MEDICARE B Update!

A NEWSLETTER FOR MAC J9 PROVIDERS

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FIRST COAST SERVICE OPTIONS INC.

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

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office manager
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- ❑ Nursing Staff
- ❑ Other _____

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

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

Drugs and Biologicals

April 2009 Medicare Part B drug and biological average sales price files

The Centers for Medicare & Medicaid Services (CMS) has made available the Medicare Part B drug and biological average sales price (ASP) payment amounts for April 1, 2009, to June 30, 2009, on the CMS Web site at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2009aspfiles.asp*. The files are located in the *Downloads* section of this Web page. Revised pricing files for January 2009, October 2008, July 2008 and April 2008 are also available for download. The 2008 revised pricing files are posted at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2008aspfiles.asp*.

Source: PERL 200903-37

Durable Medical Equipment

CMS statement on the DMEPOS competitive bidding program

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the competitive bidding program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), including a requirement that the Secretary of Health & Human Services conduct a second competition to select suppliers for round one in 2009. The Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period (IFC) on January 16, 2009. The rule incorporates into existing regulations specific statutory requirements contained in MIPPA related to the competitive bidding program.

The Administration delayed the effective date for the IFC to allow CMS officials the opportunity for further review of the issues of law and policy raised by the rule. Based upon its review and on the need to ensure that CMS is able to meet the statutory deadlines contained in MIPPA, the Administration has concluded that the effective date should not be further delayed. The rule became effective April 18, 2009. However, there will be no immediate effect on the Medicare DMEPOS benefit, and Medicare beneficiaries may continue to use their current DMEPOS suppliers at this time.

During the comment period, CMS received many suggestions from a range of stakeholders, to make further improvements to the competitive bidding program, such as ensuring that CMS's processes for collecting and evaluating bids are fair and transparent. In the upcoming weeks, CMS will be issuing further guidance on the timeline for and bidding requirements related to the round one re-bid. In finalizing these guidelines, CMS will continue to seek input from all affected stakeholders to ensure program implementation consistent with the legislative requirements.

Source: PERL 200904-26

Radiology

Medicare expands coverage of PET scans as cancer diagnostic tool

The Centers for Medicare & Medicaid Services' (CMS) coverage with evidence development (CED) project shows positron emission tomography (PET) scans as "reasonable and necessary" for initial treatment decisions of most solid tumor cancers.

CMS issued a final national coverage determination (NCD) to expand coverage for initial testing with PET scans for Medicare beneficiaries who are diagnosed with and treated for most solid tumor cancers.

This NCD removes a clinical study requirement for PET scan use in these patients.

Since 2005, Medicare coverage of PET scans for diagnosing some forms of cancer and guiding treatment has been tied to a requirement that providers collect clinical information about how the scans have affected doctors' treatment decisions. This information was gathered through the national oncologic PET registry (NOPR) observational study. Today's decision removes the requirement to report data to the NOPR when the PET scan is used to support initial treatment (or diagnosis and "staging") of most solid tumor cancers.

Medicare collects data from the NOPR under CMS' CED program. CED allows Medicare to develop evidence about how a medical technology is used in clinical practice so that Medicare can do the following:

- Clarify the impact of these items and services on the health of Medicare beneficiaries
- Consider future changes in coverage for the technology

Medicare expands coverage of PET scans as cancer diagnostic tool (continued)

- Generate clinical information that will improve the evidence base upon which providers base their recommendations to Medicare beneficiaries regarding the technology.

This decision is based, in part, on the information generated as a result of CMS' 2005 decision to require NOPR reporting for many cancer PET scans. As a result of this evidence from NOPR, CMS reconsidered its 2005 coverage policy.

This decision is the first time that CMS has reconsidered a coverage policy based on new evidence developed under the CED program.

"This expansion in coverage for PET scans shows that the coverage with evidence development program is a success," said CMS Acting Administrator Charlene Frizzera. CED allowed us to cover an emerging technology, learn more about its usage in clinical practice, and adjust our coverage policies accordingly. Thanks to CED, Medicare beneficiaries have greater access to cutting edge medical technologies and treatments."

This decision applies to PET scans used to support initial diagnosis and treatment for most types of solid tumor cancers. It also expands coverage of PET scans for subsequent follow up testing in beneficiaries who have cervical or ovarian cancer, or who are being treated for myeloma, a cancer that affects white blood cells. For these cancers, NOPR data collection will no longer be required.

It is important to note that today's decision still requires clinicians to report data to the NOPR when using PET scans to monitor the progress of treatment or remission of cancer in some cases. Although the evidence generated by the NOPR study helped CMS determine that PET scans are useful in helping guide treatment when cancer is first diagnosed, scientific evidence is not as strong in showing that PET scans are as useful in making subsequent treatment decisions for some types of cancer.

A minimally invasive diagnostic imaging procedure, PET uses a radioactive tracer to evaluate glucose metabolism in tumors and in normal tissue. The test may provide important clinical information to guide the initial treatment approach (e.g., diagnosis and "staging") for many cancers.

This additional information may help physicians to distinguish benign from cancerous lesions and better determine the extent of a tumor's growth or metastasis. PET scans have also been used in subsequent testing for cancer patients, e.g., to monitor cancer progression or remission after cancer treatment has begun.

More information about the types of cancer covered by this new policy is available in CMS' final decision memorandum. Read the final decision on the CMS Web site at *http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=218*.

Source: PERL 200904-12

Surgery

Surgery for diabetes national coverage determination

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

Provider Types Affected

All hospitals and physicians who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (MACs) for bariatric surgery procedures.

Provider Action Needed

Providers are advised that the Centers for Medicare & Medicaid Services (CMS) has developed the following national coverage determination (NCD) entitled Surgery for Diabetes:

- Effective for services performed on and after February 12, 2009, CMS determines that open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS) in Medicare beneficiaries who have type 2 diabetes mellitus (T2DM) and a body mass index (BMI) <35 are not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act, and therefore are not covered by Medicare.
- Effective for services performed on and after February 12, 2009, CMS determines that open and laparoscopic RYGBP, open and laparoscopic BPD/DS, and LAGB are covered for Medicare beneficiaries who have T2DM and a BMI ≥ 35. Additionally, CMS determines that T2DM is a comorbidity related to obesity as defined in Publication 100-03, *NCD Manual*, Section 100.1. In addition, the procedure must be performed at an approved facility. A list of approved facilities may be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp#TopOfPage*.

Ensure that your billing staffs are informed of these changes for preparing claims for covered or noncovered bariatric surgery.

Background

CMS has a specific NCD at Section 100.1 (attached to CR 6419), Bariatric Surgery for Treatment of Morbid Obesity, effective February 21. 2006. That NCD covers open and laparoscopic RYGBP, open and laparoscopic BPD/DS, and LAGB for persons with a BMI ≥35 having one or more comorbidities associated with obesity, and have been previously unsuccessful with medical treatments for obesity. The only change to this NCD is the clarification that effective February 12, 2009, T2DM is considered a comorbidity for purposes of bariatric surgery for the treatment of morbid obesity.

Surgery for diabetes national coverage eetermination (continued)

Note: This NCD does not change related NCDs in the *NCD Manual* at Sections 40.5 (Obesity), 100.8 (Intestinal Bypass Surgery), or 100.11 (Gastric Balloon for Treatment of Obesity). In addition, treatments for obesity alone remain noncovered, as does use of the open or laparoscopic sleeve gastrectomy, open adjustable gastric banding, and open and laparoscopic vertical banded gastroplasty procedures, regardless of the patient's BMI or comorbidity status.

The covered ICD-9-CM procedure and HCPCS procedure codes are listed in Attachment 1 of the transmittal of CR 6419 containing the *Medicare Claims Processing Manual* revisions. The ICD-9-CM diagnosis codes reflecting the requisite BMI indexes are also part of that attachment. The ICD-9-CM diagnosis codes indicating T2DM are listed in Attachment 2 of that same transmittal.

The remittance advice for claims for bariatric surgery that are denied or rejected by Medicare because the patient's BMI was <35 will contain a claim adjustment reason code of 167 (This (these) diagnosis(es) is (are) not covered.), a remittance advice remark code of N372 (Only reasonable and necessary maintenance/service charges are covered.), and a group code of OA (Other adjustments).

Additional Information

The official instruction, CR 6419, issued to your carrier, FI, or MAC via two transmittals. The first modifies the *Medicare Claims Processing Manual* and it is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1728CP.pdf*.

The second transmittal modifies the NCD Manual and it is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R100NCD.pdf*.

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

MLN Matters® Number: MM6419
Related Change Request (CR) #: 6419
Related CR Release Date: May 4, 2009
Effective Date: February 12, 2009
Related CR Transmittal #: R100 NCD and R1728CP
Implementation Date: May 18 2009

General Coverage

Billing routine costs of clinical trials

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

Provider types affected

Physicians and nonphysician practitioners submitting claims to Medicare administrative contractors (MACs) and carriers for clinical trials.

Provider action needed

This article is based on change request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.

Background

CR 6431 revises the Medicare Claims Processing Manual, Chapter 32, Section 69.6 (Requirements for Billing Routine Costs of Clinical Trails). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the modifier QV or Q1 is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor will not consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed 90 days after issuance of CR 6431 with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1 will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.

Billing routine costs of clinical trials (continued)

- Providers will see the following messages from their Medicare contractor with the returned claim:
  - Claims adjustment reason code 16 -- Claim/service lacks information which is needed for adjudication, and
  - As least one remark code, which may be comprised of either:
    - The remittance advice code (M76, Missing/incomplete/invalid diagnosis or condition) or
    - National council for prescription drug programs reject reason code.

Note: Healthcare Common Procedure Coding System (HCPCS) codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30
- Report a secondary diagnosis code of V70.7, and
- Identify all lines that contain an investigational item/service with a HCPCS modifier of:
  - QA/QR for dates of service before January 1, 2008, or
  - Q0 for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
  - QV for dates of service before January 1, 2008, or
  - Q1 for dates of service on or after January 1, 2008.

Additional information

If you have questions, please contact your MAC and/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 6431) issued to your MAC, or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1721CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6431	Related Change Request (CR) #: 6431
Related CR Release Date: April 29, 2009	Effective Date: For claims with dates of service on or after January 1, 2008
Related CR Transmittal #: R1721CP	Implementation Date: July 10, 2009

Medicare Claims Processing Manual clarifications for skilled nursing facility and therapy billing

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

Provider types affected

Skilled nursing facilities and other providers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or 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) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for skilled nursing facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

Background

CR 6407 provides clarifications and updates to the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS Coding Requirements). These clarifications indicate that effective January 1, 2009, the new *Current Procedural Terminology* (*CPT*) code *95992* (*Canalith repositioning procedure(s) (eg Epley maneuver, Semont maneuver), per day*) is bundled under the Medicare physician fee schedule (MPFS).

Regardless of whether *CPT* code *95992* is billed alone or in conjunction with another therapy code, separate Medicare payment is never made for this code. If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 ("Payment is included in the allowance for another service/procedure."). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

Medicare Claims Processing Manual clarifications for skilled nursing facility and therapy billing (continued)

In addition, CR 6407 provides clarifications and updates to the *Medicare Claims Processing Manual* (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that both full and partial benefits exhaust claims must be submitted by SNFs monthly. For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim; and
2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

Note: Part B 22x (SNF inpatient part B) bill types must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a noncovered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (SNF inpatient part B) bill type.

Note: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 (SNF no-payment bill type).

