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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Medicare B Update!

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

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

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

In addition to the above, other sections include:

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

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

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

GA modifier and appeals

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

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

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

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CLAIMS

Correction to the January update of correct coding initiative edits

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6818, which informs physicians that the latest package of correct coding initiative (CCI) edits, version 16.0, effective January 1, 2010, is being corrected to replace the files in CR 6728, which was released on November 20, 2009.

Background

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

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

The corrected version for 16.0 will include all previous versions and updates from January 1, 1996, to the present and will be organized in two tables: Column I/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits.

Additional information

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

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which may be found at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*.

The official instruction CR 6818, issued to your carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1891CP.pdf*.

The related *MLN Matters*® article (MM6728) may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6728.pdf*.

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

MLN Matters Number: MM6818
Related Change Request (CR) #: 6818
Related CR Release Date: January 8, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R1891CP
Implementation Date: January 15, 2010

Modification to the 2010 Healthcare Common Procedure Coding System code set

The Centers for Medicare & Medicaid Services (CMS) has released a modification to the Healthcare Common Procedure Coding System (HCPCS) code set. CMS has revised the definition for HCPCS code L8680 to "Implantable neurostimulator electrode, each". In making this change, the calendar year (CY) 2010 definition for HCPCS code L8680 reverts to the definition reflected in the CY 2009 HCPCS code set. This change has been posted to the 2010 HCPCS Corrections document located on the HCPCS Web page at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp*.

Source: CMS PERL 200912-24

Scheduled release of modifications to the HCPCS code set

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS Web site at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp*. Changes are effective on the date indicated on the update.

Source: CMS PERL 201001-03

Prompt payment interest rate revision

Interest must be paid on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2009, must have been paid before the end of business on March 31, 2009.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 3.250 percent is in effect through June 30, 2010.

Note: The amount of interest on each claim will be reported on the remittance record to the provider.

Source: Publication 100-04, Chapter 1, Section 80.2.2

How to find 2010 fee schedules for your location and line of business

As a Medicare health care provider, you know the importance of having the most current information at your fingertips, especially when that information relates to payments. For your convenience, First Coast Service Options Inc. (FCSO) offers easy access to the fee schedule information resources you need – including an interactive fee lookup tool – available at *http://medicare.fcso.com*.

Locality fee schedules are designed to advise physicians, nonphysician practitioners, and suppliers (whose payments are linked to fee schedules) of the payment amounts allowable for covered services paid from the Medicare Part B physician fee schedules (MPFS) and include allowances for professional components (modifier 26) and technical components (modifier TC), where applicable, as well for global procedures. Locality fee schedules also inform nonparticipants how much they can legally charge when filing an unassigned claim. How do you find fee schedule information for your location? It's easy.

First, select your location and line of business (Part A or Part B) on the homepage of the FCSO Medicare provider Web site. This will allow you to view information that pertains specifically to your geographic location as well as your type of business. After you have selected your location, you may easily select your line of business and go directly to the *Fee Schedules* page in one step. Just select *Fee Schedules* from the category list under Part A or Part B.

Note: You can also access the *Fee Schedules* page for your line of business from the *Quick Find* drop-down menu or the Part A or Part B homepage.

Once you have arrived on the *Fee Schedules* page (Part A or Part B), you'll have access to the following resources:

- The latest news and information about fee schedules in the News information box
- Location-specific fee information for most Medicare-covered procedure codes with FCSO's easy-to-use, interactive look-up tool. To use this helpful tool, make your selection from a set of code lists, scroll to the code desired, press the *Query Fee* button, and the applicable fee(s) will be returned.
- Printable portable document format (PDF) fee schedules (Part B only)
- Compressed, tab-delimited text files that may be downloaded and used in a spreadsheet or database
- Fee schedules and fee schedule-related information from previous payment years in FCSO's comprehensive archive
- A link to CMS' national physician fee schedule database tool to find fee information based upon a single, list, or a range of Healthcare Common Procedure Coding System (HCPCS) criteria.

Ambulance

MIPPA ambulance provisions expired December 31

Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided for an increase in the ambulance fee schedule amounts for covered ground ambulance transport. For transports that originated in urban areas, the increase was two percent. For transports that originated in rural areas, the increase was three percent. The increases were applicable only for claims with dates of service July 1, 2008, through December 31, 2009.

Further, Section 146(b)(1) of MIPPA amended the designation of rural areas for air ambulance services. The statute specified that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services should continue to be treated as a rural area for purposes of making air ambulance service payments under the ambulance fee schedule. This statute was also applicable only for claims with dates of service July 1, 2008, through December 31, 2009.

As such, as of January 1, 2010, for ground and air ambulance claims received with dates of service on this date and beyond, Medicare will no longer be paying ground and air ambulance service providers based on these two expired provisions.

Diagnostic Services

Place and date of service instructions for interpretation of diagnostic tests

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 fiscal intermediaries [FI], carriers, or Medicare administrative contractors (A/B MAC) for the furnishing and interpretation of diagnostic tests.

What you need to know

Change request (CR) 6375, from which this article is taken, informs Medicare contractors (FIs, carriers, and A/B MACs) about the correct place of service (POS) codes and the date of service (DOS) for the interpretation of diagnostic tests. Be sure your billing staff is aware of the correct DOS and is aware of how Medicare contractors determine correct POS coding to assure proper payment of your claims.

Background

You may find the instructions that CR 6375 provides your Medicare contractor regarding the correct POS and DOS codes for the interpretation (or professional component) of diagnostic tests in this Background section. Please note that place of service (POS) codes do not determine Medicare payment for the interpretation of a diagnostic test, but rather reflect where the service was provided.

Date of service (DOS) codes

As of July 1, 2010, Medicare contractors will consider, and providers must remember, that the appropriate DOS for the professional component is the actual calendar date that the interpretation was performed. For example, if the test or technical component was performed on April 30 and the interpretation was read on May 2, the actual calendar date or DOS for the performance of the test is April 30 and the actual calendar date or DOS for the interpretation or read of the test is May 2.

Note: Special rules apply for the DOS of the technical component of clinical laboratory and pathology specimens and are contained in 42 CFR 414.510.

Place of service codes

A description of the correct POS codes for performing the interpretation of diagnostic tests in various locations is provided as follows:

Interpretation performed in physician's home

If the interpretation takes place in a physician's home, the POS would be either "office" (POS 11 -- if it meets the definition of an office) or "other" (POS 99).

Interpretation performed in a hotel room

If the interpretation takes place in a hotel room, the POS would be "office" (POS 11) if the hotel room is considered as the physician's office. If both the physician and the patient are located in the hotel room at the time that the interpretation is performed, the POS code would most likely be the new POS code for "temporary lodging" (POS 16). If the hotel room is neither the office of the physician nor the temporary lodging of the patient then the correct code would be "other" (POS 99).

Interpretation provided telephonically by wireless remote

As described in the *Medicare Benefit Policy Manual* Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services); Diagnostic tests (such as a radiological image, an electrocardiogram, an electroencephalogram, or a tissue sample) can also be interpreted through the use of a telecommunications system, obviating the requirement for a face-to-face encounter with the patient. The POS code for such a removed interpretation is generally the place where the interpretation is read,

Place and date of service instructions for interpretation of diagnostic tests (continued)

using the cited ZIP code as the documentation for the setting where the interpretation takes place. (The *Medicare Benefit Policy Manual* is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the Centers for Medicare & Medicaid Services (CMS) Web site.)

Interpretation performed in an office suite that is neither the test location nor the physician's office

If the interpretation is performed in a location other than the physician group's main location, and that location meets the definition of an office, the POS code is "office" (POS 11). If the physician performs the interpretation from home, the POS code is either "office" (POS 11), or "other" (POS 99).

Interpretation provided under arrangement to a hospital

If a diagnostic test has separate technical (TC) and professional components (PC), and is provided under arrangements to a hospital, the physician who reads the test can bill and be paid for the professional component.

If the interpretation is performed in the hospital setting, the POS code is "hospital outpatient" (POS 22). If it is performed at a location other than the location of the physician's office and the location meets the definition of an office, the POS code is "office" (POS 11). If the physician performs the interpretation from home, the POS code is either "office" (POS 11), or "other" (POS 99).

When, on the other hand, a physician performs a diagnostic test under arrangements to a hospital, and the test and the interpretation are not separately billable; the physician cannot bill for the interpretation. The hospital is the only entity that can bill for the diagnostic test which includes the interpretation, and there is no POS code for the interpretation. The POS code for the test including the interpretation is "hospital outpatient" (POS 22).

Interpretation not performed under SNF consolidated billing

Physician services are one of the service categories excluded by law from SNF consolidated billing provision. Physician services are separately billable to the Medicare Part B carrier. So, since many diagnostic tests include both a technical component and a professional component, two bills will need to be generated. For example, the physician service exclusion applies only to the professional component of a SNF diagnostic radiology service (representing the physician's interpretation of the diagnostic test). Again, the physician service for the interpretation is billed directly to the Medicare Part B carrier.

Interpretation of purchased diagnostic services

The *Medicare Claims Processing Manual* Chapter 13 (Radiology Services and Other Diagnostic Procedures), Section 20.2.4 (Purchased Diagnostic Tests – Carriers) provides the physician billing requirements applicable to purchased diagnostic services. (This manual is also available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site.)

In addition, the POS code rules are the same for both diagnostic tests/interpretations and for purchased diagnostic tests/interpretations (those that are not personally performed or supervised by a physician), both requiring the appropriate POS code and the ZIP code.

Most commonly, the service's purchaser performs the interpretation and purchases the technical component. In this case, the technical component provider must be enrolled in the Medicare program and the purchaser can bill for both the professional component (PC) and the technical component (TC).

In less common specified circumstances, the interpretation can be purchased from another entity and the purchaser can bill for the interpretation even though they did not perform it; but the interpreting physician must be enrolled in Medicare.

In either circumstance, the services must be performed in the "United States," which means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands and American Samoa.

Interpretation provided outside of the United States

Generally, Medicare will not pay for health care or supplies performed/provided outside the United States (U.S.). As above, the term "outside the U.S." means anywhere other than the 50 states., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

The exceptions to the "outside the U.S." exclusion are the following:

- The patient is in the U.S. when a medical emergency occurs and the foreign hospital is closer than the nearest U.S. hospital that can treat the illness or injury.
- The patient is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the illness or injury. The requirement of traveling through Canada "without unreasonable delay" is determined by Medicare on a case-by-case basis.
- The patient lives in the U.S. and the foreign hospital is closer to his/her home than the nearest U.S. hospital that can treat their medical condition, regardless of whether it is an emergency.
- The patient is on board a ship and receives emergency or non-emergency services in the territorial waters of the U.S.

Note: Physician and ambulance services furnished in connection with a covered foreign hospitalization above are also covered.

The POS code that should be used for Medicare-covered services that meet one of these exceptions to the "outside the U.S." exclusion is the place where the service was actually furnished (e.g., the hospital emergency room or cruise ship, etc.).

When determining which POS code to use in these situations, you should note that CMS clarified in the *Medicare Benefit Policy Manual*, chapter 16, (General Exclusions From Coverage), Section 60 (Services Not Provided Within United States) that:

Place and date of service instructions for interpretation of diagnostic tests (continued)

> "Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India".

Important note: In all cases in which the appropriate POS code may be unclear, your Medicare contractor makes the final determination of which code applies.

Additional information

You may find the official instruction, CR 6375, issued to your FI, carrier, or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1873CP.pdf* on the CMS Web site. You will find the updated sections of the *Medicare Claims Processing Manual* Chapter 26 (Completing and Processing Form CMS-1500 Data Set) as an attachment to that CR.

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

MLN Matters Number: MM6375
Related Change Request (CR) #: 6375
Related CR Release Date: December 11, 2009
Effective Date: January 4, 2010
Related CR Transmittal #: R1873CP
Implementation Date: January 4, 2010, except July 1, 2010, for DOS instruction in this article.

Payment to physician or other supplier for diagnostic tests subject to the anti-markup payment limitation

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

Provider types affected

Physicians and other suppliers (such as physician organizations) submitting claims to Medicare contractors (carriers and/or Medicare administrative contractors [MACs]) for diagnostic tests (excluding clinical diagnostic laboratory tests) provided to Medicare beneficiaries.

Provider action needed

This article pertains to change request (CR) 6733 which alerts providers that the Centers for Medicare & Medicaid Services (CMS) is revising the section of the *Medicare Claims Processing Manual* to implement changes to 42 CFR section 414.50 that were made in the CY 2009 PFS final rule (73 FR 69799, November 19, 2008). These changes include two alternative methods for determining when not to apply the anti-markup payment limitation. CR 6371 is a related CR, which described the claims processing instructions for implementing the recent changes to the anti-markup payment limitation rules. The MLN Matters® article for CR 6371 may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6371.pdf* on the CMS Web site. In order to make the regulatory changes, CMS is replacing Section 30.2.9 and deleting Section 30.2.9.1 of Chapter 1, *Medicare Claims Processing Manual*. CMS is also removing references of the terms "purchased diagnostic test" and "purchased test interpretation" in the manual and substituting references to the "anti-markup test." For those billing for these services, be sure to understand when the anti-markup limitation applies, as described in CR 6733.

Background

Section 1842(n)(1) of the Social Security Act requires CMS to impose a payment limitation on certain diagnostic tests where the physician performing or supervising the test does not share a practice with the billing physician or other supplier. Such a test was formerly referred to as a "purchased diagnostic test". In the CY 2009 MPFS final rule (73 FR 69799, November 19, 2008), CMS finalized changes to 42 CFR section 414.50 to include alternative methods to determine when not to apply anti-markup rules.

CR 6733 provides instructions for determining when the anti-markup payment limitation applies and when it does not apply.

Note that when the anti-markup provision applies, it is applicable to the professional component as well as the technical component of a diagnostic test that is billed by a physician or other supplier that did not perform the test.

When anti-markup payment limitation applies

A diagnostic test, payable under the Medicare physician fee schedule (MPFS), is performed by a physician who does not meet the requirements, described in 42 *Code of Federal Regulations* (CFR) section 414.50 and in the revised section 30.2.9 of the *Medicare Claims Processing Manual*, for "sharing a practice" with the billing physician or other supplier. When the anti-markup payment limitation applies, payment to the billing physician or other supplier (less any applicable deductibles or coinsurance) for the technical component (TC) or professional component (PC) of the diagnostic test may not exceed the lowest of the following amounts:

1. The performing supplier's net charge to the billing physician or other supplier.
2. The billing physician or other supplier's actual charge.
3. The MPFS amount for the test that would be allowed if the performing supplier had billed directly.

The net charge must be determined without regard to any charge that reflects the cost of equipment or space leased to the performing physician.

When anti-markup payment limitation will not apply

- If the physician or other supplier does not order the diagnostic test, or

Payment to physician or other supplier for diagnostic tests subject to the anti-markup payment limitation (continued)

- If the performing/supervising physician is deemed to "share a practice" with the billing physician or other supplier.

There are two alternative methods for determining whether the performing/supervising physician is deemed to "share a practice." Those alternatives are below.

Alternative one, "substantially all services" test

If the performing physician (the physician who supervises or conducts the TC, performs the PC, or both) furnishes substantially all (at least 75 percent) of his or her professional services through the billing physician or other supplier, the anti-markup payment limitation will not apply.

Alternative two, "site of service/same building" test

- If the TC or the PC is supervised/performed in the "office of the billing physician or other supplier" by a physician owner, employee, or independent contractor of the billing physician or other supplier, the anti-markup payment limitation will not apply.
- The "office of the billing physician or other supplier" is any medical office space, regardless of the number of locations, in which the ordering physician regularly furnishes patient care. This includes space where the billing physician or other supplier furnishes diagnostic testing services, if the space is located in the "same building" in which the ordering physician regularly furnishes patient care.
- If the billing physician or other supplier is a physician organization, the "office of the billing physician or other supplier" is space in which the ordering physician provides substantially the full range of patient care services that the ordering physician provides generally. With respect to the TC, the performing physician is the physician who conducted and/or supervised the TC, and with respect to the PC, the performing physician is the physician who personally performed the PC.

Key billing points of CR 6733

- The anti-markup payment limitation will apply if the performing physician does not "share a practice" with the billing physician or other supplier who ordered the test.
- If the anti-markup payment limitation applies, the billing physician or other supplier will be paid for the TC or PC of the diagnostic test (less any applicable deductibles or coinsurance) the lower of: (1) the performing physician's net charge to the billing physician or other supplier; (2) the billing physician or other supplier's actual charge; or, (3) the MPFS amount for the test that would be allowed if the performing physician had billed directly.
- The anti-markup payment limitation will not apply if the performing/supervising physician "shares a practice" with the billing physician or other supplier.
- If the performing physician (the physician who supervises or conducts the TC, performs the PC, or both) furnishes substantially all (at least 75 percent) of his or her professional services through the billing physician or other supplier, the anti-markup payment limitation will not apply.
- If the TC or PC is supervised/performed in the "office of the billing physician or other supplier" or in the "same building" by a physician owner, employee, or independent contractor of the billing physician or other supplier, the anti-markup payment limitation will not apply.
- The billing physician or other supplier must keep on file the name, the national provider identifier, and address of the performing physician. The physician or other supplier furnishing the TC or PC of the diagnostic test must be enrolled in the Medicare program. No formal reassignment is necessary.

