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

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

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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.

Find out first: Subscribe to FCSO *eNews*

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, subscribe to *eNews*, and stay informed.

CLAIMS

2010 annual update for the health professional shortage area bonus payments

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

Provider types affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries in HPSAs.

What you need to know

Change request (CR) 6581, from which this article is taken, alerts providers that the 2010 file will be posted to the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413[b]) mandated that the automated health professional shortage area (HPSA) bonus payment files be updated annually. CMS will create a new automated HPSA bonus payment file for claims with dates of service on or after January 1, 2010, through December 31, 2010, and post it to the Web site in early December of 2009.

You will find the annual HPSA bonus payment file and other important HPSA information at *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/* on the CMS Web site. You should also review the CMS Web site to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf* on the CMS Web site and following the instructions on the page.

Additional information

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

The official instruction (CR 6581) issued to your MAC, carrier, and/or FI may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1789CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6581
Related Change Request (CR) #: 6581
Related CR Release Date: August 7, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1789CP
Implementation Date: January 4, 2010

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Timely claim filing guidelines

All Medicare claims must be submitted to the contractor within the established timeliness parameters. The time parameters are:

Dates of Service	Last Filing Date
October 1, 2007 – September 30, 2008	by December 31, 2009
October 1, 2008 – September 30, 2009	by December 31, 2010
October 1, 2009 – September 30, 2010	by December 31, 2011

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) 6587, which provides a reminder for physicians to take note of the quarterly updates (version 15.3) to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in July 2009.

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 15.3, is effective October 1, 2009, and includes all previous versions and updates from January 1, 1996, to the present.

Additional information

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.

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 6587) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1785CP.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: MM6587
Related Change Request (CR) #: 6587
Related CR Release Date: July 31, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R1785CP
Implementation Date: October 5, 2009

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Find your favorites fast – use Quick Find

Looking for the fastest way to find your favorite sections of our Web site? It's easy -- just use the Quick Find navigational tool. Located on the left-hand side of every page, this convenient drop-down menu allows you to jump to the most popular pages on the site -- with just one click. You'll find links to the Part A and Part B homepages as well as quick links to the procedure-diagnosis lookup tool, local coverage determinations (LCDs), fee schedules, publications, and more. Find out how easy is to find what you need fast -- use Quick Find.

Diabetic Services

Diabetes self-management training certified diabetic educator

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

Provider types affected

Physicians , providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for diabetes self-management training (DSMT) services provided to Medicare beneficiaries.

Impact on providers

This article is based on change request (CR) 6510 which recognizes the American Association of Diabetes Educators (AADE) as an approved DSMT national accreditation organization. CR 6510 also implements the following exception for DSMT in rural areas: an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by the Centers for Medicare & Medicaid Services (CMS) may furnish training and is deemed to meet the multidisciplinary team requirement.

Background

The Centers for Medicare & Medicaid Services (CMS) announced in their final notice published in the *Federal Register* (Volume 74, February 27, 2009) that the American Association of Diabetes Educators (AADE) is approved as a national accreditation organization to furnish DSMT and is recognized as a national accrediting organization for accrediting entities to furnish outpatient DSMT to Medicare beneficiaries. See the *Federal Register* (V74, February 27, 2009) at *http://edocket.access.gpo.gov/2009/pdf/E9-3287.pdf* on the Internet.

Providers and suppliers of DSMT services may submit requests for accreditation through the AADE, and Medicare contractors shall recognize the AADE as an approving entity for the DSMT program billable through Medicare.

In addition, if providers/suppliers had a valid AADE certificate disapproved by their Medicare contractor, they may ask their contractor to reprocess that application.

CR 6510 also amended the *Medicare Benefit Policy Manual* (Chapter 15 [Covered Medical and Other Health Services]) to clarify that there is an exception for who can provide DSMT in a rural area as follows:

"…Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. There is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement."

See the *Code of Federal Regulations* (CFR), Title 42, Chapter IV, Section 410.144(a)(4)(C)(ii) which describes the exception for DSMT in rural areas at *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr410.144.pdf* on the Internet.

Additional information

The official instruction, CR 6510, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R109BP.pdf* on the CMS Web site. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

MLN Matters® Number: MM6510
Related Change Request (CR) #: 6510
Related CR Release Date: August 7, 2009
Effective Date: March 30, 2009
Related CR Transmittal #: R109CP
Implementation Date: September 8, 2009

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Drugs and Biologicals

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

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6585 and instructs Medicare contractors to download and implement the October 2009 average sales price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2009, April 2009, January 2009, and October 2008, files. Medicare will use the October 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2009, with dates of service October 1, 2009, through December 31, 2009. See the Background and Additional information sections of this article for further details regarding these changes.

Background

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

ASP methodology

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

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

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

Drugs furnished during filling or refilling an implantable pump or reservoir

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

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

Use of quarterly payment files

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

Files	Effective Dates of Service
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and ASP NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008

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

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

Additional information

The official instruction (CR 6585) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1795CP.pdf* on the CMS Web site.

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

CMS would like providers to be aware that the following *MLN* products are available through the *MLN* catalogue:

1. The guide at *http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf* describes topics such as: types of Remittance Advice (RA), the purpose of the RA and types of codes that appear on the RA.
2. A fact sheet at *http://www.cms.hhs.gov/PQRI/Downloads/PQRIEPrescribingFactSheet.pdf* introduces the e-Prescribing Incentive Program as authorized by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).
3. The brochure at *http://www.cms.hhs.gov/MLNProducts/downloads/Protectingpracbroch508-09.pdf* highlights some the steps providers can employ to protect their practices from inappropriate Medicare business interactions.

MLN Matters® Number: MM6585
Related Change Request (CR) #: 6585
Related CR Release Date: August 14, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R1795CP
Implementation Date: October 5, 2009

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Durable Medical Equipment

Compliance standards for consignment closets and stock and bill arrangements

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

Provider types affected

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) which maintain inventory at a practice location owned by a physician or nonphysician practitioner for the purpose of DMEPOS distribution and which submit claims to the national supplier clearinghouse Medicare administrative contractor (NSC-MAC) are affected. In addition, physicians and nonphysician practitioners who maintain DMEPOS inventory at the physician or nonphysician practitioner's practice location for the purpose of DMEPOS distribution should be aware of this issue.

Provider action needed

DMEPOS suppliers, physicians and nonphysician practitioners who maintain consignment closets and stock and bill arrangements for DMEPOS must comply with current standards, which may be verified by the NSC-MAC. Providers should assure that their billing staff is advised of these billing and compliance standards.

Background

This article is based on change request (CR) 6528, which defines and prohibits certain arrangements where an enrolled DMEPOS supplier maintains inventory at a practice location that is not owned by the enrolled DMEPOS supplier, but rather, owned by a physician or nonphysician practitioner for the purpose of DMEPOS distribution, commonly referred to as a consignment closet and/or stock and bill arrangement. A common practice example is that of an enrolled physician practice that allows DMEPOS owned by a separately enrolled DMEPOS supplier to be kept at the physician's practice location.

CR 6528 instructs the NSC-MAC that use of consignment closets and/or stock and bill arrangements, as defined in the background above, must be in compliance with current standards. In addition, the CR defines additional specific compliance standards for NSC-MAC validation for consignment closets and stock and bill arrangements added to the *Medicare Program Integrity Manual* (PIM), Chapter 10, Section 21.8, and viewable as an attachment to CR 6528 at *http://www.cms.hhs.gov/Transmittals/downloads/R297PI.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Medicare allows Medicare enrolled DMEPOS suppliers to maintain inventory at a practice location owned by a physician or nonphysician practitioner for the purpose of DMEPOS distribution when the following conditions are met by the DMEPOS supplier and verified by the NSC-MAC:

Compliance standards for consignment closets and stock and bill arrangements (continued)

- The title to the DMEPOS shall be transferred to the enrolled physician or nonphysician practitioner's practice at the time the DMEPOS is furnished to the beneficiary.
- The physician or nonphysician practitioner's practice shall bill for the DMEPOS supplies and services using their own enrolled DMEPOS billing number.
- All services provided to a Medicare beneficiary concerning fitting or use of the DMEPOS shall be performed by individuals being paid by the physician or nonphysician practitioner's practice, not by any other DMEPOS supplier.
- The beneficiary shall be advised that, if they have a problem or questions with the DMEPOS, they should contact the physician or nonphysician practitioner's practice, not the DMEPOS supplier who placed the DMEPOS at the physician or nonphysician practitioner's practice.

The NSC-MAC shall verify that no more than one enrolled DMEPOS supplier shall be enrolled and/or located at the same practice location. **Note**: This prohibition does not exist for one or more physicians enrolled as DMEPOS suppliers at the same physical location. A practice location shall have a separate entrance and separate post office address, recognized by the United States Postal Service.

The NSC-MAC customer service personnel shall respond to direct provider and/or supplier questions concerning compliance with this policy. The responsibility for determining compliance with these provisions is the responsibility of the DMEPOS supplier, physician, or nonphysician practitioner.

Additional information

If you have questions, please contact the Medicare NSC-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 6528, issued to the Medicare NSC-MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R297PI.pdf* on the CMS Web site.

MLN Matters® Number: MM6528
Related Change Request (CR) #: 6528
Related CR Release Date: September 1, 2009
Effective Date: September 8, 2009
Related CR Transmittal #: R300PI
Implementation Date: March 1, 2010

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Additional claim processing instructions for DMEPOS items

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

Provider types affected

Providers and suppliers billing Medicare carriers and Medicare administrative contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6573 in order to augment previously issued CR 5917. In CR 5917 CMS instructed Medicare contractors to process and pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME when submitted by suppliers that are enrolled with both the national supplier clearinghouse (NSC) and with their local carrier/MAC. Although CR 5917 reinstated the local carrier/A/B MAC jurisdiction for claims for these items, the instruction was not clear about the jurisdiction or payment rules to apply when the beneficiary resides outside of the local carrier/A/B MAC jurisdiction. Be sure billing staff are aware of the changes.

Background

CR 6573 clarifies the claims filing jurisdiction and payment policies for claims submitted under the guidelines established in CR 5917 when the beneficiary is located outside of the local carrier/A/B MAC's jurisdiction. Payment of DMEPOS items is based on the fee schedule amount for the state where the beneficiary maintains their permanent residence.

CR 6573 also makes a correction to CR 5917 to replace the list of codes that may be billed, originally included as Attachment A to CR 5917, with the revised list of HCPCS codes attached to CR 6573 and available at *http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf* on the CMS Web site. (In CR 5917 this list included codes for implanted devices, which may not be separately billed to the carrier/MAC by DMEPOS suppliers.)

Key points of CR 6573

- Suppliers that are enrolled with the NSC as a DMEPOS supplier may enroll with and bill claims to their local carrier/A/B MAC for any of the attached list of DMEPOS items when billed under the guidelines established in CR 5917, including items furnished to beneficiaries who reside in other states.
- Medicare contractors will determine the claims filing jurisdiction for items billed under the guidelines established in CR 5917 based on the location of the supplier, in accordance with Chapter 1, Section 10 of the *Medicare Claims Processing Manual* available at *http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf* on the CMS Web site.
- Medicare contractors will pay claims for items submitted under the guidelines established in CR 5917 by applying the appropriate fee schedule amount for the state where the beneficiary maintains his or her permanent residence.
- Under no circumstances may any entity enrolled as a DMEPOS supplier with the NSC, that is not the physician or provider that implants the device, bill the carrier/A/B MAC for an implanted device. However,

Additional claim processing instructions for DMEPOS items (continued)

DMEPOS suppliers may bill for any of the replacement parts, accessories or supplies for prosthetic implants and surgically implanted DME included in the attached revised list of HCPCS codes, under the guidelines established in CR 5917.

Additional information

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

The official instruction (CR 6573) issued to your Medicare carrier or A/B MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf* on the CMS Web site. CR 6573 contains the DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME (Rev. March 2009) and that list is an attachment to CR 6573.

To review MM5917, the *MLN Matters*® article related to CR 5917, go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5917.pdf* on the CMS Web site.

MLN Matters® Number: MM6573
Related Change Request (CR) #: 6573
Related CR Release Date: August 14, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R531OTN
Implementation Date: January 4, 2010

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Areas and product categories included in the DMEPOS Competitive Bidding Program round one rebid in CY 2009

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

Provider types affected

Medicare DMEPOS suppliers that bill DME Medicare administrative contractors (DME MACs) as well as providers that bill Medicare regional home health intermediaries (RHHIs) or Part A/B Medicare administrative contractors (A/B MACs) whom refer or order DMEPOS for Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6571 in order to identify the nine metropolitan statistical areas (MSAs) as well as product categories in which the DMEPOS competitive bidding round one re-bid will occur in CY 2009 under section 1847 of the Social Security Act.

Key points of CR 6571

As mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the DMEPOS Competitive Bidding round one rebid in 2009 will occur in the following nine MSAs:

- Cincinnati -- Middletown (Ohio, Kentucky and Indiana)
- Cleveland -- Elyria -- Mentor (Ohio)
- Charlotte -- Gastonia -- Concord (North Carolina and South Carolina)
- Dallas -- Fort Worth -- Arlington (Texas)
- Kansas City (Missouri and Kansas)
- Miami -- Fort Lauderdale -- Miami Beach (Florida)
- Orlando (Florida)
- Pittsburgh (Pennsylvania)
- Riverside -- San Bernardino -- Ontario (California)

Further information on the boundaries and list of zip codes for each competitive bid area (CBA) and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp* on the CMS Web site and following the link to Competitive Bidding Implementation Contractor (CBIC).

The DMEPOS Competitive Bidding round one rebid in 2009 will include the following nine product categories:

- Oxygen supplies and equipment
- Standard power wheelchairs, scooters, and related accessories

Areas and product categories included in the DMEPOS Competitive Bidding Program ... (continued)

- Complex rehabilitative power wheelchairs and related accessories (group 2)
- Mail-order diabetic supplies
- Enteral nutrients, equipment and supplies
- Continuous positive airway pressure (CPAP), respiratory assist devices (RADs), and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Support surfaces (group 2 mattresses and overlays) in Miami

The MSAs and product categories that are included in the DMEPOS Competitive Bidding round one rebid in 2009 may also be found at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp* on the CMS Web site.