Additional information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1706CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you have any questions, please contact your 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: MM6407
Related Change Request (CR) #: 6407
Related CR Release Date: March 27, 2009
Effective Date: October 1, 2006
Related CR Transmittal #: R1706CP
Implementation Date: April 27, 2009

Clarification on provider information required on Medicare claims for routine foot care services

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

Provider Types Affected

This article is for informational purposes only for providers billing Medicare contractors (carriers or Part A/B Medicare administrative contractors (MACs)) for routine foot care services. It is an overview of existing policy and no change in policy is being conveyed

Note: This article was rescinded on April 22, 2009. Some of the information needs to be changed to provide better clarity on these services.

MLN Matters Number: SE0907
Related Change Request (CR) #: SE0907
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Electronic Data Interchange

Instructions for utilizing 837 professional claim adjustment segments for Medicare secondary payer Part B claims

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

Provider types affected

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

Note: This article was rescinded on March 27, 2009, when the related change request (CR) 6211 was rescinded. CR 6211 was replaced by CR 6427, which may be found at *http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf* on the CMS Web site. The related *MLN Matters* article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6427.pdf* on the CMS Web site. This information was previously published in the December 2008 *Medicare B Update!* page 15.

MLN Matters Number: MM6211 *Revised*
Related Change Request (CR) #: 6211
Related CR Release Date: December 12, 2008
Effective Date: April 1, 2009
Related CR Transmittal #: R62MSP
Implementation Date: April 6, 2009

Instructions for utilizing 837 professional claim adjustment segments for Medicare secondary payer Part B claims

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

Provider types affected

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

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6427 (rescinds and fully replaces CR 6211), which informs Medicare contractors about the changes necessary to derive Medicare secondary payer (MSP) payment calculations from incoming 837 4010-A1 claim transactions.

Caution -- what you need to know

CR 6427 is limited to providers billing Part B contractors (carriers and MACs) and DME MACs.

Go -- what you need to do

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

Background

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

This article is to remind you to include CAS related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these

Instructions for utilizing 837 professional claim adjustment segments for MSP Part B claims (continued)

adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6427 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements
- Physician and suppliers code for the CAS claims to reflect any adjustments made by primary payers, and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.

Adjustments made by the payer are reported in the CAS on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code contractual obligation (CO) to identify your contractual adjustment amount, also known as the obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the *CMS Internet Only Manuals* 100-05 and in the federal regulations at 42 CFR 411.32 and 411.33. Physician and suppliers should no longer identify the OTAF in the CN1 segment of the 837.

Additional information

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

The official instruction (CR 6427) issued to your Medicare contractor is available at *http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf* on the CMS Web site.

MLN Matters Number: MM6427
Related Change Request (CR) #: 6427
Related CR Release Date: March 27, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R67MSP
Implementation Date: July 6, 2009

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FRAUD AND ABUSE

An open letter from the Office of the Inspector General

This open letter refines the Office of the Inspector General (OIG)'s self-disclosure protocol (SDP) to build upon the initiative announced in my April 24, 2006, open letter. The 2006 open letter promoted the use of the SDP to resolve matters giving rise to civil monetary penalty (CMP) liability under both the anti-kickback statute and the physician self-referral ("Stark") law. As part of our ongoing efforts to evaluate and prioritize our work, these refinements aim to focus our resources on kickbacks intended to induce or reward a physician's referrals. Kickbacks pose a serious risk to the integrity of the health care system, and deterring kickbacks remains a high priority for OIG.

To more effectively fulfill our mission and allocate our resources, we are narrowing the SDP's scope regarding the physician self-referral law. OIG will no longer accept disclosure of a matter that involves only liability under the physician self-referral law in the absence of a colorable anti-kickback statute violation. We will continue to accept providers into the SDP when the disclosed conduct involves colorable violations of the anti-kickback statute, whether or not it also involves colorable violations of the physician self-referral law. Although we are narrowing the scope of the SDP for resources purposes, we urge providers not to draw any inferences about the government's approach to enforcement of the physician self-referral law.

To better allocate provider and OIG resources in addressing kickback issues through the SDP, we are also establishing a minimum settlement amount. For kickback-related submissions accepted into the SDP following the date of this letter, we will require a minimum $50,000 settlement amount to resolve the matter. This minimum settlement amount is consistent with OIG's statutory authority to impose a penalty of up to $50,000 for each kickback and an assessment of up to three times the total remuneration. See 42 U.S.C. Section 1320a-7a(a)(7). We will continue to analyze the facts and circumstances of each disclosure to determine the appropriate settlement amount consistent with our practice, stated in the 2006 open letter, of generally resolving the matter near the lower end of the damages continuum, i.e., a multiplier of the value of the financial benefit conferred.

These refinements to the OIG's SDP are part of our ongoing efforts to develop the SDP as an efficient and fair mechanism for providers to work with OIG collaboratively. Further information about our SDP may be found at *http://oig.hhs.gov/fraud/selfdisclosure.asp*.

I look forward to continuing our joint efforts to promote compliance and protect the federal health care programs and their beneficiaries.

Sincerely,

Daniel R. Levinson Inspector General

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General Information

MLN tools to assist with conversion of the international classification of diseases codes

The General Equivalence Mappings -- ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet (March 2009) that provides information and resources regarding the general equivalence mappings that were developed as a tool to assist with the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition (ICD-10) and the conversion of ICD-10 codes back to ICD-9-CM, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* (*MLN*) at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10_GEM_factsheet.pdf*.

The general equivalence mappings information discussed in this fact sheet has also been posted in the CMS frequently asked questions database at *https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=l2s5Zouj*. If you are unable to access any of the hyperlinks in this message, please copy and paste the URL into your Internet browser.

Source: PERL 200904-08

ICD-10-CM/PCS national provider conference call

Providers may now register for the Centers for Medicare & Medicaid Services' ICD-10-CM/PCS implementation and general equivalence mappings (crosswalks) national provider conference call that will be conducted on May 19, 2009, from 1:00 p.m.-2:30 p.m. ET. This conference call will include a discussion of the following topics:

- An overview of the ICD-10 final rule, which requires the implementation of ICD-10-CM/PCS on October 1, 2013
- The differences between ICD-9-CM and ICD-10-CM/PCS codes
- The use of the general equivalence mappings that have been created to assist in converting policies, edits, and trend data from ICD-9-CM to ICD-10-CM/PCS, and
- Available resources to assist in planning with transitioning from ICD-9-CM to ICD-10-CM/PCS.

Conference call discussion materials and registration information may be accessed at *http://www.cms.hhs.gov/ICD10/07a_2009_CMS_Sponsored_Calls.asp*.

Source: PERL 200904-17 & PERL 200904-21

ICD-10-CM/PCS conference call transcripts

The audio transcripts of the following ICD-10-CM/PCS conference calls (sponsored by the Centers for Medicare & Medicaid Services in 2008) are now available and may be accessed in the *Downloads* section of the 2008 CMS Sponsored Calls Web page, located at *http://www.cms.hhs.gov/ICD10/07_Sponsored_Calls.asp*.

- Hospital staff (October 14)
- Other Part A and Part B providers (November 12)
- Physicians (November 17)

Source: PERL 200903-36

Healthcare common procedure coding system update

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the healthcare common procedure coding system (HCPCS) code set. These changes have been posted to the HCPCS Web page at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp*. Changes are effective on the date indicated on the update.

Source: PERL 200904-06

CMS proposes Medicare hospice fiscal year 2010 wage index 2008

Proposal includes physician narrative for certification of illness

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule to update the Medicare hospice wage index for fiscal year (FY) 2010.

Payments to Medicare participating hospices are estimated to decrease by approximately 1.1 percent in FY 2010. The decrease in the hospice payments is the net result of a 3.2 percent reduction in payments due to the phase-out of a temporary adjustment used in calculating the wage index, partially offset by an estimated 2.1 percent increase in the hospital market basket indicator of costs.

The elimination of this adjustment with a two-year phase-out would result in more accurate payments and saves Medicare $2.9 billion over five years. The phase-out would include a 75 percent reduction for FY 2010 and ultimately eliminate it in FY 2011. As such, hospice expenditures are estimated to be about $13 billion in 2010 for more than 3,000 for-profit and not-for-profit hospices across the country.

The Medicare Payment Advisory Commission (MedPAC) reports that through 2015, hospice expenditures are projected to grow at a rate that outpaces those projected for hospitals, skilled nursing facilities, physician services or home health care.

In the Medicare hospice-wage index FY 2009 final rule, CMS laid out a plan to phase-out the budget neutrality adjustment factor (BNAF) over a three year period, with the first BNAF reduction of 25 percent in the fiscal year 2009 wage index. With the passage of the American Recovery and Reinvestment Act, Congress suspended the BNAF reduction set for 2009. However, the legislation did not affect FYs 2010 and 2011. CMS plans to reduce the BNAF by 75 percent in FY 2010 and ultimately eliminate it in FY 2011.

The BNAF was implemented in 1997 as part of an effort to change from an outdated wage index to a more current and accurate method for determining hospice payments. In order to minimize disruption to services this special adjustment was applied.

This proposed regulation would bring the Medicare hospice wage index more in line with that used for home health agencies, while maintaining the fiscal integrity of Medicare and allowing continued access to services for its beneficiaries. Both hospices and home health agencies are home-based benefits, which compete in the same labor markets.

The rule also proposes to adopt a MedPAC recommendation that would increase accountability in the physician hospice certification and recertification process. MedPAC found an increasing proportion of hospice patients with stays exceeding 180 days and significant variation in hospice length of stay. Therefore, CMS is proposing that hospice physicians who certify or recertify a beneficiary as terminally ill write a short narrative on the certification form. The narrative would briefly describe the clinical evidence supporting a life expectancy of six months or less.

Background

The Medicare hospice benefit is intended to assist terminally ill patients, with a prognosis of six months or less if the disease runs its normal course, to remain in their homes. The focus of care shifts from curative to palliative care for relief of pain and symptom management. The law requires that hospice physicians certify that the patient is terminally ill, with a life expectancy of six months or less, and periodically recertify that the patient continues to be terminally ill.

Payment is made to a hospice for each day that an individual elects the benefit. Payment rates are adjusted to reflect local differences in area wage levels using a hospice-specific wage index, which is based on hospital wage data. Overall aggregate payments to a hospice are subject to a statutorily prescribed aggregate cap amount.

The number of Medicare-certified hospices has increased significantly since 1997, up by over 70 percent. The number of Medicare beneficiaries in hospice care has also grown rapidly from just over 400,000 in 1998 to close to one million in 2007.

Proposed Rule Details

This proposed rule also solicits comments on a number of potential policy changes for the future. In order to increase accountability in the recertification process, the rule seeks comment on requiring a physician or nurse practitioner to visit every hospice patient after 180 days on the benefit, and every benefit period thereafter.

This proposed rule also solicits comments on broader payment reform, such as alternate methods to calculate the hospice aggregate cap.

This proposed rule will be published at the *Federal Register* on April 24, 2009. Comments are due 60 days after publication by June 22, 2009. A link to the proposed rule is available at *http://www.federalregister.gov/OFRUpload/OFRData/2009-09417_PI.pdf*.

Source: CMS PERL 200904-25

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

It's fast, secure, and easy to use

Now there is a better way for provider and supplier organizations to enroll in Medicare or make a change to their Medicare enrollment information. The Centers for Medicare & Medicaid Services (CMS) announces the availability of Internet-based provider enrollment, chain and ownership system (PECOS) to provider and supplier organizations. They may use Internet-based PECOS to enroll in Medicare, make a change in their Medicare enrollment information, view their existing Medicare enrollment information, voluntarily withdraw from the Medicare program, or check on the status of an Internet-submitted Medicare enrollment application.

Internet-based PECOS is already available to physicians and nonphysician practitioners in all 50 states and the District of Columbia. CMS expects to make Internet-based PECOS available to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in the future.