Note: When billing for the TC or PC of a diagnostic test (other than a clinical diagnostic laboratory test) that is performed by another physician, the billing entity must indicate the name, address and NPI of the performing physician in Item 32 of the CMS-1500. However, if the performing physician is enrolled with a different B/MAC, the NPI of the performing physician is not reported on the CMS-1500. In this instance, the billing entity must submit its own NPI with the name, address, and ZIP code of the performing physician in Item 32 of the CMS-1500, or electronic equivalent. The billing supplier should maintain a record of the performing physician's NPI in the clinical record for auditing purposes.

- If the billing physician or other supplier performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically (ANSI X12 837) or on separate claims if billing on paper (CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Additional information

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

The official instruction, CR 6733, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1892CP.pdf*. The revised portion of the *Medicare Claims Processing Manual* is attached to CR 6733.

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Related Change Request (CR) #: 6733
Related CR Release Date: January 15, 2010
Effective Date: March 15, 2010
Related CR Transmittal #: R1892CP
Implementation Date: March 15, 2010

End-stage Renal Disease

Coverage of kidney disease patient education services

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

Provider types affected

This article affects physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for kidney disease education services provided to Medicare beneficiaries diagnosed with stage IV chronic kidney disease (CKD).

Provider action needed

Stop -- impact to you

This article is based on change request (CR) 6557 which implements kidney disease education (KDE) services as a Medicare Part B covered benefit for Medicare beneficiaries diagnosed with stage IV CKD.

Caution -- what you need to know

KDE services are designed to provide beneficiaries with comprehensive information regarding the management of comorbidities, including for purposes of delaying the need for dialysis; prevention of uremic complications; and each option for renal replacement therapy. This benefit is also designed to be tailored to individual needs and provide the beneficiary with the opportunity to actively participate in his/her choice of therapy. The Centers for Medicare & Medicaid Services (CMS) issued two new Healthcare Common Procedure Coding System (HCPCS) codes to be used to report covered KDE services: G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session; per one hour) and G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour).

Go -- what you need to do

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

Background

By definition, CKD is kidney damage for three months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones. When chronic kidney disease progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (dialysis) or a kidney transplant to maintain life.

Individuals with CKD may benefit from KDE interventions due to the large amount of medical information that could affect patient outcomes, including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA Section 152(b); see *http://waysandmeans.house.gov/MoreInfo.asp?section=45*) added KDE services as a Medicare Part B covered benefit for Medicare V CKD who have received a referral from the physician managing the beneficiary's kidney condition.

KDE content requirements

CMS published regulations implementing this provision at 42 CFR 410.48. Medicare Part B covers KDE services, provided by a qualified person, who provides comprehensive information regarding the management of comorbidities, including for the purpose of delaying the need for dialysis; the prevention of uremic complications; therapeutic options, treatment modalities, and settings, including a discussion of the advantages and disadvantages of each treatment option, and how the treatments replace the kidney; opportunities for beneficiaries to actively participate in the choice of therapy; and be tailored to meet the needs of the individual beneficiary involved.

KDE outcomes assessments

Qualified persons that provide KDE services will develop outcomes assessments that are designed to measure beneficiary knowledge about CKD and its treatment. It also serves to assist KDE educators and CMS in improving subsequent KDE programs and patient understanding and assessing program effectiveness. The assessment will be administered to the beneficiary during a KDE session, and will be made available to CMS upon request.

KDE billing instructions

Change request (CR) 6557 instructs Medicare contractors to pay for KDE services that meet the following conditions:

- No more than six sessions of KDE services are provided in a beneficiary's lifetime
- Sessions billed in increments of one hour (if the session is less than one hour, it must last at least 31 minutes in order to be billed, in which case a session less than one hour and longer than 31 minutes is billable as one session)
- Sessions furnished either individually or in a group setting of two to 20 individuals (who need not all be Medicare beneficiaries); and
- Furnished, upon the referral of the physician managing the beneficiary's kidney condition, by a qualified person meaning a:
    - Physician, physician's assistant, nurse practitioner, or clinical nurse specialist

Coverage of kidney disease patient education services (continued)

- Hospital, critical access hospital (CAH), skilled nursing facility (SNF) comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that is located in a rural area; or
- Hospital or CAH that is paid as if it were located in a rural area (hospitals and CAHs reclassified as rural under section 42 CFR 412.103).

The following providers are not 'qualified persons' and are excluded from furnishing KDE services:

- A hospital, SNF, CORF, HHA, or hospice located outside of a rural area (using the actual geographic location core-based statistical area [CBSA] to identify facilities located outside of a rural area under the Medicare physician fee schedule [MPFS], unless the services are furnished by a hospital or CAH that is treated as being in a rural area (such claims are denied with claims adjustment reason code [CARC] 170 [Payment is denied when performed/billed by this type of provider]) and Medicare summary notice (MSN) 21.6 (This item or service is not covered when performed, referred, or ordered by this provider.), and
- Renal dialysis facilities (type of bill (TOB) 72x).

CMS issued two new HCPCS codes G0420 and G0421 to be used to report covered KDE services in the January 2010 Integrated Outpatient Code Editor (IOCE) and MPFS database and identified the payment amounts in the final 2010 MPFS. One of these HCPCS codes must be present, along with ICD-9-CM code 585.4 (chronic kidney disease, stage IV [severe]), in order for a claim to be processed and paid correctly.

Medicare contractors will deny claims for KDE services billed without ICD-9-CM code 585.4 using CARC 167 (This (these) diagnosis(es) is(are) not covered.)

Medicare contractors will deny claims with HCPCS G0420 or G0421 and ICD-9-CM 585.4 for more than six sessions using claims adjustment reason code (CARC) 119 (Benefit maximum for this time period or occurrence has been reached).

Medicare will not pay a professional claim and an institutional claim for HCPCS G0420 or G0421 and ICD-9-CM 585.4 where both claims contain the same date of service. If such claims are received, the initial claim is paid and subsequent claims are denied using CARC 18 (Duplicate claim/service).

Note: If a signed ABN was provided, Medicare contractors will use group code PR (patient responsibility), and the liability falls to the beneficiary. If an ABN was not provided, contractors use group code CO (contractual obligation) and the liability falls to the provider.

The following additional billing requirements are applicable to KDE claims submitted by institutional providers to MACs or FIs:

- MACs/FIs will reimburse for KDE services when rendered in a rural area and submitted on the following TOBs: 12x, 13x, 22x, 23x, 34x, 75x, 81x, and 82x. Note: TOB 85x is reimbursable for KDE services regardless of the provider's geographical location.
- MACs/FIs will use the actual geographic location CBSA to identify facilities located in rural areas under the MPFS.
- KDE services are covered when claims containing the above-mentioned TOBs are received from section 401 hospitals (the provider is found on the annually updated Table 9C of the inpatient prospective payment system final rule).
- Revenue code 0942 (Other therapeutic services; education/training) should be reported when billing for KDE services on TOBs 22x, 23x, 34x, 75x, 81x, 82x, and 85x.
- Medicare will return to provider hospice claims, TOBs 81x and 82x, billing for KDE services with revenue code 0942 when any other services are also included.
- Hospices must include value code 61 or G8 when billing for G0420 or G0421.
- Hospital outpatient departments should bill for KDE services under any valid/appropriate revenue code, and they are not required to report revenue code 0942. Maryland hospitals under jurisdiction of the Health Services Cost Review Commission, TOBs 12x and 13x, are paid on an inpatient Part B basis in accordance with the terms of the Maryland waiver.

Additional information

Be aware that Medicare contractors will not search their files for claims with service dates on or after January 1, 2010, that are processed prior to the implementation of CR 6557. However, if you identify such claims to your Medicare contractor, they will adjust them. The official instruction, CR 6557, was issued via two transmittals, one revising the *Medicare Claims Processing Manual*, Chapter 32, Section 20, and one for revisions to the *Medicare Benefit Policy Manual*, Chapter 15, Section 310. These transmittals are available at *http://www.cms.hhs.gov/Transmittals/downloads/R1876CP.pdf* and *http://www.cms.hhs.gov/Transmittals/downloads/R117BP.pdf*, respectively, on the CMS Web site. If you have questions, please contact your carrier, FI, A/B MAC, or RHHI at their toll-free numbers, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS Web site.

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Related CR Release Date: December 18, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1876CP and R117BP
Implementation Date: April 5, 2010

Evaluation and Management

Expansion of Medicare telehealth services for calendar year 2010

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

Provider types affected

Physicians, hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries are affected by this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) added three Healthcare Common Procedure Coding System (HCPCS) codes, *96150-96152*, to the list of Medicare distant site telehealth services for individual health and behavior assessment and intervention (HBAI) services. CMS also added three new HCPCS codes, G0425-G0427, for initial inpatient telehealth consultations and expanded coverage of HCPCS codes G0406-G0408, for follow-up inpatient telehealth consultations, to include telehealth services furnished to beneficiaries in a SNF.

These changes are discussed in the calendar year (CY) 2010 physician fee schedule final rule (with comment period [CMS-1413-FC]). This article highlights the related policy instructions. Be sure your billing staff is aware of these changes.

Background

As noted in the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC; see *http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf*), CMS did the following:

- Added three codes to the list of Medicare distant site telehealth services for **individual health and behavior assessment and intervention (HBAI) services**
- Added three codes for **initial inpatient telehealth consultations, and**
- Expanded the definition of **follow-up inpatient telehealth consultations** to include consultative visits furnished via telehealth to beneficiaries in SNFs as well as hospitals).

These codes are included in the calendar year (CY) 2010 HCPCS annual update. Change request (CR) 6705 adds the relevant policy instructions to the manuals, as finalized in the regulations.

The list of Medicare telehealth services was expanded to include:

Individual HBAI, as described by:

- ***CPT* code *96150*** (initial assessment): Practitioners conducting the initial assessment of the patient to determine the biological, psychological, and social factors affecting the patient's physical health and any treatment problems
- ***CPT* code *96151*** (re-assessment): Practitioners conducting a re-assessment of the patient to evaluate the patient's condition and determine the need for further treatment. A re-assessment may be performed by a clinician other than the one who conducted the patient's initial assessment; and
- ***CPT* code *96152*** (intervention-individual): Practitioners conducting intervention services provided to an individual to modify the psychological, behavioral, cognitive, and social factors affecting the patient's physical health and well being. Examples include increasing the patient's awareness about his or her disease and using cognitive and behavioral approaches to initiate physician prescribed diet and exercise regimens, and

Initial inpatient telehealth consultations provided at various levels of complexity as described by:

- **HCPCS G0425** (problem focused): Practitioners taking a problem focused history, conducting a problem focused examination, and engaging in medical decision making that is straightforward. At this level of service, practitioners would typically spend 30 minutes communicating with the patient via telehealth;
- **HCPCS G0426** (detailed): Practitioners taking a detailed history, conducting a detailed examination, and engaging in medical decision making that is of moderate complexity. At this level of service, practitioners would typically spend 50 minutes communicating with the patient via telehealth; and
- **HCPCS G0427** (comprehensive): Practitioners taking a comprehensive history, conducting a comprehensive examination, and engaging in medical decision making that is of high complexity. At this level of service, practitioners would typically spend 70 minutes or more communicating with the patient via telehealth.

In addition, effective January 1, 2010, the following is valid when billed for telehealth services furnished to beneficiaries in hospitals or SNFs:

Follow-up inpatient telehealth consultations, described by:

- **HCPCS G0406**: Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
- **HCPCS G0407**: Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth, and
- **HCPCS G0408**: Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth.

Expansion of Medicare telehealth services for calendar year 2010 (continued)

Note that codes G0406-G0408 have been effective since January 1, 2009, but were only valid for telehealth services provided to a beneficiary in an inpatient hospital. As of January 1, 2010, these three codes are also billable for telehealth services furnished to beneficiaries in a SNF.

The following telehealth modifiers are required when billing for telehealth services with codes *96150-96152*, G0406-G0408, and G0425-G0427:

GT – via interactive audio and video telecommunications system
GQ – via asynchronous telecommunications system

Note: Consistent with existing telehealth policy, all telehealth services must be billed with either modifier GT or GQ to identify the telehealth technology used to provide the service.

Effective January 1, 2010, CMS eliminated the use of all AMA *Current Procedural Terminology* (*CPT*) consultation codes. (See the *MLN Matters*® article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf* for full details.) Because revisions in consultation services payment policy affect telehealth policy, CR 6705 includes references to the revisions relevant to professional consultations furnished via telehealth.

Effective January 1, 2010:

- CMS will no longer recognize office/outpatient consultation *CPT* codes *99241-99245*.
- Instead, physicians and practitioners are instructed to bill a new or established patient visit *CPT* code in the range of *CPT* codes *99201-99215*, as appropriate to the particular patient, for all office/outpatient visits furnished via telehealth; and
- CMS will no longer recognize initial inpatient consultation *CPT* codes *99251-99255*.
- Instead, CMS created HCPCS codes G0425-G0427 specific to the telehealth delivery of initial inpatient consultations to retain the ability for practitioners to furnish and bill for initial inpatient consultations delivered via telehealth.

This expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, payment or billing methodology applicable to Medicare telehealth services as set forth in the *Medicare Benefit Policy Manual* (Chapter 15, Section 270) and the *Medicare Claims Processing Manual* (Chapter 12, Section 190). These manuals are available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Additional Information

The official instruction, CR 6705, was issued in two transmittals to your carrier, FI, and A/B MAC. The first transmittal revises the *Medicare Benefit Policy Manual* and is available at *http://www.cms.hhs.gov/Transmittals/downloads/R118BP.pdf* and the second transmittal, which modifies the *Medicare Claims Processing Manual*, is at *http://www.cms.hhs.gov/Transmittals/downloads/R1881CP.pdf*.

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*.

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Effective Date: January 1, 2010
Related CR Transmittal #: R1881CP and R118BP
Implementation Date: January 4, 2010

New feedback page

One of the trends identified in the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) was our providers' preference to have more ways to communicate with us. Our new Feedback page offers our customers the convenience of a central "hub" for communication and includes three interactive feedback, available at *http://medicare.fcso.com/feedback/*.

Laboratory/Pathology

Calendar year 2010 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

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

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article is based on change request (CR) 6657 which provides instructions for the CY 2010 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure your billing staffs are aware of these changes and the special edition *MLN Matters*® article SE1001, which is discussed later in this article.

Background

Update to fees

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for CY 2010 is (-1.4) percent. (The relevant section of the Act is available at *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the Internet.) Further, Section 145 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) adjusted the annual update by 0.5 percent through CY 2013. Therefore, the annual update for CY 2010 is (1.9) percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2010 is 0 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). For a cervical or vaginal smear test (Pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge.

Note: The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National minimum payment amounts

For a cervical or vaginal smear test (Pap smear), Medicare payment is the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2010 national minimum payment amount is $15.13 ($15.42 plus (1.9) percent update for CY 2010). The affected codes for the national minimum payment amount are:

88142	*88143*	*88147*	*88148*	*88150*	*88152*	*88153*	*88154*	*88164*	*88165*	*88166*
88167	*88174*	*88175*	G0123	G0143	G0144	G0145	G0147	G0148	P3000	

National limitation amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Social Security Act.

Access to data file

Internet access to the CY 2010 clinical laboratory fee schedule data file is available at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the Centers for Medicare & Medicaid Services (CMS) Web site. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 14, 2009, CMS hosted a public meeting to solicit input on the payment relationship between CY 2009 codes and new CY 2010 *Current Procedural Terminology* (*CPT*) codes. Notice of the meeting was published in the *Federal Register* on May 22, 2009, and on the CMS Web site approximately June 15, 2009. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the CMS Web site. Additional written comments from the public were accepted until September 18, 2009. CMS has posted a summary of the public comments and the rationale for their final payment determinations on the CMS Web site also.

