MEDICARE B Update!

A NEWSLETTER FOR MAC J9 PROVIDERS

In This Issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office manager
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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.

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

The *Medicare B Update!* is a comprehensive publication developed by First Coast Service Options, Inc. (FCSO) for Part B providers in Florida, Puerto Rico, and U.S. Virgin Islands.

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

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

Following the table of contents, an administrative information section, the *Update!* content information is categorized as follows.

- The **claims** section provides claim submission requirements and tips.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by *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.

The *Medicare B Update!* represents formal notice of coverage policies

Articles included in each Update! represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

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.

Ambulatory Surgical Center

Physician and nonphysician practitioner services reassigned to ambulatory surgical centers

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 contractors (carriers or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6358 which instructs Medicare contractors to modify their systems to correctly accept, process, and provide payment for physician and nonphysician practitioner services reassigned to ambulatory surgical centers (ASCs).

Caution -- what you need to know

ASCs, that have entered into reassignment agreements with physician or nonphysician practitioners, and whose reassignment has been approved by the Centers for Medicare & Medicaid Services (CMS) through the CMS-855R, may bill for and receive payment for reassigned physician and nonphysician practitioner professional services. CR 6358 instructs Medicare contractors to modify their systems to correctly accept and process reassignment claims from ASCs, and reprocess valid reassignment claims brought to their attention for dates of service on or after January 1, 2008, that were not previously paid to either the ASC or the physician/nonphysician practitioner.

Go -- what you need to do

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

Background

The Social Security Act Section 1842(b)(6) (see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm* on the Internet) states in part, that no payment for a service may be made to anyone other than the physician or other person who provided the service, unless one of the exceptions to the prohibition on reassignment is met.

When applicable, physicians and nonphysician practitioners may reassign their right to bill and receive payment to an ASC if they meet the reassignment exceptions in Title 42 of the *Code of Federal Regulations* (CFR) Section 424.80 (see *http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr424.82.pdf* on the Internet), and the *Medicare Claims Processing Manual* (Chapter 1, Sections 30.2.6, and 30.2.7; see *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS Web site).

ASC payment system updates were provided by:

- CR 5572 (Transmittal R1245CP, May 18, 2007)
- CR 5680 (Transmittal R77BP, August 29, 2007), which is available at *http://www.cms.hhs.gov/transmittals/downloads/R77BP.pdf* on the CMS Web site.

However, the system updates made to the ASC payment system by CR 5572 and CR 5680 did not include necessary system provisions to correctly process claims for physician and nonphysician practitioners who reassign benefits to ASCs under the ASC payment system for dates of services on or after January 1, 2008. CR 6358 remedies that problem and Medicare contractors will accept and process reassignment claims from ASCs. Also, Medicare contractors will reprocess valid reassignment claims brought to their attention for dates of service on or after January 1, 2008, that were not previously paid to either the ASC or the physician/nonphysician practitioner.

Note: Medicare requires a valid reassignment application(s) to be on file with Medicare contractors in order to pay ASCs for physician or nonphysician practitioner services.

Additional information

The official instruction, CR 6358, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R488OTN.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6358
Related Change Request (CR) #: 6358
Related CR Release Date: May 1, 2009
Effective Date: January 1, 2008
Related CR Transmittal #: R488OTN
Implementation Date: October 5, 2009

Diabetic Services

Training Medicare patients on use of home glucose monitors and related billing information

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

Provider types affected

Physicians, providers, suppliers, and other healthcare professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for Medicare-covered diabetes self management training (DSMT) benefits.

Provider action needed

This special edition article is being provided to help clarify the physician's role in prescribing and/or providing blood glucose self-testing equipment and supplies and diabetes self-management training (DSMT) covered for Medicare beneficiaries with diabetes. The article reminds providers and suppliers about who may bill for DSMT and gives an overview of this benefit.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 23.6 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. This special edition article presents an overview of diabetes supplies and self-management training covered by Medicare.

Diabetes self-management training (DSMT)

The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of diabetes DSMT services when these services are furnished by a certified provider who meets certain quality standards. The DSMT program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified nonphysician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified nonphysician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training)
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training), and
- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in a file that includes the original order from the physician and any special conditions noted by the physician. When the training under the order is changed, the training order/referral must be signed by the physician or qualified nonphysician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT's program records.

Initial training

The initial year for DSMT is the 12-month period following the initial date, and Medicare will cover initial training that meets the following conditions:

- DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109
- DSMT is furnished within a continuous 12-month period
- DSMT does not exceed a total of 10 hours (the 10 hours of training can be done in any combination of 1/2 hour increments)
- With the exception of 1 hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries, and
- The one hour of individual training may be used for any part of the training including insulin training.

Follow-up training

Medicare covers follow-up training under the following conditions:

- No more than two hours individual or group training is provided per beneficiary per year
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries
- Follow-up training for subsequent years is based on a 12-month calendar after completion of the full 10 hours of initial training
- Follow-up training is furnished in increments of no less than one-half hour, and
- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

Training Medicare patients on use of home glucose monitors and related billing information (continued)

Note: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

Certified providers of DSMT

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to their Medicare contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under title XVIII, and meets certain quality standards. CMS has designated all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical equipment suppliers as certified. All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

Coding and payment of DSMT services

The following Healthcare Common Procedure Coding System (HCPCS) codes should be used for DSMT:

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes, and

G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Additional information

See the *Medicare Benefits Policy Manual* (Chapter 15, Section 300) at *http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf* for complete details on Medicare's policy for DSMT.

See the *Medicare Claims Processing Manual* (Chapter 18, Section 120.1 [Coding and Payment of DSMT Services]) at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf* for detailed billing instructions for DSMT.

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

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Implementation Date: N/A

Drugs and Biologicals

July 2009 quarterly average sales price update and revision to prior files

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 6471 and instructs Medicare contractors to download and implement the July 2009 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised April 2009, January 2009, October 2008, and July 2008, files. They will use the July 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2009, with dates of service July 1, 2009, through September 30, 2009.

Background

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

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

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

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

July 2009 quarterly average sales price update and revision to prior files (continued)

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

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of NOC HCPCS codes.

ASP methodology

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

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

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP plus 5 percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP plus 4 percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly. There are exceptions to this general rule and they are stated in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3 and may be reviewed at *http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf* on the CMS Web site.

Drugs furnished during filling or refilling an implantable pump or reservoir

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

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

Use of quarterly payment files

The following table shows how the quarterly payment files will be applied:

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

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

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 6471) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1737CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6471
Related Change Request (CR) #: 6471
Related CR Release Date: May 15, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1737
Implementation Date: July 6, 2009

Durable Medical Equipment

Durable Medical Equipment, Prosthetics, Orthotics and Supplies supplier accreditation

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

Note: CMS has revised *MLN Matters* special edition article SE0903 to provide important information for suppliers who choose not to become accredited. The MLN Matters article SE0903 was published in the March 2009 *Medicare B Update!* (pages 16-19).

Provider types affected

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

Provider action needed

Stop – impact to you

DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) suppliers enrolled with the national supplier clearinghouse (NSC) are required to obtain accreditation by **September 30, 2009.**

Caution – what you need to know

In order to obtain or retain a Medicare Part B billing privileges, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health & Human Services as noted below in this article) must comply with the Medicare program's supplier standards and quality standards and become accredited. These standards may be found in 42 CFR 424.57 or on page 36 and 37 of the CMS 855S. A DMEPOS supplier's Medicare Part B billing privileges will be revoked **on or after October 1, 2009,** if the DMEPOS supplier fails to obtain accreditation unless the DMEPOS supplier submits a voluntary termination to the NSC **by September 30, 2009.**

Go – what you need to do if you choose not to become accredited

For those DMEPOS suppliers who choose not to become accredited at this time, they will need to submit an amended CMS-855S application which reflects their voluntary termination. This will prevent the supplier from being revoked and subsequently barred from the Medicare program, as cited in 42 CFR Section 424.535(c). For pharmacies that choose not to become accredited but wish to remain a DMEPOS supplier in order to continue to bill Medicare for drugs and biologicals only, an amended CMS 855S will have to be completed. In addition to updating their application, the supplier must ensure that they have checked the appropriate boxes in Section 2 (C) to reflect which drugs and biologicals they will provide to beneficiaries. Providers and suppliers can find the latest version of CMS 855S on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf*.

