MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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

TABLE OF CONTENTS

Medicare B Update!

Vol. 7, No. 6
June 2009

Publications staff

Terri Drury
Millie C. Pérez
Mark Willett
Robert Petty

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

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

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

CLAIMS

Quarterly update to correct coding initiative edits

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6469, which provides a reminder for physicians to take note of the quarterly updates to correct coding initiative (CCI) edits. The last quarterly release of the edit module was issued in April 2009. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

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

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

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

The latest package of CCI edits, version 15.2, is effective July 1, 2009, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

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

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site. The official instruction (CR 6469) issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1746CP.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: MM6469
Related Change Request (CR) #: 6469
Related CR Release Date: May 22, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1746CP
Implementation Date: July 6, 2009

Sign up to our *eNews* electronic mailing list

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

Ambulatory Surgical Center

July update to the ambulatory surgical center payment system and policy changes

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

Provider types affected

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

Provider action needed

This article is based on CR 6496 which describes changes to, and billing instructions for, payment policies implemented in the July 2009 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created level II HCPCS codes for drugs and biologicals. Be sure your billing staff is aware of these changes.

Background

Final policy under the revised ASC payment system, as set forth in the final rule CMS-1517-F, requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly. Therefore, beginning with the update notification (Transmittal R1488CP, CR 5994) issued April 9, 2008, the Centers for Medicare & Medicaid Services (CMS) has issued quarterly updates to ASC payment rates for separately paid drugs and biologicals. CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes, as appropriate. CR 6496 provides the new HCPCS codes for 12 separately payable drugs and biologicals, and two new Category III *Current Procedural Terminology* (*CPT*) codes for surgical procedures that will be added to the ASC list of covered surgical procedures effective July 1, 2009.

In CR 6496, CMS issued instructions to their contractors to modify their systems to include new payment rates for all separately payable drugs and biologicals and to update the payment indicators for payable and non-payable ASC services.

Key points

CMS reminds ASCs that under the ASC payment system if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

CMS also reminds ASCs that updated drug payment rates effective July 1, 2009 are included in the July 1, 2009 updated ASC Addendum BB that will be posted on the CMS Web site at the end of June.

Eleven new HCPCS drug codes have been created that are separately payable for dates of service on or after July 1, 2009. The new HCPCS codes, the long descriptors, and payment indicators (PIs) are identified in the following table:

New drugs and biologicals separately payable under the ASC payment system, effective July 1, 2009.

HCPCS	Long Descriptor	P I
C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	K2
C9251	Injection, C1 esterase inhibitor (human), 10 units	K2
C9252	Injection, plerixafor, 1 mg	K2
C9253	Injection, temozolomide, 1 mg	K2
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	K2
C9361	Collagen matrix nerve wrap (neuromend collagen nerve wrap), per 0.5 centimeter length	K2
C9362	Porous purified collagen matrix bone void filler (integra mozaik osteoconductive scaffold strip), per 0.5 cc	K2
C9363	Skin substitute, integra meshed bilayer wound matrix, per square centimeter	K2
C9364	Porcine implant, permacol, per square centimeter	K2
Q2023	Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per I.U.	K2
Q4116	Skin substitute, alloderm, per square centimeter	K2

The payment rates for several HCPCS codes were incorrect in the January 2009 ASC DRUG file that CMS supplied to its contractors. Suppliers who think they may have received an incorrect payment between January 1, 2009, and March 31, 2009, may voluntarily submit claims to their contractors for reprocessing after July 6, 2009. The corrected payment rates are shown in the following table:

July update to the ambulatory surgical center payment system and policy changes (continued)

Updated payment rates for certain HCPCS codes, effective January 1, 2009, through March 31, 2009

HCPCS	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1441	Filgrastim 480 mcg injection	K2	$304.27
J1740	Ibandronate sodium injection	K2	$136.35
J2505	Injection, pegfilgrastim 6mg	K2	$2,135.12
J7513	Daclizumab, parenteral	K2	$341.09

CMS has determined that two new Category III *CPT* codes are appropriate for payment in ASCs, effective July 1, 2008. Payment rates for these services may be found in the July 2009 updated ASC Addendum AA that will be posted on the CMS Web site at the end of June. The new Category III codes, their descriptors and their ASC payment indicators are as follows:

Category III *CPT* codes implemented as ASC covered surgical procedures as of July 1, 2009

CPT	Long Descriptor	PI
0200T	*Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles*	G2
0201T	*Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needles*	G2

CR 6496 also provides reminders about the correct reporting of drugs and biologicals when used as implantable devices and the correct reporting of units for drugs.

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 6496) issued to your Medicare MAC and/or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1759CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6496 *Revised*
Related Change Request (CR) #: 6496
Related CR Release Date: June 19, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1759CP
Implementation Date: July 6, 2009

Clarification to *MLN Matters* article MM6496

The purpose of this article is to clarify what action needs to occur for HCPCS codes J1441, J1740, J2505, J7513, processed for dates of service January 1, 2009, through March 31, 2009.

The *MLN Matters* article MM6496 (last paragraph on page 6 of this publication) indicates:

"Suppliers who think they may have received an incorrect payment between January 1, 2009, and March 31, 2009, may voluntarily submit claims to their contractors for reprocessing after July 6, 2009."

Provider action required

A resubmitted claim may potentially be denied as a duplicate. To avoid these denials, providers who think they may have received an incorrect payment need to contact their Medicare contractor and request an adjustment/reopening.

Drugs and Biologicals

July 2009 quarterly update to drug and biological HCPCS codes

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

Provider types affected

Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and durable medical equipment Medicare administrative contractors (DME MACs) for drugs and biologicals provided to Medicare beneficiaries.

Provider action needed

This article explains updates, effective for dates of service on or after July 1, 2009 (unless otherwise specified), to HCPCS codes for certain drugs and biologicals. Ensure that your staffs are aware of these changes.

Background

The HCPCS code set is updated on a quarterly basis. This article describes updates for specific drug/biological HCPCS codes. Effective for claims with dates of service on or after July 1, 2009, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	TOS Code	MPFSDB* Status Indicator
Q2023	Xyntha, inj	Injection, factor VIII (antihemophilic factor, recombinant) (xyntha), per i.U.	1	E
Q4115	Alloskin skin sub	Skin substitute, alloskin, per square centimeter	1	E
Q4116	Alloderm skin sub	Skin substitute, alloderm, per square centimeter	1	E

* MPFSDB -- Medicare physician fee schedule database

The Medicare coverage indicator for the following codes was incorrectly listed on the January 2009, HCPCS code set file. With the July 2009 quarterly update to the HCPCS code set, we are correcting the file to show a Medicare coverage indicator of the letter “D”. The letter “D” indicates that “special coverage instructions apply” and the applicable special coverage instructions are provided in the local coverage determinations (LCD) regarding inhalation drugs. These updates are based on change request (CR) 5981 and are effective for claims with dates of service on or after April 1, 2008. Note that Medicare contractors will not search for and adjust claims processed before this change is implemented. However, they will adjust such claims that you bring to their attention.

HCPCS Code	Short Description	Medicare Coverage Indicator
J7611	Albuterol non-comp con	D
J7612	Levalbuterol non-comp con	D
J7613	Albuterol non-comp unit	D
J7614	Levalbuterol non-comp unit	D

Additional information

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

The official instruction, CR 6477, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1752CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6477
Related Change Request (CR) #: 6477
Related CR Release Date: June 5, 2009
Effective Date: July 1, 2009, except as noted in article
Related CR Transmittal #: R1752CP
Implementation Date: July 6, 2009

Clarification for billing Part B versus Part D for the anti-emetic aprepitant (Emend®)

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

Provider types affected

Providers and suppliers rendering services to beneficiaries with cancer chemotherapy-induced nausea and vomiting (CINV).

Provider action needed

This article describes the Centers for Medicare & Medicaid Services (CMS) policy distinguishing Part B versus Part D billing for the anti-emetic medication aprepitant (Emend®) for CINV. Be sure your billing staff is aware of this information.

Issue

How to determine if Part B or Part D should be billed for a drug regimen of aprepitant when used to alleviate chemotherapy induced nausea-vomiting. CMS has received questions with regard to billing aprepitant when used as a complete replacement for intravenous therapy or as a completion of a 48-hour regimen where IV aprepitant is given the day of chemotherapy and the oral medication is given days two though three of therapy. This article provides information in response to these questions.