Calendar year 2010 annual update for clinical laboratory fee schedule and laboratory services subject to ... (continued)

Pricing information

The CY 2010 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415*, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

For dates of service from January 1, 2010, through December 31, 2010, the fee for clinical laboratory travel code P9603 is $1.00 per mile and the fee for clinical laboratory travel code P9604 is $10.00 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2010, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2010 clinical laboratory fee schedule also includes codes that have a modifier QW to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the CY 2010 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping information

- New code *83987* is priced at the sum of the rates of codes *82800* and *87015*.
- New code *84145* is priced at the same rate as code *84146*.
- New code *84431* is priced at the same rate as code *83520*.
- New code *86305* is priced at the same rate as code *86316*.
- New code *86352* is priced at the sum of the rates of codes *86353* and *82397*.
- New code *86780* is priced at the same rate as code *86781*.
- New code *86825* is priced at three times the rate of code *86356*.
- New code *86826* is priced at the same rate as code *86356*.
- New code *87150* is priced at the same rate as code *87798*.
- New code *87153* is priced at the sum of the rates of codes *83891, 83898, 83904, 83912*, and half of code *87900*.
- New code *87493* is priced at the same rate as code *87798*.
- New code *88738* is priced at the same rate as code *88740*.
- New code *80069QW* is priced at the same rate as code *80069* beginning December 4, 2008.
- New code *82040QW* is priced at the same rate as code *82040* beginning January 1, 2009.
- New code *82043QW* is priced at the same rate as code *82043* beginning October 1, 2009.
- New code *82550QW* is priced at the same rate as code *82550* beginning December 4, 2008.
- New code *87905QW* is priced at the same rate at code *87905* beginning January 1, 2009.
- Code *83876* is priced at the same rate as code *83880*.
- HCPCS Code G0430 is priced at the same rate as code *80100*.
- HCPCS Code G0431 is priced at the same rate as code *80101*.
- Code *82307* is deleted beginning January 1, 2010.
- Code *82042QW* is deleted beginning July 1, 2009.
- Code *83520QW* is deleted beginning October 1, 2009.
- Code *86781* is deleted beginning January 1, 2010.
- For CY 2010, there are no new test codes to be gap filled.

Special information regarding codes G0430, G0431, *80100*, and *80101*

A special edition *MLN Matters*® article is available regarding the use of these four codes. That article is at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1001.pdf*. Clinical laboratories billing these codes should review this special edition article for important information regarding the billing of these codes, especially for services from January 1, 2010, through March 31, 2010, inclusive.

Calendar year 2010 annual update for clinical laboratory fee schedule and laboratory services subject to ... (continued)

Laboratory costs subject to reasonable charge payment in CY 2010

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 *Code of Federal Regulations* (CFR) 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as prescribed by Section 1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2010 is 0 percent.

Manual instructions for determining the reasonable charge payment may be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8. That manual is available at *http://www.cms.hhs.gov/manuals/IOM/list.asp*. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, Chapter 8, Section 60.3 instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood products					
P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 20.5 through 20.54:

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine					
86850	*86860*	*86870*	*86880*	*86885*	*86886*
86890	*86891*	*86900*	*86901*	*86903*	*86904*
86905	*86906*	*86920*	*86921*	*86922*	*86923*
86927	*86930*	*86931*	*86932*	*86945*	*86950*
86960	*86965*	*86970*	*86971*	*86972*	*86975*
86976	*86977*	*86978*	*86985*		

Reproductive medicine procedures					
89250	*89251*	*89253*	*89354*	*89255*	*89257*
89258	*89259*	*89260*	*89261*	*89264*	*89268*
89272	*89280*	*89281*	*89290*	*89291*	*89335*
89342	*89343*	*89344*	*89346*	*89352*	*89353*
89354	*89356*				

Additional information

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

The official instruction (CR 6657) issued to your Medicare MAC, carrier, and/or FI may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1884CP.pdf*.

MLN Matters® Number: MM6657
Related Change Request (CR) #: 6657
Related CR Release Date: December 23, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1884CP
Implementation Date: January 4, 2010

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Additional information regarding the calendar year 2010 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

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

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article describes how clinical diagnostic laboratories should bill for certain types of tests that are covered under Medicare and paid based on the clinical laboratory fee schedule (CLFS). Specifically, the article addresses billing of four codes (G0430, G0431, *80100*, and *80101*) during the period of January 1, 2010, through March 31, 2010. Further information will be provided regarding billing after March 31, 2010. Be sure billing staff are aware of these changes.

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) hosts an annual public meeting concerning new test codes that have been established by the *Common Procedural Terminology* (*CPT*) committee and that will be covered by Medicare and paid based on the CLFS.

This year, two new G codes were established: G0430 and G0431. When these two new codes were introduced at the annual public meeting during 2009, members of the laboratory industry expressed concern about how these two new codes would be described and when they should be billed. This article seeks to clarify these issues.

It came to CMS' attention that some companies were using questionable billing practices concerning *CPT* codes *80100* and *80101*. In addition, *CPT* code *80100* describes only chromatographic testing for the presence of drugs, which left certain laboratories unable to bill accurately when this type of testing was performed, but the chromatographic method was not utilized. Therefore, CMS created two new G codes to operate in place of and alongside *CPT* codes *80100* and *80101*.

Following are the current definitions of all test codes addressed in this issue:

- *CPT* code *80100*: *Drug screen, qualitative; multiple drug classes chromatographic method, each procedure*
- G0430: Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
- *CPT* code *80101*: *Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
- *CPT* code *80101QW*: *Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
- G0431: Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class

From January 1, 2010, through March 31, 2010, when performing a qualitative drug screening test for multiple drug classes using chromatographic methods, *CPT* code *80100* is the appropriate code to bill. New test code G0430 was created to limit the billing to one time per procedure and to remove the limitation of the method (chromatographic) when this method is not being used in the performance of the test. As a result, when performing a qualitative drug screening test for multiple drug classes that does not use chromatographic methods, new test code G0430 is the appropriate code to bill.

New test code G0431 is a direct replacement for *CPT* code *80101*. However, CMS is delaying this replacement until April 1, 2010.

Similarly, from January 1, 2010, through March 31, 2010, when performing a qualitative drug screening test for a single class of drugs, regardless of the testing methodology, those clinical laboratories that do not require a CLIA certificate of waiver should bill new test code G0431. Those clinical laboratories that do require a CLIA certificate of waiver should continue to utilize *CPT* code *80101QW*.

Further direction on this matter will be provided by April 1, 2010.

Additional information

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

MLN Matters® Number: SE1001
Related Change Request (CR) #: 6657
Related CR Release Date: N/A
Effective Date: January 1, 2010
Related CR Transmittal #: N/A
Implementation Date: January 4, 2010

Medicare Physician Fee Schedule

Emergency update to the 2010 Medicare physician fee schedule database

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

Note: The files associated with change request (CR) 6796 include a legislative change to the CY 2010 conversion factor update and changes as a result of technical corrections to the malpractice relative value units. The conversion factor for CY 2010 is $36.0846.

Provider types affected

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

Provider action needed

This article is based on CR 6796 which amends payment files that were issued to Medicare contractors based on the 2010 MPFS final rule. Be sure your billing staff is aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1847.htm*) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2010 MPFS final rule. CR 6796 amends those payment files. CR 6796 provides corrections, effective for dates of service on or after January 1, 2010, to those files. These changes include the following:

CPT/HCPCS	Action
0575F	Procedure status: M
20550	Bilateral indicator: 1
4270F	Procedure status: M
4280F	Procedure status: M
50543	Bilateral indicator: 1
50548	Bilateral indicator: 1
80100	Procedure status: X
A4641	Procedure status: C
A4642	Procedure status: C
A9698	Procedure status: X
S2118	Procedure status: I
S2270	Procedure status: I
S3628	Procedure status: I
S3711	Procedure status: I
S3860	Procedure status: I
S3861	Procedure status: I
S3862	Procedure status: I
S9433	Procedure status: I

In addition, the relative value units (RVUs) of a number of *CPT*/HCPCS (*19340, 42145, 64490, 64491, 64492, 64493, 64494, 64495, 77785, 77785-TC, 77786, 77786-TC, 77787, 77787-TC, 93740*, and *93770*) were changed. To view the specific RVU changes for these codes, see Attachment 1 of CR 6796 at *http://www.cms.hhs.gov/Transmittals/downloads/R1887CP.pdf*.

Additional information

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*.

MLN Matters® Number: MM6796
Related Change Request (CR) #: 6796
Related CR Release Date: January 6, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R1887CP
Implementation Date: January 4, 2010

2010 MPFS policies and telehealth originating site facility fee payment amount

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, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries and paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 6756 which provides a summary of the policies in the 2010 MPFS and announces the telehealth originating site facility fee payment amount. Be sure billing staff are aware of these Medicare changes.

Background

The Social Security Act (Section 1848(b)(1) at *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2010.

The Social Security Act (Section 1834(m) at *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm* established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 21, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI) as defined in Section 1842(i)(3) of the Social Security Act (or the ACT). The MEI increase for calendar year (CY) 2010 is 1.2 percent. The telehealth originating site facility fee (HCPCS code Q3014) for 2010 is 80 percent of the lesser of the actual charge or $24.00.

Summary of other key changes discussed by CR 6756

Practice expense (PE) issues

The two primary data sources used to calculate practice expense (PE) relative value units (RVUs) are:

1. Specialty-specific survey data on indirect practice expenses
2. Procedure specific data on direct practice expenses, based primarily on American Medical Association (AMA) recommendations reviewed by CMS

Recently, the AMA conducted a new physician practice information survey (PPIS) and expanded it to include nonphysician practitioners paid under the MPFS. The incorporation of the AMA's contemporaneous, consistently collected, multi-specialty PPIS data into the calculation of the resource-based practice expense (PE) RVUs ensures that the practice expense RVUs reflect the best and most current data available. In the CY 2010 MPFS proposed rule, CMS proposed to include the data collected by the AMA's PPIS into the calculation of resource-based practice expense RVUs. In the 2010 MPFS final rule, CMS finalized it's proposal to use the PPIS survey date to calculate PE RVUs. CMS believes the impact of using the new PPIS data warrants a four year transition for existing 2009 *CPT* codes from the current PE RVUs to the PE RVUs developed using the new PPIS data. New and substantially revised *CPT* codes will not be subject to a transition. CMS will also continue using the oncology supplemental survey data for the drug administration codes.

Equipment utilization rate

In the CY 2010 MPFS proposed rule, CMS proposed to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for expensive equipment (purchase price over $1 million). Many of these high cost diagnostic imaging services are currently subject to a statutory payment limit based on the outpatient prospective payment system payment rates (OPPS cap). In the MPFS final rule, CMS finalized the proposal to increase the equipment utilization rate to 90 percent for expensive diagnostic equipment priced at more than $1 million. This change will be transitioned over a four year period. CMS is not finalizing the proposal to increase the utilization rate assumption for expensive therapeutic equipment.

Geographic practice cost indices: locality discussion

In the CY 2010 MPFS proposed rule, CMS noted that the legislative 1.0 work geographic practice cost indices (GPCIs) floor established by section 134 of the Medicare Improvements for Patients and Providers Act (MIPPA) expires December 31, 2009. The proposed CY 2010 GPCIs did not include the 1.0 floor. In the MPFS final rule, CMS summarized comments received on their report on potential alternative locality configurations. Also in the final rule, CMS reiterated that they are not proposing any changes in the PFS locality structure but will continue to review the options available. A final report will be posted to the CMS Web site after further review of the studied alternative locality approaches.

Malpractice RVUs

Section 1848(c) of the Act required the implementation of resource-based Malpractice (MP) RVUs for services furnished beginning January 1, 2000. Section 1848(c)(2)(B)(i) of the Act requires that CMS review and, if necessary, adjust RVUs no less often than every five years. The law requires that the updates to the MP RVUs are budget neutral overall. In 2005, CMS implemented the results of the first comprehensive review of the MP RVUs. The second update must be implemented for CY 2010. In the past, the MP RVUs for technical component (TC) services (for example diagnostic tests) and the TC portion of global services were based on historical allowed charges and were not resource based due to a lack of available malpractice premium data for nonphysician suppliers. In the CY 2010 PFS proposed rule, CMS discussed the proposed methodology and updated premium data for the second update of malpractice RVUs. CMS proposed to use medical physicist premium data as a proxy for the malpractice premiums paid by all entities providing TC services; primarily independent diagnostic testing facility (IDTFs).

2010 MPFS policies and telehealth originating site facility fee payment amount (continued)

Other than this TC change, the proposed rule methodology conceptually followed the same approach, with some minor refinements, used to originally develop the resource based MP RVUs.

In the CY 2010 MPFS final rule, CMS finalized the updated malpractice RVUs. Due to newly available data, CMS will use malpractice premium data for IDTFs instead of medical physicist premium data to determine the malpractice premiums paid by technical component suppliers.

Specific coding issues related to physician fee schedule consultation services

In the CY 2010 MPFS proposed rule, CMS proposed to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G codes. CMS justified this proposal on the grounds that, in light of recent reductions in the documentation requirements for consultation services, the resources involved in doing an inpatient or office consultation are not sufficiently different than the resources required for an inpatient or office visit to justify the existing differences in payment levels. Eliminating the consultation codes would have the effect of increasing payments for the office visit codes that are billed by most physicians, and most commonly by primary care physicians. Although all physicians would gain from the increased payment for office visits, the net result would be a reallocation of payments from specialists (who bill consultation codes much more frequently) to primary care physicians.

In the CY 2010 MPFS final rule, CMS finalized the proposal to eliminate the use of all consultation codes (inpatient and office/outpatient consultation codes used for various places of service) except telehealth consultation G codes. As requested by the surgical specialties, CMS increased the surgical global period RVUs to reflect the resulting increases in the RVUs for the visit codes.

For more information on revisions to consultation services please see transmittal 1875, CR 6740, dated December 14, 2009. A related *MLN Matters*® article, MM6740, is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf*.

Initial preventive physical exam

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B for the initial preventive physical exam (IPPE), also known as the "Welcome to Medicare" visit. MIPPA made several changes to the IPPE including expanding the benefit period to not later than 12 months after an individual's first coverage period begins under Medicare Part B. Last year CMS implemented the MIPPA revisions to the benefit, but retained the existing value, and requested comments on whether it should be revalued. In the CY 2010 PFS proposed rule, CMS proposed to increase the work RVUs to the same level as a level four new patient office visit. In the CY 2010 MPFS final rule, CMS adopted this proposal. Consequently, the work RVU for the IPPE will increase from 1.34 to 2.30.

Canalith repositioning

In the CY 2009 MPFS final rule, a new *CPT* code *95992* for canalith repositioning procedure(s) was bundled with E/M codes. After the final rule was published, CMS recognized that physical therapists that had previously been performing this service now had no way to bill for it since they cannot bill for E/M services. In the 2010 MPFS proposed rule, CMS proposed to change the indicator to I (invalid). In the CY 2010 MPFS final rule, CMS finalized the proposal to make the *CPT* code for canalith repositioning invalid. Physicians will continue to be paid for this service as part of an E/M service. Physical therapists will continue to use one of the more generally defined "always therapy" *CPT* codes.

Clarification concerning certain audiology codes

In the CY 2010 MPFS final rule, CMS is clarifying that therapeutic and/or management activities are not payable to audiologists because they do not fall under the diagnostic tests benefit category designation.

MIPPA provisions

Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

By statute, Medicare pays 50 percent of the approved amount for outpatient mental health treatment services, while paying 80 percent of the approved amount for outpatient physical health services. Section 102 of the MIPPA gradually phases out the limitation by 2014. When the provision is fully implemented, CMS will pay outpatient mental health services at the same level as other Part B services. For 2010, CMS will pay 55 percent of the approved amount for outpatient psychiatric services.

Section 139: Improvements for Medicare Anesthesia Teaching Programs

Section 139 of MIPPA establishes a special payment rule for teaching anesthesiologists and provides a directive to the Secretary of Health and Human Services (HHS) regarding payments for the services of teaching certified registered nurse anesthetists (CRNAs). It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount. These provisions are effective for services furnished on or after January 1, 2010.

The special payment rule for teaching anesthesiologists allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist's involvement in the training of residents in either a single case or in two concurrent anesthesia cases. In the CY 2010 MPFS final rule, CMS will apply the special payment rule to teaching anesthesiologists in the following three cases:

- The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case)
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case)
- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules

2010 MPFS policies and telehealth originating site facility fee payment amount (continued)

Anesthesia handoff

MIPPA Section 139 requires the teaching anesthesiologist to be present at the key or critical portions of an anesthesia procedure. It also specifies that the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. However, in the proposed rule CMS proposed that the teaching anesthesiologist must be present during key or critical portions of a procedure. Anesthesiologists advised CMS that it may be common practice for different members of a teaching anesthesia group to provide a service instead of a single teaching anesthesiologist. This practice is referred to as an anesthesia handoff.

In the 2010 MPFS final rule, CMS finalized an alternative option that permits handoffs between members of the same anesthesia group for key or critical portions of a procedure. This option is consistent with current anesthesia practice and it is less disruptive to current anesthesia practice arrangements. CMS may propose to standardize protocols and quality rules for handoffs in the future.

