MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office manager
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Find out first: Subscribe to FCSO eNews

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Medicare B Update!

Vol. 7, No. 10
October 2009

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

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

- The **claims** section provides claim submission requirements and tips.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **local coverage determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **general information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- **Educational resources**, and
- **Addresses,** and **phone numbers**, and **Web sites** for Florida and the U.S. Virgin Islands.

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

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

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the Quarterly Provider Update by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found on CMS's BNI Web site at *http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage.*

Note: Beginning March 3, 2008, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN (CMS-R-131 [03/08]) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (CMS-R-131G), ABN-L (CMS-R-131L), and NEMB (CMS-20007). Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid. Additional information is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier **GZ** may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier **GZ** is billed, the provider assumes financial responsibility if the service or item is denied.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier **GA** (wavier of liability statement on file).

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Refer to the Address, Phone Numbers, and Web sites section of this publication for the address in which to send written appeals requests.

Find out first: Subscribe to FCSO eNews

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Ambulance

Billing ambulance transport with more than one patient onboard

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

Provider types affected

Providers and suppliers, submitting claims to Medicare contractors (carriers, fiscal intermediaries [FI], and A/B Medicare administrative contractors [A/B MAC]) for ambulance services provided to Medicare beneficiaries, are affected.

Provider action needed

This article advises ambulance suppliers that change request (CR) 6621 communicates claims processing instructions for ambulance service claims submitted for trips with more than one patient onboard. These changes are to be added to the Ambulance chapter of the *Medicare Claims Processing Manual* (Chapter 15). Please inform your billing staffs of these changes.

Background

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR 6621 to highlight changes that are to be made to the *Medicare Claims Processing Manual*, Chapter 15 - Ambulance Services. This article is informational in nature, since CR 6621 revises that manual to incorporate information previously released via transmittal B-02-060, CR1945, "Payment Policy When More Than One Patient is Onboard an Ambulance" on September 27, 2002, and Transmittal A-02-108, CR 2186, "Multiple Patient Ambulance Transport" on October 25, 2002.
These changes to the Medicare Claims Processing Manual are:

- Ambulance suppliers submitting a claim using the CMS-1500, or the electronic equivalent ANSI X12N 837, for an ambulance transport with more than one Medicare beneficiary onboard must use the modifier GM (multiple patient on one ambulance trip) for each service line item. In addition, suppliers are required to submit to B/MACs/carriers documentation to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim (HIC) numbers for each Medicare beneficiary. B/MACs/carriers shall calculate payment amounts based on policy instructions found in the *Medicare Benefit Policy Manual*, Chapter 10 – Ambulance Services, Section 10.3.10 – Multiple Patient Ambulance Transport.
- For claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter.

Additional information

The official instruction, CR 6621, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1821CP.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6621
Related Change Request (CR) #: 6621
Related CR Release Date: September 25, 2009
Effective Date: October 26, 2009
Related CR Transmittal #: R1821CP
Implementation Date: October 26, 2009

Drugs and Biologicals

Influenza vaccine payment allowances – annual update for 2009-2010 season

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 submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for influenza vaccines provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6608 to update payment allowances, effective September 1, 2009, for influenza vaccines when payment is based on 95 percent of the average wholesale price (AWP).

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or frederally qualified health center (FQHC), in which cases, payments for the vaccines are based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Key points

The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year. CR 6608 provides the payment allowances for the following influenza virus vaccines: *Current Procedural Terminology* (*CPT*) codes *90655*, *90656*, *90657*, *90658*, and *90660* when payment is based on 95 percent of the AWP.

Note: For information about billing the H1N1 influenza vaccine, please see the MLN Matters® article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6617.pdf* on the CMS Web site.

Effective September 1, 2009, these Medicare Part B payment allowances for influenza vaccines are as follows:

CPT Code	Allowance
90655	$15.447
90656	$12.541
90657	$5.684
90658	$11.368

CPT 90660 (FluMist, a nasal influenza vaccine) may be covered if the local Medicare contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for *CPT 90660* is $22.316 (effective September 1, 2009).

These payment allowances were published as a part of the July 2009 quarterly ASP drug pricing files, as specified in CR 6471. See *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6471.pdf* on the CMS Web site to view the article related to CR 6471.

Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 6608. However, they will adjust such claims that you bring to their attention.

Additional information

You may find the official instruction, CR 6608, issued to your Medicare carrier, FI or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1824CP.pdf* on the CMS Web site.

If you have any questions, please contact your Medicare 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.

Educational products are available through the *MLN* catalogue free of charge. The *MLN* catalogue is available at *http://www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf* on the CMS Web site. The specific products that may be of interest to providers who use the information in MM6608 are as follows:

The *Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B)* is available at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf* on the CMS Web site.

The *Adult Immunizations* brochure provides a basic overview of Medicare's influenza, pneumococcal and hepatitis B vaccine benefits and is available at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf* on the CMS Web site.

MLN Matters® Number: MM6608
Related Change Request (CR) #: 6608
Related CR Release Date: October 2, 2009
Effective Date: September 1, 2009
Related CR Transmittal #: R1824CP
Implementation Date: November 2, 2009

Annual clotting factor furnishing fee update

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 billing Medicare carriers, fiscal intermediaries (FIs), Medicare administrative contractors (MAC), or regional home health intermediaries (RHHI) for services related to the administration of blood clotting factors to Medicare beneficiaries.

What you need to know

CR 6673, from which this article is taken, announces that for calendar year (CY) 2010, the blood clotting factor furnishing fee of $0.170 per international unit (I.U.) is added to the payment limit for a blood clotting factor that is not included on the average sale price (ASP) or not otherwise classified (NOC) files.

Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) Section 303(e)(1) added section 1842(o)(5)(C) to the Social Security Act (the Act) which requires that, beginning January 1, 2005, a furnishing fee be paid for items and services associated with the administration of blood clotting factors.

It further specifies that for CY 2006 (and subsequent years) this furnishing fee will be equal to the fee for the previous year, increased by the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. The blood clotting furnishing factors for years 2005-2010 are displayed in the following table:

Blood Clotting Factor Furnishing Fee	
Furnishing Fee (per IU)	**Calendar Year**
$0.170	2010
$0.164	2009
$0.158	2008
$0.152	2007
$0.146	2006
$0.140	2005

Previously, the Centers for Medicare & Medicaid Services (CMS) included the clotting factor furnishing fee in the payment limit for Healthcare Common Procedure Coding System (HCPCS) code J7197 “Antithrombin III (human), per I.U.”. This code does not describe a hemophilia clotting factor, and therefore the payment limit for it should not include the clotting factor furnishing fee. Thus, CR 6673 provides further clarification that the payment limit for J7197 does not include the clotting factor furnishing fee and Medicare will not make separate payment for the clotting factor furnishing fee for J7197.

Additional information

You may find more information about the blood clotting furnishing factor by going to CR 6673, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1829CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) 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: MM6673
Related Change Request (CR) #: 6673
Related CR Release Date: October 16, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1829
Implementation Date: January 4, 2010

October 2009 average sales price file is now available

The Centers for Medicare & Medicaid Services has posted the revised October 2009 average sales price (ASP) and not otherwise classified (NOC) pricing files, which are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a1_2009aspfiles.asp*.

Source: PERL 200910-07

Durable Medical Equipment

Information about the DMEPOS competitive bidding program – round 1 rebid

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 suppliers that furnish Medicare Part B durable medical equipment, prosthetic devices, prosthetic or orthotic items and supplies (DMEPOS) to Medicare beneficiaries. Critical changes are coming that will affect the way Medicare pays for DMEPOS and how Medicare determines who can bill for DMEPOS. This article provides important reminders about some of these changes, which will be occurring in the very near future and how these changes affect suppliers who will participate in the DMEPOS competitive bidding program.

Suppliers are urged to review this article and be sure they are prepared for these changes in order to continue providing DMEPOS to Medicare patients.

Provider action needed

Stop -- impact to you

The Centers for Medicare & Medicaid Services (CMS) reminds DMEPOS suppliers enrolled with the national supplier clearinghouse (NSC) they are required to obtain accreditation by October 1, 2009, unless exempt, and obtain a surety bond by October 2, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

Caution -- what you need to know

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. Voluntary termination allows you to re enroll once you meet the requirements to participate in the Medicare program. If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Go -- what you need to do

Whether or not you plan to remain as a Medicare supplier, it is recommended that you review this information. Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

Background

This article includes important reminder information for suppliers who will continue to serve as suppliers for Medicare beneficiaries on and after October 1, 2009.

Voluntary and non-voluntary terminations/enrollment

Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by October 1, 2009 and October 2, 2009, respectively.

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

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

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

Accreditation

In a previous *MLN Matters*® article, SE0903, CMS informed suppliers of the importance of accreditation and the consequences of not being accredited on or before September 30, 2009. That article is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf* on the CMS Web site.

If you have already been notified by an approved accrediting organization that each of your practice locations has been accredited, the accreditation organization will notify the NSC that your DMEPOS supplier practice locations have been accredited. However, DMEPOS suppliers who obtained accreditation after September 1, 2009, but before October 1, 2009, should submit proof of accreditation to the NSC via submission of an amendment to their CMS-855S.

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

Accreditation and DMEPOS Competitive Bidding

Suppliers choosing to participate in the DMEPOS Competitive Bidding Program must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

Information about the DMEPOS competitive bidding program – round 1 rebid (continued)

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

Get accredited: Medicare DMEPOS suppliers, unless exempt, must be accredited by October 1, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

Get bonded: Medicare DMEPOS suppliers, unless exempt, must obtain and submit a surety bond by October 2, 2009. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of surety companies from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies;" the Web site is located at *http://www.fms.treas.gov/c570/c570_a-z.html* on the Internet. When submitting your DMEPOS surety bond to the NSC, you are required to submit sections 1, 2A1, 12, and either 15 (if you are the authorized officials [AO] or 16 (if you are the delegated official) of the CMS-855S. By submitting the required sections of the CMS-855S, you will help to ensure that NSC is able to correctly associate your DMEPOS surety bond to your enrollment record.

Accessing the processes for the round 1 rebid

On August 3, 2009, CMS issued the bidding timeline for the round 1 rebid of the DMEPOS Competitive Bidding Program and initiated a comprehensive bidder education campaign. The CMS contractor, CBIC, is the focal point for bidder education. Please visit the CBIC's dedicated Web site, *http://www.dmecompetitivebid.com/*, for important information, including bidding rules, user guides, frequently asked questions, policy fact sheets, checklists, and bidding information charts. The CBIC toll-free help desk, 1-877-577-5331, is open to help bidders with all of their questions and concerns. All suppliers interested in bidding are urged to sign up for e-mail updates on the home page of the CBIC Web site. The round 1 rebid will result in significant changes in the way Medicare pays for certain types of DMEPOS and it is critical that suppliers understand the process and what it takes to be eligible to bid.

In prior communications, CMS has described the processes for registering to use CMS systems. (See the *MLN Matters*® article, SE0915, at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0915.pdf* on the CMS Web site.) For the round 1 rebid, it is imperative that suppliers register so they will be able to participate in the bidding process for the categories of DMEPOS to be obtained only through the competitive bidding program.

Round 1 rebid registration milestones

Suppliers should be well into, if not completely through, this registration process. Registering now allows the AO and/or backup authorized official (BAO) time to correct the supplier's NSC records if their name, date of birth, and SSN does not match what is on file with NSC. CMS recommends that BAOs register no later than October 9, 2009, so that they will be able to assist AOs with approving EU registration. Registration will close on November 4, 2009, at 9:00 p.m. (ET)–no AOs, BAOs, or EUs can register after registration closes. The legal name, date of birth, and social security number (SSN) of the AO and BAOs must match what is on file with the NSC in order to register successfully. To register, go to *http://www.dmecompetitivebid.com/* on the Competitive Bidding Implementation Contractor (CBIC) Web site.

If you have not started this process, please review the *Individuals Authorized Access to the CMS Computer Services (IACS) Reference Guide* at *http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/IACS_Reference_Guide.pdf/$FIle/IACS_Reference_Guide.pdf?Open&cat=Suppliers* for step-by-step instructions on registration. The CBIC Web site also has the following useful tools:

- A registration checklist
- Quick step guides; and frequently asked questions
- All suppliers interested in bidding are urged to sign up for e-mail updates on the home page of the CBIC Web site. If you have any questions about the registration process, please contact the CBIC customer service center at 1-877-577-5331.

The target deadline for AOs interested in participating in the round 1 rebid to register was September 14, 2009. If you are an AO who has not yet registered – do it **today**! Visit *http://www.dmecompetitivebid.com/* to register.

Additional information

For more information on the DMEPOS competitive bidding program, visit *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/* on the CMS Web site. For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on the CMS Web site. Frequently asked questions (FAQs) on the surety bond requirement can be found on the NSC's FAQ page at *http://www.palmettogba.com/nsc* on the Internet.

MLN Matters® Number: SE0925
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

Radiology

FDG positron emission tomography for solid tumors and myeloma

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 other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) when providing F-18 flouro-D-glucose (FDG) positron emission tomography (PET) scans to Medicare beneficiaries. Note that the term FDG PET includes FDG PET/CT (computed tomography).

What you need to know

Change request (CR) 6632, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is revising the *Medicare National Coverage Determinations Manual*, Section 220.6: Positron Emission Tomography (PET) Scans. Specifically, in CR 6632, CMS announces (effective April 3, 2009) a national coverage determination (NCD) that adopts a two-part framework which differentiates the use of F-18 flouro-D-glucose (FDG) PET imaging in the initial antitumor treatment strategy, from its other uses related to guiding subsequent antitumor treatment strategies after the completion of initial treatment. This framework replaces the previous, four-part framework that contained the diagnosis, staging, restaging, and monitoring response to treatment.

Background

The NCD that CR 6632 announces requires the replacement of the four-part framework (mentioned in the previous paragraph) with a two-part one that differentiates FDG PET imaging used for initial anti-tumor treatment strategy from subsequent anti-tumor treatment strategies after the completion of initial treatment. In so doing, it provides that (effective for services provided on or after April 3, 2009) the terms "diagnosis" and "staging" are to be replaced with "Initial Treatment Strategy," and the terms "restaging" and "monitoring" are to be replaced with "Subsequent Treatment Strategy." CMS is making this change for most solid tumor oncologic indications and myeloma.

NCD requirements

Initial anti-tumor treatment strategy

CMS will cover one FDG PET study for beneficiaries who have solid tumors that are biopsy proven or strongly suspected based on other diagnostic testing when the beneficiary's treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for one of the following therapeutic purposes related to the initial treatment strategy:

- Whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure.
- The optimal anatomic location for an invasive procedure.
- The anatomic extent of tumor when the recommended antitumor treatment reasonably depends on the extent of the tumor.

There are some exceptions to this initial treatment strategy:

- CMS will nationally noncover the use of FDG PET imaging to determine initial treatment strategy in patients with adenocarcinoma of the prostate.
- CMS will continue to cover FDG PET imaging for the initial treatment strategy for male and female breast cancer when used in staging distant metastasis. FDG PET imaging for diagnosis and initial staging of axillary nodes will remain noncovered.
- CMS will continue noncoverage of FDG PET for the evaluation of regional lymph nodes in melanoma. Other uses to determine initial treatment strategy remain covered.
- CMS will continue to cover FDG PET imaging as an adjunct test for the detection of pre-treatment metastasis (i.e., staging) in newly diagnosed cervical cancers following conventional imaging that is negative for extra-pelvic metastasis.

All other uses of FDG PET for the initial treatment strategy for beneficiaries diagnosed with cervical cancer will only continue to be covered through coverage with evidence development (CED).

Specifically, CMS will cover one initial FDG PET study for patients with newly diagnosed cervical cancer (when not used as an adjunct test to detect pre-treatment metastases following conventional imaging that is negative for extra-pelvic metastasis) only when the beneficiary's treating physician determines that the FDG PET study is needed to inform the initial anti-tumor treatment strategy, and the beneficiary is enrolled in, and the FDG PET provider is participating in, an FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Clinical studies for which CMS will provide coverage must answer one or more of the following three questions:

Prospectively, in Medicare beneficiaries with newly diagnosed cervical cancer who have not been found following conventional imaging to be negative for extra-pelvic metastases and whose treating physician determines that the FDG PET study is needed to inform the initial anti-tumor treatment strategy, does the addition of FDG PET imaging lead to:

- A change in the likelihood of appropriate referrals for palliative care?
- Improved quality of life? or
- Improved survival?

The study must adhere to the standards of scientific integrity and relevance to the Medicare population as described in the following section on subsequent anti-tumor treatment strategy (items a through m).

