above the level of service that ends up being provided to the Medicare beneficiary. In this, as in most instances, Medicare pays only for the level of service provided, and then only when the service provided is medically necessary.

Adjustments for fee schedule payment rates for ground ambulance transports

The payment rates under the fee schedule (FS) for ground ambulance transports (both the FS base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004, through December 31, 2006, as well as July 1, 2008, through December 31, 2009. For ground ambulance transport services furnished where the POP is urban, the rates are increased by one percent for claims with dates of service July 1, 2004, through December 31, 2006, in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by two percent for claims with dates of service July 1, 2008, through December 31, 2009, in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. For ground ambulance transport services furnished where the POP is rural, the rates are increased by two percent for claims with dates of service July 1, 2004, through December 31, 2006, in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by three percent for claims with dates of service July 1, 2008, through December 31, 2009, in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008. These amounts are incorporated into the fee schedule amounts that appear in the ambulance FS file maintained by CMS and downloaded by CMS contractors.

Billing instruction reminder information

Independent ambulance suppliers may bill on CMS-1500 or the ANSI X12N 837P data set. These claims are processed using the multi-carrier system (MCS).

Institution based ambulance providers may bill on CMS-1450 or the ANSI X12N 837I. These claims are processed using the fiscal intermediary shared system (FISS).

Institutional providers and suppliers must report an origin and destination modifier for each ambulance trip provided in Healthcare Common Procedure Coding System (HCPCS)/rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes
E = Residential, domiciliary, custodial facility (other than 1819 facility)
G = Hospital-based end-stage renal disease (ESRD) facility
H = Hospital
I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
J = Freestanding ESRD facility
N = Skilled nursing facility
P = Physician's office
R = Residence
S = Scene of accident or acute event
X = Intermediate stop at physician's office on way to hospital (destination code only)

In addition, institutional providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services

While combinations of these items may duplicate other HCPCS modifiers, when billed with an ambulance transportation code, the reported modifiers may only indicate origin/destination.

Additional information

The official instruction, CR 6347, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1696CP.pdf* on the CMS Web site. The revised portions of Chapter 15 of the *Medicare Claims Processing Manual* are attached to CR 6347.

A version of the ambulance fee schedule is also posted to the CMS Web site (*http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp*) for public use.

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.

MLN Matters Number: MM6347
Related Change Request (CR) #: 6347
Related CR Release Date: March 6, 2009
Effective Date: April 1, 2009
Related CR Transmittal #: R1696CP
Implementation Date: April 6, 2009

Updates to the ambulance instructions in the Medicare Benefit Policy Manual

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6318 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR 6318 to highlight the revisions to the *Medicare Benefit Policy Manua*l, Chapter 10 - Ambulance Services. The article is informational in nature, since CR 6318 revises that manual to incorporate information previously released via Transmittal AB-02-130 and updates to the *Medicare Claims Processing Manual*, Chapter 15, which is available at *http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf* on the CMS Web site.

Background

Key points

The key updates made to Chapter 10 of the *Medicare Benefit Policy Manual* are as follows:

- **Chapter 10/Section 10.4**. Medically appropriate air ambulance transportation is a covered service regardless of the state or region in which it is rendered. However, Medicare contractors approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate. There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

  1. **Fixed Wing Air Ambulance (FW)**: Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

  2. **Rotary Wing Air Ambulance (RW)**: Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

- **Chapter 10/Section 10.4.2**. Medical reasonableness is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health. A list of examples of cases for which air ambulance could be justified is available in section 10.4.2, which is attached to CR 6318. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.

- **Chapter 10/Section 20/20.1.2 – Beneficiary Signature Requirements**. Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

  1. The beneficiary's legal guardian;
  2. A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary;
  3. A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs;
  4. A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary;
  5. A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1 – 4); and/or
  6. A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least four years from the date of service.

  Note: A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

- **Chapter 10/Section 30.1.1**. This section is revised to add information regarding advanced life support (ALS) assessments. The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the

Updates to the ambulance instructions in the Medicare Benefit Policy Manual (continued)

call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

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 official instruction (CR 6318) issued to your Medicare FI, carrier or MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R103BP.pdf* on the CMS Web site.

MLN Matters Number: MM6318
Related Change Request (CR) #: 6318
Related CR Release Date: February 20, 2009
Effective Date: January 5, 2009
Related CR Transmittal #: R103BP
Implementation Date: March 20, 2009

Ambulatory Surgical Center

April 2009 update to the ambulatory surgical center payment system

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

Provider types affected

Ambulatory surgical centers (ASCs) that submit claims to Medicare administrative contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

Provider action needed

This article is based on change request (CR) 6424 which describes changes to, and billing instructions for, payment policies implemented in the April 2009 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals. Be sure your billing staff is aware of these changes.

Background

CR 6424 describes changes to, and billing instructions for, payment policies implemented in the April 2009 ASC payment system update. Final policy under the revised ASC payment system, as set forth in the final rule CMS-1517-F, requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly. Therefore, beginning with the update notification (Transmittal R1488CP, CR 5994) issued April 9, 2008, the Centers for Medicare & Medicaid Services (CMS) has issued quarterly updates to ASC payment rates for separately paid drugs and biologicals. CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes, as appropriate. CR 6424 provides an updated payment rate for a current HCPCS drug code, a payment rate and descriptor for a newly created HCPCS drug code and a corrected payment rate for another HCPCS drug code.

In CR 6424, CMS issues instructions to their contractors to modify their systems to include new payment rates for some separately payable drugs and biologicals. CR 6424 also includes updates to the *Medicare Benefit Policy Manual*, Chapter 15, section(s) 260.1 and the M*edicare Claims Processing Manual*, Chapter 14, section(s) 10.1. The revised language in these manuals clarifies CMS policy related to potential changes in Medicare certification status by ASCs that are operated by hospitals and is intended to prohibit such an entity from switching from one payment method to another to maximize revenues.

Key points of CR 6424

CR 6424 provides the following key points of information:

- CMS reminds ASCs that under the ASC payment system if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process.

Updates to the ambulance instructions in the Medicare Benefit Policy Manual (continued)

In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

- One new HCPCS drug code has been created that is payable for dates of service on or after April 1, 2009. The new HCPCS code is C9249, the long descriptor is Injection, certolizumab pegol, 1 mg, and the payment indicator (PI) is K2.
- Corrections to the ASC PI and payment rate for HCPCS code J3300 (Injection, triamcinolone acetonide, preservative free, 1 mg) effective January 1, 2009 were included in the January 26, 2009, *Federal Register*. The short descriptor is Triamcinolone A inj PRS-free, the PI is K2 and the payment rate is $3.18. ASCs may submit a claim(s) to receive separate payment for this HCPCS code when the service was originally provided as a packaged service to the surgical procedure during the affected dates of service.
- For dates of service beginning April 1, 2009, HCPCS code C9247 (Injection, iobenguane, I-123, diagnostic) is eligible for separate payment under the ASC payment system when it is provided integral to a covered surgical procedure. The short descriptor for HCPCS code C9247 is Inj, iobenguane, I-123, dx and the updated PI is K2.
- ASCs are reminded of the correct reporting of drugs and biologicals when used as implantable devices and the correct reporting of units for drugs.
- The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) extended the requirement for CMS to pay hospitals for brachytherapy sources for the period of July 1, 2008, through December 31, 2009, at the hospital's charges adjusted to costs. ASC payment policy is to make payment at the OPPS rate for brachytherapy sources when a prospective rate is available. Consistent with the MIPPA, there is no prospective rate under the OPPS for the period July 1, 2008, through December 31. 2009. Therefore, for those dates of service payment to ASCs for brachytherapy sources will be made at contractor-priced amounts, consistent with ASC payment policy when no OPPS prospective rate is available.

Additional information

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

The official instruction (CR 6424) was issued to your Medicare MAC and/or FI in the following two transmittals, which may be found on the CMS Web site.

http://www.cms.hhs.gov/transmittals/downloads/R1698CP.pdf
http://www.cms.hhs.gov/transmittals/downloads/R104BP.pdf

MLN Matters Number: MM6424
Related Change Request (CR) #: 6424
Related CR Release Date: March 13, 2009
Effective Date: April 1, 2009
Related CR Transmittal #: R104BP, R1698CP
Implementation Date: April 6, 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.

Note: This article was revised on March 12, 2009, to reflect a revised transmittal related to change request (CR) 6366. The CR release date, transmittal number, and the Web address for accessing that transmittal were changed. All other information remains the same. This information was previously published in the February 2009 *Medicare B Update!* page 7.

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 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.

Heartsbreath test for heart transplant rejection (continued)

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 three 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 of CR 6366

- 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 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/R1697CP.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 *Revised*
Related Change Request (CR) #: 6366
Related CR Release Date: March 12, 2009
Effective Date: December 8, 2008
Related CR Transmittal #: R1697CP and R99NCD
Implementation Date: April 6, 2009

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.

Drugs and Biologicals

April 2009 update and previous revisions to the quarterly ASP Medicare Part B drug pricing file updates

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6380 which informs Medicare contractors that on or after December 16, 2008, the January 2009 average sales price (ASP) file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. In addition, on or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the Centers for Medicare & Medicaid Services (CMS) ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary.

Background

The Medicare Modernization Act of 2003 (Section 303(c); see *http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf* on the CMS Web site) revised the payment methodology for Part B-covered drugs and biologicals that are not paid on a cost or prospective payment basis. The vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology. Pricing for compounded drugs is performed by your local Medicare contractor.

CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by the Social Security Act (Section 1847A; see *http://www.ssa.gov/OP_Home/ssact/title18/1847.htm* on the Internet). As part of this effort, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. Specifically, CMS considers:

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

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

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

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of "not otherwise classified (NOC)" HCPCS codes.

ASP methodology

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. Note that payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the integrated outpatient code editor (I/OCE) through separate instructions.

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

- End-stage renal disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5 percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4 percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update these payment allowance limits quarterly.

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

Exceptions to this general rule as summarized below.

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the ambulatory payment classification (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. The payment allowance limits were not updated in 2008. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- Payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2009, the blood clotting furnishing factor of $0.164 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

Note: At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS Web site.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B drug pricing file or NOC pricing file are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005. Your Medicare contractor, at their discretion, may contact CMS to obtain payment limits for new drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors will determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

Quarterly payment files

On or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR 6380 (April 1, 2009) for the dates of service noted in the table that follows.

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

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

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008

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

Drugs furnished during filling or refilling an implantable pump or reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm* on the Internet) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

Additional information

The official instruction, CR 6380, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1685CP.pdf* on the CMS Web site.

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

MLN Matters Number: MM6380
Related CR Release Date: February 20, 2009
Related CR Transmittal #: R1685CP
Related Change Request (CR) #: 6380
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Durable Medical Equipment

DMEPOS supplier accreditation

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

Provider types affected

All providers and suppliers that furnish Medicare Part B durable medical equipment (DME), prosthetic devices, prosthetic or orthotic items, and medical supplies to Medicare beneficiaries.

Provider action needed

Stop -- impact to you

DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) providers and suppliers enrolled in the Medicare Part B program are required to obtain accreditation by September 30, 2009.

Caution -- what you need to know

In order to retain or obtain a Medicare Part B billing number, all DMEPOS providers and suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health and Human Services as noted below in this article) must comply with the Medicare program's supplier standards and quality standards and become accredited. A DMEPOS supplier's Medicare Part B billing privileges will be revoked on October 1, 2009, if the DMEPOS supplier fails to obtain accreditation by September 30, 2009.

DMEPOS supplier accreditation (continued)

Go -- what you need to do

DMEPOS providers and suppliers that have not yet done so should contact an accreditation organization (AO) right away to obtain information about the accreditation process and submit an accreditation application to the AO of their choosing. Suppliers can find a list of the deemed accrediting organizations at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf* on the CMS Web site.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a)(20) to the Social Security Act (the Act) that required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to receive or retain a provider or supplier number.

Covered items and services

Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834 (a) (13), Section 1834 (h) (4) and Section 1842 (s) (2) of the Act. The covered items and services include:

- Durable medical equipment (DME)
- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral and enteral nutrient, equipment and supplies
- Blood products
- Transfusion medicine, and
- Prosthetic devices, prosthetics, and orthotics.

Noncovered items

- Medical supplies furnished by home health agencies
- Drugs used with DME (inhalation drugs and drugs infused with a DME pump)
- Implantable items, and
- Other Part B drugs:
- Immunosuppressive drugs
- Anti-emetic drugs.

DMEPOS quality standards

The quality standards, published at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationStandards.pdf* on the CMS Web site, are separated into two sections and have three appendices as follows:

- Section I includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management, product safety and information management.
- Section II contains service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver and follow-up service.
- Appendix A addresses respiratory equipment, supplies and services.
- Appendix B addresses manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- Appendix C addresses custom fabricated and custom fitted orthoses, prosthetic devices, external breast prostheses, therapeutic shoes and inserts and their accessories and supplies, and custom-made somatic, ocular and facial prostheses.

Accreditation deadline for DMEPOS suppliers

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required all DMEPOS suppliers to meet quality standards for Medicare accreditation by September 30, 2009.

Who needs accreditation?

The September 30, 2009, accreditation deadline applies to all Medicare Part B enrolled providers and 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. The accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers.

As of March 1, 2008, new DMEPOS providers and suppliers submitting an enrollment application to the national supplier clearinghouse (NSC), except those eligible professionals and other persons mentioned below, must be accredited prior to submitting the application. The NSC shall reject the enrollment application unless the DMEPOS supplier demonstrates an approved accreditation.

Who is exempt?

MIPPA stated that certain eligible professionals and other persons do not have to be accredited by September 30, 2009, unless the Secretary determines that the quality standards are specifically designed to apply to such professionals and persons. In addition, those providers that were accredited prior to the enactment of MIPPA (July 15, 2008) will not have to undergo a re-accreditation process.

The eligible professionals that are exempt from the September 30, 2009, accreditation deadline include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act)
- Physical therapists
- Occupational therapists
- Qualified speech-language pathologists
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Certified nurse-midwive
- Clinical social workers
- Clinical psychologists
- Registered dietitians, and
- Nutritional professionals.

DMEPOS supplier accreditation (continued)

Additionally MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the September 30, 2009, accreditation deadline unless the Secretary determines that the quality standards are specifically designed to apply to such other persons. At this time, these "other persons" are only defined as the following practitioners:

- Orthotists
- Prosthetists
- Opticians
- Audiologists.

Accreditation process

The accreditation process takes an average of six to seven months but may take up to nine months to complete for a Medicare enrolled or new DMEPOS supplier that submits a complete application to an accrediting organization (AO) and has no deficiencies to correct post onsite-survey.

Pre-application process

- A DMEPOS supplier that wishes to become accredited should contact the AOs and obtain information about each organization's accreditation process.
- The supplier should review the information and choose the organization to which it will apply.
- The AO will assist the supplier to determine what changes will be required to meet the accreditation standards (e.g., modify existing services, practices, developing appropriate policies and procedures, develop an implementation plan, timeline, and training employees).
- The supplier should apply for accreditation after the changes are in place or during implementation.

Application review and on-site survey

- The supplier submits a completed application to the AO with all the supporting documentation.
- The AO reviews the application and documentation (verify licensures, organizational chart, etc.).
- The on-site surveys are conducted minimally every three years and are unannounced.
- The AO will determine whether to accredit the supplier based on the submitted data and the results of the on-site survey.

Key points

All Medicare Part B enrolled DMEPOS providers and suppliers are required to obtain accreditation by September 30, 2009.

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

DMEPOS suppliers submitting applications to an accrediting organization after January 31, 2009, may or may not have their accreditation decision by the September 30, 2009, deadline.