Certified registered nurse anesthetist (CRNA) teaching payment policy

Section 139(b) of the MIPPA instructs the HHS Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under Section 139(a) of the MIPPA.

In the 2010 MPFS final rule, CMS allows the teaching CRNA, who is not medically directed, to be paid the full fee for his/her involvement in two concurrent cases with student nurse anesthetists. Other payment policies would remain unchanged.

Additional information

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

The official instruction, CR 6756, issued to your Medicare MAC, carrier, or FI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R615OTN.pdf*.

MLN Matters® Number: MM6756
Related Change Request (CR) #: 6756
Related CR Release Date: December 29, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R615OTN
Implementation Date: January 4, 2010

General Coverage

Medically unlikely edits

Background

The Centers for Medicare & Medicaid Services (CMS) developed the Medically unlikely edit (MUE) program to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/*CPT* code descriptors, *CPT* coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

- An MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service.
- The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims.
- Note that the MUE program provides a method to report medically likely UOS in excess of an MUE.

Key points

All CMS claim processing contractors (including contractors using the Fiscal Intermediary Shared System (FISS)) shall adjudicate MUEs against each line of a claim rather than the entire claim. If a HCPCS/CPT code is changed on more than one line of a claim by using CPT modifiers, the claim processing system separately adjudicates each line with that code against the MUE.

Fiscal intermediaries (FIs), carriers and Medicare administrative contractors (MACs) processing claims shall deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/CPT code on the claim line. Since claim lines are denied, the denial may be appealed.

Since each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of *CPT* modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE. The following *CPT* modifiers will accomplish this purpose:

Medically unlikely edits (continued)

76 Repeat procedure by same physician

77 Repeat procedure by another physician

91 Repeat clinical diagnostic laboratory test

59 Distinct procedural service. Note: Providers/suppliers should use modifier 59 only if no other modifier describes the service

Anatomic modifiers (e.g., RT, LT, F1, F2)

On or about October 1, 2008, CMS announced that it would publish at the start of each calendar quarter the majority of active MUEs and post them on the MUE Web page at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage*.

Note that, at the onset of the MUE program, all MUE values were confidential, and for use only by CMS and CMS contractors. Since October 1, 2008, CMS has published most MUE values at the start of each calendar quarter. However, some MUE values are not published and continue to be confidential information for use by CMS and CMS contractors only. The confidential MUE values shall not be shared with providers/suppliers or other parties outside the CMS contractor's organization. The files referenced in the business requirements of this CR contain both published and unpublished MUE values. In the MUE files each HCPCS code has an associated "publication indicator". A publication indicator of "0" indicates that the MUE value for that code is confidential, is not in the CMS official publication of the MUE values, and should not be shared with providers/suppliers or other parties outside the CMS contractor's organization. A publication indicator of "1" indicates that the MUE value for that code is published and may be shared with other parties.

The full set of MUEs is available for the CMS contractors only via the Baltimore data center. A test file will be available about two months before the beginning of each quarter, and the final file will be available about six weeks before the beginning of each quarter. Note that MUE file updates are a full replacement. The MUE adds, deletes, and changes lists will be available about five weeks before the beginning of each quarter.

This CR provides updates and clarifications to MUE requirements established in 2006.

Policy

The NCCI contractor produces a table of MUEs. The table contains ASCII text and consists of six columns (Refer to Appendix 1 – Tabular Presentation of the Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare Carrier System (MCS), one for contractors using the VIPS Medicare System (VMS) system, and one for the contractors using the FISS system.

Contractors shall apply MUEs to claims with a date of service on or after the beginning effective date of an edit and before or on the ending effective date.

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, *Program Integrity Manual (PIM)*, Chapter 3, Section 5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

The CMS will set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

Since claim lines are denied, denials may be appealed.

Appeals shall be submitted to local contractors not the MUE contractor, Correct Coding Solutions, LLC.

Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and contractors will download via the Network Data Mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI contractor. The NCCI contractor may refer those concerns to CMS, and CMS may act to change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. A provider/supplier shall not issue an advance beneficiary notice of noncoverage (ABN) in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE. The denied units of service shall be a provider/supplier liability.

The CMS will distribute the MUEs as a separate file for each shared system when the quarterly NCCI edits are distributed.

Additional information

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

For complete details regarding CR 6712 please see the official instruction issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/transmittals/downloads/R617OTN.pdf*.

Source: Publication 100-20, Transmittal 617, Change request 6712

Timely claim filing guidelines

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

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

Pharmacogenomic testing for warfarin response

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 [A/B MAC]) for providing pharmacogenomic testing to predict warfarin (Coumadin®) responsiveness to Medicare beneficiaries should be aware of this article.

What you need to know

CR 6715, from which this article is taken, announces that effective August 3, 2009, pharmacogenomic testing to predict warfarin responsiveness is covered only when provided to Medicare beneficiaries in the context of a prospective randomized, controlled clinical study when that study meets certain criteria as outlined in the *Medicare National Coverage Determinations* (*NCD*) *Manual*, Chapter 1, Section 90.1 (Pharmacogenomic Testing to Predict Warfarin Responsiveness), which you may find as an attachment to CR 6715. Pharmacogenomic testing for warfarin responsiveness is limited to testing for CYP2C9 or VKORC1 alleles. Testing is covered for Medicare beneficiaries who: 1) Are candidates for anticoagulation therapy with warfarin, 2) Have not been previously tested for CYP2C9 or VKORC1 alleles, and 3) Have received fewer than five days of warfarin in the anticoagulation regimen for which the testing is ordered. Pharmacogenomic testing for the presence of the CYP2C9 and VKORC1 alleles to predict warfarin responsiveness is covered only once in a patient's lifetime.

Background

There has been considerable public interest in the use of pharmacogenomic testing (testing of how an individual's genetic makeup, or genotype, affects the body's response to drugs) to predict a patient's response to warfarin sodium (an orally administered anticoagulant drug marketed most commonly as Coumadin®). Warfarin affects the vitamin K-dependent clotting factors II, VII, IX, and X, and is thought to interfere with clotting factor synthesis.

The elimination of warfarin is almost entirely by metabolic conversion to inactive metabolites by cytochrome P450 (CYP) enzymes in liver cells. CYP2C9 is the principal cytochrome P450 enzyme that modulates the anticoagulant activity of warfarin. From results of clinical studies, genetic variation in the CYP2C9 and/or VKORC1 genes can, in concert with clinical factors, predict how each individual responds to warfarin.

On August 4, 2008, the Centers for Medicare & Medicaid Services (CMS) opened a national coverage analysis (NCA) to determine if the use of pharmacogenomic testing for warfarin responsiveness is reasonable and necessary under the Medicare program. On August 3, 2009, CMS issued a final decision stating that the available evidence does not demonstrate that pharmacogenomic testing to predict warfarin responsiveness improves health outcomes in Medicare beneficiaries, and is therefore not reasonable and necessary under Section1862(a)(1)(A) of the Social Security Act (the Act).

However, the CMS decision also states that the available evidence does support pharmacogenomic testing for warfarin responsiveness under coverage with evidence development (CED). CR 6715 announces that, effective August 3, 2009, the available evidence supports that CED under Section 1862(a)(1)(E) of the Act is appropriate for pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin responsiveness by any method, and is therefore covered when provided to Medicare beneficiaries who are candidates for anticoagulation therapy with warfarin only if they have not been previously tested for CYP2C9 or VKORC1 alleles; and have received fewer than five days of warfarin in the anticoagulation regimen for which the testing is ordered.

Further, such patients must be enrolled in a prospective, randomized, controlled clinical study that addresses one or more aspects of the specific research questions, and the study must adhere to standards of scientific integrity and relevance to the Medicare population. See Publication 100-03, *NCD Manual*, Chapter 1, Section 90.1, for detailed study requirements/criteria.

Note: This NCD does not determine coverage to identify CYP2C9 or VKORC1 alleles for other purposes, nor does it determine national coverage to identify other alleles to predict warfarin responsiveness. Further, CMS believes that the available evidence does not demonstrate that pharmacogenomic testing of CYP2C9 or VKORC1 alleles to predict warfarin responsiveness improves health outcomes in Medicare beneficiaries outside the context of CED, and is therefore not reasonable and necessary under Section 1862(a)(1)(A) of the Act.

Billing requirements

A new temporary Healthcare Common Procedure Coding System (HCPCS) Level II code effective August 3, 2009, G9143 (warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)), has been developed to enable the implementation of pharmacogenomic testing under CED. Please note that this would be a once-in-a-lifetime test unless there is a reason to believe that the patient's personal genetic characteristics would change over time.

Institutional clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- Value code D4 and 8-digit clinical trial number (when present on the claim)
- ICD-9 diagnosis code V70.7
- Condition code 30

(For these three elements, please see MM5790 – Use of an 8-Digit Registry Number on Clinical Trial Claims at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5790.pdf*)

- **HCPCS modifier Q0**: outpatient claims only (please see MM5805 – New Healthcare Common Procedure Coding System (HCPCS) Modifiers when Billing for Patient Care in Clinical Research Studies at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5805.pdf*, and

Pharmacogenomic testing for warfarin response (continued)

- **HCPCS code G9143** (mandatory with the April 2010 Integrated Outpatient Code Editor and the January 2011 clinical laboratory fee schedule (CLFS) updates). Prior to these times, clinical studies should bill Medicare contractors for this test as they currently do absent these instructions, and the Medicare contractors should process and pay those claims accordingly.

Practitioner clinical trial claims for pharmacogenomic testing for warfarin response are identified through the presence of all of the following elements:

- ICD-9 diagnosis code V70.7
- eight-digit clinical trial number (when present on the claim)
- HCPCS modifier Q0, and
- HCPCS code G9143 (to be carrier-priced for claims with dates of service on and after August 3, 2009, processed prior to the January 2011 CLFS update).

Payment requirements

You should be aware that Medicare will track whether a beneficiary receives once-in-a-lifetime pharmacogenomic testing for warfarin response and will generate a Medicare line-item denial if a subsequent test is submitted for payment. Your carrier, FI, or MAC will provide the following messages to enforce the one-time limitation for the test:

Claim adjustment reason code (CARC) 50: These are noncovered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present. (The aforementioned note is a revision to CARC 50 effective 04/01/2010.)

Remittance advice remark code (RARC) N362: The number of Days or Units of Service exceeds our acceptable maximum.

Group code CO: contractual obligation

Medicare summary notice (MSN) 16.76: This service/item was not covered because you have exceeded the lifetime limit for getting this service/item. (Este servicio/articulo no fue cubierto porque usted ya se ha pasado del limite permitido de por vida para recibirlo.) (MSN 16.76 is effective for dates of service on and after August 3, 2009.)

Additionally, Medicare will return to provider/return as unprocessable claims for pharmacogenomic testing for warfarin response when not billed with HCPCS modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study) on the same line with HCPCS G9143 using the following messages:

CARC 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.

Group code CO: contractual obligation

MSN 16.77 – This service/item was not covered because it was not provided as part of a qualifying trial/study. (Este servicio/articulo no fue cubierto porque no estaba incluido como parte de un unsayo clinico/estudio calificado.) (MSN 16.77 is effective for dates of service on and after August 3, 2009.)

If your claim contains the modifier Q0 and HCPCS G9143 but does not contain the V70.7 diagnosis code, those claim lines will generate a return to provider/return as unprocessable with the following messages:

CARC 16: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

RARC 64: Missing/incomplete/invalid other diagnosis.

Group code CO: contractual obligation, and

MSN 16.77: This service/item was not covered because it was not provided as part of a qualifying trial/study. (Este servicio/articulo no fue cubierto porque no estaba incluido como parte de un unsayo clinico/estudio calificado.) (MSN 16.77 is effective for dates of service on and after August 3, 2009.)

Please note that effective for claims with dates of service August 3, 2009, through April 4, 2010, your contractors will not search their files to adjust previously processed claims, but will adjust any claims that you bring to their attention.

Additional information

You may find more information about pharmacogenomic testing for warfarin response by going to CR 6715, which was issued in two transmittals. The first transmittal updates the *Medicare National Coverage Determinations Manual*, Chapter 1, Section 90.1 (Pharmacogenomic Testing to Predict Warfarin Responsiveness) and that transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R111NCD.pdf*. The second transmittal, *http://www.cms.hhs.gov/Transmittals/downloads/R1889CP.pdf*, updates the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 240 (Pharmacogenomic Testing for Warfarin Response).

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

MLN Matters® Number: MM6715
Related Change Request (CR) #: 6715
Related CR Release Date: January 8, 2010
Effective Date: August 3, 2009
Related CR Transmittal #: R1889CP and R111NCD
Implementation Date: April 5, 2010

New place of service code for walk-in retail health clinic

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

Provider types affected

This article is for physicians; nonphysician practitioners; ambulatory surgical centers (ASC); independent diagnostic testing facilities (IDTFs); durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers; and clinical diagnostic laboratories submitting claims to Medicare carriers, Parts A and B Medicare administrative contractors (A/B MACs) and DME MACs.

Provider action needed

This article, based on change request (CR) 6752, advises you that the current place of service (POS) code set has been updated to add a new code of 17 (walk-in retail health clinic). The code's description is as follows: "a walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other place of service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services."

Note: For the health care industry, the HIPAA effective date of the new POS code for walk-in retail health clinics is no later than May 1, 2010, with covered entities permitted to use it at any time after which the new code is posted to the Centers for Medicare & Medicaid Services (CMS) POS Web page.

You need to know that Medicare has not identified a need for this new code. Therefore, you should continue to use the billing instructions for immunizations described in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12 837 standards requires that each electronic claim transaction include a POS code from the POS code set maintained by CMS. As a payer, Medicare must be able to recognize as valid any valid code from the POS code set that appears on the HIPAA standard claim transaction. In accordance with HIPAA, Medicare will be able to recognize POS code 17 as valid by May 1, 2010, with plans to do so by March 11, 2010.

The new code 17 was established because industry entities other than Medicare identified a need to track the suppliers and settings of immunizations in greater detail than afforded through the current POS code set; these entities specifically wished to capture the walk-in retail health clinic, which they believe will be a common setting for immunizations.

Medicare has not identified a need for this new code, and physicians and other providers/suppliers are instructed to continue to use the billing instructions for immunizations described in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.

Additional information

The official instruction, CR 6752, issued to your carrier, A/B MAC, or DME MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1869CP.pdf*. If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6752
Related Change Request (CR) #: 6752
Related CR Release Date: December 11, 2009
Effective Date: March 11, 2010
Related CR Transmittal #: R1869CP
Implementation Date: March 11, 2010

Processing claims rejecting for gender/procedure conflict

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

Note: This article was revised on December 21, 2009, to reflect a revised change request (CR) 6638 that was issued on December 18, 2009. The CR release date, transmittal number, and the Web address for accessing CR 6638 were revised in this article. All other information remains the same. This information was previously published in the November 2009 *Medicare B Update!* pages 24-25.

Provider types affected

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

Provider action needed

Stop -- impact to you

This article is based on CR 6638 which provides instructions for completing Part A and Part B claims for gender specific services for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

Caution -- what you need to know

Claims for some beneficiaries are being rejected by Medicare systems due to gender specific edits, and this is resulting in inappropriate denials for Part A and Part B claims. CR 6638 instructs that for Part A claims processing, institutional providers should report condition code 45 (ambiguous gender category) on inpatient or outpatient services that can be subjected to gender specific editing (i.e., services that are considered female or male only) for the above defined beneficiaries. CR 6638 instructs physicians and nonphysician practitioners that for Part B professional claims the modifier KX (Requirements specified in the medical policy have been met) should be billed on the detail line with any procedure code(s) that are gender specific for the affected beneficiaries.

Go -- what you need to do

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

Background

Claims for some services for beneficiaries described above may be inadvertently denied due to sex related edits unless these services are billed properly.

As a result of the number of subject claims received that are being denied due to sex/diagnosis and sex/procedure edits, the National Uniform Billing Committee (NUBC) approved condition code 45 (ambiguous gender category) to identify these unique claims and to allow the sex related edits to be processed correctly.

CR 6638 instructs institutional providers submitting Part A claims to report condition code 45 (ambiguous gender category) on inpatient or outpatient services for effected beneficiaries where the service performed is gender specific (i.e., services that are considered female or male only). This claim level condition code should be used by providers to identify these unique claims and to allow the sex related edits to be processed correctly by Medicare systems and allow the service to continue normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.

The modifier KX, which is defined as "Requirements specified in the medical policy have been met", is a multipurpose informational modifier for Part B professional claims. In addition to its other existing uses, the modifier KX should also be used to identify services that are gender specific (i.e., services that are considered female or male only) for effected beneficiaries on claims submitted by physicians and nonphysician practitioners to Medicare carriers and MACs. Use of the modifier KX will alert the carrier/MAC that the physician/practitioner is performing a service on a patient for who gender specific editing may apply, and that the service should be allowed to continue with normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.