Suppliers and providers may call the provider contact centers with competitive bidding inquiries at the CBIC Competitive Bidding Program Helpdesk at 1-877-577-5331 or go to the "Contact Us" feature on the CBIC Competitive Bidding Program Web site at *http://www.dmecompetitivebid.com/* on the Internet to submit competitive bidding specific questions.

Background

The Medicare payment for most DMEPOS is currently based on fee schedules. However, section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which amended section 1847 of the Social Security Act (the Act), mandates a competitive bidding program to replace the current DMEPOS fee schedule payment amounts for selected items in selected areas.

The statute provides that competitive bidding will apply to DME meeting the definition of a "covered item" as specified in section 1834(a) (13) of the Act, including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with DME, but excluding class III devices under the Federal Food, Drug and Cosmetic Act. Competitive bidding will also apply to enteral nutrients, equipment, and supplies. Further, competitive bidding will apply to off-the-shelf orthotics described in section 1861(s)(9) for which payment would otherwise be made under Section 1834(h) which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

The statute, as amended by the MMA, also provided for phasing in competitive bidding beginning in 10 of the largest MSAs. Areas that may be exempt from the DMEPOS competitive bidding program include rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service.

Round one of the DMEPOS competitive bidding program was implemented on July 1, 2008, in ten competitive bidding areas, as mandated by the MMA. However, as part of MIPPA, Congress enacted a temporary delay in the competitive bidding program for round one competitive bidding areas. The law required CMS to terminate the existing contracts that were awarded in round one and conduct a second round one competition (the "round one rebid") in 2009. The MIPPA also excluded certain round one DMEPOS items and areas from the competitive bidding program. Section 154(a) of the MIPPA exempted group three complex rehabilitative power wheelchairs and related accessories when furnished in connection with such wheelchairs for the round one rebid and subsequent rounds of the program, as well as, negative pressure wound therapy (NPWT) items and services from the round one rebid competition. The MIPPA also excluded Puerto Rico as an area so that the round one rebid competition covers nine, instead of ten of the largest MSAs. Except for the aforementioned exceptions, section 154(a) of the MIPPA requires that the round one rebid occur in 2009 with the same items and services and the same areas as in round one.

Additional information

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

The official instruction (CR 6571) issued to your Medicare DME/MAC, RHHI or A/B MAC is available at *http://www.cms.hhs.gov/Transmittals/downloads/R527OTN.pdf* on the CMS Web site.

For clarification of the initial delay in the DMEPOS competitive bidding program you may review MM6203 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6203.pdf* on the CMS Web site.

MLN Matters® Number: MM6571
Related Change Request (CR) #: 6571
Related CR Release Date: August 3, 2009
Effective Date: August 3, 2009
Related CR Transmittal #: R527OTN
Implementation Date: September 3, 2009

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Registration is open for suppliers interested in DMEPOS competitive bidding

Registration is now open and available to all suppliers interested in participating in the round 1 rebid of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding Program. Interested suppliers may submit their bids using an online application. To help ensure bid security and privacy, suppliers must first register to obtain a user ID and password. Only suppliers that have a user ID and password will be able to use the online bidding system; suppliers that do not register will not be able to bid.

If you are a supplier interested in bidding, register now -- don't wait. Designate one authorized official (AO) listed on the CMS-855S enrollment form to act as your AO for registration purposes. The AO must register first and must approve other supplier employee requests to register. The AO's user ID and password will be sent by mail and should be delivered within 10 days after successful registration. After an AO successfully registers, the AO may designate other supplier employees to serve as backup authorized officials (BAO) and/or end users (EU). BAOs and EUs must also register in order to be able to use the online bidding system. Legal names, dates of birth, and SSNs of all users must match the information on file with the Social Security Administration. Legal names, dates of birth, and SSNs of all users must match what is on file with the Social Security Administration.

We strongly urge all AOs to register no later than September 14, 2009, to ensure that BAOs and EUs have time to register before bidding begins. We recommend that BAOs register no later than October 9, 2009, so that they will be able to assist AOs with approving EU registration. Registration will close on November 4, 2009, at 9:00 p.m. (ET); no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) Web site at *http://www.dmecompetitivebid.com*. Please review the IACS Reference Guide for step-by-step instructions on registration. The CBIC Web site also has the following useful tools: A registration checklist, quick step guides, and frequently asked questions. All suppliers interested in bidding are urged to sign up for e-mail updates on the homepage of the CBIC Web site.

We would like to remind all suppliers interested in bidding that we will be holding the first in a series of eight special open door forum (ODF) bidders' conferences for the round 1 rebid of the DMEPOS Competitive Bidding Program on August 19, 2009, from 2:00-3:00 p.m. (ET). This special ODF will provide an overview of what to expect during the bidder education period and provide suppliers with a step-by-step explanation of the registration process. In addition, common registration issues will be identified from the original round 1 of the DMEPOS Competitive Bidding Program, and refinements to the bidding system will be discussed. The PowerPoint presentation for the conference, along with information on how to participate, may be found on the CBIC Web site.

If you have any questions about the registration process, please contact the CBIC Customer Service Center at 1-877-577-5331. For information about the competitive bidding areas and product categories included in the round 1 rebid, as well as bidder education materials, please visit the CBIC Web site at *http://www.dmecompetitivebid.com*.

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

Source: CMS PERL 200908-19

Medicare provider enrollment reminder for DMEPOS suppliers

With the implementation of the surety bond requirements for certain suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in October 2009, the Centers for Medicare & Medicaid Services (CMS) reminds DMEPOS suppliers that each practice location of a DMEPOS supplier must be enrolled in the Medicare program. Each practice location of a DMEPOS supplier is required by Medicare regulations to be uniquely identified. As a result, each practice location must have its own unique national provider identifier (NPI) and its own Medicare-assigned provider transaction access number (PTAN). With the exception described in the "Important note" below, there should be a one-to-one relationship between a DMEPOS supplier's NPI and its PTAN. The PTAN is assigned to a DMEPOS supplier by the national supplier clearinghouse (NSC) upon enrollment in the Medicare program. (The PTAN has previously been referred to as the NSC number.)

Important note: DMEPOS suppliers who are sole proprietorship business structures with more than one practice location must ensure that each location is enrolled in Medicare. Each practice location would be assigned a PTAN upon its enrollment. However, as a sole proprietorship, the business is legally one and the same as the person who is the sole proprietor and, therefore, like any individual, is eligible for only a single NPI.

Source: CMS PERL 200908-12

Reminders for getting ready for DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 1 rebid is coming soon.

Summer 2009

- 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 list of products and services found in Section 2.D
- The authorized official(s) information in Sections 6A and 15
- The correspondence address in Section 2A2 of the CMS-855S.

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*) 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 *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;" located at: *http://www.fms.treas.gov/c570/c570_a-z.html*.

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

DMEPOS supplier accreditation and surety bond requirement deadlines coming in October

Suppliers may choose to voluntarily terminate enrollment if they do not plan to comply

Medicare suppliers DMEPOS, unless exempt, must be accredited and obtain a surety bond by October 1, 2009, and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntary terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page 4 of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the NSC. By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll*. Frequently asked questions (FAQs) on the surety bond requirement may be found on the NSC's FAQ page at *http://www.palmettogba.com/nsc*.

Take action now to prepare for the Medicare DMEPOS Competitive Bidding Program

A special edition *MLN Matters* education article identifying steps suppliers should take in preparation for the DMEPOS Competitive Bidding Program to ensure successful bidder registration is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0915.pdf*.

Source: CMS PERL 200908-13

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Evaluation and Management

Telehealth services in Indian Health Service or tribal providers

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

Provider types affected

Indian Health Service (IHS) and tribal providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MAC) for providing telehealth services to Medicare beneficiaries.

What you need to know

Change request (CR) 6493, from which this article is taken, expands the instructions for telehealth services (effective January 1, 2009) to include IHS and tribal providers as eligible to receive the telehealth originating site facility fee. The CR also clarifies the payment basis to the distant site physician or practitioner. You should make sure that your billing staffs are aware of this new information.

Background

CR 6493, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is expanding the instructions for telehealth services to include Indian Health Service (IHS) and tribal providers.

Effective January 1, 2009, IHS and tribal providers are included in the telehealth service polices (presented below) and eligible to receive:

- The originating site facility fee (generated from an originating site facility service in which the beneficiary is presented to the distant site practitioner), and
- The payment to the distant site physician or practitioner (usually a professional consultation).

Telehealth policies

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended Section 1834 of the Social Security Act (the Act) to provide for an expansion of Medicare payment for telehealth services. With this amendment, effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. In addition, BIPA does not require that a practitioner present the patient for interactive telehealth services.

Originating site facility and distant site practitioner services

The originating site facility fee is equal to $23.72 for the period January 1, 2009, through December 31, 2009. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI). For CY 2009, the payment amount is 80 percent of the lesser of the actual charge or $23.72. (No clinic visit is to be billed if this is the only service received.)

The following facility types are authorized by law to be eligible for payment of the telehealth originating site facility fee when a beneficiary is presented to a distant site practitioner:

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)
- A critical access hospital (CAH)
- A rural health clinic (RHC), and
- A federally qualified health center (FQHC).

Note: Except for the federal telemedicine demonstration in Alaska and Hawaii, eligibility of originating sites is limited to rural health professional shortage areas (HPSAs) and counties not classified as a metropolitan statistical area (MSA).

IHS/tribal facilities should submit claims for the originating site facility fee on types of bills (TOB) 12x, 13x, 71x, 73x, or 85x, using HCPCS code Q3014 and revenue code 0780.

Distant site practitioners include only physicians and selected medical practitioners, specifically physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse-midwives, clinical social workers (CSW), clinical psychologists (CP), or registered dietician or nutrition professionals.

Distant site practitioners services are payable as if they were provided face-to-face, using the Medicare physician fee schedule (MPFS); and are based on 80 percent of the Medicare physician fee schedule (MPFS) payment amount for a physician, and the appropriate step down percentages for other practitioners. The usual Part B coinsurance and deductible apply, but are waived for IHS/tribal facilities.

Billing providers should use the following Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology* (*CPT*) codes on claims for distant site practitioner services:

- Consultations (*CPT* codes *99241* - *99255*)
- Office or other outpatient visits (*CPT* codes *99201* - *99215*)
- Individual psychotherapy (*CPT* codes *90804* - *90809*)
- Pharmacologic management (*CPT* code *90862*)
- Psychiatric diagnostic interview examination (*CPT* code *90801*)
- Individual medical nutrition therapy (HCPCS/*CPT* codes G0270, *97802*, and *97803*)

Telehealth services in Indian Health Service or tribal providers (continued)

- Neurobehavioral status exam (*CPT* code *96116*), and
- Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408).

You must include either the GT modifier (for interactive telecommunications) on your claims, or the GQ modifier (for the store and forward communication) if used in the federal telemedicine demonstration in Alaska or Hawaii.

Additional information

Your Medicare contractor will not search their files to find and adjust claims with dates of service on or after January 1, 2009, that were processed prior to the January 4, 2010, implementation date of CR 6493. However, they will adjust such claims that you bring to their attention.

You may find more information about the provision of telehealth services by IHS or tribal providers by going to CR 6493, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1776CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. You will find the updated *Medicare Claims Processing Manual*, Chapter 19 (Indian Health Services), Sections 100.16 (Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners), 100.16.1 (FI-Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners), 100.16.2 (FI – Telehealth Originating Site Facility Fee – Medicare Part B - Payment Policy) and (FI - Telehealth Originating Site Facility Fee - Medicare Part B - Claims Processing) as an attachment to that CR.

You might also want to review *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 190 (Medicare Payment for Telehealth Services); and *Medicare Benefit Policy Manual* Chapter 15 (Covered Medical and Other Health Services), Section 270 (Telehealth Services) for more information on telehealth services. This manual is available at *http://www.cms.hhs.gov/manuals/IOM/list.asp* on the CMS Web site.

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

MLN Matters® Number: MM6493
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Related CR Release Date: July 24, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R1776CP
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Hospice

Final wage index changes for the Medicare hospice benefit

Hospices serving Medicare beneficiaries will see a 1.4 percent increase in their payments for fiscal year 2010 according to a final regulation released by the Centers for Medicare & Medicaid Services (CMS).

The hospice payment increase is the net result of a 2.1 percent increase in the "hospital market basket," an indicator of input price increases, offset by a 0.7 percent decrease in payments to hospices due to CMS' revised policy to phase out its wage index budget neutrality factor.

Specifically, the final rule revises the phase-out of the wage index budget neutrality adjustment factor (BNAF) which was made final in the fiscal year (FY) 2009 final rule, to now occur over seven years. Under CMS's final policy, the budget neutrality adjustment will be reduced by 10 percent in FY 2010, and 15 percent each year from FY 2011 through FY 2016.

The rule also adopts a Medicare Payment Advisory Commission (MedPAC) recommendation which requires physicians to complete a narrative on the certification and recertification describing the clinical justification for the patient's terminal prognosis. The proposed rule also sought comments on future hospice payment reform, the cap calculation methodology, and on requiring physician visits to evaluate eligibility in patients with longer lengths of stay. CMS will consider the comments in future analyses.

This final rule reflects the ongoing efforts of CMS to support beneficiary access to hospice services while maintaining responsible financial stewardship of the Medicare Trust Fund.

Final rule details

The BNAF is to be phased-out over seven years, beginning with a 10 percent reduction in FY 2010, and followed by an additional 15 percent reduction in each of the next six fiscal years. Phase-out will be complete in FY 2016. This more gradual phase-out provides opportunity for CMS to consider the effects of a reduction in payments in the context of hospice payment reform, which is under consideration. The 10 percent reduction to the BNAF is partially offset by the annual market basket increase, which is 2.1 percent for fiscal 2010.

This rule also makes final a change to the physician certification process, where doctors will be required to submit a brief narrative supporting a patient's life expectancy of six months or less.

A link to the final rule, which is published in the *Federal Register* on August 6, 2009, is available at *http://www.federalregister.gov/inspection.aspx*.

Source: CMS PERL 200907-35

Laboratory/Pathology

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.

Note: The Centers for Medicare & Medicaid Services has rescinded change request 6457 and the related *MLN Matters* article MM6457. This information was previously published in the June 2009 *Medicare B Update!* page 14.