Background

CMS provides Part B reimbursement for oral anti-emetic drugs when used as a full therapeutic replacement for intravenous dosage forms as part of a cancer chemotherapeutic regimen, when the drugs are administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent. Aprepitant (Emend®) is indicated for use as an anti-emetic for CINV when part of a three drug combination regimen.

The three-drug combination is:

- Aprepitant
- A 5-HT3 antagonist (e.g. granisetron, ondansetron, or dolasetron), and
- Dexamethasone (a corticosteroid).

The three drug combination protocol requires the first regimen dose to be administered before, at, or immediately after the time of the anti-cancer chemotherapy administration. The second day, on which only aprepitant is given, is defined as "within 24 hours," and the third day, on which again only aprepitant is given, is defined as "within 48 hours" of the chemotherapy administration. These drugs may be supplied by the physician in the office, by an inpatient or outpatient provider (e.g., hospital, critical access hospital, or skilled nursing facility), or through a supplier, such as a pharmacy.

The physician must indicate on the prescription that the beneficiary is receiving the oral anti-emetic drug as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen in order for the beneficiary to receive coverage under Part B. Where the drug is provided by a facility, the beneficiary's medical record maintained by the facility must be documented to reflect that the beneficiary is receiving the oral anti-emetic drug as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. All three drugs in the combination oral anti-emetic regimen must be on the same claim to be eligible for Part B reimbursement.

Coverage of Emend® under the Part B program

Medicare Part B covers Emend® when used as part of the following regimen:

- IV Emend® provided on day 1 would be covered under B. Payment for oral Emend® on days two and three would not be made under Part B but should be billed under Part D.
- Days one through three of the oral anti-emetic three-drug combination of Emend®, a 5-HT3 antagonist, and dexamethasone. This regimen acts as a full replacement for IV anti-emetic therapy for patients receiving one or more of the following anti-cancer chemotherapeutic agents:
  - Carmustine
  - Cisplatin
  - Cyclophosphamide
  - Dacarbazine
  - Doxorubicin
  - Epirubicin
  - Lomustine
  - Mechlorethamine
  - Streptozocin

Coverage of Emend® under the Part D program

The Part D program will generally cover Emend® when it is not prescribed in accordance with the above Medicare Part B coverage guidelines. If Emend® IV is given on day one, then oral Emend® is given on days two though three, the oral Emend® must be billed to Part D. To assist in billing of Emend®, CMS recommends physicians indicate on a prescription that the Emend® is being used as part of a CINV chemotherapeutic drug regimen, what day of treatment the patient is on (e.g. post chemo day two) and whether the IV or oral form of the drug was given on day 1.

Additional information

Additional information on this issue is available in the *MLN Matters®* article MM5655 available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5655.pdf* on the CMS Web site.

If you have questions on the proper billing of aprepitant, contact your Medicare carrier, fiscal intermediary, or Medicare administrative contractor at their toll free number, which is available at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

MLN Matters® Number: SE0910
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

Durable Medical Equipment

July 2009 update for durable medical equipment, prosthetics, orthotics, and supplies

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for DMEPOS provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6511 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is located in Section 60, Chapter 23 of the *Medicare Claims Processing Manual* and is located at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf* on the CMS Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at *http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp* on the CMS Web site.

Key points of change request 6511

- The following table identifies the 2009 fees for the Healthcare Common Procedure Codes System (HCPCS) codes K0739/E1340.

State	K0739/E1340	State	K0739/E1340
AK*	25.27	MT	13.41
AL*	13.41	NC	13.41
AR*	13.41	ND*	16.72
AZ*	16.59	NE	13.41
CA*	20.58	NH*	14.40
CO*	13.41	NJ*	18.10
CT*	22.40	NM*	13.41
DC*	13.41	NV*	21.37
DE*	24.71	NY*	24.71
FL*	13.41	OH*	13.41
GA*	13.41	OK	13.41
HI*	16.59	OR	13.41
IA*	13.41	PA*	14.40
ID*	13.41	PR	13.41
IL	13.41	SC	13.41
IN	13.41	SD*	14.99
KS	13.41	TN	13.41
KY	13.41	TX	13.41
LA	13.41	UT*	13.45
MA*	22.40	VA	13.41
MD	13.41	VI	13.41
ME*	22.40	VT*	14.40
MI	13.41	WA*	21.37
MN	13.41	WI	13.41
MO	13.41	WV	13.41
MS	13.41	WY*	18.70
RI*	15.99		

* Denotes revised for the 2009 fee schedule

- The 2009 allowed payment amounts for HCPCS codes E1340/K0739 are revised as part of this quarterly update to reflect updates that were brought to CMS' attention. The allowed payment amounts (listed above) for codes E1340/K0739 are effective as follows:
  - For claims with dates of service from January 1, 2009, through March 31, 2009, submitted using HCPCS code E1340 (Repair or non-routine service for DME requiring the skill of a technician, labor component, per 15 minutes), and
  - For claims with dates of service from April 1, 2009, through December 31, 2009, submitted using HCPCS code K0739 (Repair or non-routine device for DME other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes).

July 2009 update for durable medical equipment, prosthetics, orthotics, and supplies (continued)

- Medicare contractors will adjust previously processed claims for HCPCS code E1340/K0739 with dates of service on or after January 1, 2009, through June 30, 2009, if they are resubmitted as adjustments.
- HCPCS codes A6545, E0656, E0657 and L0113 were added to the HCPCS file effective January 1, 2009.

  The fee schedule amounts for these HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2009.
- These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for the above codes with dates of service on or after January 1, 2009, which have already been processed, will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.
- As part of this update CMS is adding the modifier AW to the fee schedule file for HCPCS code A6545 (Gradient compression wrap, non-elastic, below knee, 30-50 MM HG, each). HCPCS code A6545 is covered when it is used in the treatment of an open venous stasis ulcer. Currently, HCPCS code A6545 is noncovered for the following conditions:
  - Venous insufficiency without stasis ulcers, prevention of stasis ulcers, prevention of the reoccurrence of stasis ulcers that have healed, and treatment of lymphedema in the absence of ulcers. In these situations, since an ulcer is not present, the gradient compression wraps do not meet the definition of a surgical dressing. Suppliers are advised that when the non-elastic gradient compression wrap HCPCS code A6545 is used in the treatment of an open venous stasis ulcer, it must be billed with the modifier AW. Claims for HCPCS code A6545 that do not meet the covered indications should be billed without the AW modifier and as such, will be denied as noncovered.
- As part of this update, the fee schedule amounts for HCPCS code K0606 (Automatic external defibrillator, with integrated electrocardiogram analysis, garment type) billed without the modifier KF are being removed from the DMEPOS fee schedule file.
- A one-time notification regarding the changes in payment for oxygen and oxygen equipment as a result of the MIPPA of 2008 and additional instructions regarding payment for DMEPOS was issued on December 23, 2008, (transmittal 421, CR 6297). A related *MLN Matters*® article may be reviewed at *http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6297.pdf* on the CMS Web site). CR 6297 included 2009, labor payment rates for HCPCS codes E1340, L4205 and L7520.
- In 2009, code K0739 was established in the HCPCS file to replace code E1340 for Medicare claims for the repair of beneficiary-owned DME with dates of service on or after April 1, 2009, (see transmittal 443, CR 6296 issued on February 13, 2009, which may be reviewed at *http://www.cms.hhs.gov/transmittals/downloads/R443OTN.pdf* on the CMS Web site). The 2009 allowed payment amounts for HCPCS code E1340 mapped directly to code K0739.

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. For complete details regarding this CR please see the official instruction (CR 6511) issued to your Medicare MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1754CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6511
Related Change Request (CR) #: 6511
Related CR Release Date: June 5, 2009
Effective Date: January 1, 2009, for implementation of fee schedule amounts for codes in effect then; April 1, 2009, for code K0739; July 1, 2009, for all other changes
Related CR Transmittal #: R1754CP
Implementation Date: July 6, 2009

Next steps in preparation for DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round one re-bid is coming soon.