Background

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

Covered items and services

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

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

Noncovered items

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

DMEPOS quality standards

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

- **Section I** includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management, product safety and information management.
- **Section II** contains service standards, including intake,

DMEPOS supplier accreditation (continued)

delivery and setup, training and instruction of the beneficiary and/or their caregiver and follow-up service.

- **Appendix A** addresses respiratory equipment, supplies and services.
- **Appendix B** addresses manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- **Appendix C** addresses custom fabricated and custom fitted orthoses, prosthetic devices, external breast prostheses, therapeutic shoes and inserts and their accessories and supplies, and custom-made somatic, ocular and facial prostheses.

Accreditation deadline for DMEPOS suppliers

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) set a deadline for all DMEPOS suppliers to be accreditated **by September 30, 2009**.

Who needs accreditation?

The September 30, 2009, accreditation deadline applies to all suppliers of DME, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics that are enrolled with NSC. The accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers.

Who is exempt?

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

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

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

- Orthotists
- Prosthetists
- Opticians
- Audiologists.

Key points

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

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

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

A DMEPOS supplier's Medicare Part B billing privileges will be revoked on or after October 1, 2009, if the DMEPOS supplier fails to obtain accreditation or a voluntary termination has not been received by the NSC by September 30, 2009. **If a supplier chooses not to become accredited, they must submit an amended CMS 855S to prevent revocation and subsequent exclusion from the Medicare program.**

Accreditation frequently asked questions (FAQs)

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

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

2. Who are the approved DMEPOS accrediting organizations?

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

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

Accreditation cannot be transferred upon merger, acquisition or sale of a supplier. As specified in 42 CFR 424.57 (c) (3), CMS, the NSC and the accrediting

DMEPOS supplier accreditation (continued)

organization must be notified when a new DMEPOS location is opened.

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

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

5. **Is information transferred between the accreditor and NSC?**

   Transfer of information between these two entities concerning their findings does occur.

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

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

Additional information

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site. There is additional information on the accreditation process at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp#TopOfPage* on the CMS Web site.

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

Evaluation and Management Services

Update to the list of Medicare telehealth services

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

Provider types affected

Hospitals, provider-based renal dialysis facilities, physicians, and practitioners who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (MACs) for Medicare telehealth services related to end-stage renal disease.

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6458, which updates the list of Medicare telehealth services to reflect the coding changes for ESRD-related services that took effect during the 2009 Healthcare Procedural Coding System (HCPCS) update.

Caution -- what you need to know

The list of approved telehealth services is updated to reflect the deletion of the ESRD-related G-codes and the addition of the *CPT* codes. The established policy for telehealth services has not changed.

Go -- what you need to do

You should use the updated codes and advise your billing staff of the coding changes.

Background

The 2009 HCPCS update added several new *Current Procedural Terminology* (*CPT*) procedure codes related to ESRD services and deleted the related G-codes, effective for dates of service on or after January 1, 2009. A number of these ESRD-related services are on the list of approved telehealth services. The list of approved telehealth services has been updated to reflect the deletion of the G-codes and the addition of the *CPT* codes. The established policy for telehealth services has not changed.

Code changes

- Effective January 1, 2009, carriers and MACs will pay for *CPT* codes *90951*, *90952*, *90954*, *90955*, *90957*, *90958*, *90960*, and *90961* according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GT or GQ.
- Effective January 1, 2009, FIs or MACs will pay for *CPT* codes *90951*, *90952*, *90954*, *90955*, *90957*, *90958*, *90960*, *and 90961* according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GT or GQ by critical access hospitals that have elected method II on type of bill 85x.

Note: Contractors do not have to search their files and reprocess claims for *CPT* codes 909*51*, *90952*, *90954*, *90955*, *90957*, *90958*, *90960*, and *90961* with dates of service on or after January 1, 2009, but will adjust any claims for these services that you bring to their attention.

Update to the list of Medicare telehealth services (continued)

Additional information

For complete details regarding this CR please see the official instruction (CR 6458) issued to your Medicare contractor. That instruction was issued in two transmittals. The transmittal revising the *Medicare Benefit Policy Manual* is at *http://www.cms.hhs.gov/Transmittals/downloads/R105BP.pdf* on the CMS Web site. The transmittal conveying changes to the *Medicare Claims Processing Manual* is at *http://www.cms.hhs.gov/Transmittals/downloads/R1716CP.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6458
Related Change Request (CR) #: 6458
Related CR Release Date: April 24, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R105BP and R1716CP
Implementation Date: May 26, 2009

Hospice

Adding a new specialty code for hospice and palliative care

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

Provider types affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (MAC) for hospice and palliative care services provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) will add a new physician specialty code to categorize hospice and palliative care. This new physician specialty code is 17. Medicare physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) when they enroll in the Medicare program. Medicare specialty codes describe the specific/unique types of medicine that physicians practice. Specialty codes are used by CMS for programmatic and claims processing purposes.

Additional information

You may find the official instruction, change request 6311, issued to your FI or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1715CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. If you have any questions, please contact your carrier, FI, or MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

MLN Matters® Number: MM6311
Related Change Request (CR) #: 6311
Related CR Release Date: April 24, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R1715CP
Implementation Date: October 5, 2009

Laboratory/Pathology

July 2009 changes to the laboratory national coverage determination edit software

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6481, which announces the changes that will be included in the July 2009 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in April 2009. Be sure staff is aware of these changes.

Background

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

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

CR 6481 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for July 2009 as described below. These changes become effective for services furnished on or after July 1, 2009 and are as follows:

For prothrombin time (PT)
Add ICD-9-CM codes 200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, and 440.4 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (PT) (190.17) NCD.

For serum iron studies
Add ICD-9-CM codes 200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, and 202.70-202.78 to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.

For lipid testing
Add ICD-9-CM code 440.4 to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD.

For gamma glutamyl transferase
Add ICD-9-CM codes 200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78 and 202.70-202.78 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

Additional information

If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site. The official instruction (CR 6481) issued to your Medicare MAC, carrier, and/or FI may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1735CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6481
Related Change Request (CR) #: 6481
Related CR Release Date: May 15, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1735CP
Implementation Date: July 6, 2009

Routine Foot Care

Clarification -- billing of routine foot care when payment ceases for loss of protective sensation evaluation and management

Background

The Centers for Medicare and Medicaid Services (CMS) is clarifying the requirement for podiatric treatment in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 32, Section 80.8). This clarification is necessary to support podiatric coverage requirements found in the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 290).

Common working file (CWF) utilization edits (Section 80.8)

Edit 1

Should CWF receive a claim from an FI for G0245 or G0246 and a second claim from a contractor for either G0245 or G0246 (or vice versa) and they are different dates of service and less than six months apart, the second claim will reject. CWF will edit to allow G0245 or G0246 to be paid no more than every six months for a particular beneficiary, regardless of who furnished the service. If G0245 has been paid, regardless of whether it was posted as a facility or professional claim, it must be six months before G0245 can be paid again or G0246 can be paid. If G0246 has been paid, regardless of whether it was posted as a facility or professional claim, it must be six months before G0246 can be paid again or G0245 can be paid. CWF will not impose limits on how many times each code can be paid for a beneficiary as long as there has been six months between each service.

The CWF will return a specific reject code for this edit to the contractors and fiscal intermediaries (FIs) that will be identified in the CWF documentation. Based on the CWF reject code, the contractors and FIs must deny the claims and return the following messages:

MSN 18.4: This service is being denied because it has not been __ months since your last examination of this kind (Note: Insert six as the appropriate number of months.)

