MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

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

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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.

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Ambulatory Surgical Center

October 2009 update to the ASC payment 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 providers, i.e., ASCs, who submit claims to Medicare contractors, i.e., Medicare administrative contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

Provider action needed

This article is based on change request (CR) 6629 which describes changes to, and billing instructions for, payment policies implemented in the October 2009 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals. Be sure your billing staff is aware of these changes.

Background

Final policy under the revised ASC payment system, as set forth in the final rule CMS-1517-F, requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly. Therefore, beginning with the update notification (Transmittal R1488CP, CR 5994) issued April 9, 2008, the Centers for Medicare & Medicaid Services (CMS) has issued quarterly updates to ASC payment rates for separately paid drugs and biologicals. CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes, as appropriate. CR 6629 provides the new HCPCS code for one separately payable drug that will be added to the ASC list of covered ancillary items effective October 1, 2009.

Key points of change request 6629

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

CMS also reminds ASCs that updated drug payment rates effective October 1, 2009 are included in the October 1, 2009, updated ASC Addendum BB that will be posted at *http://www.cms.hhs.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage* on the CMS Web site at the end of September.

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

One new HCPCS drug code has been created that is separately payable for dates of service on or after October 1, 2009. The new HCPCS code, the long descriptor, and payment indicator (PI) are identified in the following table:

HCPCS	Long Descriptor	Payment Indicator
Q2024	Injection, Bevacizumab, 0.25 mg	K2

HCPCS code Q2024 is included in the October 2009 quarterly updates transmittals for the OPPS and ASC payment system. However, this code is not on the 2009 HCPCS file. CMS issued instructions to your Medicare contractors to manually add this code to their systems.

ASC payment rate for certain newly payable HCPCS codes effective October 1, 2009

For dates of service beginning October 1, 2009, HCPCS code Q4115 (Skin substitute, alloskin, per square centimeter) is eligible for separate payment under the ASC payment system when it is provided integral to a covered surgical procedure. HCPCS code Q4115, the long descriptor, and the updated PI are displayed in the following table:

HCPCS	Long Descriptor	Payment Indicator
Q4115	Skin substitute, alloskin, per square centimeter	K2

Updated payment rates for certain HCPCS codes effective April 1, 2008, through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 ASC DRUG file. The corrected payment rates are listed below. Suppliers who think they may have received an incorrect payment between April 1, 2008, and June 30, 2008, may voluntarily submit those claims to their Medicare contractors for reprocessing.

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1440	Filgrastim 300 mcg injection	K2	$197.37
J1441	Filgrastim 480 mcg injection	K2	$303.75

October 2009 update to the ASC payment system (continued)

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J2505	Injection, pegfilgrastim 6mg	K2	$2,179.44
J2788	Rho d immune globulin 50 mcg	K2	$26.06
J2790	Rho d immune globulin inj	K2	$83.63
J9050	Carmus bischl nitro inj	K2	$155.30

Updated payment rates for certain HCPCS codes effective July 1, 2008, through September 30, 2008

The payment rates for several HCPCS codes were incorrect in the July 2008 ASC DRUG file. The corrected payment rates are listed below. Suppliers who think they may have received an incorrect payment between July 1, 2008, and September 30, 2008, may voluntarily submit those claims to their contractors for reprocessing.

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1438	Etanercept injection	K2	$172.44
J1440	Filgrastim 300 mcg injection	K2	$197.44
J1626	Granisetron HCl injection	K2	$5.28
J2505	Injection, pegfilgrastim 6mg	K2	$2,154.48
J2788	Rho d immune globulin 50 mcg	K2	$26.70
J2790	Rho d immune globulin inj	K2	$84.15
J9208	Ifosfomide injection	K2	$34.10
J9209	Mesna injection	K2	$7.86
J9226	Supprelin LA implant	K2	$14,463.26

Updated payment rates for certain HCPCS codes effective October 1, 2008, through December 31, 2008

The payment rates for several HCPCS codes were incorrect in the October 2008 ASC DRUG file. The corrected payment rates are listed below. Suppliers who think they may have received an incorrect payment between October 1, 2008, and December 31, 2008, may voluntarily submit those claims to their contractors for reprocessing.

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1441	Filgrastim 480 mcg injection	K2	$304.32
J2505	Injection, pegfilgrastim 6mg	K2	$2,175.85
J9209	Mesna injection	K2	$6.99
J9226	Supprelin LA implant	K2	$14,413.33
J9303	Panitumumab injection	K2	$81.86

Updated payment rates for certain HCPCS codes effective July 1, 2009, through September 30, 2009

The payment rates for several HCPCS codes were incorrect in the July 1, 2009 ASC DRUG file. The corrected payment rates are listed below. Suppliers who think they may have received an incorrect payment between July 1, 2009, and September 30, 2009, may voluntarily submit those claims to their contractors for reprocessing.

HCPCS Code	Short Descriptor	Status Indicator	Corrected Payment Rate
90585	Bcg vaccine, percut	K2	$115.47
C9359	Implnt,bon void filler-putty	K2	$65.21
J9031	Bcg live intravesical vac	K2	$114.73
J9211	Idarubicin hcl injection	K2	$126.12
J9265	Paclitaxel injection	K2	$7.62
J9293	Mitoxantrone hydrochl / 5 MG	K2	$66.26
Q0179	Ondansetron hcl 8 mg oral	K2	$7.91

Correct reporting of drugs

CR 6629 also provides reminders about the correct reporting of drugs and biologicals when used as implantable devices and the correct reporting of units for drugs.

Additional information

If you have questions, please contact your Medicare MAC or 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 6629) issued to your Medicare MAC and/or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1806CP.pdf* on the CMS Web site.

October 2009 update to the ASC payment system (continued)

MLN Matters® Number: MM6629
Related Change Request (CR) #: 6629
Related CR Release Date: August 28, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R1806CP
Implementation Date: October 5, 2009

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October 2009 update to the ASC payment system -- HCPCS code Q4115

Change request (CR) 6629 updates the ambulatory surgical center (ASC) payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals.

One of the key points of this change request includes that for dates of service beginning October 1, 2009, HCPCS code Q4115 (skin substitute, alloskin, per square centimeter) is eligible for separate payment under the ASC payment system when it is provided integral to a covered surgical procedure.

Note: HCPCS code Q4115 is listed as noncovered in FCSO's local coverage determination (LCD) (L29279 for Florida and L29393 for Puerto Rico/U.S. Virgin Islands), and therefore will not be covered by FCSO. FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Source: Change request 6629

Ambulatory surgical centers payment indicator file error and reiteration of beneficiary liability policy

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 or Medicare administrative contractors (MAC) for providing intraocular lens replacement services in ambulatory surgical centers (ASC).

What you need to know

Change request (CR) 6630, from which this article is taken, corrects the ASC payment indicator (ASCPI) file payment indicator assigned to Healthcare Common Procedure Coding System (HCPCS) codes V2787 (Astigmatism correcting function of intraocular lens) and HCPCS V2788 (Presbyopia correcting function of intraocular lens). It notifies your carrier or MAC that the correct payment indicator ("Y5") previously assigned to these codes is incorrect and instructs them to download files containing the corrected payment indicator ("E5")

You should make sure that your billing staffs are aware of this correction, and that your carrier or MAC will search for, and adjust, affected claims with dates of service on/or after January 1, 2009. Please see the *Background* section for more information.

Background

This article alerts carriers and MACs that the payment indicator ("Y5") assigned to HCPCS V2787 (Astigmatism correcting function of intraocular lens) and HCPCS V2788 (Presbyopia correcting function of intraocular lens) in earlier CRs (CR 6184 issued on October 17, 2008; CR 6424 issued on March 13, 2009; and CR 6496 issued on May 22, 2009) was incorrect and results in incorrect beneficiary liability assignment and messaging on Medicare summary notices (MSNs). CR 6630 notifies the carriers and MACs that the corrected payment indicator assigned to these codes is "E5".

Your carrier or MAC will install replacement ASCPI files for January, 2009, April 2009, and July 2009 (which have been corrected to reflect payment indicator of "E5" for both V2787 and V2788). They will search for, and adjust, affected claims to trigger the correct beneficiary liability message for codes V2787 and V2788 for dates of service on or after January 1, 2009.

Additional information

You may find the official instruction, CR 6630, issued to your carrier or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R546OTN.pdf* on the CMS Web site

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

MLN Matters® Number: MM6630
Related Change Request (CR) #: 6630
Related CR Release Date: August 28, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R546OTN
Implementation Date: September 29, 2009

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Consolidated Billing

2010 annual update to the skilled nursing facility consolidated billing

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, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

This article is based on change request (CR) 6619 which provides the 2010 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (SNF CB) that will be used in Medicare claim processing systems. Be sure billing staff are aware of these updates.

Background

Medicare's claim processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. These edits only allow services that are excluded from SNF CB to be separately paid by Medicare contractors. The related policy is contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6) which is available at *http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf* on the Centers for Medicare & Medicaid Services (CMS) Web site.

Physicians and providers are advised that, by the first week in December 2009, new code files will be posted at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS Web site.

Institutional providers should note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* on the CMS Web site in order to understand the major categories including additional exclusions not driven by HCPCS codes.

Additional information

You may find information related to SNFs and Medicare on the CMS SNF center at *http://www.cms.hhs.gov/center/snf.asp* on the CMS Web site.

The official instruction, CR 6619, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1814CP.pdf* on the CMS Web site. If you have any questions, please contact your carrier, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

MLN Matters® Number: MM6619
Related Change Request (CR) #: 6619
Related CR Release Date: September 4, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1814CP
Implementation Date: January 4, 2010

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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.

Drugs and Biologicals

Medicare fee-for-services billing for the administration of the influenza A virus vaccine

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

Provider types affected

Physicians, providers, and suppliers administering the influenza A (H1N1) vaccine to Medicare patients are affected by this article.

Provider action needed

This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine. All providers administering this vaccine should review this article and be sure that their billing staffs are aware of this information.

Background

Medicare Part B provides coverage for the seasonal influenza virus vaccine and its administration as part of its preventive immunization services. The Part B deductible and coinsurance do not apply for the seasonal influenza virus vaccine and its administration. Typically, the seasonal influenza vaccine is administered once a year in the fall or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when deemed to be a medical necessity. The H1N) virus has been identified as an additional type of influenza. The H1N1 virus vaccine will be provided to Medicare Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the administration of the H1N1 vaccine.

The Centers for Medicare & Medicaid Services (CMS) has created two new HCPCS codes for H1N1, effective for dates of service on and after September 1, 2009:

G9141 Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)
G9142 Influenza A (H1N1) vaccine, any route of administration

Payment for G9141 (Influenza A (H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis V04.81 (influenza), and, depending on the provider type, using revenue code 771. The same billing rules apply to the H1N1 virus vaccine as the seasonal influenza virus vaccine with one exception. Since the H1N1 vaccine will be made available at no cost to providers, Medicare will not pay providers for the vaccine. Providers do not need to place the G9142 (HIN1 vaccine code) on the claim. However, if the G9142 appears on the claim, only the claim line will be denied.