Summer 2009

- The Center for Medicare & Medicaid Services (CMS) announces bidding schedule/schedule of education events
- CMS begins bidder education campaign
- Bidder registration period to obtain user ID and passwords begins

Fall 2009

- Bidding begins

If you are a supplier interested in bidding, prepare now -- don't wait

Update your national supplier clearinghouse (NSC) files: DMEPOS supplier standard # 2 requires all suppliers to notify the NSC of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update the following sections:

Next steps in preparation for DMEPOS competitive bidding (continued)

- list of products and services found in section 2.D
- authorized official(s) information in sections 6A and 15
- correspondence address in section 2A2

This is especially important for suppliers who will be involved in the Medicare DMEPOS Competitive Bidding Program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC Web site (*http://www.palmettogba.com/nsc*) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get licensed: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. As part of the bid evaluation we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

Get accredited: CMS would like to remind DMEPOS suppliers that time is running out to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of six months to complete. DMEPOS suppliers should contact a CMS deemed accreditation organization to obtain information about the accreditation process and the application process. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS Web site: *http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Get bonded: CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009, deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of sureties from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies"; the Web site is located at: *http://www.fms.treas.gov/c570/c570_a-z.html*.

Visit the CMS Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/* for the latest information on the DMEPOS competitive bidding program.

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

Source: PERL 200906-12

Reminder: Time is running out for DMEPOS supplier accreditation

Deadline is September 30, 2009

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

In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary) must comply with the Medicare program's supplier standards and quality standards to become accredited. The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, and prosthetics and orthotics.

Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers must also meet the September 30, 2009, deadline for DMEPOS accreditation. Certain eligible professionals and other persons as specified by the Secretary are exempt from the accreditation requirement.

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

Source: PERL 200906-01

Laboratory/Pathology

New waived tests

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6459 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has listed the twelve latest tests approved by the Food and Drug Administration (FDA) as waived tests under Clinical Laboratory Improvement Amendments of 1988 (CLIA). The tests newly added to the waived tests are indicated in the *Background* section. Be sure your billing staff are aware of these changes.

Background

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The tests are valid as soon as they are approved. The *CPT* codes for the following new tests **must** have the modifier QW to be recognized as a waived test.

CPT Code	Effective Date	Description
87880QW	September 25, 2008	Quidel QuickVue In-Line Strep A {direct from throat swab}(K934484/A013)
80069QW	December 4, 2008	Abaxis Piccolo Blood Chemistry Analyzer (Piccolo Renal Function Panel){Whole Blood}
80069QW	December 4, 2008	Abaxis Piccolo xpress Chemistry Analyzer (Piccolo Renal Function Panel){Whole Blood}
82374QW, 82435QW, 82550QW, 82565QW, 82947QW, 84132QW, 84295QW, 84520QW	December 4, 2008	Abaxis Piccolo Blood Chemistry Analyzer (Piccolo Metlyte 8 Panel Reagent Disc) {Whole Blood}
82374QW, 82435QW, 82550QW, 82565QW, 82947QW, 84132QW, 84295QW, 84520QW	December 4, 2008	Abaxis Piccolo xpress Chemistry Analyzer (Piccolo Metlyte 8 Panel Reagent Disc) {Whole Blood}
81003QW	January 5, 2009	Jant Pharmacal Corporation Accustrip URS Reader
80101QW	January 5, 2009	Aventir Biotech LLC Home Check Multiple Drug Cup Test {Professional version}
80101QW	January 5, 2009	Syntron Bioresearch Quikscreen Multiple Drug Cup Test {Professional version}

The new waived *CPT* code, *80069QW* has been assigned for the albumin, total calcium, carbon dioxide, chloride, creatinine, glucose, phosphorus, potassium, sodium and urea nitrogen tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Piccolo Renal Function Panel){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Piccolo Renal Function Panel){Whole Blood}.

The new waived *CPT* code, *82550QW* has been assigned for the creatine kinase test performed using the Abaxis Piccolo Blood Chemistry Analyzer (Piccolo Metlyte 8 Panel Reagent Disc) {Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Piccolo Metlyte 8 Panel Reagent Disc) {Whole Blood}.

For 2009, the description for *CPT* code *82040* was modified from albumin; serum to albumin; serum, plasma or whole blood. Therefore, the *CPT* code assigned to the whole blood albumin tests performed on the following test systems has been changed from *82042QW* (albumin; urine or other source quantitative, each specimen) to *82040QW* with an effective date of January 1, 2009;

- Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
- Abaxis Piccolo xpress Chemistry Analyzer {Liver Panel Plus} (Whole Blood)
- Arkay SPOTCHEM EZ Chemistry Analyer (Spotchem II Basicpanel 1){Whole Blood}
- Abaxis Piccolo Blood Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}
- Abaxis Piccolo xpress Chemistry Analyzer (General Chemistry 13 Panel){Whole Blood}

New waived tests (continued)

The Medicare contractor shall deny the use of code *82042QW* for claims submitted by facilities with a valid, current CLIA certificate of waiver with dates of service on or after July 1, 2009.

Other key points

- Only the following tests (*CPT* codes: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013,* and *85651*) **do not** require a modifier QW to be recognized as a waived test.
- Medicare carriers and MACs will not search their files to adjust claims affected by this change, but processed prior to the implementation of CR 6459. They will, however, adjust such claims that you bring to their attention.

Additional information

To see the official instruction (CR 6459) issued to your Medicare carrier and/or MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1751CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

MLN Matters® Number: MM6459
Related Change Request (CR) #: 6459
Related CR Release Date: June 5, 2009
Effective Date: July 1, 2009
Related CR Transmittal #: R1751CP
Implementation Date: July 6, 2009

Billing instructions for professional and technical components rendered on different dates

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

Provider types affected

Providers who submit claims to Medicare administrative contractors (MACs) or carriers for clinical laboratory and pathology services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6457 alerting providers that the Centers for Medicare & Medicaid Services (CMS) is providing clarification regarding global billing for technical component (TC) and professional component (PC) with different dates of service (DOS). The CR updates the *Medicare Claims Processing Manual*, Chapter 16 to include billing instructions concerning billing in this instance. When the TC and PC of pathology services are performed on different DOS bill them as separate line items even if they are performed by the same independent laboratory. Global billing is not appropriate for this instance.

Background

The *Federal Register*, calendar year (CY) 2007 physician fee schedule (PFS) final rule (72 FR 66275) established a new DOS for the technical component of pathology. This rule was implemented with CR 6018, Transmittal 1515 issued on May 23, 2008. The *MLN Matters*® article for CR 6018 may be reviewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6018.pdf* on the CMS Web site. During the comment period for this rule, one commenter asked whether the DOS requirement applies to pathology tests where the TC and the PC are performed by the same lab and billed globally. CMS responded that contractors would receive instructions stating that when the TC and PC of pathology services are performed on different DOS, they should be billed as separate line items even if the services are performed by the same independent laboratory. Global billing is not appropriate for this instance.

Additional information

For complete details regarding this CR please see the official instruction (CR 6457) issued to your Medicare MAC, or carrier. That instruction may be viewed by going to *http://www.cms.hhs.gov/Transmittals/downloads/R1744CP.pdf* on the CMS Web site.

For further clarification on one-line global billing for purchased services, refer to the *Medicare Claims Processing Manual*, Chapter 1, Section 10.1.1.2. at *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS Web site.

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.

MLN Matters® Number: MM6457
Related Change Request (CR) #: 6457
Related CR Release Date: May 22, 2009
Effective Date: August 24, 2009
Related CR Transmittal #: R1744CP
Implementation Date: August 24, 2009

Medicare Physician Fee Schedule Database

July 2009 update to the Medicare physician fee schedule database

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

Provider types affected

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

Provider action needed

This article is based on CR 6484, which amends payment files that were issued to Medicare contractors based on the 2009 MPFS final rule. Be sure billing staff are aware of the *Current Procedure Terminology* (*CPT*)/Healthcare Common Procedure Coding System (HCPCS) changes made in this July Update to the 2009 MPFSDB.

Background

Payment files were issued to contractors based upon the 2009 MPFS final rule. CR 6484 amends those payment files. Changes included in the July Update to the 2009 MPFSDB are as follows:

The following changes are effective for dates of service on and after January 1, 2009:

CPT/HCPCS	Action
50593	Bilateral indicator = 1
77421	Global physician supervision diagnostic indicator = 09
77421TC	Physician supervision diagnostic indicator = 02
92025	Global bilateral indicator = 2
92025TC	Bilateral indicator = 2
9202526	Bilateral indicator = 2

Note: Changes to *CPT* code *93351* were included in the April update to the MPFSDB. Fully implemented facility practice expense relative value units (PE RVUs) were inadvertently not listed in Attachment 1 of the April update but were included on the payment files. Included are the fully implemented facility PE RVUs for *CPT* code *93351*. This service is typically not paid under the Medicare physician fee schedule when provided in a facility setting and the fully implemented facility PE RVUs listed below are informational only.