Fast

By submitting an initial Medicare enrollment application through Internet-based PECOS, a provider or supplier organization's enrollment application can be processed as much as 50 percent faster than by paper. This means that it will take less time to enroll or make a change in an existing enrollment record.

For information about the types of changes that enrolled Medicare provider and supplier organizations must report, go to the *Downloads* section of the Medicare provider/supplier enrollment page at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Secure

Internet-based PECOS meets all required government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only individuals whose identities have been verified by CMS and who have been approved by a provider or supplier organization's authorized official may use Internet-based PECOS on behalf of that provider or supplier organization. The PECOS user IDs and passwords that these individuals establish will protect the access to the given provider or supplier organization's Medicare enrollment information. PECOS users should change their passwords frequently (at least once a year). By safeguarding their user IDs and passwords, PECOS users will be taking an important step in protecting the provider or supplier organization's Medicare enrollment information. CMS does not disclose Medicare provider or supplier enrollment information to anyone except when authorized or required to do so by law.

Easy to use

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process ensures that provider and supplier organizations complete and submit only the information necessary to facilitate the action they wish to take. The CMS external user services (EUS) help desk (1-866-484-8049) is available and staffed to respond to questions about using Internet-based PECOS, such as navigating through the screens, and to receive reports of systems problems as noted by users.

Obtaining approval to use Internet-based PECOS for a provider or supplier organization

There are several steps that must be completed before a provider or supplier organization can use Internet-based PECOS. These steps are described in detail in the document entitled, "Getting Started with Internet-based Provider Enrollment, Chain and Ownership System (PECOS) -- Information for Provider and Supplier Organizations," which will soon be available in the *Downloads* section on the Medicare provider/supplier enrollment page at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*. Below is an overview of the process.

1. The first step is taken by the authorized official (AO) of the provider or supplier organization. This is done only one time. He or she will register in the Internet-based PECOS Identification and Authentication System (PECOS I&A) by going to *https://pecos.cms.hhs.gov*. CMS will verify the information provided and the CMS EUS help desk will notify the AO of the verification.
2. An individual who will use Internet-based PECOS to submit enrollment applications for the provider or supplier organization will also register in PECOS I&A. This individual may be an employee of the provider or supplier organization, or an employee of a separate organization. CMS will verify the information provided and the permission of the AO for that individual to use Internet-based PECOS on behalf of the provider or supplier organization. The individual will complete the security consent form and have it signed by an official of his or her employer and by the AO of the provider or supplier organization. The individual will mail the signed and dated security consent form to the CMS EUS help desk. The AO will need to periodically log onto Internet-based PECOS to see if there is a pending request for permission to access Internet-based PECOS on behalf of the provider or supplier organization. More than one person may be approved to use Internet-based PECOS on behalf of a given provider or supplier organization, but the security consent form is completed only one time.
3. Once the registration and verification processes are completed, the CMS EUS help desk will notify the AO of the establishment of the relationship between the provider or supplier organization and the organization that will be using Internet-based PECOS on its behalf.

It may take several weeks for the registration and verification processes to be completed. Therefore, we encourage the AO of a provider or supplier organization to begin the registration process now; before the provider or supplier organization has the need to use Internet-based PECOS to submit a Medicare enrollment application or enrollment update.

If a provider or supplier organization has an immediate need to submit a Medicare enrollment application to enroll or to report a change in enrollment information and the steps above have not been successfully completed, the provider or supplier organization should complete and submit the paper version of the Medicare enrollment application (CMS-855).

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

Submitting an enrollment application using Internet-based PECOS

After the steps above are successfully completed, the individual who will be using Internet-based PECOS is considered a PECOS user. If a PECOS user has not already done so, he or she should visit the Medicare provider enrollment Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* to download and read the documents relating to Internet-based PECOS. CMS advises PECOS users to review this information before logging onto Internet-based PECOS.

After reading the informational documents referenced above, a PECOS user will log onto Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*. He or she will complete, review, and submit the Medicare enrollment application over the Internet to the designated Medicare contractor. Internet-based PECOS will guide the user through each of these processes.

Internet-based PECOS enables the user to print a copy of the enrollment application, if desired. We recommend this be done so the provider or supplier organization has a copy for its records.

As part of the enrollment application submittal process, the AO of the provider or supplier organization must sign and date the two-page certification statement that the user will print from Internet-based PECOS. The user must mail the signed and dated certification statement, along with any required supporting paper documentation, to the designated Medicare contractor. The Medicare contractor will not begin processing the application that was submitted over the Internet until it has received the signed and dated certification statement.

Limitations of Internet-based PECOS

At this time, Internet-based PECOS is unable to handle changes of ownership applications from provider and supplier organizations. Therefore, changes of ownership must be submitted using the paper Medicare enrollment application (CMS-855) process. Internet-based PECOS will be able to accommodate changes of ownership at a future date.

Additional information

Several documents about Internet-based PECOS for provider and supplier organizations will soon be available in the *Downloads* section of the Medicare provider/supplier enrollment Web page at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Source: PERL 200904-01

Incorporation of regulatory changes related to provider enrollment

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

Provider action needed

All Medicare physicians, providers, and suppliers, as well as those who are considering applying to participate in the program should be aware of the new rule and of upcoming changes to the Medicare enrollment process.

Background

CR 6310 implements regulatory changes found in the CY 2009 Medicare physician fee schedule final rule with comment (CMS-1403-FC). Significant changes are summarized below.

Effective date of Medicare billing for physicians, certain nonphysician practitioners, and physician and nonphysician practitioner organizations

- Carriers and Part A and Part B Medicare administrative contractors (A/B MACs) will establish the effective date of Medicare billing privileges (see 42 CFR 424.520(d)) for physicians, nonphysician practitioners, and physician or nonphysician practitioner organizations. Physicians, nonphysician practitioners and physician and nonphysician practitioner organizations will no longer be allowed to establish retrospective Medicare effective billing dates.
- Carriers and A/B MACs will establish an effective date of Medicare billing privileges for the following individuals and organizations: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, and physician and nonphysician practitioner organizations (e.g., clinics/group practices).
- The effective date of Medicare billing privileges for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location.

Note: The date of filing for Internet-based provider enrollment, chain and ownership system (PECOS) applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement that were both processed to completion.

- The individuals and organizations identified above may, however, retrospectively bill for services when:
  - The supplier has met all program requirements, including state licensure requirements, and
  - The services were provided at the enrolled practice location for up to --
    - 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
    - 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. section 5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

Incorporation of regulatory changes related to provider enrollment (continued)

Timeframes for reporting changes of information

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals, and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph, the following changes must be reported within 30 days:
  - A change of ownership
  - A final adverse action, or
  - A change in practice location.
- If an individual or organization identified above does not comply with the reporting requirements relating to, respectively, final adverse actions and practice location changes, the supplier may be assessed an overpayment back to the date of the final adverse action or change in practice location.

Application rejections and denials for physician and certain nonphysician practitioner applications

- Carriers and A/B MACs will deny, rather than reject, incomplete applications submitted by physicians, nonphysician practitioners, and physician or nonphysician practitioner organizations.
- This change will allow the individuals and organizations identified above to preserve their effective date of filing by submitting a corrective action plan or an appeal and submitting the missing information/ documentation to allow the carrier or A/B MAC to adjudicate the enrollment application to completion.

Revocation effective dates

- A revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction, (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion, debarment, felony conviction, license suspension or revocation, or the date that the Centers for Medicare & Medicaid Services (CMS) or its contractor determined that the provider or supplier is no longer operational.
- Any physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., clinic/group practices) consisting of the individuals previously identified, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

Requirements for maintaining ordering and referring documentation

- Carriers or A/B MACs may revoke the billing privileges of any provider or supplier that fails to comply with Medicare's ordering and referring documentation requirements as specified in 42 CFR 424.5216 (f).
- Such revocation is also possible in cases where the physician or nonphysician practitioner fails to maintain written ordering and referring documentation for seven years from the date of service.
- Off-site or electronic storage of the ordering and referring documentation described in 42 CFR section 424.516(f) is not precluded, as long as these records are readily accessible and retrievable.

Other changes

- Final adverse action is defined.

Additional information

The official instruction (CR 6310) issued to your carrier, FI, and A/B MAC, regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R289PI.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: MM6310
Related Change Request (CR): 6310
Related CR Release Date: April 15, 2009
Related CR Transmittal #: R289PI
Effective Date: January 1, 2009
Implementation Date: April 1, 2009

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Overview of the 2009 PQRI and electronic prescribing incentive program

Provider types affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) or the new 2009 e-Prescribing incentive program.

Provider action needed

This article is based on change request (CR) 6394, which gives high-level overviews of the 2009 PQRI implementation and the new 2009 e-Prescribing Incentive Program implementation. Make sure that your billing staffs are aware of the PQRI reporting changes and the e-Prescribing Incentive Program.

Background

The 2006 Tax Relief and Health Care Act (P.L. 109-432) (TRHCA) required CMS to establish a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007. CMS named this program the Physician Quality Reporting Initiative (PQRI).

For the 2009 PQRI, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (P.L. 110-173) (MMSEA) required the Secretary to select measures for 2009 through rulemaking and to establish alternative reporting criteria and alternative reporting periods for reporting measures groups and for registry-based reporting. In addition, the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA), which was enacted on July 15, 2008, includes many provisions that impact the 2009 PQRI. The 2009 PQRI requirements are outlined in the 2009 Medicare physician fee schedule (MPFS) final rule with comment period that was published in the *Federal Register* on November 19, 2008 (visit *http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf* on the Internet) and are summarized below.

Section 132 of the MIPPA also authorizes a new and separate incentive program for eligible professionals who are successful electronic prescribers (e-Prescribers) as defined by MIPPA. This new incentive is separate from and is in addition to the PQRI. The 2009 program requirements for the e-Prescribing Incentive Program are also outlined in the 2009 MPFS final rule with comment period and summarized below.

The purpose of this article is to give high-level overviews of the 2009 PQRI implementation and the new 2009 e-Prescribing Incentive Program implementation, as directed by the statute. Detailed information, educational materials, and supportive tools for the 2009 PQRI and the 2009 e-Prescribing Incentive Program will be posted as they become available on the CMS PQRI Web site at *http://cms.hhs.gov/PQRI* and the CMS e-Prescribing Incentive Program Web site at *http://cms.hhs.gov/ERXIncentive*, respectively. In addition, there are fact sheets available for the 2009 PQRI and e-Prescribing programs at *http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf* and *http://www.cms.hhs.gov/ERxIncentive/Downloads/erx_incentive_program_simple_factsheet.pdf*, respectively.

The 2009 PQRI overview section below highlights changes from the 2008 PQRI with respect to: (1) eligible professionals, (2) form and manner of reporting, (3) reporting periods, (4) payment for reporting, (5) individual quality measures, (6) measures groups, (7) determination of satisfactory reporting, (8) validation, (9) appeals, and (10) confidential feedback reports.

The 2009 e-Prescribing Incentive Program overview section of this article addresses: (1) eligible professionals, (2) form and manner of reporting, (3) reporting periods, (4) payment for reporting, (5) determination of a successful e-prescriber, and (6) confidential feedback reports.

2009 PQRI overview

Eligible professionals

Beginning with the 2009 PQRI, the definition of "eligible professional" has been expanded to include qualified audiologists, as required by the MIPPA. Therefore, for the 2009 PQRI, the following professionals are eligible to participate in PQRI:

Medicare physicians

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine, and
- Doctor of Chiropractic.