Payment will not be made to providers for office visits when the only purpose of the visit is to administer either the seasonal and/or the H1N1 vaccine(s).

Providers who normally participate in the Medicare Part B program as mass immunizer roster billers and mass immunizer centralized billers may submit H1N1 administration claims using the roster billing format. The same information must be captured for the H1N1 roster claims as it is for the seasonal influenza roster claims. The roster must contain, at a minimum, the following information:

- Provider name and number
- Date of service
- Control number for Medicare contractor
- Patient's health insurance claim number
- Patient's name
- Patient's address
- Date of birth
- Patient's sex
- Beneficiary's signature or stamped "signature on file"

For this upcoming flu season, Medicare will reimburse Medicare beneficiaries, up to the fee schedule amount, for the administration of H1N1 influenza vaccine when furnished by a provider not enrolled in Medicare. Beneficiaries must submit a CMS-1490S to their local Medicare contractor. Medicare will reimburse beneficiaries for the administration of the H1N1 vaccine, but not the H1N1 vaccine itself because the H1N1 vaccine will be furnished at no cost to all providers. Medicare beneficiaries may not be charged any amount for the H1N1 vaccine itself.

Finally, Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. We understand that such preparations are critical for the upcoming flu season, especially in planning for the influenza A [H1N1] vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e. the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claim processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A [H1N1] vaccination, then Medicare will pay for both.

Medicare fee-for-services billing for the administration of the influenza A virus vaccine (continued)

However, as noted earlier, please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

Additional information

If you have any questions, please contact your FI, 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.

You may also want to review the following *MLN Matters*® articles:

MM6626 (October 2009 Update of the Hospital Outpatient Prospective Payment System [OPPS])
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6626.pdf

MM6617 (October Update to the 2009 Medicare Physician Fee Schedule Database [MPFSDB])
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6617.pdf on the CMS Web site.

MLN Matters® Number: SE0920
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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Coverage and reimbursement rules for the H1N1 vaccine and seasonal flu

A new special edition *MLN Matters*® article regarding billing for the administration of the influenza A (H1N1) vaccine is now available. This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine and also addresses seasonal flu coverage and reimbursement.

Note that Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. The Centers for Medicare & Medicaid Services understands that such preparations are critical for the upcoming flu season, especially in planning for the influenza A (H1N1) vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e., the number of doses of a vaccine, and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claim processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims, and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A (H1N1) vaccination, then Medicare will pay for both.

Please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

All providers administering flu vaccine should review this article and be sure that their billing staffs are aware of this information. For more information, please read the article located at
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0920.pdf.

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

Source: PERL 200909-03

October 2009 average sales price files are now available

The Centers for Medicare & Medicaid Services (CMS) has posted the October 2009 average sales price (ASP) files and crosswalks, which are available for download at
http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2009aspfiles.asp.

Source: PERL 200909-24

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

October 2009 quarterly HCPCS update

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

Provider types affected

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

Provider action needed

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

Background

The HCPCS code set is updated on a quarterly basis. This article describes updates for specific HCPCS codes and the October 2009, update has only one new code payable for Medicare. Effective for claims with dates of service on or after October 1, 2009, the following HCPCS code will be payable for Medicare:

HCPCS Code Q2024
Short description: Bevacizumab injection
Long description: Injection, bevacizumab, 0.25 mg
Type of service code: 1or P
Medicare physician fee schedule database status indicator: E

There are no deletions of HCPCS codes effective for October 1, 2009.

Additional Information

If you have questions, please contact your Medicare carrier, FI, DME MAC and/or MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site. The official instruction, change request (CR) 6594, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1805CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6594
Related Change Request (CR) #: 6594
Related CR Release Date: August 28, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R1805CP
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.

Note: This article was revised on September 2, 2009, to reflect the revised change request (CR) 6528, issued by the Centers for Medicare & Medicaid Services on September 1, 2009. The CR release date, transmittal number, implementation date, and the Web address for accessing CR 6528 have been changed. All other information remains the same. This information was previously published in the August 2009 *Medicare B Update!* pages 9-10.

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 are advised of these billing and compliance standards.

Background

This article is based on 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/R300PI.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:

- 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/R300PI.pdf* on the CMS Web site.

MLN Matters® Number: MM6528 *Revised*
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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Evaluation and Management

Value of family history under the initial preventive physical exam benefit

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 and providers who submit claims to Medicare carriers and/or Medicare administrative contractors (A/B MACs) for the one-time initial preventive physical exam (IPPE) provided to Medicare beneficiaries within the first 12 months that an individual is enrolled in Part B.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) wants to remind providers that the IPPE visit includes a number of important required prevention-related elements, such as (among other things):

1. A review of the individual's family health history; and
2. Education, counseling, and referral of the individual for other Medicare covered screenings and preventive services. A convenient tri-fold brochure explaining the expanded benefits of the IPPE is available at *http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf* on the CMS Web site.

Background

An individual's family history may be helpful to the physician or other clinician performing the IPPE visit in determining whether an individual is at risk for various forms of cancer and other medical problems. At present, a Medicare beneficiary may qualify for the following covered preventive services based on the individual's family history:

- A one-time ultrasound screening for abdominal aortic aneurysm (AAA) for an asymptomatic individual, but only if referred by a doctor of medicine or osteopathy or a qualified nonphysician practitioner (a physician assistant, nurse practitioner, or clinical nurse specialist) as a result of the IPPE visit.
- A colonoscopy screening every two years for an asymptomatic individual considered at high risk for colorectal cancer because he or she has:
  - A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp
  - A family history of familial adenomatous polyps, or
  - A family history of hereditary nonpolyposis.
- An annual glaucoma screening examination for an asymptomatic individual, including:
  - A dilated eye examination with an intraocular pressure measurement, and
  - A direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination.
- One diabetes screening test (fasting blood glucose test or post-glucose challenge tests) per calendar year for an individual who has been previously tested, but not diagnosed with pre-diabetes, or who has never been tested before, after referral from a physician or qualified nonphysician practitioner, if the individual has a family history of diabetes and is also 65 years of age or older, is overweight, or meets at least one other risk factor for coverage as described in the applicable Medicare guidelines.
- Two diabetes screening tests per calendar year for an individual who has been diagnosed with pre-diabetes, after referral from a physician or qualified nonphysician practitioner, if the individual has a family history of diabetes and is also either 65 years of age or older or is overweight or meets at least one other risk factors for coverage as described in the applicable Medicare guidelines.

Additional information

If you have questions, please contact your Medicare carrier and/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.

Extensive information on the IPPE is available at *http://www.cms.hhs.gov/WelcometoMedicareExam/02_Provider%20Resources.asp* on the CMS Web site.

MLN Matters® Number: SE0918
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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Clarification of visit requirements under the ESRD monthly capitation payment

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

Provider types affected

Physicians and other practitioners who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MAC]) for providing outpatient end-stage renal disease (ESRD) services to Medicare beneficiaries.

Provider action needed

Stop -- impact to you

This special edition article clarifies visit requirements under the ESRD monthly capitation payment (MCP).

Caution -- what you need to know

Once a patient is on dialysis, the MCP physician (or practitioner) must furnish at least one face-to-face visit per month to the beneficiary in his/her office, outpatient hospital, or other outpatient setting, which can include the patient's home as well as in the dialysis facility. The MCP physician (or practitioner) is not required to furnish the visit while the patient is dialyzing.

Go -- what you need to do

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

Background

The Centers for Medicare & Medicaid Services (CMS) is providing this special edition article to clarify visit requirements under the ESRD MCP as described in change request (CR) 5931 "Manualization of Payment for Outpatient End Stage Renal Related (ESRD) Services." An *MLN Matters*® article related to CR 5931 is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5931.pdf* on the CMS Web site.

Once the ESRD beneficiary is on dialysis, the MCP physician (or practitioner) must furnish at least one face-to-face visit per month to the beneficiary. MCP visits may be furnished in a physician's office, outpatient hospital or other outpatient setting including the patient's home as well as in the dialysis facility. The MCP physician (or practitioner) is not required to furnish the visit while the patient is dialyzing.

For example, a comprehensive monthly visit could be furnished in a physician's office; at a different time than the beneficiary's dialysis session.

Additional information

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: SE0921
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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Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is most convenient for you. It's the next best thing to being there – to learn how now, visit *http://medicare.fcso.com/Online_learning/151240.asp*.

Laboratory/Pathology

New waived tests

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

Provider types affected

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

Provider action needed

This article, based on change request (CR) 6570, alerts clinical laboratories and providers that the Centers for Medicare & Medicaid Services (CMS) has listed the latest tests approved by the Food and Drug Administration (FDA) as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The tests newly added to the waived tests are in the table in the *Background* section of this article. Be sure your billing staffs are aware of these changes.

Background

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

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The *Current Procedural Terminology* (*CPT*) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attachment to CR 6570 at *http://www.cms.hhs.gov/Transmittals/downloads/R1799CP.pdf* on the CMS Web site (i.e., *CPT* codes: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*) do not require a QW modifier to be recognized as a waived test.

CPT Code	Effective Date	Description
*82274*QW G0328QW	December 4, 2008	Jant pharmacal accutest immunological fecal occult blood test (iFOBT)
*84703*QW	January 26, 2009	Siemens clinitek status urine chemistry analyzer
82962, *82465*QW	January 29, 2009	Roche Diagnostics Accutrend Plus System {fingerstick whole blood}
*82274*QW G0328QW	March 5, 2009	Henry schein one step+ iFOBT
*81003*QW, *82044*QW, *82570*QW	March 5, 2009	Siemens clinitek status urine chemistry analyzer
*87804*QW	March 10, 2009	Earlydetect Pro Influenza A test
*87804*QW	March 10, 2009	Earlydetect Pro Influenza B Test
*83986*QW	March 16, 2009	Lil' drug store products inc. Vagi-screen vaginal health test
*86308*QW	April 14, 2009	Acceava mono II {whole blood}
*80101*QW	April 30, 2009	1 Step detect associates DTX drug test cup integrated E-Z split key cup II
*87880*QW	May 21, 2009	Inverness medical signify strep A cassette (Inverness medical innovations)
*86318*QW	May 21, 2009	Inverness medical signify h. pylori whole blood
*86318*QW	May 21, 2009	Earlydetect H. pylori whole blood rapid test

In addition, the *CPT* code assigned to the hemoCue albumin 201 system has been changed from *83520*QW to *82043*QW, with an effective date of October 1, 2009. Medicare contractors will deny the use of code *83520*QW submitted by facilities with a valid, current CLIA certificate of waiver for dates of service on or after October 1, 2009

Please note that your Medicare contractor will not search their files to either retract payment or retroactively pay claims processed before CR 6570 is implemented. However, they will adjust claims that you bring to their attention.