FDG positron emission tomography for solid tumors and myeloma (continued)

Subsequent anti-tumor treatment strategy

For tumor types other than breast, colorectal, esophagus, head and neck (non-CNS/thyroid), non-small cell lung, and thyroid cancers, lymphoma, and melanoma, CMS has determined that FDG PET imaging for subsequent antitumor treatment strategy may be covered as research through CED.

However, CMS will cover a subsequent FDG PET study for tumor types other than breast, colorectal, esophagus, head and neck (non-CNS/thyroid), non-small cell lung, and thyroid cancers, lymphoma, and melanoma, when the beneficiary's treating physician determines that the FDG PET study is needed to inform the subsequent antitumor treatment strategy and the beneficiary is enrolled in, and the FDG PET provider is participating in, the following types of prospective clinical study:

- A FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Qualifying clinical studies must ensure that specific hypotheses are addressed; appropriate data elements are collected; hospitals and providers are qualified to provide the PET scan and interpret the results; participating hospitals and providers accurately report data on all enrolled patients not included in other qualifying trials through adequate auditing mechanisms; and all patient confidentiality, privacy, and other federal laws must be followed.

The clinical studies for which CMS will provide coverage must answer one or more of the three questions below.

Prospectively, in Medicare beneficiaries whose treating physician determines that the FDG PET study is needed to inform the subsequent anti-tumor treatment strategy, does the addition of FDG PET imaging lead to:

- A change in the likelihood of appropriate referrals for palliative care?
- Improved quality of life? or
- Improved survival?

The study must adhere to the following standards of scientific integrity and relevance to the Medicare population

a. The principal purpose of the research study is to test whether a particular intervention improves the participant's health outcomes.

b. The research study is well-supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

c. The research study does not unjustifiably duplicate existing studies.

d. The research study design is appropriate to answer the research question being asked in the study.

e. The research study is sponsored by an organization or individual capable of executing the proposed study successfully.

f. The research study is in compliance with all applicable Federal regulations concerning the protection of human subjects found in the *Code of Federal Regulations* (CFR) at 45 CFR 46. If a study is regulated by the Food and Drug Administration (FDA), it also must be in compliance with 21 CFR Parts 50 and 56.

g. All aspects of the research study are conducted according to the appropriate standards of scientific integrity.

h. The research study has a written protocol that clearly addresses, or incorporates by reference, the Medicare standards.

i. The clinical research study is not designed to exclusively test toxicity or disease pathophysiology in health individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life-threatening as defined in 21 CFR 312.81(a) and the patient has no other viable treatment options.

j. The clinical research study is registered on the *http://www.clinicaltrials.gov* Web site by the principal sponsor/investigator prior to the enrollment of the first study subject.

k. The research study protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if such are negative or the study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors. However, a full report of the outcomes must be made no later than three years after the end of data collection.

l. The research study protocol must explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

m. The research study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

Consistent with Section 1142 of the Social Security Act, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

As exceptions to the subsequent treatment strategy section above:

- CMS has determined that FDG PET for subsequent treatment strategy in Medicare beneficiaries with ovarian cancer is nationally covered.

FDG positron emission tomography for solid tumors and myeloma (continued)

- CMS has determined that FDG PET for subsequent treatment strategy in Medicare beneficiaries with cervical cancer is nationally covered.

Myeloma

CMS has determined that FDG PET for initial treatment strategy and subsequent treatment strategy in Medicare beneficiaries with myeloma is nationally covered.

Further exceptions

CMS will continue to cover FDG PET for subsequent treatment strategy for specific indications in the following nine tumor types:

- Breast
- Cervix
- Colorectal
- Esophagus
- Head and neck (non-CNS/thyroid)
- Lymphoma
- Melanoma
- Non-small cell lung
- Thyroid

The CMS has transitioned the prior framework—diagnosis, staging, restaging, and monitoring response to treatment—into the initial treatment strategy and subsequent treatment strategy framework while maintaining current coverage.

The chart below summarizes section 220.6.1:

Table 1
FDG PET Coverage for Solid Tumors and Myeloma

Tumor Type	Initial Treatment Strategy (formerly "diagnosis" & "staging")	Subsequent Treatment Strategy (formerly "restaging" & "monitoring response to treatment")
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head & neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	CED
Cervix	See note (1) below or CED	Cover
Small cell lung	Cover	CED
Soft tissue sarcoma	Cover	CED
Pancreas	Cover	CED
Testes	Cover	CED
Breast (female and male)	See note (2)	Cover
Melanoma	See note (3)	Cover
Prostate	Noncover	CED
Thyroid	Cover	See note (4) or CED
All other solid tumors	Cover	CED
Myeloma	Cover	Cover
All other cancers not listed herein	CED	CED

Notes:

(1) **Cervix**: Covered for the detection of pre-treatment metastases (i.e., staging) in newly diagnosed cervical cancer subsequent to conventional imaging that is negative for extra-pelvic metastasis. All other uses are CED.

(2) **Breast**: Noncovered for initial diagnosis and/or staging of axillary lymph nodes. Covered for initial staging of metastatic disease.

(3) **Melanoma**: Noncovered for initial staging of regional lymph nodes. All other uses for initial staging are covered.

(4) **Thyroid**: Covered for subsequent treatment strategy of recurrent or residual thyroid cancer of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and have a negative I-131 whole body scan. All other uses for subsequent treatment strategy are CED.

FDG positron emission tomography for solid tumors and myeloma (continued)

Coding and billing requirements

CR 6632 also announces new modifiers for PET imaging, effective for services provided on or after April 3, 2009.

Modifier PI – Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing. Short descriptor: PET tumor init tx strat

Modifier PS – Positron emission tomography (PET) or PET/computed tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent anti-tumor strategy. Short descriptor: PET tumor subsq tx strategy

Note: The two new FDG PET oncologic modifiers are included in the July quarterly update of the integrated outpatient code editor (IOCE) with an effective date of April 1, 2009. As of October 30, 2009, all FDG PET oncologic-related claims for dates of service on or after April 3, 2009, must include one of these two new modifiers in order for the claim to be processed correctly.

Medicare claim processing requirements in CR 6632 are as follows:

- For claims with dates of service on or after April 3, 2009, Medicare will accept and pay for FDG PET claims as specified in the CR 6632 NCD to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors.

Claims that your carrier, FI, or A/B MAC receive after October 30, 2009 (for dates of service on or after April 3, 2009), will return as unprocessable (professional claims) or as return to provider (institutional claims) if they do not include the modifier PI with one of the following PET or PET/CT CPT codes when billing to inform the initial treatment strategy for solid tumors: *78608, 78811, 78812, 78813, 78814, 78815,* or *78816*.

- Your carrier or A/B MAC will return as unprocessable those professional claims for the subsequent treatment strategy without the modifier PS **and** a *CPT* code of *78608, 78811, 78812, 78813, 78814, 78815,* or *78816*, **and** an ICD-9 cancer diagnosis code.

Should your carrier, FI, or A/B MAC return your claim that does not contain the modifier PI or PS, they will use the following messages:

- **Claim adjustment reason code 4** – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- **Remittance advice remark code MA-130** – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- **Remittance Advice Remark Code M16** – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

For claims with dates of service on or after April 3, 2009, Medicare will return as unprocessable, return to provider, FDG PET oncologic claims for initial or subsequent treatment strategy when performed under CED billed without:

- PET/PET/CT CPT code in 6632.1.1, **and**
- modifier PI **or** PS, **and** an ICD-9 cancer code diagnosis code, **and** modifier Q0

For claims with dates of service on or after April 3, 2009, Medicare will return as unprocessable, return to provider, FDG PET oncologic claims for initial or subsequent treatment strategy when performed under CED billed without:

- PET/PET/CT CPT code in 6632.1.1, **and**
- modifier PI **or** PS, **and** an ICD-9 cancer code diagnosis code, **and** modifier Q0

You should also be aware that your carrier, FI, or A/B MAC will not search their files for FDG PET oncologic-related claims with dates of service April 3, 2009, through October 29, 2009, processed prior to October 30, 2009. However, they may adjust claims that you bring to their attention.

Additional information

CR 6632 was issued in two transmittals. One transmittal conveys the revisions to the *Medicare National Coverage Determinations Manual*, and the other conveys the changes to the *Medicare Claims Processing Manual*. These transmittals are at *http://www.cms.hhs.gov/Transmittals/downloads/R108NCD.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R1833CP.pdf*, respectively.

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

MLN Matters® Number: MM6632
Related Change Request (CR) #: 6632
Related CR Release Date: October 16, 2009
Effective Date: April 3, 2009
Related CR Transmittal #: R1833CP and R108NCD
Implementation Date: October 30, 2009

Magnetic resonance imaging

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 contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [MAC]) should be aware of this issue if they provide magnetic resonance imaging (MRI) services to Medicare beneficiaries.

What you need to know

Historically, the use of MRI for blood flow determination has been a Medicare "noncovered" procedure. CR 6672, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) found that the noncoverage of MRI for blood flow determination is no longer supported by the available evidence. Therefore, effective September 28, 2009, CMS is removing blood flow measurement as a nationally noncovered indication for MRI, and is giving local Medicare contractors the discretion to cover (or not to cover) this use of MRI in blood flow measurement. You should ensure that your billing staffs are aware of this change.

Background

CMS received a request to delete the national noncoverage of blood flow measurement from the MRI national coverage determination (NCD) in section 220.2 (Magnetic Resonance Imaging), Subsection C.2 (National noncovered Indications) of the *Medicare National Coverage Determinations Manual* because of an apparent contradiction between this noncoverage provision and the national coverage of MRI under the Magnetic Resonance Angiography NCD in Section 220.3 (Magnetic Resonance Angiography).

In concert with this change, the following four *Current Procedural Terminology* (*CPT*) codes will be changed from "noncovered" to "covered" and will appear in the January 2010 integrated outpatient code editor (IOCE) quarterly updates:

- *75558 Cardiac MRI for morphology/function w/o contrast materials; w/flow/velocity quantification*
- *75560 Cardiac MRI for morphology/function w/o contrast materials; w/flow/velocity quantification & stress*
- *75562 Cardiac MRI for morphology/function w/o contrast materials; followed by contrast materials/ further sequences, w/flow/velocity quantification*, and
- *75564, Cardiac MRI for morphology/function w/o contrast materials; followed by contrast materials/ further sequences, w/flow/velocity quantification & stress*.

Please note that all other MRI uses noted in the NCD Manual, Section 220.2 remain unchanged, including noncoverage of imaging of cortical bone and calcifications, procedures involving spatial resolution of bone and calcifications, for patients with FDA-approved (for an MRI environment) implanted cardioverter-defibrillators or cardiac pacemakers, or for patients with metallic clips on vascular aneurysms.

CMS also received a separate request to revise the reference to cardiac pacemakers to permit coverage for MRI when a beneficiary has an implanted device that has been designed, tested and Food and Drug Administration (FDA)-labeled for use in the MRI environment. In response to this request, CMS has not found evidence that MRI improves health outcomes in beneficiaries who have an implanted cardioverter-defibrillator or cardiac pacemaker approved by FDA for use in an MRI environment; in fact, CMS notes that there are currently no such devices. Therefore, no changes are proposed as a result of this request and the current policy remains in effect.

Note that your Medicare contractor will not search for previously-processed claims with dates of service of September 28, 2009, through December 31, 2009, but will adjust any claims that you bring to their attention.

Additional information

CR 6672 was issued in two transmittals. One transmittal updated the *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 4 (Sections 200 – 310.1) Coverage Determination, Section 220.2 (Magnetic Resonance Imaging) and that transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R107NCD.pdf* on the CMS Web site. The other transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R1831CP.pdf* and that transmittal updates the *Medicare Claims Processing Manual*, Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 40 (Magnetic Resonance Imaging (MRI) Procedures).

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

MLN Matters® Number: MM6672
Related Change Request (CR) #: 6672
Related CR Release Date: October 16, 2009
Effective Date: September 28, 2009
Related CR Transmittal #: R1831CP & R107NCD
Implementation Date: January 4, 2010

Therapy Services

Comprehensive outpatient rehabilitation facility coverage

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

Provider types affected

Comprehensive outpatient rehabilitation facilities who bill Medicare fiscal intermediaries (FI) and Medicare administrative contractors (A/B MAC) for providing CORF services to Medicare beneficiaries.

What you need to know

Change request (CR) 6005, from which this article is taken, announces that, based on changes in the 2008 Medicare physician fee schedule (MPFS) regulation (Published in the *Federal Register* on November 27, 2007), the *Medicare Benefit Policy Manual*, Chapter 12, (Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage) has been amended to clarify general requirements, covered and non-covered services, provisions of services, and particular CORF services

Specifically (effective January 1, 2008), these changes are incorporated in the manual: 1) Define that all CORF services must be directly related to the physical therapy (PT), occupational therapy (OT), speech language pathology (SLP) or respiratory therapy (RT) rehabilitation therapy plan of treatment; and 2) Clarify that the physician must wholly develop the rehabilitation therapy plan of treatment, 3) only a respiratory therapist (not a respiratory technician) can provide respiratory therapy, 4) social and psychological services (not mental health services) are core CORF services (which must be reasonable and medically necessary and directly related to the PT, OPT, SLP, or RT rehabilitation therapy plan of treatment), and 5) that physician "incident-to" services cannot be provided in a CORF.

Make sure that your billing staffs are aware of these CORF manual changes.

Background

CR 6005 announces that (effective January 1, 2008) the *Medicare Benefit Policy Manual*, Chapter 12 (Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage) is amended to reflect changes announced in the 2008 MPFS regulation and to clarify general requirements, covered and noncovered services, provisions of services, and specific CORF services.

Note: A CORF's purpose is to permit the beneficiary to receive multidisciplinary rehabilitation services at a single location in a coordinated fashion. Section 1861 (cc) of the Social Security Act specifies that no service may be covered as a CORF service if it would not be covered as an inpatient hospital service when provided to a hospital patient. (This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care), but rather only that the service would be covered if provided in a hospital. The requirement for CORF outpatient mental health limitation is deleted.

The policy changes that CR 6005 announces are synthesized as follows.

- CORF services are covered only if they are medically necessary and relate directly to the rehabilitation of injured, disabled, or sick patients.

Required services

The CORF must provide these core services: a) CORF physicians' services, b) physical therapy services, and c) social and psychological services.

1. CORF physician services are those physician-performed professional services that are administrative in nature; such as consultation with, and medical supervision of, nonphysician staff; patient case review conferences; utilization review; the review of the therapy/pathology plan of treatment, as appropriate; and other facility medical and administration activities necessary to provide skilled rehabilitation services (those that PTs, OTs, SLPs and RTs provide), and other services that directly relate to the rehabilitation plan of treatment.

   Please be aware that diagnostic or therapeutic services that a CORF (or other) physician provides to a CORF patient are not CORF physician services. These services are separately payable to the physician under the MPFS, at the non-facility payment amount billed as if provided in the physician's office.

   Remember that to become a CORF patient, a beneficiary must be under the care of a physician who certifies that he/she needs skilled rehabilitation services. If the referring physician does not specify the rehabilitation goals for PT, OT, SLP, or RT services; the CORF physician must established them. Further, either the referring physician or the CORF physician must establish, and sign, a rehabilitation plan of treatment prior to the beginning treatment.

   In addition, the CORF physician or the referring physician, must review the treatment plan for respiratory therapy services at least every 60 days; and for physical therapy, occupational therapy, speech-language pathology, and for all other services at least once every 90 days; certifying that the plan is being followed and that the patient is making progress in attaining the established rehabilitation goals.

Note: The CORF physician must be present in the facility enough to ensure that CORF services are provided in accordance with accepted principles of medical practice, medical direction, and medical supervision.

2. Physical therapy services should comprise a clear majority of the total CORF services . To supervise CORF physical therapy services, the physical therapist must be on the CORF premises (or must be available to the physical therapy assistant through direct telecommunications for consultation and assistance) during the CORF's operating hours.

Comprehensive outpatient rehabilitation facility coverage (continued)

3. Social and psychological services are covered only if the patient's physician (or CORF physician) establishes that the services directly relate to the patients rehabilitation plan of treatment and are needed to obtain the rehabilitation goals. Social and psychological services include only those services that address the patient's response and adjustment to the rehabilitation treatment plan; rate of improvement and progress towards the rehabilitation goals; or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory plan of treatment.

Notes:

1) CORF social and psychological services are the same, whether provided by either a qualified social worker or psychologist. Qualifications for individuals providing CORF social and psychological services are a Bachelors of Science for social workers and a Masters-level degree for psychologist;

2) Social and psychological services do not include services for mental health diagnoses.

Optional services

In addition to the above three required core services, the CORF may also furnish the following other covered and medically necessary items and services; as long as they directly relate to, and are consistent with, the rehabilitation treatment plan, and are necessary to achieve the rehabilitation goals.