It takes an average of six to seven months but could take as long as 9 months for a DMEPOS supplier to complete the accreditation process. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

A DMEPOS supplier's Medicare Part B billing privileges will be revoked on October 1, 2009, if the DMEPOS supplier fails to obtain accreditation by September 30, 2009.

Note: The current delay in the DMEPOS Competitive Bidding Program has no impact on the September 30, 2009, accreditation deadline.

Accreditation frequently asked questions (FAQs)

1. Do the accrediting organizations have enough capacity to get everyone who applies at least nine months before September 30, 2009 accredited by the deadline?

   Yes. The AO's have increased surveyor staffing anticipating the additional workload. A DMEPOS supplier should choose an AO based upon their deemed status, policies, procedures and the philosophy of the organization. CMS encourages suppliers to ask the AO's questions, such as, how long it takes to become accredited from application to accreditation decision. The time to become accredited can take up to nine months for some organizations.

2. Who are the approved DMEPOS accrediting organizations?

   In November 2006, CMS approved (deemed) 10 national accreditation organizations that will accredit providers and suppliers of DMEPOS as meeting new quality standards under Medicare Part B. Most of the accreditation organizations are authorized to accredit all major supplier types, and most will be able to accredit both national and local suppliers, as well as mail order companies. A list of the CMS-approved deemed accreditation organizations and information about the types of suppliers each accrediting organization is approved to accredit and how to contact a deemed accrediting organization is posted at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf* on the CMS Web site.

3. Is accreditation transferable upon merger, acquisition or sale of a supplier?

   Accreditation cannot be transferred upon merger, acquisition or sale of a supplier. As specified in 42 CFR 424.57(c)(3), CMS, the NSC and the accrediting organization must be notified when a new DMEPOS location is opened.

4. If I have just recently received a survey by an accreditor, will I be subject to a site visit by a representative of the national supplier clearinghouse (NSC)?

   These actions are independent of one another. The accreditor checks quality standards. The NSC site visit concerns enforcing supplier standards. In many cases a new supplier will receive a site survey by the AO and a site visit by the NSC.

DMEPOS supplier accreditation (continued)

5. Is information transferred between the accreditor and NSC?

   Transfer of information between these two entities concerning their findings does occur. The NSC needs to know if a supplier is accredited prior to issuing an enrollment number, thus they will need to verify the accreditation status.

6. Will the accreditation survey efforts be coordinated with reenrollment efforts?

   Not at the present time. A supplier must meet both the NSC supplier standards and the accreditation requirements on a continuous basis. We are not changing reenrollment dates and timeframes to match survey timeframes.

Additional information

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

There is additional information on the accreditation process at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp#TopOfPage* on the CMS Web site.

MLN Matters Number: SE0903 *Revised* Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: March 1, 2009
Related CR Transmittal #: N/A Implementation Date: N/A

DMEPOS supplier accreditation -- time is running out

Deadline is September 30, 2009

Time is running out for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. While the accreditation process takes on average six to seven months, the process could take as long as nine months to complete. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

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 of Health & Human Services) must comply with the Medicare program's supplier standards and quality standards to become accredited. 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, and 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 the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp*.

Source: PERL 200903-25, PERL 200903-33

DMEPOS supplier accreditation -- get it now

Deadline is September 30, 2009

This is a reminder to 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 200903-11

Laboratory/Pathology

Codes subject to and excluded from Clinical Laboratory Improvement Amendments edits

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6356. The Centers for Medicare & Medicaid Services (CMS) is issuing CR 6356 to identify code changes, including modifiers for 2009 that are both subject to CLIA edits and excluded from CLIA edits. Be sure billing staff is aware of the changes.

Background

The Clinical Laboratory Improvement Amendments (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level. The HCPCS codes that are considered a laboratory test under CLIA change each year.

Discontinued codes

The following *CPT*/HCPCS codes were discontinued on December 31, 2008:

G0394 Blood occult test (e.g., guaiac), feces for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection)
88400 *Bilirubin, total trancutaneous*
0026T *Lipoprotein, direct measurement, intermediate density lipoprotein (IDL) (remnamt lipoproteins)*
0041T *Urinalysis infectious agent detection, semi-quantitative analysis of volatile compounds.*

New codes

For 2009, the following new HCPCS codes are excluded from CLIA edits and do not require a facility to have a CLIA certificate:

88720 *Bilirubin, total trancutaneous*
88740 *Hemoglobin, quantitative, transcutaneous, per day; carboxyhemoglobin*
88741 *Hemoglobin, quantitative, transcutaneous, per day; methemoglobin*

The HCPCS codes listed in the chart that follows are new for 2009 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3). A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

CPT	Description
83876	*Myeloperoxidase (MPO)*
83951	*Oncoprotein; des-gamma-carboxy-prothrombin (DCP)*
85397	*Coagulation and fibrinolysis, functional activity, not otherwise specified (eg, ADAMTS-13) each analyte*
87905	*Infectious agent enzymatic activity other than virus (eg, sialidase activity in vaginal fluid)*

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to implementation of these changes. However, contractors will adjust such claims that you bring to their attention.

Additional information

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

The official instruction (CR 6356) issued to your Medicare A/B MAC or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1687CP.pdf* on the CMS Web site.

MLN Matters Number: MM6356
Related Change Request (CR) #: 6356
Related CR Release Date: February 20, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R1687CP
Implementation Date: April 6, 2009

Changes to the laboratory national coverage determination edit software for April 2009

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6383 which announces the changes that will be included in the April 2009 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in January 2009. See the *Background* section of this article for further details regarding these changes.

Background

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

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

CR 6383 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for April 2009 as described below. These changes become effective for services furnished on or after April 1, 2009, and are as follows:

For blood counts

- Add ICD-9-CM codes 525.71, 525.72 and 525.73 to the list of ICD-9-CM codes that do not support medical necessity for blood counts (190.15) NCD.

For partial thromboplastin time (PTT)

- Add ICD-9-CM codes 535.70 and 535.71 to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.

For prothrombin time (PT)

- Add ICD-9-CM codes 414.3, 535.70, and 535.71 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.

For serum iron studies

- Add ICD-9-CM codes 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 535.70, and 535.71 o the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.

For blood glucose testing

- Add ICD-9-CM code 414.3 to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD.

For lipid testing

- Add ICD-9-CM code 414.3 to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD.

For gamma glutamyl transferase

- Add ICD-9-CM codes 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, and 208.92 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

For fecal occult blood test (FOBT)

- Add ICD-9-CM codes 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 535.70 and 535.71 to the list of ICD-9-CM codes covered by Medicare for the FOBT (190.34) NCD.

Additional information

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

The official instruction (CR 6383) issued to your Medicare MAC, carrier, or FI may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1684CP.pdf* on the CMS Web site.

MLN Matters Number: MM6383
Related Change Request (CR) #: 6383
Related CR Release Date: February 13, 2009
Effective Date: April 1, 2009
Related CR Transmittal #: R1684CP
Implementation Date: April 6, 2009

New waived tests

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6370 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has listed the twelve latest tests approved by the Food and Drug Administration (FDA) as waived tests under Clinical Laboratory Improvement Amendments of 1988 (CLIA). The tests newly added to the waived tests are in the table under the *Background* section of this article. Be sure your billing staffs are aware of these changes.

Background

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

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. *The Current Procedural Terminology* (*CPT*) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attachment to CR 6370 at *http://www.cms.hhs.gov/Transmittals/downloads/R1689CP.pdf* on the CMS Web site (i.e., *CPT* codes: *81002, 81025, 82270, 82272, G0394, 82962, 83026, 84830, 85013*, and *85651*) do not require a modifier QW to be recognized as a waived test.

CPT Code	Effective Date	Description
87880QW	July 17, 2008	Henry Schein One Step+ Strep A Dipstick Test
81003QW	October 17, 2008	Consult diagnostics Urine Analyzer
82465QW (Contact your contractor for claims instructions), *82947QW, 82950QW, 82951QW, 82952QW, 83036QW, 84478QW*	October 31, 2008	Wako APOLOWAKO Analyzer (Whole Blood)
83986QW	November 4, 2008	Common Sense Ltd. Norma-Sense Vaginal Discharge pH Test
80101QW	November 4, 2008	Mossman Associates, Inc. NicCheck I Test Strips
83036QW	November 13, 2008	Siemens DCA 2000 Analyzer
83036QW	November 13, 2008	Siemens DCA 2000+ Analyzer
82565QW	November 13, 2008	Abbott i-STAT Crea Cartridge {Whole Blood}
82947QW, 82950QW, 82951QW, 82952QW	November 13, 2008	Abbott i-STAT G Cartridge {Whole Blood}
82435QW, 82947QW, 82950QW, 82951QW, 82952QW, 84132QW, 84295QW, 84520QW, 85014QW	November 13, 2008	Abbott i-STAT 6+ Cartridge {Whole Blood}
82947QW, 82950QW, 82951QW, 82952QW, 84132QW, 84295QW, 85014QW	November 13, 2008	Abbott i-STAT EC4+ Cartridge {Whole Blood}
84295QW, 84132QW, 85014QW	November 13, 2008	Abbott i-STAT E3+ Cartridge {Whole Blood}

Please note that your Medicare contractor will not search their files to either retract payment or retroactively pay claims processed before CR 6370 is implemented; however, they will adjust claims that you bring to their attention.

Additional information

You may find the official instruction, CR 6370, issued to your carrier or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1689CP.pdf* on the CMS Web site.

If you have any questions, please contact your 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.

MLN Matters Number: MM6370
Related CR Release Date: February 27, 2009
Related CR Transmittal #: R1689CP
Related Change Request (CR) #: 6370
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Medicare Physician Fee Schedule

April update to the 2009 Medicare physician fee schedule database

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6397 which amends payment files that were issued to contractors based upon the 2009 MPFS final rule. Physical therapists should pay particular attention to the *Background* section regarding the billing of canalith repositioning procedures.

Background

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

Canalith repositioning

In the 2009 MPFS final rule, the Centers for Medicare & Medicaid Services (CMS) discussed a newly created *CPT* code *95992*, describing canalith repositioning procedures. CMS indicated that, prior to the new *CPT* code, this service was billed by physicians as part of an evaluation and management (E/M) service, and by other practitioners, primarily therapists, using existing codes. CMS assigned the code a status indicator of B (bundled), and stated that bundling this code is most appropriate because this service is currently being paid for as part of an E/M service. However, since therapists also provide this service and they cannot bill for E/M services, they should continue to bill *CPT* code *97112* for this service.

2009 Physician Quality Reporting Initiative Program

CMS identified a technical problem affecting twenty quality-data codes (QDCs) used for reporting thirteen quality measures through the claims-based method for the 2009 PQRI. These twenty QDCs are new codes for the 2009 PQRI. The *CPT* II codes and the 2009 PQRI measures affected are listed below.

CPT II Code	Measure #	Measure
3250F	99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3250F	100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3570F	147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
3016F	173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening
3455F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
4195F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
4196F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
3470F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3471F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3472F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
1170F	178	Rheumatoid Arthritis (RA): Functional Status Assessment
3475F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
3476F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
0540F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4192F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4193F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4194F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4148F	183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV
4149F	184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV

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

CPT II Code	Measure #	Measure
0529F	185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
4267F	186	Wound Care: Use of Compression System in Patients with Venous Ulcers

In most instances, the technical problem has caused line items containing any of the QDCs listed above to reject/return as unprocessable. In those circumstances, the eligible professional (EP) received a message other than N365 indicating that the procedure code was not accepted for reporting proposes. Since this is an issue that affects claims-based PQRI reporting only, the reporting of quality measures through registries is not affected.

CMS is actively working with the carriers and A/B MACs to address this issue. All carriers and A/B MACs will be able to accept the affected codes within the next three weeks. Once this has been accomplished, submission of the affected *CPT* II codes will result in the normal N365 message on the remittance advice indicating that the code has been accepted for reporting purposes.

In order to minimize any adverse impact on EPs for determination of satisfactory reporting for affected measures, CMS will exclude from the reporting denominator all cases for dates before which the carriers and A/B MACs could accept the affected *CPT* II codes, unless inclusion of cases for such dates is more favorable to the EP. In view of this, EPs have the option to seek correction of 1st quarter (i.e., January 1 to March 31, 2009) QDC submissions which were returned as unprocessed if desired, but EPs would not be required to seek correction for the affected codes. The two basic options for EPs are:

A. Do not seek correction of the submitted codes which were returned unprocessed.

As indicated above, CMS will exclude from the determination of satisfactory reporting cases for dates prior to the date the carriers and A/B MACs can process the relevant codes. Thus, EPs are not required to seek correction of claims. On the other hand, EPs who have begun to submit codes for the affected measures should continue to submit such codes. The beginning of acceptance of the codes will be apparent when the N365 message is noted on the remittance advice. The 2009 reporting period will not be changed and the EP who qualifies for the incentive based on the listed or affected measures will receive the two percent incentive payment with respect to the entire reporting period.

B. Seek correction of the submitted codes that were returned unprocessed.

In certain circumstances, EPs may desire to seek correction of the unprocessed claims. To accomplish this, EPs who have already billed and included any of the listed QDCs for dates of service January 1, 2009, and after and received a message other than N365 on their remittance advice, can call their carrier or A/B MAC and request a correction beginning April 1, 2009. In this case the EP should be prepared to give specific claim information to the carrier or A/B MAC, such as, the internal control number (ICN), the beneficiary's health insurance claim number (HIC), dates of service and the QDCs. EPs who began reporting the affected measures using the measures group consecutive method during the first three months of 2009 may find that it is worthwhile to pursue correction.

Note: PQRI reporting and performance rate analysis for only the affected measures will initially be performed after excluding cases for the first three months of 2009. If an EP does not qualify based on this calculation, then the EP's claims without excluding claims for the first three months of 2009 will be evaluated. Thus, the determination of satisfactory reporting will be evaluated both ways for all EPs who report on the relevant measures.

Other specific changes included in the April update to the 2009 MPFSDB are detailed in attachment 1 of CR 6397. That CR is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1691CP.pdf* on the CMS Web site. Key changes, however, are summarized as follows:

These *Current Procedural Terminology* /Healthcare Common Procedure Coding System (*CPT*/HCPCS) codes are assigned a procedure status = M as follows:

0529F, 0540F, 1170F, 3016F, 3250F, 3455F, 3470F, 3471F, 3472F, 3475F, 3476F, 3570F, 4148F, 4149F, 4192F, 4193F, 4194F, 4195F, 4196F, 4267F, G8489, G8490, G8491, G8492, G8493, G8494

These *CPT*/HCPCS codes are assigned a procedure status = I as follows:

0575F, 4270F, 4271F, 4279F, 4280F

Physicians/providers should also note the following:

CPT/HCPCS	Action
93351 Global	**Long Descriptor**: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision **Short Descriptor**: Stress tte complete

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

CPT/HCPCS	Action
93351 TC	**Long Descriptor**: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision **Short Descriptor:** Stress tte complete
93351 26	**Long Descriptor**: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision **Short Descriptor**: Stress tte complete

Descriptor changes

The long descriptor has been revised for the following codes:

HCPCS Code	Revised Long Descriptor	Revised Short Descriptor
G0248	Demonstration, prior to initiation of home INR monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient's ability to perform testing and report results	N/A
G0249	Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests	N/A
G0250	Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests	N/A

Change in procedure status for *CPT* code 0085T

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. *CPT* code *0085T*, breath test for heart transplant rejection, is assigned procedure status of N and is no longer payable by Medicare.

Additional information

The official instruction, CR 6397, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1691CP.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.