Practitioners

- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist (and anesthesiologist assistant)
- Certified nurse midwife
- Clinical social worker
- Clinical psychologist
- Registered dietician
- Nutrition professional, and
- Audiologists (as of January 1, 2009)

Therapists

- Physical therapist
- Occupational therapist, and
- Qualified speech-language therapist.

All Medicare-enrolled professionals in these categories are eligible to participate in the 2009 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, some professionals are eligible to participate but are not able to participate for one or more reasons.

Professionals eligible to participate but not able to participate include:

1. Professionals paid under or based upon the MPFS billing Medicare carriers or Medicare administrative contractors (MACs) who do not bill directly. For example, qualified speech-language therapists do not currently bill Medicare directly. It is anticipated that qualified speech-language therapists will begin billing

Overview of the 2009 PQRI and electronic prescribing incentive program (continued)

Medicare directly on July 1, 2009, at which point they would be able to participate.

2. Professionals paid under the MPFS billing Medicare fiscal intermediaries (FIs) or MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level:

   - Critical access hospital (CAH), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the FI/MAC for the professional services provided by the physician or practitioner.
   - All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

Services payable under fee schedules or methodologies other than the MPFS are not included in PQRI (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, independent laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

Form and manner of reporting

For 2009, eligible professionals can continue to choose whether to report through claims-based submission or through a qualified PQRI registry. In addition, eligible professionals can continue to choose to report on individual quality measures or on measures groups.

- For claims-based submission, there is no need to enroll or register to begin claims-based reporting for the 2009 PQRI. Participating eligible professionals whose Medicare patients fit the specifications of the 2009 PQRI quality measures and/or measures groups will simply report the appropriate current procedural terminology (*CPT*) category II codes or G-codes (where *CPT* category II codes are not yet available) on their claims. *CPT* category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: the CMS-1500 or the equivalent electronic transaction claim, the 837-P.

The applicable *CPT* category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the quality-data code applies. Additional guidance about how to implement 2009 PQRI claims-based reporting of measures to facilitate satisfactory reporting of quality data codes by eligible professionals for the 2009 PQRI is available in the 2009 PQRI implementation guide, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI Web site at *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

- For registry-based reporting, eligible professionals should submit information to a qualified PQRI clinical data registry and authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

For 2009, CMS will conduct another self-nomination process for registries so additional registries can potentially be approved for submitting quality measures data for the 2009 PQRI. Registries qualified to submit data on behalf of their eligible professionals in 2008 are not required to self-nominate again for 2009 unless they are unsuccessful at submitting 2008 data by March 31, 2009. The list of qualified registries for the 2009 PQRI will be available on the CMS PQRI Web site at *http://www.cms.hhs.gov/PQRI* on the CMS Web site in the summer of 2009.

Reporting periods

There are no changes to the PQRI reporting period or the alternative reporting periods for measures group reporting or for registry-based reporting for 2009. In other words, the 2009 PQRI reporting period continues to be the entire calendar year. There also continues to be two alternative reporting periods for measures group reporting and for registry-based reporting (i.e., the entire calendar year and a six-month reporting period beginning July 1, 2009).

Payment for reporting

Participating eligible professionals who satisfactorily report as prescribed by the 2009 MPFS final rule with comment period (and as summarized below in the Determination of Satisfactory Reporting section) may earn a 2.0 percent incentive payment. Because claims processing times may vary, participating eligible professionals should submit claims from the end of 2009 promptly, so that those claims will reach the Medicare's National Claims History (NCH) file by February 28, 2010. PQRI incentive payments will be paid as a lump sum in mid-2010.

The PQRI incentive payment will apply to allowed charges for all covered professional services, under the MPFS not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the MPFS do not apply to the PQRI incentive payment.

For 2009, the analysis of satisfactory reporting will continue to be performed at the individual eligible professional level using individual-level national provider identifier (NPI) data. CMS, however, will continue to use the taxpayer identification number (TIN) as the billing unit, so any PQRI incentive payments earned will be paid to the TIN holder of record. PQRI incentive payments will be paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS will continue to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the PQRI incentive payment under more than one TIN will receive a separate PQRI incentive payment associated with each TIN.

Overview of the 2009 PQRI and electronic prescribing incentive program (continued)

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, Section 1848(m)(1)(A)(ii) of the Act specifies that any PQRI incentive payment earned will be paid to the employers or facilities.

Individual quality measures

The 2009 PQRI includes a total of 153 quality measures. This total includes 52 new measures. In addition, whereas all of the 2008 PQRI quality measures were reportable either through claims-based submission or registry-based reporting, 18 of the 153 PQRI quality measures for 2009 are reportable only through registries. A complete list of the 2009 PQRI individual quality measures can be found in the 2009 PQRI Quality Measures List, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI Web site at *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

Measures groups

There are seven measures groups for the 2009 PQRI. More detailed information on these measures groups is available in the fact sheet at *http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf* on the CMS Web site.

Determination of satisfactory reporting

In order to qualify to earn an incentive payment, eligible professionals must meet the criteria for satisfactorily reporting data on PQRI quality measures. For the 2009 PQRI, there are a total of nine reporting options, or ways in which an eligible professional can attempt to satisfactorily report. Although there are multiple reporting options for satisfactory reporting, an eligible professional only needs to satisfactorily report under one option to qualify for the 2.0 percent incentive payment for the applicable reporting period. An eligible professional who qualifies for more than one reporting period will receive the incentive payment for the longest reporting period for which the professional qualifies. Only one incentive payment may be obtained regardless of how many reporting options the eligible professional chooses.

While the number of reporting options remains the same as in 2008, there are some differences between the 2008 PQRI reporting options and the 2009 PQRI reporting options. The 2009 PQRI reporting options, including any changes, are also detailed in the fact sheet at *http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf* on the CMS Web site and are included in CR 6394 at *http://www.cms.hhs.gov/transmittals/downloads/R459OTN.pdf* on the CMS Web site.

As stated in the *Payment for reporting* section, the analysis of whether an eligible professional has satisfactorily reported will continue to be performed at the individual eligible professional level using the individual-level NPI. The eligible professional's individual NPI must be listed along with the HCPCS codes for services, procedures, and quality data on the claim. Thus, to participate in the 2009 PQRI, eligible professionals must have their individual-level NPIs and must consistently use their individual NPIs to correctly identify their services, procedures, and quality-data codes for an accurate determination of satisfactory reporting.

Eligible professionals select the quality measures and/or measures groups that are applicable to their practices. If an eligible professional submits data for a quality measure or a measures group, then that measure or measures group is presumed to be applicable for the purposes of determining satisfactory reporting. For eligible professionals choosing to report on individual quality measures, CMS recommends that eligible professionals report on every quality measure that is applicable to their patient populations to increase the likelihood that they will reach the 80 percent satisfactorily reporting requirement for the requisite number of measures.

As detailed information, education, and tools to support satisfactory claims-based reporting of individual quality measures and/or measures groups become available, they will be posted on the CMS PQRI Web site at *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

Validation

Section 1848(m)(5)(D)(ii) of the Social Security Act (the Act) permits CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional have been reported. Under the claims-based reporting method of individual measure(s), the determination of satisfactory reporting, as defined by statute, will itself serve as a general validation because the analysis will assess whether quality-data codes are appropriately submitted by an eligible professional in a sufficient proportion of the instances when a reporting opportunity exists. In addition, for those eligible professionals who satisfactorily submit quality-data codes for fewer than three PQRI measures, a two-step measure-applicability validation (MAV) process will determine whether they should have submitted quality-data codes for additional measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the incentive payment. More information on the MAV process for the 2009 PQRI is available in the Analysis and payment section of the CMS PQRI Web site at *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

Appeals

For the 2009 PQRI, the statute specifically states that there will be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, or (3) the incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

Confidential feedback reports

CMS will provide confidential feedback reports on 2009 PQRI reporting to participating eligible professionals at or near the time that the lump sum incentive payments are made in 2010. Access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2009 PQRI or to receive an incentive payment.

In addition, Section 1848(m)(5)(G) of the Act requires CMS to post on the CMS Web site, in an easily understandable format, a list of the names of the eligible

Overview of the 2009 PQRI and electronic prescribing incentive program (continued)

professionals who satisfactorily submitted data on quality measures under PQRI. Therefore, the names of eligible professionals who satisfactorily submitted data on quality measures for the 2009 PQRI will be posted at *http://www.medicare.gov* on the Internet after the lump sum incentive payments are made in 2010.

e-Prescribing Incentive Program Overview

Eligible professionals

For the 2009 E-Prescribing Incentive Program, "eligible professional" includes the same list of professionals as previously shown as eligible for the PQRI program.

However, in order to participate in this incentive program, a professional in one of categories of eligible professionals must be authorized by his or her respective state laws to prescribe medication and prescribing medications must fall within the individual eligible professional's scope of practice.

All Medicare-enrolled professionals in these categories are eligible to participate in the 2009 e-Prescribing Incentive Program, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, some professionals are eligible to participate but are not able to participate for one or more reasons and the reasons are the same as those which preclude professionals from participating in PQRI as mentioned earlier in this article.

Professionals not eligible to participate in the e-Prescribing Incentive Program and not able to qualify to earn an incentive payment are those that are not defined as eligible professionals in the Medicare Improvements for Patients and Providers Act of 2008.

Services payable under fee schedules or methodologies other than the MPFS are not included in e-Prescribing Incentive Program (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, independent laboratories, hospitals [including method I critical access hospitals], rural health clinics, ambulance providers, and ambulatory surgery center facilities).

The e-Prescribing Incentive Program fact sheet at *http://www.cms.hhs.gov/ERxIncentive/Downloads/erx_incentive_program_simple_factsheet.pdf* on the CMS Web site provides an excellent guide for participation in the program.

Form and manner of reporting

For 2009, participation in the e-Prescribing Incentive Program is limited to the submission of quality data codes for the e-prescribing measure through Medicare's claims processing system, as described in the 2009 MPFS final rule with comment period. There is no need to enroll or register to begin claims-based reporting for the 2009 e-Prescribing Incentive Program.

Participating eligible professionals who bill for the services or procedures included in the denominator of the 2009 e-prescribing measure will report the corresponding appropriate numerator G-code on their claim. Claims-based reporting may be via the CMS-1500 or the equivalent electronic transaction claim, the 837-P. The specifications for the 2009 e-prescribing measure are available on the CMS e-Prescribing Incentive Program Web site at *http://www.cms.hhs.gov/ERXIncentive* on the CMS Web site.

The applicable *CPT* category II code or G-code quality data must be reported on the same claim as the billable service or procedure to which the quality-data code applies. The 2009 e-prescribing measure does not require a diagnosis code to help determine the denominator.

Reporting periods

For 2009, the reporting period for the e-Prescribing Incentive Program is the entire calendar year, or January 1, 2009-December 31, 2009.

Payment for reporting

For 2009, eligible professionals, who are determined to be "successful e-prescribers" (as discussed below),may earn an incentive payment equal to 2.0 percent of the total estimated allowed charges for all such MPFS-covered professional services: (1) furnished by the eligible professional during the reporting period of January 1 through December 31, 2009, (2) received into the CMS NCH file by February 28, 2010, and (3) paid under or based upon the MPFS. Because claims processing times may vary, participating eligible professionals should submit claims service dates late in 2009 promptly, so that those claims will reach Medicare's NCH file by February 28, 2010. CMS anticipates that the e-prescribing incentive payments will be paid as a lump sum in mid-2010. There is no beneficiary co-payment or notice to the beneficiary regarding the e-prescribing incentive payments.

According to the statute, however, there is a limitation with regard to the application of the incentive. For 2009, the incentive does not apply to eligible professionals, for the reporting period, if the Medicare allowed charges for all covered professional services for the codes to which the e-prescribing measure applies are less than 10 percent of the total of the allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional. Under the e-Prescribing Incentive Program, covered professional services are those paid under or based upon the MPFS.