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

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Medicare travel allowance fees for collection of specimens

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

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for clinical laboratory specimen collection services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6524 which updates the Medicare travel allowance fees for collection of specimens for calendar year (CY) 2009. Subsequent updated travel allowance amounts will be issued by the Centers for Medicare & Medicaid Services (CMS) on an annual basis via a recurring update CR.

Background

CR 6524 clarifies payment of travel allowances, either on a per mileage basis (Healthcare Common Procedure Coding System [HCPCS] code P9603) or on a flat rate basis (HCPCS code P9604) for CY 2009.

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under the Social Security Act (Section 1833(h)(3); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the Internet), and payment is made based on the clinical laboratory fee schedule.

Travel allowance for 2009

The travel codes allow for payment either on a per mileage basis (HCPCS code P9603) or on a flat rate per trip basis (HCPCS code P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Medicare allows contractor discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor.

Per mile travel allowance (HCPCS Code P9603)

The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

CR 6524 instructs that Medicare contractors will pay for HCPCS code P9603, where the average trip to the patients' homes exceeds 20 miles round trip, at a total of $1.00 per mile. This includes:

- The federal mileage rate of $0.55 per mile plus
- An additional $0.45 per mile to cover the technician's time and travel costs.

Contractors shall have the option of establishing a higher per mile rate for HCPCS code P9603, in excess of the minimum $1.00 per mile, if local conditions warrant it.

Medicare travel allowance fees for collection of specimens (continued)

The minimum mileage rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule (CLFS) as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles that are not actually traveled by the laboratory technician.

Per flat-rate trip basis travel allowance (HCPCS Code P9604)

CR 6524 also instructs that Medicare contractors shall pay for HCPCS code P9604 on a flat-rate trip basis travel allowance of $10.00 per trip.

Additional information

The official instruction, CR 6524, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1790CP.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6524
Related Change Request (CR) #: 6524
Related CR Release Date: August 7, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R1790CP
Implementation Date: October 5, 2009

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Surgery

Using modifier 50 and add-on codes for facet joint injection services

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

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FI] and Medicare administrative contractors [MAC]) for facet joint injections performed on Medicare beneficiaries.

Provider action needed

This article clarifies the appropriate use of modifier 50 and add-on codes for facet joint injection services. Physicians who perform facet joint injections on both the right and left sides of one level of the spine must use modifier 50 with the appropriate *CPT* codes when submitting claims. Physicians who perform facet joint injections on multiple levels on the same side of the spine must use the *CPT* add-on codes to represent these additional levels injected, instead of using modifier 50. Physicians should ensure that billing staffs are aware of this clarification.

Background

Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. The *CPT* codes used for facet joint injections are:

Facet joint injection CPT codes and descriptions

***CPT* Code**	**Description**
64470	Injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical/thoracic; single level
64472 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; cervical/thoracic; each additional level
64475	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; single level
64476 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; each additional level

The primary codes, *64470* and *64475*, are used for a single injection in the cervical/thoracic or lumbar/sacral area of the spine, respectively. Each primary code has an associated add-on code for use when injections are provided at multiple spinal levels. The add-on codes are *64472* (cervical/thoracic) and *64476* (lumbar/sacral).

Using modifier 50 and add-on codes for facet joint injection services (continued)

Bilateral injections are performed on the right and left sides of one joint level. The Centers for Medicare & Medicaid Services (CMS) requires physicians to indicate a bilateral injection by using billing modifier 50 and the appropriate *CPT* code. If a physician performs multiple bilateral injections, modifier 50 should accompany each facet joint injection *CPT* code.

The Office of the Inspector General (OIG) recently conducted a medical record review of facet joint injection services performed in 2006 and released a final report, titled, "Medicare Payments for Facet Joint Injection Services," OEI-05-07-00200. The OIG found that physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50. This report is viewable at *http://www.oig.hhs.gov/oei/reports/oei-05-07-00200.pdf* on the Internet.

To summarize, when facet joint injections are performed on both the right and left sides of a level of the spine, physicians must use modifier 50 and the appropriate primary *CPT* code. When facet joint injections are performed at more than one level, physicians must use add-on codes *64472* or *64476* to represent additional levels of the spine injected.

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 issued to your Medicare carrier, FI and/or MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R526OTN.pdf* on the CMS Web site.

MLN Matters® Number: MM6518 *Revised*
Related Change Request (CR) #: 6518
Related CR Release Date: July 31, 2009
Effective Date: August 31, 2009
Related CR Transmittal #: R526OTN
Implementation Date: August 31, 2009

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Therapy Services

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

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

Note: This article was revised on August 14, 2009, to clarify the *CPT* codes that physicians (*95992*) and therapists (*97112*) are to use for canalith repositioning as noted in change request (CR) 6397. All other information is the same. This information was previously published in the May 2009 *Medicare B Update!* page 15.

Provider types Affected

Skilled nursing facilities and other providers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for skilled nursing facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

Background

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

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

Please note that physicians should use *CPT* code *95992* for canalith repositioning and therapists must use *CPT* code *97112* for canalith repositioning, as indicated in Transmittal # 1691, change request 6397. The *MLN Matters*® article related to that transmittal is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6397.pdf* on the CMS Web site.

In addition, CR 6407 provides clarifications and updates to the *Medicare Claims Processing Manual* (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that both full and partial benefits exhaust claims must be submitted by SNFs monthly. For benefits exhaust

Medicare Claims Processing Manual clarifications for SNF and therapy billing (continued)

bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

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

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

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

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

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

Additional information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1733CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

MLN Matters® Number: MM6407 *Revised*
Related Change Request (CR) #: 6407
Related CR Release Date: May 8, 2009
Effective Date: October 1, 2006
Related CR Transmittal #: R1733CP
Implementation Date: April 27, 2009

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General Coverage

Use of CR modifier and DR condition code on disaster/emergency-related claims

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [MACs]) for disaster/emergency-related services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6451, which updates and amends claims processing requirements for the use of condition codes and modifiers on Medicare fee-for-service claims when the furnishing of an item or service to a Medicare beneficiary was affected by a disaster or other general public emergency. CR 6451 also establishes a new chapter in the *Medicare Claims Processing Manual* dedicated to standing policies and procedures applicable to disasters and other public emergencies. Please make sure your billing staff is familiar with these changes, especially if they submit claims affected by emergencies to Medicare.

Background

As part of its response to the 2005 Katrina hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency. The DR condition code and CR modifier were also authorized for use on claims for items and services affected by subsequent emergencies. Based on that experience, the Medicare fee-for-service program is refining the uses of both the

Use of CR modifier and DR condition code on disaster/emergency-related claims (continued)

code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/suppliers in emergency situations without adding undue administrative burden associated with claim submission. The use of the "CR" modifier and "DR" condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.

Key points of CR 6451

The DR condition code: The title of the DR condition code is "disaster related" and its definition requires it to be "used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster." The DR condition code is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. In previous emergencies, use of the DR condition code was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned directly or indirectly on the presence of a "formal waiver."

The CR modifier: Both the short and long descriptors of the CR modifier are "catastrophe/disaster related." The CR modifier is used in relation to Part B items and services for both institutional and non-institutional billing. Non-institutional billing, i.e., claims submitted by "physicians and other suppliers", are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format. In previous emergencies, use of the CR modifier was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned directly or indirectly on the presence of a "formal waiver."

Formal waivers: A "formal waiver" is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers. One type is a waiver of a requirement specified in Section 1135(b) of the Social Security Act (Act). Although Medicare payment rules themselves are not "waivable" under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred. The second type of formal waiver is a waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the "three-day qualifying hospital stay" requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Social Security Act.

Further instructions in the event of a disaster or emergency: In the event of a disaster or emergency, CMS will issue specific guidance to Medicare contractors that will contain a summary of the Secretary's declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.

Additional information

The official instruction, CR 6451, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1784CP.pdf* on the CMS Web site.
If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

MLN Matters® Number: MM6451
Related Change Request (CR) #: 6451
Related CR Release Date: July 31, 2009
Effective Date: August 31, 2009
Related CR Transmittal #: R1784CP
Implementation Date: August 31, 2009

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Web Site Survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

Electronic Data Interchange

HHS delegates authority for the HIPAA security rule to Office for Civil Rights

On August 3, 2009, Office for Civil Rights (OCR) announced that the Secretary of Health and Human Services (HHS) has delegated to the director of the OCR, the authority to administer and enforce the Health Insurance Portability & Accountability Act of 1996 (HIPAA) security rule. This action by Secretary Sebelius will improve HHS' ability to protect individuals' health information by combining the authority for administration and enforcement of the federal standards for health information privacy and security called for in the HIPAA.

The transition of authority for the administration and enforcement of the security rule is expected to be seamless with no interruption in the management or processing of any complaints filed prior to the transition. Consumers may continue to submit HIPAA security complaints using the on-line resource -- the Administrative Simplification Enforcement Tool (ASET), found at *https://htct.hhs.gov/aset/*. New security complaints may also be sent to the Office for Civil Rights. For more information and detailed instructions on how to submit a complaint to OCR, visit the OCR Web site: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*. The transition of security complaints from CMS to OCR has no impact on how complaints about transactions and codes sets or unique identifiers are filed or processed. CMS retains its enforcement authority for these other HIPAA rules.

View the *Federal Register* notice of the delegation of authority at *http://www.hhs.gov/ocr/privacy/srdelegationofauthority2009.pdf* and the Secretary's press release at *http://www.hhs.gov/news/press/2009pres/08/20090803a.html*.

Source: CMS PERL 200908-14

Third national Medicare fee-for-service educational call on HIPAA version 5010

5010: Taking EDI to the next level

Conference call details
Date: September 9, 2009
Conference Title: Third National Medicare FFS Education Call on HIPAA Version 5010
Time: 2:00 p.m.-3:30 p.m. (ET)

The Centers for Medicare & Medicaid Services (CMS) will present the third in a series of national education conference calls focused on Medicare fee-for-service (FFS) implementation of HIPAA Version 5010. The presentation will cover Medicare FFS error handling transactions (TA1, 999, and 277CA), planned use of each transaction and applicable rules and exceptions for the Medicare FFS program. The presentation is geared to billing software programmers or developers that reside within provider organizations. A question and answer (Q&A) session will follow the presentation that will give participants an opportunity to ask questions of CMS' subject matter experts.

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, not to allow participation. **Registration will close at 2:00 p.m. (ET) on September 8, 2009**, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call, participants need to go to *http://www2.eventsvc.com/palmettogba/090909*.
2. Fill in all required data.
3. Verify your time zone is displayed correctly the drop-down box.
4. Click "Register."
5. You will be taken to the "Thank you for registering" page and will receive a confirmation e-mail shortly thereafter.

Note: Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

A few days prior to the call (not before September 6), check the *Educational Resources* page on CMS' 5010 Web page at *http://www.cms.hhs.gov/Versions5010andD0/40_Educational_Resources.asp* to obtain a copy of the presentation that will be used during the call.

Learn more about 5010 -- visit CMS' dedicated page on the Web at *http://www.cms.hhs.gov/Versions5010andD0/*.

Source: CMS PERL 200908-31

Healthcare provider taxonomy code updates effective October 1, 2009

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

Source: Publication 100-04, Transmittal 1794, CR 6598

General Information

Reporting non-tax withholding due to Federal Payment Levy Program

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

Provider types affected

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

What you need to know

Change request (CR) 6228, from which this article is taken, notifies providers that (effective October 1, 2009) in addition to collecting for overdue taxes (effective October 1, 2008), the Centers for Medicare & Medicaid Services (CMS) will also levy non-tax debt offsets against Medicare providers to repay unpaid debts owed to other federal agencies, such as educational loans.

Make sure that your billing staffs are aware that both tax and non-tax debt, subject to Federal Payment Levy Program (FPLP), will be withheld from Medicare payments.

If you have a question about the non-tax payment reduction, call the Treasury Department's Financial Management Service (FMS) at 1-800-304-3107.

Background

The Taxpayer Relief Act of 1997 authorized the FPLP, which the Internal Revenue Service (IRS) and the Treasury Department's Financial Management Service implemented in July 2000. This program gives CMS the authority to collect overdue taxes through a levy on certain federal payments; including those made to providers, contractors, and vendors doing business with the government.

The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to fully implement the FPLP for Medicare payments for overdue taxes, and extends it to also include a levy for non-tax debt.

CR 6125 (Reporting Withholding Due to IRS Federal Payment Levy Program [FPLP] on the Remittance Advice) issued on August 15, 2008, covers the implementation of the debt levy for overdue taxes, effective October 2008. (A related *MLN Matters* article is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf* on the CMS Web site.), CR 6228, from which this article is taken, notifies providers that (effective October 1, 2009) non-tax debt offsets will also be levied against Medicare providers to repay unpaid debts owed to other Federal agencies, such as from educational loans.

Should you owe such taxes and/or debt, and your payments are reduced:

- For tax levy (effective October 1, 2008), your Medicare remittance advice will reflect the provider level adjustment code (PLB) of "WU" in the PLB03-1 data field (however, in the HIPAA 835, PLB reason code "LE" will replace currently used WU for: Third Party Payment (TPP) - Garnishments, including attorneys, Child Support, Alimony, Secondary Corporation, and Change of Ownership). In addition, the toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field.
- For non-tax debt levy (effective October 1, 2009), your Medicare remittance advice will reflect the PLB code of "ZZ" in the PLB03-1 data field, and the amount of the withholding can be found in the PLB04 field. In addition, the toll-free FMS number will appear in the PLB03-2 data field.

Notes:

1) Due to current privacy rules and regulations, the IRS is the only agency that can discuss the tax-related debt question with you, and FMS/Treasury is the only agency that can discuss the non-tax debt issue with you. Thus, if you have questions, contact them at the toll-free numbers just mentioned, instead of contacting your Medicare contractor.

2) Please observe that the toll-free IRS telephone number for questions regarding tax-related withholding is not the same as the toll-free FMS/Treasury toll-free telephone number for non-tax withholding questions.