1. Occupational therapy services
2. Speech-language pathology services
3. Respiratory therapy services include only those services that a qualified respiratory therapist can appropriately provide to CORF patients under a physician-established respiratory therapy plan of treatment, in accordance with current medical and clinical standards.

   These services include the physiological monitoring necessary to furnish them, and rather than paid separately, the payment is bundled into the payment for respiratory therapy services. Diagnostic and other medical services provided in the CORF setting are not considered CORF services, and therefore may not be included in a respiratory therapy plan of treatment because these are covered under separate benefit categories.

   Please take note that services performed by respiratory therapy technicians are not covered because the current medical standards for skilled respiratory therapy services provided to patients in the CORF setting require the educational requirements of respiratory therapists.

   Examples of specific RT CORF services include the respiratory therapist assessing the patient to determine the appropriateness of pursed lip breathing activity and checking the patient's oxygen saturation level (via pulse oximetry). If appropriate, the respiratory therapist may then provide the initial training in order to ensure that the patient can accurately perform this activity; and again check the patient's oxygen saturation level, or perform peak respiratory flow, or other respiratory parameters.

   These types of services are considered "physiological monitoring" and are bundled into the payment for Healthcare Common Procedure Coding System (HCPCS) codes G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes [includes monitoring]), G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes [includes monitoring]), and G0239 (Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals [includes monitoring]).

   Another example of monitoring includes the provision of a six minute walk test that is typically conducted before the start of the patient's respiratory therapy activities, and the time to provide this walk "test" assessment can be included as part of the HCPCS code G0238.

   Note: Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary to the treatment of the patient's condition and can usually be given to a patient during the course of treatment by any of the health personnel involved therein, e.g., physician, nurse, respiratory therapist.

4. Prosthetic and orthotic devices are covered, including the testing, fitting, or training in their use
5. Nursing services (which must be provided by an individual meeting the qualifications of a registered nurse [RN], rather than a licensed practical nurse [LPN]) are provided as an adjunct to the rehabilitation treatment plan of treatment, and must be reasonable and medically necessary. For example, a registered nurse may perform (including patient instruction): the proper procedure of "in and out" urethral catheterization, tracheostomy tube suctioning, or the cleaning for ileostomy or colostomy bags.

   Note: Nursing services may not be a substitute for or supplant the services of physical therapists, occupational therapists, speech-language pathologist and respiratory therapists, but instead must lend support to or further the rehabilitation services and goals.

6. CORFs can provide pneumococcal, influenza, and hepatitis B vaccines to its patients provided the facility is "primarily engaged in providing (by or under the supervision of a physician) restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons."

   Note: Because no drugs and biologicals are currently identified as appropriate to a therapy rehabilitation treatment plan, CORFs may not submit claims for drugs and biologicals.

7. Supplies and durable medical rquipment (DME) – CORFs may not bill for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding *Current Procedural Terminology* code in the 29XXX series
8. Physical therapy, occupational therapy, and speech-language pathology services may be furnished in the patient's home, as CORF services, when payment for these therapy services is not otherwise made under the Medicare home health benefit, and

Comprehensive outpatient rehabilitation facility coverage (continued)

9. A single home PT, OT, or SLP environment evaluation visit, which includes evaluating the potential impact of the home environment on the rehabilitation goals, is limited to the services that one professional (who must be either a PT, OT, or SLP, as appropriate) provides, when the corresponding treatment plan identifies the home environment evaluation as necessary. The patient must be present during the home environment evaluation visit.

Note: When, in addition to the required physical therapy, a CORF provides OT, SLP and/or RT services; the physical therapy services must represent the predominate rehabilitation service.

Note: Hyperbaric oxygen services, infusion therapy services, cardiac rehabilitation services, or diagnostic sleep studies are not considered CORF services because they do not meet the definition, nor do they relate to the rehabilitation treatment plan. These, and other services not specifically listed as CORF services, may be covered under other Medicare benefits categories, such as physician services and diagnostic services.

Payment rules

The payment basis for CORF services is 80 percent of the lesser of: 1) the actual charge for the services; or 2) the MPFS amount for the service, when the MPFS establishes a payment amount for such service. Payment for CORF services under the PFS is made for all CORF services (PT, OT, SLP, RT, and the related nursing and social and psychological services); which are part of, or relate directly to, the rehabilitation treatment plan.

If there is no fee schedule amount for a covered CORF item or service, payment is based on the lesser of 80 percent of actual charges for the services provided or the amount determined by the local Medicare contractor.

Payment for covered DME, orthotic and prosthetic devices and supplies that a CORF provides is based on the lesser of 80 percent of actual charges; or the payment amount established under the DMEPOS fee schedule, or the single payment amount established under the DMEPOS competitive bidding program (provided that payment for such an item is not included in the payment amount for other CORF services).

Payment for CORF social and psychological services is made under the MPFS only for HCPCS Code G0409, as appropriate, only when billed using revenue codes 0560, 0569, 0910, 0911, 0914 and 0919.

Payment for CORF respiratory therapy services is made under the MPFS when provided by a respiratory therapist as defined at 42 CFR 485.70(j), only to the extent that these services support or are an adjunct to the rehabilitation plan of treatment, and only when billed using revenue codes 0410, 0412 and 0419. When provided as part of a CORF respiratory therapy rehabilitation treatment plan, separate payment is not made for diagnostic tests or for services related to physiologic monitoring services; which are bundled into other therapy services appropriately performed by respiratory therapist, such as HCPCS G-codes G0237, G0238, and G0239. These three HCPCS codes are specific to services provided under the respiratory therapy plan of treatment and, as such, are not designated as subject to the therapy caps.

CORF nursing services are paid under the MPFS for nursing services, but only when provided by a registered nurse, and only to the extent that these services support or are an adjunct to the rehabilitation services that PTs, OTs, SLPs, and RTs provide, and are consistent with the rehabilitation treatment plan. In addition, payment for CORF nursing services is made only when provided by a registered nurse, and coded with HCPCS code G0128 (Direct (face-to-face with patient) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each per 10 minutes beyond the first 5 minutes) is used to bill for these services, and only with revenue codes revenue 0550 and 0559.

Note: Services provided under the "incident to" benefit may not be recognized as CORF services. Services furnished by CORF personnel, including registered nurses, physical therapists, occupational therapists, speech-language pathologist and respiratory therapists are not considered furnished incident-to physician services.

Payment for covered pneumococcal, influenza, and hepatitis B vaccines provided in the CORF setting is based on 95 percent of the average wholesale price. The registered nurse provides administration of the vaccines using *CPT* code *90471*.

- Finally, CR 6005 announces that the requirement for CORF outpatient mental health treatment limitation is deleted.

Additional information

This article only summarizes the CORF manual revision made by CR 6005 and you may find the complete details by reviewing CR 6005, located at *http://www.cms.hhs.gov/Transmittals/downloads/R111BP.pdf* on the CMS Web site. You will find the updated *Medicare Benefit Policy Manual*, Chapter 12, (Comprehensive Outpatient Rehabilitation Facility [CORF] Coverage), as an attachment to CR 6005.

In addition, for specific payment requirements for CORF, items and services, see the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), which you may find at *http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6005
Related Change Request (CR) #: 6005
Related CR Release Date: September 25, 2009
Effective Date: July 7, 2008
Related CR Transmittal #: R111BP
Implementation Date: October 26, 2009

General Coverage

Wrong surgical/other invasive procedure performed on a patient and/or body part

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

Note: This article was revised on September 29, 2009, to reflect the issuance of a revised change request (CR) 6405, which the Centers for Medicare & Medicaid Services issued on September 25, 2009. As a result, the CR release date, transmittal number, and the Web address for accessing CR 6405 were changed. Also, for the revisions to the *Medicare Claims Processing Manual*, see the article related to CR 6634 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6634.pdf* on the CMS Web site. All other information remains the same. This information was previously published in the July 2009 *Medicare B Update!* pages 28-30.

Provider types affected

Physicians, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs] or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop -- impact to you

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (*BPM*) Chapter 1, Sections 10 and 180 and Chapter 16, Section 120. This is pursuant to the *National Coverage Determinations* (*NCDs*) made as part of CR 6405.

Caution -- what you need to know

For inpatient claims, hospitals are required to submit a no-pay claim (TOB 110) when the erroneous surgery related to the NCD is reported. If there are covered services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the noncovered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

Go -- what you need to do

Make sure that your billing staff are aware of these new billing and claim requirements.

Background

In 2002, the National Quality Forum (NQF) published Serious Reportable Events in Healthcare: A Consensus Report, which listed 27 adverse events that were "serious, largely preventable and of concern to both the public and health care providers." (That report is available at *http://www.qualityforum.org/Publications/2002/Serious_Reportable_Events_in_Healthcare.aspx* on the Internet.) These events and subsequent revisions to the list became known as "never events." This concept and need for the proposed reporting led to NQF's "Consensus Standards Maintenance Committee on Serious Reportable Events," which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally noncover the three surgical errors and sets billing policy to implement appropriate claims processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (*BPM*) Chapter 1, Sections 10 and 180, and Chapter 16, Section 120. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

Note: Related services do not include performance of the correct procedure.

Definitions

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the *Current Procedural Terminology* (*CPT*) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

- A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.
- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

Note: Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

Beneficiary liability

Generally, a beneficiary liability notice such as an advance beneficiary notice of noncoverage (ABN) or a hospital issued notice of noncoverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the *Medicare Claims Processing Manual*, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the noncovered item/service. (The *Medicare Claims Processing Manual* is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the *Medicare Claims Processing Manual*, Chapter 30, Section 200.

Thus, a provider cannot shift financial liability for the noncovered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the *Medicare Claims Processing Manual*.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the noncovered surgical error that would not be considered a related service to the noncovered surgical error (see Chapter 1, Sections 10 and 180, and Chapter 16, Section 120, of the *Benefit Policy Manual*).

Implementation

Inpatient claims

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to submit a no-pay claim (TOB 110) when the erroneous surgery related to the NCD is reported. If there are covered services/procedures provided during the same stay as the erroneous surgery, hospitals are then required to submit two claims:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11x (with the exception of 110), and,
- The other claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).

Note: Both the covered and noncovered claim must have a matching statement covers period.

For discharges on or after January 15, 2008, and before October 1, 2009, the noncovered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in form locator (FL) 80 (Remarks), or the 837i (electronic) claim form, loop 2300, one of the applicable 2-digit surgical error codes as follows:

- MX – for a wrong surgery on patient
- MY – for surgery on the wrong body part, or
- MZ – for surgery on the wrong patient.

For discharges on or after October 1, 2009, hospitals will refer to MM6634 for how to submit an erroneous surgery claim. MM6634 may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6634.pdf* on the CMS Web site.

The claim for the noncovered services will be denied using:

- Claim adjustment reason code (CARC) 50 - These are noncovered services because this is not deemed a 'medical necessity' by the payer.
- Group Code CO - Contractual Obligation.

Outpatient, ambulatory surgical centers (ASCs), other appropriate bill types and practitioner claims

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery wrong body part
- PB: Surgery wrong patient
- PC: Wrong surgery on patient

Contractors will suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Contractors will create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence will be added to the list, and an MPP event or a system control facility (SCF) rule will be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors will then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

- CARC 50 – these are noncovered services because this is not deemed a 'medical necessity" by the payer.
- Group Code - CO – contractual Obligation

Related claims

Within five days of receiving a claim for a surgical error, contractors will begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors will review any claims applied to SCF rules and MPP events to identify incoming claims that have the potential to be related. When Medicare identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors will continue to review beneficiary history for related claims and take appropriate action as necessary.

Additional information

For complete details regarding this CR please see the official instruction (CR 6405) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction was issued in two transmittals. The first transmittal presents the national coverage determination related to this issue and that transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf* on the CMS Web site. The other transmittal presents the claim processing instructions. That transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R1819CP.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6405 *Revised*
Related Change Request (CR) #: 6405
Related CR Release Date: September 25, 2009
Effective Date: January 15, 2009
Related CR Transmittal #: R1819CP and R102NCD
Implementation Date: July 6, 2009, for those billing carriers and Part B MACs; October 5, 2009, for FIs and Part A MACs

Clarification of the use of modifiers when billing 'wrong surgery on a patient'

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, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop -- impact to you

The Healthcare Common Procedure Coding System (HCPCS) modifier PC (Wrong Surgery on Patient) was recently established in change request (CR) 6405, along with two other modifiers, for use in Medicare billing, to be appended, where appropriate, to all claim lines related to a surgical error.

Caution -- what you need to know

Some providers or their billing services may be incorrectly using the HCPCS modifier PC to indicate the professional component for certain services not related to surgical error when the modifier 26 should have been used. You need to be aware that the use of the modifier PC on Medicare claims will result in the claim being denied.

Go -- what you need to do

Please be sure that you and your billing personnel/services prepare claims submitted to Medicare with the correct codes in order for the claims to process correctly.

Background

This special edition article clarifies the correct use of certain HCPCS modifiers. To briefly clarify, please note that:

- **Modifier PC** is used to identify wrong surgery on patient. The modifier PC is to be appended, where appropriate, to all claim lines related to a surgical error.
- **Modifier 26** is used to identify the professional component of a service or a procedure.

As appropriate, please review "MM6405: Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient," which explains the wrong surgery HCPCS modifiers. This article is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6405.pdf* on the CMS Web site.

Additional information

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

MLN Matters® Number: SE0927
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

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 October 5, 2009, to reflect a revision to change request (CR) 6417 that was issued on October 2, 2009. The effective date, CR release date, transmittal number, and the Web address for accessing CR 6417 were revised. All other information remains the same. This information was previously published in the September 2009 *Medicare B Update!* pages 23-24.

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. *MLN Matters* 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 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 change request (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 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. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring 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. 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.
- 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.

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

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 claim 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/R572OTN.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: October 2, 2009
Effective Dates: Phase 1: October 5, 2009,
Phase 2: January 1, 2010
Related CR Transmittal #: R572OTN
Implementation Dates: Phase 1: October 5, 2009,
Phase 2: January 4, 2010

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Electronic Data Interchange

Update of remittance advice remark codes and claim adjustment reason codes

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

Provider action needed

Change request (CR) 6604, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs). Be sure billing staff are aware of these changes.

Background

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

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Internet. The lists following the end of the *Additional Information* section summarizes the latest changes.

Additional information

To see the official instruction (CR 6604) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1804CP.pdf* on the CMS Web site.

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

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

New codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	1/1/2010

Modified codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 04/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. This change to be effective 04/01/2010: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
54	Multiple physicians/assistants are not covered in this case. This change to be effective 04/01/2010: Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
55	Procedure/treatment is deemed experimental/investigational by the payer. This change to be effective 04/01/2010: Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010

Update of remittance advice remark codes and claim adjustment reason codes (continued)

Code	Current Narrative	Effective Date (per WPC posting)
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. This change to be effective 04/01/2010: Procedure/treatment has not been deemed `proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. This change to be effective 04/01/2010: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 04/01/2010: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
90	Ingredient cost adjustment. This change to be effective 04/01/2010: Ingredient cost adjustment. Note: To be used for pharmaceuticals only.	4/1/2010

Deactivated codes - CARC

Code	Current Narrative	Effective Date
156 *	Flexible spending account payments. Note: Use code 187.	10/1/2009

* Also included in CR 6453

New codes - RARC

Code	Current Narrative	Medicare Initiated
N519	Invalid combination of HCPCS modifiers.	No
N520	Alert: Payment made from a Consumer Spending Account.	No

Modified codes – RARC:
None

Deactivated codes – RARC
None

MLN Matters® Number: MM6604
Related CR Release Date: August 28, 2009
Related CR Transmittal #: R1804CP

Related Change Request (CR) #: 6604
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Medicare Remit Easy Print software version 2.7 is available

Version 2.7 of the Medicare Remit Easy Print (MREP) software is available for download at *http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp* on the CMS Web site. For a description of the changes in this version, see the "What's New" section of the *Medicare Remit Easy Print User Guide – Version 2.7* at *http://www.cms.hhs.gov/AccesstoDataApplication/Downloads/EasyPrintUserGuide.pdf*.

Source: PERL 200910-21

Activation of new coordination of benefits agreement trading partner dispute error code

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, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6640, which conveys a new coordination of benefits agreement (COBA) trading partner dispute error code that the coordination of benefits contractor (COBC) will return to Medicare contractors when certain claims are not accepted by supplemental payers. Billing staff should be aware of this change.