The e-prescribing incentive payment will apply to allowed charges for all covered professional services, not just those charges associated with the e-prescribing measure. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the MPFS amounts for assigned and non-assigned claims will not apply to the incentive. The statute defines e-prescribing covered services as those paid under or based upon the MPFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

For 2009, the analysis of determining successful e-prescribers will be performed at the individual eligible professional level using individual-level NPI data. CMS, however, will use the TIN as the billing unit, so any e-prescribing incentive payments earned will be paid to the TIN holder of record. E-prescribing incentive payments will be paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS will group claims by TIN for payment purposes.

Overview of the 2009 PQRI and electronic prescribing incentive program (continued)

As a result, a provider with multiple TINs who qualifies for the e-prescribing incentive payment under more than one TIN will receive a separate e-prescribing incentive payment associated with each TIN. In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, section 1848(m)(2)(A) of the Act specifies that any e-Prescribing incentive payment earned will be paid to the employers or facilities.

Determination of a successful e-prescriber

For purposes of qualifying for the e-prescribing incentive payment for 2009, an eligible professional will be considered a successful e-prescriber if he/she reported the applicable e-Prescribing quality measure in at least 50 percent of the cases in which such measure is reportable by the eligible professional during the reporting period.

Confidential feedback reports

CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump sum incentive payments are made in 2010. As with PQRI, access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2009 e-Prescribing Incentive Program or to receive an incentive payment.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS Web site, in an easily understandable format, a list of the names of the eligible professionals who are successful e-prescribers. Therefore, the names of eligible professionals who are determined to be successful e-prescribers for the 2009 e-Prescribing Incentive Program will be posted at *http://www.medicare.gov* on the Internet after the lump sum incentive payments are made in 2010.

Additional information

The official instruction (CR 6394) issued to your carrier and/or A/B MAC, regarding this change may be viewed *at http://www.cms.hhs.gov/transmittals/downloads/R459OTN.pdf* on the CMS Web site.

Once again, there are fact sheets available for the 2009 PQRI and e-Prescribing programs at *http://www.cms.hhs.gov/PQRI/downloads/PQRIWhatsNew2009Final.pdf* and *http://www.cms.hhs.gov/ERxIncentive/Downloads/erx_incentive_program_simple_factsheet.pdf*, respectively.

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: MM6394
Related Change Request (CR) #: 6394
Related CR Release Date: March 20, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R459OTN
Implementation Date: June 22, 2009

2009 PQRI electronic health record specifications now posted

The 2009 data submission specifications for use in the 2009 Physician Quality Reporting Initiative (PQRI) electronic health record (EHR) test are now posted on the QualityNet Web site.

As described in the 2009 Medicare physician fee schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) is testing EHR data submission in cooperation with electronic health record vendors. These vendors were selected from those who self-nominated per a process described in the 2008 final PFS rule. The 2009 testing process will be similar to the testing process used for 2008. If this means of data submission is used in a future PQRI reporting year, EHR vendors (who are successful with the 2009 testing process) will be qualified for PQRI data submission via EHRs. There is no incentive payment available through EHR-based data submission for 2009.

The measure specifications for the 2009 EHR test measures are also available on the QualityNet Web site: select PQRI from the drop-down menu (under the Physician Offices tab), then click on the EHR Specifications link (located on the left navigation bar). The following link will take you to the QualityNet Web site: *http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1214232460333.*

A link to the QualityNet Web site is also available at *http://www.cms.hhs.gov/PQRI* on the CMS PQRI Web site under the *Related Links Outside CMS* tab. Additional information related to the EHR test is also available on the CMS PQRI Web site under the *Reporting and Measures/Codes* sections listed in the left navigation bar.

Detailed information on the 2009 PQRI program requirements may be found in the final 2009 Medicare PFS rule with comment period that was published in the *Federal Register* on November 19, 2008. A copy of the final rule with comment period is on display at the *Federal Register* and may be viewed at: *http://edocket.access.gpo.gov/2008/pdf/E8-14949.pdf*. Additionally, the CMS PQRI Web page *http://www.cms.hhs.gov/PQRI* on the CMS Web site is the primary resource for frequently asked questions, helpful tools, and information on the PQRI program.

Source: PERL 200904-13

Two new electronic prescribing pages now available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that two new pages have been created on the 2009 Electronic Prescribing (e-Prescribing) Incentive Program Web page on the CMS Web site.

- e-Prescribing Measure – this page contains several resources including: measure specifications, new claims-based reporting principles and a sample e-Prescribing claim. To access these resources, visit *http://www.cms.hhs.gov/ERxIncentive/06_E-Prescribing_Measure.asp*.
- Educational Resources – this page contains *MLN Matters* articles, e-Prescribing Incentive Program fact sheets, a link to *Medicare's Practical Guide to the e-Prescribing Incentive Program*, and information on how to receive continuing education credits related to the e-Prescribing Incentive Program. To access these resources and information, visit *http://www.cms.hhs.gov/ERxIncentive/09_Educational_Resources.asp*.

New and updated information will continually be added, so please visit the e-Prescribing Incentive Program Web page on a frequent basis at *http://www.cms.hhs.gov/ERXIncentive*.

Source: PERL 200904-27

New common working file Medicare secondary payer type for workers' compensation

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

Note: This article was revised on March 20, 2009, to reflect a revised transmittal related to CR 5371. The CR was changed to clarify some of the requirements. The CR release date, transmittal numbers (see above), and the Web address for accessing that transmittal were changed. All other information remains the same. This information was previously published in the January 2009 *Medicare B Update!* page 42.

Provider types affected

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

What you need to know

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

Background

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

The CMS has determined that establishing a new MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist Medicare contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

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

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

Additional information

You may find the official instruction (CR 5371) issued to your Medicare contractor in two transmittals: *http://www.cms.hhs.gov/Transmittals/downloads/R1703CP.pdf*, and *http://www.cms.hhs.gov/Transmittals/downloads/R65MSP.pdf* on the CMS Web site.

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

MLN Matters Number: MM5371 *Revised*
Related Change Request (CR) #: 5371
Related CR Release Date: March 20, 2009
Effective Date: July 1, 2009
Related CR Transmittal #s: R1703CP, 65MSP
Implementation Date: July 6, 2009

New Medicare pilot program helps eliminate unnecessary hospital re-admissions

Fourteen communities funded to reduce rates of hospital re-admissions and fragmentation of care

The Centers for Medicare & Medicaid Services (CMS) announced the 14 communities around the nation that have been chosen for the agency's Care Transitions Project, seeking to eliminate unnecessary hospital readmissions.

"Our data show that nearly one in five patients who leave the hospital today will be readmitted within the next month, and that more than three-quarters of these re-admissions are potentially preventable," said CMS acting administrator Charlene Frizzera. "This situation can be changed by approaching health care quality from a community-wide perspective, and focusing on how all of the members of an area's health care team can better work together in the best interests of their shared patient population."

The goal of the project is to improve health care processes so that patients, their caregivers, and their entire team of providers have what they need to keep patients from returning to the hospital for ongoing care needs. By promoting seamless transitions from the hospital to home, skilled nursing care, or home health care, this community-wide approach seeks not only to reduce hospital readmissions but also to yield sustainable and replicable strategies that achieve high-value health care for Medicare beneficiaries.

"The Care Transitions Project is a new approach for CMS," said Barry M. Straube, M.D., chief medical officer for CMS and its Office of Clinical Standards & Quality director. "Rather than focusing on one global problem and trying to apply a one-size-fits-all solution across the country, care transitions experts will look in their own backyards to learn why hospital readmissions occur locally and how patients transition between health care settings. Based on this community-level knowledge, care transitions teams will design customized solutions that address the underlying local drivers of re-admissions."

Communities in the following regions have been selected to participate in the project: Providence, R.I.; Upper Capitol Region, N.Y.; western Pennsylvania; southwestern New Jersey; metro Atlanta east, Ga.; Miami, Fla.; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing Area, Mich.; Omaha, Neb.; Baton Rouge, La.; northwest Denver, Colo.; Harlingen, Texas; and Whatcom County, Wash. The work of the project will respond to the unique needs of each of the 14 communities. Each of the care transitions communities is led by a state quality improvement organization (QIO). QIOs work throughout the country as part of CMS's quality program to help health care providers, consumers, and stakeholder groups to refine care delivery systems to make sure all Medicare beneficiaries get the high-quality, high-value health care they deserve.

Each QIO in the project is required to work with partners to implement the following:

a) hospital and community system-wide interventions

b) interventions that target specific diseases or conditions, and

c) interventions that target specific reasons for admission.

The following QIOs serve as care transitions leaders throughout the country: Quality Partners of Rhode Island, IPRO Inc. (New York), Quality Insights of Pennsylvania, Healthcare Quality Strategies Inc. (New Jersey), Georgia Medical Care Foundation Inc., FMQAI (Florida), AQAF (Alabama), Health Care Excel (Indiana), MPRO (Michigan), CIMRO of Nebraska, Louisiana Health Care Review, Colorado Foundation for Medical Care, TMF Health Quality Institute (Texas), and Qualis Health (Washington).

CMS will monitor the success of this project by watching the rates at which patients in these communities return to the hospital. Re-admission rates for hospitals have been tracked by CMS for some time and will be available to consumers later this year through the Hospital Compare Web site at *http://www.hospitalcompare.hhs.gov*.

The Care Transitions Project will continue in all 14 communities through summer 2011. For more information about the Care Transitions Project, visit *http://www.cfmc.org/caretransitions/*. To learn more about the work that QIOs are doing across the country, visit *http://www.cms.hhs.gov/qualityimprovementorgs*.

Source: PERL 200904-19

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 to the quick reference immunization billing chart

The revised Medicare preventive services quick reference information: Medicare Part B immunization billing chart (revised March 2009), which provides billing and coding information related to adult immunizations, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

Printed copies will be available at a later date.

Source: PERL 200904-28

Medicare payment policy publications are now available in print format

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

Outpatient maintenance dialysis -- end-stage renal disease fact sheet (revised February 2009) -- provides general information about outpatient maintenance dialysis for end-stage renal disease, the composite payment rate system, and separately billable items and services.

Medicare physician fee schedule fact sheet (revised January 2009) -- provides general information about the Medicare physician fee schedule.

Hospital outpatient prospective payment system fact sheet (revised January 2009) -- provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set.

Hospice payment system fact sheet (revised January 2009) -- provides general information about the Medicare hospice benefit including coverage of hospice services, certification requirements, election periods, and how payment rates are set.

Clinical laboratory fee schedule fact sheet (revised February 2009) -- provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set.

Acute inpatient prospective payment system fact sheet (revised January 2009) -- provides general information about the acute inpatient prospective payment system (IPPS) including IPPS payment rates and how IPPS payment rates are set.

Home health prospective payment system fact sheet (revised December 2008) -- provides information about coverage of home health services and elements of the home health prospective payment system.

Ambulance fee schedule fact sheet (revised January 2009) -- provides general information about the ambulance fee schedule.

Ambulatory surgical center fee schedule fact sheet (revised January 2009) -- which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined.

Source: PERL 200904-03

Five-star provider preview reports now available

The five-star provider preview reports are now available. Providers can access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of MDS 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.

There will be no helpline access for the months of May and June to coincide with the release of each month's preview data. You may e-mail five-star provider preview questions during these months, to *BetterCare@cms.hhs.gov*. The helpline will begin quarterly operation beginning in July.

Nursing home compare was updated with April's five-star data on Thursday, April 23, 2009.