93351 Global Fully Implemented Facility PE RVU: 5.07

93351 TC Fully Implemented Facility PE RVU: 4.15

93351 26 Fully Implemented Facility PE RVU: 0.92

The following changes are effective for dates of service on and after July 1, 2009:

CPT/HCPCS	Action
90670	Long Descriptor: *Pneumococcal conjugate vaccine, 13 valent, for intramuscular use* Short descriptor: Pneumococcal vacc, 13 val im Procedure Status: X
92507	PC/TC Indicator = 7
92508	PC/TC Indicator = 7
92526	PC/TC Indicator = 7
92597	PC/TC Indicator = 7
92607	PC/TC Indicator = 7
92608	PC/TC Indicator = 7
92609	PC/TC Indicator = 7
96125	PC/TC Indicator = 7
0199T	Long descriptor: *Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude) including interpretation and report* Short descriptor: Physiologic tremor record Procedure Status: C

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

CPT/HCPCS	Action
0200T	Long descriptor: *Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles* Short descriptor: Perq sacral augmt unilat inj Procedure Status: C
0201T	Long descriptor: *Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needles* Short descriptor: Perq sacral augmt bilat inj Procedure Status: C
0202T	Long descriptor: *Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine* Short descriptor: Post vert arthrplst 1 lumbar Procedure Status: C
Q2023	Long descriptor: *Injection, factor VIII (antihemophilic factor, recombinant) (Xyntha), per I.U.* Short descriptor: Xyntha, inj Procedure Status: E
Q4115	Long descriptor: *Skin substitute, alloskin, per square centimeter* Short descriptor: Alloskin skin sub procedure Status: E
Q4116	Long descriptor: *Skin substitute, alloderm, per square centimeter* Short descriptor: Alloderm skin sub Procedure Status: E

Additional information

If you have questions, please contact your Medicare carrier, FI and/or MAC at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.
The official instruction, CR 6484, issued to your Medicare carrier, FI and/or MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1748CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6484
Related Change Request (CR) #: 6484
Related CR Release Date: May 29, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R1748CP
Implementation Date: July 6, 2009

Sign up to our *eNews* electronic mailing list

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

Therapeutic Services

Coding and Medicare payment decision for negative pressure wound therapy devices

The Centers for Medicare & Medicaid Services' (CMS) preliminary Healthcare Common Procedure Coding System (HCPCS) coding and preliminary Medicare payment decisions for negative pressure wound therapy (NPWT) devices are now published in the July 9, 2009, NPWT public meeting agenda. This public meeting affords stakeholders an opportunity to provide input concerning the preliminary decision.

The Medicare Improvements for Patients and Providers Act of 2008 required the Secretary to evaluate existing HCPCS codes for NPWT devices to ensure accurate reporting and billing for the items and services under such codes, use an existing process for the consideration of coding changes, and consider all relevant studies and information furnished through the process.

CMS partnered with Agency of Healthcare Research and Quality (AHRQ) to commission a review of NPWT devices to ensure all relevant studies and information on NPWT were captured. The Economic Cycle Research Institute (ECRI) solicited information from stakeholders and searched literature in conducting this review. A draft report of their findings was published for comment in April 2009. After analysis of comments received, ECRI concluded that the available evidence does not support significant therapeutic distinction of a NPWT system or component of a system. The report summarizes the decision made by the CMS HCPCS workgroup. The final report will be publicly available no later than June 10, 2009, on AHRQ's homepage for the Technology Assessment Program at *http://www.ahrq.gov/clinic/techix.htm*.

Source: PERL 200906-16

General Coverage

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.

Note: This article was revised on May 29, 2009, to clarify in the "What you need to know" section that change request (CR) 6417 does not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed in the article can order or refer or any claims edits that may be in place with respect to those restrictions. All other information is the same. This information was previously published in the May 2009 *Medicare B Update!* pages 19-20.

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

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 note: The changes being implemented with CR 6417 does not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed above can order or refer or any claims edits that may be in place with respect to those restrictions. 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.

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

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.

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 *Revised*
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

2009 ICD-9-CM changes

The 2009 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2008. Updated diagnosis codes must be used for all services billed on or after October 1, 2008. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. Florida Medicare has reviewed all local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2009 ICD-9-CM update. The table on the following pages lists the LCDs affected and the specific conditions revised as a result of the 2009 ICD-9-CM update:

Source: PERL 200906-23

Expanded instructions for reassignment of benefits

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 and A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries where payment is reassigned to an ambulatory surgical center (ASC) or to another physician's practice.

Provider action needed

This article is based on change request (CR) 6470 and provides clarifying information regarding 1) reassignment of benefits to an ASC, and 2) situations in which a solo physician/practitioner to whom another physician/practitioner has reassigned his/her benefits dies or has his/her Medicare billing privileges revoked.

Background

Physicians and nonphysician practitioners may reassign their benefits to an ASC if they meet the reassignment exceptions in the *Code of Federal Regulations* (CFR; Title 42, Section 424.80), and the *Medicare Claims Processing Manual* (Chapter 1, Sections 30.2.6 and 30.2.7). You can review 42 CFR 424.80 at *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr424.80.pdf* on the Internet, and Chapter 1, Sections 30.2.6 and 30.2.7 of the *Medicare Claims Processing Manual* at *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Ambulatory surgical centers and reassignment

If a physician or nonphysician practitioner wishes to reassign their benefits to an existing (and currently enrolled ASC), both the individual and the ASC must sign form CMS-855R (Visit *http://www.cms.hhs.gov/CMSforms/CMSforms/ItemDetail.asp?ItemID=CMS019478* on the CMS Web site).

However, it is not necessary for the ASC to separately enroll as a group practice in order to receive benefits. It can accept reassignment as an ASC.

Reassignment and revoked/deceased physicians and practitioners

There are situations where a physician/nonphysician practitioner (the "owning physician/practitioner"):

- Owns 100 percent of his/her own practice
- Employs another physician/non-physician practitioner (the "employed physician/practitioner") to work with him/her, and
- Accepts reassigned benefits from the employed physician/practitioner.

If the owning physician/practitioner dies or has his/her billing privileges revoked:

- The practice is no longer eligible to receive Medicare payments for services furnished after date of death or revocation effective date, and
- All reassignments are automatically terminated.

In these situations, neither the owning physician/practitioner nor the practice is eligible to participate in Medicare, and the billing privileges for both are revoked in accordance with the revocation procedures outlined in the *Medicare Program Integrity Manual* (Chapter 10 [Medicare Provider/Supplier Enrollment]). This policy applies to practices established as a sole proprietorship, a Professional Corporation (PC), a Professional Association (PA), or a solely-owned Limited Liability Company (LLC). In addition, the Medicare contractor will terminate the reassignments effective on the date of death or the effective date of the revocation.

Additional information

The official instruction, CR 6470, issued to your carrier or A/B MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R291PI.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: MM6470
Related Change Request (CR) #: 6470
Related CR Release Date: June 12, 2009
Effective Date: January 1, 2008
Related CR Transmittal #: R291PI
Implementation Date: October 5, 2009

Electronic Data Interchange

Remittance advice remark code and claim adjustment reason code update

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

Provider types affected

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

Provider action needed

Change request (CR) 6453, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective July 1, 2009. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets are used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated three times a year (early March, July, and November) although the Committee meets every month.

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes. The CARC list is also updated three times a year (early March, July, and November) along with the RARC list.

Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Internet. The lists at the end of the Additional information section of this article summarize the latest changes to these lists, as announced in CR 6453.

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

Additional information

As a reminder, CR 6336 noted that CARC 17 is being replaced with two new CARCs:

226 Information requested from the Billing/Rendering Provider was not provided or was insufficient/ incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

227 Information requested from the patient/insured/ responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

To see the official instruction (CR 6453) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1734CP.pdf* on the CMS Web site.

For additional information about remittance advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf* on the CMS Web site.