Background

The COBC consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) developed and further refined the COBC detailed error report process through the issuance of CR 3709 (See Transmittals 474, dated February 11, 2005, at *http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf* on the CMS Web site) and CR 5472 (See Transmittal 1189 dated February 28, 2007, at *http://www.cms.hhs.gov/Transmittals/Downloads/R1189CP.pdf* on the CMS Web site).

Under the COBC detailed error report process, the COBC reports to Medicare contractors, via a standard detailed error report layout, any of the following error conditions that resulted in their claims not being crossed over:

- Incoming flat file contained structural problems ("111" flat file errors)
- Incoming flat file contained claims with Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) compliance errors ("222" errors), and
- The COBA trading partner rejected the contractors' claims ("333" trading partner dispute errors).

Note: Crossover is the transfer of processed claim data from Medicare operations to commercial insurance companies that sell supplemental insurance benefits to Medicare beneficiaries and to Medicaid (or state) agencies.

Depending upon the error percentage encountered in association with errored claims, Medicare contractors then, after five business days, automatically generate special provider notification letters informing the affected physician/supplier/provider that the beneficiary's claim(s) cannot be crossed over.

In earlier instructions CMS directed Medicare contractors to suppress creation of their standard provider notification letters when they receive any of the following "333" dispute reason codes via the COBC detailed error reports:

- 00100—duplicate claim
- 000110—duplicate claim within the same ISA-IEA loop, and
- 000120—duplicate claim within the same ST-SE loop.

CMS made this decision primarily for two reasons:

1. It was believed that these particular error conditions were out of the control of the billing provider.
2. It would be futile for the provider to bill the claims to the COBA trading partner outside the crossover process given that the entity had already received the claim, as witnessed by its lodging of a dispute on the basis of duplicate claim receipt.

Currently, the only in-use "333" dispute codes that will trigger provider notification letters are the following:

- 000200 -- Claim for provider ID/state should have been excluded; 000300—beneficiary not on eligibility-file
- 000500 -- Incorrect claim count; 000600—claim does not meet selection criteria
- 000700 -- HIPAA Error
- 009999 -- Other

Through CR 6640, the COBC will activate dispute reason code 000400 (previously reserved for future use) as a new "333" trading partner dispute code. As a result of this action, the COBC will:

1. Transmit error code 000400 to Medicare contractor when indicated via the COBC detailed error report, and
2. Include within the error description field on the COBC Detailed Error Report the following standard message: "No provider agreement with Medicaid/other payer; claims crossover not possible."

Also, as a result of CR 6640, all Medicare contractors will generate error code 000400 when received via their COBC detailed error report with accompanying error message on their outgoing notification letters to providers, physicians, or suppliers. As indicated in CR 6640, upon receipt of the contractor-generated special letters, affected providers, physicians, or supplier may wish to contact their patient's indicated supplemental payer to determine next steps.

Activation of new coordination of benefits agreement trading partner dispute error code (continued)

Additional information

The official instruction, CR 6640, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R562OTN.pdf* on the CMS Web site.

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

MLN Matters® Number: MM6640
Related CR Release Date: September 25, 2009
Related CR Transmittal #: R562OTN
Related Change Request (CR) #: 6640
Effective Date: October 26, 2009
Implementation Date: October 26, 2009

Medicare administrative contractor transition and outbound HIPAA transactions

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 operating in multiple states under a single national provider identifier (NPI) and receiving Health Insurance Portability and Accountability Act (HIPAA) outbound transactions from Parts A and B (A/B) Medicare administrative contractors (MACs) are affected.

Provider action needed

This article, based on change request (CR) 6599, informs all physicians, and providers who operate in multiple states under a single NPI that, beginning with the effective date of January 1, 2010, they will receive HIPAA outbound transactions separated by the appropriate contractor identifier (ID) number assigned to a MAC in files generated by Medicare's multi-carrier claim system (MCS) that process Part B claims. Ensure that your billing staffs are aware of this change.

Background

Through implementation of Medicare Contracting Reform, the Centers for Medicare & Medicaid Services (CMS) is integrating the administration of Medicare Parts A and B for the fee-for-service benefit to new entities called Medicare administrative contractors (MACs). CMS designed the new MAC jurisdictions to balance the allocation of workloads, promote competition, account for integration of claims processing activities, and mitigate the risk to the Medicare program during the transition to the new contractors. The result is jurisdictions that reasonably balance the number of fee-for-service beneficiaries and providers across states.

When there is a provider with a single NPI who provides services across states, Medicare-generated outbound transactions (835 – Health Care Claim Payment/ Advice and 277 – Health Care Claim Status Notification) do not report the appropriate contractor ID in the envelope. The outbound transaction reported the first contractor ID for the MAC in the envelope when the transaction included multiple claims and status responses from a provider covering multiple states. This created an issue for clearinghouses trying to forward the correct 835/277 to the appropriate provider location. Beginning January 1, 2010, Medicare will generate separate professional outbound files by the appropriate contractor ID number assigned to a MAC.

Additional information

If you have questions, please contact your 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 6599, issued to your Medicare A/B or DME MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R544OTN.pdf* on the CMS Web site.

MLN Matters® Number: MM6599
Related Change Request (CR) #: 6599
Related CR Release Date: August 28, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R544OTN
Implementation Date: January 4, 2010

General Information

One-time mailing of supplier responsibilities letter – individual practitioners only

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

Provider types affected

All physician and nonphysician practitioners with Medicare billing privileges are affected.

Provider action needed

Stop -- impact to you

All physicians and nonphysician practitioners must comply with Medicare reporting responsibilities and report relevant address and other enrollment changes in a timely manner. For example, failure to report an address change timely may affect your billing privileges and payment of claims.

Caution -- what you need to know

The Centers for Medicare & Medicaid Services (CMS) has directed Medicare contractors (carriers and Medicare administrative contractors [MACs]) to notify all sole proprietor physicians and nonphysician practitioners of their reporting responsibilities with a one-time mailing. Contractors must complete this mailing to physicians, who are sole proprietors, by November 30, 2009, and to sole proprietor nonphysician practitioners by December 31, 2009.

Go -- what you need to do

You need to review the mailing and ensure that you have complied with the reporting responsibilities. Make sure your billing staffs are aware of these responsibilities.

Background

Currently, the CMS and the Medicare contractors conduct general outreach to physicians and nonphysician practitioners about their reporting responsibilities. This article is based on change request (CR) 6278, which is a continuation of this outreach. The CMS has directed Medicare contractors to notify all physicians and nonphysician practitioners of their reporting responsibilities using CMS developed fact sheets available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/PhysicianReportingResponsibilities.pdf* and *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/nonphysicianReportingResponsibilities.pdf* on the CMS Web site, via established communication channels (i.e., listserv announcements, bulletins, etc.).

Contractors must notify all active physicians and nonphysician practitioners of their reporting responsibilities with a one-time mailing using the CMS developed materials cited above. Contractors must complete this mailing to sole proprietor physicians by November 30, 2009, and to sole proprietor nonphysician practitioners by December 31, 2009.

Medicare contractors will deactivate the billing privileges for any physician or nonphysician practitioner for whom the mail is returned as undeliverable and the contractor does not already have a change of address enrollment application pending from the physician or nonphysician practitioner.

The Medicare contractor will then mail a revalidation letter with another copy of the responsibilities letter to any physician or nonphysician practitioner whose billing privileges are deactivated. The contractor will determine the most feasible address to use in mailing this revalidation letter, which will explain the need to report current address information via a CMS-855.

Billing privileges will remain deactivated until the CMS-855 is received and processed. Claims for services rendered from the date of deactivation until the date of reactivation may not be payable per 42 *Code of Federal Regulations* (CFR) 424.516(d)(1)(iii) and 42 CFR 424.540(a)(2). Contractors will follow the procedures in the *Program Integrity Manual* Chapter 10 Section 13 to reactivate Medicare billing privileges.

Additional information

If you have questions, please contact your Medicare 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.

The official instruction, CR 6278, issued to your Medicare carrier or MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R568OTN.pdf* on the CMS Web site.

Following are the titles and brief descriptions of the fact sheets cited in the *Background* section (along with their Web addresses) which may be downloaded from the CMS Web site:

Fee-For-Service Provider Enrollment Reporting Responsibilities for Individual Physicians Enrolled in the Medicare Program

After enrolling in the Medicare program, all physicians are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. This fact sheet outlines such reportable events for physicians. (March 2009) (ICN# 901643)

One-time mailing of supplier responsibilities letter -- individual practitioners only (continued)

Fee-For-Service Provider Enrollment Reporting Responsibilities for Individual Nonphysician Practitioners Enrolled in the Medicare Program

After enrolling in the Medicare program, all nonphysician practitioners are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. This fact sheet outlines such reportable events for individual nonphysician practitioners. (March 2009) (ICN# 901644)

MLN Matters® Number: MM6278
Related Change Request (CR) #: 6278
Related CR Release Date: October 2, 2009
Effective Date: November 2, 2009
Related CR Transmittal #: R568OTN
Implementation Date: November 2, 2009

Fistula first breakthrough initiative provides roadmap to reach 66 percent goal

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the Fistula First Breakthrough Initiative (FFBI) has released a strategic plan that aims to achieve CMS goal that two-thirds (66 percent) of prevalent hemodialysis patients will use an arteriovenous (AV) fistula as their primary method of vascular access.

The FFBI strategic plan focuses on seven strategies and two policy recommendations. The plan was developed by conducting a root-cause analysis that identified the underlying barriers to AV fistula placement and use. A technical expert panel identified potential solutions to address the root causes.

Led by the FFBI coalition, with support from the end-stage renal disease (ESRD) network organizations and the quality improvement organizations (QIOs) under CMS leadership, the strategic plan includes the following concepts:

1. Nephrologist as leader: Encourage and support nephrologists to take a leadership role and be accountable for vascular access management in all hemodialysis patients.
2. Leveraging partnerships: Partner with organizations to improve AV fistula placement and utilization rates.
3. Hospital systems: Modify hospital systems to promote AV fistula placement.
4. Patient self-management: Promote patient self-management through the stages of chronic kidney disease.
5. Addressing access problems: Promote fast-track protocols for rapid identification and referral of vascular access problems, which include failure to mature, revisions of the failing AV fistula, and failure to place an AV fistula.
6. Practitioner training and credentialing: Promote training, experience, and credentialing of healthcare professionals in the area of hemodialysis vascular access management.
7. FFBI change concepts: Expand and endorse the current change concepts for education and promotion throughout the renal, surgical, and interventional communities.

The percentage of prevalent hemodialysis patients in the U.S. with an AV fistula as their primary vascular access was 32.4 percent (87,344 patients) at the beginning of 2003. By May 2009, this percentage had increased to 52.6 percent (179,113 patients). As a result, nearly 92,000 additional patients experienced improved adequacy, fewer hospitalizations, fewer infections, and a lowered mortality risk than those with other forms of vascular access. The dramatic change in practice patterns that produced the improvement was due to the targeted efforts of many organizations and individuals, facilitated by the Fistula First Breakthrough Initiative. However, the CMS goal, based upon achievable practice, is a prevalent AV fistula utilization rate of 66 percent, which means that there are additional opportunities for improvement.

The FFBI strategic plan presents recommendations for accountability and organizational, behavioral, and infrastructural changes across health care systems which, if implemented, will result in sustainable outcomes improvement.

To read the FFBI strategic plan online, please visit *http://www.fistulafirst.org* on the Internet. To learn more about the portfolio of CMS ESRD quality projects online visit, *http://www.cms.hhs.gov/ESRDQualityImproveInit/* on the CMS Web site.

Source: PERL 200910-23

New USP standards for heparin products will result in decreased potency

For the Centers for Medicare & Medicaid Services providers and interested health care advocates

To ensure the quality of heparin and to guard against potential contamination, the United States Pharmacopeia (USP), a nonprofit standard-setting organization, adopted new manufacturing controls for heparin effective October 1. These changes include a modification of the reference standard for the drug's unit dose resulting in a 10 percent reduction in potency. A link to a U.S. Food and Drug Administration (FDA) health alert is provided in the FDA press release (link provided below).

While there are concerns that quantities of the former dosage may linger for some months, it is important to share this update with health care providers, advocacy groups, and others. The FDA news release is available at *http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm184674.htm*.

Source: PERL 200910-03

Updates to physician payment information for value-driven health care

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 and 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 page where it may be viewed along with hospital quality information at *http://www.medicare.gov*.

On August 28, 2009, Medicare posted an update to the ASC data. The physician payment data was posted on September 25, 2009. Hospital outpatient department 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 200909-38

Hospital outpatient department payment information for value-driven health care

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 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. An update to the physician payment data was posted on September 25, 2009, and an update to the hospital outpatient department data was posted on October 14, 2009. The information is being displayed in the same format as in previous years, updated with calendar year (CY) 2008 data. The posting updates may be found at: *http://www.cms.hhs.gov/HealthCareConInit/*.

Source: PERL 200910-22

Unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

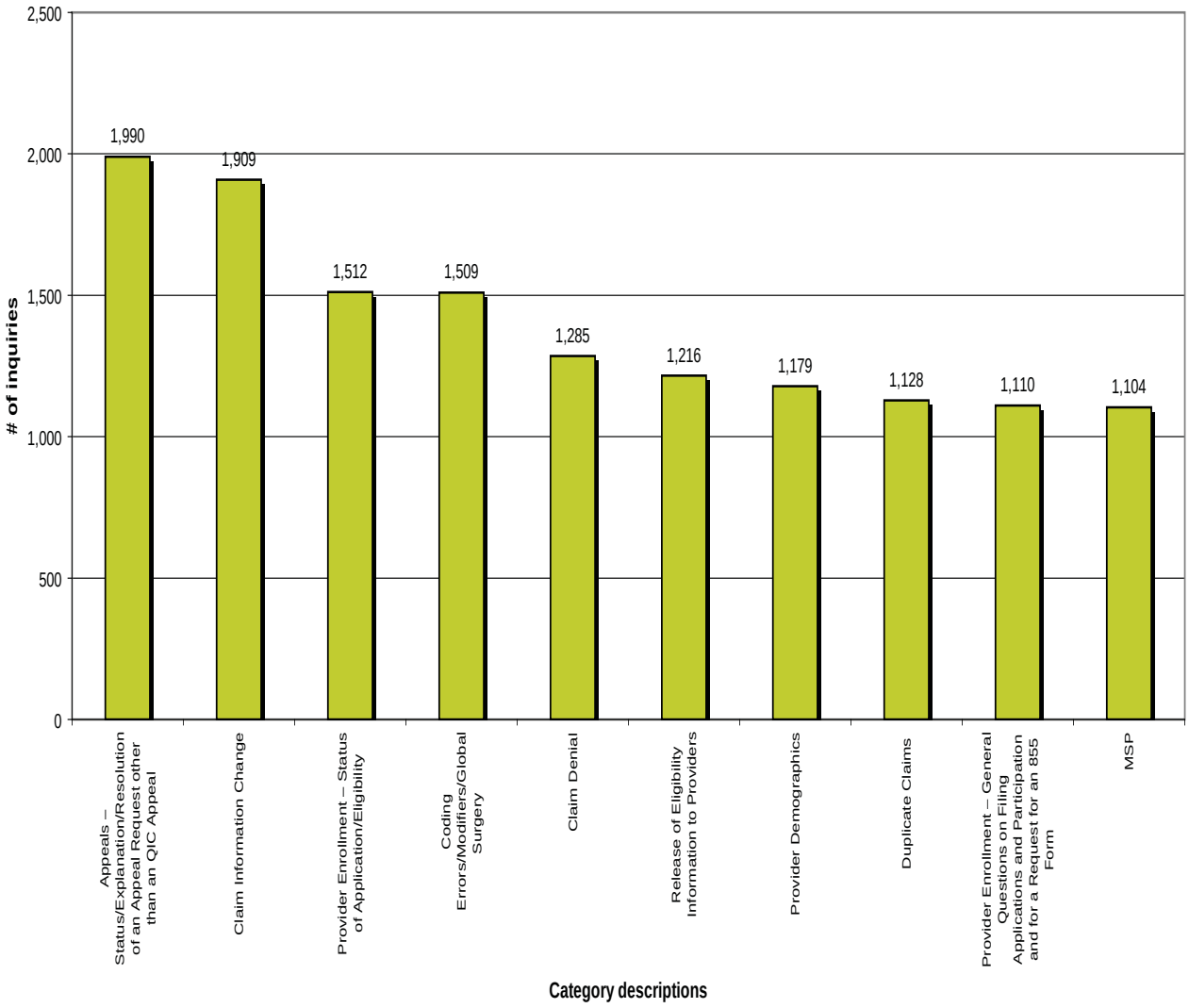
> The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Transmittal 50, CR 3274