Source: PERL 200904-22

New version of the minimum data sets available for download

The minimum data sets, version 3.0 (MDS 3.0) timeline has been posted. Please go to the Downloads section on the MDS 3.0 for Nursing Home Web page at *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*.

Source: PERL 200904-27

Reminder: Time is running out for DMEPOS supplier accreditation

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 to complete, 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) 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/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 200904-05, PERL 200904-23, PERL 200904-29

Medicare announces funding for state health insurance counseling programs for 2009

Funding designed to help people with Medicare

Nearly $36 million in funding is being distributed to the 54 state health insurance assistance programs (SHIPs) to help people with Medicare get more information about their health care choices.

The $35.8 million in funding is the first installment of federal grant funds provided to SHIPs by the Centers for Medicare & Medicaid Services (CMS) for the grant year beginning April 1, 2009, and ending March 31, 2010.

An additional $1.5 million in performance-based funding will be awarded in September 2009. SHIPs are state-based programs that use community-based networks to provide Medicare beneficiaries with local, personalized assistance on a wide variety of Medicare and health insurance topics.

"State Health Insurance Assistance Programs serve an important role in providing information and support to people with Medicare where they live," said CMS acting administrator Charlene Frizzera. "These funds help ensure SHIPs continue their work with state and local governments, community-based organizations and others to meet the needs, beyond health care, of our Medicare beneficiaries."

CMS expects the SHIPs to use the 2009 funding to conduct targeted community-based outreach to people with Medicare who may be unable to access other sources of information. SHIPs will also provide outreach and assistance to current and newly eligible Medicare beneficiaries and their caregivers, with a special emphasis on reaching people who will most likely be eligible for Medicare's low-income subsidy if they enroll in Medicare prescription drug coverage.

CMS will continue to support the quality of services provided by SHIPs through training, technical assistance, the SHIP resource center, and the online tools at *http://www.medicare.gov* to help people with Medicare.

Source: PERL 200904-11

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.

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.

New LCDs

A0425 Non-emergency ground ambulance services -- new LCD

LCD ID number: L29953 (Florida)
LCD ID number: L29955 (Puerto Rico/U.S. Virgin Islands)

A new LCD that addresses non-emergency ground ambulance services has been developed. The LCD clarifies indications and limitations according to Medicare national guidelines. The "ICD-9 Codes that Support Medical Necessity" section of the LCD includes the following ICD-9-CM codes:

- V49.84 (Bed confinement status)
- V49.89 (Other specified conditions influencing health status)

In addition, coding guidelines were developed to provide information regarding crew, vehicle, destination, and physician certification statement (PCS) requirements.

Effective date

This new LCD is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Intravitreal bevacizumab (Avastin®) -- new LCD

LCD ID number: L29959 (Florida)
LCD ID number: L29961 (Puerto Rico/U.S. Virgin Islands)

Prior to the development of this new local coverage determination (LCD), First Coast Service Options Inc. (FCSO) gave consideration for intravitreal bevacizumab (Avastin®) on an individual case-by-case basis for the treatment of age-related macular degeneration (AMD). This information was published in an article (article ID number A41456), updated on August 1, 2008. After numerous requests for FCSO to provide the coverage requirements for intravitreal bevacizumab (Avastin®), FCSO has developed this new LCD.

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).

Based on published reports and widespread clinical use, there is compelling evidence of bevacizumab's safety and efficacy for CNV in AMD and also in proliferative diabetic retinopathy, neovascular glaucoma, macular edema, retinal and iris neovascularizations and branch and central retinal vein occlusions, due to common VEGF-induced pathogenic pathways. The ophthalmology community is increasingly using intravitreal bevacizumab in the treatment of these conditions that have not responded to other accepted therapies.

FCSO Medicare will consider bevacizumab (Avastin®) given by intravitreal injection medically reasonable and necessary for patients who are deemed by their treating ophthalmologist to have failed U.S. Food & Drug Administration (FDA) approved therapies, or in the judgment of the treating ophthalmologist, based on his/her experience, are likely to have a therapeutic response from the use of intravitreal bevacizumab which is comparable to results from other approved treatments for conditions outlined in this LCD.

The LCD outlines indications and limitations of coverage and/or medical necessity, documentation requirements and coding guidelines for the off-label use of intravitreal bevacizumab (Avastin®). HCPCS code J3490, unclassified drug. should be billed for intravitreal bevacizumab, along with *CPT* code *67028*, intravitreal injection of a pharmacologic agent. In addition, the following ICD-9-CM codes are considered medically reasonable and necessary for the off-label uses described in this LCD: 362.02, 362.07, 362.16, 362.35, 362.36, 362.52, 362.53, 362.83, 364.42 and 365.63.

Bevacizumab (Avastin®; Genentech) is FDA approved for treatment of select cancers as a systemic drug. However, this LCD only addresses the use of bevacizumab for ophthalmic off-label indications (not approved by the FDA). HCPCS codes J9035, injection, bevacizumab, 10 mg does not apply to the intravitreal administration since the agent has been processed by compounding pharmacies.

Effective date

This new LCD is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) 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.

75722 Renal angiography -- new LCD

LCD ID number: L29941 (Florida)
LCD ID number: L29943 (Puerto Rico/U.S. Virgin Islands)

Diagnostic arteriography is an invasive method of evaluating vascular disease. It involves percutaneous passage of a needle and/or catheter into an artery under fluoroscopic guidance, followed by injection of contrast material and imaging of the vascular distribution in question using serial film or digital imaging systems, under conscious sedation.

With modern noninvasive imaging techniques (e.g., duplex ultrasonography, gadolinium enhanced magnetic resonance angiography (MRA), computed tomographic angiography [CTA]), the need for renal arteriography has been significantly reduced. Currently, renal arteriography is mainly used in conjunction with lesions that can potentially be treated or to analyze renal vasculature preoperatively.

Recent data analysis demonstrated the need for the development of a local coverage determination (LCD) to outline indications and limitations of coverage for the following *CPT*/HCPCS codes:

75722 *Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation*

75724 *Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation*

G0275 Renal angiography, nonselective, one or both kidneys, performed at the same time as cardiac catheterization and/or coronary angiography, includes positioning or placement of any catheter in the abdominal aorta or near the origins (ostia) of the renal arteries, injection of dye, flush aortogram, production of permanent images, and radiologic supervision and interpretation (list separately in addition to primary procedure)

This new LCD outlines the indications and limitations of coverage, documentation requirements and utilization guidelines and contains a coding guideline attachment for the above listed procedure codes. In addition, the ICD-9-CM codes that support medical necessity are listed out accordingly.

For *CPT* codes *75722* and *75724* the following ICD-9-CM codes are medically necessary: 189.0, 189.1, 198.0, 223.0, 223.1, 233.9, 401.0, 405.01, 405.11, 405.91, 440.1, 441.00, 441.01, 441.02, 441.03, 441.1, 441.2, 441.3, 441.4, 441.5, 441.6, 441.7, 441.9, 442.1, 442.2, 442.83, 442.84, 443.22, 443.23, 444.0, 444.81, 445.02, 445.81, 447.3, 447.6, 557.0, 557.1, 557.9, 593.81, 593.9, 599.70, 747.62, 794.4, 902.40, 959.12, 959.8, 996.1, V42.0, and V58.44.

For HCPCS code G0275 the following ICD-9-CM codes are medically reasonable and necessary: 401.0, 402.00, 402.01, 403.00, 403.01, 404.00-404.03, 404.10-404.13, 405.01, 405.11, 440.1, 442.1, 445.81, and 447.3.

Effective date

This new LCD is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) 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.

95805 Polysomnography and sleep testing -- new LCD

LCD ID number: L29949 (Florida)
LCD ID number: L29951 (Puerto Rico/U.S. Virgin Islands)

Sleep studies and polysomnography (PSG) refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six or more hours with physician review, interpretation and report. Normally, sleep studies and PSG for sleep disorders are performed in sleep centers or laboratories. However, the diagnosis of obstructive sleep apnea (OSA) for coverage of continuous positive airway pressure (CPAP) may also be established by home sleep testing (HST).

Effective for claims with dates of service on and after March 13, 2008, the Centers for Medicare & Medicaid Services (CMS) determined that CPAP therapy when used in adult patients with OSA is considered reasonable and necessary under specified criteria which are listed in the *Medicare National Coverage Determinations (NCD) Manual*, Pub 100-03, Chapter 1, Section 270.4. Medicare will allow for coverage of CPAP therapy based upon a diagnosis of OSA by unattended home HST.

Based on the above CMS decision and criteria for specified medical conditions outlined by CMS for sleep disorder clinics, this local coverage determination (LCD) is being developed to include polysomnography and sleep testing CPT codes as well as the 2009 HCPCS codes (G0398, G0399, and G0400) for HST devices.

Indications and limitations of coverage criteria for specific medical conditions performed in sleep disorder clinics are included, as well as indications and limitations of coverage for unattended HST for OSA with the types of allowed devices defined. In addition, ICD-9-CM codes, documentation/credentialing requirements, utilization guidelines, and coding guidelines were included.

Effective date

This new LCD is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Revisions to LCDs

BOTULINUMTOXINS: Botulinum toxins -- revision to the LCD

LCD ID number: L29088 (Florida)
LCD ID number: L29103 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins 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. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD has been revised under "Off-label indications for Botox" to add language regarding coverage for neurogenic urinary incontinence and neurogenic detrusor overactivity in patients when documented oral therapy of this condition has failed. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has also been revised to add ICD-9-CM codes 596.54, 596.55 and 596.59 for HCPCS code J0585. The "Sources of Information and Basis for Decision" section of the LCD has also been updated.

Effective date

This LCD revision is effective for services rendered on or after April 6, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

IDTF Independent diagnostic testing facility -- revision to the LCD

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for independent diagnostic testing facility (IDTF) 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. Since that time, the LCD and coding guideline attachment have been revised. The following revisions have been made to the LCD:

- Language has been added to the"Ordering of Tests" section of the LCD regarding a physician's signature.
- Language has been revised in the "Physicians Supervision" section of the LCD to clarify a supervising physician's qualification requirements.
- The "Sources of Information and Basis for Decision" section of the LCD has been updated
- Two new sections,"Tests Personally Performed by a Physician" and "Requirements for Cardiac Catheterization Procedures Performed in an IDTF", have been added to the LCD.

The new section for "requirements for cardiac catheterization procedures performed in an IDTF" includes specific training requirements for physician and nonphysician personnel and/or accreditation requirements for the cardiac catheterization lab. This new section also includes physician supervision and interpreting physician qualification requirements, the cardiac catheterization procedure codes that are considered appropriate for an IDTF place of service and limitations associated with the performance of cardiac catheterization in an IDTF place of service.

The coding guidelines attachment has been revised as follows:

- Language has been added to the "Interpreting Physicians" section to indicate that an interpreting physician for a test billed by an IDTF is required to meet the same qualification requirements as the supervising physician for that test.
- The "Credentialing Matrix" section has been revised to change the title of column "Supervising Physician Qualification/Proficiency Requirements" to "Supervising Physician and Interpreting Physician Qualification Requirements". In addition, the "Credentialing Matrix" section has been revised to delete *CPT* code *76800* (*Ultrasound, spinal canal and contents*) and *CPT* code *95806* (*Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist*), as these services are not considered appropriate for an IDTF place of service.
- Cardiac catheterization *CPT* codes and associated training requirements for personnel have been added to the "Credentialing Matrix" section, with the exception of *CPT* code *93514* (*Left heart catheterization by left ventricular puncture*), *CPT* code *93524* (*Combined transseptal and retrograde left heart catheterization*), and *CPT* code *93528* (*Combined right heart catheterization with left ventricular puncture [with or without retrograde left heart catheterization]*), as these codes are not considered safe when performed in an IDTF setting.
- The"Supervising Physician and Interpreting Physician Qualification Requirements" section of the"Credentialing Matrix" for sleep studies (*CPT* codes *95805*, *95807*, *95808*, *95810*, *95811*, G0398, G0399, and G0400) has been revised to read"Board Certified (ABMS) Physician Certified by ABSM: Sleep Medicine or ABMS: Sleep Medicine". The"Technician Qualification Requirements" section for *CPT* codes *95805*, *95807*, *95808*, *95810* and *95811* has been revised to add CRT: SDS or RRT: SDS credentials.
- The "Supervising Physician and Interpreting Physician Qualification Requirements" section has been revised to add Board Certified (ABMS) "urologist", "cardiologist", and "vascular surgeon" for select *CPT* codes.