RA claim adjustment reason code 96 -- noncovered charges, along with remark code M86: Service denied because payment already made for same/similar procedure within set time frame.

Edit 2

The CWF will edit to allow G0247 to pay only if either G0245 or G0246 has been submitted and accepted as payable on the same date of service. CWF will return a specific reject code for this edit to the contractors and FIs that will be identified in the CWF documentation. Based on this reject code, contractors and FIs will deny the claims and return the following messages:

MSN 21.21: This service was denied because Medicare only covers this service under certain circumstances.

RA claim adjustment reason code 107: The related or qualifying claim/service was not identified on this claim.

Edit 3

Once a beneficiary's condition has progressed to the point where routine foot care becomes a covered service, payment will no longer be made for LOPS evaluation and management services. Those services would be considered to be included in the regular exams and treatments afforded to the beneficiary on a routine basis. The physician or provider must then just bill the routine foot care codes, per Pub 100-02, Chapter 15, Section 290.

The CWF will edit to reject LOPS codes G0245, G0246, and/or G0247 when on the beneficiary's record it shows that one of the following routine foot care codes were billed and paid within the prior six months: *11055*, *11056*, *11057*, *11719*, *11720*, and/or *11721*.

The CWF will return a specific reject code for this edit to the contractors and FIs that will be identified in the CWF documentation. Based on the CWF reject code, the contractors and FIs must deny the claims and return the following messages:

MSN 21.21: This service was denied because Medicare only covers this service under certain circumstances.

RA claim adjustment reason code 96 -- noncovered charges, along with remark code M86: Service denied because payment already made for same/similar procedure within set time frame.

Source: Publication 100-04, Transmittal 1742, Change request 6456

Therapy Services

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.

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/R1733CP.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: May 8, 2009
Effective Date: October 1, 2006
Related CR Transmittal #: R1733CP
Implementation Date: April 27, 2009

Speech-language pathology private practice payment policy

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

Provider types affected

Speech-language pathologists in private practice who wish to bill Medicare carriers and Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries.

What you need to know

CR 6381, from which this article is taken, announces that Medicare will begin paying for appropriate claims submitted by enrolled speech-language pathologists for services provided in private practice on or after July 1, 2009. See the *Background* section of this article for additional important details.

Background

Historically, Medicare could only pay for speech-language pathology (SLP) services if the services were billed by an enrolled provider or supplier of services. CR 6381, from which this article is taken, announces that Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) has amended the Social Security Act to authorize:

- The Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services, consistent with the enrollment policies that apply to physical therapists and occupational therapists in private practice; and
- SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009.

This amendment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. CMS will begin enrolling SLPs on June 2, 2009 CMS, and will accept (and pay for) appropriate claims for services provided on or after July 1, 2009 by enrolled SLPs in private practice for dates of service beginning July 1, 2009.

Note: A therapist is considered to be in private practice if the therapist maintains office space at his or her own expense and furnishes services only in that space or in the patient's home; or is employed by another supplier of services such as a physician or another therapist and furnishes services in settings where therapy is provided at the expense of that supplier.

You should be aware that:

1. No other provider or supplier other than the skilled nursing facility (SNF) will be paid for these services during the time the beneficiary is in a covered Part A stay.

   For information regarding SNF consolidated billing see the *Medicare Claims Processing Manual* Chapter 6 (SNF Inpatient Part A Billing, Section 10 (Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview).

2. The home health prospective payment system (HHPPS) requires home health agencies (HHA) to provide (either directly or under arrangements) all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health plan of care (POC). No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay.

   For information regarding HH consolidated billing see the *Medicare Claims Processing Manual* Chapter 10 (Home Health Agency Billing), Section 20 (Home Health Prospective Payment System (HHPPS) Consolidated Billing).

In addition, note that your carrier or MAC will apply therapy caps and exceptions, as appropriate, to speech language pathology services rendered by speech language pathologists in private practice. Information regarding therapy caps and exceptions for 2009 is available in the *MLN Matters* article related to CR 6321. That article is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6321.pdf* on the CMS Web site.

Additional information

You may find more information about the speech-language pathology private practice payment policy by going to CR 6381, which was issued in two transmittals. You will find the updated portions of Medicare manuals attached to these transmittals as follows:

- The revised chapters of the *Medicare Claims Processing Manual* are available attached to the transmittal at *http://www.cms.hhs.gov/Transmittals/downloads/R1717CP.pdf* on the CMS Web site; and
- The revised chapter of the *Medicare Benefit Policy Manual* is available at *http://www.cms.hhs.gov/Transmittals/downloads/R106BP.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6381
Related Change Request (CR) #: 6381
Related CR Release Date: April 24, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R106BP and R1717CP
Implementation Date: July 6, 2009

General Coverage

The ICD-10 Clinical Modification/Procedure Coding System (CM/PCS)--the next generation of coding

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

Note: This article was revised on May 14 and May 19, 2009, to modify the description of the ICD-10-CM diagnoses codes in the *Structural differences between the two coding systems* section and to modify a Web address in the *Additional information* section to link to the ICD-10 final rule. All other information remains the same. This information was previously published in the October 2008 *Medicare B Update!* pages 33-34.

Provider types affected

This article is informational only for all physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This special edition article (SE0832) outlines general information for providers detailing the International Classification of Diseases, 10th Edition (ICD-10) classification system. Compared to the current ICD-9 classification system, ICD-10 offers more detailed information and the ability to expand specificity and clinical information in order to capture advancements in clinical medicine. Providers may want to become familiar with the new coding system.

The system is not yet implemented in Medicare's fee-for-service (FFS) claims processes so no action is needed at this time.

Background

A number of other countries already use ICD-10, including:

- United Kingdom (1995)
- France (1997)
- Australia (1998)
- Germany (2000)
- Canada (2001)

ICD-10-CM/PCS consists of two parts:

ICD-10- CM (Clinical Modification)

The diagnosis classification system was developed by the Centers for Disease Control and Prevention for use in all United States of America health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM).

ICD-10- PCS (Procedure Coding System)

The procedure classification system was developed by CMS for use in the U.S. for inpatient hospital settings ONLY. The new procedure coding system uses seven alpha or numeric digits while the ICD-9-CM coding system uses three or four numeric digits.

ICD-10-CM/PCS

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services
  - Increased sensitivity when refining grouping and reimbursement methodologies
  - Enhanced ability to conduct public health surveillance, and
  - Decreased need to include supporting documentation with claims.
- Includes updated medical terminology and classification of diseases.
- Provides codes to allow comparison of mortality and morbidity data.
- Provides better data for:
  - Measuring care furnished to patients
  - Designing payment systems
  - Processing claims
  - Making clinical decisions
  - Tracking public health
  - Identifying fraud and abuse, and
  - Conducting research.

Structural differences between the two coding systems

1. Diagnoses codes

ICD-9-CM diagnoses codes are 3-5 digits in length with the first digit being alpha (E or V) or numeric and digits 2-5 being numeric. For example:

- 496 – Chronic airway obstruction not elsewhere classified (NEC)
- 511.9 – Unspecified pleural effusion, and
- V02.61 – Hepatitis B carrier.

ICD-10-CM diagnoses are 3-7 digits in length with the first digit being alpha, digits 2 and 3 being numeric and digits 4-7 are alpha or numeric. The alpha digits are not case sensitive. For example:

- A78 – Q fever
- A69.21 – Meningitis due to Lyme disease, and
- S52.131a – Displaced fracture of neck of right radius, initial encounter for closed fracture.

The ICD-10 Clinical Modification/Procedure Coding System. . . (continued)

2. Procedure codes

ICD-9-CM procedures are 3 – 4 digits in length and all digits are numeric. For example:

- 43.5 – Partial gastrectomy with anastomosis to esophagus, and
- 44.42 – Suture of duodenal ulcer site.