Florida fee revisions

	Participating			Nonparticipating			Limiting Charge			
Code/Mod	Loc 99	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	
93351	248.50	267.12	283.72	236.08	253.76	269.53	271.49	291.83	309.96	
93351TC	150.49	165.35	178.28	142.97	157.08	169.37	164.41	180.64	194.77	
9335126	98.00	101.76	105.44	93.10	96.67	100.17	107.07	111.17	115.19	
G0270	25.32	26.22	27.01	24.05	24.91	25.66	27.66	28.65	29.51	
G0270	23.63	24.38	25.08	22.45	23.16	23.83	25.82	26.64	27.40	
G0392	2,063.97	2,217.37	2,329.31	1,960.77	2,106.50	2,212.84	2,254.89	2,422.48	2,544.77	
G0392	502.38	524.40	551.53	477.26	498.18	523.95	548.85	572.91	602.55	

*Represents facility rate

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

	Participating			Nonparticipating			Limiting Charge			
Code/Mod	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	**Loc 99**	**Loc 03**	**Loc 04**	
G0393	1,551.63	1,668.54	1,751.10	1,474.05	1,585.11	1,663.55	1,695.16	1,822.88	1,913.08	
G0393	318.55	331.72	347.31	302.62	315.13	329.94	348.02	362.40	379.44	
G9041	27.55	28.36	29.10	26.17	26.94	27.65	30.10	30.98	31.79	
G9042	14.61	15.37	16.07	13.88	14.60	15.27	15.96	16.79	17.56	
G9043	14.61	15.37	16.07	13.88	14.60	15.27	15.96	16.79	17.56	
G9044	12.55	13.17	13.78	11.92	12.51	13.09	13.71	14.39	15.05	

*Represents facility rate

Puerto Rico fee revisions

Code/Mod	Participating	Nonparticipating	Limiting Charge	
93351	192.00	182.40	209.76	
93351TC	105.32	100.05	115.06	
9335126	86.69	82.36	94.71	
G0270	22.58	21.45	24.67	
G0270	21.33	20.26	23.30	*
G0392	1,591.75	1,512.16	1,738.99	
G0392	437.61	415.73	478.09	*
G0393	1,190.97	1,131.42	1,301.13	
G0393	279.62	265.64	305.48	*
G9041	25.07	23.82	27.39	
G9042	12.31	11.69	13.45	
G9043	12.31	11.69	13.45	
G9044	10.70	10.17	11.69	

*Represents facility rate

U.S. Virgin Islands fee revisions

Code/Mod	Participating	Nonparticipating	Limiting Charge	
93351	249.96	237.46	273.08	
93351TC	152.21	144.60	166.29	
9335126	97.75	92.86	106.79	
G0270	25.41	24.14	27.76	
G0270	23.65	22.47	25.84	*
G0392	2,117.90	2,012.01	2,313.81	
G0392	491.46	466.89	536.92	*
G0393	1,597.39	1,517.52	1,745.15	
G0393	313.10	297.45	342.06	*
G9041	27.60	26.22	30.15	
G9042	14.63	13.90	15.98	
G9043	14.63	13.90	15.98	
G9044	12.51	11.88	13.67	

*Represents facility rate

MLN Matters Number: MM6397
Related CR Release Date: March 4, 2009
Related CR Transmittal #: R1691CP
Related Change Request (CR) #: 6397
Effective Date: January 1, 2009
Implementation Date: April 6, 2009

Therapy Services

Outpatient therapy caps with exceptions in calendar year 2009

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6321 which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy cap exceptions for 2009 and updates the dollar amount of the therapy caps for 2009. Be sure billing staff is aware of the updates.

Background

The Balanced Budget Act of 1997 established limits on outpatient therapy services. These limits change annually. The Deficit Reduction Act of 2005 allowed CMS to establish an exceptions process, which began January 1, 2006 and was extended by later legislation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the exceptions process for therapy caps through December 31, 2009. CR 6321 makes no change to the exceptions process.

CR 6321 revises the *Medicare Claims Processing Manual* Chapter 5, Section 10.2 (The Financial Limitation) to include the outpatient therapy cap exceptions for 2009. The revised manual chapter is included as attachment to CR 6321, and the following is extracted from that attachment:

Financial limitations on outpatient therapy services, as described in the *Medicare Claims Processing Manual* (Chapter 5, Section 10.2 [The Financial Limitation]) were $1,740 in 2006, $1,780 in 2007, and $1,810 for 2008.

For 2009, the financial limitations are as follows:

- The annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is $1,840
- The separate limit for occupational therapy is $1,840

An advance beneficiary notice of noncoverage (ABN) is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements before the cap is reached. The ABN informs the beneficiary of their potential financial obligation to the provider and provides guidance regarding appeal rights. Since therapy that exceeds the cap is statutorily excluded from Medicare coverage, the ABN is not required. However, the ABN may be used on a voluntary basis to inform the beneficiary of potential liability for therapy that exceeds the cap.

Note: The ABN-G is no longer effective as of March 1, 2009. The revised ABN (CMS-R-131) must now be used and the revised ABN is available for download at *http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip* on the CMS Web site.

Additional information

The official instruction, CR 6321, issued to your carrier, FI, MAC, and RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1678CP.pdf* on the CMS Web site.

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

MLN Matters Number: MM6321 *Revised*
Related Change Request (CR) #: 6321
Related CR Release Date: February 13, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R1678CP
Implementation Date: April 6, 2009

Adding a new specialty code for speech-language pathologists

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

Provider types affected

Speech-language pathologists (SLP) and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (MACs) for speech-language pathology services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6292, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) has developed a new specialty code to categorize speech pathology services. This new code (specialty code 15) is effective July 1, 2009.

Providers and suppliers use CMS specialty codes to ensure that their claims are processed and paid correctly. Section 143 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amends the Social Security Act to permit SLPs to apply for enrollment as suppliers in Medicare beginning July 1, 2009. This will allow SLPs in private practice to bill Medicare directly for their services.

Additional information

You may find the official instruction, CR 6292, issued to your carrier, FI, or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1686CP.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.

MLN Matters Number: MM6292
Related Change Request (CR) #: 6292
Related CR Release Date: February 20, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1686CP
Implementation Date: July 6, 2009

General Coverage

Claims processing instructions for diagnostic tests subject to the anti-markup pricing limitation

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

Provider types affected

Physicians and other suppliers (such as physician organizations) submitting claims to Medicare contractors (carriers and/or Medicare administrative contractors [MACs]) for diagnostic tests (excluding clinical diagnostic laboratory tests) provided to Medicare beneficiaries.

Provider action needed

This article pertains to change request (CR) 6371, which clarifies changes finalized in the calendar year (CY) 2009 Medicare physician fee schedule (MPFS) final rule with comment related to diagnostic tests and the revised anti-markup provisions in section 414.50 of the Medicare regulations. Although this article provides instructions to your carrier or MAC that describe how to apply the anti-markup payment limitation, it also provides instructions for determining when the anti-markup payment limitation applies and when it does not apply. (Note that the anti-markup payment limitation applies to tests formerly referred to as "purchased diagnostic tests".) Over time, the Centers for Medicare & Medicaid Services (CMS) will change all references to "purchased diagnostic tests" in Medicare manuals to "anti-markup test(s)". Until then, you and your billing staffs should consider any reference to a "purchased diagnostic test" to be a reference to an anti-markup test. Basically, the anti-markup provision applies when a physician or other supplier orders a diagnostic test (payable under the MPFS and excluding clinical diagnostic laboratory tests) and bills for the technical component (TC) or professional component (PC) of the test that is performed or supervised by a physician or other supplier who does not "share a practice" with the billing physician or other supplier that ordered the test. CR 6371 discusses some specific criteria that should be used to determine when the anti-markup payment limitation applies and when it does not apply. This new anti-markup provision does not apply to independent laboratories. The revisions in CR 6371 are summarized below in the *Background* and *Key billing points* sections of this article.

Claims processing instructions for diagnostic tests subject to the anti-markup pricing limitation (continued)

Background

Section 1842(n)(1) of the Social Security Act requires CMS to impose a payment limitation on certain diagnostic tests where the physician performing or supervising the test does not share a practice with the billing physician or other supplier. Such a test was formerly referred to as a "purchased diagnostic test". In the CY 2009 MPFS final rule (73 FR 69799, November 19, 2008), CMS finalized changes to 42 CFR section 414.50 to include alternative methods to determine when not to apply anti-markup rules.

The anti-markup payment limitation applies when a diagnostic test (payable under the MPFS and excluding clinical diagnostic laboratory tests) is performed or supervised by a physician or other supplier who does not share a practice with the physician or other supplier that ordered and billed for the test. The anti-markup payment limitation will apply in cases where a physician does not meet the criteria for satisfying the "substantially all services" test or the "site of service" test defined below. Payment to the billing physician or other supplier that ordered the test (less the applicable deductibles and coinsurance paid by or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

- The performing supplier's net charge to the billing physician or other supplier.
- The billing physician or other supplier's actual charge.
- The fee schedule amount for the test that would be allowed if the performing supplier billed directly (42 CFR 414.50[a][1]).

The net charge must be determined without regard to any charge that reflects the cost of equipment or space leased to the performing supplier by the billing physician or other supplier (42 CFR 414.50[a][2][i]). The provision of Chapter 16, Section 40.2 of the *Medicare Claims Processing Manual* still applies, thus this new anti-markup provision does not apply to independent laboratories.

When anti-markup does not apply

The anti-markup payment limitation will not apply if the performing physician "shares a practice" with the ordering/billing physician or other supplier. As set forth in 42 CFR 414.50(a)(2), there are two alternatives for determining whether a performing/supervising physician shares a practice with the ordering/billing physician or other supplier. The two alternatives are:

Alternative one – substantially all services requirement

Under the first alternative, if the performing physician (that is, the physician who supervises the TC or performs the PC, or both) furnishes substantially all (at least 75 percent) of his or her professional services through the billing physician or other supplier, the anti-markup payment limitation will not apply. If the performing physician does not meet the "substantially all services" requirement, a "site of service" analysis may be applied on a test-by-test basis to determine whether the anti-markup payment limitation applies.

Alternative two – site of service test

The second alternative is the "site of service" test. Only TCs conducted and supervised and PCs performed in the "office of the billing physician or other supplier" by a physician owner, employee or independent contractor of the billing physician or other supplier will avoid application of the anti-markup payment limitation. The "office of the billing physician or other supplier" is any medical office space, regardless of the number of locations, in which the ordering physician regularly furnishes patient care. This includes space where the billing physician or other supplier furnishes diagnostic testing, if the space is located in the "same building" (as defined in 42 CFR 411.351) in which the ordering physician regularly furnishes patient care.

If the billing physician or other supplier is a physician organization (as defined in 42 CFR 411.351), the "office of the billing physician or other supplier" is space in which the ordering physician provides substantially the full range of patient care services that the ordering physician generally provides. With respect to the TC, the performing supplier is the physician that supervised the TC and, with respect to the PC, the performing supplier is the physician that performed the PC. Thus, if the "site of service" requirements are met, the anti-markup payment limitation will not apply.

Key billing points

- Medicare contractors will accept and process claims for either the technical component (TC) or the professional component (PC) of diagnostic tests (other than clinical diagnostic laboratory tests) submitted with the proper coding in the purchased service segments of the ANSI X12 837P electronic claim format. More than one test subject to the anti-markup payment limitation may be submitted on the electronic claim. However, when billing such multiple tests, the total anti-markup service amount must be submitted for each service. Medicare contractors will return claims as unprocessable if multiple anti-markup tests are submitted without line level anti-markup amount information included.
- When billing using the CMS-1500, each component of the test must be submitted on a separate claim form.
- For diagnostic test claims submitted on a CMS-1500, Medicare contractors will return as unprocessable those claims received with more than one TC or PC service charge when item 20 of the CMS-1500 is marked "YES". In returning such claims, Medicare contractors will use the following when returning a claim as unprocessable:

  Reason code 125 – Submission/billing error(s), and **Remittance advice (RA) remark code M65** - One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician
- For diagnostic test claims submitted on a CMS-1500, Medicare contractors will return as unprocessable those claims submitted with "YES" marked in Item 20 but no charge amount entered. Medicare contractors will use the following when returning such a claim as unprocessable:

Claims processing instructions for diagnostic tests subject to the anti-markup pricing limitation (continued)

Reason code 16 - Claim/service lacks information which is needed for adjudication, and

RA remark code MA111 - Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.

- For diagnostic test claims submitted on a CMS-1500, Medicare contractors will return as unprocessable those claims received with the "YES" indicator checked and a dollar amount in item 20 but no location information (name, address, city, state, and ZIP) for the physician/supplier from whom the diagnostic test was acquired in Item 32. Medicare contractors will use the following when returning a claim as unprocessable:

  Reason code 16 - Claim/service lacks information which is needed for adjudication, and
  RA remark code N294 - Missing/incomplete/invalid service facility primary address

Additional information

If you have questions, please contact your Medicare carrier and/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 official instruction, CR 6371, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R445OTN.pdf* on the CMS Web site.

MLN Matters Number: MM6371
Related Change Request (CR) #: 6371
Related CR Release Date: February 13, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R445OTN
Implementation Date: July 6, 2009

Electronic Data Interchange

Update of the remittance advice remark and claim adjustment reason 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 who submit claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries.

Provider action needed

CR 6336, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective April 1, 2009, for Medicare. Be sure billing staff are aware of these changes.

Background

Two code sets (the group and the reason and remark code sets) must be used to report payment adjustments in remittance advice transactions. For Medicare, remark codes must also be used when appropriate to report additional explanation for any adjustment or to provide general policy information. The reason codes are also used in some coordination of benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. RARC list is updated three times a year (early March, July, and November), although the committee meets every month.

The CARC list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated at the same time and posted *at http://www.wpc-edi.com/Codes* on the Internet. The lists summarizing the latest changes may be found at the end of the *Additional information* section.

CMS has also developed a tool to help you search for a specific category of remark code and that tool is available at *http://www.cmsremarkcodes.info* on the Internet. Note that this Web site does not replace the Washington Publishing Company (WPC) site. That site is *http://www.wpc-edi.com/Codes* and should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional information

To see the official instruction (CR 6336) issued to your Medicare contractor refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1674CP.pdf* on the CMS Web site. For additional information about remittance advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf* on the CMS Web site. If you use the Medicare Remit Easy Print software from your Medicare contractor, you may need to download the updated version when it is available on April 6, 2009.

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.

New codes - CARC

Code	Current Narrative	Effective Date
226	Information requested from the billing/rendering provider was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	9/21/2008
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	9/21/2008
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008

Modified codes – CARC

Code	Current Modified Narrative	Effective Date
148	Information requested from the billing/rendering provider was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	7/1/2009

Update of the RARC and CARC, continued

Deactivated codes - CARC

Code	Current Narrative	Effective Date
17	Requested information was not provided or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)	7/1/2009
B18	This procedure code and modifier were invalid on the date of service.	3/1/2009

New codes - RARC

Code	Current Narrative	Medicare Initiated?
N505	**Alert**: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.	No
N506	**Alert**: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.	No
N507	Plan distance requirements have not been met.	No
N508	**Alert**: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an explanation of benefits electronically or in the mail. Contact the insurer if there are any questions.	No
N509	**Alert**: A current inquiry shows the member's consumer spending account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the consumer spending account will depend on the availability of funds and determination of eligible services at the time of payment processing.	No
N510	**Alert**: A current inquiry shows the member's consumer spending account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the consumer spending account will depend on the availability of funds and determination of eligible services at the time of payment processing.	No
N511	**Alert**: Information on the availability of consumer spending account funds to cover the member liability on this claim/service is not available at this time.	No
N512	**Alert**: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	No
N513	**Alert**: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.	No
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Yes
N515	**Alert**: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

Modified or deactivated codes - RARC

There are no modified or deactivated RARC codes in CR 6336.