You may find the following details about non-tax FPLP withholding of interest:

- CMS may reduce federal payments subject to the non-tax levy by 100 percent, (or the exact amount of the non-tax debt owed if it is less than 100 percent of the payment); and this levy is continuous until the non-tax debt is paid in full, or other arrangements are made to satisfy the debt.
- The Medicare provider payment offset priority order is: 1) Medicare accounts receivable (AR) debt, 2) FPLP offsets for federal tax debt at 15 percent maximum of the payable amount, 3) administrative offsets for federal non-tax debt at 100 percent of the payable amount, and 4) third-party payments (TPP).
- Within each payment offset priority category, CMS will collect the oldest debts first, namely the FPLP offsets for federal tax debt and the administrative offsets for federal non-tax debt.
- CMS will implement a minimum $25 threshold for tax and non-tax debt offsets.
- The Treasury Department will process refunds to providers from CMS over-collections of FPLP federal tax debt or administrative offsets for federal non-tax debt.

Additional information

You may find the official instruction, CR 6228, issued to your carrier, FI, or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R503OTN.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site. You may also want to review the article related to CR 6125 (Reporting Withholding Due to IRS Federal Payment Levy Program (FPLP) on the Remittance Advice), which you may find at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf* on the CMS Web site.

Use of CR modifier and DR condition code on disaster/emergency-related claims (continued)

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

MLN Matters® Number: MM6228
Related Change Request (CR) #: 6228
Related CR Release Date: June 12, 2008
Effective Date: January 1, 2009
Related CR Transmittal #: R503OTN
Implementation Date: October 5, 2009

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Guidance on using Internet-based Provider Enrollment, Chain and Ownership System

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

Provider types affected

This article is for physicians, nonphysician practitioners, and organization providers and suppliers who are enrolled or wish to enroll in the Medicare program. Note: Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) do not, at this time, have the option of using Internet-based Provider Enrollment, Chain and Ownership System (PECOS). The availability of Internet-based PECOS to DMEPOS suppliers will be announced at a future date.

Provider action needed

This special edition (SE) article alerts physicians, nonphysician practitioners, providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is reaching out to assist those providers and suppliers who wish to use Internet-based PECOS for enrollment in Medicare and/or to maintain the currency of the enrollment data they have on file with Medicare. Internet-based PECOS offers physicians, nonphysician practitioners, and organization providers and suppliers a means of applying for enrollment and updating their enrollment information faster than the paper enrollment process that required the use of the paper CMS-855 series of forms. The documents that describe Internet-based PECOS are available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage* on the CMS Web site.

Background

Internet-based PECOS has been available to physicians and nonphysician practitioners since December 2008, and to organization providers and suppliers since April 1, 2009. (As noted above, DMEPOS suppliers may not use the system at this time, but will be able to do so at a future date.) There are certain pre-requisites that must be met before one can use Internet-based PECOS. In addition, the processes for physicians and nonphysician practitioners differ somewhat from those used by provider and supplier organizations. This article will present a high-level overview of these processes and will direct physicians, nonphysician practitioners, providers, and organization providers and suppliers to other sources available via the *Medicare Learning Network* (*MLN*) that will enable them to learn more.

An important benefit for all physicians, nonphysician practitioners, and organization providers and suppliers is that Internet-based PECOS speeds up the completion of their initial Medicare enrollment application as well as the update of their enrollment information when changes occur. CMS timelines for Medicare contractors to process Internet-submitted enrollment applications are more stringent than those for paper:

- Contractors must process 90 percent of Web-based applications (e.g., initial enrollments and changes of information) within 45 days of receipt of the signed and dated certification statement and supporting documentation.
- Contractors must process 80 percent of initial paper applications within 60 days, and 80 percent of paper changes of information within 45 days.

With the temporary exception of the DMEPOS suppliers, physicians, nonphysician practitioners, and organization providers and suppliers can use the Internet to enroll in Medicare, to update their existing enrollment information, to view their existing enrollment information, or to voluntarily terminate their Medicare enrollment. Once a provider or supplier submits an application via the web, the provider or supplier can view the status of that application beginning 15 days after the submission. (The 15-day time frame allows sufficient time for the Medicare enrollment contractor to have received the signed and dated certification statement and begin action on the application. More information about the Certification Statement will be supplied later in this article.)

One crucial point that physicians, nonphysician practitioners, and organization providers and suppliers should understand is that, if they want to use Internet-based PECOS to update or view their Medicare enrollment information, or to terminate their enrollment in Medicare, they must first have an enrollment record in PECOS. If a physician, nonphysician practitioner, or organization provider or supplier enrolled in Medicare more than five years ago and has not submitted any updates or changes to their enrollment record over the past five years, it is very likely that the provider or supplier is not in PECOS. If one of these providers or suppliers accesses Internet-based PECOS attempts to view or update the enrollment record, there will be nothing there to view or update. Providers and suppliers who find themselves in this situation will have

Guidance on using Internet-based Provider Enrollment, Chain and Ownership System (continued)

to revalidate their enrollment with Medicare. In order to revalidate, the provider or supplier has to furnish all the information necessary to initially enroll in Medicare. This will get the provider or supplier into PECOS and will ensure that their enrollment information, which may have changed over the years, is current. If they never submitted the CMS-588 Electronic Funds Transfer Agreement, they will have to do so as part of the revalidation. Providers and suppliers can revalidate their enrollment via Internet-based PECOS or they can fill out the appropriate paper CMS-855 Medicare provider enrollment forms and mail them to the appropriate enrollment contractor.

The remainder of this article provides the overviews of the processes for using Internet-based PECOS and identifies other sources of information.

Physicians and nonphysician practitioners

Before a physician or nonphysician practitioner initiates a Medicare enrollment action using Internet-based PECOS, he or she will need the following:

- An active national provider identifier (NPI)
- A National Plan and Provider Enumeration System (NPPES) user ID and password
- Personal identifying information, which includes the physician's or nonphysician practitioner's legal name on file with the Social Security Administration, date of birth, and social security number
- Professional license and certification information, which includes information regarding the physician's or nonphysician practitioner's professional license, professional school degrees or certificates
- Practice location information, which includes information regarding the physician's or nonphysician practitioner's medical practice location
- The legal business name of a solely-owned professional association (PA), professional corporation (PC), or limited liability company (LLC) on file with the Internal Revenue Service and appearing on the IRS CP575 form
- A photocopy of the CP-575 form
- The NPI of the PA, PC, or LLC, and
- Any federal, state, and/or local (city/county) business licenses, certifications and/or registrations specifically required by that business to operate as a health care facility, and
- If applicable, information about any final adverse action that impacts the physician or nonphysician practitioner.

Internet based PECOS can be accessed with the same User ID and password that a physician or nonphysician practitioner uses for NPPES. If the physician or nonphysician practitioner does not have an NPPES user ID and password and needs help in obtaining one, he or she may contact the NPI Enumerator at 1-800-465-3203 or send an e-mail to *customerservice@npienumerator.com* on the Internet.

Note: CMS recommends that a physician or nonphysician practitioner change his/her NPPES password before accessing Internet based PECOS for the first time and at least once a year thereafter. Although the User ID cannot be changed, the password should be changed periodically – at least once a year. If you need help in changing your password, contact the NPI Enumerator at 1-800-465-3203 or send an e-mail to *customerservice@npienumerator.com* on the Internet

For physicians and nonphysician practitioners, there are three basic steps to completing an enrollment action using Internet-based PECOS.

- Use your National Plan and Provider Enumeration System (NPPES) user ID and password to log on to Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*
- Complete, review, and submit the electronic enrollment application via Internet-based PECOS;
- Print, sign and date the certification statement and mail with all supporting paper documentation to the designated Medicare contractor within seven days of electronic submission.

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

The certification statement must be signed by the physician or nonphysician practitioner enrolling or making changes to enrollment information. Signatures must be original and in ink (blue ink recommended). Copied or stamped signatures or dates will not be accepted.

The physician or nonphysician practitioner assumes full and complete liability for new and updated Medicare enrollment information that is transmitted to the enrollment contractor via Internet-based PECOS once the enrollment contractor receives the signed and dated certification statement.

While CMS encourages physicians and nonphysician practitioners to print and retain a copy of the Internet-submitted enrollment application for their records, physicians and nonphysician practitioners should only mail the Certification Statement and supporting documentation to the designated Medicare contractor. Do not mail the copy of the enrollment application to the designated Medicare contractor; to do so may delay the processing of the application.

For more information about Internet-based PECOS, along with questions and answers (Q&As), go to the *Downloads* section at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage* on the CMS Web site.

Provider and supplier organizations

Before a provider or supplier organization can use Internet based PECOS, the organization's authorized official (AO) must take the first step. Below is the process that occurs for an organization provider or supplier to gain access to Internet-based PECOS:

Guidance on using Internet-based Provider Enrollment, Chain and Ownership System (continued)

1. The organization provider/supplier's AO goes into PECOS I&A and registers. As part of this process, the AO must mail a photocopy of the CP-575 to the CMS EUS Help Desk so that the help desk can verify the organization provider/supplier.
2. The help desk verifies both the organization provider/supplier and the AO, and approves the AO's registration. The AO receives a system-generated e-mail indicating that the registration has been approved.
3. Once the AO receives this notification, the AO can let the end-user know that he/she can register in PECOS.
4. The end-user goes into PECOS I&A and registers. The registration request will be directed to the AO of the provider/supplier organization.
5. The AO must approve or reject the end-user in PECOS I&A.
6. Once the end-user has been approved in PECOS I&A by the AO for access on behalf of the organization provider/supplier, the end-user will receive a system-generated e-mail indicating that he/she has been approved.
7. The end-user then logs into PECOS and downloads the security consent form. He or she fills it out, obtains the signature/date of signature of the AO, and mails the completed security consent form to the CMS EUS Help Desk at P.O. Box 792750, San Antonio, TX 78216.
8. The help desk verifies the information on the security consent form and also calls the AO to verify that the AO did, in fact, sign the security consent form.
9. Once the information on the security consent form has been confirmed, the help desk approves the security consent form in PECOS and an e-mail is sent to the AO notifying the AO that the end user's organization has been approved to use Internet-based PECOS on behalf of the organization provider/supplier.
10. It is the AO's responsibility to notify the end-user's organization that the end-user can now use Internet-based PECOS. An e-mail is sent to the AO (step 9) because the AO is ultimately responsible for the enrollment information and who has access to that enrollment information. It is the AO's responsibility to inform the end-user that the security consent form has been approved.

Note: The Security Consent Form is completed only one time to establish the relationship between the provider or supplier organization and the employer organization whose employee(s) would submit enrollment applications on behalf of the provider or supplier organization. More than one individual may request access to Internet-based PECOS for a given provider or supplier organization, but the security consent form is generated and completed by the first (if more than one) approved user who logs on to Internet-based PECOS to submit an enrollment application for the given provider or supplier organization. A security consent form must be completed, signed and dated, and mailed to the CMS EUS Help Desk even if the employer organization is the provider or supplier organization.

More detail about obtaining access to Internet-based PECOS for providers and suppliers can be found in the document entitled, "Getting Started with Internet-based Provider Enrollment, Chain and Ownership System (PECOS) – Information for Provider and Supplier Organizations," along with Q&As is available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf* on the CMS Web site.

Limitations of Internet-based PECOS for Provider and Supplier Organizations

There are some scenarios that Internet-based PECOS cannot accommodate at this time; they will be available at a future date. These scenarios are:

- Changes in taxpayer identification number (TIN). These must be done using the paper enrollment application (CMS-855).
- Changes in legal business name (LBN). These must be done using the paper enrollment application (CMS-855).
- An enrolled Medicare Part A provider or supplier organization wants to enroll with a Medicare carrier or A/B Medicare administrative contractor (MAC) to bill for Part B services. This must be done using the paper enrollment application (CMS-855).

These scenarios are listed in the document entitled, "Overview of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) – Information for Provider and Supplier Organizations," available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/OrganizationOverview.pdf* on the CMS Web site.

Additional information

The CMS External User Services (EUS) Help Desk contact information for providers and suppliers using Internet-based PECOS may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/ContactInformation.pdf* on the CMS Web site. The help desk hours of operation are Monday – Friday, from 6 a.m. to 6 p.m. (CT). The help desk toll-free number is 1-866-484-8049 and their e-mail address is *eussupport@cgi.com*. Questions about accessing and using Internet-based PECOS should be directed to the CMS EUS Help Desk.

The overall CMS site regarding provider and supplier enrollment may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on the CMS Web site. From there, click on "Internet-based PECOS" on the left-hand side to go to information specific to Internet-based PECOS.

If you have Medicare enrollment policy 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.

Remember that for security reasons, passwords should be periodically, at least once a year. Physicians and nonphysician practitioners should read and fully understand the document entitled, "Medicare Physician and Nonphysician Practitioners - Protecting Your Privacy, Protecting Your Medicare Enrollment Record." which is available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/MedPhysPrivacy.pdf* on the CMS Web site.

Guidance on using Internet-based Provider Enrollment, Chain and Ownership System (continued)

MLN Matters® Number: SE0914
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

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NPPES update announcement for physicians

If an academic medical institution or university obtained your national provider identifier (NPI) for you, ensure your National Plan and Provider Enumeration System (NPPES) record reflects your current information.

Health care providers, including physicians, began applying for NPIs on May 23, 2005. Since then, the NPPES has assigned nearly three million NPIs. More than 700,000 NPIs have been assigned to physicians.

Many physicians were assigned their NPIs upon their graduation from medical school. Often, the administrative staff at the physicians' academic medical centers or universities applied for the physicians' NPIs. The administrative staff handled similar actions for their new physicians and had, in their records, all the information that needed to be furnished on the application for an NPI. Some of these NPIs may have been assigned as long as four years ago.

The Centers for Medicare & Medicaid Services (CMS) is required by regulation to make available to the public certain information about health care providers that is contained in their NPPES records. This information includes the name, provider type (e.g., physician), business practice location address, business mailing address, and business practice location telephone number. Publicly available NPPES information can be found in the NPI Registry, a query-only database which anyone can access on the Internet (*https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*), and in a monthly downloadable file that individuals with the necessary technical expertise can download from the Internet (*http://nppesdata.cms.hhs.gov/cms_NPI_files.html*). Health plans, health care clearinghouses, health care providers, and others with a need to know can easily use the NPI Registry to view data for a particular health care provider simply by entering the health care provider's name or NPI. The downloadable file is used primarily by health plans and other large health industry organizations that need information for all or most of the health care providers who have NPIs and who may need to sort or otherwise manipulate the data in the file to suit their business needs.