New waived tests (continued)

Additional information

You may find the official instruction, CR 6570, issued to your carrier or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1799CP.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6570
Related Change Request (CR) #: 6570
Related CR Release Date: August 21, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R1799CP
Implementation Date: October 5, 2009

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Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology. CPT* codes, descriptions and other data only are copyrighted 2008 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.

Medicare Physician Fee Schedule Database

October update to the 2009 Medicare physician fee schedule database

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6617 which amends payment files that were issued to contractors based upon the 2009 MPFS final rule. Billing staff should be aware of these updates.

Background

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

The key change in CR 6617 is the assignment of H1N1 vaccine and administration level II Healthcare Common Procedure Coding System (HCPCS) codes. In anticipation of the availability of a vaccine for the H1N1 virus in the fall of 2009, the Centers for Medicare & Medicaid Services (CMS) is creating two new Level II HCPCS codes that are effective September 1, 2009. Similar to the influenza vaccine and its administration, one HCPCS code has been created to describe the H1N1 vaccine itself (G9142, Influenza A (H1N1) vaccine, any route of administration), while another HCPCS code has been created to describe the administration of the H1N1 vaccine (G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family). More information on the H1N1 flu and the associated vaccine may be found at the Centers for Disease Control and Prevention Web site at *http://www.cdc.gov/h1n1flu/* on the Internet.

Under the MPFS, HCPCS codes G9141 and G9142 will be assigned status indicator "X," indicating these codes represent an item or service that is not within the statutory definition of "physicians' services" for MPFS payment purposes. CMS anticipates the H1N1 vaccine will be supplied at no cost to providers. Payment will be made to a provider for the administration of the H1N1 vaccine, even if the vaccine is supplied at no cost to the provider. Payment for the administration of the H1N1 vaccine is the same as the payment established for G0008 and G0009, codes used for reporting the administration of the influenza or pneumococcal vaccine. Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine. Beneficiary copayment and deductible do not apply to HCPCS code G9141.

CR 6617 also clarifies transmittal 1691, CR 6397, dated March 4, 2009, and transmittal 1748, CR 6484, dated May 29, 2009, which included PE RVUs for *CPT* code *93351* (26). Transmittal 1748 noted that this service is typically not paid under the Medicare physician fee schedule when provided in a facility setting and the PE RVUs noted were informational only. CMS is clarifying that *CPT* code *93351* (26) is payable when performed by a physician in a facility setting.

Specific changes included in the October Update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6617. That CR is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1810CP.pdf* on the CMS Web site. Key changes, however, are summarized as follows:

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

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

CPT/HCPCS	Action
38999	Assistant at surgery indicator: 0
55899	Assistant at surgery indicator: 0
69200	Bilateral indicator: 1
93503	Transitional facility PE RVU: 0.75 Fully implemented facility PE RVU: 0.77

The following change is effective for dates of service on and after October 1, 2009:

CPT/HCPCS	Action
Q2024	Long descriptor: Injection, bevacizumab, 0.25 mg Short descriptor: Bevacizumab injection Procedure status: E

Additional information

The official instruction, CR 6617, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1810CP.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.

Fee revisions

The following fees represent payment files issued to contractors as a result of 2009 Medicare physician fee schedule (MPFS) final rule.

Florida fee revision

	Participating			Nonparticipating			Limiting Charge		
Code	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99	Loc 03	Loc 04	Loc 99
93503	148.72	156.71	142.79	141.28	148.87	135.65	162.48	171.21	156.00

U.S. Virgin Islands fee revision

Code	Participating	Nonparticipating	Limiting Charge
93503	138.69	131.76	151.52

MLN Matters® Number: MM6617
Related Change Request (CR) #: 6617
Related CR Release Date: September 1, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R1810CP
Implementation Date: October 5, 2009

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Radiology

Screening computed tomography colonography for colorectal cancer

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 [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for colorectal cancer screening services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6578 which instructs that the Centers for Medicare & Medicaid Services (CMS) has determined that current evidence is inadequate to conclude that computed tomography colonography (CTC) is an appropriate colorectal cancer screening test under section 1861(pp)(1) of the Social Security Act (the Act). Therefore, effective May 12, 2009, CTC for colorectal cancer screening, also known as virtual colonoscopy, remains nationally noncovered by Medicare. Medicare contractors will continue to process claims for CTC for colorectal cancer screening without change.

Background

Medicare covers colorectal cancer screening for average-risk individuals age 50 and older using:

- Fecal occult blood testing
- Sigmoidoscopy
- Colonoscopy, and
- Barium enema.

On March 5, 2008, the American Cancer Society, the US Multi Society Task Force on Colorectal Cancer, and the American College of Radiology issued new cancer screening guidelines, including a recommendation that CTC be considered an acceptable option for colorectal cancer screening for such individuals. CTC (also referred to as virtual colonoscopy) uses computed tomography (CT) to acquire images and advanced 2-dimensional (2D) or 3-dimensional (3D) image display techniques for interpretation.

Neither Medicare law nor regulations identify the CTC test as a possible coverage option under the colorectal cancer screening benefit. However, under 42 CFR 410.37(a)(1) [see *http://www.gpoaccess.gov/CFR/retrieve.html*], CMS is allowed to use the national coverage determination (NCD) process to determine coverage of other types of colorectal cancer screening tests that are not specifically identified in law or regulations as it determines to be appropriate, in consultation with appropriate organizations.

Following a thorough review of the evidence, meetings with medical professional organizations, and conducting a Medicare Evidence Development and Coverage Advisory Committee Meeting, CMS has determined that the current evidence is inadequate to conclude that CTC is an appropriate colorectal cancer screening test under the Act (section 1861(pp)(1); see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet).

Additional information

The official instruction, CR 6578, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R105NCD.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.

Providers may also be interested in the *Medicare Learning Network* brochure on cancer screenings that is available for download at *http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf* on the CMS Web site.

MLN Matters® Number: MM6578
Related Change Request (CR) #: 6578
Related CR Release Date: August 7, 2009
Effective Date: May 12, 2009
Related CR Transmittal #: R105NCD
Implementation Date: September 8, 2009

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Surgery

Surgery for diabetes national coverage determination

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

Note: This article was revised on August 21, 2009, to show the correct group code of "CO" (Contractual Obligation) at the end of the *Background* section. All other information remains the same. This information was previously published in the April 2009 *Medicare B Update!* pages 6-7.

Provider types affected

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

Provider action needed

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

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

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

Background

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

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

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

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

Additional information

The official instruction, CR 6419, issued to your carrier, FI, or MAC via two transmittals. The first transmittal modifies the *Medicare Claims Processing Manual* and it is at *http://www.cms.hhs.gov/Transmittals/downloads/R1728CP.pdf* on the CMS Web site. The second transmittal modifies the *NCD Manual* and it is available at *http://www.cms.hhs.gov/Transmittals/downloads/R100NCD.pdf* on the CMS Web site.

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

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

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Correct billing for facet joint injection services

The Centers for Medicare & Medicaid Services (CMS) recently released *MLN Matters* article MM6518, which provides information concerning the appropriate use of modifier 50 and add-on *Current Procedural Terminology* codes (*CPT*) for facet joint injection services. The Office of the Inspector General (OIG) recently conducted a medical record review of facet joint injection services performed in 2006 and found that physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50.

It has come to our attention that confusion remains regarding correct physician billing for these services. The examples below illustrate incorrect and correct billing for bilateral facet joint injections at the C7, T1, and T2 vertebrae. Note that both the initial and add-on codes should be billed with modifier 50.

Correct example

CPT code	Modifier
64470	*50*
64472	*50*
64472	*50*

Incorrect example

CPT code	Modifier
64470	*50*
64472	
64472	
64472	
64472	

Billing using the method shown in the incorrect example above will result in an overpayment to the physician. Billing in this manner intentionally may be considered fraudulent billing.

Note: This information applies only to physician billing; it does not apply to facility billing.

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Source: Change request 6518

General Coverage

Billing correctly for the professional component with modifier 26

First Coast Service Options Inc. (FCSO) has noticed an excessive amount of providers billing incorrectly for the professional component by submitting modifier PC with the *CPT*/HCPCS code in question versus using correct modifier 26. The definitions of these modifiers are as follows:

Modifier 26: Professional component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Modifier PC: Wrong surgery on patient

Modifier PC is used by hospital outpatient departments, ambulatory surgical centers and other practitioners and it must be appended to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009. In addition, all claims identified with modifier PC with date of services on or after January 15, 2009 will be denied. Furthermore, Medicare will also not cover hospitalizations and other services related to the noncovered surgery as defined in the *Medicare Benefit Policy Manual*.

For more information on modifier PC as it relates to wrong surgery on a patient, refer to the *MLN Matters*® article MM6405 included in the July 2009 *Medicare B Update!* (pages 28-30).

Action required by providers

- Providers must ensure that when billing for the professional component of a procedure, the service must be properly identified by adding modifier *26* to the appropriate *CPT*/HCPCS code. This action will eliminate unnecessary delays and/or denial of the professional component procedure and claims for related services.
- Providers whose claim(s) were billed in error with modifier PC and have been denied for wrong surgery must request an appeal. Your appeal request will also alert Medicare to remove edit logic that was installed for the beneficiary and date of service of the wrong surgery (based on the initial claim).
- Do not correct and resubmit the claim. Until Medicare has removed the edit logic, all claims for the beneficiary with a date of service of the wrong surgery will continue to deny.

Source: Change request 6405

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Medicare Parts A and B coverage and prior authorization

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

Provider types affected

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

Provider action needed

This article is based on the Social Security Act and other laws which describe covered and noncovered items and services and their payment under Part A and Part B. Originally, the Social Security Act did not authorize any form of "prior authorization" for Medicare services. The law was subsequently changed to allow prior authorization of limited items of durable medical equipment and physicians' services. Currently, Medicare does not pre-authorize coverage of any item or service that will receive payment under Part A or B, except for custom wheelchairs. Please advise all staff and inform your Medicare patients, as appropriate, that Medicare does not currently pre-authorize coverage for any item or service other than custom wheelchairs.

Background

The overall scope of allowable benefits under the Medicare program is prescribed by law. When Medicare was established, Congress included certain provisions on the broad categories of items and services that may be covered under the Medicare program as well as provisions on certain items and services that were to be excluded from coverage. Congress also included in Section 1862(a)(1)(A) of the Social Security Act the following provision:

"Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which…are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,…"

This clause has become known as the "reasonable and necessary" provision. Medicare coverage and payment for items and services is therefore contingent upon a determination that an item and service:

- Falls within a benefit category
- Is not specifically excluded from coverage, and
- The item or service is "reasonable and necessary" unless specifically excluded from meeting this provision.

Also, as prescribed by law, the Centers for Medicare & Medicaid Services (CMS) develops national coverage determinations (NCDs), which are national policy statements granting, limiting, or excluding Medicare coverage for a particular item or service. NCDs may be found in the *Medicare National Coverage Determinations Manual* (Publication #100-03) at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site.