MLN Matters Number: MM6336
Related CR Release Date: January 30, 2009
Related CR Transmittal #: R1674CP
Related Change Request (CR) #: 6336
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Healthcare provider taxonomy code updates effective April 1, 2009

Effective April 1 2009, the healthcare provider taxonomy codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of HPTC is available from the Washington Publishing Company Web site at: *www.wpc-edi.com/codes/taxonomy*. If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level deletion (rejection) may occur. To ensure you do not receive a claim or file level rejection it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system please contact your software support vendor.

Source: Change request 6382

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

General Information

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 March 5, 2009, to reflect the revised CR 6139, which CMS re-issued on March 4, 2009. (The effective and implementation dates for providers were previously changed to April 6, 2009 by Transmittal R23COM on February 10.) In this revision of the article, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same. This information was previously published in the February 2009 *Medicare B Update!* pages 17-18.

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 five-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 five-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 five-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

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

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 five-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 e-mails 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 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 e-mail 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 five-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 five-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/R25COM.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.

MLN Matters Number: MM6139 *Revised*
Related Change Request (CR) #: 6139
Related CR Release Date: March 4, 2009
Effective Date: April 6, 2009
Related CR Transmittal #: R25COM
Implementation Date: April 6, 2009, for providers

Instructions for the implementation of the Internet-based Provider Enrollment, Chain and Ownership System

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

Provider types affected

All physicians, providers, and suppliers who submit CMS-855 applications into the PECOS system via the Internet to Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], carriers or regional home health intermediaries [RHHIs]).

Provider action needed

This article is based on change request (CR) 6231 and alerts providers to the fact that the information about Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications provided in previously issued CR 5954 is now incorporated into Centers for Medicare & Medicaid Services (CMS) *Medicare Program Integrity Manual* Chapter 10─Medicare Provider/Supplier Enrollment, which is available at *http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf* on the CMS Web site. CMS emphasizes that none of the material in CR 5954 is changing in any way; the material is simply being shifted to Chapter 10.

Background

CR 6231 describes the PECOS CMS-855 applications. Specifically, this directive incorporates all of the instructions contained in CR 5954 into the *Medicare Program Integrity Manual* Chapter 10 - Medicare Provider/Supplier Enrollment. Consequently, CR 6231 rescinds and replaces CR 5954.

Key points of CR 6231

Effective immediately CMS has incorporated the instructions regarding PECOS applications into the *Medicare Program Integrity Manual* Chapter 10. The instructions are as follows:

- If the provider fails to submit a signed and dated certification statement to the Medicare contractor within 15 calendar days of the date on which it submitted its Internet-based PECOS CMS-855 to the contractor, the contractor may reject the application.
- For initial CMS-855 applications sent via the Internet-based PECOS, it is only necessary that the dated signature of at least one of the provider's authorized officials be on the certification statement that must be sent in by the 15th day. The signatures of the other authorized and delegated officials will be collected through the normal application development process.
- If the provider submits an undated certification statement or a certification statement on which the Web Tracking ID does not match that in PECOS, the Medicare contractor will treat it as a non-submission.

Instructions for the implementation of the Internet-based PECOS (continued)

- If your contractor determines that additional or clarifying information is needed, the contractor will send an e-mail to the provider: (1) requesting said data along with, as necessary, a signed and dated certification statement; and (2) listing a date(s) by which the information and certification statement, respectively, must be submitted to the contractor.
- Note that your contractor may, at its discretion, initiate a follow-up contact with you after sending the e-mail, but is not required to do so.
- If the provider fails to submit the requested additional/clarifying information and the accompanying certification statement within 30 calendar days from the date the contractor sent the e-mail, the contractor may reject the provider's application.
- If the contractor receives the additional/clarifying information from the provider, the contractor will not recommence its processing of the application until the accompanying certification statement is received in the contractor's provider enrollment department.
- The provider must submit all applicable supporting documentation (e.g., licenses, CMS-588) with its Internet-based PECOS application. (It is not necessary, however, for the provider to submit the supporting documentation: (1) in the same package as the certification statement, or (2) prior to its submission of the certification statement.)

Additional information

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

For complete details regarding this CR please see the official instruction (CR 6231) issued to your Medicare A/B MAC, FI, carrier or RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R271PI.pdf* on the CMS Web site.

MLN Matters Number: MM6231
Related Change Request (CR) #: 6231
Related CR Release Date: October 24, 2008
Effective Date: November 24, 2008
Related CR Transmittal #: R271PI
Implementation Date: November 24, 2008

Disclosure of physician ownership in hospitals

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

Provider types affected

Physician-owned hospitals and physicians with hospital ownership interests who bill Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (MAC) for services provided to Medicare beneficiaries in those physician-owned hospitals.

What you need to know

Change request (CR) 6306, from which this article is taken, announces that:

- Physician-owned hospitals are required to disclose to their patients the names of the physician owners and the names of immediate family members of the physician who have an ownership or investment interest in the hospital; and
- Physicians are required to disclose to their patients at the time of referral if they (or their immediate family members) have an ownership or investment interest in the hospitals to which they refer patients for treatment.

Hospitals that fail to disclose this information to patients may lose their provider agreements to participate in the Medicare program, and physicians who fail to disclose this information to patients may lose their hospital medical staff memberships.

You should make sure that you have appropriate hospital physician-ownership disclosure procedures in place and that you are providing appropriate disclosures to your patients.

Background

The Code of Federal Regulations Title 42, Volume 3,Section 489.3 defines a physician-owned hospital as any participating hospital (as defined in section 489.24) in which a physician, or their immediate family member, has an ownership or investment interest. Pursuant to Section 489.3, hospitals that do not have any physician owners who refer patients to the hospital are exempt from these disclosure requirements.

Section 5006 of the Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, required the Secretary of Health and Human Services (HHS) to develop a "strategic and implementing plan" to address certain issues related to physician investment in specialty hospitals. Accordingly (in order to allow patients to make informed decisions regarding their treatment and to decide if the existence of a hospital-related financial relationship suggests a conflict of interest that may not be in their best interest), in the August 8, 2006 final report to Congress on this requirement, the Centers for Medicare & Medicaid Services (CMS) stated the adoption of a disclosure requirement that would require both hospitals and physicians to disclose to patients whether the hospital is physician-owned and if the referring physician is a physician owner of the hospital.

Specifically, the FY 2008 and FY 2009 inpatient prospective payment system (IPPS) regulations require hospitals to disclose to patients whether they are physician-owned, and if so, to disclose the physician owners' names. This ownership or investment interest may be through equity, debt, or other means (including an interest in the

Disclosure of physician ownership in hospitals (continued)

entity that holds an ownership or investment interest in the hospital.) In disclosing this ownership relationship, hospitals must furnish written notice to each patient at the beginning of their hospital stay, or outpatient visit, that the hospital is physician-owned. The notice must disclose the fact that the hospital meets the Federal definition of a physician-owned hospital, and that the list of physician owners or their immediate family members (who have an ownership or investment interest in the hospital) is available upon request and must be provided to the patient at the time of the request.

These regulations also require each physician who is a member of the hospital's medical staff to agree (as a condition of continued medical staff membership or admitting privileges), to disclose to all patients that he or she refers to the hospital (in writing at the time of the referral), any ownership or investment interest that he/she, or an immediate family member, holds in the hospital.

You should be aware that if a physician-owned hospital fails to disclose physician ownership information as required, it may lose its provider agreement to participate in the Medicare program. Similarly, if a physician fails to disclose his/her hospital ownership or investment information, he or she may lose hospital medical staff membership.

Additional information

The official instruction issued to your Medicare carrier, FI, or MAC, CR 6306, is available at *http://www.cms.hhs.gov/Transmittals/downloads/R58GI.pdf* on the CMS Web site. If you are interested in reading about physician hospital ownership disclosure in the *Code of Federal Regulations* Title 42, Volume 3, Section 489.3, you may find it at *http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr489.3.pdf* on the Internet.

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.

MLN Matters Number: MM6306
Related Change Request (CR) #: 6306
Related CR Release Date: March 6, 2009
Effective Date: June 8, 2009
Related CR Transmittal #: R58GI
Implementation Date: June 8, 2009

Reporting the NPI on claims for reference laboratory and purchased services performed outside the billing jurisdiction

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

Provider types affected

Physicians and other providers who bill Medicare carriers and Medicare administrative contractors (MAC) for reference laboratory or purchased diagnostic services.

What you need to know

Change request (CR) 6362, from which this article is taken, establishes an exception to the standard reporting of the national provider identifier (NPI) on Medicare fee-for-service claims for reference laboratory and purchased diagnostic services performed by a provider located outside the jurisdiction of your Medicare contractor. When you bill for either of these services (reference laboratory services listed on the Clinical Laboratory Fee Schedule, or purchased diagnostic services) and the services were performed by a provider located in another Medicare contractor's jurisdiction, you must report your own NPI on the Medicare claim as the performing provider and annotate the claim with the performing provider's name, address and ZIP code. Be sure to record the performing provider's NPI in the clinical records for auditing purposes. You should make sure that your billing staff has been made aware of this NPI documentation requirement.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for health care providers; and the January 23, 2004 final rule establishes the national provider identifier (NPI) as this standard.

All entities covered under HIPAA must comply with the requirements of the final rule (45 CFR Part 162, CMS-0045-F), which requires that (effective May 23, 2008) covered health care providers, suppliers, and health plans (other than small plans) must use the NPI on paper or electronically-submitted Medicare fee-for-service claims.

If you, as the billing provider, outsource Medicare-covered services to another Medicare-enrolled provider you are "purchasing" these services and ordinarily would report, on the claim, both your own NPI (as the billing provider) and also the performing provider's NPI. However, when the performing provider is geographically located in a different Medicare contractor's jurisdiction, your carrier or MAC will not have a record of the performing provider's NPI. CR 6362, from which this article is taken, clarifies billing instructions on using the NPI in these situations.

Specifically, CR 6362 requires that when you submit paper or electronic Medicare claims for reference laboratory or purchased diagnostic services that are performed by a provider outside of your billing jurisdiction; you should report your own NPI in the performing provider's NPI data field and annotate the claim with the performing provider's name, address, and ZIP code. The billing provider must keep the performing provider's NPI in the clinical records for auditing purposes.

You should be aware that your carrier or MAC will return as unprocessable your claims for reference laboratory or purchased diagnostic services that are performed outside the billing jurisdiction; if you submit them without your NPI in item 32a, and the name, address, and ZIP code of the

Reporting the NPI on claims for reference laboratory and purchased services performed outside the . . . (continued)

performing provider in item 32 of the CMS-1500, or on the ANSI X12 837P electronic claim form in the appropriate data field.

Note: CR 6362 establishes this previously discretionary requirement as mandatory, and also, supplements and manualizes CR 5289 which was issued October 27, 2006, as Transmittal 243. (You might want to review the related *MLN Matters* article MM5289, Reporting the National Provider Identifier (NPI) on Physician Claims for Clinical Diagnostic Services Purchased Outside of the Local Carrier's Jurisdiction, which you may find at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5289.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Additional information

You may find more information about reporting your NPI on claims for reference laboratory and purchased diagnostic services performed outside of your billing jurisdiction by going to CR 6362, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1690CP.pdf* on the CMS Web site.

You will find the updated *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Sections 40.1.1.1 (Paper Claim Submission to Carriers/B MAC) and 40.1.1.2 (Electronic Claim Submission to Carriers/B MAC) as an attachment to that CR.

If you have any questions, please contact your 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.

MLN Matters Number: MM6362
Related Change Request (CR) #: 6362
Related CR Release Date: February 27, 2009
Effective Date: March 27, 2009
Related CR Transmittal #: R1690CP
Implementation Date: March 27, 2009

Enhancements to the National Plan and Provider Enumeration System

On March 7, the National Plan and Provider Enumeration System (NPPES) underwent system maintenance.

The following enhancements were incorporated into NPPES:

- The NPPES application help page text was revised to ensure consistency with the instructions found on the revised National Provider Identifier (NPI) Application/Update Form (CMS-10114 [11/08]).
- NPPES Web users are required to change their passwords after the enumerator has reset them. When the enumerator resets a user's password, the user will be redirected to the password reset page to change the reset password to a password of his/her choice. NPPES will also enforce a minimum password length of eight characters.

The following enhancements were incorporated into the NPI Registry:

- The "doing business as" (DBA) search feature was restored.
- The NPI Registry is updated daily.
- The NPI Registry displays all results in all capital letters. This change does not affect the way information is displayed in a health care provider's NPPES record.

Electronic file interchange (EFI)

The electronic file interchange (EFI) user manual and technical companion guide have been revised. These changes do not impact the EFI XML Schema.

Additional information

Health care providers can apply for an NPI online at *https://nppes.cms.hhs.gov*. Health care providers needing assistance with applying for an NPI or updating their data in NPPES records may contact the NPI enumerator at 1-800-465-3203 or e-mail the request to the NPI enumerator at *CustomerService@NPIEnumerator.com*.

Source: PERL 200902-37

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.

Update on ICD-10 code sets and standards governing electronic transactions

On January 15, the U.S. Department of Health and Human Services released two final rules that will facilitate the United States' ongoing transition to an electronic health care environment through adoption of an updated set of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.

In accordance with the White House Chief of Staff's memorandum of January 20, 2009, titled "Regulatory Review," a determination has been made that the effective date will not be extended and the comment period will not be reopened for either of these rules.

- The first rule finalizes new code sets to be used for reporting diagnoses and procedures on health care transactions. This final rule replaces the ICD-9-CM code sets, developed nearly 30 years ago, with greatly expanded ICD-10 code sets.
- The second final rule adopts updated versions of the standards governing electronic transactions under the authority of the Health Insurance Portability and Accountability Act of 1996. The updated versions replace the current standards and will promote greater use of electronic transactions.

In response to public comments suggesting that more time would be needed for effective industry implementation, the final rules include later compliance dates. More specifically, the final rules provide compliance dates of Jan. 1, 2012, for the transaction standards and Oct. 1, 2013, for the ICD-10 code sets.

Source: PERL 200903-18

Five-star provider preview reports now available

The five-star provider preview reports were available beginning Wednesday, March 18, 2009. Providers can access the report from the minimum data set (MDS) state welcome pages available on the state servers for submission of minimum data set data.

Provider preview access information

Visit the MDS state welcome page (available on the state servers where you submit MDS data) to review your results. To access the five-star provider preview 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."

Note: "st" is the 2-digit postal code of the state in which your facility is located, and "facid" refers to the state-assigned facility identifier for your facility.

Nursing Home Compare updated March's five-star data on Thursday, March 26, 2009.

Source: PERL 200903-21

Additional Physician Quality Reporting Initiative resource documents

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of two additional resource documents for providers participating in the Physician Quality Reporting Initiative (PQRI) program. The following resources, which were discussed during the February 18 national provider call, have now been posted to the PQRI Web page at *http://www.cms.hhs.gov/PQRI* on the CMS Web site:

January 1-September 30, 2008, aggregate quality data code (QDC) error report: This report contains aggregate-level information about the quality data codes submitted January 1-September 30, 2008, by measure, for the PQRI program. This information is available as a downloadable document in the *Downloads* section of the *Analysis and Payment* page.

Status update regarding *Current Procedural Terminology (CPT)* II coding issue for the 2009 PQRI: This is an update regarding a recently identified *CPT* II coding issue, which affected several quality data codes (QDCs) used for reporting a number of quality measures through the claims-based reporting method for 2009 PQRI. For information and guidance regarding this issue, please see the downloadable document in the *Downloads* section of the *Measures/Codes* page.

Source: PERL 200902-36

Skilled Nursing Facility Spell of Illness Quick Reference Chart

The revised *Skilled Nursing Facility (SNF) Spell of Illness Quick Reference Chart* (January 2009), which provides Medicare claims processing information related to SNF spells of illness, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/SNFSpellIllnesschrt.pdf*.