ICD-10-PCS procedures are 7 digits in length with each of the 7 digits being either alpha or numeric. The alpha digits are not case sensitive. Letters O and I are not used to avoid confusion with the numbers 0 and 1. For example:

- 0FB03ZX – Excision of Liver, Percutaneous Approach, Diagnostic, and
- 0DQ10ZZ – Repair upper esophagus, open approach.

Note that ICD-10-CM/PCS would not affect physicians, outpatient facilities, and hospital outpatient departments' usage of *Current Procedural Terminology* (*CPT*) codes on Medicare FFS claims as *CPT* use would continue.

Additional information

The Centers for Medicare & Medicaid Services (CMS) has developed a dedicated Web page for ICD-10 information. That page is at *http://www.cms.hhs.gov/ICD10* on the CMS Web site.

Details on the ICD-10-PCS Coding System, mappings, and a related training manual may be found at *http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp#TopOfPage* on the CMS Web site.

The ICD-10 final rule is available at *http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf* on the Internet.

Details on the ICD-10-CM coding system, mappings, and guidelines may be found at *http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm* on the Internet and also at *http://www.cms.hhs.gov/ICD10/03_2008_ICD_10_CM.asp#TopOfPage* on the CMS Web site.

Many private sector professional organizations and businesses have resources available that may help with ICD-10-CM/PCS implementation planning.

Please note that the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act (HIPAA) standard. The dedicated CMS ICD-10 page also has links to these resources in the "Related Links Outside of CMS" at the bottom of the page.

MLN Matters® Number: SE0832 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Billing routine costs of clinical trials

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

Note: This article was revised on May 26, 2009, revising the transmittal number, change request (CR) effective date, and the Web address for accessing CR 6431. Also, the sentence at the end of the *Background* section, which read "Institutional providers should also note that they must not bill outpatient clinical trial services and non-clinical trial services on the same claim for Medicare beneficiaries enrolled in managed care plans." was deleted. This information was previously published in the April 2009 *Medicare B Update!* pages 7-8.

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 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.
- 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.

Billing routine costs of clinical trials (continued)

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 Medicare 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 Medicare MAC, or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1743CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6431 *Revised*
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 and processed after July 10, 2009
Related CR Transmittal #: R1743CP
Implementation Date: July 10, 2009

Expansion of the current scope of editing for ordering/referring providers

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

Provider types affected

Physicians and nonphysician practitioners who order and/or refer services that are billed to Medicare carriers or Part B Medicare administrative contractors (MAC) for Medicare beneficiaries.

What you need to know

Change request (CR) 6417, on which this article is based, announces that in order to comply with Social Security Act requirements, the Centers for Medicare & Medicaid Services (CMS) is expanding claim editing to verify that the ordering/referring provider on a claim is enrolled in Medicare and is eligible to order or refer Medicare services. Please refer to the *Background* section for more details.

Background

Only physicians and nonphysician practitioners (who meet the definitions at section 1861(r) and 1842(b)(18)(C) of the Social Security Act [the Act]) are eligible to order or refer services for Medicare beneficiaries. In addition, Section 1833(q) of the Act requires that all physicians and nonphysician practitioners who meet these definitions must be uniquely identified on all claims for services that they order or refer. More specifically, effective January 1, 1992, a physician or supplier who bills Medicare for a service or item that was the result of an order or referral must show the name and unique identifier of the ordering/referring provider on the claim. As of May 23, 2008, this unique identifier must be the national provider identifier (NPI).

CR 6417, from which this article is taken, announces that, effective October 5, 2009, CMS is expanding claim editing to meet these Social Security Act requirements to verify that the ordering/referring provider on a claim is enrolled in Medicare and is eligible to order or refer.

CR 6417 provides that only the following provider specialties can order or refer beneficiary services:

- Doctor of Medicine or Osteopathy
- Dental Medicine
- Dental Surgery
- Podiatric Medicine
- Optometrist
- Chiropractic Medicine
- Physician Assistant
- Certified Clinical Nurse Specialist
- Nurse Practitioner
- Clinical Psychologist
- Certified Nurse Midwife, or
- Clinical Social Worker.

During phase 1 implementation (beginning October 5, 2009), if the claim does not pass the edits described above, Medicare will continue to process the claim and will include an informational message on the remittance advice.

In phase 2, if the billed service requires an ordering/referring provider and none is present, the claim will not be paid.

If the ordering/referring provider is on the claim, Medicare will verify the ordering/referring provider's NPI and name reported on the claim against Medicare's provider enrollment records to ensure the ordering/referring provider is enrolled in Medicare and is a specialty eligible to order or refer.

Notes: If multiple provider identification numbers (PINs) are associated to the NPI in MCS, Medicare contractors will use the first active PIN with an eligible specialty to order and refer.

Expansion of the current scope of editing for ordering/referring providers (continued)

Therefore, upon phase 2 implementation and thereafter, the claim that does not pass the edits described above the claim will not be paid.

All physician and nonphysician practitioners who order and refer items or services for Medicare beneficiaries should verify their Medicare enrollment. They may do so by going to *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage* on the CMS Web site..

Additional information

You may find the official instruction, CR 6417, issued to your carrier or B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R470OTN.pdf* on the CMS Web site.

If you have any questions, please contact your carrier or 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: MM6417
Related Change Request (CR) #: 6417
Related CR Release Date: April 24, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R470
Implementation Date: October 5, 2009

Requirements for specialty codes

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/or carriers for services provided to Medicare beneficiaries.

Provider action needed

This article is informational only and is based on change request (CR) 6303 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is to revising the *Medicare Claims Processing Manual*, Chapter 26, Section 10.8 in order to clarify the criteria CMS considers when reviewing Medicare physician/nonphysician practitioner specialty code requests.

Background

Medicare physician/nonphysician practitioner specialty codes describe the specific/unique types of medicine that physicians and nonphysician practitioners (and certain other suppliers) practice. Physicians self-designate their Medicare physician specialty on their Medicare enrollment application (CMS-855I, which is available at *http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf* on the CMS Web site) or on the Internet-based provider enrollment, chain and ownership system. nonphysician practitioners are assigned a Medicare specialty code when they enroll based on their profession. Specialty codes are used by CMS for programmatic and claims processing purposes. Physicians and nonphysician practitioners self-designate their Medicare physician/nonphysician practitioner specialty on the CMS-855I when they enroll in the Medicare program. The specialty code becomes associated with the claims submitted by that physician or nonphysician practitioner. Medicare physician/nonphysician practitioner specialty codes describe the specific/unique types of medicine that physicians and nonphysician practitioners (and certain other suppliers) practice. Specialty codes are used by CMS for programmatic and claims processing purposes.

CMS will consider certain criteria for approving or disapproving requests from physician specialty associations for inclusion in the list of Medicare physician/nonphysician practitioner specialty codes. Medicare contractors (carriers and MACs) may not approve/disapprove any specialty code requests. They must send all requests specialty codes to CMS central office.

Key points of CR 6303

- Your Medicare contractor has been advised of the criteria CMS considers when reviewing Medicare physician/ nonphysician practitioner specialty code requests.
- When considering a request for expanding the specialty code list for physician and /nonphysician practitioners, CMS will take into consideration the following:
  - Whether the requested specialty has the authority to bill Medicare independently
  - The requester's clearly stated reason or purpose for the code
  - Evidence that the practice pattern of the specialty is markedly different from that of the dominant parent specialty

Requirements for specialty codes (continued)

- Evidence of any specialized training and/or certification required
- Whether the specialty treats a significant volume of the Medicare population
- Whether the specialty is recognized by another organization, such as the American Board of Medical Specialties
- Whether the specialty has a corresponding healthcare provider taxonomy code.

Additional information

If you have questions, please contact your Medicare MAC or carrier at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site. The official instruction (CR 6303) issued to your Medicare MAC and/or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1725CP.pdf* on the CMS Web site.