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

New codes -- CARC

Code	Current Narrative	Effective Date per WPC Posting
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR.	1/25/2009
230	No available or correlating *CPT*/HCPCS code to describe this service, Note: Used only by Property and Casualty	1/25/2009

Remittance advice remark code and claim adjustment reason code update (continued)

Modified codes -- CARC

Code	Current Narrative	Effective Date per WPC Posting
187	Health Savings account payments. This change to be effective 10/1/2009: Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	1/25/2009

Deactivated codes -- CARC

Code	Current Narrative	Effective Date
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	7/1/2009
156	Flexible spending account payments. Note: Use code 187.	10/1/2009

New codes -- RARC

Code	Current Narrative	Medicare Initiated
N516	Records indicate a mismatch between the submitted NPI and EIN.	No
N517	Resubmit a new claim with the requested information	Yes
N518	No separate payment for accessories when furnished for use with oxygen equipment.	Yes

Modified codes -- RARC

Code	Current Narrative	Medicare Initiated
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Start: 01/01/1997 Last Modified: 03/01/2009 Notes: (Modified 4/1/07. 3/1/2009)	Yes
N109	This claim/service was chosen for complex review and was denied after reviewing the medical records. Start: 02/28/2002 | Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	Yes
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. Start: 04/01/2007 | Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	Yes

Deactivated codes -- RARC

Code	Current Narrative	Medicare Initiated
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead) Start: 11/01/2008 | Stop: 10/01/2009	Yes

MLN Matters® Number: MM6453 Related Change Request (CR) #: 6453
Related CR Release Date: May 15, 2009 Effective Date: July 1, 2009
Related CR Transmittal #: R1734 Implementation Date: July 6, 2009

FRAUD AND ABUSE

The Medicare-Medicaid data matching project

In 2003, the Centers for Medicare & Medicaid Services (CMS) initiated a project with the state of Florida designed to share and analyze both Medicare and Medicaid data to better coordinate benefit integrity efforts between the two programs. Now known as Medi-Medi, claim data from both programs is analyzed together to detect patterns that may not be evident when billings for either program are viewed in isolation. As a result of combining the data, previously undetected patterns may be identified, such as "time bandits"; that is, providers who bill for a total of more than 24 hours in a day to both programs. This project allows vulnerabilities in both programs to be identified, and where appropriate, actions can be taken to protect the federal share of Medicaid and Medicare dollars.

First piloted in California in 2001, Medi-Medi is being expanded nationally with the enactment of the Deficit Reduction Act of 2005. In all of the projects, federal and state law enforcement and program integrity partners work together to identify fraudulent behaviors.

Since 2005, the Florida Medi-Medi project has generated 38 investigations with over $57 million in overpayments associated with those investigations. A recent project, which matched hospice-claim data between the two programs, uncovered the following activity:

> Analysis was conducted on claims for hospice services furnished to dually eligible Medicare and Medicaid recipients. Over $1.8 million was identified in duplicate payments for 262 dually-eligible recipients; that is, both Medicare and Medicaid each paid for the same services as a primary payer where Medicare should have been the primary payer. The state overpaid hospice providers who submitted the duplicate claims and is recovering the over $1.8 million in overpayments. Without the data matching, the overpayments would not have been identified nor recovered.

These are the types of patterns that a project like Medi-Medi, which shares and compares billings from both programs, is uniquely designed to discover. All Medi-Medi projects conduct analyses to determine if, and to what extent, vulnerabilities, fraudulent activities, and/or overpayments may exist.

SafeGuard Services LLC is the zone program integrity contractor (ZPIC) for Florida, Puerto Rico, and the U.S. Virgin Islands. The ZPIC is responsible for identifying and investigating health care fraud for the Medicare program. Its scope of work also includes the Florida Medi-Medi Data Matching Project in collaboration with the Agency for Health Care Administration's (AHCA) Office of Inspector General/Medicaid Program Integrity (IOG/MPI) and the Medicaid Fraud Control Unit.

Beware of scam targeting physicians' offices

A scam has been identified where perpetrators are sending faxes to physicians' offices posing as the Medicare carrier or Medicare administrative contractor (MAC). The fax instructs the recipient to respond to a questionnaire and to provide an account information update within 48 hours in order to prevent a gap in Medicare payments. The fax may have the Centers for Medicare & Medicaid Services (CMS) or contractor logo to enhance the appearance of authenticity.

Medicare fee-for-service (FFS) providers, including physicians and nonphysician practitioners, should be wary of this type of request. If you receive a request for information in the manner described above, please check with your contractor before submitting any confidential information. Medicare providers should only send information to a Medicare contractor using the address found in the *Download* section of the CMS Web site found at *http://www.cms.hhs.gov/MLNGenInfo/* or *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

FCSO contact information

The toll-free number for First Coast Service Options Inc. (FCSO) Medicare Part B Customer Service Center is 1-866-454-9007. A complete listing of contact information for FCSO is available at *http://medicare.fcso.com/Contacts/*.

The address for FCSO's Provider Enrollment department is:

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

Source: PERL 200906-30

General Information

Influenza pandemic emergency -- the Medicare program prepares

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

Note: This article was revised on May 29, 2009, to include a link to change request (CR) 6284, which was recently issued by the Centers for Medicare & Medicaid Services (CMS). All other information remains the same. This information was previously published in the December 2008 *Medicare B Update!* page 38.

Provider types affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs], durable medical equipment Medicare administrative contractors [DME MACs], carriers or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Impact on providers

This article is informational only and is alerting providers that CMS has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background

As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that may be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; and
2. The Secretary of the Department of Health and Human Services declares under section 319 of the Public Health Service Act that a public health emergency exists; and
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to section 1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

Dedicated CMS Web page now available

Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at *http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp* on the CMS Web site. That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional information

Additional CMS influenza pandemic policy documents include:

- CR 6146, which may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf* on the CMS Web site.
- CR 6164, which may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf* on the CMS Web site.
- CR 6174, which may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf* on the CMS Web site.
- CR 6209, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R411OTN.pdf* on the CMS Web site.
- CR 6256, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R428OTN.pdf* on the CMS Web site.
- CR 6280, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R441OTN.pdf* on the CMS Web site.
- CR6284, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R439OTN.pdf* on the CMS Web site.
- CR 6378, which is available at *http://www.cms.hhs.gov/Transmittals/downloads/R454OTN.pdf* on the CMS Web site.

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

MLN Matters Number: SE0836 *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

What's new with 2009 PQRI and e-Prescribing incentive programs

New educational resource article on the 2009 Physician Quality Reporting Initiative (PQRI) and electronic prescribing (e-Prescribing) programs

A new educational resource article has been posted to the PQRI Web page on the CMS Web site. The article titled *Physician Quality Reporting Initiative (PQRI) & e-Prescribing: Implementation Advice for the Office Manager* outlines step-by-step how to get started in reporting 2009 PQRI measures and is available at *http://www.cms.hhs.gov/PQRI/31_PQRIToolKit.asp* on the CMS Web site as a downloadable document. Scroll down to the *Downloads* section and select *2009 PQRI and E-Prescribing Implementation Advice* link.

Three available PQRI help desk resources

The following resources are available to assist eligible professionals with their questions on the PQRI initiative:

Provider call center directory

- Remittance advice notices
- Incentive payment distribution status
- Adjustments made to incentive payment due to sanctions/overpayments

For contact information, see the *Provider Center Toll-free Numbers Directory*, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

External user services (EUS) -- 7:00 a.m.-7:00 p.m. (ET)

- Registering/creating an IACS account
- Accessing an IACS account
- Changing an IACS account
- Approving users into an organization

Phone: 1-866-484-8049
TTY: 1-866-523-4759

QualityNet help desk -- 7:00 a.m.-7:00 p.m. (CT)

- General CMS PQRI and e-Prescribing information
- PQRI portal password issues
- PQRI feedback report availability and access

Phone: 1-866-288-8912

Related links

- Information on the CMS PQRI initiative may be found on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.
- Information on the CMS e-Prescribing incentive program may be found on the CMS Web site at *http://www.cms.hhs.gov/ERxIncentive*.

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

Source: PERL 200905-36

Qualified registries available for 2009 Physician Quality Reporting Initiative reporting

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of qualified registries for 2009 Physician Quality Reporting Initiative (PQRI) reporting.

A list of qualified registries may be accessed under the Reporting section page on the CMS Web site at *http://www.cms.hhs.gov/PQRI*. Each of the registries listed has gone through a vetting process. CMS believes that it is highly likely each of these registries will be successful in their data submission for the PQRI program.

Eligible professionals who wish to participate in the 2009 PQRI using one of the registry-based options may contact the registries for additional details on participation options.

Available information on the CMS Physician Quality Reporting Initiative may be found at *http://www.cms.hhs.gov/PQRI* on the CMS Web site.

Source: PERL 200906-27

Information for eligible professionals who participated in the 2007 PQRI

The Centers for Medicare & Medicaid Services (CMS) has announced that the 2007 Physician Quality Reporting Initiative (PQRI) feedback reports that have been posted since July 2008 on *https://www.qualitynet.org/portal/server.pt* will be archived effective June 30, 2009, and will no longer be available to eligible professionals (EPs) who participated in the 2007 PQRI.