Additional Information

The official instruction, CR 6638, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1877CP.pdf*. 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*.

MLN Matters® Number: MM6638 *Revised*
Related Change Request (CR) #: 6638
Related CR Release Date: December 18, 2009
Effective Date: April 1, 2010
Related CR Transmittal #: R1877CP
Implementation Date: April 5, 2010

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 January 22, 2010, to correct the references to the *Medicare Benefit Policy Manual*. The reference for the revised manual should have stated Chapter 1, Sections 10 and 120, and Chapter 16, Section 180. All other information is unchanged. This information was previously published in the October 2009 *Medicare B Update!* pages 18-20.

Note: Additional information on the use of the PA, PB, and PC modifiers discussed in this article is available in the *MLN Matters*® article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6718.pdf*.

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 120 and Chapter 16, Section 180. This is pursuant to the national coverage determinations (NCDs) made as part of change request (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*.) 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 120, and Chapter 16, Section 180. 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.
- 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).

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

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 Claim Processing Manual* is available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.)
- 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 120, and Chapter 16, Section 180, 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*.

The claim for the noncovered services will be denied using:

- Claim adjustment reason code (CARC) 50 - These are non-covered 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:

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

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

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 NCD related to this issue and that transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf*.

The other transmittal presents the claim processing instructions. That transmittal is at *http://www.cms.hhs.gov/Transmittals/downloads/R1819CP.pdf*.

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*.

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

Expiration of various payment provisions under the Medicare program

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

Provider types affected

All Medicare providers should take note of this article.

Provider action needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected providers that a number of Medicare payment provisions, such as the following will no longer be in effect when the provisions sunset as of December 31, 2009:

- Therapy cap exceptions process
- Allowing independent laboratories to bill for the technical component of physician pathology services furnished to hospital patients

CMS continues to work with Congress on significant legislation which affects the Medicare program. We believe some or all of these provisions may be extended as part of this legislation. We encourage you to monitor activity on the Hill and stay apprised of the status of potential legislation. In the meantime, if such legislation is enacted, Medicare will notify its contractors to again process claims consistent with the extended provisions.

Claims for services furnished on or before December 31, 2009, will be processed under normal conditions.

For services provided on or after January 1, 2010, health care providers may choose, to the extent possible, to hold their claims (that is, not submit their claims to Medicare) until it becomes clearer as to whether new legislation will be enacted to extend these provisions. If legislation is enacted, claims submission for affected services may resume. Otherwise, claims submitted with dates of service on or after January 1, 2010, will not be paid in accordance with expiring provisions because there would no longer be any statutory basis for such payment.

CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue. Finally, be on the alert for more information about this and other legislative provisions which may affect you.

MLN Matters® Number: SE0931
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2010
Related CR Transmittal #: N/A
Implementation Date: January 1, 2010

Sunset payment of Indian Health Services

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

Provider types affected

Indian Health Service (IHS) tribe and tribal organizations and facilities submitting claims to Medicare contractors.

Provider action needed

This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that, per the provisions of Section 630 of the MMA, certain Part B services will no longer be covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, Congress is considering new legislation that may extend this provision beyond December 31, 2009. If such legislation is enacted, Medicare will notify contractors to again process claims for these IHS services.

These services include the following:

- Durable medical equipment, prosthetics, and orthotics
- Therapeutic shoes
- Clinical laboratory services
- Surgical dressings, splints and casts
- Drugs (those processed by the J4 A/B Medicare administrative contractor (MAC) and the DME MACs)
- Ambulance services
- Influenza and pneumonia vaccinations, and
- Screening and preventive services.

Claims for services furnished on or before December 31, 2009, will be processed under normal conditions.

For services provided on or after January 1, 2010, health care providers may choose, to the extent possible, to hold their claims (that is, not submit their claims to Medicare) until it becomes clearer as to whether new legislation will be enacted to extend this provision. If legislation is enacted, claims submission for these items and services may resume. Otherwise, claims for these items and services, submitted with dates of service on or after January 1, 2010, will be denied because there would no longer be any statutory basis for such payment.

Depending on the effective date of possible legislation which extends coverage of these items and services, claims which were originally submitted and denied may be eligible for payment. If this has occurred, the submitter must contact the entity that processes their claims to have the claims adjusted. Affected providers need not resubmit their claims nor appeal the original denial.

CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue. Finally, be on the alert for possible action by Congress to extend this provision.

MLN Matters® Number: SE0930
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2010
Related CR Transmittal #: N/A
Implementation Date: January 1, 2010

Expiration of Medicare processing of certain Indian Health Service Part B claims

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

Note: This article has been replaced by article SE0930, which is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0930.pdf*. Information on *MLN Matters* article SE0912 was previously published in the July 2009 *Medicare B Update!* page 28.

MLN Matters® Number: SE0912 *Replaced*
Related Change Request (CR) #: 3288
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Enrollment application reminder

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

Electronic Data Interchange

Implementation of HIPAA version 5010 276/277 claim status second phase

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], DME Medicare administrative contractors [DME MACs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries should be aware of this issue.

Provider action needed

This article is based on change request (CR) 6721 which provides technical directions to Medicare shared system maintainers and Medicare contractors regarding the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 version 005010 health care claim status request and response (276/277) transaction sets. Providers need to be aware of their own requirements to be fully compliant with the X12 5010 standards by January 1, 2012. Extensive information regarding the standards, along with helpful guidance for providers, is available at *http://www.cms.hhs.gov/Versions5010andD0/*. Note that the above implementation dates relate only to Medicare contractors completion of work on this particular phase of the implementation.

Background

CR 6721 provides technical direction to the following Medicare Shared System Maintainers and Medicare contractors for implementing the second phase of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 version 005010 health care claim status request and response (276/277) transaction sets. The CR also contains details on the common edits and enhancement module (CEM) software for the inbound claim status inquiry process.

CMS has prepared a comparison of the current X12 HIPAA electronic data interchange (EDI) standards (version 4010/4010A1) with version 5010 and the National Council for Prescription Drug Programs (NCPDP) EDI standards version 5.1 to version D.0. The 4010A1 implementation guides and the 5010 technical report 3 (TR3) documents served as reference materials during the preparation of the comparison excel spreadsheets. CMS is making the side-by-side comparison documents available for download in both Microsoft Excel and PDF formats. The comparisons were performed for Medicare fee-for-service business use and while they may serve other uses, CMS does not offer to maintain this product for purposes other than Medicare fee-for-service. You may find these documents at *http://www.cms.hhs.gov/MFFS5010D0/20_Technical%20Documentation.asp#TopOfPage*.

Additional information

The official instruction, CR 6721, 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/R623OTN.pdf*.

You may also review the final rule as published in the *Federal Register* on January 16, 2009 by the Department of Health and Human Services 45 CFR Part 162, Subpart N—Health Care Claim Status at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf*.

You may find more information about HIPAA version 5010 and NCPDP version D.0. at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp*. A special edition *MLN Matters*® article, SE0832, on the ICD-10 code set is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf*.

MLN Matters® Number: MM6721
Related Change Request (CR) #: 6721
Related CR Release Date: January 15, 2010
Effective Date: April 1, 2010 (except July 1, 2010 for Jurisdiction 9 MAC)
Related CR Transmittal #: R623OTN
Implementation Date: April 5, 2010 (except July 6, 2010 for Jurisdiction 9 MAC)

Medicare Remit Easy Print software update

The latest claim adjustment reason codes and remittance advice remark codes are available in the Codes.ini file for the MREP software. You may access this file in the zipped folder for "Medicare Remit Easy Print - Version 2.7" at *http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*.

Source: CMS PERL 201001-21

Implementation of the HIPAA version 5010 in jurisdiction 9

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

Provider types affected

All physicians, providers and suppliers who bill the Parts A and B (A/B) Medicare administrative contractor (A/B MAC) only in jurisdiction 9 (Florida, Puerto Rico, and U.S. Virgin Islands) for services provided to Medicare beneficiaries are affected by change request (CR) 6745. Providers in other jurisdictions should look for articles concerning their readiness and the readiness of their MACs for version 5010. Providers in jurisdictions 10 and 14 were previously informed of this activity in *MLN Matters* article MM6595, released on August 28, 2009, available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6595.pdf*.

Provider action needed

Stop -- impact to you

If you submit claims to the A/B MAC in jurisdiction 9, you need to be aware that CR 6745 directs the A/B MAC in this jurisdiction to begin implementing HIPAA version 5010. Implementation of HIPAA 5010 will require changes to software, systems and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you and your staff are aware of this HIPAA change being implemented by your MAC and be alert to future directions for this implementation.

Caution -- what you need to know

Effective January 1, 2012, you must be ready to submit your claims electronically using the X12 version 5010. CMS will provide additional information to assist you and keep you informed of progress on Medicare's implementation of HIPAA 5010 through a variety of communication vehicles. This article explains what your A/B MAC must do to begin the process of implementing the HIPAA 5010 standard transaction.

Go -- what you need to do

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

Background

CMS is now implementing the next version of the HIPAA transactions. The purpose of CR 6745 is to instruct the A/B MAC for jurisdiction 9 to prepare their systems to process ASC X12 version 005010 transaction. The Secretary of the Department of Health & Human Services (DHHS) adopted Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 as the next HIPAA transaction standards for covered entities to exchange HIPAA transactions. The final rule was published on January 16, 2009. All covered entities have to be fully compliant on January 1, 2012.

Additional information

The official instruction, CR 6745, issued to your Medicare A/B MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R621OTN.pdf*.

You may find more information about HIPAA 5010 by going to *http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp* on the Electronic Billing & EDI Transactions page. Medicare has prepared a comparison of the current X12 HIPAA EDI standards (version 4010/4010A1) with version 5010, and has made the side-by-side comparison available at this Web site.

MLN Matters® Number: MM6745
Related Change Request (CR) #: 6745
Related CR Release Date: January 15, 2010
Effective Date: March 1, 2010
Related CR Transmittal #: R621OTN
Implementation Date: March 1, 2010

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.

FRAUD AND ABUSE

OIG reports $20.97 billion in savings and recoveries in FY 2009

In its *Semiannual Report to Congress*, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) today announced significant audit, investigation, and evaluation accomplishments for the second half of fiscal year (FY) 2009 (April 1, 2009-September 30, 2009) and for FY 2009 in total. OIG reported savings and expected recoveries of $20.97 billion for all of FY 2009.

Specifically, OIG's $20.97 billion in savings and expected recoveries includes $16.48 billion in implemented recommendations to put funds to better use, $4 billion in investigative receivables, and $492 million in audit receivables.

> We continue to make significant progress in our fight against fraud, waste, and abuse in HHS programs, particularly Medicaid and Medicare," said Inspector General Daniel R. Levinson. "We're doing this by leveraging our audit, legal, evaluation, and investigative tools, as well as employing the latest in data analysis technology. But the results we've achieved are due primarily to the hard work of our professional staff and effective collaboration with our government partners. We will remain aggressive in our mission to protect the integrity of these vital programs.

Additionally, in FY 2009, OIG excluded 2,556 individuals and organizations from participation in federal health care programs. OIG also reported 671 criminal actions against individuals or organizations that engaged in crimes against HHS programs and 394 civil actions, including False Claims Act and unjust enrichment suits filed in federal district court, Civil Monetary Penalties Law (CMPL) settlements, and administrative recoveries related to provider self-disclosure matters.

Significant OIG accomplishments during the semiannual reporting period include the following:

Medicare Fraud Strike Force operations lead to sentencing of seven Miami-area residents in Medicare infusion fraud scheme

Seven employees of a Miami infusion clinic were ordered to pay $19.8 million in restitution and sentenced to prison terms ranging from 37 to 97 months. In their guilty pleas, the individuals admitted to activities including manipulating patients' blood samples to generate false medical records, ordering and administering medications to treat conditions that were falsely documented with fraudulent test results, and billing Medicare for services that were medically unnecessary or never provided.

This operation was conducted by the Medicare Fraud Strike Force, a key component of the joint HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team, known as HEAT. During the reporting period, Medicare Fraud Strike Force investigations resulted in the filing of charges against 138 individuals or entities, 44 convictions, and $40.7 million in investigative receivables.

State and local pandemic influenza preparedness

During this semiannual period, we issued two reports related to states' and localities' pandemic influenza preparedness. Our key findings include the following:

- In one review we found that although the majority of selected localities had begun planning to distribute and dispense vaccines and antiviral drugs, more needs to be done to improve localities' ability to respond to an influenza pandemic. Specifically, in their preparedness plans, selected localities had not addressed most of the vaccine and antiviral drug distribution and dispensing preparedness items identified in HHS guidance. Further, although all of the selected localities conducted exercises related to vaccine and antiviral drug distribution and dispensing, most did not create after-action reports and improvement plans for these exercises. (OEI-04-08-00260)
- In a second review, we found that although selected states and localities are making progress in preparing for a medical surge, they need to do more to improve their ability to respond to an influenza pandemic. Specifically, fewer than half of the selected localities had started to recruit the medical volunteers required to respond to a medical surge, and none of the states reviewed had implemented electronic systems to manage volunteers. Moreover, although all of the selected localities had acquired limited medical equipment for a pandemic, only three of the five states had electronic systems to track beds and equipment. Also, most of the selected localities had not identified guidelines for altering triage, admission, and patient care during a pandemic. (OEI-02-08-00210)

Pfizer Inc. enters into settlement for marketing and promotion practices

Pfizer Inc. entered into a $1 billion civil False Claims Act settlement with the United States in connection with Pfizer's marketing and promotion practices associated with the anti-inflammatory drug Bextra and several other drugs. The settlement agreement is part of a global criminal, civil, and administrative settlement with Pfizer and its subsidiary, Pharmacia & Upjohn Company, Inc., which also includes a comprehensive five-year corporate integrity agreement (CIA) between Pfizer and OIG.

[Note to editors: Pfizer and Pharmacia & Upjohn agreed to pay a total of $2.3 billion in this case, the largest health care fraud settlement in history, to resolve both the civil and criminal liability arising from the illegal promotion of certain pharmaceutical products. The criminal portion of the settlement is not included in this semiannual report because it became effective after September 30, 2009.]

OIG reports $20.97 billion in savings and recoveries in FY 2009 (continued)

Medicaid personal care claims made by providers in New York City

We estimated that New York State improperly claimed $275.3 million in federal Medicaid reimbursement for some personal care claims submitted by providers in New York City during calendar years 2004 through 2006. The improper claims occurred because the state did not adequately monitor New York City's personal care services program for compliance with federal and state requirements. We recommended that the state refund $275.3 million, work with the Centers for Medicare & Medicaid Services to resolve two Consumer Directed Personal Assistance Program (CDPAP) claims, improve its monitoring of New York City's personal care services program, and promulgate specific regulations related to CDPAP claims. The state disagreed with our first recommendation and with several of our findings. (A-02-07-01054)

Barriers to the Food and Drug Administration's response to food emergencies

In two reviews, we addressed the Food and Drug Administration's (FDA) responsibilities for overseeing the safety of food in both the human and pet food supply.

- In one review, OIG found that in the event of a food emergency, FDA would likely have difficulty tracing food products through the food supply chain. We were able to trace only 5 of the 40 products reviewed through each stage of the food supply chain. For 31 of the 40 products, we could identify the facilities that likely handled the products, and for the remaining 4 products, we could not identify the facilities. Furthermore, 59 percent of the facilities reviewed did not meet FDA's requirements to maintain records about their sources, recipients, and transporters, and 25 percent were not aware of these requirements.

  We recommended, among other things, that FDA consider seeking additional statutory authority to strengthen its lot-specific information requirements and to request facilities' records at any time. We also recommended that FDA work with the industry to develop needed guidance and that FDA address issues related to mixing raw food products from a large number of farms. FDA agreed to consider these recommendations. (OEI-02-06-00210)

- In the second review, we found that FDA did not have statutory authority to require pet food manufacturers or importers to initiate recalls of contaminated food or to assess penalties for recall violations. Furthermore, FDA's existing regulations were issued as nonbinding recall guidance for firms. We found that FDA's lack of authority, coupled with its sometimes-lax adherence to its recall guidance and internal procedures, limited FDA's ability to ensure that contaminated pet food was promptly removed from retailers' shelves. Our report contained detailed recommendations for strengthening FDA's recall authority and improving its monitoring of recalls. FDA agreed or agreed in principle with all of our recommendations. (A-01-07-01503)

Nursing home executive agrees to permanent exclusion

The President and Chairman of the Board of Pleasant Care Corporation (Pleasant Care), Emmanuel Bernabe, agreed to be permanently excluded from federal health care programs following an investigation of substandard care at nursing homes formerly operated by Pleasant Care. OIG alleged that Bernabe, through his management and oversight of Pleasant Care, caused services to be furnished to Pleasant Care residents that substantially departed from the professional standard of care. For example, Pleasant Care failed to maintain adequate staffing levels, properly administer medication, provide adequate hydration and nutrition, and prevent accidents.