MLN Matters Number: MM6303
Related Change Request (CR) #: 6303
Related CR Release Date: May 1, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1725CP
Implementation Date: July 6, 2009

Electronic Data Interchange

Overview of the Health Insurance Portability and Accountability Act 5010

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

Provider types affected

All physicians, providers, and suppliers who bill Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

What you need to know

Stop -- impact to you

The implementation of Health Insurance Portability and Accountability Act (HIPAA) 5010 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation will require changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you are aware of these HIPAA changes and plan for their implementation.

Caution -- what you need to know

The Administrative Simplification Act (ASCA) requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Therefore, effective January 1, 2012, you must be ready to submit your claims electronically using the X12 version 5010 and NCPDP version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. The Centers for Medicare & Medicaid Services (CMS) will provide additional information to assist you and keep you apprised of progress on Medicare's implementation of HIPAA 5010 through a variety of communication vehicles. Remember that the HIPAA standards, including the X12 version 5010 and version D.0 standards, are national standards and apply to your transactions with all payers, not just with Medicare fee-for-service (FFS). Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare expects to begin transitioning to the new formats January 1, 2011, and ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.

Go -- what you need to do

In preparing for the implementation of these new X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others. The transactions and code sets final rule published on Aug. 17, 2000, adopted standards for the statutorily identified transactions, some of which were modified in a subsequent final rule published on Feb. 20, 2003.

These current versions of the standards (the Accredited Standards Committee X12 version 4010/4010A1 for health care transactions, and the NCPDP version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. On January 16, 2009, HHS announced a final rule that replaces the current version 4010/4010A and NCPDP version 5.1 with version 5010 and version D.0, respectively.

Over 99 percent of Medicare Part A claims and over 95 per cent of Medicare Part B claims transactions are received electronically and it is imperative that providers be ready for these new standards in order to continue submitting claims electronically. The remainder of this article will provide some rationale for the new standards and also provide some guidance to providers on preparing for this implementation.

Version 5010 (healthcare transactions)

Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). It is more specific in requiring the data that is needed, collected, and transmitted in a transaction (such as tightened, clear situational rules, and in misunderstood areas such as corrections and reversals, refund processing, and recoupments). Further, the new claims transaction standard contains significant improvements for the reporting of clinical data, enabling the reporting of ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes, and distinguishes between principal diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.

Finally, version 5010 also addresses a variety of currently unmet business needs, including an indicator on institutional claims for conditions that were "present on

An introductory overview of the HIPAA 5010 (continued)

admission," and accommodating the use of the ICD-10 code sets, which are not supported by version 4010/4010A1.

Version D.0 (pharmacy claims)

Version D.0 specifically addresses business needs that have evolved with the implementation of the Medicare prescription drug benefit (Part D) as well as changes within the health care industry. New data elements and rejection codes in version D.0 will facilitate both coordination of benefits claims processing and Medicare Part D claims processing.

In addition, version D.0:

- Provides more complete eligibility information for Medicare Part D and other insurance coverage
- Better identifies patient responsibility, benefits stages, and coverage gaps on secondary claims, and
- Facilitates the billing of multiple ingredients in processing claims for compounded drugs.

The 5010/D.0 rule also adopts a standard for the Medicaid pharmacy subrogation transaction(known as NCPDP version 3.0), as currently one does not exist for this process by which state Medicaid agencies recoup funds for payments they have made for pharmacy services for Medicaid recipients, when a third party payer has primary financial responsibility. Since many states presently conduct this transaction electronically, and employ a variety of standards with different payers, adoption of a standard for this transaction will increase efficiencies and reduce costs for Medicaid programs.

The compliance date for implementing version 5010 and version D.0 is January 1, 2012, to allow time to test the standards internally, to ensure that systems have been appropriately updated, and then to transition to the new formats between trading partners before the compliance date. For the Medicaid pharmacy subrogation standard, the compliance date is also January 1, 2012, except for small health plans, which must be compliant on January 1, 2013.

CMS progress in implementing the new standards

CMS is well into the process of readying its FFS Medicare systems to handle the 5010/D.0 standards. All Medicare systems will be ready to handle the new standards by January 1, 2011. Medicare plans for its systems to handle the current 4010A standard and the new 5010/D.0 standards for incoming claims and inquiries and for outgoing replies and remittances from January 1, 2011, until January 1, 2012. This will allow providers who are ready to begin using the new standards on January 1, 2011, while providing an additional year for all providers to be ready.

In addition, where possible, CMS will be making system enhancements concurrent with the 5010/D.0 changes. These enhancements include capabilities such as:

- Implementing standard acknowledgement and rejection transactions across all jurisdictions (TA1, 999 and 277CA transactions)
- Improving claims receipt, control, and balancing procedures
- Increasing consistency of claims editing and error handling
- Returning claims needing correction earlier in the process, and
- Assigning claim numbers closer to the time of receipt.

Additional information

You may find more information about HIPAA 5010 by going to *http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp* on the *Electronic Billing & EDI Transactions* page on the CMS Web site. Medicare has prepared a comparison of the current X12 HIPAA EDI standards (version 4010/4010A1) with version 5010 and the NCPDP EDI standards version 5.1 to D.0, and has made these side-by-side comparisons available at this Web site. These comparisons may be of interest to other covered entities and their business associates.

A special edition *MLN Matters*® article on the ICD-10 code set is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf* on the CMS Web site.

CMS will also use the open door forums and listservs as means of keeping providers informed of its implementation progress and will also use the vehicles to assist providers in getting ready for the new standards. Information on the open door forums is available at *http://www.cms.hhs.gov/OpenDoorForums/* on the CMS Web site. Information about listservs (email updates) is available at *http://www.cms.hhs.gov/AboutWeb site/EmailUpdates/* on that same site.

In addition, a fact sheet on HIPAA 5010 is available at *http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3246&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date* on the CMS Web site. Finally, you may read the proposed rule in the *Federal Register*, Vol. 73, No. 164, Friday, August 22, 2008 at *http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf*; and the final rule in the *Federal Register*, Vol. 74, No. 11, Friday, January 16, 2009, at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf* on the CMS Web site.

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

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Effective Date: N/A
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Implementation Date: N/A

General Information

Mandatory claims submission and its enforcement

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

Provider types affected

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

Provider action needed

Stop -- impact to you

The Centers for Medicare & Medicaid Services (CMS) is issuing this special edition article to remind physicians and suppliers of the Medicare requirements for mandatory electronic claims submission and its enforcement.

Caution -- what you need to know

The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment.

Go -- what you need to do

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

Background

The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment. Compliance to mandatory claim filing requirements is monitored by CMS, and violations of the requirement may be subject to a civil monetary penalty of up to $2,000 for each violation, a 10 percent reduction of a physician's/supplier's payment once the physician/supplier is eventually brought back into compliance, and/or Medicare program exclusion. Medicare beneficiaries may not be charged for preparing or filing a Medicare claim.

For the official requirements, see the following:

- Social Security Act (Section 1848(g)(4)(A); "Physician Submission of Claims") at *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet.
- Requirement to file claims -- the *Medicare Claims Processing Manual*, Chapter 1, Section 70.8.8: *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS Web site.

Exceptions to mandatory filing

Physicians and suppliers are not required to file claims on behalf of Medicare beneficiaries for:

- Used durable medical equipment (DME) purchased from a private source
- Medicare secondary payer (MSP) claims when you do not possess all the information necessary to file a claim
- Foreign claims (except in certain limited situations)
- Services furnished by opt-out physicians or practitioners (except in emergency or urgent care situations when the opt-out physician or practitioner has not previously entered into a private contract with the beneficiary)
- Services that are furnished for free, or
- Services paid under the indirect payment procedure.

For further details, see the *Medicare Claims Processing Manual* (Chapter 1, Section 70.8.8.8) at *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS Web site.