Many of the physicians whose academic medical centers or universities obtain their NPIs for them have moved on in their careers to new locations. Many have not updated their NPPES information to show new business practice location addresses, business mailing addresses, or business practice location telephone numbers. As a result, the information in the NPI Registry and in the downloadable file is out of date. Academic medical centers and universities whose addresses and telephone numbers were entered into NPPES as the business practice locations, business mailing addresses, and business practice location telephone numbers for the physicians who they formerly employed are now being burdened with the receipt of mail and telephone calls for physicians who are no longer there.

It is not the responsibility of the academic medical centers or the universities to continue to update the NPPES records of physicians who are no longer working for them. In most cases, the academic medical centers and universities do not have the updated information and, therefore, are unable to contact the physicians to ask that they update their NPPES information.

Unless physicians have agreements in place for others to keep their NPPES information up to date, the physicians themselves are responsible for ensuring that their NPPES records contain accurate and current information.

Some of these physicians may have enrolled in health plans and may be sending claims electronically to health plans or conducting other electronic health transactions with health plans. These physicians are "covered entities" under the Health Insurance Portability and Accountability Act (HIPAA). As covered entities, they are required by regulation to update their NPPES records within 30 days of any change. Those who have NPIs but who do not conduct electronic health transactions with health plans, and, thus, are not covered entities, are encouraged to keep their NPPES information up to date.

We remind all health care providers who have NPIs, not just the physicians specially noted above, to view their NPPES records and, if corrections are necessary, to furnish the updates. Health care providers who established user IDs and passwords in NPPES can easily access their NPPES records to make updates. Those who did not establish user IDs and passwords may do so at any time. For assistance in setting up user IDs and passwords, or in situations where the user ID or password has been forgotten, health care providers should contact the NPI Enumerator at 1-800-465-3203. If they prefer, health care providers may furnish their updates by filling out the paper NPI application (CMS-10114) and mailing the completed form to the NPI enumerator. The instructions are on the form, along with the mailing address of the NPI enumerator. The form may be downloaded from the CMS forms Web page (*http://www.cms.hhs.gov/cmsforms*) or one may be obtained by contacting the NPI enumerator at the number above.

Source: CMS PERL 200908-05

Provider enrollment reminder for physicians, nonphysicians, and group practices

The Centers for Medicare & Medicaid Services (CMS) reminds physicians, nonphysician practitioners, and group practices that they are required to notify their designated Medicare contractor regarding (1) a change in ownership, (2) a change in practice location, including a change in reassignment of benefits, or (3) any final adverse action (e.g., license suspension/ revocation or felony conviction) within 30 days of the reportable event. By reporting changes as soon as possible, but within 30 days of the reportable event, will help to ensure that claims are processed correctly.

They are also encouraged to update their Medicare enrollment information on file with the Medicare contractor if not done so since November 2003.

They can use CMS' electronic enrollment process, known as Internet-based Provider Enrollment, Chain and Ownership System (PECOS), to enroll or make a change in an existing enrollment record.

Information in regard to reporting responsibility and other informational material regarding provider enrollment may be found on the Medicare Provider/Supplier Enrollment section of the CMS Web site, *http://www.cms.hhs.gov/MedicareProviderSupEnroll*, and in the documents available for downloading in the *Downloads* section of each Web page.

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

Source: CMS PERL 200908-11

Medicare demonstrations show paying for quality health care pays off

Demonstrations being conducted by the Centers for Medicare & Medicaid Services (CMS) continue to provide strong evidence that offering financial incentives for improving or delivering high quality care increases quality and can reduce the growth in Medicare expenditures.

CMS is announcing new results from three of these demonstrations, one for large physician practices, one for small and solo physician practices, and one for hospitals. CMS is also announcing the start of three additional value based purchasing demonstrations.

> "We continue to be encouraged by the progress of our ongoing programs that test value based-purchasing across a variety of health care services," said Charlene Frizzera, Acting Administrator of CMS; "Building on those efforts, we are pleased to announce the start of our Nursing Home Value-Based Purchasing Demonstration and two gainsharing demonstrations." "What we learn from the various Medicare demonstrations help to achieve the Administration's goals of paying for high quality and efficient health care in America," said Jonathan Blum, director of the CMS' Center for Medicare Management and acting director of the Center for Health Plan Choices. "Building on these findings, we will aggressively test new demonstration concepts to continue to meet these goals."

The CMS value-based purchasing (VBP) initiative is designed to tie Medicare payments to performance on quality and efficiency and is part of CMS' effort to transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care.

Entering its fifth year, the Hospital Quality Incentive Demonstration (HQID) shows continued quality improvement among participating hospitals. In addition, physician practices participating in the Physician Group Practice (PGP) Demonstration continue to improve quality for patients with chronic illnesses or requiring preventive care.

And more than 560 small and solo physician practices participating in the Medicare Care Management Performance (MCMP) Demonstration are being rewarded for providing high quality care in the delivery of preventive care and care for patients with chronic illnesses.

New demonstration programs include the Nursing Home Value-Based Purchasing Demonstration, the Medicare Hospital Gainsharing Demonstration, and the Physician Hospital Collaboration Demonstration. The nursing home demonstration program will reward facilities that can improve or deliver high quality care in four specific areas: staffing, resident outcomes, avoidable hospitalizations and reductions in deficiency citations. The gainsharing and physician hospital collaboration programs will evaluate whether gainsharing leads to improvements in quality and efficiency. The demonstrations provide a promising opportunity for hospitals and physicians to join forces to improve quality and efficiency of care, establish effective means to govern use of inpatient resources, reduce costs, and share the rewards. Overall, demonstrations give CMS the opportunity to work closely with providers to improve quality and efficiency and serve as a vehicle to test various VBP methodologies.

Hospitals continue to improve quality

The HQID is sponsored by Medicare in partnership with Premier, Inc., a national hospital quality measurement organization. The demonstration, which began in 2003 with hospitals in 38 states, was designed to test payment incentives under Medicare to see if they would improve the safety, quality, and efficiency of inpatient services by linking incentives to improved quality.

Participants raised overall quality by an average of 17 percentage points over four years, based on their performance on more than 30 nationally standardized and widely accepted care measures for patients in five clinical areas -- heart attack, coronary bypass graft, heart failure, pneumonia, and hip and knee replacements.

CMS is awarding incentive payments totaling $12 million in year four to 225 hospitals for top performance, top improvements and overall attainment in the five clinical areas. Through the first four years, CMS awarded more than $36.6 million to top performers. After the initial three years

Medicare demonstrations show paying for quality health care pays off (continued)

of the demonstration, CMS extended the project for three additional years to test new incentive models, and ways to improve patient care.

Physician groups improve quality and share savings

All ten of the physician groups participating in the PGP demonstration achieved benchmark performance on at least 28 of the 32 measures reported in year three of the demonstration. Two groups -- Geisinger Clinic in Danville, Penn. and Park Nicollet Health Services in St. Louis Park, Minn. -- achieved benchmark performance on all 32 performance measures.

Over the first three years of the demonstration, the physician groups increased their quality scores an average of 10 percentage points on ten diabetes measures, 11 points on ten congestive heart failure (CHF) measures, six points on seven coronary artery disease (CAD) measures, 10 points on two cancer screening measures, and one percentage point on three hypertension measures.

Under the PGP demonstration, physician groups earn incentive payments based on the quality of care they provide and the estimated savings they generate in Medicare expenditures for the patient population they serve. As a result of their efforts to reduce the growth rate in Medicare expenditures, five physician groups will receive performance payments totaling $25.3 million as part of their share of $32.3 million of savings generated for the Medicare Trust Funds in performance year three.

Over 560 small physician practices earn incentive payments for quality performance

In the first year of the MCMP demonstration, almost all of the 610 participating small and solo physician practices are being rewarded for performance on 26 quality measures. CMS is awarding approximately $7.5 million dollars in incentive payments to over 560 practices in California, Arkansas, Massachusetts, and Utah. The average payment per practice is $14,000 but some practices earned as much as $62,500. Last year, CMS paid out over $1.5 million in incentives for reporting baseline quality measures.

The goal of the MCMP demonstration is to promote the use of health information technology to improve the quality of care for beneficiaries with chronic conditions.

Doctors in small to medium sized practices who meet clinical performance standards on each measure are eligible to receive financial rewards under the MCMP demonstration. The demonstration also provides an additional bonus to practices that report the data using an electronic health record (EHR) certified by the Certification Commission for Health Information Technology. Twenty-three percent of practices were able to submit at least some of the measures from a certified EHR.

Nearly 200 nursing homes in three states testing value-based purchasing

Nearly 200 nursing homes in three states will participate in a Medicare demonstration to determine if financial incentives will improve the quality of the care they provide.

The Nursing Home Value-Based Purchasing Demonstration will reward those facilities that improve or deliver quality care in four areas: nurse staffing, resident outcomes, avoidable hospitalizations, and reduction of the scope and severity of deficiency citations the home may have received during inspections. Nursing homes will be awarded points in each of these areas; homes with the highest scores or greatest improvement will become eligible for a performance payment. Savings that result from improved quality and efficiency will be used to fund incentive pools in each state.

CMS will conduct the demonstration in 79 homes in New York, 62 in Wisconsin, and 41 in Arizona. Each of these states assisted in the recruitment process by encouraging facilities to apply to CMS. Participating homes were then selected from the applicant pool.

The demonstration will run from July 2009 through June 2012, at which time its effectiveness will be evaluated to inform Medicare value-based purchasing policies.

14 hospitals collaborating with over 1,000 physicians in gainsharing demonstrations

CMS also announced today it will operate two demonstrations to evaluate gainsharing as a means of aligning incentives between hospitals and physicians to improve quality of care and overall hospital efficiency. Gainsharing occurs when a hospital pays incentives to a physician who assists in saving internal hospital costs while improving quality and efficiency and is normally restricted in Medicare's fee-for-service program.

The Medicare Hospital Gainsharing Demonstration began in October 2008. This demonstration consists currently of two sites, Beth Israel Medical Center in New York City and Charleston Area Medical Center in West Virginia. Under this demonstration, CMS will evaluate whether gainsharing leads to short-term improvements in quality and efficiency during the inpatient stay and immediately following discharge.

The Physician Hospital Collaboration Demonstration, comprised of a consortium of twelve hospitals administered by the New Jersey Hospital Association, began in July. This demonstration is designed to track patients beyond a hospital episode to determine the impact of hospital-physician collaborations on preventing short- and longer-term complications and duplication of services.

These demonstrations will allow physicians to share in the savings generated by the adoption of structural and procedural changes made to improve the quality of inpatient hospital care.

For additional information on VBP demonstrations, visit the demonstrations Web page at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp*.

Source: CMS PERL 200908-27

ICD-10-Clinical Modification/Procedure Coding System publications

The following ICD-10-CM/PCS publications are available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

ICD-10-CM/PCS Myths & Facts (June 2009) -- presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System, is now available in print format. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

ICD-10-CM-PCS Bookmark (revised August 2009) -- provides information about the ICD-10-Clinical Modification/Procedure Coding System including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system may be found, is now available in downloadable format at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10ClinModBookmrk.pdf*.

Source: CMS PERL 200908-14

Transcript available for the June 23 ICD-10 conference call

The written and audio transcript summaries of the "Introduction to ICD-10-CM/PCS for Physician Specialty Group Representatives" conference call, which was conducted by the Centers for Medicare & Medicaid Services on June 23, 2009, are now available in the *Downloads* section at *http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp*.

Source: CMS PERL 200907-31

Telehealth services fact sheet

The Telehealth Services Fact Sheet (July 2009), which provides information about originating sites, distant site practitioners, telehealth services, and billing and payment for professional services furnished via telehealth and for the originating site facility fee, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf*.

Source: CMS PERL 200907-32

August is Immunization Awareness Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered vaccines. Medicare provides coverage for seasonal influenza, pneumococcal, and hepatitis B vaccines for qualified beneficiaries.

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 by educating them about their risk factors and reminding them of the importance of getting vaccinations that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered immunization services:

- The *MLN* Preventive Services Educational Products Web Page -- provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products, including Medicare-covered adult immunizations, and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- *Quick Reference Information: Medicare Part B Immunization Billing* -- a double-sided chart that provides coverage and coding information on Medicare-covered immunizations. *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*
- *Quick Reference Information: Medicare Preventive Services* -- a double-sided chart that provides coverage and coding information on Medicare-covered preventive services, including immunizations. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- *Adult Immunizations brochure* -- this brochure provides information on risk factors and coverage for the season influenza, pneumococcal, and hepatitis B vaccines. *http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf*

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products.