To read the full *Semiannual Report to Congress*, go to the following link: *http://oig.hhs.gov/publications/docs/semiannual/2009/semiannual_fall2009.pdf.*

Source: Office of Inspector General News, December 3, 2009

Sign up to our *eNews* electronic mailing list

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

HHS employs new tougher standards in calculation of improper Medicare payment rates for 2009

Part of administration-wide strategy to eliminate errors and prevent waste and fraud

As part of the Obama Administration's goal of reducing waste, fraud and abuse in Medicare, the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) significantly revised and improved its calculations of Medicare fee-for-service (FFS) error rates in 2009, reflecting a more complete accounting of Medicare's improper payments than in past years. These improvements will provide CMS with more complete information about errors so that the Agency can better target improper payments.

> The Obama Administration is committed to strengthening and improving the Medicare and Medicaid systems and doing everything we can to be responsible and vigilant stewards of these programs that millions of Americans rely upon," said HHS Secretary Kathleen Sebelius. "From the very start of the Administration, the President has directed all the agencies across government to use honest budgeting and to take the hardest, most detailed look possible at what was happening with taxpayer dollars inside our agencies and inside critical programs. This year, we made the call to stop calculating our error rate in fee-for-service Medicare the way that the previous Administration did and to start using a more rigorous method in calculating this rate in keeping with our mandate to root out errors and fraud.

The Medicare, Medicaid and Children's Health Insurance Program (CHIP) improper payment rates are issued annually as part of the U.S. Department of Health and Human Services (HHS) Agency Financial Report.

While improper payment rates are not necessarily an indicator of fraud in Medicare or any other federal health care program, they do provide HHS, CMS, and its partners who are responsible for the oversight of Medicare and Medicaid funds a more complete assessment of how many errors need to be fixed.

> If we aren't honest about the problem, there is no way we can get to a solution. Through a more stringent review of Medicare claims, we've been able to establish a more complete accounting of errors, enabling CMS to take more actionable steps to further reduce the error rate and identify abusive or potentially fraudulent actions before they become problems," said Sebelius. "This change in calculating the error rate is just one part of our larger Administration-wide effort to reduce waste, fraud and abuse in health care. In addition to the establishment of HEAT, the joint task force that was established earlier this year with the Department of Justice, we've taken aggressive steps at HHS and CMS to improve our oversight of the Medicare trust funds and the taxpayer dollars that pay for the health care of millions of older and vulnerable Americans.
>
> As we move forward in our review of the Medicare and Medicaid error rate data, we expect to be able to determine if there are specific trends that can better help us identify weaknesses in our programs or systems," said Acting CMS Administrator Charlene Frizzera. "We hope to be able to use data available through the use of new electronic health record reporting that can help in the design of new and innovative approaches to finding emerging trends and vulnerabilities in high risk areas such as durable medical equipment and home health.

Sebelius and Frizzera also pointed out the HHS and the CMS would invest more time and resources into working with providers to eliminate errors through increased and improved training and education outreach.

> It's important that we continue to work closely with doctors, hospitals and other health care providers to make sure they understand and follow the more comprehensive fee-for-service requirements," said Frizzera. "We are committed to working closely with them to reduce the rate of improper payments.

Source: CMS Press Release, November 18, 2009

Find your favorites fast – use Quick Find

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

General Information

Providers randomly selected to participate in the Medicare contractor provider satisfaction survey urged to respond

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

Provider types affected

Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care practitioners that received a letter indicating they were randomly selected to participate in the 2010 Medicare contractor provider satisfaction survey (MCPSS) should review this article.

Provider action needed

This special edition article alerts providers that the Centers for Medicare & Medicaid Services (CMS) has launched the fifth annual national administration of the MCPSS. If you received a letter indicating you were randomly selected to participate in the 2010 MCPSS, CMS urges you to take a few minutes to go online and complete this important survey via a secure Internet Web site. Responding online is a convenient, easy, and quick way to provide CMS with your feedback on the performance of your FFS contractor. Survey questionnaires can also be submitted by mail, secure FAX, and over the telephone.

Background

CMS is responsible for the administration of the FFS Medicare program and does so primarily through its Medicare FFS contractors. As Medicare's agents, these contractors are responsible for executing the daily operational aspects of the FFS Medicare program by processing and paying the more than $370 billion in Medicare claims each year and performing other related business functions that support regular daily interactions with Medicare FFS providers.

The MCPSS that is conducted annually by CMS is designed to collect quantifiable data on provider satisfaction with the performance of Medicare FFS contractors. The MCPSS offers Medicare FFS providers an opportunity to give CMS valuable feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. Survey questions focus on seven key business functions of the provider-contractor relationship:

- Provider inquires
- Provider outreach & education
- Claim processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit & reimbursement

The MCPSS is a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which mandated CMS to develop contract performance requirements, including measuring health care provider satisfaction with Medicare contractors. The MCPSS enables CMS to hear provider concerns, monitor trends, improve contractor oversight, and increase efficiency of the Medicare program. The MCPSS provides contractors with more insight into their provider communities and allows them to make process improvements based on provider feedback.

The 2010 MCPSS study

Sample selection

Each year, a new random sample of Medicare FFS providers is selected to participate in the MCPSS. For the 2010 MCPSS study, CMS will ask approximately 30,000 Medicare FFS providers and suppliers to participate in the MCPSS. The sample is scientifically designed, and then randomly selected, to represent the community of more than 1.5 million Medicare providers nationwide who serve Medicare beneficiaries across the country. The sample includes Medicare FFS physicians, limited licensed practitioners (LLP), labs, hospitals, skilled nursing facilities (SNF), rural health clinics (RHC), home health agencies (HHA), federally qualified health centers (FQHC), hospice facilities, end-stage renal disease (ESRD) facilities, durable medical equipment (DME) suppliers, ambulance service providers, and other Part A institutional facilities and Part B health care practitioners. Those health care providers randomly selected to participate in the 2010 MCPSS were notified in January.

Web-based survey questionnaire

CMS continues to make completing and returning the survey simple by migrating to an easy to use Web-based survey. Providers selected to participate in the 2010 study will have access to an online Web-based survey tool where they can rate their contractor's performance and complete and submit their survey questionnaire over a secure Internet Web site. The Internet is a quick, convenient, and environmentally friendly way for providers to contribute directly to CMS' understanding of contractor performance. CMS encourages all participants with Internet access to submit their completed survey online. Participants may also submit their completed survey questionnaire via mail, secure FAX, and over the telephone. The 2010 MCPSS takes approximately 20 minutes to complete.

New satisfaction rating scale

The 2010 survey questions use a fully-labeled five-point Likert response scale with "1" representing "very dissatisfied" and "5" representing "very satisfied". In contrast to previous years' surveys which used a six-point scale, where only the end-points were labeled, this new scale assigns words to every answer category and includes a neutral category. The change will allow CMS to communicate a well-defined message about the performance of the Medicare contractors. While only health care providers selected to participate in the 2010 MCPSS may complete and return the survey questionnaire, a sample of the 2010 MCPSS questionnaire is available for viewing at *http://www.cms.hhs.gov/mcpss* for informational purposes.

Providers randomly selected to participate in the MCPSS urged to respond (continued)

Reporting results

CMS will analyze the 2010 MCPSS data and release a summary report on the CMS Web site in the summer of 2010. The report prepared for this study will summarize findings across the sample and will not associate responses with a specific individual, practice, or facility. CMS has contracted with SciMetrika, a public health consulting firm, to administer this important survey and report statistical data to CMS.

Provider participation key to success of study

Participation in the MCPSS is voluntary, however, the survey offers providers the opportunity to contribute directly to CMS' understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. The views of every health care provider asked to participate in the 2010 study are very important to the success of this study, as each one represents many other organizations that are similar in size, practice type, and geographical location.

The feedback captured through the MCPSS is important. CMS urges all providers selected to participate in the 2010 study to take this opportunity to provide CMS with their feedback on the performance of the Medicare FFS contractor that processes and pays their Medicare claims. CMS requests that you complete your survey questionnaire as quickly as possible when you receive it.
CMS is listening and wants to hear from you.

Additional information

For more information about the MCPSS, including results of the 2009 MCPSS, please visit *http://www.cms.hhs.gov/mcpss*.

MLN Matters Number: SE1005
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

CMS launches fifth annual Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about your satisfaction with the services provided by Medicare fee-for-service (FFS) contractors that process and pay Medicare claims. CMS has launched the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers the opportunity to give CMS feedback on their interactions with Medicare FFS contractors. Approximately 30,000 randomly selected providers will be notified in January that they have been selected to participate in the survey. CMS urges all health care providers that are selected to participate in the 2010 survey to take a few minutes to complete and return this important survey. To read the CMS press release announcing the launch of the 2010 MCPSS, go to *http://www.cms.hhs.gov/MCPSS/Downloads/2010_MCPSS_contractor_survey.pdf*.

CMS is listening and wants to hear from you.

Source: CMS PERL 201001-04

Setting regulations and standards for electronic health record incentive program

Public encouraged to comment on new regulations

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology encourage public comment on two regulations that lay a foundation for improving quality, efficiency, and safety through meaningful use of certified electronic health record (EHR) technology. The regulations will help implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act).

A proposed rule issued by CMS outlines proposed provisions governing the EHR incentive programs, including defining the central concept of "meaningful use" of EHR technology. An interim final regulation (IFR) issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open to public comment.

> "Widespread adoption of electronic health records holds great promise for improving health care quality, efficiency, and patient safety," said, National Coordinator for Health Information Technology David Blumenthal, M.D., M.P.P. "The Recovery Act's financial incentives demonstrate Congress' and the Administration's commitment to help providers adopt and make meaningful use of EHR technology so they can give better care and their patients' experience of care will improve. Over time, we believe the EHR incentive program under Medicare and Medicaid will accelerate and facilitate health information technology adoption by more individual providers and organizations throughout the health care system."
>
> "These regulations are closely linked," said Charlene Frizzera, CMS Acting Administrator. "CMS's proposed regulation would define and specify how to demonstrate 'meaningful use' of EHR technology, which is a prerequisite for receiving the Medicare incentive payments. Our rule also outlines the proposed payment methodologies for the Medicare and Medicaid EHR incentive programs. ONC's regulation sets forth the standards and specifications that will enhance the interoperability, functionality, utility and security of health information technology."

Setting regulations and standards for electronic health record incentive program (continued)

CMS and ONC worked closely to develop the two rules and received input from hundreds of technical subject matters experts, health care providers, and other key stakeholders. Numerous public meetings to solicit public comment were held by three federal advisory committees: the National Committee on Vital and Health Statistics (NCVHS), the Health IT Policy Committee (HITPC), and the Health IT Standards Committee (HITSC). HITSC presented its final recommendations to the National Coordinator in August 2009.

These recommendations, along with all other input, were considered to help inform the development of the regulations announced today.

The IFR issued by ONC describes the standards that must be met by certified EHR technology to exchange healthcare information among providers and between providers and patients. This initial set of standards begins to define a common language to ensure accurate and secure health information exchange across different EHR systems. The IFR describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications and allergies; and standards for the secure transportation of this information using the Internet.

The IFR calls for the industry to standardize the way in which EHR information is exchanged between organizations, and sets forth criteria required for an EHR technology to be certified. These standards will support meaningful use and data exchange among providers who must use certified EHR technology to qualify for the Medicare and Medicaid incentives.

Under the statute, HHS is required to adopt an initial set of standards for EHR technology by Dec. 31, 2009. The IFR will go into effect 30 days after publication, with an opportunity for public comment and refinement over the next 60 days. A final rule will be issued in 2010. "We strongly encourage stakeholders to provide comments on these standards and specifications," Dr. Blumenthal said.

The Recovery Act established programs to provide incentive payments to those eligible professionals and hospitals that not only participate in Medicare and Medicaid but also adopt and make "meaningful use" of certified EHR technology.

Incentive payments may begin as soon as October 2010 to eligible hospitals. Incentive payments to other eligible providers may begin in January 2011.

The proposed rule would define the term "meaningful EHR user" as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives and measures would include use of certified EHR technology in a manner that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information.

The proposed rule would define meaningful use for the Medicare EHR incentive programs. It proposes one definition that would apply to eligible professionals participating in the Medicare fee-for-service and the Medicare Advantage EHR incentive programs as well as a proposed definition that would apply to eligible hospitals and critical access hospitals. These definitions also would serve as the minimum standard for eligible professionals and eligible hospitals participating in the Medicaid EHR incentive program. The rule proposes that states could request CMS approval to implement additional meaningful use measures, as appropriate, but could not request approval of fewer or less rigorous meaningful use measures than required by the rule.

This rule proposes a phased approach to implement the proposed requirements for demonstrating meaningful use. This approach would initially establish reasonable criteria for meaningful use based on currently available technological capabilities and providers' practice experience. CMS will establish stricter and more extensive criteria for demonstrating meaningful use over time, as anticipated developments in technology and providers' capabilities occur.

CMS provides a 60-day comment period on the proposed rule. "The definition and requirements for demonstrating meaningful use of EHR technology are proposals. CMS welcomes and will give serious consideration to comments that improve our proposal while achieving the goals Congress established for the EHR incentive programs," Frizzera said.

The CMS proposed rule and fact sheets may be viewed at *http://www.cms.hhs.gov/Recovery/11_HealthIT.asp*.

ONC's interim final rule may be viewed at *http://healthit.hhs.gov/standardsandcertification*.

In early 2010, ONC intends to issue a notice of proposed rulemaking related to the certification of health information technology.

Additional Web site resources

- The Recovery Act Health IT page *http://www.cms.hhs.gov/Recovery/11_HealthIT.asp*
- Direct link to CMS regulation *http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf*
- A copy of the ONC regulation is available at *http://healthit.hhs.gov/standardsandcertification*
- The HHS press release is available at *https://www.cms.hhs.gov/apps/media/press_releases.asp*
- The CMS fact sheets are available at *https://www.cms.hhs.gov/apps/media/fact_sheets.asp*

Source: CMS PERL 200912-34

2010 PQRI and eRx updates

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce updates to several 2010 PQRI and eRx measures-related documents. The updated documents are now available on the CMS PQRI Web page at *http://www.cms.hhs.gov/PQRI* and the CMS eRx Web page at *http://www.cms.hhs.gov/ERxincentive*, respectively.

2010 measures groups specification update

Version 3.0 of the *Measures Groups Specifications Manual* released in November 2009 for 2010 PQRI, has been revised. Version 3.1 of the *2010 PQRI Measures Groups Specifications Manual and Release Notes* reflects a change to the denial remark code note for several measures groups. Correct G-codes specific to each measures group have been replaced within this document.

For further details, the updated *2010 PQRI Measures Groups Specifications Manual and Release Notes* is now available on the CMS PQRI Web page at *http://www.cms.hhs.gov/pqri*. Click on the link to the *Measures Codes* section on the left side of the page.

2010 measure specifications update

Version 4.0 of the *Measure Specifications Manual and Release Notes*, which was released in November 2009 for PQRI 2010, has been updated.

- Two updates were made to Version 4.1 of the *Measure Specifications Manual*
  - Measure #193: Additional information was added to the note for numerator coding option *CPT II 4256F*
  - Measure #94: *CPT 92567* was added to the denominator coding
- Version 4.1 of the release notes was updated in several areas:
  - Two temporary measure numbers have been replaced with final measure numbers
  - Measures #21 and #22: A *CPT* code that was listed as being deleted from the denominator coding was revised to reflect the correct code
  - Measure #48: *CPT* codes listed as being added and deleted from the denominator coding have been updated to reflect they were only added to the measure.

The updated version of the *2010 PQRI Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and Release Notes* is now available on the CMS PQRI Web page at *http://www.cms.hhs.gov/pqri*. Click on the link to the *Measures Codes* section on the left side of the page

Final 2010 EHR measures specifications

The final *2010 EHR Measures Specifications and 2010 EHR Measures Specifications -- Release Notes* have been modified and are now available on the CMS Web site. Please note, changes were made to this document, as some encounter codes were identified as noncovered services under the Medicare physician fee schedule and will not be counted in the denominator population for PQRI reporting calculations. To access these final documents, please visit the CMS PQRI Web page at *http://www.cms.hhs.gov/pqri*. Click on the link to the *Alternative Reporting Mechanisms* section on the left side of the page.

2010 PQRI single source code master update

The *2010 PQRI Single Source Code Master* document released in November 2009 for PQRI 2010, has been revised to add *CPT 92567* to the denominator coding for measure #94. The updated document is now available on the CMS PQRI Web page at *http://www.cms.hhs.gov/pqri*. Click on the link to the *Measures Codes* section on the left side of the page.