Note: You are not required to file a claim for a service that is categorically excluded from coverage (e.g., cosmetic surgery, personal comfort services, etc; see 42 CFR 411.15 for details). However, many Medicare supplemental insurance policies pay for services that Medicare does not allow, and they may require a Medicare denial notice.

Beneficiary submitted claims

The current Medicare manual requirement instructs Medicare contractors (carriers and MACs) to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided. Medicare contractors are instructed to process beneficiary submitted claims for services that:

- Are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details at *http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf* on the internet) in accordance with its normal processing procedures, and
- Are covered by Medicare when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment form CMS-1490S; *see http://www.cms.hhs.gov/CMSForms/CMSForms/* or *http://www.cms.hhs.gov/cmsforms/downloads/cms1490s-english.pdf* on the CMS Web site) and all supporting documentation associated with the claim, including an itemized bill with the following information:
  - Date of service
  - Place of service
  - Description of illness or injury
  - Description of each surgical or medical service or supply furnished
  - Charge for each service
  - The doctor's or supplier's name, address, and

Mandatory claims submission and its enforcement (continued)

- The provider or supplier's national provider identifier (NPI).

If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims when the beneficiary used CMS-1500 with instructions how to complete and return the appropriate beneficiary claims CMS-1490S for processing.

When manually returning a beneficiary submitted claim (CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:

- The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and
- In order to submit the claim, the provider must enroll in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:

- Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and
- Submit a complete CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the beneficiary's claim form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

Additional information

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

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Implementation Date: N/A

Important information regarding Centers for Medicare & Medicaid Services national claim crossover process

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

Provider types affected

All Medicare physicians, providers, and suppliers.

Provider action needed

Physicians, providers, and suppliers should note that this special edition article is to request that they allow sufficient time for the Medicare crossover process before attempting to balance bill their patients' supplemental insurers and payers for amounts remaining after Medicare's payment determination on their submitted claims.

Background

The Centers for Medicare & Medicaid Services (CMS) consolidated the "automatic" or eligibility file-based crossover process under the coordination of benefits contractor (COBC) as of September 2006. Under the "automatic" crossover process, other supplemental insurers, including Medicaid agencies, sign a standard national coordination of benefits agreement (COBA) with the CMS contractor, the COBC. They then submit enrollment information via a standard eligibility file feed through a secure connection with the COBC. Within this eligibility feed, the supplemental insurers identify their covered members or policy/ certificate holders for Medicare claim matching purposes. The COBC, in turn, transmits this information to the CMS common working file (CWF). After the CMS CWF system tags individual claims for crossover to a designated insurer, it then prompts the Medicare contractor to send the adjudicated claims to the COBC for crossover purposes once the claims have met their payment floor requirements, as prescribed by CMS.

The CMS consolidated the Medigap claim-based crossover process under the COBC in October 2007. Under this process, the COBC assigns to a Medigap plan a five-digit Medigap claim-based COBA ID (range 55000 through 59999) to ensure that if participating Part B physicians or suppliers enter that value on incoming paper CMS-1500 claim forms or 837 professional claims, the Medicare contractor will be able to transfer the claims to the COBC for crossover to that specific Medigap plan.

Important: Virtually all Medigap insurers participate in the automatic or eligibility file-based crossover process. Approximately ten or eleven Medigap plans avail themselves of the less commonly used Medigap claim-based crossover process, which cannot be used in association with Part A 837 institutional claims (including inpatient, outpatient, home health, and hospice related types of bills) or with claims for which the physician or supplier is non-participating with Medicare. These insurers, some of whom also participate in part in the automatic crossover process, may be referenced at *http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf* on the CMS Web site.

Important information regarding CMS national claims crossover process (continued)

Situations where balance billing of supplemental insurers is justified

Situation 1: Claim data errors encountered

Approximately 98 percent of all claims that Medicare indicates crossed-over, as annotated on its generated 835 electronic remittance advice (ERA) and standard paper remittance advice (SPR), actually were successfully transmitted to supplemental insurers. For the remaining two percent of cases, the physician, provider, or supplier's claims fail Health Insurance Portability and Accountability Act (HIPAA) compliance within the COBC's code validation routine. In addition, due to Medicare's shared claims processing systems problems, Medicare contractors occasionally transmit structurally unusable claims to the COBC. Such claims are rejected back to the Medicare contractor within 24 hours of receipt. Finally, the COBC may, in some instances, successfully transmit claims to various supplemental insurers only to have them rejected due to issues such as national provider identifier (NPI) mismatch (dispute error code 200), claims selection criteria problems (dispute error code 600), and less frequently HIPAA compliance matters (dispute error code 700).

When the COBC rejects claims back to the Medicare contractors, they issue special correspondence letters (sent to your Medicare on-file "correspondence" address) to your organization within five business days from COBC's rejection action. The special letters indicate the affected claims, including health insurance claim number (HICN) and associated internal control number (ICN)/ document control number (DCN), along with an error code and error description specifying why the COBC could not cross-over the affected claims. This same procedure occurs when insurers reject claims, typically several days later through a dispute process with the COBC, with the exception that standard verbiage is carried on the special letter indicating that the affected claim(s) was/were rejected by the supplemental insurer and an associated dispute error code appears (e.g., 200, 600, 700). When providers receive such notifications, they should then attempt to bill the supplemental insurer or benefit program, given that Medicare was unable to cross-over the affected claim(s) successfully.

Situation 2: Patient's insurer not part of crossover process

If you can clearly determine that your patient's insurer cannot or will not voluntarily participate in the CMS national crossover process, you are, of course, within your rights to balance bill your patient's supplemental insurer.

A special note regarding claim repair processes

When a Medicare contractor's volume of HIPAA compliance rejections equals or exceeds four percent of all claims that the affected Medicare contractor transmitted to the COBC for a given day, or if entire envelopes of claims fail structural editing at the COBC, that Medicare contractor is instructed by CMS to go into "claim repair mode." That is, the Medicare contractor is to do the following:

- Determine how long it will take, working through its shared claims processing system maintainer, to effectuate a correction of the errored claims; and
- Subject to concurrence from CMS, initiate a claim repair for all claims with a given error condition. Typically, most repairs are accomplished within 10 to 15 business days from the date when the COBC rejected the claims.

Important: At CMS direction, most Medicare contractors, including Medicare administrative contractors (MACs), will alert you to such situations in the interests of ensuring that you do not balance bill your affected patients' supplemental insurers or benefit programs. In the majority of instances, Medicare contractors will issue the special correspondence letters, which have been held within the system, if they have determined through consultation with CMS that a claims repair cannot be accomplished. You may also receive additional information about the abandonment of a claims repair process via the affected Medicare contractors' provider Web site.

Requested physician, provider, and supplier action

Recently, CMS has received a growing number of complaints from supplemental insurers about their receipt of paper SPRs or printed 835 ERAs that physician, provider, and supplier billing vendors are generating well in advance of their receipt of the CMS "official" Medicare crossover claims. Consequently, these supplemental insurers are in receipt of duplicate claim pairings—one generated on paper by the provider and another, the "official" crossover claim, generated from the COBC.

Since payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued, CMS requests that you do not bill your patients' supplemental insurers for a minimum of 15 work days after receiving the Medicare payment.

This should allow sufficient time for any potential CMS-approved Medicare claims recovery situations should they need to occur and for the supplemental insurer to take actions necessary to issue payment determination following its receipt of a Medicare crossover claim. Additionally, CMS requests that physicians, providers, and suppliers take the following actions before balance billing their patients' supplemental insurers:

- Check the following CMS Web site for verification that your patient's supplemental insurer is participating in the automatic crossover process nationally with the CMS COBC: *http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf* on the CMS Web site. Note: As verified by the spreadsheet's header, this document is a listing of all participants in the Medicare automatic crossover process. It is not just a listing of beneficiary and provider contact information for each insurer indicated.
- Prior to submitting a claim to a supplemental payer/ insurer, you should utilize available self-service tools to research the status of your supplemental payment (e.g., the supplemental insurer's Web site, or claims automated "hot line," as applicable).