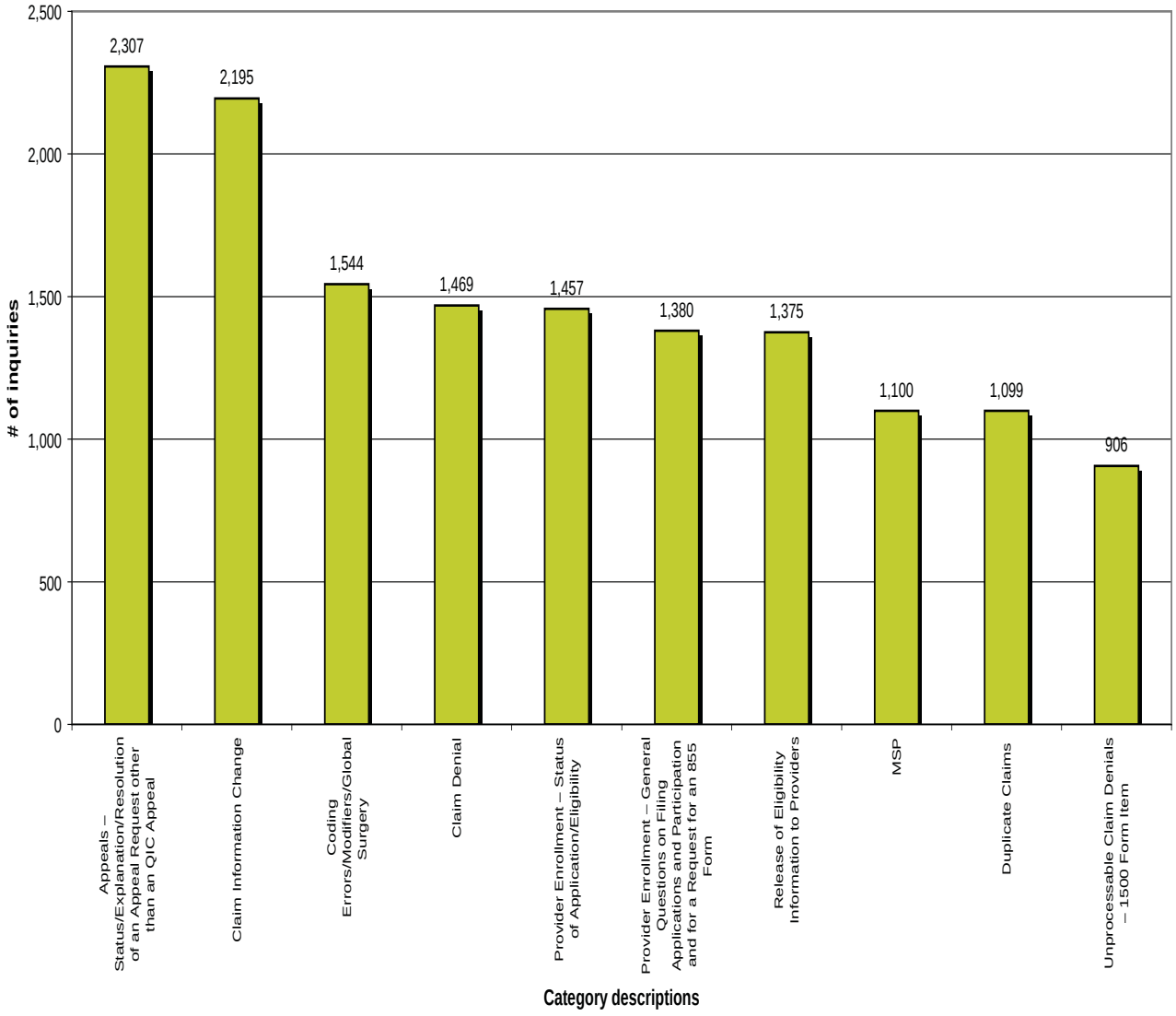
Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries about the importance of taking advantage of immunizations and other preventive services covered by Medicare.

Source: CMS PERL 200908-10

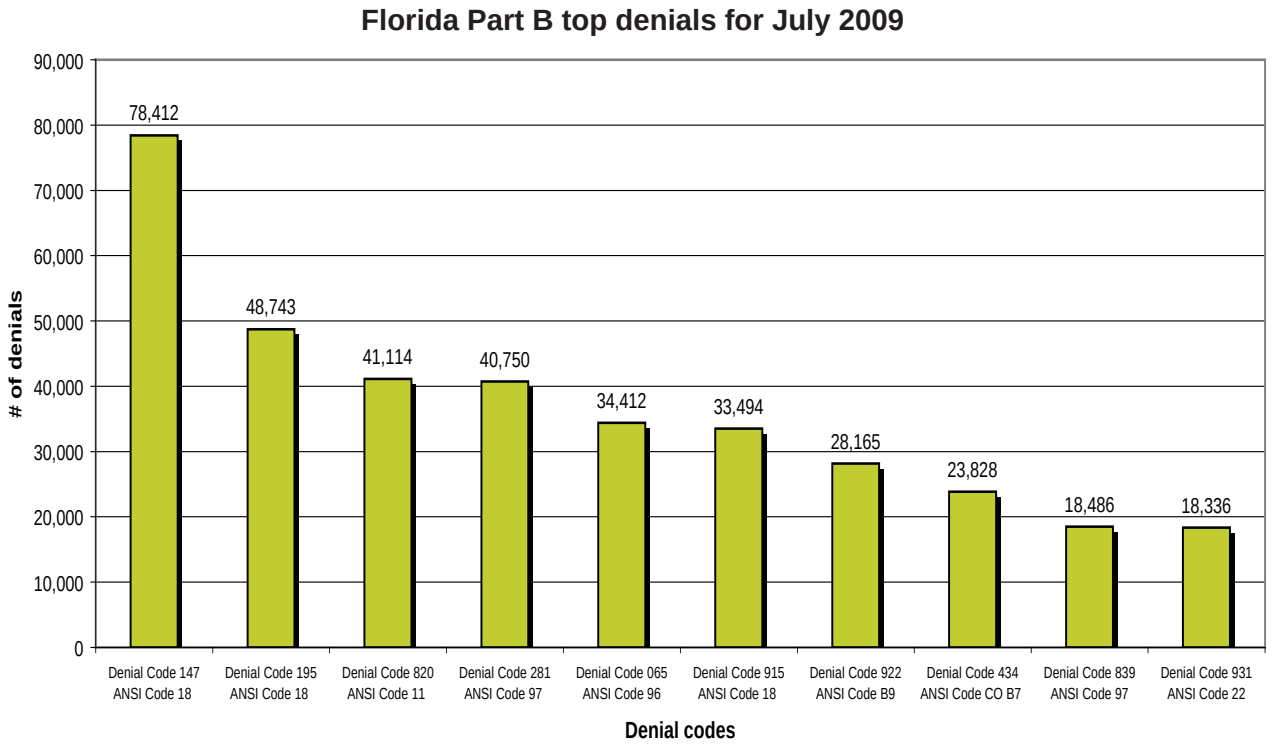
Top inquiries, denials, and return unprocessable claims for July 2009

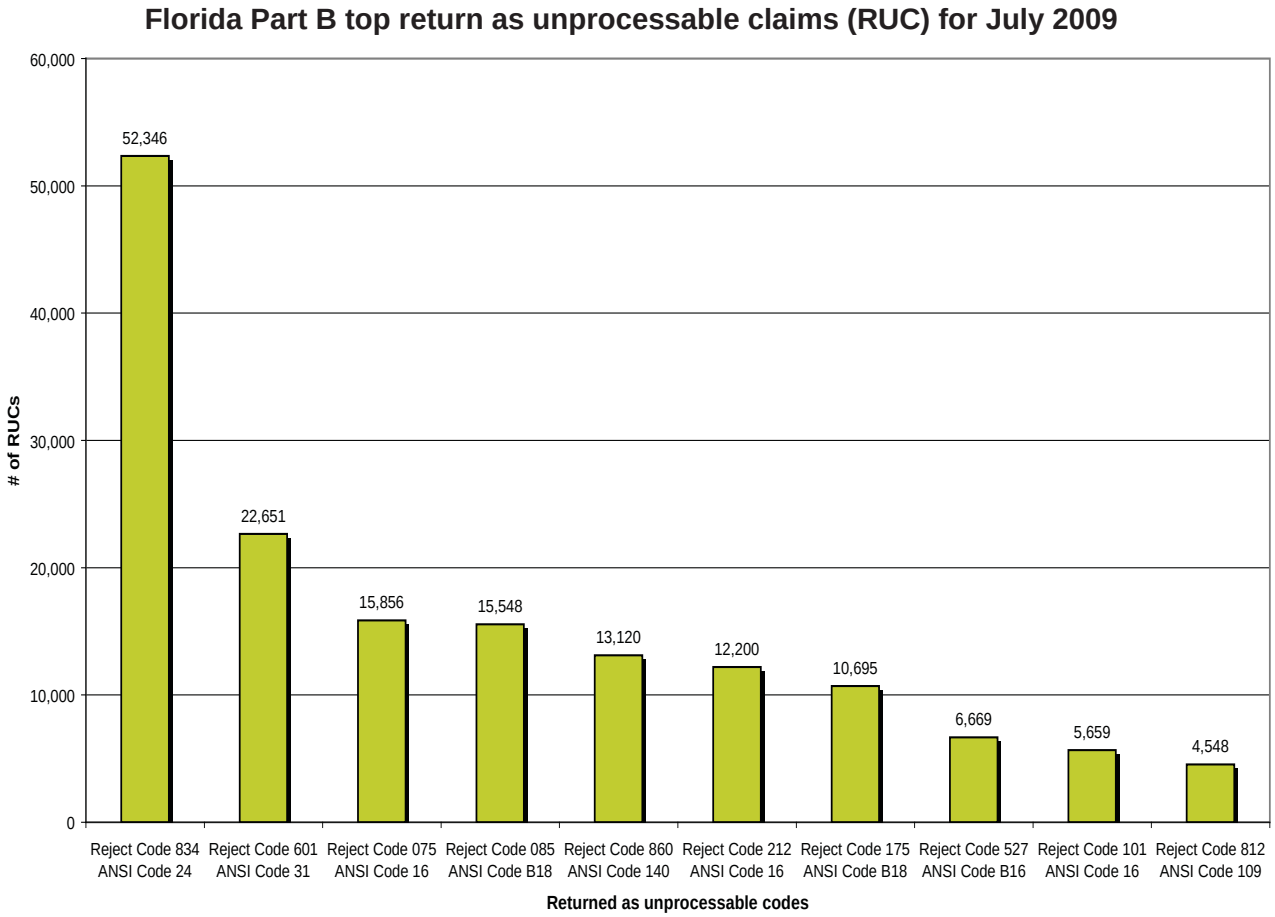
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Island providers during July 2009. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part B top inquiries for July 2009

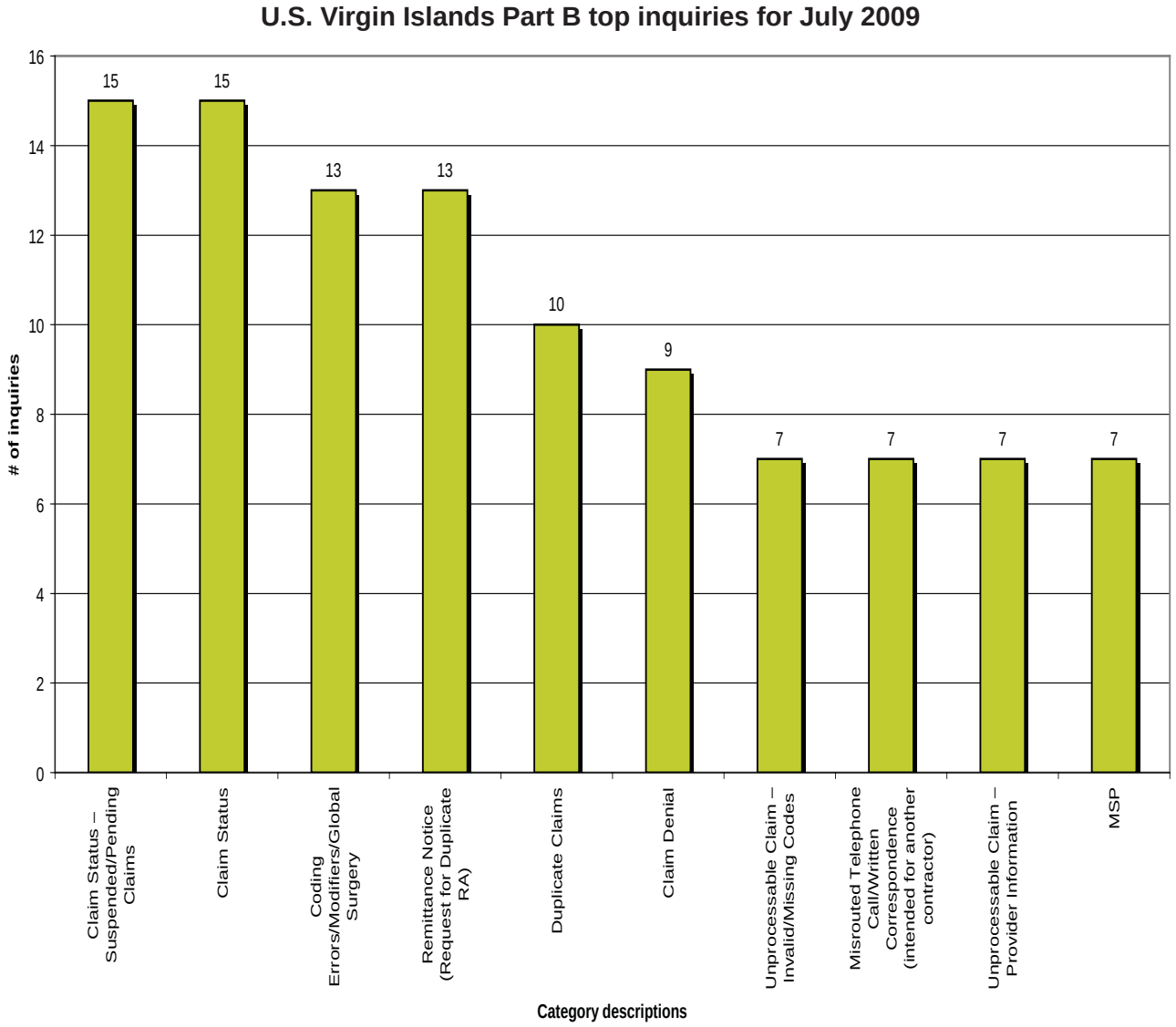


Top inquiries, denials, and return unprocessable claims for July 2009 (continued)





Top inquiries, denials, and return unprocessable claims for July 2009 (continued)