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

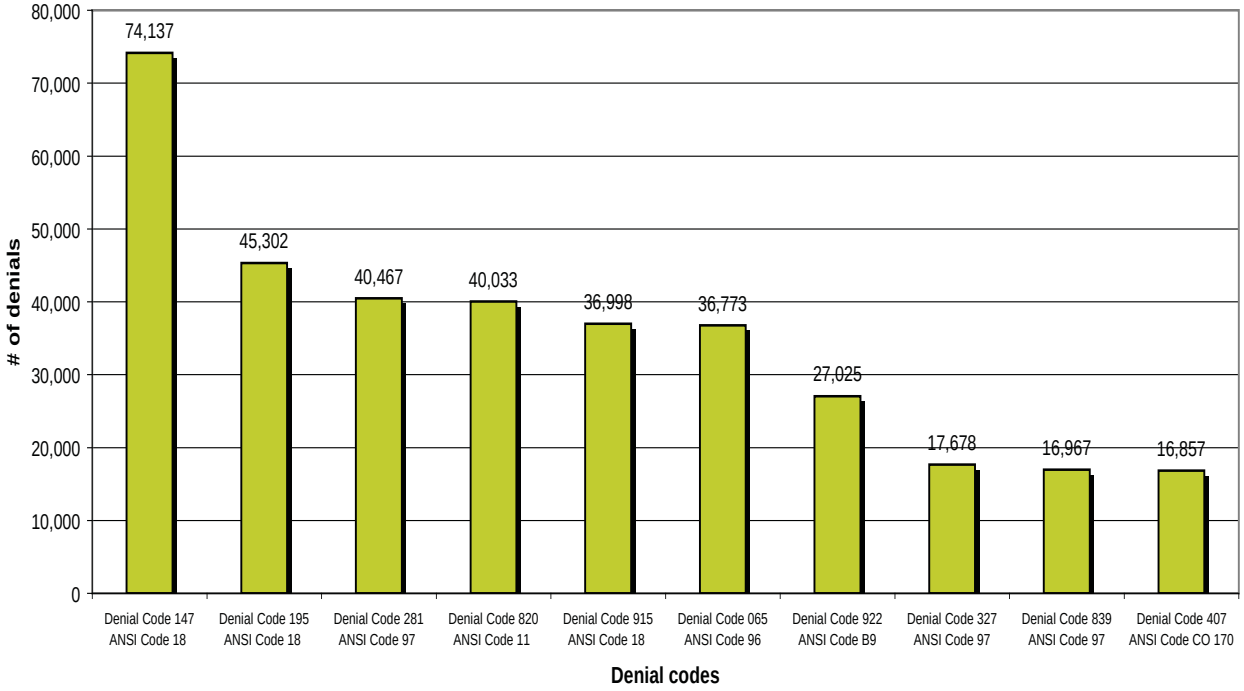


Find LCDs faster on our new medical coverage page

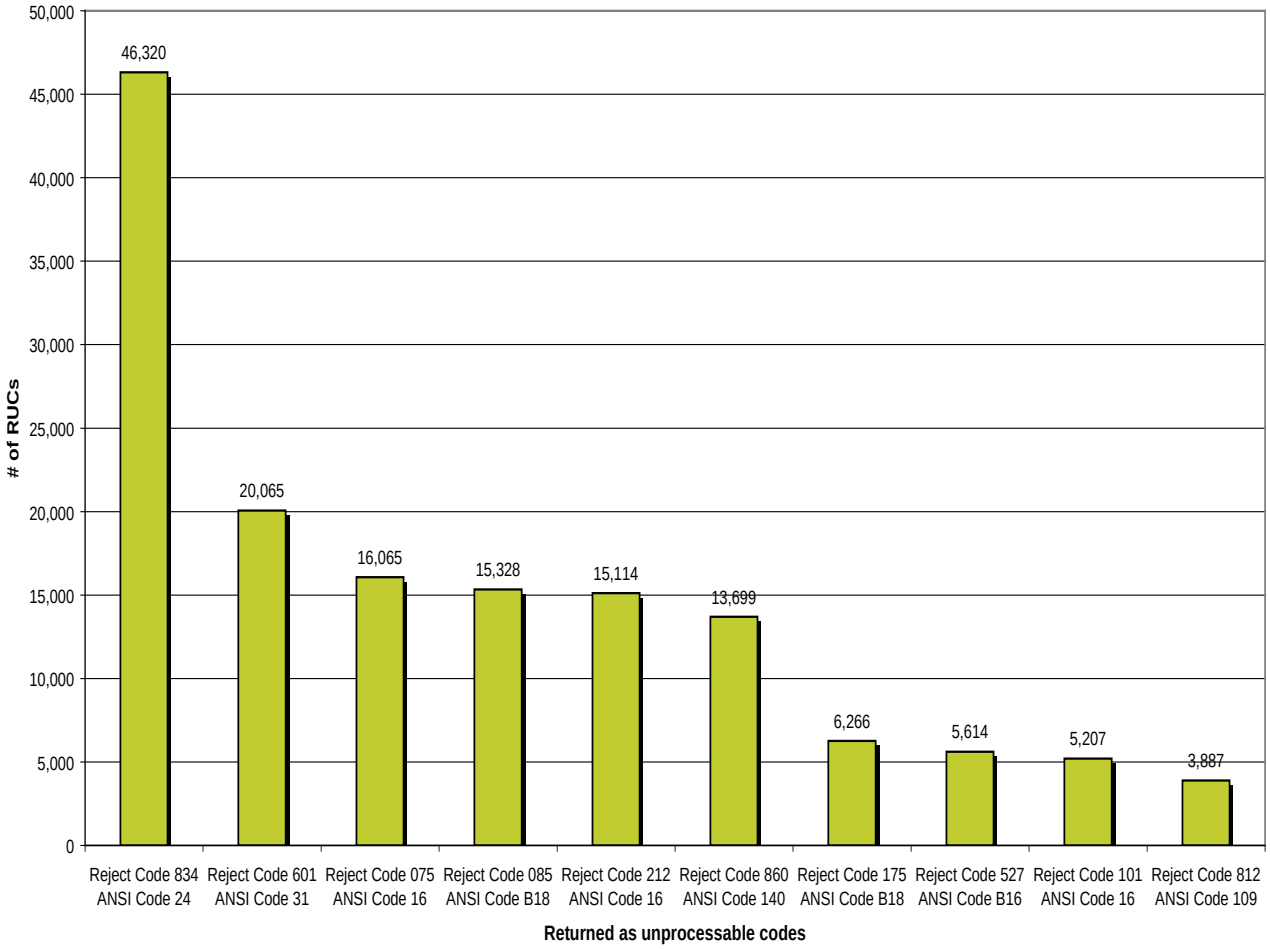
Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news and resources you need more quickly and easily than ever before -- try it today. *http://medicare.fcso.com/Landing/139800.asp*.

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

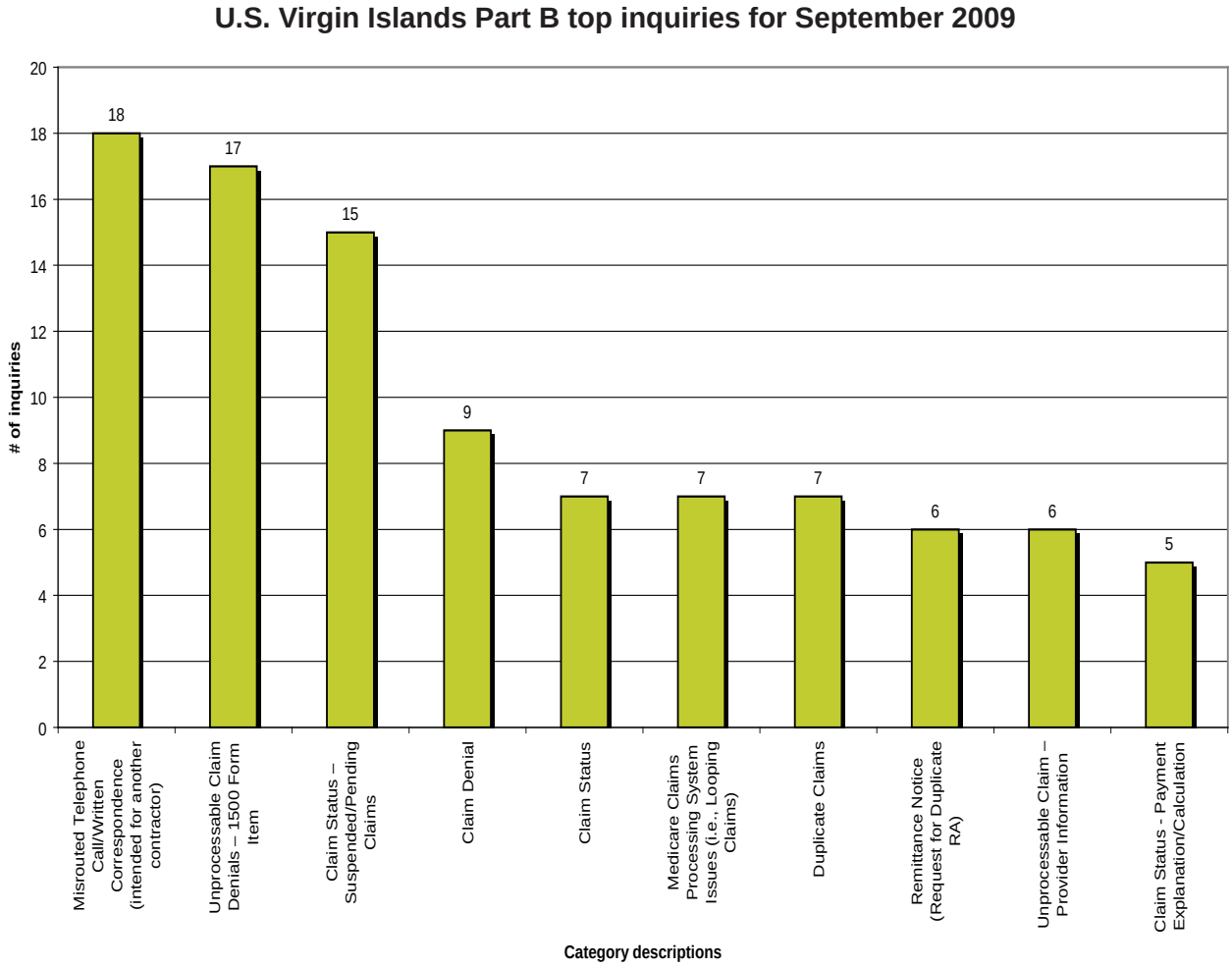
Florida Part B top denials for September 2009



Florida Part B top return as unprocessable claims (RUC) for September 2009



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



Timely claim filing guidelines for all Medicare providers

Medicare regulations establish a time limit for submitting claims to the contractor within the established timeliness parameters. In general, such claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is the second year after the year in which such services were furnished. Based on this regulation, providers have a minimum of 15 months to a maximum of 27 months.

The time parameters are:

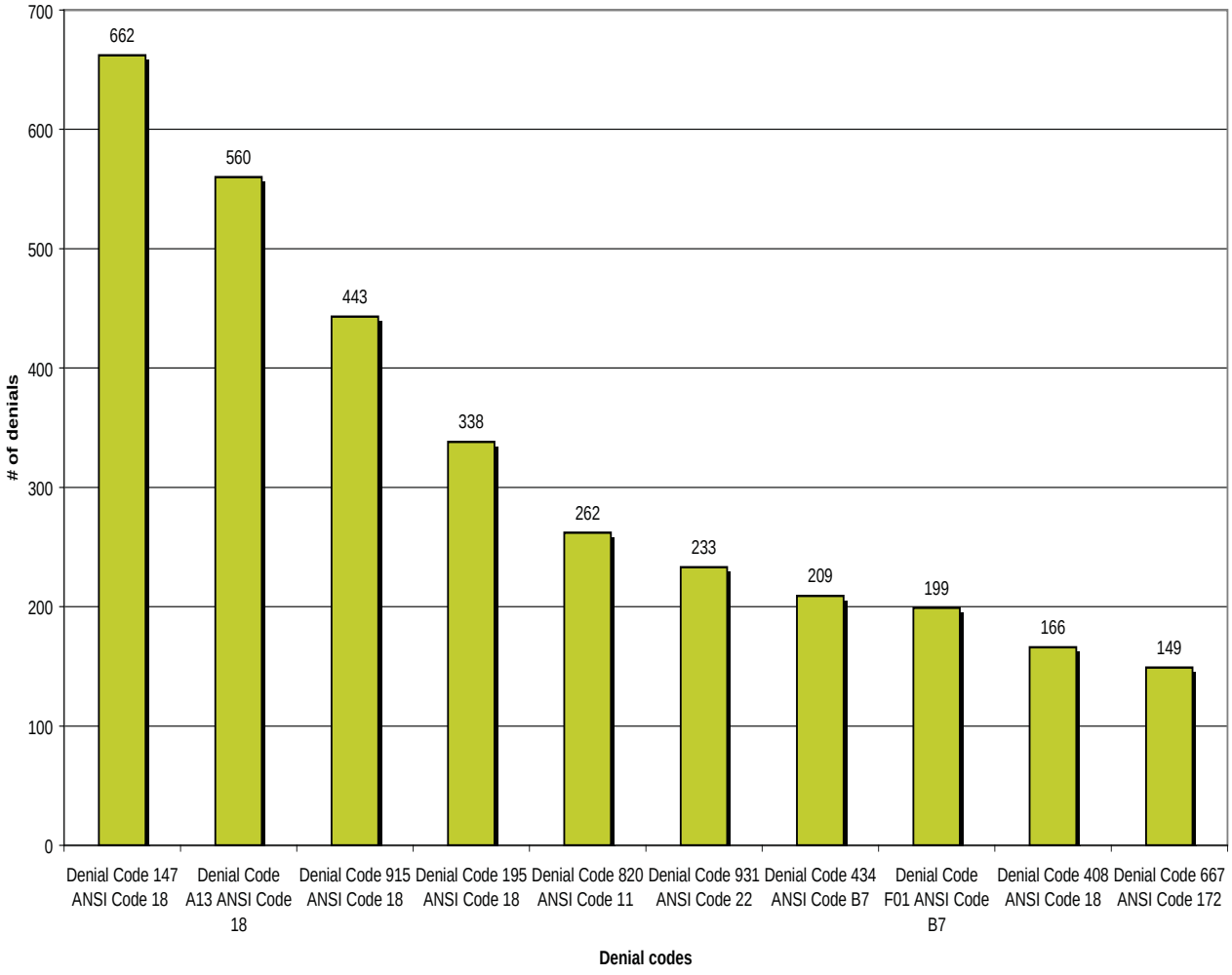
Dates of Service	Last Filing Date
October 1, 2007 – September 30, 2008	by December 31, 2009
October 1, 2008 – September 30, 2009	by December 31, 2010
October 1, 2009 – September 30, 2010	by December 31, 2011
October 1, 2010 – September 30, 2011	by December 31, 2012

Medicare determines whether a claim has been filed timely by comparing the date the services were furnished (line item date or claim statement "from" date) to the receipt date applied to the claim when it is received. If the span between these two dates exceeds the time limitation, the claim is considered to have been not timely filed. When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination". As such, the determination that a claim was not filed timely is not subject to appeal.

Source: CMS Pub. 100-04 (*Medicare Claim Processing Manual*), Chapter 1, Section 70

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

U.S. Virgin Islands Part B top denials for September 2009



How to avoid duplicate claim denials

First Coast Service Options Inc (FCSO) offers a free Web-based training (WBT) course specific to duplicate claims. To access the "Duplicate Claims – Part B WBT," visit our FCSO Medicare Training Web site *http://www.fcsomedicaretraining.com*.

FCSO offers free educational sessions throughout the year, focused on particular billing issues you may be experiencing. These may include webcasts and seminars on avoiding duplicate claims for Part B.