For those items or services whose coverage is not determined in law, regulation or NCD, the local Medicare contractors are authorized to develop local coverage determinations (LCDs) to further determine coverage of items and services covered by Medicare. LCDs specify under what conditions an item or service is considered to be "reasonable and necessary". Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, including comments from the provider community. LCDs may be found on the CMS coverage Web page and your local contractor's Web site.

If a provider believes that a Medicare NCD or LCD needs to be revised, they should request CMS or its contractors to reconsider the existing NCD or LCD. What factors CMS considers when deciding to open or reopen an NCD may be found at *https://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=6* on the CMS Web site. To request a new LCD or an LCD reconsideration, the provider should contact the local Medicare contractor.

In regard to prior authorization under fee-for-service Medicare, providers should be aware that section 1834(a)(15)(c) of the Social Security Act allows for an advance determination of Medicare coverage (ADMC) for certain items of durable medical equipment (DME). The only items of DME currently subject to this provision are custom wheelchairs. Also, Section 938 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173) required the Secretary to establish a "Prior Determination" process for a limited number of physicians' services under Medicare. Implementation of this provision is pending. It should also be noted that Medicare Part C & Part D programs are authorized to have and may require prior authorizations for services billed to them.

Additional information

The Social Security Act Amendments of 1965, Section 1862 (a)(1)(A) may be viewed at *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Social Security Web site.

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

MLN Matters® Number: SE0916
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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Items or services furnished to Medicare beneficiaries in state or local custody

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, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and/or A/B MACs) for services provided to individuals or groups of individuals who are in "custody" under a penal statute or rule.

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6544, which describes special conditions that must be met in order for Medicare to make payment for services provided to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute or rule.

Caution -- what you need to know

CR 6544 instructs Medicare contractors that "payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: state or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and the state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Go -- what you need to do

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

Background

Under the Social Security Act (Section 1862(a)(2); see *http://www.ssa.gov/OP_Home/ssact/title18/1862.htm* on the Internet), the Medicare program does not pay for services if:

- The beneficiary has no legal obligation to pay for the services, and
- No other person or organization has a legal obligation to provide or pay for that service.

In addition, under the Social Security Act (Section 1862(a)(3)), if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services.

In the fiscal year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule published in the *Federal Register*, Volume 72, Number 162 (72 FR 47409 and 47410 – August 22, 2007; see *http://edocket.access.gpo.gov/2007/07-3820.htm* on the Internet), the Centers for Medicare & Medicaid Services (CMS) clarified the regulations at 42 CFR Section 411.4(b) (See *http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr411.4.htm* on the Internet) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are:

- Under arrest
- Incarcerated
- Imprisoned
- Escaped from confinement
- Under supervised release
- On medical furlough
- Required to reside in mental health facilities
- Required to reside in halfway houses
- Required to live under home detention, or
- Confined completely or partially in any way under a penal statute or rule.

The *Medicare Claims Processing Manual*, Chapter 1, Section 10.4 describes the special conditions that must be met in order for Medicare to make payment for individuals who are in custody as follows:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and
2. The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Providers and suppliers are reminded that if they render services or items to a prisoner or patient in a jurisdiction that meets these conditions of 42 CFR 411.4(b), they are to include modifier QJ on claims submitted to carriers, A/B MACs, or DME MACs or use condition code 63 on institutional claims sent to Medicare FIs or A/B MACs.

CR 6544 also amends the *Medicare Benefit Policy Manual* (Chapter 16, Section 50.3.3) and the *Medicare Claims Processing Manual* (Chapter 1, Section 10.4) in order to be consistent with 42 CFR Section 411.4(b). These revisions are included as attachments to CR 6544.

Additional information

There are two transmittals associated with the official instruction, CR 6544, issued to your carrier, FI, and A/B MAC regarding this change. The first transmittal amends the *Medicare Claims Processing Manual* and it may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1812CP.pdf* on the CMS Web site. The second transmittal amends the *Medicare Benefit Policy Manual* and it may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R110BP.pdf* on the CMS Web site.

If you have any questions, please contact your carrier, DME MAC, 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.

Items or services furnished to Medicare beneficiaries in state or local custody (continued)

MLN Matters® Number: MM6544
Related Change Request (CR) #: 6544
Related CR Release Date: September 4, 2009
Effective Date: December 7, 2009
Related CR Transmittal #: R1812CP and R110BP
Implementation Date: December 7, 2009

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

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

Note: This article was revised on September 14, 2009, to provide further clarification of what will happen during the two phases of implementing this change. This information was previously published in the July 2009 *Medicare B Update!* pages 31-32.

Provider types affected

Physicians, nonphysician practitioners, and other Part B providers and suppliers submitting claims to carriers or Part B Medicare administrative contractors (MACs) for items or services that were ordered or referred. (A separate article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to change request (CR) 6421. That article is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6421.pdf* on the CMS Web site.)

Provider action needed

This article is based on CR 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and nonphysician practitioners who are eligible to order/refer such services. Physician and nonphysician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty who are eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

Background

CMS is expanding claim editing to meet the Social Security Act requirements for ordering and referring providers. Section 1833(q) of the Social Security Act requires that all ordering and referring physicians and nonphysician practitioners meet the definitions at section 1861(r) and 1842(b)(18)(C) and be uniquely identified in all claims for items and services that are the results of orders or referrals. Effective January 1, 1992, a provider or supplier who bills Medicare for an item or service that was ordered or referred must show the name and unique identifier of the ordering/referring provider on the claim.

The providers who can order/refer are:

- Doctor of medicine or osteopathy
- Dental medicine
- Dental surgery
- Podiatric medicine
- Optometry
- Chiropractic medicine
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

Claims that are the result of an order or a referral must contain the national provider identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

Key points

- During Phase 1 (October 5, 2009-January 3, 2010): If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. If the ordering/referring provider is not in PECOS the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and the Part B provider or supplier will receive a warning message on the remittance advice. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the remittance advice.
- During Phase 2, (January 4, 2010, and thereafter): If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected (returned as unprocessable). If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring

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

provider is in PECOS and eligible to order and refer. If the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected (returned as unprocessable). If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected (returned as unprocessable).

- In both phases, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do* on the CMS Web site. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp* on the CMS Web site. Once at that site, scroll to the *Downloads* section of that page and click on the materials that apply to you and your practice.

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

Additional information

You may find the official instruction, CR 6417, issued to your carrier or B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R510OTN.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6417 *Revised*
Related Change Request (CR) #: 6417
Related CR Release Date: June 26, 2009
Effective Dates: Phase 1: October 1, 2009
Phase 2: January 1, 2010
Related CR Transmittal #: R510OTN
Implementation Dates: Phase 1: October 5, 2009
Phase 2: January 4, 2010

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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

Claim status category code and claim status code update

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 submitting claims to Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, A/B Medicare administrative contractors (MAC) and durable medical equipment MACs (DME MACs) for Medicare beneficiaries are affected.

Provider action needed

This article, based on change request (CR) 6609, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 were updated during the June 2009 meeting of the national code maintenance committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on the Internet on or about June 30, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status codes and claim status category codes approved by the national code maintenance committee in the X12 276/277 health claim status request and response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

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

The official instruction, CR 6609, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1797CP.pdf* on the CMS Web site.

MLN Matters® Number: MM6609
Related Change Request (CR) #: 6609
Related CR Release Date: August 14, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R1797CP
Implementation Date: October 5, 2009

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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.*

Provider Enrollment

Announcing the release of the revised CMS-855 Medicare enrollment applications

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

Provider types affected

This article is for all Medicare physicians, nonphysician practitioners, and other suppliers (excluding suppliers of durable medical equipment, prosthetics, orthotics, and supplies).

Background

Based on the publication of the final rule with comment titled, "Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; Revisions to the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions; and the Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-1403-FC/CMS-1270-F2," the Centers for Medicare & Medicaid Services (CMS) issued revised Medicare enrollment applications for physicians, nonphysician practitioners and other suppliers (except DMEPOS suppliers) using the CMS-855B and/or the CMS-855I to enroll or make a change in their enrollment information.

While Medicare contractors will continue to accept the 02/2008 version of the Medicare enrollment application through November 30, 2009, physicians, nonphysician practitioners, and other suppliers should begin to use the new Medicare enrollment applications (i.e., "(02/2008) (EF 07/2009)") immediately. Initially, these applications will be available only from the CMS provider enrollment Web site. The link for that CMS Web site is listed in the Additional information section of this article. In the coming weeks, these forms will also be available from the Medicare carriers and A/B Medicare administrative contractors (MACs).

Key points

This special edition outlines the significant revisions to the Medicare CMS-855B and CMS-855I enrollment applications and they are as follows:

Application-specific changes for physicians and nonphysician practitioners (CMS-855I)

- Incorporated conforming regulatory changes throughout the application
- Added speech language pathologist to pages 1 and 9
- Changed the term "adverse legal action" to "final adverse action" throughout the document
- Removed the reference to the Healthcare Integrity and Protection Data Bank from page 12
- Clarified that a "individual (type 1) NPI" should be provided on page 4
- Revised and clarified #2 on the certification statement (page 25)
- Added the phrase "(blue preferred)" after "All signatures must be original and signed in ink" on page 26

Application-specific changes for clinics/group practices and certain other suppliers (CMS-855B)

- Incorporated conforming regulatory changes throughout the application
- Removed "Slide Preparation Facility" from pages 1 and 9
- Removed "Public Health/Welfare Agency" from page 9
- Removed the sentence "If you are a single specialty clinic/group practice, the specialty must be reported" from page 9
- Changed the term "adverse legal action" to "final adverse action" throughout the document
- Removed the reference to the Healthcare Integrity and Protection Data Bank from page 11
- Revised and clarified #1 on the certification statement (page 30), and
- Added the phrase "(blue preferred)" after "All signatures must be original and signed in ink" on pages 31, 32, 33, and 46.

In addition, and consistent with CMS' change request 6499, the supporting documentation sections of the CMS-855I and CMS-855B applications have been revised to limit the amount of supporting documentation required when submitting the Medicare enrollment application.

Announcing the release of the revised CMS-855 Medicare enrollment applications (continued)

Additional information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or A/B MAC serving your area, visit the CMS provider enrollment Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on the CMS Web site.

Also, special edition article SE0612 contains helpful information about the Medicare enrollment process. You may review the article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf* on the CMS site.

MLN Matters® Number: SE0924
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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Enhancements and updates to the national plan and provider enumeration system

On September 13, 2009, the national plan and provider enumeration system (NPPES) underwent system maintenance. As such, neither NPPES nor the national provider identifier (NPI) registry was available on September 13, 2009.

Upon successful login, the following security enhancements have been incorporated into NPPES:

- NPPES Web users will be prompted to select five secret questions and provide answers to those questions. These five secret questions and answers will be saved and used for verification in order to allow NPPES Web users to reset their own passwords.
- NPPES Web users will be required to wait 24 hours before attempting to change their passwords once they have already successfully reset their passwords.

Electronic file interchange

In addition, the electronic file interchange (EFI) user manual and technical companion guide have been revised. The upcoming changes will not impact the EFI XML schema.