Source: PERL 200902-31

New Web page for e-Prescribing incentive program

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the new e-Prescribing) Incentive program Web page at *http://www.cms.hhs.gov/ERXIncentive* on the CMS Web site. All information about the e-Prescribing incentive program has been moved from the CMS Physician Quality Reporting Initiative (PQRI) Web page at *http://www.cms.hhs.gov/PQRI* to *http://www.cms.hhs.gov/ERXIncentive*.

This new Web page provides information about the new e-Prescribing incentive program that was authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

Please note that many new resources have also been added to the e-Prescribing incentive Web page as part of the migration to the new URL.

Included on this page in the *Downloads* section is:

- A 2009 e-Prescribing incentive program made simple fact sheet
- A Spanish version of the Introduction to e-Prescribing Incentive fact sheet
- A sample electronic prescribing claim
- Information on how to access the audiotapes and slides from the national e-Prescribing conference that was held in October 2008 for continuing education credit.

New and updated information will be added frequently, so please visit the e-Prescribing incentive program Web page at *http://www.cms.hhs.gov/ERXIncentive*.

Source: PERL 200903-14

March Is National Nutrition Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. More than 13.7 million Americans at least 60 years or older are diagnosed with diabetes or chronic kidney disease 1. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management as well as other health outcomes and may also help delay disease progression.

Medicare coverage

Medicare provides coverage of MNT for beneficiaries diagnosed with diabetes and/or renal disease (except for those receiving dialysis) and post renal transplant when provided by a registered dietitian or nutrition professional who meets the provider qualifications requirement. A referral by the beneficiary's treating physician indicating a diagnosis of diabetes or renal disease is required. Medicare provides coverage for three hours of MNT in the first year, two hours in subsequent years, and additional hours in certain situations.

Note: For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular filtration rate (GFR) 13-50 ml/min/1.73m2].

What can you do?

As a trusted source of health care information, your patients rely on their physician's or other health care professional's recommendations. CMS requests your help to ensure that all eligible people with Medicare take full advantage of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- **The MLN Preventive Services Educational Products Web Page** -- provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- **Diabetes-Related Services Brochure** -- this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*. To order copies of the brochure, go to the MLN Product Ordering System located at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5.*
- The CMS Web site provides additional information about the MNT benefit at *http://www.cms.hhs.gov/MedicalNutritionTherapy/.*

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

For more information about National Nutrition Month® or to "Find a Nutrition Professional," please visit *http://www.eatright.org*.

1Department of Health & Human Services. Centers for Disease Control and Prevention, "2007 National Diabetes Fact Sheet," accessed at *http://apps.nccd.cdc.gov/ddtstrs/FactSheet.aspx*. The United States Renal Data System, "2008 USRDS Annual Data Report (ADR) Atlas," accessed at *http://www.usrds.org/2008/pdf/V1_Precis_2008.pdf*.

Source: PERL 200903-05

March 12 is World Kidney Day

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of the diabetes-related services that are covered by Medicare.

More than 13.7 million Americans at least 60 years or older are diagnosed with diabetes or chronic kidney disease (CKD) [1]. Detection and proper treatment of kidney disease is crucial to helping Medicare beneficiaries to avoid complications and lead healthier, longer lives.

Medicare covers a range of dialysis-related services to eligible Medicare beneficiaries, including dialysis and transplant services.

Medicare's efforts to improve kidney disease detection

Tens of millions of Americans who have diabetes or high blood pressure are at risk for kidney disease and many do not know it. People with diabetes and high blood pressure, the leading risk factors for the disease, should check their kidney function with:

- an annual urine screening (micro-albumin test)
- a blood pressure check, and
- a blood test to determine eGFR (estimated glomerular filtration rate).

Throughout National Kidney Month, CMS' Quality Improvement Organizations (QIOs) are working in eleven states throughout the country to urge high-risk patients to ask their doctors for this life-saving screening.

QIOs are partnering with primary care physicians, nephrologists, and vascular surgeons to improve care for patients with CKD to prevent or slow the progression of the disease. QIOs work throughout the country with healthcare providers, consumers, and stakeholder groups to refine care delivery systems to make sure all patients, particularly patients from underserved populations, get the right care at the right time.

For more information

- CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for kidney dialysis and transplant-related services.
  - **Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services** -- this informative guide provides information to physicians regarding Medicare coverage of kidney-related services, including how your patients can obtain Medicare coverage if their kidneys fail and how Medicare pays for kidney dialysis and transplants. This guide is available at *http://www.cms.hhs.gov/MLNProducts/downloads/Book_Kidney_Dialysis-Final.pdf*.
  - **Outpatient Maintenance Dialysis End Stage Renal Disease Fact Sheet** -- this fact sheet provides information on the composite rate system Medicare uses to pay for outpatient dialysis, including separately billable items and services. This fact sheet is available at *http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymtfctsht508-09.pdf*.
- For information to share with your Medicare patients, visit: *http://www.medicare.gov*.
- For more information about World Kidney Day, please visit the National Kidney Foundation's World Kidney Day Web site at: *http://www.kidney.org/news/wkd/*.
- To learn more about how QIOs are working to increase kidney disease screening rates, visit *http://www.qualitynet.org/medqic*.

[1] Department of Health and Human Services. Centers for Disease Control and Prevention, "2007 National Diabetes Fact Sheet," accessed at *http://apps.nccd.cdc.gov/ddtstrs/FactSheet.aspx*. The United States Renal Data System, "2008 USRDS Annual Data Report (ADR) Atlas," accessed at: *http://www.usrds.org/2008/pdf/V1_Precis_2008.pdf*.

Source: PERL 200903-15

March 24 is Diabetes Alert Day

Diabetes is the sixth leading cause of death in the United States. However, early detection and treatment of diabetes may prevent or delay many of the complications associated with the disease.

In conjunction with Diabetes Alert Day, the Centers for Medicare & Medicaid Services (CMS) would like to remind health care professionals that Medicare provides coverage for several diabetes-related services, including:

- diabetes screening tests
- diabetes self-management training
- medical nutrition therapy, and
- certain other diabetes supplies and services.

CMS offers several educational products related to Medicare-covered preventive services, including diabetes services. Please visit the *Medicare Learning Network* for more information, including the following diabetes-related pages:

- **The *MLN* Preventive Services Educational Products Web Page** -- provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
- **Diabetes-Related Services Brochure** -- this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.

March 24 is Diabetes Alert Day (continued)

To order copies of the brochure, go to the MLN Product Ordering System located at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

The CMS Web site provides additional information about the medical nutrition therapy benefit at *http://www.cms.hhs.gov/MedicalNutritionTherapy/*.

For more information diabetes, please visit the National Diabetes Education Program Web site at *http://www.ndep.nih.gov/*. This site contains several publications to help you educate your patients about diabetes prevention, including The Road to Health Toolkit, which contains resources specifically tailored for community health workers in Hispanic/Latino and African-American communities, who are at a higher risk for type 2 diabetes.

Source: PERL 200903-20

March is National Colorectal Cancer Awareness Month

In conjunction with National Colorectal Cancer Awareness Month, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for certain colorectal cancer screenings. Colorectal cancer affects both men and women of all racial and ethnic groups, is most often found in people age 50 and older, and the risk increases with age. Screening can help prevent and detect colorectal cancer in its earliest stages when outcomes are most favorable.

Medicare covered colorectal cancer screenings

Medicare provides coverage of colorectal cancer screenings for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered in place of the screening colonoscopy. An individual is considered to be at high risk for colorectal cancer if he or she has had colorectal cancer before or has a history of polyps, has a family member who has had colorectal cancer or a history of polyps, or has a personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Medicare provides coverage for the following colorectal cancer screenings subject to certain coverage, frequency, and payment limitations:

- fecal occult blood test (FOBT)
- colonoscopy
- sigmoidoscopy
- barium enema (as an alternative to a covered screening flexible sigmoidoscopy or screening colonoscopy)

Prevention is key

Colorectal cancer is the second leading cause of death from cancer in the United States; however, it doesn't have to be. Colorectal cancer is largely preventable through screening. The United States Preventive Services Task Force (USPSTF) found convincing evidence that certain screenings for colorectal cancer can detect early-stage cancer and adenomatous polyps and reduce colorectal cancer mortality (see the USPSTF link below for more information). CMS needs your help to ensure that all eligible people with Medicare get screened for colorectal cancer. Talk with your Medicare patients and their caregivers about the importance of getting screened. Patients who were screened before becoming Medicare beneficiaries should be encouraged to continue with screening at clinically appropriate intervals.

Additional information

- CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

The *MLN* Preventive Services Educational Products Web Page -- provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Cancer Screenings Brochure -- this tri-fold brochure provides health care professionals with an overview of cancer screenings covered by Medicare, including colorectal cancer screening services. *http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf*. To order copies of the brochure, go to the MLN Product Ordering Page located at: *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*.

- For information to share with your Medicare patients, visit *http://www.medicare.gov*.
- The United State Preventive Services Task Force (USPSTF) recently revised its colorectal cancer screening recommendations: *http://www.ahrq.gov/clinic/uspstf/uspscolo.htm*.
- The Carolinas Center for Excellence Web site is a great resource for examining screening rates at a local level: *http://www2.thecarolinascenter.org/crc/crc.aspx?tabid=229*.
- The American Cancer Society offers free materials to help clinicians continue encouraging colorectal cancer screening among patients 50 and older: *http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp*.
- The National Colorectal Cancer Roundtable, which is convened by the Centers for Disease Control and Prevention (CDC) and the American Cancer Society, provides resources for providers, including a guide for primary care physicians: *http://www.nccrt.org/*. For more information about National Colorectal Cancer Awareness Month, please visit *http://www.preventcancer.org/colorectal3c.aspx?id=1036*.

Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened: It could save their lives.

Source: PERL 200903-03

National patient safety awareness week

March 8-14, 2009, is national patient safety awareness week. The Centers for Medicare & Medicaid Services (CMS) reminds beneficiaries and health care professionals what patients and their local healthcare providers can do to improve the safety of care. CMS is also working to make health care safer through its Quality Improvement Organization (QIO) program.

What can patients/consumers do to make health care safer?

According to the National Patient Safety Foundation, consumers can help bring patient safety to the forefront of healthcare providers' agendas:

- Ask your hospital or health care professional about patient safety and how communication and partnership between you and your providers can be improved.
- Ask your hospital or health care organization what they are doing for Patient Safety Awareness Week, and attend events to learn more about patient safety.
- Communicate with your provider about your health care safety concerns.
- Let your health care provider know who they should talk with in the case that you are unable to speak for yourself.

Consumers can also work with the Quality Improvement Organization (QIO) in their state to raise concerns about the quality or safety of care they or a loved one have received under the Medicare program. QIOs will work to find the reason why things happened to cause the concern and to determine the likelihood that it will happen again. The purpose of a quality of care review is not to punish the doctor but to help improve care delivery for future patients. In cases where chances are high that the scenario will happen again, the QIO will help health care providers make changes in procedures to prevent future problems.

CMS has published two guides for consumers about working with QIOs about quality/safety of care problems.

- *Quality of Care Concerns: What Can Your Quality Improvement Organization Address? (Publication CMS-11362)*, available at *http://www.medicare.gov/Publications/Pubs/pdf/11362.pdf*.
- *Frequently Asked Questions: What to Do If You Have a Quality of Care Concern (Publication CMS-11348)*, available at *http://www.medicare.gov/Publications/Pubs/pdf/11348.pdf*.

Consumers can learn more about how the QIO works with them in their state by visiting the directory of QIOs at *http://www.medicare.gov/Contacts*.

What is CMS doing to make health care safer?

In addition to working with consumers on quality of care problems, QIOs are working nationwide with select hospitals and nursing homes to improve patient safety by:

- Improving surgical safety/infection rates
- Reducing rates of certain infections in hospitals
- Intensively working with "nursing homes in need"
- Improving care for patients with heart failure
- Preventing pressure ulcers (bed sores) in patients from nursing homes and hospitals
- Eliminating physical restraints in nursing homes, and
- Combating drug-drug interactions and potentially inappropriate medication errors.

Health care professionals can learn more about how QIOs are making care safer at *http://www.qualitynet.org/medqic*. CMS' Web site contains more information about each of these tasks as well as tools designed to help providers improve quality in each of these areas. Professionals can also contact the Patient Safety QIO Support Center at *psqiosc@okqio.sdps.org*.

Source: PERL 200903-19

Advance notice of 2010 methodological changes for Medicare Part C and D plans

The Centers for Medicare & Medicaid Services (CMS) issued the advance notice of changes in methods used to calculate capitation rates for payments to Medicare Advantage organizations for 2010. The advance notice also announced policy and technical changes to the payment methodology for Medicare Advantage and Medicare prescription drug plans. The advance notice is issued annually 45 days before the final rates are announced, in accordance with statute.

The technical adjustments announced included a preliminary estimate of a 0.5 percent increase in the national per capita Medicare advantage growth percentage. For 2010, Part C capitation rates will be based on 2009's county capitation rates updated by the Medicare Advantage growth percentage. The growth percentage is the estimated growth in per capita expenditures for all Medicare beneficiaries whether they are receiving their coverage through Medicare Advantage or Medicare prescription drug plans.

The final capitation rates for each county are scheduled to be announced on April 6, 2009. The county capitation rates define the upper limit for CMS payments to Medicare Advantage plans.

The advance notice also described changes in risk adjustment of payments to Medicare Advantage and to Medicare prescription drug plans. Under risk adjustment, higher payments are directed to plans enrolling beneficiaries with greater health care costs. The notice announced preliminary estimates of the normalization factors used to maintain average Part C and Part D risk scores at 1.0 in the payment year. The preliminary estimate of the normalization factor applied to Part C risk scores for aged and disabled beneficiaries is 1.041.

The advance notice may be viewed at *http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2010.pdf*.

Comments

In order to receive consideration prior to the April 6, 2009, release of the Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, comments were required to be received by 6:00 p.m. ET on March 6, 2009.

Source: PERL 200902-39

Information to include in communications to your membership

Help your association members stay up-to-date on the latest Medicare-related information! Below is a brief news item that we encourage you to put in your next newsletter, bulletin, or whatever vehicle you use to provide your members with news they need to know:

> Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare administrative contractor [MAC]) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor Web site and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for "listserv" or "e-mail list" to find the registration page. If you do not know the Web address of your contractor's homepage, it is available at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

Through their electronic mailing lists, Medicare contractors serve as a valuable source of news and information regarding Medicare business in specific provider practice locations, including local coverage determinations and local provider education events.

So do your members a favor and help us spread the word!

Source: PERL 200902-38

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

In the United States, 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, your family, and friends by getting and giving the flu shot. Don't get or give the flu.

Remember: Influenza and pneumococcal vaccinations plus 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 *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf* on the CMS Web site.

Source: PERL 200903-03

Individuals authorized access to CMS computer services—provider community

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

Note: This article was revised on February 20, 2009, to reflect current terminology and processes as reflected on the IACS Web site. Please note that the Center for Medicare & Medicaid Services (CMS) will notify providers as CMS applications integrated CMS security system known as the individuals authorized access computer services (IACS) become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example, *MLN Matters* articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This information was previously published in the September 2008 *Medicare B Update!* pages 75-78.

The first in a series of articles

These articles will help providers to register for access to CMS online computer services when directed to do so by CMS. This article contains:

- Questions and answers to get you started, and
- Overview of the registration process for IACS defined provider/supplier organization users.

Provider types affected

Medicare physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS at this time. DMEPOS suppliers may want to review question # 11 below.

What providers need to know

CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and

Individuals authorized access to CMS computer services—the first in a series (continued)

do not include FI/carrier/MAC-supplied Internet applications. Details of these provider applications that are integrated with IACS will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access in the IACS. The IACS Web page is at *http://www.cms.hhs.gov/IACS* on the CMS Web site. The specific community for providers may be accessed by clicking on the "Provider/Supplier Community" in the left margin of the aforementioned Web site. Or, you can go directly to the "Provider/Supplier Community" page at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp* on the CMS Web site.