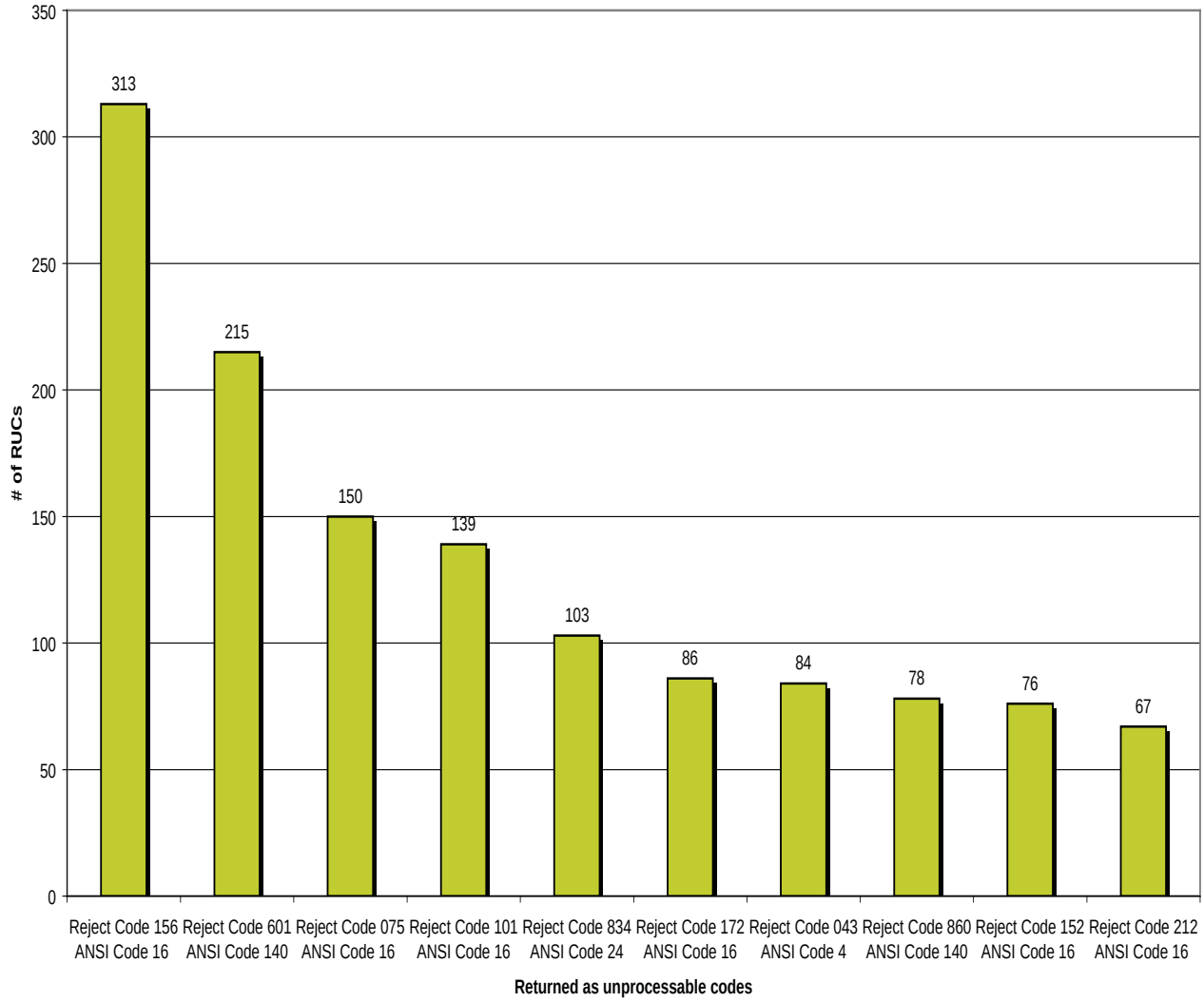
The current educational events calendar is available at *http://medicare.fcso.com/Education_resources/139814.asp*.

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 September 2009 (continued)

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



Correcting a returned claim for invalid or missing rendering physician

Additional frequently asked questions and answers (FAQs) on unprocessable claims and more are available at *http://medicare.fcso.com/FAQs/138143.asp*.

Q. I received a claim returned as unprocessable with CO-16 (or CO-B16), with a message code indicating "Rendering Physician # Invalid/Missing; Submit a new claim." How do I correct this?

A. You would verify and correct (or enter) the rendering physician's national provider identifier (NPI) in the 2310B rendering provider loop, segments NM 108 (XX) and NM109 (NPI) of the 837P electronic claim or the lower, non-shaded portion of Item 24J of the CMS-1500.

Note: The rendering provider's NPI must be reported in the rendering physician number section if a billing group's information is indicated in the billing provider information area (2010AA billing provider loop of the 837P electronic claim or Item 33 of the CMS-1500).

For additional guidance on how to report a rendering physician's billing information, see the "Claim completion FAQs" at *http://medicare.fcso.com/FAQs/138141.asp*.

Once the information is verified and corrected, the claim should be resubmitted.

Alternative process for individual eligible professionals to access PQRI and e-Prescribing feedback reports

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

Provider types affected

Individual eligible professionals (EPs) requesting reports based on their individual national provider identifier (NPI) have an alternative means of accessing those reports. Physicians and other practitioners who qualify as individual EPs under the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) and the 2009 e-Prescribing Incentive Program can request feedback reports through their claims processing contractor. The *MLN Matters* article (MM6394) listing individual EPs under these incentive programs may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6394.pdf* on the CMS Web site.

What you need to know

- CMS has created an alternative process that individual EPs may use to request 2007 re-run and 2008 PQRI feedback reports based on their individual NPI.
- Based on the nature of your questions (e.g., status of your PQRI incentive payment, measures, coding, or the feedback reports), you may need to contact different entities.
- e-Prescribing feedback reports for data submitted in calendar year 2009 will be available in late 2010. CMS will notify EPs when they can begin requesting these reports using this alternative process.

You should make sure your billing staffs are aware of this information. Please refer to the information below for more details.

Background

In the past, EPs could only access PQRI feedback reports through a secure Web site after first registering in the CMS security system known as Individuals Authorized Access to the CMS Computer Services (IACS). CMS is now offering an alternative feedback report request process which will be available beginning October 19, 2009.

This new process eliminates the need for individual EPs to register in IACS for their feedback report.

Alternative PQRI feedback report request process for individual EPs

Beginning on October 19, 2009, individual EPs can call their respective carrier or A/B MAC provider contact center to request 2007 re-run and 2008 PQRI feedback reports that will contain data based on their individual NPI. This means that EPs who are part of a group practice can get their individual feedback reports as well.

When requesting feedback reports, EPs will be asked to provide an e-mail address. EPs can then expect to receive the e-mailed feedback report within 30 days of the request. If no report is available, the provider will receive an e-mail notification.

EPs requesting reports based on taxpayer identification number for group practice information

EPs who request feedback reports based on taxpayer identification number (TIN) or group practice information will still be required to access their PQRI feedback reports via the PQRI Portal after first registering in IACS. An IACS user identification and password is required to access the PQRI Portal. The PQRI Portal may be found at *http://www.qualitynet.org/pqri* on the Internet.

Correct contact based on questions

CMS has provided the following resources to answer your questions about the PQRI and e-Prescribing programs, incentive payments, feedback reports, and IACS registration and account issues.

1. A/B MAC and carrier provider contact centers can answer questions concerning incentive payment status, such as:
   - Was my incentive payment sent?
   - What is my incentive payment amount?
   - What does my remittance advice(s) mean?

   To get a list of provider contact centers, see *http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.
2. Quality Net Help Desk can provide general PQRI and e-Prescribing information as well as answer questions about PQRI feedback report availability and access, coding, measures, and the feedback reports themselves. Examples of questions they can assist with include:
   - Do I have a PQRI feedback report available for this TIN or NPI?
   - When will my PQRI feedback reports be available?
   - Why am I unable to view my PQRI feedback report on the PQRI portal?
   - Did I qualify for a PQRI incentive payment?
   - When will my PQRI incentive payment be available?

Alternative process for individual eligible professionals to access PQRI and e-Prescribing feedback reports (continued)

- Can you explain a specific part of my PQRI feedback report?

Contact the QualityNet Help Desk Monday-Friday from 7:00 a.m.-7:00 p.m. (CT) at 1-866-288-8912 or by e-mail: *qnetsupport@sdps.org*.

3. External User Services (EUS) can resolve issues concerning IACS registration and account issues such as:
   - I need help registering in IACS
   - I need help accessing my IACS account
   - I need help changing my IACS account, and
   - I need help approving users in my organization.

   Contact EUS at 1-866-484-8049 Monday-Friday from 7:00 a.m.-7:00 p.m. (ET) or by e-mail: *EUSsupport@cgi.com*.

Additional information

Please remember that EP and group practice provider enrollment information must be current in the Medicare Provider Enrollment Chain and Ownership System (PECOS) in order to request an IACS account. An IACS account is needed to access the PQRI Portal and view or download TIN-level PQRI feedback reports. See *http://www.cms.hhs.gov/MedicareProviderSupEnroll/* for more information, including a link to Internet-based PECOS.

To get a list of provider enrollment contact numbers, see *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf* on the CMS Web site.

For information about IACS, see *http://www.cms.hhs.gov/IACS* on the CMS Web site.

There are other sources where you can find additional information.

- For PQRI pogram information and resources, see *http://www.cms.hhs.gov/PQRI* on the CMS Web site.
- To download a copy of the *2007 Re-Run and 2008 PQRI Feedback Report User Guide*, see *http://www.cms.hhs.gov/PQRI/2008/list.asp#TopOfPage* on the CMS Web site. On the 2008 PQRI Program Web page, check the following option: [X]' Show only items whose Type is'. Then select *Feedback Reports* from the drop own list.
- To download a copy of *A Guide for Understanding the 2008 PQRI Incentive Payment*, see *http://www.cms.hhs.gov/PQRI/downloads/GuideUnderstanding2008PQRIIncentivePayment072109.pdf* on the CMS Web site.
- To download a copy of *A Guide for Understanding the 2007 Re-Run PQRI Incentive Payment*, see *http://www.cms.hhs.gov/PQRI/Downloads/GuideforUnderstanding2007Re-RunPQRIIncentivePayment063_508.pdf* on the CMS Web site.
- To access the PQRI Portal and to verify the 2007 Re-Run or 2008 PQRI Feedback Report availability for a TIN or NPI, see *http://www.qualitynet.org/pqri* on the QualityNet Web site.
- To download the *PQRI Portal User Guide*, see the *Downloads* section on *http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage* on the CMS Web site. (This document will be available by October 30, 2009.)
- For general e-Prescribing information, see *http://www.cms.hhs.gov/eRxIncentive* on the CMS Web site.

MLN Matters® Number: SE0922
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

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

Health information technology news – a message from Dr. Blumenthal

The Office of the National Coordinator for Health Information Technology (ONC) has distributed this message through their communication channels and posted it on their Web site at the following link *http://healthit.hhs.gov/portal/server.pt?open=512&objID=1350&parentname=CommunityPage&parentid=5&mode=2&in_hi_userid=11113&cached=*.

"Meaningful" Progress toward Electronic Health Information Exchange

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

I recently reported on our announcement of State Health Information Technology Grants and grants to establish Health Information Technology Regional Extension Centers, as authorized under the Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act of 2009 (the Recovery Act).

Today I want to discuss the important term "meaningful use" of electronic health records (EHRs) – both as a concept that underlies the movement toward an electronic health care environment and as a practical set of standards that will be issued as a proposed regulation by the end of 2009.

The HITECH Act provisions of the Recovery Act create a truly historic opportunity to transform our health system through unprecedented investments in the development of a nationwide electronic health information system. This system will ultimately help facilitate, inform, measure, and sustain improvements in the quality, efficiency, and safety of health care available to every American. Simply put, health professionals will be able to give better care, and their patients' experience of care will improve, leading to better health outcomes overall.

As many of you are aware, the HITECH Act provides incentive payments to doctors and hospitals that adopt and meaningfully use health information technology. Eligible physicians, including those in solo or small practices, can receive up to $44,000 over five years under Medicare or $63,750 over six years under Medicaid for being meaningful users of certified electronic health records. Hospitals that become meaningful EHR users could receive up to four years of financial incentive payments under Medicare beginning in 2011, and up to six years of incentive payments under Medicaid beginning in October 2010.

The HITECH Act's financial incentives demonstrate Congress' and the Administration's commitment to help those who want to improve their care delivery, and will serve as a catalyst to accelerate and smooth the path to HIT adoption by more individual providers and organizations. The dollars are tangible evidence of a national determination to bring health care into the 21st century.

The Office of the National Coordinator for Health Information Technology (ONC) is charged with coordinating nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. ONC is working with the Centers for Medicare & Medicaid Services (CMS), through an open and transparent process, on efforts to officially designate what constitutes "meaningful use."

ONC has already engaged in a broad range of efforts to support the development of a formal definition of meaningful use. The HITECH Act designated a federal advisory committee, the HIT Policy Committee, with broad representation from major health care constituencies, to provide recommendations to ONC on meaningful use. The HIT Policy Committee has provided two sets of recommendations, informed by input from a variety of stakeholders. ONC and CMS have also conducted a series of listening sessions to solicit feedback from more than 200 representatives of various constituent groups and an open comment period where over 800 public comments were submitted and reviewed. The second set of recommendations on meaningful use was issued at a July 16 HIT Policy Committee meeting and details can be found at *healthit.hhs.gov/policycommittee*.

CMS is expected to publish a formal definition of meaningful use, for the purposes of receiving the Medicare and Medicaid incentive payments, by December 31, 2009. At that time, the public will be able to comment on the definition, and such comments will be considered in reaching any final definition of the term.

By focusing on "meaningful use," we recognize that better health care does not come solely from the adoption of technology itself, but through the exchange and use of health information to best inform clinical decisions at the point of care. Meaningful use of EHRs, we anticipate, will also enable providers to reduce the amount of time spent on duplicative paperwork and gain more time to spend with their patients throughout the day. It will lead us toward improvements and sustainability of our health care system that can only be attained with the help of a reliable and secure nationwide electronic health information system.

The concept of meaningful use is simple and inspiring, but we recognize that it becomes significantly more complex at a policy and regulatory level. As a result, we expect that any formal definition of "meaningful use" must include specific activities health care providers need to undertake to qualify for incentives from the federal government.

Ultimately, we believe "meaningful use" should embody the goals of a transformed health system. Meaningful use, in the long-term, is when EHRs are used by health care providers to improve patient care, safety, and quality.

What's next?

As stated above, the next step in our process is a notice of proposed rulemaking in late 2009 with a public comment period in early 2010. As this process unfolds, we will continue to talk and share experiences about transitioning to EHRs, and to help deepen understanding among physicians and hospitals about the use of EHRs. We will also present programs designed to help smooth the transition process, and identify activities physicians and hospitals can engage in now to promote adoption of EHRs. As efforts advance, we will turn our attention to other necessary supporting programs, some of which you will hear more about in the coming weeks, including defining what constitutes a "certified" EHR, which is one of the requirements to qualify for Medicare and Medicaid incentives.

Health information technology news -- a message from Dr. Blumenthal (continued)

In the meantime, what can providers do to move toward becoming "meaningful users" – even in the absence of a formal definition? Naturally, while understanding that the final definition will be adopted through a formal rulemaking process, it will be helpful to be as familiar as possible with the discussion of meaningful use criteria to date. (You will find that information posted at *healthit.hhs.gov/meaningfuluse*.)

Armed with an understanding of the discussion of meaningful use as it unfolds, providers can begin to consider how their own practices or organizations might be reshaped to enhance the efficiency and quality of care through the use of an electronic health record system. Be assured you will not be alone as you seek to adopt an EHR system. Through our recently announced collaborative HITECH grants programs and others to be initiated later this year, we will continue to support providers in moving forward. Additional details about the grants are also available in my previous update and at *healthit.hhs.gov/HITECHgrants*.

To some providers, particularly small or already stretched physician practices or small, rural hospitals, the path toward meaningful use may still seem arduous. To others, who would just prefer to stick with the "status quo," it may seem like an unwanted intrusion. We believe that the time has come for coordinated action. The price of inaction -- in adverse events, lost patient lives, delayed or improper treatments, unnecessary procedures, excessive costs, and so on -- is just too high, and will only get worse.

There is much at stake and much to do. We must relieve the crushing burden of health care costs in this country by improving efficiency, and assuring the highest level of patient care and safety regardless of geography or demographics. By using current technologies in a meaningful way, as well as technology to be developed in the future, we will take great strides toward solving some of the most vexing problems facing our health care system and creating a new platform for innovative solutions to health care.

I look forward to providing periodic updates, and to continued interactions with all the communities that have so much to gain from this profound transformation.

Sincerely,

David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health & Human Services

This letter is part of a series of ongoing updates from the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology. For more information and to receive regular updates from the Office of the National Coordinator for Health Information Technology, please subscribe to our Health IT News list at https://service.govdelivery.com/service/subscribe.html?code=USHHS_188.

If you have difficulty viewing this message, please view it online. To ensure that you receive future correspondence, please add this e-mail address to your list of secure addresses.

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

Source: PERL 200910-26

Local Coverage Determinations

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Local Coverage Determinations – Table of Contents

Advance beneficiary notice

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

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

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

Revisions to LCDs

Intravitreal bevacizumab (Avastin®) – revision to the LCD

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

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) was effective for services rendered on or after June 30, 2009. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services transmittal 1810, change request 6617, dated September 1, 2009, the "*CPT*/HCPCS Codes"' section of the LCD has been revised to delete HCPCS code J3490 (unclassified drugs) and replace it with HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg).