Additional information

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

Not sure if you have already obtained an NPI or cannot remember your NPI, you may visit the NPI Registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do* to search for the information. The NPI Registry enables you to search for a provider's NPPES information, which includes the NPI. All information displayed in the NPI Registry is done so in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or legal name/legal business name. There is no charge to use the NPI Registry.

Visit the Centers for Medicare & Medicaid Services' dedicated NPI Web page at *http://www.cms.hhs.gov/NationalProvIdentStand* for additional NPI education and information.

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

Source: PERL 200909-16

General Information

Medicare fee-for-service emergency preparedness questions and answers

The Centers for Medicare & Medicaid Services (CMS) has updated the Medicare fee-for-service emergency preparedness questions and answers (Q&As). The emergency Q&As are posted in a document at *http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp*.

These Q&As include a section applicable to the H1N1 flu virus.

The document is dated to reflect the posting date. As additions and changes are made to the document, the download name will change to reflect the date. Please take note that these Q&As do not address the waiver situation requirements addressed in Title XVIII of the Social Security Act, Section 1135.

Source: PERL 200908-35

Influenza pandemic emergency -- the Medicare program prepares

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

Note: The Centers for Medicare & Medicaid Services rescinded this article on September 11, 2009. This information was previously published in the June 2009 *Medicare B Update!* page 23.

MLN Matters Number: SE0836 *Rescinded*
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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2009 Medicare contractor provider satisfaction survey results available

The results of the 2009 Medicare contractor provider satisfaction survey (MCPSS) are now available.

The MCPSS enables the Centers for Medicare & Medicaid Services (CMS) to gauge provider satisfaction with key services performed by the Medicare fee for-service (FFS) contractors that process and pay the more than $300 billion in Medicare claims each year.

Respondents rated their FFS contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The 2009 MCPSS marked the fourth annual administration of the survey.

The national average has remained relatively stable through each MCPSS administration. The 2009 national average was 4.54, compared to last year's national average of 4.51. The MCPSS was sent early this year to more than 32,000 randomly selected providers, including physicians, suppliers, health-care practitioners and institutional facilities that serve Medicare beneficiaries across the country.

As in 2008, provider inquiry measure was cited as the top indicator of satisfaction. For the fourth consecutive year this business function was cited as one of the key predictors of provider satisfaction. Claim processing remained a strong predictor of provider satisfaction as in the past three years.

The public reporting of the results over the last four years has increased awareness about the MCPSS. CMS has used the MCPSS to establish a uniform measure of provider satisfaction with FFS contractor performance.

Each FFS contractor receives an individual report of findings specific to their organization, which may be used to implement process improvement initiatives.

The results of the 2009 survey are available through the CMS and MCPSS Web pages at: *http://www.cms.hhs.gov/MCPSS/ and https://www.mcpsstudy.org/*.

Source: PERL 200909-23

Information on value-driven health care initiative on ambulatory surgery center

To support the delivery of high-quality, efficient health care and enable consumers to make more informed health care decisions, the U.S. Department of Health & Human Services is making cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2007 and 2008 about the payments it made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

The hospital information is posted on the Hospital Compare Web site where it may be viewed along with hospital quality information. The Hospital Compare Web site may be found at *http://www.medicare.gov*.

On August 28, 2009, Medicare posted an update to the ASC data. Hospital outpatient department and physician payment data will be updated later this year. The information is being displayed in the same format as in previous years, updated with calendar year 2008 data. The posting updates may be found at *http://www.cms.hhs.gov/HealthCareConInit/*.

Source: PERL 200908-42

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

2009 PQRI and electronic prescribing (e-Prescribing) program Web-based training course

The Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network* (*MLN*) is pleased to announce that the PQRI and e-Prescribing Web-based training course is now available.

The course provides information to physicians, health care professionals, and medical administrative staff on the completion, submission and maintenance of the documentation required to successfully participate in PQRI and e-Prescribing programs. The course offers continuing education credits; please see the course description page for the details.

The course may be accessed by going to *http://www.cms.hhs.gov/MLNGenInfo* and scrolling down to the Related Links Inside CMS section and selecting Web Based Training (WBT) Modules. Once on the Web-based training module page, select Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing Incentive Program (E-Prescribing) (September 2009).

MLN announces new and revised MLN articles on the 2009 PQRI

- ***New*** - MM6514 Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs
  http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6514.pdf
- ***Revised*** - SE0830 Steps for Individual Eligible Professionals to Access Their 2007 Physician Quality Reporting Initiative (PQRI) Feedback Reports Personally
  http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf
- ***Revised*** - SE0831 Steps for Organizations to Access Their 2007 Physician Quality Reporting Initiative (PQRI) Feedback Reports
  http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf

These new and revised articles are intended to assist eligible professionals and group practices who report PQRI quality measures data to Medicare.

Three PQRI help desk resources available for eligible professionals

Provider call center directory

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

For contact information, see the "Provider Center Toll-free Numbers Directory" by clicking the link under the Related Links Inside CMS section below and scrolling down to the Downloads section.

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

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

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

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

- General CMS PQRI & ERX information
- PQRI portal password issues
- PQRI feedback report availability and access

Phone: 1-866-288-8912

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

All publicly available information on the CMS e-Prescribing incentive program may be found at *http://www.cms.hhs.gov/ERxIncentive*.

Source: PERL 200909-26

September is Prostate Cancer 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 prostate cancer screenings.

Medicare provides annual coverage for digital rectal exams (DREs) and prostate specific antigen tests (PSAs) 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 screenings that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered prostate cancer screenings:

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* -- provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including prostate cancer screening. *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- *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 prostate cancer screenings, and resources for health care professionals and their staff. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- *Quick Reference Information: Medicare Preventive Services* -- this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including prostate cancer screenings. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- *Cancer Screenings brochure* -- this brochure provides information on coverage for Medicare-covered cancer screenings, including screenings for prostate cancer. *http://www.cms.hhs.gov/MLNProducts/downloads/cancer_screening.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 cancer screenings and other preventive services covered by Medicare.

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

Source: PERL 200909-06

Fact sheet for the introduction to ICD-10-CM/PCS now available

The revised publication titled *ICD-10-CM/PCS: An Introduction fact sheet* (August 2009), which was previously titled ICD-10-Clinical Modification/Procedure Coding System fact sheet, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2009.pdf*.

This fact sheet provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations.

Source: PERL 200908-33

Revised ICD-10-CM/PCS Bookmark

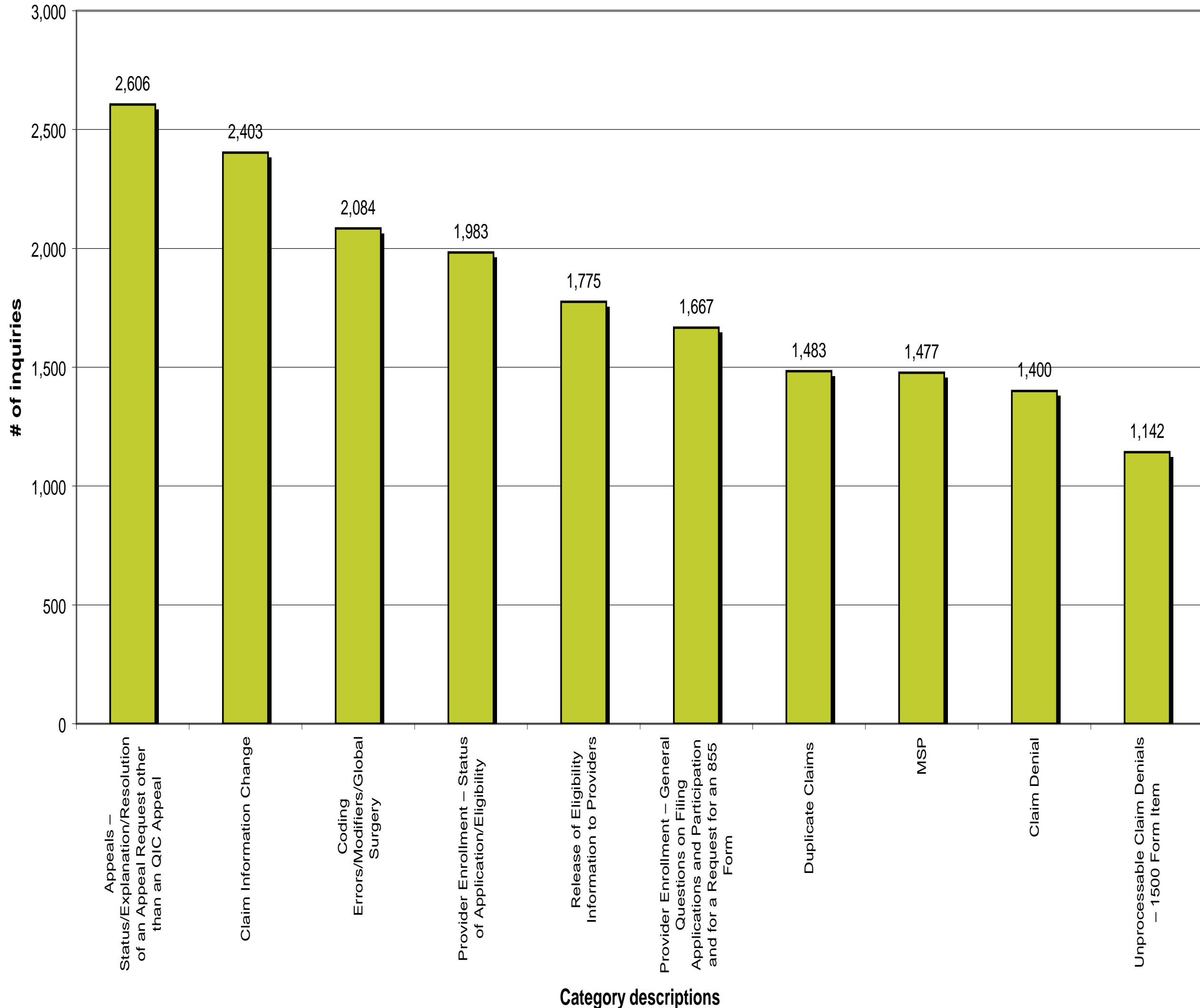
The revised *ICD-10-CM/PCS Bookmark* (August 2009), which provides information about the ICD-10-Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system may be found, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

Source: PERL 200908-40

Top inquiries, denials, and return unprocessable claims for August 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 Islands providers during August 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 August 2009