Archiving is required to create server space for new feedback reports related to the 2008 PQRI and the 2007 PQRI re-run participation. Only those EPs who previously did not qualify by submitting at least one quality data code successfully, but are newly qualified following the back-end system analysis and re-run of 2007 PQRI data, will receive a 2007 PQRI re-run feedback report.

All eligible professionals who successfully submitted at least one quality data code for the 2008 PQRI will receive a feedback report. These reports should be available in October 2009.

The 2008 PQRI incentive payment will be distributed by the carrier and/or A/B MAC in October 2009. The 2007 PQRI re-run incentive payments will be distributed by the carrier and/or A/BMAC in November 2009.

Source: PERL 200906-19

2007 Physician Quality Report Initiative Program re-run -- frequently asked questions

The Centers for Medicare & Medicaid Services (CMS) has announced the posting of five frequently asked questions (FAQs) related to the re-run of 2007 Physician Quality Reporting Initiative (PQRI) data. The FAQs below, as well as, all PQRI FAQs may be accessed here.

CMS will be updating the FAQ section, so please continue to check it often.

FAQ # 9537

Q. What is the reason for the re-run of 2007 Physician Quality Reporting Initiative (PQRI) feedback reports and incentive payments?

A. CMS investigated reported issues following delivery of the 2007 Physician Quality Reporting Initiative (PQRI) feedback reports and incentive payments and determined that several unanticipated technical issues could be corrected by conducting back-end system analytics and re-running the data. Reports are anticipated to be available in the fall of 2009.

FAQ # 9540

Q. When will the re-run of the 2007 Physician Quality Reporting Initiative (PQRI) feedback report and incentive payment be available? How will my practice receive this information?

A. 2007 Physician Quality Reporting Initiative (PQRI) reports are anticipated to be available in the fall of 2009 and will be available to the tax identification number (TIN). These reports will be available only for those eligible professionals (EPs) who have qualified due to the back-end system analysis and re-running the data. For those EPs who already received an incentive, the re-run will not apply, thus those EPs will not receive an additional feedback report. Feedback reports will be available via the PQRI Reports Delivery System (RDS). An Individuals Authorized Access to the CMS Computer Services (IACS) user name and password will be required to access the report.

FAQ #9541

Q. Will EPs, using their individual national provider identifier (NPI), receive an additional incentive when the 2007 PQRI data is re-run in the fall of 2009?

A. No. Only those EPs who previously did not receive a bonus but are bonus eligible following the back-end system analysis and re-run of the 2007 PQRI data will potentially receive the 2007 re-run incentive.

FAQ# 9542

Q. Will there be a 2007 PQRI re-run for the MCMP and PGP demonstration projects?

A. No. Incentive payments to eligible MCMP and PGP demonstration project participants have been issued and are a separate incentive program from the PQRI.

FAQ #9543

Q. Will there be a 2007 PQRI re-run for Medicare Advantage participants?

A. Yes. Those Medicare Advantage EPs who previously did not receive a bonus but are bonus eligible following the back-end system analysis and re-run of the 2007 PQRI data will potentially receive the 2007 re-run incentive.

All publicly available information on the CMS PQRI may be found at *http://www.cms.hhs.gov/PQRI*, on the CMS Web site.

Source: PERL 200906-14

Do not forward initiative reminder

As part of the Do Not Forward (DNF) Initiative, the Centers for Medicare & Medicaid Services (CMS) has instructed contractors to use "return service requested" envelopes for all provider remittance advice mailings.

This requirement applies to the provider Medicare checks and remittance advices. When a provider check or remittance advice is returned to the contractor because of "return service requested," the following will occur:

- The contractor will flag the provider number as DNF.
- Provider enrollment will be notified of provider's new status.
- The contractor will stop sending paper checks and remittance advices to the provider.
- Electronic fund transfers will be stopped.

Only upon verification and update of all the provider's addresses will the flag be removed. Not only will the "pay to" address be verified, but also all "provider location" addresses will be verified. It is important that providers notify Medicare immediately of any change of address by completing and submitting the CMS-855I Medicare Enrollment Application for individual providers, and the CMS-855B Medicare Enrollment Application for groups and organizations.

Once the DNF flag has been removed, the contractor will:

- Pay any funds held due to DNF
- Reissue any remittance notices held due to DNF.

Source: Publication 100-04, Chapter 22, Section 50.1

Information to include in your membership communications

Help your association members stay up-to-date on the latest Medicare-related information. Below is a brief news item that we encourage you to put in your next newsletter, bulletin, or whatever vehicle you use to provide your members with news they need to know. Through their electronic mailing lists, Medicare contractors serve as a valuable source of news and information regarding Medicare business in specific provider practice locations, including local coverage determinations and local provider education events:

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

Do your members a favor and help us spread the word.

Source: PERL 200906-02

Discontinuance of the unique physician identification number registry

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

Note: This article was revised on June 1, 2009, to remove the Web link to the unique physician identification number (UPIN) registry, which is no longer maintained, and also to remove another link to the national provider identifier (NPI) contingency plan that no longer works as the information is no longer available on the Internet. This information was previously published in the October 2007 *Medicare B Update!* pages 27-28

Provider types affected

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

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 5584, which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning unique physician identification numbers (UPINs) on June 29, 2007.

Caution -- what you need to know

The NPI is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.)

Go -- what you need to do

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) Web site at *https://nppes.cms.hhs.gov/* on the CMS Web site. See the *Background* and *Additional information* sections of this article for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a final rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the NPI. The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007, (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007.

The CMS discontinued assigning UPINs on June 29, 2007. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the *Federal Register* on May 30, 2007. This notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

Discontinuance of the unique physician identification number registry (continued)

Additional information

For additional information regarding NPI requirements and use, please see *MLN Matters* articles, MM4023 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf*) titled, "Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms", and MM4293 (*http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf*) titled, "Revised CMS-1500 Claim Form", which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the NPI and renamed CMS-1500 (08-05).

The official instruction, CR 5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf* on the CMS Web site.

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

MLN Matters® Number: MM5584 *Revised*
Related Change Request (CR) #: 5584
Related CR Release Date: September 14, 2007
Effective Date: May 29, 2007
Related CR Transmittal #: R222PI
Implementation Date: June 29, 2007

Transcripts for May 19 ICD-10-CM/PCS conference call available

The written and audio transcripts of the ICD-10-CM/PCS Implementation and General Equivalence Mappings (Crosswalks) national provider conference call, which was conducted by the Centers for Medicare & Medicaid Services on May 19, 2009, are now available in the *Downloads* section at *http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp*.

Source: PERL 200906-18

New fact sheet for general equivalence mappings

The second in a series of fact sheets regarding general equivalence mapping (GEM) is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfctsht.pdf*. This GEM fact sheet, published in May 2009, provides basic information about general equivalence mappings including possible users of the GEMs, why the GEMs are needed, and how the GEM files are formatted as well as reimbursement mappings information.

Source: PERL 200906-07

Revised rural referral center fact sheet

The revised *Rural Referral Center fact sheet* (April 2009), which provides information about rural referral center program requirements, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/RuralRefCtrfctsht2008.pdf*.

Source: PERL 200906-28

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.

Revised Web-based training course for certificate of medical necessity

The Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* (*MLN*) has made available a course that contains information about the certificate of medical necessity, most commonly known as a CMN.

This course will be helpful to physicians, health care professional, and medical administrative staff in the completion, submission and maintenance of the documentation required to verify the CMN, available at *http://www.cms.hhs.gov/MLNGenInfo*. Scroll to the *Related Links Inside CMS* section at the bottom of the page. Locate and select *Certificate of Medical Necessity WBT* from the list provided. Upon completion of this course you should be able to:

- List the items that require a CMN
- Identify the responsibilities of physicians, physician assistants, nurse practitioners, or clinical nurse specialists as they relate to the CMN
- Define medical record documentation
- Identify the sections of a CMN
- List CMN common errors
- Identify CMN completion resources

Successful completion of this course requires completion of all course lessons, pre-test, course evaluation and a score of 70 percent of higher on the post-test. The CMS is authorized by IACET to offer 0.1 continuing education units (CEUs) for this program.

The CMS designates this educational activity for a maximum of one AMA PRA category one credit(s)TM. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Credit for this course expires May 4, 2012.