The LCD "Coding Guidelines" attachment has been revised to indicate HCPCS code Q2024 (Injection, bevacizumab, 0.25 mg) is used to appropriately describe smaller doses that total less than 10 mg of bevacizumab (Avastin®). This smaller dose should be billed for the Food and Drug Administration (FDA) approved treatment of metastatic colorectal cancer (i.e., ICD-9-CM codes 153.0-153.9, 154.0-154.3, 154.8, 197.5). HCPCS Q2024 (Injection, bevacizumab, 0.25 mg) should also be billed for intravitreal bevacizumab, along with *CPT 67028* (*Intravitreal injection of a pharmacologic agent*).

Effective date

This LCD revision is effective for services rendered on or after October 1, 2009. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

J2503: Macugen® (pegaptanib sodium injection) – revision to the LCD

LCD ID number: L29216 (Florida)
LCD ID number: L29361 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Macugen® (pegaptanib sodium injection) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised to include coverage of Macugen® for the treatment of diabetic macular edema. Therefore, the following sections of the LCD have been revised accordingly:

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

Effective date

This LCD revision is effective for services rendered **on or after October 13, 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.

Find LCDs faster on our new medical coverage page

Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news and resources you need more quickly and easily than ever before -- try it today. *http://medicare.fcso.com/Landing/139800.asp*.

J3487: Zoledronic acid – revision to the LCD

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

The local coverage determination (LCD) for zoledronic acid was last revised on June 30, 2009. Since that time, the Food and Drug Administration (FDA) approved a new indication for zoledronic acid (Reclast ®), HCPCS code J3488, effective May 29, 2009. This new indication is for the prevention of osteoporosis in postmenopausal women.

The "Indications and Limitations of Coverage and/or Medical Necessity," "ICD-9 Codes that Support Medical Necessity," "Utilization Guidelines," and the "Coding Guidelines" attachment have all been revised to allow for coverage of this new indication. When billing for this new indication, providers will be required to bill ICD-9-CM code V49.81 (Asymptomatic postmenopausal status [age-related] [natural]).

Effective date

This LCD revision is effective for services rendered **on or after May 29, 2009**, for claims processed **on or after October 19, 2009**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

76510: B-scan – revision to the LCD

LCD ID number: L29064 (Florida)
LCD ID number: L29082 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for b-scan was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised to include the dual diagnosis requirement for ICD-9-CM code 362.07 (Diabetic macular edema). ICD-9-CM 362.07 must be billed with ICD-9-CM code 362.01, 362.02, 362.03, 362.04, 362.05, or 362.06 for *CPT* codes *76510*, *76512*, and *76513*.

Effective date

This LCD revision is effective for claims processed **on or after October 27, 2009**, for services rendered **on or after October 1, 2005**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

77371: Stereotactic radiosurgery and stereotactic body radiation therapy – coding guidelines

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

The local coverage determination (LCD) for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) is effective for services rendered on or after October 5, 2009. First Coast Service Options Inc. (FCSO) has developed an LCD coding guideline attachment for these services that reads as follows:

Coding and pricing – MCS vs. FISS

SRS/SBRT treatment delivery is a technical service that results in claims for a facility. Hospital based facilities send claims to the fiscal intermediary shared system (FISS) for administration and payment usually via OPPS (outpatient prospective payment system). Free standing facilities send claims to the Medicare carrier system (MCS) for administration and payment via the Medicare physician fee schedule database (MPFSDB). The active codes for the two systems are not a complete cross walk and the payment is different given the different payment methodologies.

There are two LCDs for SRS/SBRT treatment delivery – one addressing the Part A system (FISS- outpatient hospital facility claims) and one addressing Part B system (MCS- for free-standing facility claims). Physician management services are not directly addressed though the applicable coding guidance in *CPT* and other applicable LCD(s) may apply. Physician services are all Part B system (MCS) claims.

The current active Part A (FISS system) codes for SRS/SBRT treatment delivery are *CPT*/HCPCS codes *77371*, G0173, G0251, G0339 and G0340.

The current active Part B (MCS system) codes for SRS/SBRT treatment delivery are *CPT* codes *77371*, *77372* and *77373*, which are priced in the MPFSDB. HCPCS codes G0339 and G0340 are currently carrier priced codes and the contractor maps these codes to *CPT* code *77373* pricing, since the contractor has adopted the *CPT* guidance that is supported by the RUC for any brand of SBRT treatment delivery.

CPT code *77373 - Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed five fractions*

77371: Stereotactic radiosurgery and stereotactic body radiation therapy – coding guidelines (continued)

Free standing facilities billing Part B (MCS system) for SBRT treatment delivery are expected to submit one unit for *CPT* code *77373* per day up to five days (five fractions) when reasonable and necessary. HCPCS codes G0339 and G0340 are administered as *CPT* code *77373*. Both the G code and *CPT* code *77373* cannot be submitted on the same day and the Medicare beneficiary should not have liability beyond their applicable co-payment/deductible for *CPT* code *77373* no matter which code is used. In cases where coverage is in question, it is recommended that an advanced beneficiary notice (ABN) be used. Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the fee-for-service (FFS) Medicare. See the Centers for Medicare & Medicaid Services (CMS) Web site for specific information *http://www.cms.hhs.gov/bni/*.

Number of units of dosimetry (*CPT* code *77300*) submitted in an SRS/SBRT episode of care

CPT code *77300*: *Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician*

The validated process of care for *CPT* code *77300* (*CPT* and RUC) does not support the units of *CPT* code *77300* dosimetry that are billed for SRS/SBRT by certain centers in Florida. In the past the contractor would see single units billed (4 - 8) on a given day for the episode of care. However, some centers started billing 10-20 times (80 to 200, and more) the units for similar cases. The contractor clarified with experts in the field as well as reviewed input in the public domain from ASTRO. ASTRO does not recommend that all 100-200 beams be billed individually as a separate service (*CPT* code *77300*), and the contractor concurs, since the work done cannot be supported by billing that amount of total RVUs. While more may be medically indicated under certain circumstances, more than ten times per course for SBRT should be very rare, and the contractor would more typically see four to eight units based on previous claims history.

Coding for SRS and SBRT surgical specialty vs. radiation oncologist physician services

As noted in the American Medical Association (AMA) *CPT* code changes 2009: An *Insider's View*, significant changes have been made to the *CPT* coding system for reporting stereotactic radiosurgery (SRS). When *CPT* code *61793* was added to the *CPT* codebook, the technology and technique of SRS was first emerging. Since that time, broader indications have been developed for SRS. Due to these changes in the technology, *CPT* code *61793* no longer adequately describes the physician work involved in the procedures. To accurately reflect the current practice of SRS, *CPT* code *61793* has been deleted and seven new codes have been established. These new codes are listed under new subheadings (Stereotactic Radiosurgery (Cranial) (*CPT* codes *61795-61800*) and Stereotactic Radiosurgery (Spinal) (*CPT* codes *63620-63621*) with guidelines to provide education for reporting these codes.

It is important to note that these new codes are not intended to report stereotactic body radiation therapy for lesions that are neither cranial nor spinal. It is also important to note that the primary codes in this series for *CPT* codes *61796*, *61798*, and *63620* are very heavily weighed and include significant work by the surgeon that must be documented.

The radiation oncologist reports the appropriate code(s) for clinical treatment planning, physics and dosimetry, treatment delivery and management from the Radiation Oncology section (77xxx series *CPT* codes). Any necessary planning, dosimetry, targeting, positioning, or blocking by the neurosurgeon or head & neck surgeon with SRS/SBRT training is included in the stereotactic radiation surgery services. The same physician should not report stereotactic radiosurgery services with radiation oncology services. If both a radiation oncologist and neurosurgeon/head & neck surgeon are performing work involving planning, dosimetry, targeting, positioning, or blocking, and management of treatment delivery, each physician should use the appropriate code(s) for the necessary work they performed (surgery section vs. radiation oncology).

To report stereotactic body radiation therapy for lesions that are neither cranial nor spinal, the radiation oncologist uses the appropriate 77xxx series *CPT* codes. If a surgeon with appropriate training in SBRT is also contributing work to the episode of care, that service should be reported with the unlisted *CPT* code *77499* (*Unlisted procedure, therapeutic radiology treatment management*) and the documentation must support the necessary work by the second physician.

Claims for SBRT with diagnosis of prostate cancer

SBRT for the treatment of prostate cancer currently does not have a positive coverage statement in the Part A and Part B LCDs given the lack of data on long-term toxicities and outcomes. Such claims will be developed (request for documentation) and payment will be considered on a case by case basis with attention to the physician documentation for that patient. It is recommended that facilities submit one claim for the treatment delivery code with the relevant treatment delivery dates so that only one letter is generated for the request for records.

In cases where coverage is in question, it is recommended that an ABN be used. Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the FFS Medicare. See CMS Web site for specific information *http://www.cms.hhs.gov/bni/*.

Effective date

This new LCD coding guideline attachment is effective for services rendered **on or after October 5, 2009**. FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

92081: Visual field examinations – revision to the LCD

LCD ID number: L29308 (Florida)
LCD ID number: L29487 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for visual field examinations was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised to include the dual diagnosis requirement for ICD-9-CM code 362.07 (Diabetic macular edema). ICD-9-CM 362.07 must be billed with ICD-9-CM code 362.01, 362.02, 362.03, 362.04, 362.05, or 362.06 for *CPT* codes *92081*, *92082*, and *92083*.

Effective date

This LCD revision is effective for claims processed **on or after October 26, 2009**, for services rendered **on or after October 1, 2005**. 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.

Additional Information

Administration of intravenous antibiotics via external infusion pump

Data analysis at First Coast Service Options Inc. (FCSO) has identified an increase in the utilization of *CPT* code *96521* (*refilling and maintenance of portable pump*). FCSO has also determined that, in many cases, external infusion pumps are being used for the administration of intravenous antibiotics outside of the physician's office. The Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) for infusion pumps, located in CMS Publication 100-03, Chapter 1, Part 4, Section 280.14, does not include the administration of intravenous antibiotics as a covered indication for external infusion pumps.

Nationally covered indications for external infusion pumps are limited to the following:

- Administration of deferoxamine for the treatment of acute iron poisoning and iron overload.
- Administration of heparin for thromboembolic disease and/or pulmonary embolism (in an institutional setting only).
- Chemotherapy infusion pump in the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable; OR, where the patient refuses surgical excision of the tumor.
- Administration of morphine in the treatment of intractable pain caused by cancer (in either an inpatient or outpatient setting, including a hospice).
- Continuous subcutaneous insulin infusion in the home setting for the treatment of diabetic patients when specified criteria are met.
- Other uses of external infusion pumps are covered if the contractor's medical staff verifies the appropriateness of the therapy and the prescribed pump for the individual patient.

There is currently insufficient published clinical data to support the safety and efficacy of external infusion pumps over disposable elastomeric pumps or the simple manual gravity drip method for the administration of intravenous antibiotics.

Cigna, the durable medical equipment Medicare administrative contractor (DME MAC) for Florida, Puerto Rico, and the U.S. Virgin Islands, has an LCD in place that clearly states the administration of intravenous antibiotics via an external infusion pump is noncovered because it is not considered medically reasonable and necessary. Antibiotics can be safely and effectively administered by the gravity drip method.

In addition, it must be noted that the Medicare program provides limited benefits for outpatient prescription drugs. Medicare covers medically necessary drugs that are administered incident-to the physician's professional services if the drugs are not usually self-administered by the patient. Per CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.3, "In order to meet the general requirements for coverage under the "incident to" provision, a Food and Drug Administration (FDA)-approved drug or biologic must:

- be of a form that is not usually self-administered
- be furnished by a physician, and
- be administered by the physician or by auxiliary personnel employed by the physician and under the physician's personal supervision." (Please note that "personal supervision" means that the physician must be in attendance during the performance of the procedure.)

Medicare does not provide reimbursement for outpatient injectable drugs unless incident-to requirements are met. When patients utilize external infusion pumps to self-administer intravenous antibiotics at home, incident-to requirements are not met. Therefore, both the infusion pump and the associated antibiotic or other injectable drug cannot be billed to Medicare.

J0881: Erythropoiesis stimulating agents – clarification on coding

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

The local coverage determination (LCD) for the erythropoiesis stimulating agents was last revised on October 1, 2009. First Coast Service Options Inc. (FCSO) recently implemented a revised LCD that streamlined the coding for all erythropoiesis stimulating agents (ESAs). FCSO published an article that summarized all coding rules for the LCD to make it easier for providers to code and bill their claims correctly. The LCD was recently revised based on the 2010 ICD-9-CM update. New ICD-9-CM codes were added for HCPCS codes J0881 and J0885. With the addition of these new codes, FCSO implemented a new dual diagnosis rule that previously was not required. FCSO is taking this opportunity to revise the previous article published which summarized ESA coding and is now outlining the new coding rules effective October 1, 2009. This article will also serve to summarize all the rules for billing non-ESRD ESAs (HCPCS codes J0881 and J0885) implemented since April 7, 2008, and how they apply to this LCD. Any questions on this LCD should be submitted to the medical policy department at *medical.policy@fcso.com*.

HCPCS codes J0881 and J0885 include two lists of ICD-9-CM codes each. The two lists for HCPCS codes J0881 and J0885 outline which ESA modifier (EA or EC) must be billed with the ICD-9-CM codes and also include the dual diagnosis requirements for the ICD-9-CM codes. These modifier designation and dual diagnosis rules are found at the beginning of each list for HCPCS codes J0881 and J0885. ICD-9-CM codes that require a dual diagnosis are designated with an asterisk (*). In addition, the "Coding Guidelines" attachment for the LCD continues to have instructions for providers on how to bill for certain noncovered indications outlined in NCD 110.21.

Coding changes

J0881: This list **does** require a dual diagnosis.

The following ICD-9-CM codes require the modifier **EA** and a dual diagnosis: 285.3 and one of the following must be billed together: 140.0-149.9, 150.0-159.9, 160.0-165.9, 170.0-176.9, 179-189.9, 190.0-199.2, 200.00-200.88, 201.00-201.98, 202.00-202.98, 203.00-203.82, 204.00-204.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, 209.30- 209.36, 209.70-209.79, 230.0-234.9, 235.0-235.9, 236.0-236.99, 237.0-237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.8, 238.9, or 239.0-239.9

J0881: This list **does not** require a dual diagnosis

The following ICD-9-CM codes require the modifier **EC**: 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, or 273.3.

J0881: This list **does** require a dual diagnosis.

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

J0885: This list **does** require a dual diagnosis.

The following ICD-9-CM codes require the modifier **EA** and a dual diagnosis: 285.3 and one of the following must be billed together: 140.0-149.9, 150.0-159.9, 160.0-165.9, 170.0-176.9, 179-189.9, 190.0-199.2, 200.00-200.88, 201.00-201.98, 202.00-202.98, 203.00-203.82, 204.00-204.92, 209.00-209.03, 209.10-209.17, 209.20-209.29, 209.30- 209.36, 209.70-209.79, 230.0-234.9, 235.0-235.9, 236.0-236.99, 237.0-237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.8, 238.9, or 239.0-239.9

J0885: This list does **not** require a dual diagnosis

The following ICD-9-CM codes require the modifier **EC**: 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, or 273.3.

J0885: This list **does** require a dual diagnosis.

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

Information found in the 'coding guidelines' attachment

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

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

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

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

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

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

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

J0881: Erythropoiesis stimulating agents – clarification on coding (continued)

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

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

The modifier **EB** is noncovered. If billed with an ESA the claim will be denied.

Effective January 1, 2008, all claims reporting ESAs J0881, J0882, J0885, or J0886 must report the most recent hemoglobin or hematocrit readings. For non-ESRD ESAs (HCPCS codes J0881 and J0885) reporting the modifier EA (anemia that is related chemotherapy), the hemoglobin or hematocrit are required to be below a certain level in order for the service to be medically necessary. Contractors are instructed, per CR 5818 to deny ESA services that report HCPCS codes J0881 or J0885 with modifier EA when Hgb is > **10.0g/L** or the Hct is > **30** percent. There is no exception to this requirement and there is no 4-week window at initiation where providers can report a level above 10.0 g/L or 30 percent and have the service paid. The entire discussion surrounding ESA administration for cancer conditions is outlined in the LCD and NCD 110.21.