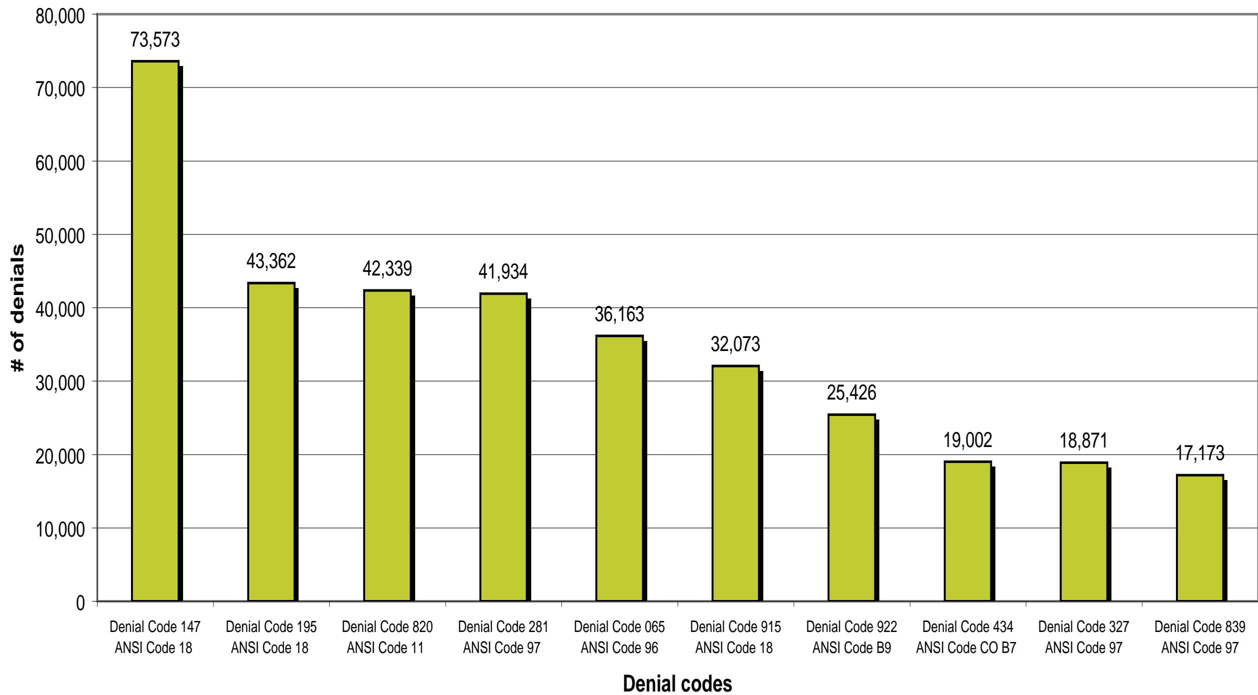


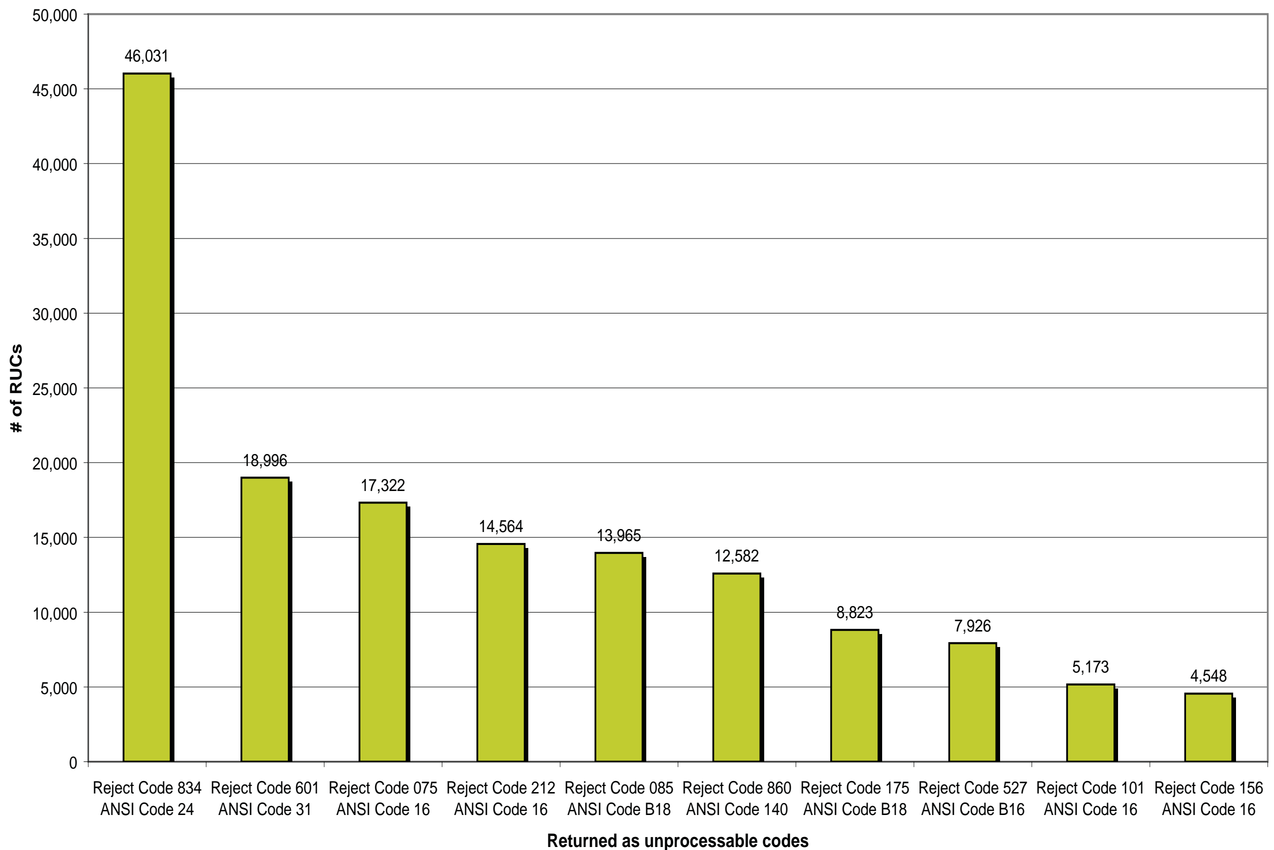
Create an account and receive your personalized Provider Data Summary report

The Provider Data Summary (PDS) is a comprehensive billing report designed to be utilized along with Medicare remittance notices (MRNs) and other provider-accessible billing resources to help identify potential Medicare billing issues through a detailed analysis of your personal billing patterns in comparison with those of similar providers. Use the PDS portal to request this useful report and enhance the accuracy and efficiency of your Medicare billing process.

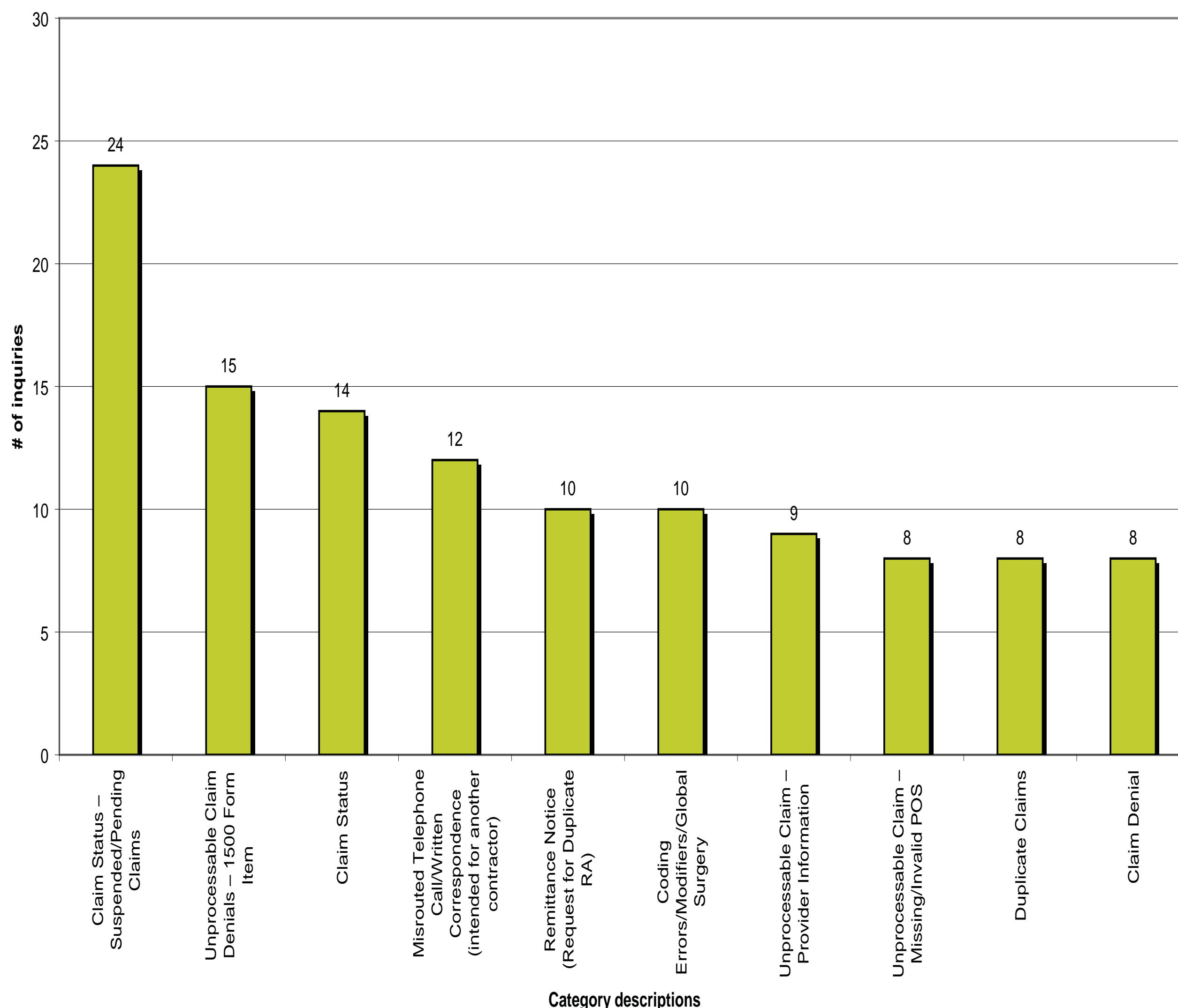
You begin the process to obtain your personalized PDS report by visiting our provider Web site at medicare.fcso.com. Once on the Web site, navigate to the “Home” link in your applicable line of business (e.g., Part A or Part B). Select “More” within the Provider Data Summary section. It is here you will find all PDS resources, including a guide, helpful FAQs, and the PDS Portal. Select the link titled “PDS Portal.” From there, you will be given the option to log in, get help with a misplaced password, or create an account.

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





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



Changes to the interactive voice response system

First Coast Service Options Inc. (FCSO) is committed to providing the best service possible to our customers. We are redesigning the interactive voice response system (IVR) to include enhanced reopening options.