Provider action needed

CMS will notify providers as internet applications integrated with IACS become available, and provide clear instructions that specify which providers should register in IACS. Do not register until you are informed to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This article and other articles in the IACS series will help you navigate this process when directed to do so by CMS. The other articles available to help with general navigation are:

- SE0753 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf* on the CMS Web site, and
- SE0754 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf* on the CMS Web site.

Questions and answers to get you started

1. What is IACS?

IACS is a security system CMS uses to control issuance of electronic identities and access to new CMS provider Web-based applications. Through IACS, provider organizations (and other communities), as defined by IACS (See question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Through IACS, provider organizations will also be able to manage users whom they authorize to conduct transactions on their behalf, which may include staff and contractors.

Note: IACS is not applicable to FI/carrier/MAC-sponsored internet applications.

2. Who can use this system?

Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the software used for DMEPOS Competitive Bidding has a dedicated version of IACS. (See question # 11 below.)

3. When should I register?

CMS will notify providers as Web-based applications integrated with IACS become available and provide clear instructions that specify which providers should register in IACS.
Do not register unless you fit the criteria in the CMS notice. For example, DMEPOS suppliers interested in becoming a contract supplier under the Medicare Competitive Bidding Program will receive explicit instructions on how and when to register for access to bidding software.

4. How long is my password valid?

Passwords expire every 60 days. After that point, when you log into IACS, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically into IACS to keep your password active.

5. How do I register as an IACS user?

IACS uses a self-registration process. The self-registration process you will follow depends on the type of IACS user you select. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

Note: User guides for the IACS community may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

The External User Services (EUS) Help Desk will support this process for IACS It may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. When would I register as an individual practitioner?

An individual practitioner (IP) is defined by IACS as a solo physician or non physician practitioner (NPP); who has not reassigned Medicare payments to a group practice. This designation is intended for practitioners who will be conducting transactions with online applications personally and who have NO staff that will be directed to access the applications on their behalf. If you will have staff or other practitioners who will need to access CMS applications, you should register as a provider organization (not as an individual practitioner). Please see #7.

CMS will match your IACS registration with Medicare enrollment data before allowing you to access a CMS application. Those providers registering as an individual practitioner who have not submitted a Medicare enrollment application (CMS-855) since November 2003 will need to update their CMS-855.

Note: See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* for more information about the Medicare enrollment process. To facilitate your enrollment into the Medicare program or updating your enrollment with Medicare, you should review the following downloadable file at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollmenttips.pdf* before submitting an enrollment application to a Medicare contractor.

Individuals authorized access to CMS computer services—the first in a series (continued)

If you enrolled in Medicare after November 2003, or have updated your enrollment since then, register as an individual practitioner following the steps in the IACS Individual Practitioner Quick Reference Guide, which may be found in the *Downloads* section of *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site. (Once at the Web site, scroll down to the *Downloads* section.)

7. When would I register as an IACS provider organization?

The term "organization", as defined by IACS, should not be confused with the term organization as it applies to provider enrollment or the NPI.

For IACS registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.

It also includes individual physicians and NPPs who want to delegate staff or surrogates to conduct transactions on their behalf (office staff, administration support etc.). In this case, for IACS registration purposes, registration must be as an organization.

IACS provider organizations require security officials (SO) (see question # 9) that establish the provider organization in IACS. All users will then be grouped together within IACS under the provider organization's SO.

8. What should I have in hand before I register as an individual practitioner?

An individual practitioner (who will be conducting transactions with online applications personally and who will have no additional staff directed to access the applications) will need to know their:

- Social security number, and
- Correspondence Information.

9. What should I have in hand before I register as a SO of a provider organization?

For an IACS provider organization, the SO of that organization will be the first person to register within IACS and will need to create their organization. The SO should have the following organizational information available before they sign on to register:

- Taxpayer identification number (TIN)
- Legal business name
- Corporate address, and
- Internal Revenue Service (IRS) Issued CP-575 hard copy form.

If the SO does not have the CP-575, a copy of other official IRS documentation may be submitted. An official IRS document should have the following information:

Required:

- IRS letterhead
- Legal business name (not handwritten), and
- TIN/EIN (not handwritten).

Examples of acceptable IRS documents include, but are not limited to:

- Copy of IRS CP-575
- Copy of IRS 147C letter, or
- Copy of Federal tax deposit coupon.
- All documents received must be legible.

10. How do I register my provider organization in IACS?

IACS is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS and then be accountable for users in the organization. Using information supplied via the IACS registration as well as a mailed-in copy of the organization's IRS documentation, CMS will verify the SO's role in the organization, the TIN and the legal business name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more details, please read the Overview section, which follows question #11.

Once you understand IACS user roles, and have designated an SO, the SO should register using the instructions in the IACS Quick Reference Guide, which is available at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

The next *MLN* article in this series of articles provides instructions for additional users to register in IACS.

11. Why is registration not available at this time for DMEPOS suppliers in IACS?

DMEPOS suppliers should not register in IACS because CMS does not have new online applications at this time. DMEPOS suppliers interested in DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which would be released closer to the bidding window.

Overview: Registering in IACS as a provider organization or a provider organization user

For IACS registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and

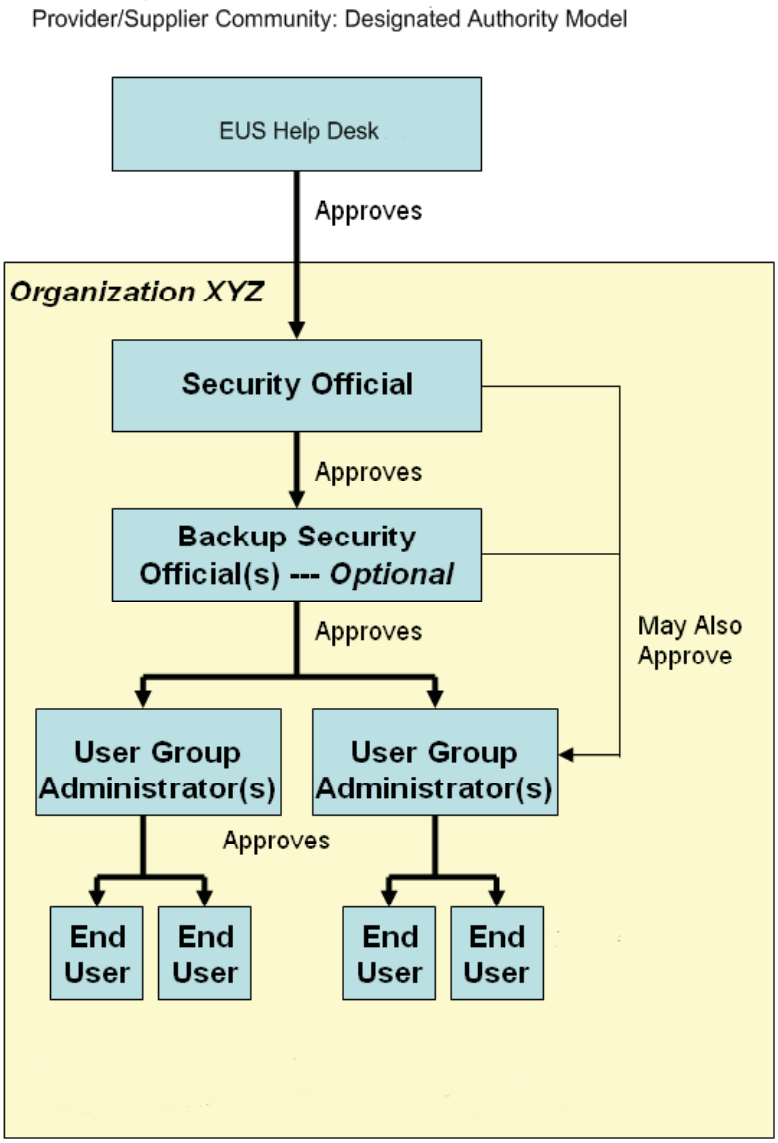
Individuals authorized access to CMS computer services—the first in a series (continued)

physician group practices. It also includes individual physicians and NPPs who want to delegate employees to conduct transactions on their behalf.

I. The registration process

IACS is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least two users, one of whom will be able to access CMS applications integrated with IACS.

The "delegated authority model" previously described is shown below. The EUS Help Desk will be responsible for approving the organization's SO. Then the SO may approve the backup security official(s) (BSO) etc.



II. Registration roles

1. The first person to register must be the SO.

The SO is the person who registers their organization in IACS and establishes the organization profile information in IACS. There can be only one SO for an organization. The SO is trusted to approve the access request of BSO(s) and can approve the access requests of user group administrators. The SO will be approved by CMS through its EUS help desk. The SO is held accountable by CMS for the behavior of those approved in the organization, including end users. The –IACS SO Quick Reference Guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS help desk.

Individuals authorized access to CMS computer services—the first in a series (continued)

2. An organization may choose to have one or more BSO (optional)

This is an optional role. You need not have a BSO. The BSO is approved by the SO. A BSO performs the same functions as a SO in an organization, with the exception of approving other BSOs and updating the organization profile. There can be one or more BSOs in an organization. The BSO can approve the access requests of user group administrators and may aid the SO with the administration of user groups and user group administrators' (UGA) accounts.

3. The next registrant must be a UGA.

The UGA is approved by the SO or BSO. The UGA is trusted to approve the access requests of end users for that user group.

A UGA registers the user group within an organization in IACS and updates the user group profile information in IACS. There can be multiple UGAs for the same user group within an organization.

If the UGA is a surrogate user (not part of the organization, but rather a contractor company working on behalf of the organization), they should select the option to create a "surrogate user group"- See Section III. Note that surrogates will not have access to the provider statistical and reimbursement (PS & R) system.

4. The next registrants are end users.

An end user is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An end user is part of a user group within the provider organization. An end user may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An end user may belong to multiple groups in one or more organizations. The end user is approved by the UGA.

Note: End users cannot register in user groups until after the UGA has been approved.

III. Surrogate user groups

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a surrogate user group. Examples include clearinghouses, credentialing departments, independent contractors. A surrogate user group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A surrogate user group may be associated with multiple provider organizations. As noted above, surrogates will not have access to the PS & R system.

1. The first contractor employee to register in a surrogate user group must be the UGA.

If there will be only one user in a surrogate group, that user must register as a UGA. The UGA for the surrogate user group will register the surrogate user group and update the user group profile information in IACS. There can be multiple UGAs within the same surrogate user group. The UGA is trusted to approve the access requests of end users for their user group.

The UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. Once approved, the UGA of a surrogate group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an end user.

An end user is approved to perform Medicare business for a surrogate or provider user group by their UGA. An end user may belong to multiple groups in one or more organizations.

Additional help

The EUS Help Desk will support the provider/supplier community with this process for IACS. It may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

Information on the steps needed for individual eligible professionals to access their 2007 Physician Quality Reporting Initiative (PQRI) Feedback Reports personally is available in *MLN Matters* article SE0830 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf* on the CMS Web site. Information on the steps for IACS defined "organizations" to access their PQRI Feedback Report is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf* on the CMS Web site.

MLN Matters Number: SE0747 *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

Individuals authorized access to CMS computer services—provider community

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

Note: This article was revised on February 20, 2009, to reflect current terminology and processes as reflected on the individuals authorized access to Centers for Medicare & Medicaid Services (CMS) computer services (IACS) Web site. Please note that CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example, *MLN Matters* articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This information was previously published in the September 2008 *Medicare B Update!* pages 79-81.

The second in a series of articles

This article contains:

- Questions and answers about the registration process for provider organizations.
- Links to the quick reference guides for completing the registration process for provider organizations.

Provider types affected

Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Do not register for IACS at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in this new series on IACS, which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

Provider action needed

CMS will inform providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This article and other articles in the IACS series will help you navigate this process when directed to do so by CMS.

What providers need to know

The CMS will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/carrier/MAC Internet applications that are hosted/managed by those entities. Details of these provider applications will be announced as they become available.

Registering in IACS

IACS protects and allows access to CMS enterprise applications. Communities (e.g., the IACS provider/supplier community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications (For example, providers need access to provider-related CMS applications). The next community which will become available is the FI/carrier/MAC community. It will be comprised of users who work within Medicare fee-for-service contracting organizations (FI's, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, Medicare providers should select the "Provider/Supplier Community".

The first *MLN Matters* article in this series provided an overview of the IACS registration process as well as registration instructions for security officials (SOs) of provider organizations and individual practitioners using IACS personally. This article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

Three questions and answers about the provider organization registration process

1. How can I get registered in IACS? Can I just figure it out by myself?

We recommend that you use the reference guides as they contain detailed explanations of the role responsibilities, acceptable data formats and interpretations of error messages. To directly access IACS, go to *https://applications.cms.hhs.gov* and then click on Enter CMS Applications Portal.

2. I will work for more than one provider, or serve in multiple roles in the same organization. Do I need to register in IACS separately for each organization or role?

No, only register once. Each user will receive only one IACS user ID and password. Once you receive approval and your user ID and password, you can add additional roles to your account.

Instructions for modifying your IACS account profile will be released shortly. In the meantime, questions may be directed to the help desk as shown in the "Additional Help" section at the end of this article.

Individuals authorized access to CMS computer services—the second in a series (continued)

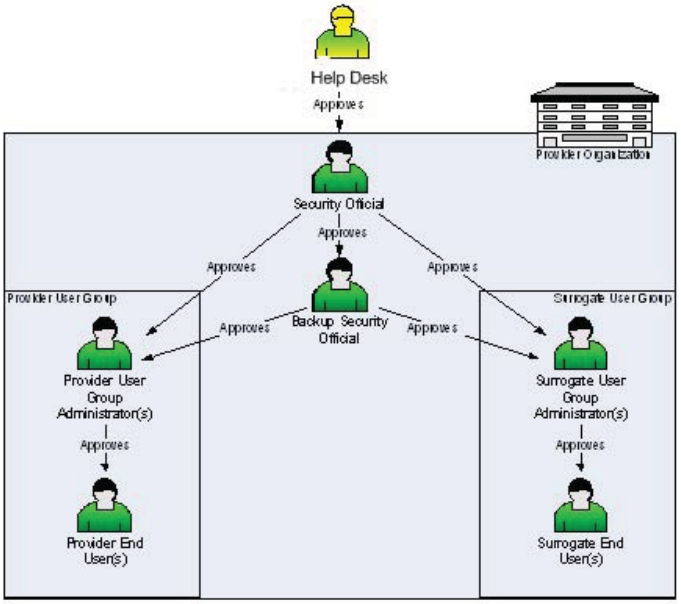
3. My organization is too small to fill all these roles. What should I do?

As few as two staff can be registered in IACS for a provider organization to access CMS enterprise applications. The first person must register as a security official (SO), the second registers as a user group administrator (UGA). The UGA may access CMS applications as approved by the SO.

The backup security official (BSO) is an optional role.

If you are an individual professional who will be using IACS personally, you may register for the single role of individual practitioner. Please refer to the first MLN article which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

IACS quick reference guides for completing the provider organization registration process



IACS registration approval process

1. BSO Guide

BSOs will request access to an organization using the IACS BSO Quick Reference Guide found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

2. User group administrator (UGA) guide

UGAs are the first user type able to request access to CMS Web-based applications. Their task, during the registration process, is to create a provider or surrogate user group, or associate with an existing provider or surrogate user group. A provider user group is a group that can be created by a UGA within an existing provider organization.

Once the user group is created and approved by the SO/BSO, end users can then submit a request to register in IACS and join that user group. The UGA will either approve or deny their request to join their user group. This is a way for users within an organization to form groups that align with business needs or any other logical grouping that is appropriate for that organization and ensure that the UGA appropriately approves each end user into their user group. The important thing to keep in mind is that the UGA will need to approve the end users in the user group for which s/he is responsible, for this reason they should know everyone in their user group.