This course and its post test score of 70 percent or higher, are approved for one CEU by the American Academy of Professional Coders (AAPC). Index # CMS06140728A

When submitting a CMS completed Web-based training course to AAPC as part of your recertification, please retain a copy of your CMS certificate and a copy of the course description that contains the AAPC index number and number of AAPC CEUs. The AAPC will request copies of these if you are selected for verification of the CEUs listed on your renewal form.

The author has no conflicts of interest to disclose.

This course was developed without any commercial support.

The Web site to view the biographical information of the course developers is available at *http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/2009_May_Biographical_Data_CMN_WBT.pdf*.

Source: PERL 200906-26

June 7 is National Cancer Survivors Day

In honor of the millions of Americans who are living with a history of cancer, the Centers for Medicare & Medicaid Services (CMS) reminds the Medicare provider community of the many cancer screenings that Medicare covers. Early detection and treatment of cancer can help Medicare patients live longer, healthier lives.

What can you do?

As a health care professional who provides care to seniors and others with Medicare, you can help protect the health of your Medicare patients who may be at risk for cancer by educating them about their risk factors and reminding them of the importance of getting the preventive cancer screenings covered by Medicare.

For more information

CMS has developed several educational products related to Medicare-covered preventive services, including screenings for various forms of cancer. Please visit the *Medicare Learning Network* for more information, including the following cancer-screening pages:

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

Cancer Screenings Brochure -- this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of cancer screening tests, including screening mammographies, screening pap tests, screening pelvic exams, colorectal screenings, and prostate cancer screenings. *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf*.

Quick Reference Information: Medicare Preventive Services -- this double-sided chart provides coverage and coding information on Medicare-covered cancer screenings. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

Thank you for helping CMS improve the health of Medicare beneficiaries who are at risk for cancer by joining in the effort to educate beneficiaries about cancer, and the importance of early detection by taking advantage of the cancer screenings covered by Medicare.

Source: PERL 200906-10

June 15-21 is National Men's Health Week and June 21 is Father's Day

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep men with Medicare healthy by ensuring that they take advantage of Medicare-covered preventive services. Medicare covers colorectal and prostate cancer screenings, among other preventive services.

What can you do?

As a health care professional who provides care to seniors and others with Medicare, you can help protect the health of your Medicare patients who may be at risk for cancer by educating them about their risk factors and reminding them of the importance of getting the preventive cancer screenings covered by Medicare. Early detection and treatment of cancer can help men with Medicare live longer, fuller, healthier lives.

For more information

CMS has developed several educational products related to Medicare-covered preventive services, including screenings for various forms of cancer. Please visit the *Medicare Learning Network* (*MLN*) for more information, including the following cancer-screening pages:

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

Cancer Screenings Brochure -- this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of cancer screening tests, including colorectal and prostate cancer screenings. *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.pdf*.

Quick Reference Information: Medicare Preventive Services -- this double-sided chart provides coverage and coding information on Medicare-covered cancer screenings. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

Thank you for helping CMS improve the health of men with Medicare who are at risk for cancer by joining the effort to educate beneficiaries about cancer, and the importance of early detection by taking advantage of the cancer screenings covered by Medicare.

Source: PERL 200906-24

Sign up to our *eNews* electronic mailing list

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

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

J0740: Ganciclovir and cidofovir -- revision to the LCD

LCD ID number: L29181 (Florida)
LCD ID number: L29342 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ganciclovir and cidofovir was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. The off-label indication of BK nephropathy and BK viremia has been added as medically reasonable for HCPCS code J0740. The "Indications and Limitations of Coverage and/or Medical Necessity," "Documentation Requirements," and "Utilization Guidelines" sections of the LCD have been revised accordingly. In addition, the following ICD-9-CM code has been added for HCPCS code J0740 as medically reasonable for this off-label indication: V42.0 (Organ or tissue replaced by transplant, kidney).

Effective date

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

J9350: Topotecan hydrochloride (Hycamtin®) -- revision to the LCD

LCD ID number: L29290 (Florida)
LCD ID number: L29479 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for topotecan hydrochloride (Hycamtin®) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. A request was received to add the off-label indication of primary central nervous system lymphoma as medically reasonable and necessary. Review of literature demonstrated that this was an acceptable request. Therefore the "Indications and Limitations of Coverage and/or Medical Necessity," "Utilization Guidelines," and "ICD-9 Codes that Support Medical Necessity" sections of the LCD have been revised accordingly. The following ICD-9-CM codes have been added as medically reasonable and necessary: 200.50-200.58.

Effective date

This LCD revision is effective for services rendered on or after June 8, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section," drop-down menu at the top of the LCD page.

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

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

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised effective March 2, 2009. Since that time, the LCD has been revised. First Coast Service Options Inc. (FCSO) received a request to remove *CPT* code *0193T* (*Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence*), which includes the Renessa® treatment for women with stress urinary incontinence, from the list of Medicare noncovered services LCD.

With emerging technologies that are billed to the Medicare contractor as either an unlisted procedure code or, when applicable, a category III *CPT* code, FCSO addresses the procedure billed as:

1. not medically necessary and not covered; or
2. medically necessary per certain criteria as indicated in the development and communication of a LCD; or
3. as is frequently the case, as we learn about the technology based on how it is billed and what has been published in the peer-reviewed literature, we will have no positive coverage statement and claims will be handled on an individual case by case basis.

FSCO is not issuing a positive coverage statement at this time regarding the Renessa® procedure. However, in order to provide an option for those physicians who are appropriately trained in treating women with stress urinary incontinence (SUI) and who are appropriately trained in performing the Renessa® procedure, we will be removing Renessa® from our noncovered

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

LCD and we will be looking at claims for the Renessa® procedure on an individual case by case basis.

The non-surgical Renessa® treatment, represented by *CPT* code *0193T* and ICD-9-CM code 625.6 (Stress urinary incontinence, female, has been approved by the Food and Drug Administration (FDA) since July 22, 2005, and is indicated for the transurethral treatment of female SUI due to hypermobility in women who have failed conservative treatment and who are not candidates for surgical therapy. FCSO expects that providers submitting claims for Renessa® are providing the services within the FDA approved guidelines and in accordance with the indications supported by peer-reviewed literature which limits its use to moderate to severe stress urinary incontinence (SUI) in females. In addition, for dates of service on or after January 1, 2009, Renessa® should no longer be reported with *CPT* code *53899* (Unlisted procedure, urinary system).

Effective date

This LCD revision is effective for services rendered on or after June 30, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section," drop-down menu at the top of the LCD page.

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

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

The local coverage determination (LCD) for the list of Medicare noncovered services was last revised effective June 30, 2009. Since that time, the LCD has been revised based on change request 6484 (July Update to the 2009 Medicare Physician Fee Schedule Database [MPFSDB]), dated May 29, 2009.

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

- Added *CPT* code *0199T* (*Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude*) including interpretation and report, as it is a screening procedure and is not medically reasonable and necessary.

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

- Added *CPT* code *90670* (*Pneumococcal conjugate vaccine, 13 valent, for intramuscular use*), as it is not FDA approved and, therefore, is noncovered.

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

- Added *CPT* code *0202T* (*Posterior vertebral joint(s) arthroplasty (e.g. facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine*), as there is no evidence to substantiate the safety and efficacy of the surgery.

Effective date

This LCD revision is effective for claims processed on or after July 6, 2009, for services rendered on or after July 1, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section," drop-down menu at the top of the LCD page.

92025: Computerized corneal topography -- coding guideline revision

LCD ID number: L29122 (Florida)
LCD ID number: L29140 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for computerized corneal topography was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the "Coding Guidelines" attachment has been revised to indicate this procedure is considered to be a unilateral or a bilateral diagnostic test; therefore, it would not be appropriate to report this procedure with the modifier 50 if performed bilaterally (CMS change request 6484, dated May 29, 2009).

Effective date

This revision to the "Coding Guidelines" attachment is effective for claims processed on or after July 6, 2009, for services rendered on or after January 1, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section," drop-down menu at the top of the LCD page.