IDTF Independent diagnostic testing facility -- revision to the LCD (continued)

- The "Technician Qualification requirements" section has been revised to update credentialing by the American Association of Electrodiagnostic Technologists (AAET) for nerve conduction studies to reflect: "AAET: R.NCS.T" for select CPT codes.
- *CPT* codes *93501*, *93508*, *93510*, *93511*, *93526*, *93527*, *93529*, *93530*, *93531*, *93532*, *93533*, *93555*, *93556*, *93561*, *93562*, *93571* and *93572* have been added to the "Credentialing Matrix" section with the following requirements: "Level of Physician Supervision" "3", "Supervising Physician and Interpreting Physician Qualification Requirements" "board certified (ABMS) cardiologist with level 2 training (minimum) as outlined by the ACC/AHA task force 3" and "Technician Qualification Requirements" "credentialed by ARRT: CI or CCI: RCIS ."

Effective date

This LCD revision is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) 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.

J0881 Erythropoiesis stimulating agents -- revision to the LCD

LCD ID number: L29168 (Florida)
LCD ID number: L29339 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for erythropoiesis stimulating agents 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. Since that time, the LCD has been revised. Since the implementation of the national coverage decision (NCD) 110.21 for non-ESRD use of erythropoiesis stimulating agents (ESAs) in cancer and related conditions, First Coast Service Options Inc (FCSO) has encountered various issues surrounding the coding of the covered and noncovered indications outlined in the LCD. Although FCSO has handled these coding issues on a case by case basis as they were brought to our attention, FCSO has determined that the coding rules as outlined needed to be streamlined in order to make it easier for providers to submit claims accurately. To address this, FCSO posted the LCD for ESAs for notice and comment from February 20, 2009-April 6, 2009, and presented the draft LCD to the Carrier Advisory Committee (CAC) at our March meetings in Florida and Puerto Rico. The language opened up for comment was limited to the ICD-9-CM codes that support medical necessity and the second set of ICD-9-CM codes bulleted out in the coding guidelines. This article serves to outline the final decisions made by FCSO, which take into account all comments received. This article will also serve to summarize all the rules for billing non-ESRD ESAs (HCPCS J0881 and J0885) implemented since April 7, 2008, and how they apply to this newly revised LCD. Any questions on this LCD should be submitted to the medical policy department at *medical.policy@fcso.com*.

The lists of "ICD-9 codes that support medical necessity" for J0881 and J0885 have been revised to now include two lists of ICD-9-CM codes for each HCPCS code. The two lists for J0881 and J0885 now outline which ESA modifier (EA or EC) must be billed with the ICD-9-CM codes and any dual diagnosis requirement for the ICD-9-CM codes. These modifier designation and dual diagnosis rules are found at the beginning of each list for J0881 and J0885. ICD-9-CM codes that require a dual diagnosis are designated with an *. In addition, the coding guidelines attachment for the LCD has been revised to instruct providers how to bill for certain noncovered indications outlined in NCD 110.21. This change is outlined in more detail below. All other language and coding have not changed due to this revision.

Coding changes made as a result of the CAC process

J0881 (This list does not require a dual diagnosis.)
The following ICD-9-CM codes require modifier EA:
140.0-149.9, 150.0-159.9, 160.0-165.9, 170.0-176.9, 179-189.9, 190.0-199.2, 200.00-200.88, 201.00-201.98, 202.00-202.98, 203.00-203.82, 204.00-204.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, 209.30, 230.0-234.9, 235.0-235.9, 236.0-236.99, 237.0-237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.8, 238.9, or 239.0-239.9

J0881 (This list does not require a dual diagnosis.)
The following ICD-9-CM codes require modifier EC:
238.71, 238.72, 238.73, 238.74, 238.75, 238.76, or 273.3.

J0881
The following ICD-9-CM codes require modifier EC and a dual diagnosis (*): 285.21* and one of the following must be billed together: 403.01*, 403.11*, 403.91*, 404.02*, 404.03*, 404.12*, 404.13*, 404.92*, 404.93*, 585.1*, 585.2*, 585.3*, 585.4*, 585.5*, or 585.9*.

J0885 (This list does not require a dual diagnosis.)
The following ICD-9-CM codes require modifier EA:
140.0-149.9, 150.0-159.9, 160.0-165.9, 170.0-176.9, 179-189.9, 190.0-199.2, 200.00-200.88, 201.00-201.98, 202.00-202.98, 203.00-203.82, 204.00-204.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, 209.30, 230.0-234.9, 235.0-235.9, 236.0-236.99, 237.0-237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.8, 238.9, or 239.0-239.9

J0885 (This list does not require a dual diagnosis.)
The following ICD-9-CM codes require modifier EC:
238.71, 238.72, 238.73, 238.74, 238.75, 238.76, or 273.3

J0881 Erythropoiesis stimulating agents -- revision to the LCD (continued)

J0885

The following ICD-9-CM codes require modifier EC and a dual diagnosis (*):285.21* and one of the following must be billed together: 403.01*, 403.11*, 403.91*, 404.02*, 404.03*, 404.12*, 404.13*, 404.92*, 404.93*, 585.1*, 585.2*, 585.3*, 585.4*, 585.5*, or 585.9*.
285.29 or 285.9 and one of the following must be billed together: 042*, 070.54*, 070.70*, 714.0*, or V07.8*.

Coding guideline changes made as a result of LCD revision

As of January 1, 2008, the following are nationally noncovered indications for non-ESRD ESAs that report ESA modifier EC. These are not to be reported with any other ESA modifier. Because no specific ICD-9-CM code exists for these indications listed, FCSO will identify these noncovered conditions with ICD-9-CM code V49.89. This will indicate the ESA was given for a nationally noncovered condition as identified in business requirement 5818.1.1 of change request (CR) 5818.

- Any anemia in cancer or cancer treatments patients due to bone marrow fibrosis
- Anemia of cancer not related to cancer treatment
- Prophylactic use to prevent chemotherapy-induced anemia \
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies, and
- Anemia due to cancer treatments if patients have uncontrolled hypertension

Please see end of article for additional list of nationally noncovered indications identified in the NCD for non-ESRD ESA use.

Summary of non-ESRD ESA coverage based on CR 5818 and CR 5699 implemented on April 7, 2008

Effective January 1, 2008, all claims reporting non-ESRD ESAs (HCPCS codes J0881 and J0885) are required to report one of the following modifiers (based on CR 5699):

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

Modifier EA should only be reported when the ESA is being given for anemia resulting from myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia that is not related to the administration of chemotherapy for one of the listed covered cancer conditions is noncovered per the NCD. Therefore it is inappropriate to append modifier EA to those ESA claims. These ESA administrations should be identified with ICD-9-CM code V49.89 (as instructed in the coding guideline of the LCD) and modifier EC should be appended.

Modifier EC should only be reported for those covered indications outlined in the LCD under "ICD-9 codes that support medical necessity" for HCPCS codes J0881 and J0885 where the anemia being treated is non-chemo/radio induced. The provider must also append modifier EC for those nationally noncovered conditions outlined in the NCD and the coding guideline of the LCD. The noncovered ICD-9-CM codes that correspond to the nationally noncovered indications are noted in the coding guideline. If one of the noncovered ICD-9-CM codes and modifier EC are billed with J0881 or J0885, the ESA will be denied.

Modifier EB is noncovered. If billed with an ESA, the claim will be denied.

Effective January 1, 2008, all claims reporting ESAs J0881, J0882, J0885, or J0886 must report the most recent hemoglobin or hematocrit readings. For non-ESRD ESAs J0881 and J0885 reporting the modifier EA (anemia that is related chemotherapy), the hemoglobin or hematocrit are required to be below a certain level in order for the service to be medically necessary. Contractors are instructed, per CR 5818 to deny ESA services that report J0881 or J0885 with and EA modifier when Hgb is > 10.0g/L or the Hct is > 30 percent. There is no exception to this requirement, and there is no four-week window at initiation where providers can report a level above 10.0 g/L or 30 percent and have the service paid. The entire discussion surrounding ESA administration for cancer conditions is outlined in the LCD and NCD 110.21.

Additional noncovered indications as identified in NCD 110.21 for non-ESRD ESA use are listed below. The ESA services for J0881 and J0885 when reported with modifier EC will be denied when the following ICD-9-CM codes are reported:

- Any anemia in cancer or cancer treatment patients due to folate deficiency 281.2
- B-12 deficiency 281.1, 281.3
- Iron deficiency 280.0-280.9
- hemolysis 282.0, 282.2, 282.9, 283.0, 283.10, 283.19, 283.2, 283.9,
- bleeding 280.0, 285.1
- anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) 205.00-205.21, 205.80-205.91,and
- erythroid cancers (207.00-207.81)

Resources for information on ESA coverage

The complete NCD may be accessed in section 110.21 of Publication (Pub.) 100-03, *Medicare National Coverage Determinations (NCD) Manual*, and claims processing instructions may be accessed in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 17, sections 80.8-80.12 and through the following link:

http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=110.21&ncd_version=1&basket=ncd%3A110%2E21%3A1%3AErythropoiesis+Stimulating+Agents+%28ESAs%29+in+Cancer+and+Related+Neoplastic+Conditions.

CR 5818, transmittal 80 and 1413, dated January 14, 2008, may be accessed through the following links:

http://www.cms.hhs.gov/transmittals/downloads/R1413CP.pdf

http://www.cms.hhs.gov/transmittals/downloads/R80NCD.pdf

J0881 Erythropoiesis stimulating agents -- revision to the LCD (continued)

CR 5699, transmittal 1412, dated January 11, 2008, may be accessed through the following link: *http://www.cms.hhs.gov/transmittals/downloads/R1412CP.pdf*.

Effective date

This revision is effective for services rendered on or after June 30, 2009. FCSO 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.

J9305 Pemetrexed -- revision to the LCD

LCD ID number: L29255 (Florida)
LCD ID number: L29464 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pemetrexed 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. Since that time, the LCD has been revised.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to update the Food and Drug Administration (FDA) approved indications.

Effective date

This revision to the LCD is effective for claims processed on or after April 7, 2009, for services rendered on or after September 26, 2008. First Coast Service Options Inc. (FCSO) 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 last revised effective March 2, 2009. Since that time, the LCD has been revised.

The "Local Noncoverage Decisions -- Procedures" section of the LCD has been revised as follows:

- Deleted *CPT* code *0187T** (*Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral*)
- Added *CPT* codes *0184T** (Transanal endoscopic microsurgery (*TEMS*) and *45999** (*Unlisted procedure, rectum (Stapled Transanal Rectal Resection [STARR])*)
- Added *CPT* code *97799** (*Unlisted physical medicine/rehabilitation service or procedure* (Vertebral Axial Decompression/Intervertebral Differential Dynamics) and similar devices that would fall under this category of a noncovered benefit for this service

The "National Noncoverage Decisions -- Procedures" section of the coding guidelines attachment has been revised to align the descriptor of vertebral axial decompression (VAX-D) (*CPT* code *97799**) with the Centers for Medicare & Medicaid Services (CMS) Manual System, Pub 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2, Section 160.16.