The IACS UGA quick reference guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Special note for UGAs of surrogate user groups

A surrogate user group is established by individuals or a company outside of the provider organization which performs Medicare work on behalf of the provider organization (a contractor for a provider organization, billing company, etc.). If you will be creating a surrogate user group, the UGA of the surrogate user group must be approved by the SO or BSO in the provider organization on whose behalf it performs work. For example: Surrogate billing company ABC will work on behalf of provider organization XYZ. Once the provider organization XYZ is approved in IACS, the surrogate billing company ABC can register in IACS and request to create a surrogate user group under the provider organization XYZ. Once approved, the UGA of a surrogate user group is issued an IACS user ID that enables the UGA to associate with other provider organizations for which it performs work without registering again.

Individuals authorized access to CMS computer services—the second in a series (continued)

At this time, a new surrogate user group must be created for each provider organization with which a UGA wishes to associate. If a surrogate user group performs work on behalf of three different provider organizations, the UGA for the surrogate user group will need to make three different requests to create three different surrogate user groups, one for each provider organization with which the UGA needs to associate. If a provider organization does not appear in IACS, they have not yet registered/been approved and you should contact them. You will not be able to associate with them until the provider organization appears in IACS.

If the provider organization does appear in IACS, each provider's SO or BSO must approve the request to associate that surrogate user group with their organization. Remember, as a surrogate user group, you will only be able to associate with provider organizations after those respective provider organizations and SOs have been approved in IACS.

In the future, CMS will explore options for simplifying this process for contractors that perform work on behalf of more than one provider organization and also to allow surrogate user groups to associate to individual practitioners within IACS.

3. IACS end user quick reference guide

An IACS end user quick reference guide may be found at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

4. IACS user guide for approvers

The IACS user guide for approvers provides step-by-step instructions that SOs, BSOs and UGAs will use to approve or deny user requests to register in IACS. The IACS user guide for approvers can be found by going to the *Downloads* section of *http://www.cms.hhs.gov/IACS/03_General_User_Guides_and_Resources.asp* on the CMS Web site.

Next steps in accessing a CMS enterprise application

A third *MLN Matters* article discussing the final steps for using IACS to access CMS enterprise applications may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0754.pdf* on the CMS Web site.

Additional help

The CMS has established an external user services (EUS) help desk to assist with your access to IACS. The EUS help desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you may find an informative reference chart outlining the steps for accessing CMS enterprise applications at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf* on the CMS Web site.

MLN Matters Number: SE0753 *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

Individuals authorized access to CMS computer services – provider community

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

Note: This article was revised on February 20, 2009, to reflect current terminology and processes as reflected on the individuals authorized access to CMS computer services (IACS)Web site. Please note that CMS will notify providers as internet applications become available, and provide clear instructions that specify which providers should register in IACS to access those applications. For example, *MLN Matters* articles SE0830 and SE0831 inform physicians how to register in IACS to access their Physician Quality Reporting Initiative (PQRI) feedback reports. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice. This information was previously published in the September 2008 *Medicare B Update!* pages 81-83.

The third in a series of articles

This article describes the three steps providers must take to access a CMS enterprise provider application including how to request a provider application role in IACS (See step 2).

Provider types affected

Medicare physicians, providers, and suppliers (collectively referred to as providers) who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], and Medicare administrative contractors [A/B MACs]).

Special note for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers: Do not register for IACS at this time. DMEPOS suppliers may want to review the first *MLN Matters* article in the series on IACS which may be found at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Individuals authorized access to CMS computer services—the third in a series (continued)

Provider action needed

CMS will notify providers as internet applications become available, and will provide clear instructions that specify which providers should register in IACS - Provider/Supplier Community. Do not register until you are notified to do so by CMS or one of its contractors and only if you meet the criteria in the notice.

What providers need to know

The CMS will announce new online enterprise applications that will allow Medicare fee-for-service (FFS) providers to access, update, and submit information over the Internet.

CMS enterprise applications are those hosted and managed by CMS and for the most part do not include internet applications offered, hosted, and managed by FIs/carriers/MACs. Details of these provider applications will be announced as they become available.

CMS will inform providers or appropriate staff when they should begin to register for access through the CMS security system known as IACS. The IACS Web page is at *http://www.cms.hhs.gov/IACS* on the CMS Web site. The specific community for providers may be accessed by clicking on the "Provider/Supplier Community" in the left margin of the aforementioned Web site. Or, you can go directly to the "Provider/Supplier Community" page at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp* on the CMS Web site.

The first article in this series provided an overview of the IACS registration process as well as registration instructions for security officials (SOs) and individual practitioners. This article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf* on the CMS Web site.

Note: Individual practitioners must use a different registration process depending on whether they will have employees use IACS and/or the CMS application on their behalf. Those using employees must register in IACS as an "Organization". See the *MLN Matters* SE0747 for more information.

The second article in this series addressed common questions and gave follow-up instructions for registering provider organizations including registration as backup security officials (BSOs), user group administrators (UGAs), and end users (EUs). It also provided instructions SOs, BSOs, and UGAs can use to approve user registration requests. This article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf* on the CMS Web site.

The three steps to access a CMS enterprise provider application

Provider IACS users must take three steps to access a CMS enterprise application:

Step 1: Be approved for an IACS role.

The first two *MLN Matters* articles in this series discussed how to register in IACS.

The purpose of the IACS registration process is to:

- Confirm the identity of the person requesting registration
- Assure registrants have a legitimate business need to access CMS provider systems
- Provide the registrant an IACS role (e.g., SO, BSO, UGA, or end user) that defines their responsibilities (if any) for approving the registration requests of others in their organization, and
- Provide the registrant a user ID and password for IACS.

Step 2: Be approved for an application role

After receiving approval for an IACS role, and obtaining an IACS user ID and password, the registered user in a provider organization may then request access to CMS provider applications. This requires specifying a role for specific applications. For example, the role may be an application approver or an application user.

This application role determines:

- Their responsibilities (if any) to approve application access requests from others in their organization;
- What CMS enterprise applications (if any) to which they have a legitimate need to access, and
- The appropriate level of access to each application for their job function (which application "role" they require).

Users who received approval in IACS in Step 1 can then request access to specific CMS enterprise applications using their IACS user ID account.

This requires requesting either an application approver or an application user role for each application needed to perform Medicare-related job functions. For provider applications, there are specific roles within the application that define what the user can do. For example, some application users may be limited to viewing information and printing reports, while others can enter, edit and submit information to CMS.

Note: Each user must request a specific application role in IACS for each CMS enterprise provider application they wish to use. Roles will be specific to each application.

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

Application approvers

Organizations must have designated persons that approve each user's request for an application role. The person who performs this task is an application approver and as such cannot personally access applications for which they serve in this role.

Individuals authorized access to CMS computer services—the third in a series (continued)

Though the UGA may frequently be the appropriate person who should have this role, organizations have discretion in how they designate the application approvers so that it is appropriate for their particular organization. For example, the UGA may be designated by the SO or BSO to serve in this role for their user group, or an end user may be approved for this role by the SO or BSO for the user group with which they are associated.

Note: If a user group does not have an application approver for an application, the requests will, by default, be routed to the SO and BSO for a decision.

Application approver key points

- An application approver must be a member of the user group(s) for which they serve as an application approver (this does not apply if the SO/BSO is the application approver).
- Providers have flexibility in assigning the application approver role.
- The UGA does not have to be the application approver within the user group.
- An end user within a user group may serve in the role of the application approver.
- A different person may serve as an application approver in a user group for each application.
- The same person can be the application approver for multiple applications in a user group.
- The same person can be the application approver for multiple user groups (though they must be a member of each group.)
- There can be multiple application approvers for the same application within the same user group. In this situation, the first approver who approves or denies the request will serve as the decision authority. All of the application approvers within the user group do not need to act on each request.
- A person can be an application approver for one application, and an application user for a different application, just not for the same one.
- If an application approver does not exist for an application in a user group, the user group requests for that application will go to the SO and BSO for a decision.
- Organizations with a large number of IACS users are encouraged to have application approvers in each user group for each application (can be the same person) so that all of the application requests are not routed to the SO and BSO as the default application approvers.

Note: System security requires a "separation of duties" – which means that those who approve user requests for CMS enterprise application roles will not have access to the applications for which they have an approver role. Therefore those in Application Approver roles will not have access to the application for which they are an approver. SO and BSOs, by definition, can never access any applications as they serve as the default application approvers as noted above.

Instructions for approving application role requests are the same as for approving IACS registration requests. The IACS User Guide for Approvers may be found by selecting General User Guides and Resources in the left column of the page at *http://www.cms.hhs.gov/IACS/04_Provider_Community.asp#TopOfPage* on the CMS Web site.

Step 3: Enter the application when it becomes available.

You will be notified as CMS enterprise applications become available. After you have been approved in Steps 1 and 2, you will be able to access available CMS enterprise applications in accordance with approved application specific roles via the CMS or application Web site.

Additional CMS partner and customer communities will use IACS

IACS protects and allows access to CMS enterprise applications. IACS Communities (e.g., the IACS - Provider/Supplier Community) are comprised of groups of users who provide a similar service to CMS and who need access to similar applications. For example, the next community will be the FI/carrier/MAC community. It will be comprised of users who work within Medicare FFS contracting organizations (FIs, carriers and MACs). Since many IACS communities will be added in the future, the IACS community's user instructions are generic to allow use by multiple communities. The rules and concepts across communities are very similar.

When given a choice in IACS to select your community, please select the "Provider/Supplier Community."

Additional help

CMS has established the external user services (EUS) help desk to support providers and Medicare contractors in their access to IACS. The EUS help desk may be reached by e-mail at *EUSSupport@cgi.com* or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

In addition, you can find an informative reference chart outlining the steps for organizations to access CMS enterprise applications at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSchart.pdf* on the CMS Web site.

Information on the steps needed to register to access Physician Quality Reporting Initiative (PQRI) feedback reports is available in *MLN Matters* articles SE0830 and SE0831. These articles are available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf*, respectively.

Individuals authorized access to CMS computer services—the third in a series (continued)

Coming soon

- CMS enterprise applications to be made available via the web include others related to the Physician Quality Reporting Initiative (PQRI) and the provider statistical and reimbursement report (PS&R).
- Instructions for modifying your user profile.
- What to do if you forget your user ID or password.
- Tools for SOs, BSOs and UGAs to manage user accounts.

MLN Matters Number: SE0754 *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

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

Note: This article was revised on March 11, 2009, to add definitions of an outgoing and incoming contractor and the article is re-issued to remind affected providers of upcoming Medicare contractor transitions. This information was previously published in the November 2008 *Medicare B Update!* pages 26-31.

Provider types affected

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

Impact on providers

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

Background

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

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

MAC implementation milestones/definitions

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

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

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

Outgoing contractor - a Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare contracting reform and whose work will transition to a MAC.

Incoming MAC - the entity that has won a contract under Medicare contracting reform and which will assume the workload that was performed by a carrier or FI.

Pre - award

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

Post - award

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

Pay attention to the mail you receive from your outgoing Medicare contractor and your new MAC--you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic fund transfers, etc.

Preparing for a transition from an FI/carrier to a Medicare administrative contractor (continued)

Sign up for your new MAC's listserv. While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Getting on the MAC listserv distribution will ensure that you receive news as it happens concerning the implementation.

Access and bookmark the MAC's Web site and visit it regularly. The MAC will have a new Web site that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.

Review the frequently asked questions (FAQs) on the MAC's Web site.

Participate in the MAC's advisory groups and "Ask the Contractor" meetings. Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC!

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

Two months prior to cutover

- **Complete and return your electronic funds transfer (EFT) agreements**. CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC. (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and submit it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. Contact your MAC with any questions concerning the agreement.

  The CMS-588 may be found at *http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf* on the CMS Web site. You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's Web site. Your contractor may also provide instructions on its Web site on accurately completing the form.

- Your new MAC may also request you to execute a **new electronic data interchange (EDI) trading partner agreement** as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available at *http://www.cms.hhs.gov/EducationMaterials/downloads/TradingPartner-8.pdf* on the CMS Web site.

  Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their Web site for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these submitter IDs and passwords to you in hardcopy or electronically. **You don't need to do anything to get the new IDs**, however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.

- **Contact your claims processing vendor and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"

- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.

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

Cutover weekend

Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend. Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.

Be aware that providers may also experience system "dark days" around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to Fiscal Intermediary Standard System (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

Be aware that some interactive voice response (IVR) functionality may also be unavailable during a dark day.

Post-cutover

The first 1-2 weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.

- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll-free number for use.

Preparing for a transition from an FI/carrier to a Medicare administrative contractor (continued)

Be prepared that you may experience longer than normal wait times for customer service representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.

Learn how to use the MAC's IVR. The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the CSR line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.

Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's Web sites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.

- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that you may experience changes in remittance advice (RA) coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS post-cutover monitoring

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

Additional assistance

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

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

Additional information

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

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

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

Attachment A
Timeline and checklist for preparing for MAC implementation
Scheduled Award Date:

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

90 days before cutover

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

Preparing for a transition from an FI/carrier to a Medicare administrative contractor (continued)

75 days before cutover
1. Check the MAC's Web site and/or listserv for outreach programs, educational and informational events, and conference calls.
2. Check your state's Medical Society or local provider organization Web site for MAC transition information, MAC coordinators.

60 days before cutover
1. Submit CMS-588 – EDI form(s) to the new MAC, if needed.
2. Register for electronic remittance advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample remittance advice (RA). RA codes are standard but use of codes may vary across contractors.

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

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

15 days before cutover
1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational.
3. Collect and record all MAC telephone and fax numbers for: general inquiry customer service, provider enrollment, provider relations, EDI and ERA.
4. Place test calls and become familiar with the MAC IVR query system.
5. Continue daily monitoring of the MAC listserv.

10 days before cutover
1. Address any existing open items.
2. Continue daily monitoring of the MAC listserv.

5-10 days after cutover
1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of the MAC listserv.
3. Monitor and follow up on the MAC open item list.

30 days after cutover
1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

Attachment B
Schedule of MAC contractor training classes

Scheduled Date	Title of Class	Attendee

Schedule of MAC conferences

Scheduled Date	Conference Subject	Attendee

Preparing for a transition from an FI/carrier to a Medicare administrative contractor (continued)

Attachment C
Important MAC Implementation Dates

MAC Dark Days	
Cutoff Date for Claims Submission	
Last date Outgoing Contractor will make Payment	
Last date Outgoing Contractor will have Telephone/ Customer Service	
Last date Outgoing Contractor will send file to Bank	
Date MAC will Accept Electronic Claims	
Date MAC will Accept Paper Claims	
Date Bill/Claim Cycle Begins	
First Anticipated MAC Payment Date	
Date MAC Begins Customer Service	

MLN Matters Number: SE0837 *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

2009 reminder for centralized billing for flu and pneumococcal vaccination claims

Centralized billing is a process in which a provider, who provides mass immunization services for influenza virus and pneumococcal pneumonia virus (PPV) immunizations, can send all claims to a single contractor for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the influenza virus and pneumococcal vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare physician fee schedule for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals.

Individuals and entities interested in centralized billing must contact CMS central office, in writing, at the following address by June 1 of the year they wish to begin centrally billing.

Center for Medicare & Medicaid Services
Division of Practitioner Claims Processing
Provider Billing and Education Group
7500 Security Boulevard Mail Stop C4-10-07
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

Criteria for centralized billing

- To qualify for centralized billing, an individual or entity providing mass immunization services for influenza virus and pneumococcal vaccinations must provide these services in at least three payment localities for which there are at least three different contractors processing claims.
- Individuals and entities providing the vaccine and administration must be properly licensed in the state in which the immunizations are given.
- Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the influenza virus and pneumococcal benefit, accepting assignment means that Medicare beneficiaries cannot be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza virus vaccination and give the beneficiary a coupon for $10 to be used in the drugstore.