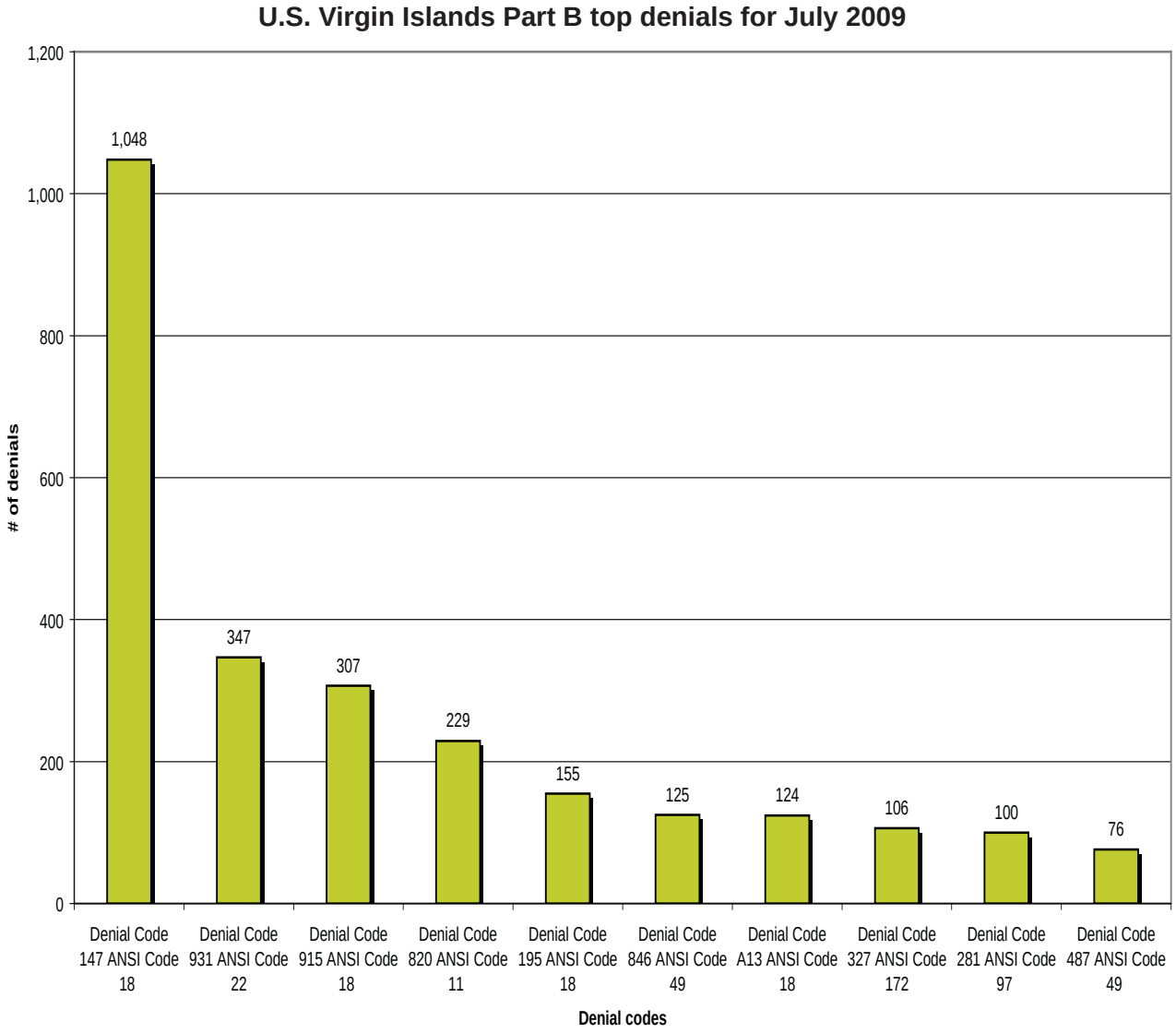
When not to show patient paid amounts on claims

Some providers who accept assignment have a concern that Medicare issues partial checks to beneficiaries. Such checks are generally issued because of a patient paid amount in item 28 of the CMS-1500 (08/05) claim form. Here are a few notes concerning this situation:

- When assignment is accepted, Medicare Part B recommends:
  - Since it is difficult to predict when deductible/coinsurance amounts will be applicable–and over-collection is considered program abuse–it is recommended that providers do not collect these amounts until Medicare Part B payment is received.
  - If you believe you can accurately predict the coinsurance amount and wish to collect it before Medicare Part B payment is received, note the amount collected for coinsurance on your claim form. It is recommended that providers do not collect the deductible prior to receiving payment from Medicare Part B because, as noted above, over-collection is considered program abuse. In addition, this practice can cause a portion of the provider's check to be issued to beneficiaries on assigned claims.
  - Do not show any amounts collected from patients if the service is never covered by Medicare Part B or you believe, in a particular case, the service will be denied payment. Where patient paid amounts are shown for services that are denied payment, a portion of the provider's check may go to the beneficiary.
- There is no need to show a patient paid amount in item 28 of form CMS-1500 (or electronic equivalent) when assignment is not accepted.

Source: CMS IOM Pub 100-04, Ch. 1, sec. 30.3.1.1 (2), 30.3.3.B (2), Ch 26, Sec 10.4

Top inquiries, denials, and return unprocessable claims for July 2009 (continued)



Duplicate denial – ANSI code CO-18

Duplicate denials occur when a provider submits more than one claim for the same patient and the claim includes identical information, such as date of service, type of service, procedure code, place of service, and billed amount. A claim may be denied as a duplicate when an automated development system (ADS) letter has been sent to the provider and the provider resubmits the claim, instead of responding promptly to the letter (e.g., regarding a national provider identifier (NPI) mismatch).

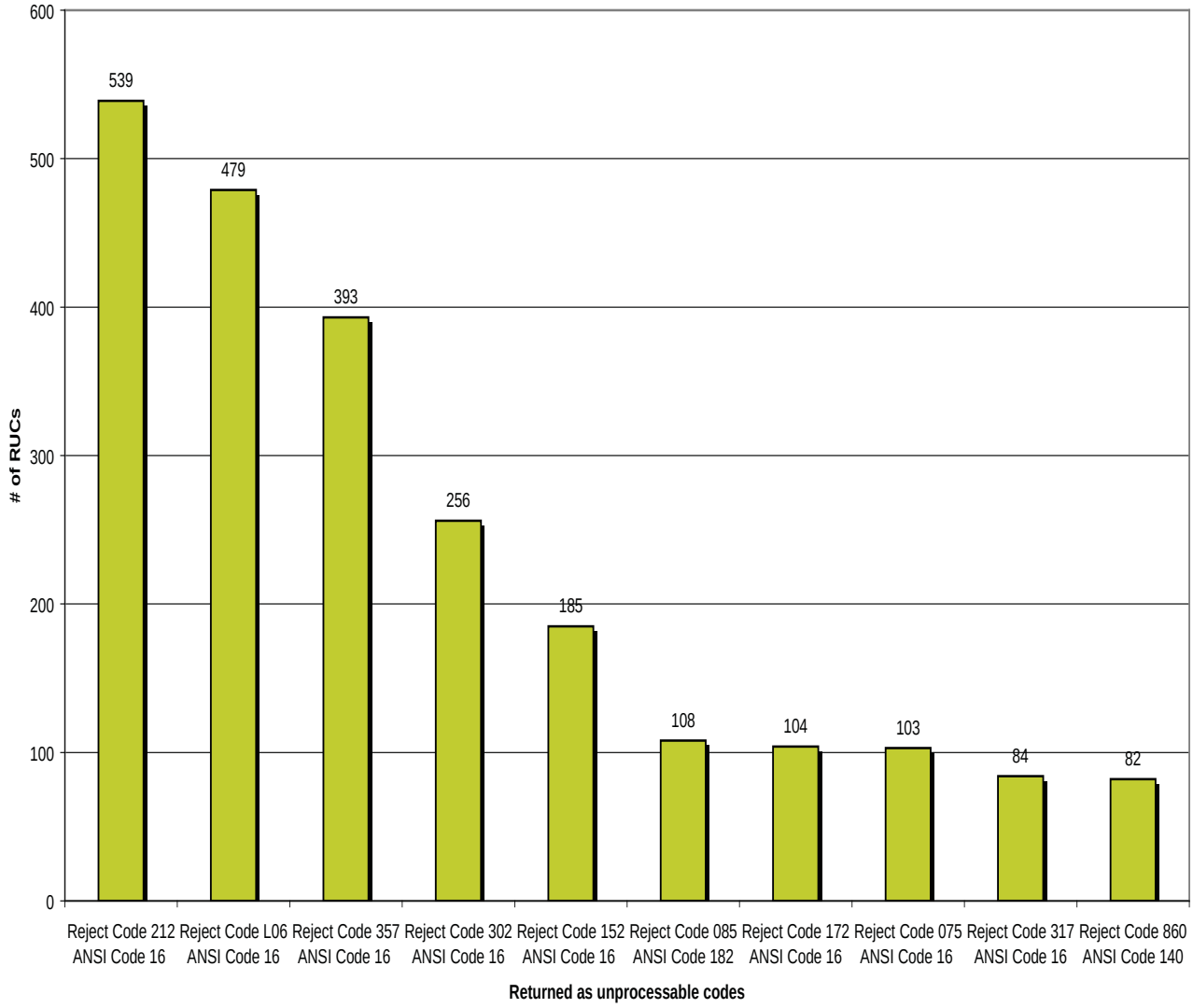
Prior to resubmitting any claim, a provider should check the status of the original claim by using the provider contact center's interactive voice response (IVR) system by calling (877) 847-4992. Always allow at least two weeks (10 business days) after submitting a claim before using the IVR to check claim status. This action will prevent unnecessary delays in the processing of claims.

When a provider resubmits a claim before the original claim has finished processing, the duplicate claim denial may appear on a remittance advice before the finalized original claim does. This is because duplicate claims do not process through the common working file (CWF), and therefore are not held on the "payment floor."

Remember: Providers have an obligation under the law to conform to the requirements of the Medicare program. Billing which appears to be a deliberate application for duplicate payment for the same services or supplies in an attempt to get paid twice may be considered fraudulent. Providers are responsible for claims submitted to Medicare on their behalf by vendors and/or clearinghouses. Ultimately, Medicare holds the provider of service accountable for duplicate claim submission.

Top inquiries, denials, and return unprocessable claims for July 2009 (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for July 2009



Rendering or ordering physician national provider identifier reminders

If the practitioner rendering the service is part of a billing group, the individual practitioner's national provider identifier (NPI) must be reported in 2310B loop, segments NM108 [XX] and NM109 [NPI], of the 837P electronic claim (Item 24J of the CMS-1500). Note: If you submit claims on the CMS-1500, report the NPI of the individual practitioner in the lower, non-shaded portion of Item 24J.

Only authorized nonphysician practitioners and the following physicians are authorized to refer and/or order services for a Medicare patient:

- A doctor of medicine or osteopathy (M.D. or D.O.)
- A doctor of dental surgery or dental medicine (D.D.S. or D.D.M.)
- A doctor of podiatric medicine (D.P.M.), but only with respect to functions which he/she is legally authorized to perform
- A doctor of optometry (O.D.), but only with respect to the provision of items or services which he/she is legally authorized to perform
- A chiropractor (D.C.) legally authorized to perform services in the jurisdiction in which he/she performs such services, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation).

Electronic Health Records

Electronic health records and the 21st century health care system

A message from Dr. David Blumenthal, National Coordinator for Health Information Technology

In my role as National Coordinator for Health IT, I have the privilege to be part of a transformative change in health care that will help to extend the benefits of health information technology (HIT) to all Americans. With the passage earlier this year of the Health Information Technology for Economic and Clinical Health (HITECH) Act, we have the tools to begin a major transformation in American health care made possible through the creation of a secure, interoperable nationwide health information network.

Of course, this system is not an end in itself. Rather, it will enable countless other improvements in the quality and efficiency of health care that will make Americans healthier and their economy stronger.

My personal belief in this transformation is not based on theory or conjecture. As a primary care physician for over 30 years, I spent the first twenty shuffling papers in search of missing studies and frequently hoping, during middle-of-the-night emergencies, that I knew enough about patients' medical histories to make good decisions. All that changed when I began to have access to patients' electronic medical records. It made me a much better doctor. I would never go back, and neither would the vast majority of American physicians who have made the leap into the electronic age.

In fact, it would be hard for any health professional today to escape the conclusion that the antiquated, paper-dominated system we now have in place isn't working well for patients, creates added costs and inefficiencies, and isn't sustainable. As we look at our nation's annual health care expenditures of approximately $2.5 trillion, there are many ways our current system fails both patients and providers. It is clear that change is necessary.

But how and why is nationwide electronic health information exchange so critical to achieving such change? Most importantly, because it provides the best opportunity for each patient to receive optimal care. The technology will make patients' complete medical information securely and reliably available to health care providers where and when it is needed – when clinician and patient are together facing medical decisions that can make a lasting difference.

Better, faster, more reliable and efficient care also ultimately reduces system-wide costs by delivering results that help to avoid expensive or prolonged hospitalization from delayed or ineffective treatment, avert costly and sometimes fatal adverse events and unnecessary procedures, and can help to eliminate the onset of disease by better informed management of each patient's health.

The goal of assuring an electronic health record for every American is daunting. We at the Office of the National Coordinator for Health Information Technology (ONC) do not pretend otherwise. We know this will be hard for some clinicians and hospitals, and we stand ready to help with resources provided by the Congress and the Administration.

We also recognize that we cannot achieve the benefits of a nationwide health information system unless we can assure all Americans that their personal health information will remain private and secure when this system exists. Putting into place safeguards for the privacy and security of this information, when it is in electronic form, will be an ongoing priority that influences and guides all of our efforts.

In the days, weeks, and months ahead, we will be rolling out a number of pivotal initiatives called for under the HITECH Act. I urge you to join and support us as we lay the foundation for every American to benefit from an electronic health record, as part of a modernized, interconnected, and vastly improved system of care delivery. We at ONC will be making every effort to keep you updated and fully engaged in all the steps of this national journey.

Sincerely,
David Blumenthal, M.D., M.P.P.

National Coordinator for Health Information Technology
U.S. Department of Health & Human Services

This letter is the first in a series of ongoing updates from the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology.

For more information and to receive regular updates from the Office of the National Coordinator for Health Information Technology, please subscribe to the Health IT News list at *https://service.govdelivery.com/service/subscribe.html?code=USHHS_188*.

If you have difficulty viewing this message, please view it online at *http://healthit.hhs.gov/portal/server.pt?open=512&objID=1327&parentname=CommunityPage&parentid=4&mode=2&in_hi_userid=11113&cached=true*. To ensure that you receive future correspondence, please add this e-mail address to your list of secure addresses.

Source: CMS PERL 200908-26

Available grants to help hospitals and doctors use electronic health records

Vice President Joe Biden announced the availability of grants worth nearly $1.2 billion to help hospitals and health care providers implement and use electronic health records. The grants will be funded by the American Recovery and Reinvestment Act of 2009 (ARRA) and will help health care providers qualify for new incentives that will be made available in 2010 to doctors and hospitals that meaningfully use electronic health records.