In addition, as a reminder, only the "official" Medicare remittance advice or HIPAA 835 ERA should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:

Important information regarding CMS national claim crossover process (continued)

- You are billing the supplemental payer/insurer after the 15 work days from the Medicare-issued payment have expired, and
- You have used the available self-service tools to confirm the status of your supplemental payment.

Additional information

You may also want to review *MLN Matters*® article MM5601 (Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)) at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf* on the CMS Web site.

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

MLN Matters® Number: SE0909
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Modification of the common working file to transmit "WC" qualifier

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6438 and is informational only for providers. In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), a prior instruction from Medicare, CR 5371, provided your Medicare contractors with instructions on the creation of a new Medicare secondary payer (MSP) code in Medicare's claims processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) has the capability to discontinue conditional payments for diagnosis codes related to WCMSA settlements.

Background

A 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 "WC" qualifier denotes a workers' compensation Medicare set-aside arrangement.) CMS has a review process for proposed WCMSA amounts and updates its systems 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.

CR 5371 added the qualifier of "WC" to distinguish a WCMSA Medicare secondary payer (MSP) auxiliary record from a WC MSP record. An *MLN Matters*® article related to CR 5371 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5371.pdf* on the CMS Web site.

Even though the "WC" qualifier was added by CR 5371, no adjustment was made to allow for the transfer of the WC modifier's alpha codes from the CWF system to other important Medicare systems and CR 6438 will implement that transfer.

Additional information

The official instruction, CR 6438, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R487OTN.pdf* on the CMS Web site.

MLN Matters® Number: MM6438
Related Change Request (CR) #: 6438
Related CR Release Date: May 1, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R487OTN
Implementation Date: October 5, 2009

Clarification about the medical privacy of protected health information

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

Note: This article was revised on May 11, 2009, to reflect updated Web addresses for several products referenced in the article. This information was previously published in the September 2007 *Medicare B Update!* pages 37-38.

Provider types affected

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

Provider action needed

The purpose of this special edition (SE) article, SE0726, is be sure that heath care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the privacy rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS privacy guidance

HHS' educational materials include a letter to healthcare providers with the following examples to clarify the privacy rule:

HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) by searching the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at *http://www.hhs.gov/hipaafaq/* on the HHS Web site.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html* on the HHS Web site.
- Review the "Summary of the HIPAA Privacy Rule" at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html* on the HHS Web site.

HIPAA does not require providers to eliminate all incidental disclosures:

- The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that rule to clarify that incidental disclosures do not violate the privacy rule when providers and other covered entities have policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR Web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the Fact Sheet on "Incidental Disclosures". The fact sheet is at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html* on the HHS Web site.

HIPAA does not cut off all communications between providers and the families and friends of patients:

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.
- The privacy rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.
- Review the provider's guide on communications with a patient's family, etc. at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf* on the HHS Web site.

HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" at *http://www.hhs.gov/ocr/privacy/hipaa/faq/administrative/485.html* on the HHS Web site.

HIPAA does not prevent child abuse reporting:

Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which may be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that may be reviewed at *http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html* on the HHS Web site.

Clarification about the medical privacy of protected health information (continued)

HIPAA is not anti-electronic:

Doctors can continue to use e-mail, the telephone, or FAX machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the privacy rule went into effect. A helpful discussion on this topic may be found at *http://www.hhs.gov/hipaafaq/providers/smaller/482.html* on the HHS Web site.

Additional information

The HHS complete listing of all HIPAA medical privacy resources is available at *http://www.hhs.gov/ocr/hipaa/* on the HHS Web site.

MLN Matters® Number: SE0726 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Notice of interest rate for Medicare overpayments and underpayments

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

The Department of the Treasury has notified the Department of Health & Human Services that the PCR **has been changed to 11 percent, effective April 16, 2009**. The PCR will remain in effect until a new rate change is published. The following table lists previous interest rates.

Period	Interest Rate
January 23, 2009-April 15, 2009	11.375%
October 22, 2008-January 22, 2009	11.375%
July 24, 2008-October 21, 2008	11.125%
April 18, 2008-July 23, 2008	11.375%
January 18, 2008-April 17, 2008	12.125%
October 19, 2007-January 17, 2008	12.5%

Source: CMS Pub. 100-06, Transmittal 151, CR 6240

Information on swine influenza

For the most current information about the swine influenza, visit the Centers for Disease Control and Prevention (CDC) Web site at *http://www.cdc.gov/swineflu/*.

At the CDC site, you will find the most current information on consumer and provider fact sheets, guidance for professionals, press briefings, and steps that you, your staff, and patients can take to protect against the infection of the swine flu.

Source: PERL 200904-32

Fact sheet to assist with converting International Classification of Diseases codes

The *General equivalence mappings - ICD-9-CM to and from ICD-10-CM and ICD-10-PCS* (March 2009) fact sheet, which 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 print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: PERL 200905-03

Revised federally qualified health center fact sheet

The revised federally qualified health center fact sheet (April 2009), which provides information about federally qualified health center (FQHC) designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC payments; and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf*.

Source: PERL 200904-31

Revised rural health clinic fact sheet

The revised rural health clinic fact sheet (April 2009), which provides information about rural health clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralHlthClinfctsht.pdf*. If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: PERL 200905-13

Five-star quality rating system -- May news

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 minimum data set data.

Provider preview access information

Visit the MDS state welcome page (available on the state servers where you submit MDS data) to review your results.

To access the five-star provider preview reports, select the "Certification and Survey Provider Enhanced Reports" (CASPER) reporting link (located at the bottom of the login page). Once in the CASPER reporting system, click on the "Folders" button and access the five-star report in your "st LTC facid" folder."

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

BetterCare@cms.hhs.gov is available to address May's data concerns and/or issues. The helpline will reopen in July to coincide with quarterly quality measure (QM) data updates. Nursing Home Compare will update with May's five-star data on Thursday, May 28, 2009.

Source: PERL 200905-31

Medicare Part B immunization billing chart

The *Medicare Preventive Services Quick Reference Information – Medicare Part B Immunization Billing Chart* (revised March 2009), which provides billing and coding information related to Medicare-covered adult immunizations, is available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: PERL 200905-05

Health care reminders for Mother's Day

May 10 is Mother's Day. The Centers for Medicare & Medicaid Services is asking the provider community to help keep women with Medicare healthy by ensuring that they take advantage of Medicare-covered preventive services. Medicare covers mammograms, bone mass measurements, screening pap tests, and screening pelvic exams, among other services, that can help women live longer, healthier lives.

The *Medicare Learning Network* (*MLN*) offers a variety of educational products related to Medicare-covered preventive services geared towards women. They include:

- **Bone Mass Measurements brochure** -- provides information on Medicare coverage of bone-mass measurements and is available at: *http://www.cms.hhs.gov/MLNProducts/downloads/bone_mass.pdf*.
- **Cancer Screenings brochure** -- provides information on Medicare coverage of cancer screenings, including screening mammography, screening pelvic exams, and screening pap tests and is available at: *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf*.

For additional educational products, including quick reference guides and Web-based training courses, please visit the Medicare Preventive Services MLN products Web site at: *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Source: PERL 200905-07

May is Older Americans Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of Medicare-covered preventive services that may help older Americans live longer, fuller, healthier lives.

Medicare provides coverage for a variety preventive screenings. These screenings may help older Americans with Medicare stay healthy and detect conditions like cancer, glaucoma, and cardiovascular disease early when treatment works best.

CMS recognizes the crucial role the Medicare provider community plays in promoting and providing their patients information about potentially life-saving preventive services. Therefore, we have created a number of products available free of charge to help you educate yourselves and your patients about Medicare-covered preventive services, including:

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

Preventive Services Brochures -- provide information on bone mass measurements, cancer and glaucoma screenings, diabetes-related services, and expanded benefits, and is available at *http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf* (scroll down to "Brochures" and choose the desired link.)