Note: The practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per section 1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment.

- The contractor assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The assigned contractor for this year is TrailBlazer Health Enterprises, LLC.

2009 reminder for centralized billing for flu and pneumococcal vaccination claims (continued)

- The payment rates for the administration of the vaccinations are based on the Medicare physician fee schedule (MPFS) for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, payments received may vary based on the geographic locality where the service was performed. Payment is made at the assigned rate.
- The payment rates for the vaccines are determined by the standard method used by Medicare for reimbursement of drugs and biologicals. Payment is made at the assigned rate.
- Centralized billers must submit their claims on roster bills in an approved electronic media claims standard format. Paper claims will not be accepted.
- Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer Health Enterprises, LLC must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the contractor will not be able to process incomplete or incorrect claims.
- Centralized billers must obtain an address for each beneficiary so that a Medicare summary notice (MSN) can be sent to the beneficiary by the contractor. Beneficiaries are sometimes confused when they receive an MSN from a contractor other than the contractor that normally processes their claims which results in unnecessary beneficiary inquiries to the Medicare contractor. Therefore, centralized billers must provide every beneficiary receiving an influenza virus or pneumococcal vaccination with the name of the processing contractor. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
- Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer Health Enterprises, LLC can provide this information.
- Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer Health Enterprises, LLC. This can be done by completing the Form CMS-855 (Provider Enrollment Application), which can be obtained from TrailBlazer Health Enterprises, LLC.
- If an individual or entity's request for centralized billing is approved, the approval is limited to the 12-month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. Claims will not be processed for any centralized biller without permission from CMS.
- Each year the centralized biller must contact TrailBlazer Health Enterprises, LLC to verify understanding of the coverage policy for the administration of the pneumococcal vaccine, and for a copy of the warning language that is required on the roster bill.
- The centralized biller is responsible for providing the beneficiary with a record of the pneumococcal vaccination.

The information in items 1 through 8 below must be included with the individual or entity's annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations
2. Estimates for the number of beneficiaries who will receive pneumococcal vaccinations
3. The approximate dates for when the vaccinations will be given
4. A list of the states in which influenza virus and pneumococcal clinics will be held
5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse)
6. Whether the nurses who will administer the influenza virus and pneumococcal vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering influenza virus and pneumococcal vaccinations
7. Names and addresses of all entities operating under the corporation's application
8. Contact information for designated contact person for centralized billing program.

CMS Publication 100-04, Chapter 18, Section 10.3.1.1

Centers for Disease Control and Prevention updates and health advisory

The Centers for Medicare & Medicaid Services has released the following information from the Centers for Disease Control and Prevention (CDC):

- Updates to the CDC information and guidance from March 9 - 16, 2009: *http://emergency.cdc.gov/coca/updates/2009/2009mar16.asp*.
- Health advisory related to invasive haemophilus influenzae type B disease in young children and the importance of receiving the primary series of the Hib vaccine: *http://www2a.cdc.gov/HAN/ArchiveSys/ViewMsgV.asp?AlertNum=00281*.

Source: PERL 200903-27

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

Advance beneficiary notice

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

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

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

Revisions to LCDs

A9600: Metastron c strontium-89 chloride -- revision to the LCD

LCD ID number: L29226 (Florida)
LCD ID number: L29364 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for metastron c strontium-89 chloride was effective for February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised to add the following statement to the "ICD-9 Codes that Support Medical Necessity" section of the LCD:

ICD-9-CM code 198.5 -- Secondary malignant neoplasm of bone and bone marrow -- only applies to HCPCS code A9600

Effective date

This LCD revision is effective for claims processed on or after March 19, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

J2505: Pegfilgrastim (Neulasta®) -- revision to the LCD

LCD ID number: L29254 (Florida)
LCD ID number: L29463 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim (Neulasta®) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCDs have been revised. First Coast Service Options Inc. (FCSO) published an article on December 2, 2008, outlining the correct administration of Neulasta® per instructions found in the LCD and Food and Drug Administration-approved labeling. FCSO encountered claims data that demonstrated providers were administering this drug outside of the established parameters. Neulasta® should not be administered 14 days before and 24 hours after the administration of cytotoxic chemotherapy.

It was brought to FCSOs attention that patients receiving dose dense chemotherapy schedules should be allowed an exception to the 14-day and 24-hour after rule since these patients would need to receive the Neulasta®, typically on the second day of the chemotherapy cycle. FCSO has reviewed the evidence submitted to support this exception and has revised the LCDs to include language allowing for this off-label administration only if the physician can document that the patient is on a dose dense chemotherapy cycle. For those patients that are not on a dose dense chemotherapy cycle, this off-label administration would not be acceptable.

Effective date

This revision is effective for services rendered on or after March 10, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

J3487: Zoledronic acid -- revision to the LCD

LCD ID number: L29312 (Florida)
LCD ID number: L29411 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for zoledronic acid was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised. On December 19, 2008, the Food and Drug Administration-approved a new indication for Zoledronic acid (Reclast®) (J3488). Reclast is now indicated for the treatment to increase bone mass in men with osteoporosis. First Coast Service Options, Inc. (FCSO) has revised the LCD for zoledronic acid to allow for this new indication for Reclast®. Language has been added to the "Indications and Limitations of Coverage and/or Medical Necessity" and "Utilization Guidelines" sections of the LCD outlining coverage criteria. In addition, the coding guidelines attachment has been revised to include this new indication.

Effective date

The revisions are effective for claims processed on or after March 10, 2009, for services rendered on or after December 19, 2008. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section..." drop-down menu at the top of the LCD page.

J9045: Carboplatin (Paraplatin®, Paraplatin-AQ®) -- revision to the LCD

LCD ID number L29089 (Florida)
LCD ID number L29104 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin®, Paraplatin-AQ®) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made based on a request for a reconsideration to add an additional indication and ICD-9-CM code to the LCD.
After review of the submitted literature and other documentation, a revision was made to add the following indication and ICD-9-CM code range to the LCD:

- Non-melanoma skin cancers (Merkel cell carcinoma)
- 173.0 - 173.9 -- Other malignant neoplasm of skin

In addition, references under the "Sources of Information and Basis for Decision" section of the LCD were updated.

Effective date

This revision to the LCD is effective for services rendered on or after March 24, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

J9263: Oxaliplatin (Eloxatin®) -- revision to the LCD

LCD ID number L29248 (Florida)
LCD ID number L29459 (Puerto Rico/U. S. Virgin Islands)

The local coverage determination (LCD) for oxaliplatin (Eloxatin®) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, a revision was made based on a request for a reconsideration to add an additional indication and ICD-9-CM code range to the LCD.

After review of the submitted literature and other documentation, a revision was made to add the following off-label indication and ICD-9-CM code range to the LCD:

In combination with other Food and Drug Administration (FDA) approved or Centers for Medicare & Medicaid Services (CMS) approved compendia supported chemotherapy regimens for the treatment of esophageal cancer.
150.0 - 150.9 - Malignant neoplasm of esophagus

In addition, verbiage was updated under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, and references were updated under the "Sources of Information and Basis for Decision" section of the LCD.

Effective date

This revision to the LCD is effective for services rendered on or after March 16, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the list of Medicare noncovered services was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised to delete *CPT* codes *0176T* and *0177T* from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions, Procedures" section of the LCD.

Effective date

This LCD revision is effective for services rendered on or after March 2, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

20550: Injection of tendon sheath, ligament or trigger points -- revision to the LCD

LCD ID number: L29199 (Florida)
LCD ID number: L29351 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for injection of tendon sheath, ligament or trigger points was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised to remove *CPT* codes *20550* (*Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* and *20551* (*Injection(s); single tendon origin/insertion*). The language pertaining to these *CPT* codes was removed from the "Indications and Limitations of Coverage and/or Medical Necessity", "ICD-9 Codes that Support Medical Necessity", and "Documentation Requirements" sections of the LCD.

The remaining *CPT* codes *20552* (*Injection(s); single or multiple trigger point(s), 1 or 2 muscle[s]*) and *20553 (Injection(s); single or multiple trigger point(s), 3 or more muscle[s]*) in the LCD address trigger point injections, therefore, the LCD number and title were changed to 20552 - Injection of Trigger Points.

Effective date

This LCD revision is effective for services rendered on or after March 17, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

66982: Cataract extraction -- revision to the LCD

LCD ID number: L29095 (Florida)
LCD ID number: L29110 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cataract extraction was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands, as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity", "Documentation Requirements" and "Sources of Information and Basis for Decision" sections of the LCD have been revised and updated:

Effective date

This LCD revision is effective for services rendered on or after March 31, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

77078: Bone mineral density studies -- revision to the LCD

LCD ID number: L29086 (Florida)
LCD ID number: L29101 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Frequency Standards" and "Utilization Guidelines" sections of the LCD have been revised to add zoledronic acid (Reclast) injection to the list of agents approved by the U.S. Food and Drug Administration for osteoporosis prevention and/or treatment.

Effective date

This LCD revision is effective for services rendered on or after March 19, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Sign up to our *eNews* electronic mailing list

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

Additional Information

Addition to the self-administered injectable drug (SAD) list

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare incident to a physician's service. Providers may read the instructions in their entirety in the *Medicare Benefit Policy Manual*, Pub 100-02, Chapter 15, Section 50.2.

Relistor® (methylnatrexone bromide) C9399/J3490 has been added to the list of excluded self-administered injectable drugs incident to a physician's service (SAD list).

Effective date

This change is effective for services rendered on or after April 20, 2009. To view the SAD list in its entirety please visit the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Intravitreal bevacizumab (Avastin®) for neovascular age-related macular degeneration -- coding and billing update

Neovascular age-related macular degeneration (AMD), when untreated or refractory to usual therapies, almost always leads to permanent blindness. Neovascular (wet) AMD is characterized by choroidal neovascularization (CNV) beneath the retina. The neovascular tissue often leaks blood and fluid, and when untreated, eventually progresses to scarring with destruction of the macula and loss of vision. As such, additional therapeutic interventions have been pursued in order to try and salvage the vision of AMD patients who have failed to respond to the usual therapies.

One of these options is the use of bevacizumab (Avastin®), a recombinant humanized monoclonal IgG1 antibody that binds to and inhibits the biologic activity of vascular endothelial growth factor (VEGF, also known as vascular permeability factor [VPF] or VEGF-A) with receptors on the surface of endothelial cells, thereby preventing cell proliferation and new blood vessel formation (i.e., angiogenesis).

Bevacizumab (Avastin®; Genentech) is approved by the Food and Drug Administration (FDA) for treatment of select cancers as a systemic drug. However, based on published reports and widespread clinical use, there is compelling evidence of bevacizumab's safety and efficacy for CNV in AMD. Ophthalmologists have been using intravitreal bevacizumab increasingly in the treatment of wet AMD.

First Coast Service Options Inc. (FCSO) will consider bevacizumab (Avastin®) given by intravitreal injection medically reasonable and necessary for patients diagnosed with neovascular (wet) AMD.

HCPCS code J9035 (Injection, bevacizumab, 10 mg) does not apply to the intravitreal administration, as a pharmacist has processed the agent. Providers billing for intravitreal bevacizumab should use *CPT* code *67028* for the intravitreal injection and HCPCS code J3490 (unclassified drugs) for the bevacizumab.

For Medicare Part A providers, "Intravitreal bevacizumab and the dosage" should be entered in item FL 80 of CMS Form UB-04 or its electronic equivalent. The administration of the intravitreal injection of bevacizumab (Avastin®) must be billed on the same claim as the drug.

For Medicare Part B providers, "Intravitreal bevacizumab and the dosage" should be entered in item 19 of the CMS-1500 or its electronic equivalent. The administration of the intravitreal injection of bevacizumab (Avastin®) must be billed on the same claim as the drug.

When performing an injection on both eyes, modifier 50 should be used and modifier RT or LT should be used for unilateral services.

Medical record documentation maintained by the performing ophthalmologist must include the following:

- The diagnosis of wet AMD (ICD-9-CM code 362.52) with leakage/fluid in the macula has been confirmed by optical coherence tomography (OCT) or fluorescein angiography.
- Actual dose administered in milligrams.
- Indication that the patient has been provided appropriate informed consent regarding the benefits and risks of this therapy and off-label use of this drug.

Providers should not submit this information with the claim. FCSO may request it separately with an additional documentation request (ADR) letter.

- The applicable ICD-9-CM code is 362.52 (exudative senile macular degeneration of retina).

Anytime there is a question whether Medicare's medical reasonableness and necessity criteria would be met; we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS/*CPT* codes. If and when a denial should be received, providers may collect from the beneficiary based on the fee schedule. The GA modifier should be billed with *67028* and J3490. For further details about CMS' beneficiary notice initiative (BNI), please point your browser to this link: *http://www.cms.hhs.gov/BNI/*.

0176T and 0177T: Transluminal dilation of aqueous outflow canal

0176T Transluminal dilation of aqueous outflow canal; without retention of device or stent
0177T with retention of device or stent

Transluminal dilation of the aqueous outflow canal or transluminal canaloplasty is a form of non-penetrating glaucoma surgery that serves as an alternative to trabeculectomy in patients requiring surgical treatment of primary open-angle glaucoma (POAG). Patients requiring surgery for POAG are those in whom medical management is no longer providing adequate results. Transluminal canaloplasty has been shown to lower the intra-ocular pressure and may be associated with fewer short- and long-term complications than trabeculectomy. The procedure involves placement of a catheter into Schlemm's canal and dilation of the canal by injection of sodium hyaluronate. The device or stent may or may not be retained in Schlemm's canal. The ICD-9-CM diagnosis code supporting the medical necessity of the procedure is 365.11 (primary open angle glaucoma), effective for services rendered on or after March 2, 2009.

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
April - May 2009

Note: Unless otherwise indicated, all FCSO educational offerings are considered to be "ask-the-contractor" events, available to all locations, and designated times are stated as ET.

Cardiology webcast
When: April 14, 2009
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Teleconference

E/M Series: "Incident to" services webcast
When: April 21, 2009
Time: 11:30 p.m. – 1:00 p.m.
Type of Event: Teleconference

Hot Topics Series: 2009 Part B updates and changes
When: May 12, 2009
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Teleconference

Two easy ways To register

Note: Unless otherwise indicated, all FCSO educational offerings are considered to be "ask-the-contractor" events, and designated times are stated as ET.

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
- Select your location (Florida, Puerto Rico, or the U.S. Virgin Islands)

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

Mail directory

Claims, additional development, general correspondence

First Coast Service Options Inc.
P. O. Box 45098
Jacksonville, FL 32232-5098

Part B flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

Electronic data interchange (EDI)

First Coast Service Options Inc.
P. O. Box 44071
Jacksonville, FL 32231-4071

Part B debt recovery, MSP inquiries and overpayments, and cash management

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider Enrollment

Where to mail Part B provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

First Coast Service Options Inc.
P. O. Box 45091
Jacksonville, FL 32232-5091

Freedom of Information Act Requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphyt
P. O. Box 2078
Jacksonville, FL 32231-0048

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

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

Local coverage determinations

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

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

Overnight mail and/or other special courier services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

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

Phone numbers

Provider 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 customer service

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

Order form for Medicare 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 Account # (use appropriate account number). Do not fax your order; it must be mailed.

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	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Non-provider 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		
		CD-ROM $55		
2009 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2009, through December 31 is available free of charge online at http://medicare.fcso.com/Data_files/ (English) or http://medicareespanol.fcso.com/Fichero_de_datos/ (Español). Additional copies or a CD-ROM are 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:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy $12		
		CD-ROM $6		
Language preference: **English** [ ] **Español** [ ]				
	Please write legibly		Subtotal	**$**
			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: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