> "With electronic health records, we are making health care safer; we're making it more efficient; we're making you healthier; and we're saving money along the way," said Vice President Biden. "These are four necessities we need for health care in the 21st-century."
>
> "Expanding the use of electronic health records is fundamental to reforming our health care system," said HHS Secretary Sebelius. "Electronic health records can help reduce medical errors, make health care more efficient and improve the quality of medical care for all Americans. These grants will help ensure more doctors and hospitals have the tools they need to use this critical technology."

The grants made available include:

- Grants totaling $598 million to establish approximately 70 health information technology regional extension centers, which will provide hospitals and clinicians with hands-on technical assistance in the selection, acquisition, implementation, and meaningful use of certified electronic health record systems
- Grants totaling $564 million to states and qualified state designated entities (SDEs) to support the development of mechanisms for information sharing within an emerging nationwide system of networks.

The extension center grants will be awarded on a rolling basis, with the first awards being issued in fiscal year 2010. Grants to states will be made in fiscal year 2010. Those interested in applying for these grants may visit *http://healthit.hhs.gov/portal/server.pt* for more information.

> "With these programs, we begin the process of creating a national, private and secure electronic health information system. The grants are designed to help doctors and hospitals acquire electronic health records and use them in meaningful ways to improve the health of patients and reduce waste and inefficiency," said Dr. David Blumenthal, National Coordinator for Health Information Technology.
>
> "They will also help states lead the way in creating the infrastructure for health information exchange, which enables information to follow patients within and across communities, wherever the information is needed to help doctors and patients make the best decisions about medical care."

The Department of Health and Human Services (HHS) will also provide additional assistance to health care providers through the Health Information Technology Research Center (HITRC). The HITRC will gather relevant information on effective practices from a wide variety of sources across the country and help the regional extension centers collaborate with one another and with relevant stakeholders to identify and share best practices in EHR adoption, effective use, and provider support.

The following two fact sheets are available:

Health Information Technology Extension Program Facts-At-A-Glance
http://www.hhs.gov/recovery/programs/hitech/factsheet.html

State Health Information Exchange Grant Programs Facts-At-A-Glance
http://www.hhs.gov/recovery/programs/hitech/stateinfoexch.html

The activities described in this release are being funded through the American Recovery and Reinvestment Act (ARRA). To track the progress of HHS activities funded through the ARRA, visit *http://www.hhs.gov/recovery*. To track all federal funds provided through the ARRA, visit *http://www.recovery.gov*.

Source: CMS PERL 200908-28

Keep Informed

Join *eNews* FCSO's electronic mailing service, to receive the most current revisions and updates. Check our upcoming provider events calendar and learn how to register for free teleconferences and webcasts that will help you increase your knowledge of the Medicare program and find ways to improve Medicare billing and payment efficiency.

Local Coverage Determinations

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Local Coverage Determinations -- Table of Contents

Advance beneficiary notice

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

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

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

New LCDs

76800: Ultrasound of the spine -- new LCD

LCD ID number: L30353 (Florida/Puerto Rico/U.S. Virgin Islands)

Ultrasound imaging is a noninvasive diagnostic imaging modality that includes exposing part of the body to high-frequency ultrasound waves to produce both imaging and Doppler examinations. The images are captured in real-time and can illustrate the structure and movement of the internal organs of the body, and blood flowing through blood vessels.

The local coverage determination (LCD) includes indications and limitations as well as coding guidelines to provide the coverage information for ultrasound of the spine. This service is considered medically reasonable and necessary when used intra-operatively for adults; and in the diagnostic evaluation of the spinal cord and canal of newborns and infants, ranging in age from birth to 24 months.

Effective date

This new LCD is effective for services rendered on or after September 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

77371: Stereotactic radiosurgery and stereotactic body radiation therapy -- new LCD

LCD ID number: L30366 (Florida/Puerto Rico/U.S. Virgin Islands)

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) are noninvasive means of administering high-dose radiotherapy to discreet tumor foci in cranial or extracranial locations respectively. The two forms of treatment share certain overarching principles, namely, the use of image guidance and related treatment delivery technology for escalating the radiation dose to the tumor with as little radiation dose to the surrounding tissue as possible. Both methods are achieved with a "sterotactic" technique, implying that fiducial reference markers serve to align the treatment machine so that an internal lesion is targeted accurately; however, notable differences in clinical applications emerge given the vastly different anatomic and clinical consideration between cranial and extracranial target lesions.

This local coverage determination (LCD) has been developed to provide indications and limitations of coverage and/or medical necessity, documentation requirements and utilization guidelines for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT).

Effective date

This new LCD is effective for services rendered on or after October 5, 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Timely claim filing guidelines

All Medicare claims must be submitted to the contractor within the established timeliness parameters. The time parameters are:

Dates of service	Last filing date
October 1, 2007 – September 30, 2008	by December 31, 2009
October 1, 2008 – September 30, 2009	by December 31, 2010
October 1, 2009 – September 30, 2010	by December 31, 2011

90862: Pharmacologic medication management for psychiatry services -- new LCD

LCD ID number: L30351 (Florida/Puerto Rico/U.S. Virgin Islands)

CPT code *90862* represents pharmacologic medication management, and is intended for use by physicians or master's prepared psychiatric nurses with state authorized prescribing privileges who are prescribing pharmacological therapy for patients with psychiatric disorders. Pharmacologic medication management involves the assessment, monitoring and prescribing of psychopharmacologic medication and includes no more than minimal psychotherapy. This *CPT* code should only be reported when the qualified clinician is providing in-depth evaluation and monitoring of psychopharmacologic medication and is personally coordinating medication decisions with the patient in a face-to-face encounter.

HCPCS code M0064 involves monitoring or changing psychopharmacologic medication, and is intended for use by the physician, physician's assistant, or advanced registered nurse with psychiatric training and acting within the scope of practice during a face-to-face encounter with the patient without providing any psychotherapy.

The local coverage determination (LCD) includes indications and limitations, ICD-9-CM codes that support medical necessity, and documentation requirements to provide the coverage information for pharmacologic medication management for psychiatry services. These services are considered medically reasonable and necessary when used to provide management of psychopharmacologic medication.

Effective date

This new LCD is effective for services rendered on or after September 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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Revisions to LCDs

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 on July 1, 2009. Since that time, the LCD has been revised to delete *CPT* code *97755* (*Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes*) from the "*CPT*/HCPCS Codes," "Local Noncoverage Decisions, Procedures" section of the LCD.

Effective date

This LCD revision is effective for services rendered on or after August 11, 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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Web Site Survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

THERSVCS: Therapy and rehabilitation services -- revision to the LCD

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

The local coverage determination (LCD) for therapy and rehabilitation services was last revised on April 6, 2009. Since that time, the "CPT/HCPCS Codes" section of the LCD has been revised to add *CPT* code *97755* (*Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes*). The "Indications and Limitations of Coverage and/or Medical Necessity" and "Documentation Requirements" sections of the LCD have also been revised to add a new section, "Assistive Technology Assessment (*CPT* code *97755*)."

Effective date

This LCD revision is effective for services rendered on or after April 11, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

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11000: Debridement services -- revision to the LCD

LCD ID number: L29128 (Florida)
LCD ID number: L29146 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for debridement services was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a revision was made based on recommendations from internal and external sources. The following sections of the LCD were updated/revised:

- Under the "LCD Title" section of the LCD, the title was changed to "Wound Debridement Services."
- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, verbiage was added/deleted under the following sub headings:
  - "Skin Debridement (*CPT* codes *11000-11001*)"
  - "Surgical Debridement (*CPT* codes *11040-11044*)"
  - "Active Wound Care Management"
- Added "Limitations" section to the LCD.
- Updated the "Documentation Requirements" section of the LCD.
- Updated the "Utilization Guidelines" section of the LCD, including clarification that all codes and all wounds are included on any given date or over time, for ulcers requiring more that eight total services.
- Updated the "Sources of Information and Basis for Decision" section of the LCD.
- Updated the LCD "Coding Guidelines" attachment.

Effective date

The revisions to this LCD are effective for services rendered on or after September 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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62263: Percutaneous lysis of epidural adhesions -- revision to the LCD

LCD ID number: L29256 (Florida)
LCD ID number: L29465 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for percutaneous lysis of epidural adhesions was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised to include endoscopic lysis of epidural adhesions. Additionally, the following revisions were made to the LCD:

- Title changed to endoscopic and percutaneous lysis of epidural adhesions
- Updated the "Sources of Information and Basis for Decision" section of the LCD
- Updated the "*CPT*/HCPCS Code" section of the LCD to include *CPT* code *64999* for billing endoscopic lysis of epidural adhesions
- Coding guidelines developed
- Addition of verbiage to include treatment of the cervical and thoracic regions of the vertebrae
- Updated the "ICD-9 Codes that Support Medical Necessity" section of the LCD to include ICD-9-CM codes 722.0, 722.4, 722.81, 722.82, 723.0, 723.4, 724.01, and 724.02.

Effective date

This LCD revision is effective for services rendered on or after September 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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64622: Destruction of paravertebral facet joint nerve(s) -- revision to the LCD

LCD ID number: L29132 (Florida)
LCD ID number: L29150 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for destruction of paravertebral facet joint nerve(s) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the following revisions were made to the LCD:

- The addition of training requirements for physicians performing destruction of the paravertebral facet joint nerve(s)
- Mandatory requirement of the use of fluoroscopy for guidance
- Identification of accepted modalities when performing destruction of the paravertebral facet joint nerve(s)
- Identification of the median branch nerve of the facet joint as the target for achieving facet joint nerve destruction
- Additional documentation requirements
- The establishment of parameters for frequency of services clarified
- Sources of information and basis for decisions updated
- The coding guidelines have been retired

Effective date

This LCD revision is effective for services rendered on or after September 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Enrollment application reminder

Providers submitting a Medicare enrollment application CMS-855A, CMS-855B or CMS-855I must submit the nine-digit ZIP code for each practice location listed on the form.

77301: Intensity modulated radiation therapy (IMRT) -- revision to the LCD

LCD ID number: L29200 (Florida)
LCD ID number: L29352 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intensity modulated radiation therapy (IMRT) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised in the following sections of the LCD:

- The revisions in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD include the following:
    - Statement added to specify that indications will include some left breast tumors due to risk to immediately adjacent cardiac and pericardial structures, and selected right breast cases in larger volume breast and larger chest wall separation distances.
    - The following new sections have been added under the 'Indications and Limitations of Coverage and/or Medical Necessity' section of the LCD:
        - Patient-Specific IMRT Treatment Verification
        - Use of Clinical Treatment Planning in IMRT (*CPT* codes *77261-77263*) Prior to the Specific IMRT Treatment Plan (*CPT* code *77301*)
        - Use of Simulation-Aided Field Setting in IMRT (*CPT* codes *77280-77295*)
        - Use of Intensity Modulated Radiotherapy Plan (*CPT* code *77301*), Including Dose Volume Histograms for Target and Critical Structure Partial Tolerance Specification
        - Use of Basic Radiation Dosimetry Calculation, Central Axis Depth Dose Calculation, TDF, NSD, Gap Calculation, Off-Axis Factor, Tissue Inhomogeneity Factors, Calculation of Non-Ionizing Radiation Surface and Depth Dose, as Required During Course of Treatment, Only When Prescribed by the Treating Physician (*CPT* code *77300*) in IMRT
        - Use of Teletherapy Isodose Plan in IMRT (*CPT* codes *77305-77321*)
        - Use of Brachytherapy Isodose Plan in IMRT (*CPT* codes *77326-77328*)
        - Use of Special Dosimetry in IMRT (*CPT* code *77331*)
        - Use of Treatment Devices (e.g., "Blocks") in IMRT (*CPT* codes *77332-77334*)
        - Use of Continuing Medical Physics Consultation in IMRT (Weekly Physics QA: *CPT* code *77336*)
        - Use of Special Medical Radiation Physics Consultation in IMRT (*CPT* code *77370*)
        - Use of Other Radiation Treatment Delivery on the Same Day as IMRT Treatment Delivery (*CPT* codes *77418*, *0073T*)
        - Radiation Treatment Management (CPT code *77427*)
        - Use of "Special Treatment Procedure" in IMRT (*CPT* code *77470*)
        - Image Guided Radiation Therapy (IGRT) Codes (*CPT* codes *76950*, *77014*, *77421*)
        - Steroscopic X-ray Guidance (*CPT* code *77421*)
- The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to provide limited coverage for *CPT* codes *0073T*, *77301* and *77418*.
- The "Documentation Requirements" section of the LCD has been revised to include requirements in regard to clinical treatment planning (*CPT* codes *77261-77263*), special treatment procedure (*CPT* code *77470*) and physician supervision (*CPT* code *77421*).
- The "Utilization Guidelines" section of the LCD has been revised to include a statement that special treatment procedure (*CPT* code *77470*) should not be reported more than once during the course of therapy.
- The "Sources of Information and Basis for Decision" section of the LCD has been updated.

Effective date

This LCD revision is effective for services rendered on or after October 5, 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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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Educational Resources

Upcoming provider outreach and education events – September 2009

Better business through better billing: Part B

When: September 8
Time: 9:00 a.m. – 12:00 p.m.
Focus: U.S. Virgin Islands

Hot Topics Series: 2009 Part B updates and changes

When: September 15
Time: 11:30 a.m. – 12:30 p.m.
Focus: Florida and the U.S. Virgin Islands

Evaluation and management (E/M) series: workshops covering the E/M of a typical patient -- session 2

When: September 22 & 24
Time: 11:30 a.m.-1:00 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 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*.

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

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

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

Miscellaneous

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

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

Provider education

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

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

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

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

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

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

Phone numbers

Providers

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

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Medicare Web sites

Provider

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

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

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

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

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

and

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare Web sites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992
E-mail Address: *AskFloridaB@fcso.com*
FAX: 1-904-361-0696

Beneficiary customer service

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

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO Account # (use appropriate account number). Do not fax your order; it must be mailed.

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Non-provider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2008 through September 2009.	40300260	Hardcopy $33		
		CD-ROM $55		
2009 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2009, through December 31, 2009 is available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies or a CD-ROM are available for purchase. The fee schedule contains calendar year 2009 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy $12		
		CD-ROM $6		
Language preference: **English** [ ] **Español** [ ]				

Please write legibly	Subtotal	**$**
	Tax (***add % for your area***)	**$**
	Total	**$**

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