2010 eRx Measure Specifications update

Version 1.0 of the *2010 eRx Release Notes*, released in November for 2010 eRx, has also been revised. The updated Version 1.1 of the *eRx Release Notes* now correctly reflects a change in the *Denominator Updates* section of the document. To access this updated document, please review the *2010 eRx Measures Specifications and Release Notes*, which available on the CMS Electronic Prescribing Incentive Program (eRx) Web page at *http://www.cms.hhs.gov/ERxincentive*. Click on the link to the *E- Prescribing Measure* section on the left side of the page.

Source: CMS PERL 200912-36

National Influenza Vaccination Week

January 10-16, 2010, is National Influenza Vaccination Week. The Centers for Disease Control and Prevention (CDC) has announced the week of January 10-16, 2010, as National Influenza Vaccination Week. This weeklong event is designed to raise awareness of the importance of continuing influenza (flu) vaccinations, as well as foster greater use of flu vaccine in January, February, and beyond. Since flu activity typically does not peak until February or later, January and February still provide good opportunities to offer flu shots.

This year, Thursday, January 15 was designated as Seniors' Vaccination Day. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare get their flu shots. Please use this weeklong event as an opportunity to place greater emphasis on flu prevention.

If you have Medicare patients who have not yet received their annual flu shots, CMS asks that you encourage these patients to protect themselves from the seasonal flu and serious complications arising from the flu virus by recommending that they take advantage of the flu shot benefit covered by Medicare. And remember, health care professionals and their staff are also at risk for contracting and spreading the flu virus, so don't forget to immunize yourself and your staff.

Note: Influenza vaccine plus its administration are covered Part B benefits. Influenza vaccine is not a Part D covered drug.

National Influenza Vaccination Week (continued)

For information about Medicare coverage of the seasonal influenza virus vaccine and its administration, as well as related educational resources for health care professionals and their staff, please go to *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf* on the CMS Web site. You will find a variety of resources that explain Medicare coverage and claim submission policies related to the seasonal influenza vaccine.

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

For more information about National Influenza Vaccination Week, please visit the Centers for Disease Control and Prevention Web site at *http://www.cdc.gov/flu/nivw/index.htm*.

Source: CMS PERL 201001-06

January is National Glaucoma Awareness Month

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of a comprehensive annual glaucoma screening exam for Medicare beneficiaries at high risk for developing glaucoma.

Medicare coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

A covered glaucoma screening includes both of the following:

- A dilated eye examination with an intraocular pressure (IOP) measurement
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination

What you can do

As a health care professional who provides care to seniors and others with Medicare, you can help protect the vision of your Medicare patients who may be at high risk for glaucoma by educating them about their risk factors and reminding them of the importance of getting an annual glaucoma screening exam.

For more information

CMS has developed several educational products related to Medicare-covered preventive services, including glaucoma screenings:

The Glaucoma Screening brochure -- provides information on risk factors, coverage, and documentation for Medicare-covered glaucoma screenings.
http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf

The MLN Preventive Services Educational Products Web Page -- provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff, including products related to Medicare-covered glaucoma screening.
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 Medicare-covered glaucoma screenings.
http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals -- this comprehensive resource provides in-depth information about the many preventive services Medicare covers, including glaucoma screenings.
http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

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

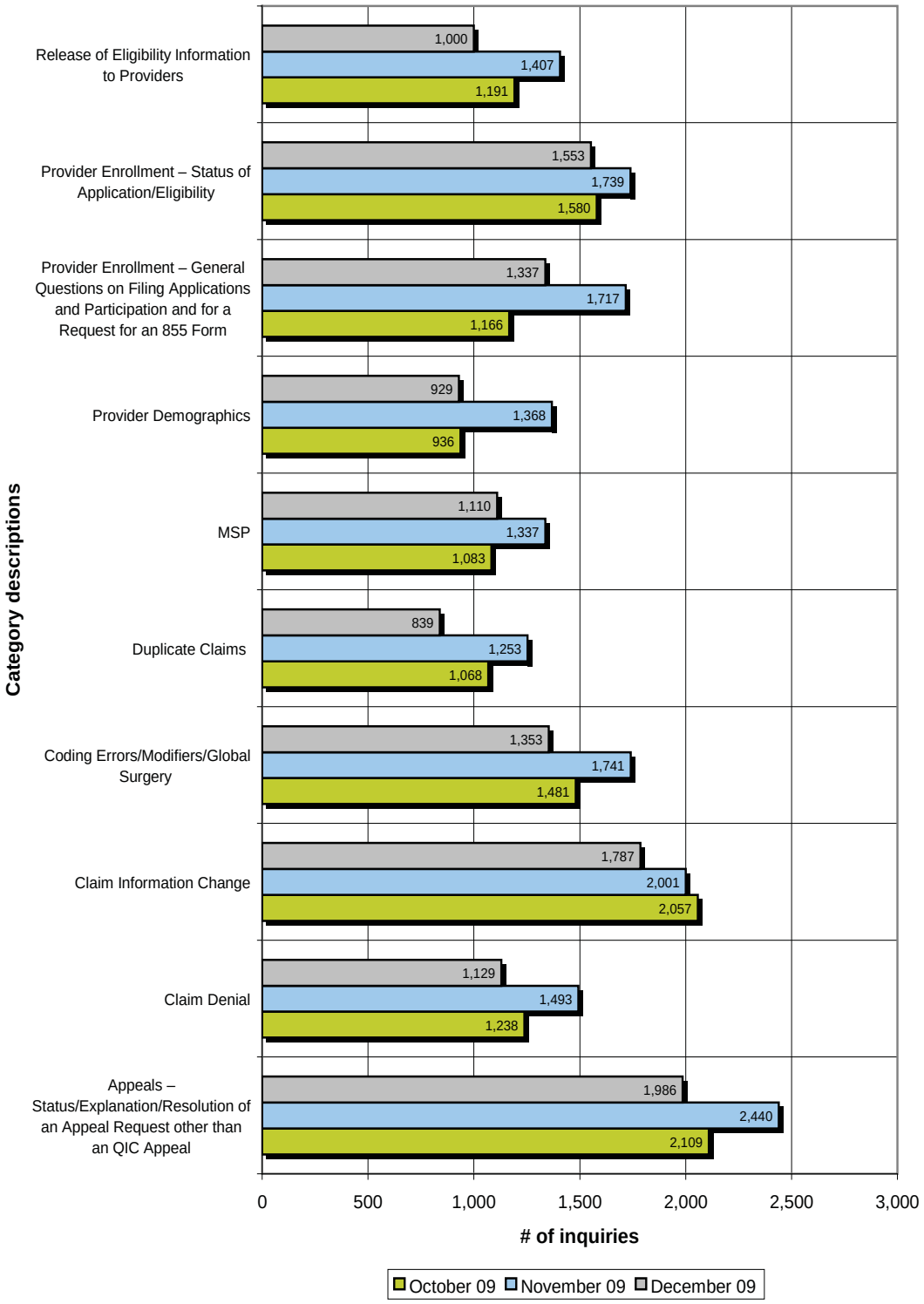
Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries at high risk for developing glaucoma about the importance of getting a Medicare-covered glaucoma screening.

Source: CMS PERL 201001-02

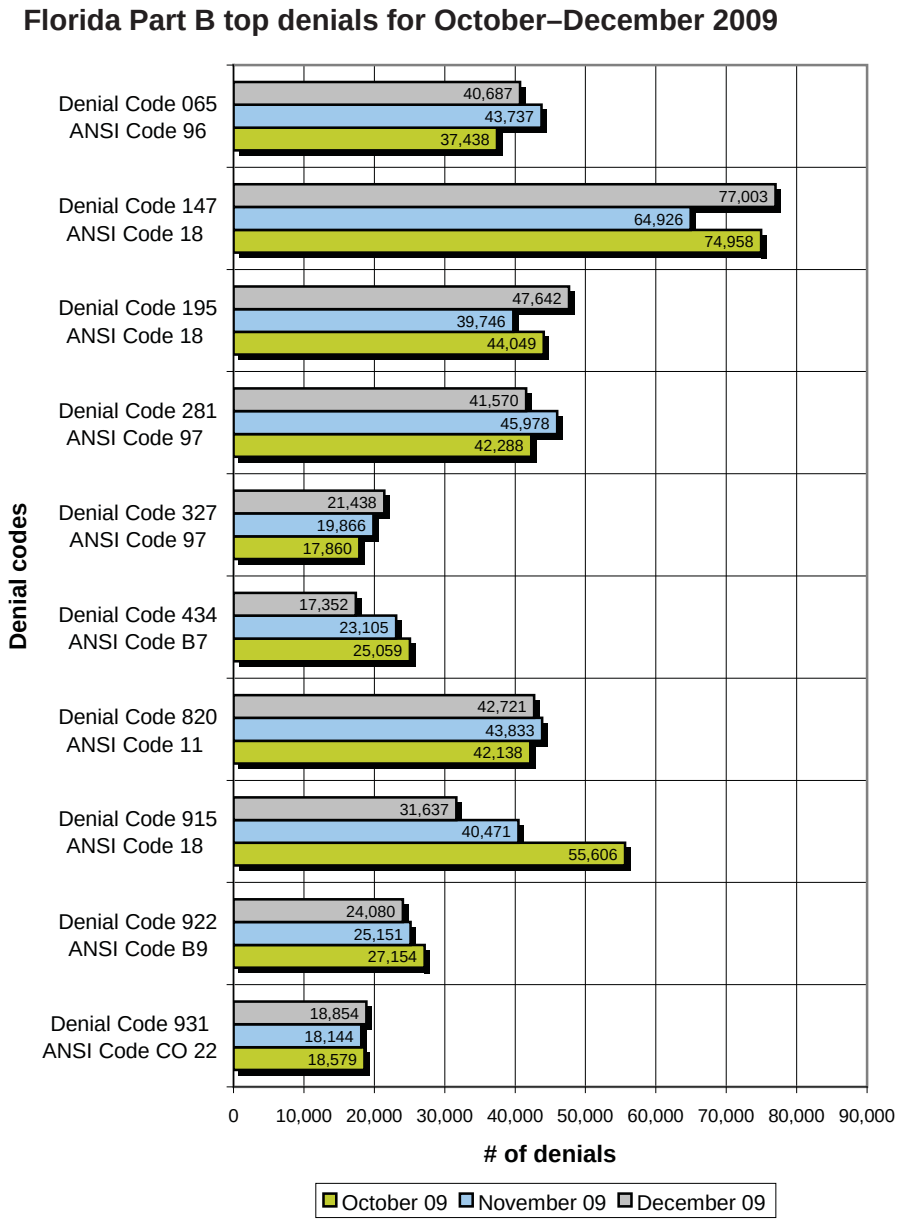
Top inquiries, denials, and return unprocessable claims for October–December 2009

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 October–December 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 October–December 2009



Top inquiries, denials, and return unprocessable claims for October–December 2009 (continued)

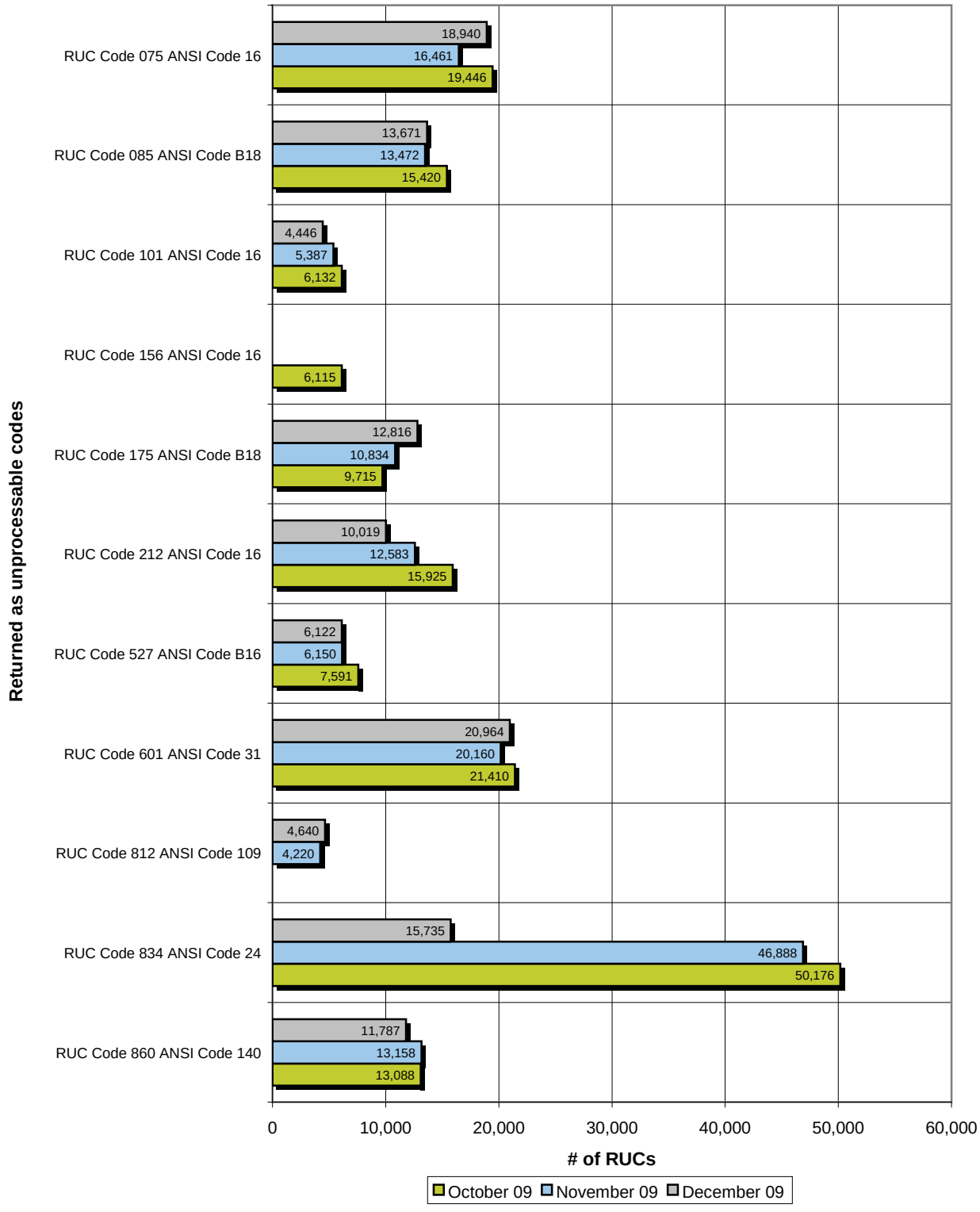


Use the PDS report to improve your Medicare billing operations

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.