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

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

Resources for information on ESA coverage

The complete NCD may be accessed in Section 110.21 of Publication (Pub.) 100-03, *Medicare National Coverage Determinations (NCD) Manual*, and claim processing instructions may be accessed in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 17, sections 80.8-80.12 and through the following link: *http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=110.21&ncd_version=1&basket=ncd percent3A110 percent2E21 percent3A1 percent3AErythropoiesis+Stimulating+Agents+percent28ESAs percent29+in+Cancer+and+Related+Neoplastic+Conditions.*

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

http://www.cms.hhs.gov/transmittals/downloads/R1413CP.pdf.
http://www.cms.hhs.gov/transmittals/downloads/R80NCD.pdf.

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

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.

Signature requirements clarification

First Coast Service Options Inc. (FCSO) has seen a significant increase in the number of comprehensive error rate testing (CERT) errors related to the lack of a legible signature in medical record documentation. The CERT contractor confirmed that the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) have clarified that providers of Medicare services must comply with the signature legibility requirements outlined in the *Medicare Program Integrity Manual*, Publication 100-08, Chapter 3, Section 3.4.1.1 B:

- *Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.* (The only exception is that facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.)

The legible identifier (signature) requirement applies to documentation for **any** service performed and billed to Medicare. The purpose of a rendering/treating/ordering practitioner's signature in patients' medical records, operative reports, orders, test findings, etc., is to support that the services have been accurately and completely documented, reviewed and authenticated.

Signature requirements clarification (continued)

The CERT contractor is rigorously enforcing the CMS requirement that all medical records subject to medical review must include a legible identifier (signature). Documentation that is submitted with an illegible signature, initials, an unauthenticated electronic signature, no signature, or an unsigned typewritten signature will be **denied** and assigned a CERT error. This error will produce an overpayment and a subsequent recoupment of funds.

Physicians, nonphysician practitioners, and other health care providers who bill Medicare contractors must remember:

- A legible signature is required on **all** medical records subject to medical review.
- Prior to submission for medical review, every medical record should be audited to ensure that the beneficiary's name, the date of service, and the signature of the provider of services are on the records.
- If the provider's signature is illegible, a signature legend/log identifying the author associated with the illegible signature or initials should be submitted with the records. This applies to records submitted to any Medicare contractor, including the Medicare administrative contractor (MAC) and the CERT contractor.
- Electronic signatures should be safeguarded against misuse (such as password protected) and should be easily identifiable as electronic, rather than typewritten, signatures.

Providers should ensure that their offices and/or billing departments are aware of these guidelines.

Appropriate use of modifier 50 for paravertebral/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 released a final report titled, "Medicare Payments for Facet Joint Injection Services," OEI-05-07-00200. The OIG found that providers incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50. This report is available at *http://oig.hhs.gov/oei/reports/oei-05-07-00200.pdf*.

It has been determined that providers reported add-on codes to indicate that they injected a contralateral (opposite) side of a spinal level, although they should have appended modifier 50 (Bilateral procedure) to the facet joint injection or destruction by neurolytic agent, paravertebral facet joint nerve *CPT* codes.

This article clarifies the appropriate use of modifier 50 and add-on codes for facet joint injection services (*CPT* codes *64470-64476*) and destruction by neurolytic agent, paravertebral facet joint nerve services (*CPT* codes *64622-64627*).

If performing facet joint injections or destruction by neurolytic agent, paravertebral facet joint nerve at the right and left side of the same spinal level — for example, the right C5-C6 and left C5-C6 — you should report only a single unit of service with modifier 50 appended for bilateral injections.

If performing facet joint injections or destruction by neurolytic agent, paravertebral facet joint nerve at the right and left side of two spinal levels — for example, the right and left C5-C6 and the right and left C6-C7— you should report both the primary and add-on services with a single unit of service with modifier 50 appended to represent multiple bilateral injections.

Providers who perform facet joint injections or destruction by neurolytic agent, paravertebral facet joint nerve on multiple levels but only on one side (unilaterally) of the spine must use the *CPT* code for the primary injection and the add-on codes for the corresponding facet joint injection services and append the anatomical modifier RT or LT to represent these additional levels injected, instead of using modifier 50.

Providers who may have inadvertently billed bilateral services using the RT/LT modifiers are encouraged to perform an internal audit, correct any errors, and submit voluntary refunds to Medicare within 45 days of this notice.

Please note: This article applies only to the physician/nonphysician community.

Cervical/Thoracic	
Initial level	Unilateral - Append anatomical modifier RT or LT
	Bilateral - Append modifier 50
Additional levels	Report per additional level
	Unilateral - Append anatomical modifier RT or LT
	Bilateral - Append modifier 50

Lumbar/Sacral	
Initial level	Unilateral - Append anatomical modifier RT or LT
	Bilateral - Append modifier 50
Additional levels	Report per additional level
	Unilateral - Append anatomical modifier RT or LT
	Bilateral - Append modifier 50

Educational Resources

Upcoming provider outreach and education events – November 2009

Hot Topics: Medicare Part B (ACT)

When: November 12
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 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.

Message from the Medicare Learning Network

The Centers for Medicare & Medicaid Services (CMS) has revised and updated the following educational resources documents:

The 2009-2010 seasonal influenza educational products and resources

This document provides a list of *Medicare Learning Network* (*MLN)* products and other resources with information about Medicare policies regarding seasonal flu, has been newly revised and updated. It is now available on the *MLN* in a downloadable, printable format at *http://www.cms.hhs.gov/MLNProducts/Downloads/Flu_Products.pdf*.

For more information about Medicare's coverage of the seasonal influenza vaccine and its administration as well as the many other preventive services Medicare covers, please go to *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS Web site.
For information on Medicare policies related to H1N1 influenza, visit *http://www.cms.hhs.gov/H1N1*.

Adult immunization

This educational brochure provides information about Medicare coverage of the seasonal influenza, pneumococcal, and hepatitis B vaccines. It is now available on the *MLN* in a downloadable, printable format at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.

Source: PERL 200910-24

Printed hardcopy versions of this brochure will be available at a later date. For more products related to Medicare-covered preventive services, please visit our preventive services educational products page at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.
Please note: The information in the adult immunizations brochure relates to seasonal influenza only. For information related to Medicare coverage and policy related to H1N1 influenza, also called "swine flu," visit *http://www.cms.hhs.gov/H1N1*.

Glaucoma screening

This educational brochure provides information about Medicare coverage of glaucoma screenings, including dilated eye examinations with an intraocular pressure measurement, direct ophthalmoscopy examinations and slit-lamp biomicroscopic examinations. It is now available on the *MLN* in a downloadable, printable format at *http://www.cms.hhs.gov/MLNProducts/downloads/Glaucoma.pdf*.

Printed hardcopy versions of this brochure will be available at a later date. For more products related to Medicare-covered preventive services, visit the CMS preventive services educational products page at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

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

Flu season is upon us

The Centers for Medicare and Medicaid Services (CMS) encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get seasonal flu shots. Flu shots are their best defense for combating flu this season. And don't forget, health care workers also need to protect themselves.

Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient as a Part B benefit. No deductible or copayment/coinsurance applies. Note that influenza vaccine is not a Part D covered drug.

For more information about Medicare's coverage of the seasonal influenza vaccine and its administration, as well as related educational resources for health care professionals, please go to *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS Web site.

For information on Medicare policies related to H1N1 influenza, please go to *http://www.cms.hhs.gov/H1N1* on the CMS Web site.

Source: PERL 200910-07

Protect your patients and yourself from influenza and get vaccinated

The Centers for Disease Control and Prevention recommends seasonal and 2009 monovalent H1N1 influenza vaccination for all healthcare workers because of their critical role in the health care system and their increased risk of exposure to patients with influenza, as well as concern about transmission of the viruses to susceptible patients. The 2009 H1N1 monovalent influenza vaccine is made in the same way as seasonal flu vaccine, which has a very good safety track record. Preliminary data suggest that the immunogenicity and safety of these vaccines are similar to those of seasonal influenza vaccines.

Seasonal influenza vaccination among healthcare personnel reduces the flu-related mortality risk among patients at highest risk of severe illness. Despite the documented benefits of healthcare worker vaccination, seasonal influenza vaccine coverage in past seasons among this group has remained low (<50 percent) nationwide.

Influenza outbreaks in hospitals and long-term care facilities have been associated with low vaccination rates among healthcare workers, while higher vaccination levels among staff are associated with a lower incidence of nosocomial influenza cases.

More information on locating 2009 monovalent H1N1 and seasonal vaccine, priority groups for vaccination, and vaccine safety is located at *http://www.flu.gov*.

The most effective way to protect yourself and your patients from flu is to be vaccinated.
It's up to you!

Source: PERL 200910-28

2009-2010 seasonal influenza resources for health care professionals

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

Provider types affected

All Medicare fee-for-service (FFS) physicians, nonphysician practitioners, providers, suppliers, and other health care professionals who bill Medicare for seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider action needed

- Keep this special edition *MLN Matters* article and refer to it throughout the 2009-2010 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction

Historically, the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu and pneumococcal immunizations. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Prevention is key to public health

While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, this year, due to planning for H1N1 flu, Medicare will make payment for seasonal flu vaccines that are provided earlier in the year than usual.

Seasonal flu vaccines can still help protect Medicare beneficiaries who get the vaccine in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

1. *MLN Matters* seasonal influenza articles

MM6608: Influenza Vaccine Payment Allowances – Annual Update for 2009-2010 Season at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6608.pdf* on the CMS Web site.

MM6539: 2009 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6539.pdf* on the CMS Web site.

MM5511: Update to *Medicare Claims Processing Manual*, Chapter 18, Section 10 for Part B Influenza Billing at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf* on the CMS Web site.

MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf* on the CMS Web site.

MM5037*:* Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (*CPT*) Code *90660* for the Reporting of the Influenza Virus Vaccine at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf* on the CMS Web site.

2. MLN Seasonal Influenza Related Products for Health Care Professionals

Quick Reference Information: Medicare Part B Immunization Billing – This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. This product is available in print and as a downloadable PDF at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf* on the CMS Web site.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Third Edition – This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered

2009-2010 seasonal influenza resources for health care professionals (continued)

by Medicare. The guide includes a chapter on seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. The guide is available as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf* on the CMS Web site.

Medicare Preventive Services Adult Immunizations Brochure – This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. This brochure is available as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf* on the CMS Web site.

Quick Reference Information: Medicare Preventive Services – This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes seasonal influenza, pneumococcal, and hepatitis B vaccines. This chart is available in print or as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf* on the CMS Web site.

Medicare Preventive Services Bookmark – This bookmark lists the preventive services and screenings covered by Medicare (including seasonal influenza) and serves as a handy reminder for health care professionals of the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. This bookmark is available in print or as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf* on the CMS Web site.

***MLN* Preventive Services Educational Products Web Page** – This *Medicare Learning Network* (*MLN*) Web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page (*http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*) for easy access.

3. Other CMS resources

- **CMS Adult Immunizations Web Page** is at *http://www.cms.hhs.gov/AdultImmunizations* on the CMS Web site.
- **CMS Frequently Asked Questions** are available at *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi* on the CMS Web site.
- ***Medicare Benefit Policy Manual*** - Chapter 15, Section 50.4.4.2 – Immunizations available at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf* on the CMS Web site.
- ***Medicare Claims Processing Manual*** – Chapter 18, Preventive and Screening Services available at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf* on the CMS Web site.
- **Medicare Part B Drug average sales price payment amounts, influenza and pneumococcal vaccines pricing** found at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp* on the CMS Web site.

4. Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009 – 2010 flu season:

- **Advisory Committee on Immunization Practices** are at *http://www.cdc.gov/vaccines/recs/acip/default.htm* on the Internet.
- **American Lung Association's Influenza (Flu) Center** is at *http://www.lungusa.org* on the Internet. This Web site provides a flu clinic locator at *http://www.flucliniclocator.org* on the Internet. Individuals can enter their ZIP code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.

Other sites with helpful information

- **Centers for Disease Control and Prevention** – *http://www.cdc.gov/flu*
- **Flu.gov** – *http://www.flu.gov*
- **Food and Drug Administration** – *http://www.fda.gov*
- **Immunization Action Coalition** – *http://www.immunize.org*
- **Immunization: Supporting a Healthy Life Throughout the Lifespan** – *http://www.nfid.org/pdf/publications/naiaw08.pdf*
- **Indian Health Services** – *http://www.ihs.gov/*
- **National Alliance for Hispanic Health** – *http://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** – *http://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** – *http://www.nlm.nih.gov/medlineplus/immunization.html*
- **National Network for Immunization Information** – *http:/www.immunizationinfo.org*
- **National Vaccine Program** – *http://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Promotion** – *http://odphp.osophs.dhhs.gov*
- **Partnership for Prevention** – *http://www.prevent.org*
- **World Health Organization** – *http://www.who.int/en* on the Internet

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov* on the Internet.

2009-2010 seasonal influenza resources for health care professionals (continued)

Important information about H1N1

Medicare will cover immunizations for H1N1 influenza, also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. H1N1 influenza vaccine is currently under production and will be available in the Fall 2009. For more information, go to *http://www.cms.hhs.gov/H1N1* on the CMS Web site.

MLN Matters® Number: SE0926
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

October is Healthy Lung 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 smoking and tobacco-use cessation counseling benefits.

Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can attribute to and exacerbate heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysm, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.

Medicare provides coverage of smoking and tobacco-use cessation counseling for beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use, or who take certain therapeutic agents whose metabolism or dosage is affected by tobacco use.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by educating them about their risk factors and encourage them to take advantage of Medicare covered smoking and tobacco-use cessation counseling benefits as appropriate.

For more information

CMS has developed several educational products related to Medicare-covered smoking and tobacco-use cessation counseling:

- **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 smoking and tobacco-use cessation counseling.
  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 products related to Medicare-covered smoking and tobacco-use cessation counseling.
  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 smoking and tobacco-use cessation counseling.
  http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **Smoking and Tobacco-Use Cessation Counseling Services** -- this brochure provides information on coverage for Medicare-covered smoking and tobacco-use cessation counseling.
  http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf

Please visit the Medicare Learning Network for more information on these and other Medicare fee-for-service educational products. For more information about the risks of smoking and resources to help encourage your patients to quit, please visit the American Lung Association "Quit Smoking" Web site at *http://www.lungusa.org/site/c.dvLUK9O0E/b.33484/k.438A/Quit_Smoking.htm*.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate eligible beneficiaries about the importance of taking advantage of smoking and tobacco-use cessation counseling services and other preventive services covered by Medicare.

Source: PERL 200910-24

Download chart on how to access CMS enterprise applications

The revised quick reference chart, *Steps to Accessing CMS Enterprise Applications for Provider Organizations* (August 2009), is now available for download. This chart for provider organizations outlines how to access the Centers for Medicare & Medicaid Services (CMS) enterprise applications. CMS enterprise applications are those hosted and managed by CMS and do not include fiscal intermediary/carrier/Medicare administrative contractor (MAC) Internet applications. You may access this product at *http://www.cms.hhs.gov/MLNProducts/downloads/IACSChart.pdf* on the CMS Web site.

Source: PERL 200909-28

Revised Medicare Learning Network publications

The following revised publications are now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2009) offers general information about the Medicare program, how to become a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and fee-for-service appeals. This publication may be accessed at *http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf*.
- The *Facilitator's Guide: Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (October 2009) includes all the information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program including instructions for facilitators, customization guide, a PowerPoint presentation with speaker notes, pre- and post-assessments, master assessment answer keys, and a course evaluation tool. This publication may be accessed at *http://www.cms.hhs.gov/MLNProducts/Downloads/facilitators_guide.zip*.

Source: PERL 200910-33

Revised ICD-10-CM/PCS: An Introduction fact sheet

The revised fact sheet titled *ICD-10-CM/PCS: An Introduction* (August 2009) 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. The revised publication 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."

Note: If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: PERL 200909-35

Revised rural health publications

The following rural health publications are now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The revised *Rural Health Bookmark* (April 2009), which provides information about educational resources that are available to the rural health community, is available in downloadable and print formats.
- The rural health fact sheet series (Summer 2009), which provides information about rural facility types and coverage and payment policies, is available in CD-ROM format. The following publications are included in the fact sheet series:

  Critical access hospital

  Federally qualified health center

  Medicare dependent hospital

  Medicare disproportionate share hospital

  Rural health clinic

  Rural referral center

  Sole community hospital

  Swing bed

  Telehealth services

To access the downloadable version of the *Rural Health Bookmark*, visit *http://www.cms.hhs.gov/MLNProducts/downloads/Ruralbookmark.pdf*.

To place your order for the print version of the *Rural Health Bookmark* or the rural health fact sheet series CD-ROM, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: PERL 200910-15

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 2009 through September 2010.	40300260	Hardcopy $33		
		CD-ROM $55		
2010 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2010, through December 31, 2010, 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 2010 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		
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(Checks made to "purchase orders" not accepted; all orders must be prepaid)

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

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