Quick Reference Guides -- provide additional information about initial preventive physical exams, immunization billing, and other preventive services, and is available at *http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf* (scroll down to "Quick Reference Information" and choose the desired link.)

Thank you for your support in helping CMS spread the word about the benefits of Medicare-covered preventive series that may help older Americans live longer, healthier lives.

Source: PERL 200905-24

May 19 is World Hepatitis Day

Hepatitis B is a highly infectious disease caused by the hepatitis B virus (HBV). Chronic HBV infection can lead to cirrhosis of the liver, liver cancer, liver failure, and death.

Medicare covers the hepatitis B vaccine and its administration for Medicare beneficiaries with an intermediate to high risk of contracting the disease. The Centers for Medicare & Medicaid Services (CMS) has created several educational products to help Medicare providers understand this benefit, including:

The Adult Immunizations brochure -- provides coverage information for the hepatitis B vaccine *http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf*.

The Medicare Preventive Services Quick Reference Information: Medicare Part B Immunization Billing Chart -- provides billing and coding information for the hepatitis B vaccine *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.

For more information about Medicare-covered preventive services, including the hepatitis B vaccine, please visit the preventive services page on the *Medicare Learning Network* at: *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: PERL 200905-25

Sign up to our *eNews* electronic mailing list

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

Local Coverage Determinations

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

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), contractors no longer include full-text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text of final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Effective and notice dates

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

Electronic notification

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

More information

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

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

Local Coverage Determinations -- Table of Contents

Advance beneficiary notice

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

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

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

Revisions to LCDs

J3487: Zoledronic acid -- revision to the LCD

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

The local coverage determination (LCD) for zoledronic acid was last revised on March 12, 2009. Since that time, it has been revised. The Food and Drug Administration (FDA) approved a new indication for zoledronic acid (Reclast®), HCPCS code J3488, on March 13, 2009. The new indication is for the treatment and prevention of glucocorticoid-induced osteoporosis in men and women who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and who are expected to remain on glucocorticoids for at least 12 months.

The following sections of the LCD have all been revised to allow for coverage of this new indication:

- Indications and Limitations of Coverage and/or Medical Necessity
- Utilization Guidelines
- ICD-9 Codes that Support Medical Necessity
- Coding Guidelines attachment

When billing for this new indication, providers will be required to bill a dual diagnosis. The dual diagnosis requirement for HCPCS code J3488 is as follows: ICD-9-CM code 733.09 (Osteoporosis, other) and ICD-9-CM code E932.0 (Adrenal cortical steroids) must be billed together.

Effective date

This LCD revision is effective for services rendered on or after March 13, 2009, for claims processed on or after June 30, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database. 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.

Additional Information

Billing for drugs usually administered orally

According to Publication 100-02, the Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services, section 50 - Drugs and Biologicals, the Medicare program provides limited benefits for outpatient drugs. The program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals (see section 50.1);
- They are of the type that are not usually self-administered (see section 50.2);
- They meet all the general requirements for coverage of items as incident to a physician's services (see sections 50.1 and 50.3);
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see section 50.4);
- They are not excluded as noncovered immunizations (see section 50.4.4.2); and
- They have not been determined by the Food and Drug Administration (FDA) to be less than effective (see section 50.4.4).

In order to meet all the general requirements for coverage under the incident-to provision, an FDA-approved drug or biological must:

- Be of a form that is not usually self-administered
- Must be furnished by a physician
- Must be administered by the physician, or by auxiliary personnel employed by the physician and under the physician's personal supervision.

The charge, if any, for the drug or biological must be included in the physician's bill, and the cost of the drug or biological must represent an expense to the physician. The program may pay for the use of an FDA-approved drug or biological, if:

- It was injected on or after the date of the FDA's approval
- It is reasonable and necessary for the individual patient
- All other applicable coverage requirements are met.

Billing for drugs usually administered orally (continued)

Medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration. Medicare Part B does not generally cover drugs that can be self-administered, such as those in pill form, or are used for self-injection. However, First Coast Service Options Inc. has received claims for many medications that, in most circumstances, would be considered self-administered oral medications (examples include, but are not limited to, Ascorbic Acid, Tagamet, Lopressor, and Vasotec, among others). In many instances, these drugs have been billed with unlisted codes such as HCPCS code J3490, which requires that this contractor review the claim for medical necessity and manually price the drug.

Contractors will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient's condition, as well as to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form.

Contractors will supplement these instructions as necessary, concerning appropriate use of specific injections in other situations. They will use these instructions to screen out questionable cases for special review, further development, or denial when the injection billed would not be reasonable and necessary. If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these instructions, the contractor excludes the entire charge (i.e., for both the drug and its administration). In addition, contractors exclude from payment any charges for other services (such as office visits), which were primarily for the purpose of administering a noncovered injection (i.e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury). Contractors must provide notice 45 days prior to the date that these drugs will not be covered, and this article serves as that notice. During the 45-day time period, contractors will maintain existing medical review and payment procedures. After the 45-day notice, contractors may deny payment for the drugs subject to the notice.

J9999: Plerixafor (MOZOBIL™) -- clarification of administration

Plerixafor (MOZOBIL™) is a hematopoietic stem cell mobilizer that was approved by the Food and Drug Administration (FDA) on December 15, 2008. It is indicated in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma. The recommended dosage and administration protocol for MOZOBIL™ is to initiate MOZOBIL™ after the patient has received G-CSF once daily for four days. The dose is selected based on 0.24mg/kg actual body weight and is administered by subcutaneous injection approximately 11 hours prior to apheresis. MOZOBIL™ may be repeated up to four consecutive days. Appropriate ICD-9-CM codes for MOZOBIL™ are 202.70-202.78, 202.80-202.88, 202.90-202.98, 203.00 and 203.01.

At this time, the only G-CSF that First Coast Service Options, Inc. (FCSO) recognizes as medically reasonable and necessary to be used in combination with MOZOBIL™ therapy is filgrastim (Neupogen®), HCPCS code J1440 or J1441. The G-CSF would be administered via subcutaneous bolus or continuous infusion once daily in the morning for four days prior to the first evening dose of MOZOBIL™. FCSO would not expect to see any chemotherapy drugs billed on the same day that Neupogen® is being administered for this course of therapy. In addition, all coverage requirements for Neupogen® outlined in the local coverage determination (LCD) for Neupogen® would still apply, including indications and limitations of coverage, ICD-9-CM codes that support medical necessity, utilization guidelines and documentation guidelines. FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Physician's order for clinical laboratory services and diagnostic procedures

First Coast Service Options Inc. continues to see a large number of errors identified by the comprehensive error rate testing (CERT) contractor for clinical laboratory services and diagnostic procedures. The errors are largely due to the absence of a physician's order on file or for failure to provide a copy of the order when documentation is requested.

It is inappropriate to bill the Medicare program for clinical laboratory services and diagnostic procedures without a physician's order. Many providers and facilities are being required to refund money to Medicare for not having a copy of the physician's order, or for not providing it when requested.

Medicare guidelines require that supporting documentation for laboratory and diagnostic services must include:

- A copy of the physician's/NPP's order
- Documentation that the test was performed
- Record of the result/report

It is imperative that complete records are submitted for review when requested. Without the appropriate physician's order, there is no way for Medicare or the CERT contractor to verify if a test was ordered or whether the exact test ordered was performed.

Educational Resources

Upcoming provider outreach and education events

June – July 2009

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

Hot Topics Series: 2009 Part B updates and changes

When: July 14
Time: 11:30 a.m. – 12:30 p.m.
Type of Event: Webcast
Focus: Florida 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: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

Freedom of Information Act
Freedom of Information Act requests
Post office box 2078
Jacksonville, Florida 32231

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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 (EDI)

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

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 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

1-904-791-8103

Electronic data interchange (EDI)

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_B/* (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, 2009 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 ♦