Additional Information

J9999: Plerixafor (MOZOBIL®) -- revision to article

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. MOZOBIL® may be billed to the Medicare contractor with HCPCS codes J3490 (Unclassified drugs) or J9999 (Not otherwise classified, antineoplastic drugs) or effective for dates of service on or after July 1, 2009, may be billed with HCPCS code C9252 (Injection, plerixafor, 1 mg). In addition, the list of ICD-9-CM codes that First Coast Service Options Inc. (FCSO) will consider as medically reasonable and necessary has been expanded to include all of the following:

200.00-200.08	200.10-200.18	200.20-200.28	200.30-200.38	200.40-200.48
200.50-200.58	200.60-200.68	200.70-200.78	200.80-200.88	202.00-202.08
202.10-202.18	202.20-202.28	202.30-202.38	202.40-202.48	202.50-202.58
202.60-202.68	202.70-202.78	202.80-202.88	202.90-202.98	203.00-203.01

At this time, the only G-CSF that 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. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

0197T/77499: Calypso® 4D localization system™

Image guided radiation therapy (IGRT) is a technique in which imaging occurs during the course of a radiation therapy session (treatment delivery) in order to ensure that the radiation is delivered to the correct target location and avoid exposure of the surrounding tissues. The current procedure terminology book (*CPT*) has three codes with descriptors applicable to IGRT: *CPT* codes *77014*, (*Computed tomography guidance for placement of radiation therapy fields*); *77421*, (*Steroscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*); and *76950*, (*Ultrasonic guidance for the placement of radiation therapy fields*). Various emerging technologies of localization and tracking of patient or tumor motion are being studied, including 3D positional or surface tracking technology. This technology is reported using *CPT* code *77499* (*Unlisted procedure, therapeutic radiology treatment management*) for dates of service prior to January 1, 2009, and *CPT* code *0197T* (*Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy [e.g., 3D positional tracking, 3D surface tracking], each fraction of treatment)* for dates of service on or after January 1, 2009).

The Calypso® 4D localization system™ used with Beacon® electromagnetic transponders is a real-time target localization and tracking system that has been approved by the Food and Drug Administration (FDA) since 2006 for use in the prostate and provides continuous target localization which aids in patient set-up and target tracking to monitor tumor position during radiation therapy delivery. The Beacon® electromagnetic transponders are designed to be used specifically with the Calypso® system to provide target localization and continuous real-time monitoring during radiation therapy for the prostate.

With emerging technologies that are billed to the Medicare contractor as either an unlisted procedure code or, when applicable, a category III *CPT* code, First Coast Service Options Inc. (FCSO) addresses the procedure billed as:

1. not medically necessary and not covered; or
2. medically necessary per certain criteria as indicated in the development and communication of a local coverage determination (LCD); or
3. as is frequently the case, as we learn about the technology based on how it is billed and what has been published in the peer-reviewed literature, we will have no positive coverage statement and claims are handled on a case by case basis.

FCSO does not have a positive coverage statement for *CPT* code *0197T* that describes the use of the Calypso® system during treatment delivery. FCSO has reviewed claims for emerging technologies such as the Calypso® system with Beacon®

0197T/77499: Calypso® 4D localization system™ (continued)

transponders in addition to current peer-reviewed literature and as of June 19, 2009, will no longer be reimbursing these procedures since there is no compelling data on the impact of this system on long term patient outcomes. Also, there is frequently static image guidance billed on the claim on the same day. In addition, some of these emerging technologies require the use of so called "smart fiducials" such as transponders or implantable tissue dosimeters. FCSO will not be paying for the additional cost of these "smart fiducials" and will only be covering gold markers.

95805: Polysomnography and sleep testing -- extended date of accreditation

LCD ID number: L29949 (Florida)

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

The new local coverage determination (LCD) for Polysomnography and sleep testing that includes home sleep testing (HST) is effective for services rendered on or after June 30, 2009, for Florida, Puerto Rico, and the U.S. Virgin Islands. A sleep facility must maintain documentation on file that indicates it is accredited by the American Academy of Sleep Medicine (AASM) or that it is accredited as a sleep laboratory by the Joint Commission. This documentation must be available to Medicare on request.

In regard to performing and billing the technical component (TC) of polysomnography (PSG) and sleep testing (including HST), sleep facilities (hospital based or affiliated) and free-standing facilities (office/clinic, independent diagnostic testing facilities, and any non-hospital-based facilities where sleep studies are performed) that are not currently accredited must be able to demonstrate that they are seeking accreditation (application sent and under review) or AASM Provisional accreditation and are complying with all other standards of care outlined in the LCD. These facilities will have until April 30, 2010, to obtain the required accreditation.

However, physicians who review and interpret (professional component [PC]) PSG and sleep testing (including HST) must currently be in compliance with credentialing/training as outlined in the LCD:

- A Diplomate of the American Board of Sleep Medicine (ABSM)
- A Diplomate in sleep medicine by a member board of the American Board of Medical Specialties (ABMS)
- An active physician staff member of an AASM accredited sleep center or sleep laboratory, or
- An active physician staff member of a joint commission accredited sleep laboratory.

In addition, sleep technicians or technologists facilitating PSG and sleep testing or facilitating HST must have appropriate personnel certification. Examples of certification/training in PSG and sleep technology for nonphysician personnel include:

- Registered Polysomnography technologist (RPSGT)
- Registered Electroencephalographic technologist (R.EEG T.) -- Polysomnography

Credentialing for sleep technicians or technologists must be provided by nationally recognized credentialing organizations such as:

- Board of Registered Polysomnographic Technologists (BRPT) that provides (RPSGT) credential
- American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRET) that provides R. EEG T.) -- Polysomnography credential
- Performed in a sleep center or laboratory accredited by the AASM, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ABSM that provides credentialing in sleep technology, or
- National Board for Respiratory Care, Inc. (NBRC) that provides specialty examination for respiratory therapists performing sleep disorders testing and therapeutic intervention (CRT-SDS and RRT-SDS)

First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section," drop-down menu at the top of the LCD page.

Sign up to our *eNews* electronic mailing list

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

Educational Resources

Upcoming provider outreach and education events -- July 2009

Hot Topics Series: 2009 Part B updates and changes

When: July 14
Time: 11:30 a.m. – 12:30 p.m.
Focus: Florida and the U.S. Virgin Islands

New Evaluation and Management (E/M) series: workshops covering E/M services of a typical patient -- session 1

When: July 21
Time: 11:30 a.m. – 1:00 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

New Evaluation and Management (E/M) series: workshops covering E/M services of a typical patient -- session 1

When: July 23
Time: 2:30 p.m. – 4:00 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways To register

Note: Unless otherwise indicated, all FCSO educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, 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.

Medifest 2009

Tuesday, September 1 & Wednesday, September 2
Location: Orlando, FL 8:00 a.m.-5:00 p.m.
Delivery language: English

Join us for First Coast Service Options' (FCSO) exciting Medicare educational event: Medifest 2009. This dynamic, face-to-face symposium will be held in Orlando, FL and is open to all members of FCSO's provider community. Take advantage of Medicare educational workshops, learning from FCSO's Medicare experts, and talk with representatives from companies offering products and services especially designed for Medicare providers.

You may attend one or both days, and each day will feature a wide selection of informative seminars and workshops designed to help you increase your knowledge of Medicare and facilitate your continued success as a Medicare provider.

You may now access our Web site for the event's agenda, individual course descriptors, and registration instructions and tools at *http://medicare.fcso.com/Medifest/*.

Sneak preview of Medifest 2009

- Part A and Part B workshop topics will be selected based upon analysis of current data, including the types of inquiries received in our provider contact center, the types of claim submission errors most frequently experienced by members of our provider community, and prepayment/postpayment medical review activity.
- Each informative workshop will feature live demonstrations and real-life scenarios (whenever possible). In addition, you'll have the opportunity to interact with your peers and Medicare experts from across the FCSO organization, engage in the learning and problem-solving process, and learn how to take advantage of the wealth of Medicare resources available on the Centers for Medicare & Medicaid (CMS) as well as the FCSO Medicare provider Web sites.
- To ensure that participants can take advantage of the intermediate and advanced-level Medicare workshops, we'll identify special FCSO Medicare educational webcasts and Web-based training (WBT) modules (offered prior to the event) to help less experienced providers acquire a solid foundation of knowledge as well as a basic understanding of the Medicare program.
- You'll have the opportunity to preview products and services designed especially for Medicare providers, including billing and practice management software and tools, and talk with the representatives of the companies that offer them.

Check our new Medifest page regularly at *http://medicare.fcso.com/Medifest/* for the latest information on the following topics:

- Agenda
- Course descriptions
- Hotel information
- Registration instructions
- Vendor information

This will be the only Medifest event in 2009 for Florida, Puerto Rico and the U.S. Virgin Island providers, so don't forget to mark your calendars:

What: Medifest 2009

When: September 1-2

Where: Renaissance Orlando Hotel Airport
5445 Forbes Place
Orlando, FL 32812
(407) 240-1000
http://www.marriott.com/hotels/travel/mcora-renaissance-orlando-hotel-airport/

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 ♦