*Services which are noncovered due to their being investigational/experimental.

Effective date

This revision to the LCD is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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SKINSUB Skin substitutes -- revision to the LCD

LCD ID number: L29279 (Florida)
LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was effective for services rendered on or after February 02, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a major revision was made based on new replacement skin substitute codes and descriptors issued by the Centers for Medicare & Medicaid Services (CMS) with the 2009 HCPCS update.

Verbiage was updated/revised under the following sections of the LCD:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Sources of Information and Basis for Decision

The allowable HCPCS codes were listed, as well as the HCPCS codes that are not covered under this LCD. A statement regarding reconsideration requests for noncovered services with supporting literature was included. The ICD-9-CM codes were also updated based on the indications of the allowable HCPCS codes. In addition, the "Coding Guidelines" attachment was revised.

Effective date

This revision to the LCD is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

THERSVCS Therapy and rehabilitation services -- revision to the LCD

LCD ID number: L29289 (Florida)
LCD ID number: L29399 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation 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. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD has been revised under "Neuromuscular Reeducation (*CPT* code *97112*)" to add language from change request (CR) 6397 regarding the Canalith repositioning procedure(s). In addition, the "coding guidelines" attachment was revised to include the changes from CR 6397, as well as language changes from CR 6321 regarding the Notice of Exclusion from Medicare Benefits (NEMB) form, the advance beneficiary notice (ABN) form, the access to accrued amount information, and the therapy cap dollar amount change for 2009.

Effective date

This LCD revision is effective for services rendered on or after January 1, 2009, for claims processed on or after April 6, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

VISCO Viscosupplementation therapy for knee -- revision to the LCD

LCD ID number: L29307 (Florida)
LCD ID number: L29408 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee 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. Since that time, the LCD has been revised.

In the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD under "Limitations" the third bullet was revised to clarify that there are no limitations for the number of courses of treatment for viscosupplementation. HCPCS code J3490 was added to the "*CPT*/HCPCS Codes", "ICD-9 Codes that Support Medical Necessity" and "Utilization Guidelines" sections of the LCD for use when billing Synvisc-one.

Effective date

This LCD revision is effective for claims processed on or after April 17, 2009, for services rendered on or after February 26. 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

70210 Radiologic examination, sinuses, paranasal -- revision to the LCD

LCD ID number: L29414 (Florida)
LCD ID number: L29415 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for radiologic examination, sinuses, paranasal 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. Since that time, the following sections of the LCD have been revised to update the verbiage:

- Indications and Limitations of Coverage and/or Medical Necessity
- Documentation Requirements
- Utilization Guidelines
- Sources of Information and Basis for Decision

The ICD-9-CM code range for acute sinusitis (461.0 – 461.9) was deleted from the LCD and the descriptors for all of the other ICD-9-CM codes were updated. The LCD title was changed to "sinus x-ray(s)" and the contractor's determination number was changed to 70210.

Effective date

This LCD revision is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

77055 Breast imaging: mammography/breast echography (sonography) -- revision to the LCD

LCD ID number: L29328 (Florida)
LCD ID number: L29329 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the breast imaging: mammography/breast echography (sonography) 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. Since that time, the LCD title was changed to reflect coverage guidelines for screening and diagnostic mammography procedures only. All coverage guidelines for other diagnostic breast procedures were deleted. Additionally, the indications for screening and diagnostic mammography procedures have been clarified, and new technology codes have been added to the "*CPT*/HCPCS Codes" section of the LCD.

Effective date

This LCD revision is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

92135 Scanning computerized ophthalmic diagnostic imaging (SCODI) -- revision to LCD

LCD ID number: L29276 (Florida)
LCD ID number: L29473 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) 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. Since that time, the LCD has been revised. First Coast Service Options Inc. (FCSO) evaluated coverage for *CPT* code *0187T*, scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, and determined coverage would be reasonable and necessary to add to the LCD for SCODI. This LCD was presented for notice and comment from February 20, 2009-April 6, 2009, and also presented to the Carrier Advisory Committee (CAC) meetings in March in Florida and Puerto Rico.

The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to include language pertaining to anterior segment SCODI. The "*CPT*/HCPCS Codes" section of the LCD has been revised to add *CPT* code *0187T* as medically reasonable and necessary. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to include appropriate ICD-9-CM codes for *CPT* code *0187T*. The "Documentation Requirements" section of the LCD has been revised to add language regarding *CPT* code *0187T*. The "Sources of Information and Basis for Decision" section of the LCD has also been revised accordingly.

Effective date

This LCD revision is effective for services rendered on or after June 30, 2009. FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

93015 Cardiovascular stress testing -- revision to the LCD

LCD ID number: L29412 (Florida)
LCD ID number: L29413 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cardiovascular stress testing 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. Since that time, the LCD has been revised to update the following sections of the LCD:

- Indications and Limitations of Coverage and/or Medical Necessity
- ICD-9 Codes that Support Medical Necessity
- Documentation Requirements
- Sources of Information and Basis for Decision

Effective date

This LCD revision is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

93798 Cardiac rehabilitation programs -- revision to the LCD

LCD ID number: L29092 (Florida)
LCD ID number: L29107 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cardiac rehabilitation programs 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. Since that time, the LCD has been revised to add ICD-9-CM code V15.1 (Surgery to heart and great vessels) to the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

Effective date

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

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.

Insulin for administration through DME (i.e., insulin pump) per 50 units (HCPCS code J1817) has been added to the Part B 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 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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PET bone imaging and sodium fluoride F-18

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate does not guarantee coverage by the Medicare program. Assignment of a payment rate only indicates how the product, procedure, or service may be paid if covered by the Program. Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage.

When billing PET bone imaging for Medicare patients, providers must use HCPCS Level II code G0235 PET imaging, any site, not otherwise specified. The Medicare national coverage determination policy for PET is considered an exclusionary policy. This means that any indication not listed in the policy is considered noncovered. Therefore, PET bone imaging is considered noncovered by Medicare, and providers are instructed by Medicare to use HCPCS Level II G codes for noncovered services for Medicare patients.

In addition, CMS Transmittal 1301, change request 5665 (July 20, 2007) states that the only PET radiopharmaceuticals Medicare will cover are Fluorodeoxyglucose F-18 (A9552), rubidium Rb-82 (A9555), and N-13 ammonia (A9526). Therefore, effective for claims processed on or after April 8, 2009, for services rendered on or after January 1, 2009, Sodium fluoride F-18 (A9580) will be denied as noncovered.

Updated Medicare coverage for off-label use of anti-cancer drugs

An off-label use of a drug is a use that is not included as an approved indication by the Food and Drug Administration (FDA) on the drug's label. For drugs used in an anti-cancer chemotherapeutic regimen, off-label indications may be covered under certain conditions. This article defines the criteria that must be met before coverage of an off-label indication of an anti-cancer drug is made. Currently, Medicare does not provide pre-authorization for drugs and biologicals. Denials may be appealed by means of the prescribed process.

In order for a Medicare administrative contractor (MAC) to support payment for an off-label indication of an anti-cancer chemotherapeutic drug, two criteria must be met:

1. Benefit category qualification as noted by the indication listed in a compendium (see below) or if no current positive compendium listing, support in the current scientific or peer-reviewed literature. (Trial studies submitted should definitively demonstrate safety and effectiveness supporting the request and must have been published in one of the Centers for Medicare & Medicaid Services (CMS)-approved journals (see list in the CMS *Medicare Benefit Policy Manual* – Pub. 100-02, Chapter 15, Section 50.4.5. C.). Abstracts or summary materials are not sufficient.)
2. If the indication is listed in one or more of the current CMS recognized compendia, the MAC confirms that the listed indication is medically reasonable and necessary after review of a copy of the **complete** compendium listing of the drug and review of the copies of current scientific or peer reviewed literature submitted by a J9 physician or appropriate stakeholder.
    - If the indication is not listed in one or more of the current CMS recognized compendia, the MAC will be limited to the review of the copies of current scientific or peer reviewed literature submitted by a J9 physician or appropriate stakeholder.
    - Also, suggested ICD-9-CM diagnosis code(s) that apply to the proposed indication should be submitted with the documentation, as well as specific information on proposed dosage schedules for the indication, if different than the FDA approved product information on dosage and administration.

CMS current compendia instruction accepts the use of compendia as the initial tool to determine whether an anti-cancer drug should be covered under Medicare Part B for an off-label indication. MAC consideration of payment for an off-label, medically accepted indication, will require that the indication be supported in either one or more of the compendia (listed below).

- American Hospital Formulary Service-Drug Information (AHFS-DI)
- National Comprehensive Cancer Network (NCCN)
- Drugs & Biologics Compendium (Thomson Micromedex DrugDex)
- Clinical Pharmacology

The above listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as medically accepted if the:

- Indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

This article is subordinate to any national coverage determination (NCD) or local coverage determination (LCD) of this MAC.

Under the above provisions, this MAC will consider coverage of an unlabeled indication after receipt and review of supporting documentation outlined above. Since this contractor does not have access to all the above listed compendia, providers should submit the complete compendia listing for each drug request. If there is an existing LCD for the drug in question, the reconsideration process will be followed. If there is no current LCD, an evaluation of the request will be made after review of the submitted literature to determine if an LCD needs to be developed.

In this article, unlabeled uses of anti-cancer drugs are limited to the treatment of malignant neoplastic conditions. Other drugs and biologicals and/or the use of anti-cancer drugs for non-cancerous conditions are outside the scope of this publication.

Educational Resources

Upcoming provider outreach and education events

May - June 2009

Fee schedule resources webcast

When: May 21
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Webcast
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

Chiropractic services

When: June 10
Time: 11:30 a.m. – 1:00 p.m.
Type of Event: Webcast
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

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.

Fee schedule resources webcast

Topic: Learn how to find fee information for most Medicare-covered procedure codes

When: Wednesday, May 21

11:30 a.m.-12:30 p.m. Delivery language: English

4:00 p.m.-5:00 p.m. Delivery language: Spanish

First Coast Service Options Inc. (FCSO) understands providers need to have fast and easy access to the resources required to submit Medicare claims successfully – the first time. That's why FCSO offers an extensive selection of Medicare resources, from informative articles and helpful tools on its provider Web sites to online training and live educational events to help providers learn how to use these valuable resources to their best advantage.

This webcast will offer providers an introduction to the fee schedule information resources available on the FCSO provider Web sites -- including an interactive fee lookup tool – and to powerful database tools offered on the Centers for Medicare & Medicaid Services (CMS) Web site.

Participants will learn how to:

- Find location-specific fee information for most Medicare-covered procedure codes with FCSO's easy-to-use, interactive look-up tool.
- Find printable portable document format (PDF) fee schedules and text-only fee schedule data files that can be imported into a spreadsheet or database.
- Research fee schedules and fee schedule-related information from previous payment years in FCSO's comprehensive archive.
- Use CMS' national physician fee schedule database tool to find fee information based upon a single, list, or a range of Healthcare Common Procedure Coding System (HCPCS) criteria.

Note: An open question-and-answer period will follow the presentation.

To participate in this webcast, please register by May 20.

For registration instructions, visit *http://medicare.fcso.com/wrapped/142808.asp*.

Please join us for this live Medicare educational event, and take advantage of this opportunity to learn about the resources you can use to find the information you need the most.

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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 ♦