The enhanced reopening options will be available in early October 2009. These new features will include:

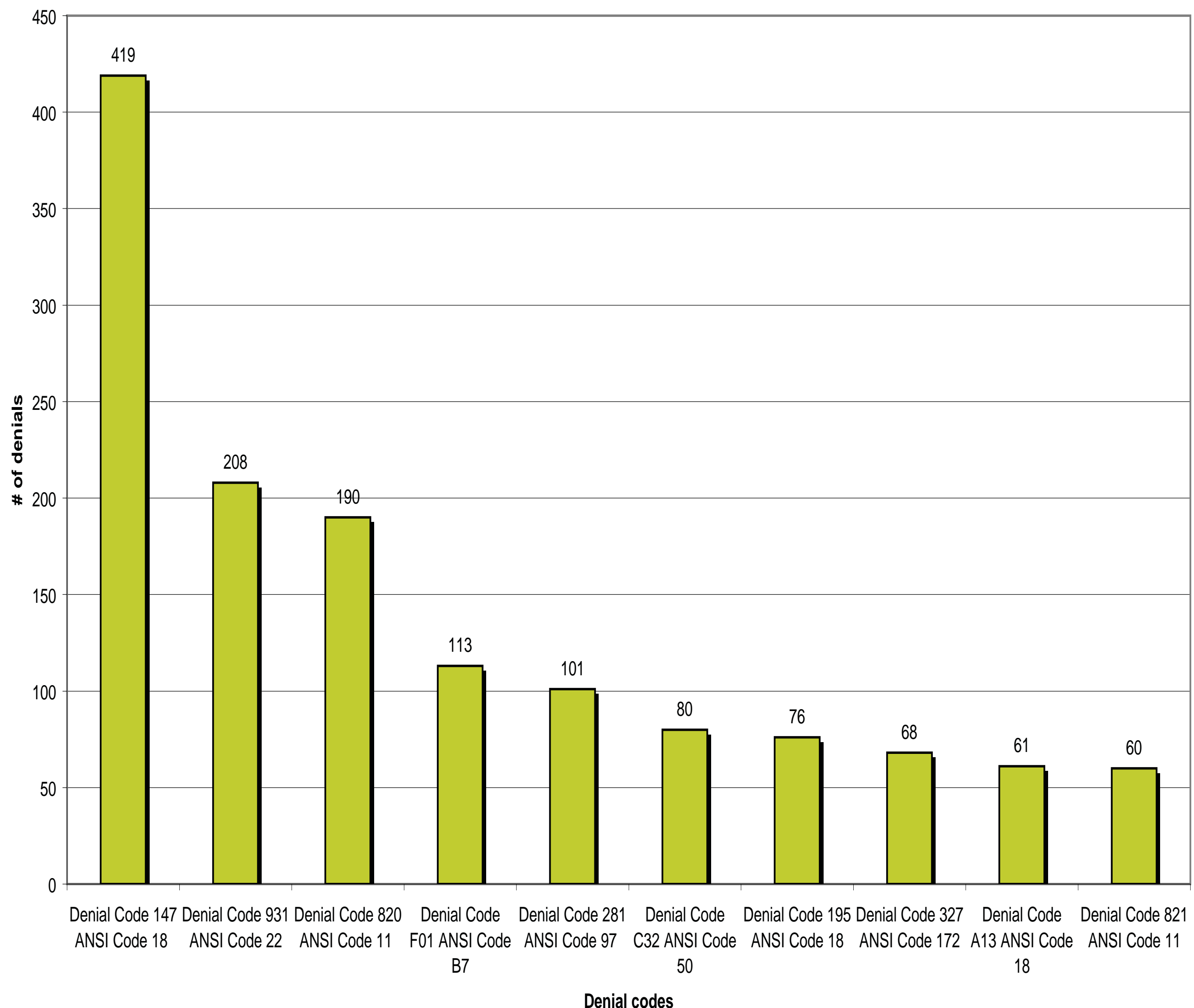
- Additional modifiers
- Multiple detail line reopenings
- Automatic notification of potential overpayments

In addition, some menu options will be revised to make reopenings easier. Check our Web site frequently; details will be provided as additional changes or enhancements are implemented.

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.*

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

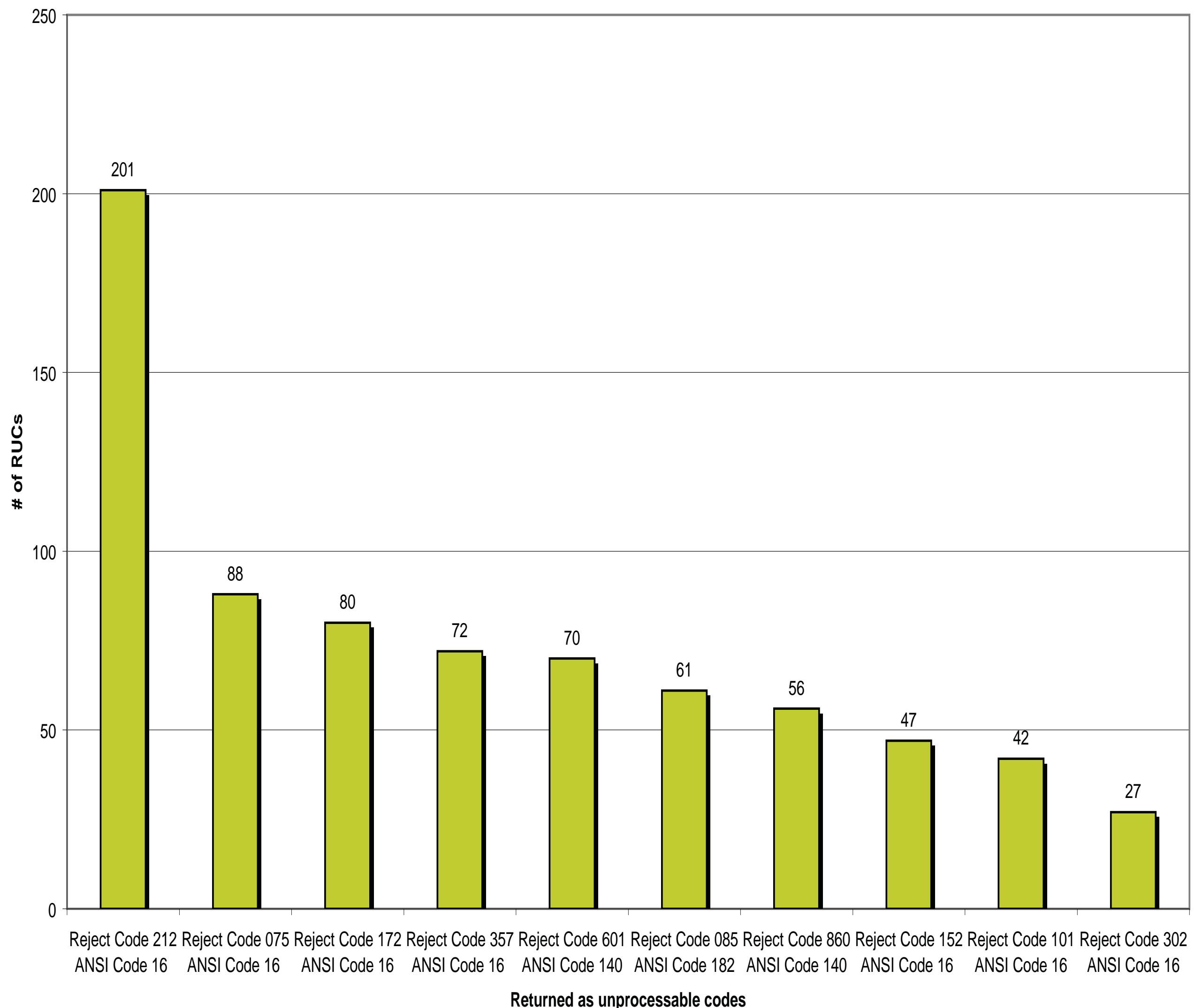


Top Part B claim denials

Share these tips and resources with all who need to know, such as your billing and IT staff, contracted billing service or clearinghouse, and software vendor. Billing Medicare correctly the first time saves everyone time and money.

- Before resubmitting a claim, check claims status through the Part B interactive voice response unit (IVR).
- Click here to view frequently-asked questions (FAQs) regarding duplicate claims.
- Do not resubmit entire claim when partial payment made; when appropriate, resubmit denied lines only.
- Ensure necessary appropriate modifier(s) are appended to claim lines.
- Refer to the Modifier FAQs on the FCSO Medicare provider Web site for additional information.
- Resources available through www.fcsomedicaretraining.com :
- Free Web-based Training (WBT) Duplicate claims -- Part B
- Recording of a webcast offered by FCSO January 21, 2009, on Understanding and resolving duplicate claim denials -- Part B may be accessed in the “Online resources,” located in the “Library” of the FCSO Medicare training Web site.

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



Unprocessable claims

Additional frequently asked questions and answers on unprocessable claims and more are available at *http://medicare.fcso.com/FAQs/index.asp*.

Q. If my claim is returned as unprocessable (e.g., if the patient's name does not match Medicare's records), what responsibility do I have, as the provider, versus that of the patient?

A. To resolve a claim returned as unprocessable, you should correct the invalid or incomplete information and submit a new claim.

- In the case of the example, correct the claim with the patient's name and Medicare number as they appear on the Medicare card. If the beneficiary insists that the Medicare card is incorrect, you should advise the beneficiary to contact their local servicing Social Security Administration (SSA) field office to obtain a new Medicare card.

A claim is generally returned as unprocessable for containing incomplete or invalid information and is not afforded appeal rights. As the claim is incomplete or invalid, the patient would not have any financial responsibility.

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

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Revisions to the LCDs

G0108: Diabetes outpatient self-management training 37
J9212: Interferon 37
11600: Excision of malignant skin lesions 37
87181: Susceptibility Studies 38
2010 ICD-9-CM changes 38

Advance beneficiary notice

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

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

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

Revisions to LCDs

G0108: Diabetes outpatient self-management training -- revision to the LCD

LCD ID number: L29133 (Florida)
LCD ID number: L29151 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for diabetes outpatient self-management training was effective for services rendered on or after February 2, 2009, for Florida, and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the Centers for Medicare & Medicaid Services (CMS) issued change request 6510, transmittal 109, dated August 7, 2009 to notify contractors that the American Association of Diabetes Educators (AADE) is a recognized national accreditation organization for accrediting entities to furnish outpatient diabetes self-management training (DSMT).

Therefore, the LCD was updated to include the AADE as a recognized national accreditation body for accrediting entities to furnish DSMT.

Effective date

This LCD revision is effective for services rendered on or after March 30, 2009. 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.

J9212: Interferon -- revision to the LCD

LCD ID number: L29202 (Florida)
LCD ID number: L29354 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for interferon was effective for services rendered on or after February 2, 2009, for Florida, and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a revision to the LCD was made to add ICD-9-CM code 238.71 (essential thrombocythemia) for HCPCS code J9214 (Interferon alfa-2b) in the "ICD-9 Codes that Support Medical Necessity" section of the LCD. Additionally, "essential thrombocythemia" was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for Interferon alfa-2b (HCPCS code J9214).

Effective date

This LCD revision is effective for claims processed on or after September 4, 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.

11600: Excision of malignant skin lesions -- revision to the LCD

LCD ID number: L29170 (Florida)
LCD ID number: L29424 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for excision of malignant skin lesions was effective for services rendered on or after February 2, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, based on a reconsideration request, a revision to the LCD was made to add diagnosis code 198.2 (Secondary malignant neoplasm of skin) to the *CPT* procedure code range *11640-11646*.

In addition to the above, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed on or after August 28, 2009, for services rendered on or after February 2, 2009, for Florida and services rendered on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. 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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87181: Susceptibility Studies -- revision to the LCD

LCD ID number: L29319 (Florida)

LCD ID number: L29396 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies was effective for services rendered on or after February 2, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) laboratory national coverage determination (NCD) edit software for October 2008, transmittal 1606, change request 6213 dated October 2, 2008, business requirement 6213.1 for urine culture (section 190.12), a revision was made to update the access instructions for the online list of covered ICD-9-CM codes in the NCD. In addition, the "CMS National Coverage Policy" section of the LCD was updated, and under the "Other Comments" section of the Coding Guidelines, the ICD-9-CM codes were removed and CMS language was added regarding editing.

Effective date

This LCD revision is effective for claims processed on or after September 15, 2009, for services rendered on or after October 1, 2008, for Florida and services rendered on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. 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.

2010 ICD-9-CM changes

The 2010 update to the ICD-9-CM diagnosis coding structure became effective October 1, 2009. Updated diagnosis codes must be used for all services billed on or after October 1, 2009. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. First Coast Service Options Inc. has reviewed all local coverage determinations (LCDs) for procedure codes with specific diagnosis criteria that are affected by the 2010 ICD-9-CM update.

The following table lists the LCDs affected and the specific conditions revised as a result of the 2010 ICD-9-CM update:

LCD title	2010 changes
20600 Arthrocentesis	Removed diagnosis 274.0 for procedure codes *20600*, *20605*, and *20610*. Added diagnosis range 274.00-274.03 for procedure codes *20600*, *20605*, and *20610*.
31231 Diagnostic Nasal Endoscopy	Changed descriptor for diagnosis range 784.40-784.49 for procedure codes *31231*, *31233*, and *31235*. Removed diagnosis 784.5 for procedure codes *31231*, *31233*, and *31235*. Added diagnosis code range 784.51-784.59 for procedure codes *31231*, *31233*, and *31235*.
31525 Diagnostic Laryngoscopy	Changed descriptor for diagnosis code 784.49 for procedure codes *31525* and *31575*. Removed diagnosis 784.5 for procedure codes *31525* and *31575*. Added diagnosis codes 438.13, 438.14, 784.42, 784.43, 784.44, and 784.51-784.59 for procedure codes *31525* and *31575*.
43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy	Added diagnosis codes 569.71-569.79, 569.87, 784.42, 784.43, and 784.44 for procedure codes *43235*, *43236*, *43237*, *43238*, *43239*, *43241*, *43243*, *43244*, *43245*, *43246*, *43247*, *43248*, *43249*, *43250*, *43251*, *43255*, and *43258*. Changed descriptor for diagnosis codes 784.49, 793.4, and 793.6 for procedure codes *43235, 43236, 43237, 43238, 43239, 43241*, *43243*, *43244*, *43245*, *43246*, *43247*, *43248*, *43249, 43250*, *43251*, *43255*, and *43258*.

2010 ICD-9-CM changes (continued)

LCD title	2010 changes
44388 Diagnostic Colonoscopy	Added diagnosis code range 569.71-569.79 for procedure codes *44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391*, and *45392*. Changed descriptor for diagnosis code 793.4 for procedure codes *44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391*, and *45392*.
62310 Epidural	Added diagnosis code range 209.70-209.79, 239.89 for procedure codes *62310, 62311, 64479, 64480, 64483*, and *64484*. Removed new diagnosis 239.81 from diagnosis range 239.0-239.9 for procedure codes 62*310, 62311, 64479, 64480, 64483*, and *64484*, as it is not appropriate.
64400 Peripheral Nerve Blocks	Added diagnosis code range 209.70-209.79 for procedure codes *64400, 64402, 64405, 64412, 64413, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64445, 64446, 64447, 64448, 64449*, and *64450*.
70540 Magnetic Resonance Imaging of the Orbit, Face, and/or Neck	Changed descriptor for diagnosis codes 784.40-784.49 and 793.0 for procedure codes *70540, 70542*, and *70543*. Removed diagnosis 784.5 for procedure codes *70540, 70542*, and *70543*. Added diagnosis code range 784.51-784.59 for procedure codes *70540, 70542*, and *70543*.
70544 Magnetic Resonance Angiography (MRA)	Added diagnosis code 416.2 for procedure code *71555*.
70551 Magnetic Resonance Imaging of the Brain	Changed descriptor for diagnosis codes 572.2 and 793.0 for procedure codes *70551*, *70552*, and *70553*. Removed diagnosis codes 768.7 and 784.5 for procedure codes *70551*, *70552*, and *70553*. Added diagnosis code ranges 768.70-768.73 and 784.51-784.59 for procedure codes *70551, 70552*, and *70553*.
72141 Magnetic Resonance Imaging of the Spine	Changed descriptor for diagnosis code 793.99 for procedure codes *72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157*, and *72158*. Removed diagnosis code 239.8 for procedure codes *72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157*, and *72158*. Added diagnosis code 239.89 for procedure codes *72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157*, and *72158*.
73218 Magnetic Resonance Imaging of Upper Extremity	Changed descriptor for diagnosis codes 793.7 and 996.43 for procedure codes *73218, 73219, 73220, 73221, 73222*, and *73223*. Removed diagnosis code 274.0 for procedure codes *73218, 73219, 73220, 73221, 73222*, and *73223*. Added diagnosis codes 274.00-274.03 and 359.71 for procedure codes *73218, 73219, 73220, 73221, 73222*, and *73223*.
76510 B-Scan	Removed diagnosis code 239.8 for procedure codes *76510*, *76512*, and *76513*. Added diagnosis code range 239.81-239.89 for procedure codes *76510, 76512*, and *76513*.

2010 ICD-9-CM changes (continued)

LCD title	**2010 changes**
77055 Screening and Diagnostic Mammography	Add diagnosis 793.82 for procedure codes *77055, 77056*, G0204 and G0206. Changed descriptor for diagnosis code 793.89 for procedure codes *77055*, *77056*, G0204 and G0206.
78460 Cardiovascular Nuclear Imaging Studies	Added diagnosis 995.24 for procedure codes *78460, 78461*, *78464, 78465, 78478*, and *78480*.
82310 Total Calcium	Added diagnosis codes 209.31-209.36 and 787.04 for procedure code *82310*. Changed descriptor for diagnosis code range 584.5-584.9 for procedure code *82310*.
82330 Ionized Calcium	Added diagnosis code 787.04 for procedure code 82330.
83735 Magnesium	Added diagnosis codes 569.87 and 787.04 for procedure code *83735*. Changed descriptor for diagnosis code range 584.5-584.9 for procedure code *83735*.
83970 Parathormone (Parathyroid Hormone)	Added diagnosis code 787.04 for procedure code *83970*.
84100 Serum Phosphorus	Changed descriptor for diagnosis codes 584.5-584.9, 793.0, and 793.7 for procedure code *84100*. Removed diagnosis code 799.2 for procedure code *84100*. Added diagnosis codes 799.21 and 799.22 for procedure code *84100*.
85651 Sedimentation Rate, Erythrocyte	Removed diagnosis code 279.4 for procedure code *85651* and *85652*. Added diagnosis code range 279.41-279.49 for procedure code *85651* and *85652*.
92081 Visual Field Examinations	Removed diagnosis code 239.8 for procedure codes *92081*, *92082*, and *92083*. Added diagnosis code range 239.81-239.89 for procedure codes *92081*, *92082*, and *92083*.
92250 Fundus Photography	Removed diagnosis code 239.8 for procedure code *92250*. Added diagnosis code range 239.81-239.89 for procedure code *92250*.
93312 Transesophageal Echocardiogram	Changed descriptor for diagnosis code 453.2 for procedure codes *93312*, *93313, 93314, 93315, 93316, 93317*, and *93318*.
93886 Transcranial Doppler Studies	Removed diagnosis code 348.8 for procedure codes 9*3886, 93888, 93890, 93892*, and *93893*. Added diagnosis code range 348.81-348.89 for procedure codes *93886, 93888, 93890, 93892*, and *93893*.
93965 Non-invasive Evaluation of Extremity Veins	Changed descriptor for diagnosis code range 453.40-453.42 for procedure codes *93965*, *93970*, and *93971*. Removed diagnosis code 453.8 for procedure codes *93965*, *93970*, and *93971*. Added diagnosis codes 453.50-453.52, 453.6, 453.71, 453.72, 453.73, 453.74, 453.81, 453.82, 453.83, and 453.84 for procedure codes *93965*, *93970*, and *93971*.

2010 ICD-9-CM changes (continued)

LCD title	2010 changes
93975 Duplex Scanning	Changed descriptor for diagnosis code 793.6 for procedure codes *93975, 93976, 93978*, and *93979*. Changed descriptor for diagnosis codes 453.2 and 784.49 for procedure codes *93978* and *93979*. Removed diagnosis code 784.5 for procedure codes *93978* and *93979*. Added diagnosis codes 784.42, 784.43, 784.44, and 784.51-784.59 for procedure codes *93978* and *93979*.
95115 Allergen Immunotherapy	Added diagnosis code 372.06 for procedure codes *95115*, *95117*, and *95165*.
J0800 Corticotropin	Removed diagnosis code 274.0 for procedure code J0800. Added diagnosis codes 274.00-274.03 and 372.06 for procedure code J0800
J0881 Erythropoiesis Stimulating Agents	Added diagnosis codes 285.3, 209.31-209.36, and 209.70-209.79 for procedure code J0881 and J0885 with an EA modifier. This will require a dual diagnosis (285.3 and one of the malignancy codes listed in List 2 must be billed together).
PULMDIAGSVCS Pulmonary Diagnostic Services	Changed descriptor for diagnosis code 793.1 for procedure codes *93720, 93721, 93722, 94010, 94060, 94070, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725*, and *94750*.

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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.*

Educational Resources

Upcoming provider outreach and education events – November 2009

Evaluation and management (E/M) series: workshops covering the E/M of a typical patient -- session 3

When: November 17
Time: 11:30 a.m.-1:00 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

Evaluation and management (E/M) series: workshops covering the E/M of a typical patient -- session 3

When: November 19
Time: 2:30 p.m.-4:00 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

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

Online: Simply log on to your account on our provider training Web site at *www.fcsomedicaretraining.com* and select the course you wish to register for. Class materials will be available under "My Courses" no later than one day before the event.

FAX: Providers without Internet access can leave a message on our Registration Hotline at 904-791-8103 requesting a fax registration form. Class materials will be faxed to you the day of the event.

Tips for using 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:

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Medicare Publications
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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)

MEDICARE B Update!

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

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