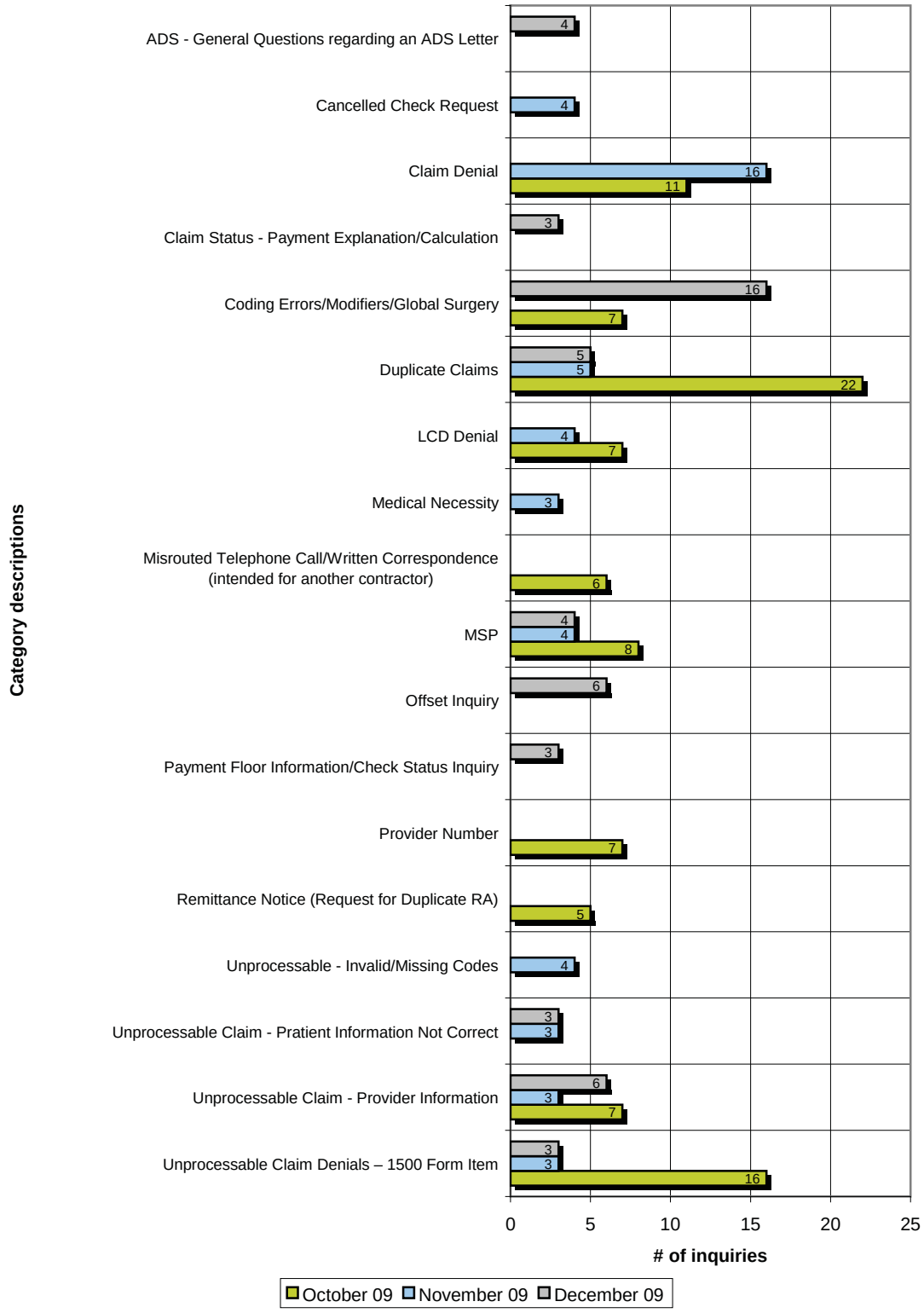
Top inquiries, denials, and return unprocessable claims for October–December 2009 (continued)

Florida Part B top return as unprocessable claims (RUC) for October–December 2009



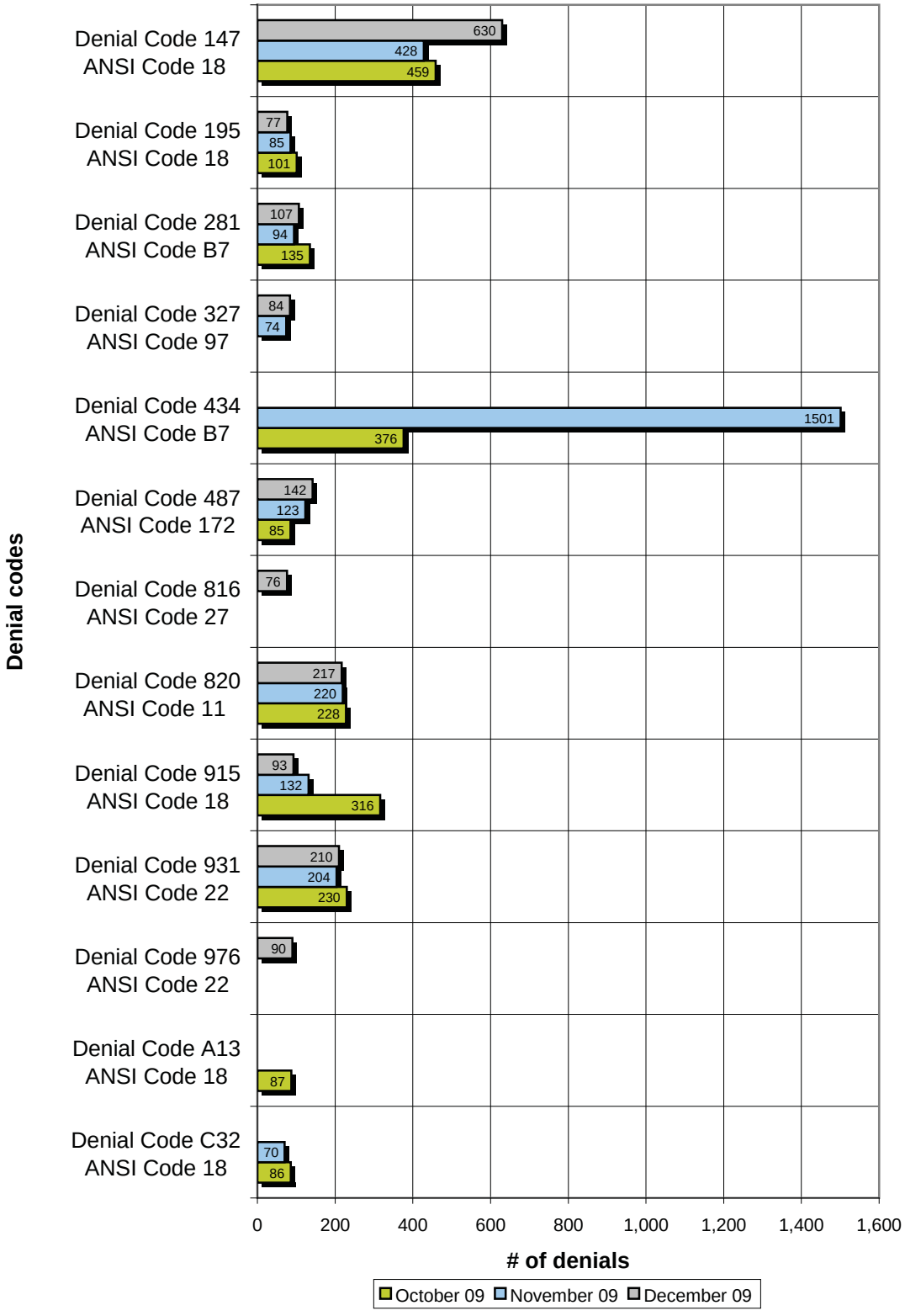
Top inquiries, denials, and return unprocessable claims for October–December 2009 (continued)

U.S. Virgin Islands Part B top inquiries for October–December 2009



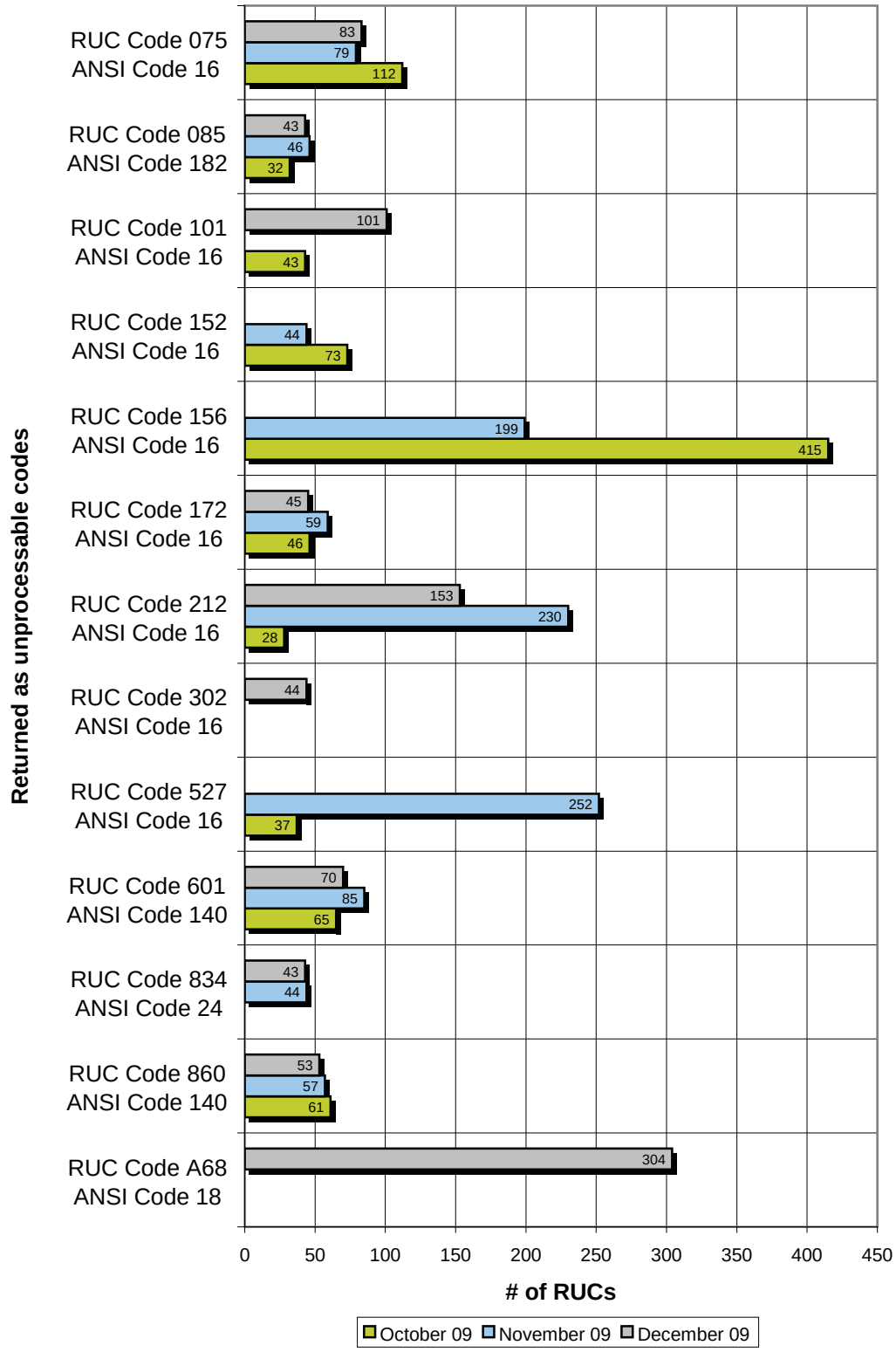
Top inquiries, denials, and return unprocessable claims for October–December 2009 (continued)

U.S. Virgin Islands Part B top denials for October–December 2009



Top inquiries, denials, and return unprocessable claims for October–December 2009 (continued)

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



Local Coverage Determinations

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Local Coverage Determinations – Table of Contents

Advance beneficiary notice

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

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

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

Revisions to LCDs

J3487: Zoledronic acid -- revision to the LCD

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

The local coverage determination (LCD) for zoledronic acid was last revised on October 19, 2009. Since that time, it has been updated. On October 19, 2009, First Coast Service Options Inc. (FCSO) added the Food and Drug Administration (FDA) approved indication for prevention of osteoporosis in postmenopausal women as medically reasonable and necessary for HCPCS code J3488 (Injection, zoledronic acid [Reclast®], 1mg) under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. Since that time, further correspondence and research has shown that this FDA-approved indication is not covered by Medicare as it is not medically reasonable and necessary in the diagnosis and treatment of a specific illness or injury as defined under section 1862 (a)(1)(A) and as stated in Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4. Therefore, this FDA approved indication has been moved to the "Limitations" section of the LCD.

In addition to the above revisions, for HCPCS code J3488, the "Utilization Guidelines" section of the LCD and the "Coding Guidelines" attachment have been revised to remove all language referencing coverage for this indication. This revision also requires the removal of ICD-9-CM diagnosis code V49.81 (Asymptomatic postmenopausal status [age related] [natural]), as a covered diagnosis code for HCPCS code J3488. FCSO will no longer accept diagnosis code V49.81 as an allowable code for the prevention of osteoporosis in postmenopausal women, as this indication is not medically reasonable and necessary for the diagnosis and treatment of a specific illness or injury. All other indications listed for HCPCS code J3488 will remain covered per the guidelines outlined in this LCD.

Effective date

This revision is effective for claims processed **on or after January 15, 2010**, for services rendered on **or after May 29, 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.

J9045: Carboplatin (Paraplatin®, Paraplatin-AQ®) -- revision to the LCD

LCD ID number: L29089 (Florida)
LCD ID number: L29104 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin®, Paraplatin-AQ®) was most recently revised on March 24, 2009. Since that time, a revision was made to the LCD based on the annual 2010 ICD-9-CM Update for Merkel cell carcinoma.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis code range 173.0-173.9 was deleted and replaced with diagnosis code range 209.31-209.36 to be used for Merkel cell carcinoma.

Effective date

This LCD revision is effective for claims processed **on or after January 19, 2010**, 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.

New feedback page

One of the trends identified in the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) was our providers' preference to have more ways to communicate with us. Our new Feedback page offers our customers the convenience of a central "hub" for communication and includes three interactive feedback, available at *http://medicare.fcso.com/feedback/*.

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

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

The local coverage determination (LCD) for therapy and rehabilitation services was most recently revised on August 3, 2009. Since that time, language has been revised regarding a change in the dollar amount of the therapy cap in the financial limitation for therapy caps section of the LCD in accordance with the Centers for Medicare & Medicaid Services (CMS) change request 6660, transmittal 1851, dated November 13, 2009. In addition, the therapy cap dollar amount was revised in accordance with change request 6719, transmittal 1851, dated November 13, 2009 to the following specific limitations:

- For 2010, the annual limit on the allowed amount for outpatient physical therapy and speech language pathology combined is $1860; the limit for occupational therapy is $1860.
- The following language has been added to the coding guidelines attachment in accordance with change request 6719:

  Effective January 1, 2010, *CPT* code *95992 – Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*, is removed from the online therapy code list, which is available at: *http://www.cms.hhs.gov/TherapyServices/05AnnualTherapyUpdate.asp#TopOfPage*.

  Effective January 1, 2010, *CPT* code *92520 – Laryngeal function studies (ie, aerodynamic testing and acoustic testing)* – which is considered a "sometimes therapy" code, is added to the online therapy code list.
- The online therapy code list includes all of the "always" and "sometimes" therapy procedure codes. (Pub. 100-04, Chapter 5, Section 20.B)

Effective date

This LCD revision is effective for services rendered **on or after January 1, 2010**. 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.

17311: Mohs micrographic surgery (MMS) -- revision to the LCD

LCD ID number: L29230 (Florida)
LCD ID number: L29366 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Mohs micrographic surgery (MMS) was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a revision was made to the LCD based on the annual 2010 ICD-9-CM Update for Merkel cell carcinoma.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis code range 209.31-209.36 was added for Merkel cell carcinoma.

Effective date

This LCD revision is effective for claims processed **on or after January 19, 2010**, 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.

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*.

80076: Hepatic (liver) function panel -- revision to the LCD

LCD ID number: L29188 (Florida)
LCD ID number: L29435 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hepatic (liver) function panel was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a reconsideration request was evaluated and the following revision was made to the LCD:

- Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, the diagnosis codes 286.9, 287.5, 578.0, 578.1, 780.79, 789.2, 789.59, 791.4, V01.79, and V87.39 were added to the LCD.

Effective date

This LCD revision is effective for services rendered **on or after January 12, 2010**. 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

Billing and coding of synvisc and synvisc-one

Effective January 1, 2010, HCPCS code J7325 should be used to bill synvisc and synvisc-one. Providers should indicate the number of milligrams (mg) administered in the quantity billed (Q/B) field of the claim form. Synvisc is administered once a week for three weeks. Therefore, the Q/B field should reflect 16 mg. Synvisc-one is administered as a one time dose. Therefore, the Q/B field should reflect 48 mg. Failure to bill as instructed will result in an incorrect payment of services.

84295: Serum sodium

First Coast Service Options Inc (FCSO) has been made aware of an issue regarding providers receiving denials when billing *CPT* code *84295* (*Sodium; serum, plasma or whole blood*) and ICD-9-CM code 585.6 (End-stage renal disease) for hemodialysis patients when modifiers CB and CF and several other modifiers identified for the automated multichannel chemistry tests (AMCC) were appended that noted the service rendered were outside the composite rate. CMS Publication 100-02, Chapter 11, Section 30.2.2 lists *CPT* code *84295* as excluded from the composite rate for hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemofiltration patients.

Modifier CB is defined as services ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable.

FCSO has researched and corrected the issue. Providers who are billing per the language in Pub 100-02, Chapter 11, Section 30.2.2 for *CPT* code *84295* should append at least the CB modifier to the line for *CPT* code *84295* and ICD-9-CM code 585.6. Providers may append other modifiers as appropriate for AMCC services.

Effective date

This correction is effective for claims processed **on or after January 25, 2010**, for services rendered **on or after October 1, 2006**.

Sign up to our eNews electronic mailing list

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

Educational Resources

Upcoming provider outreach and education event

February 2010 – March 2010

Evaluation and Management (E/M) Series: Session 4

When: February 25
Time: 2:00-3:30 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

Hot Topics: Medicare Part B (ACT)

When: March 10
Time: 11:30 a.m.-1:00 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

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

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

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

Never miss a training opportunity

We know our providers have busy schedules and may not have the time to participate in every live event. If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the FCSO Medicare training Web site at *www.fcsomedicaretraining.com*, download the recording of the event, and listen to the webcast when you have the time.

- It's the next best thing to being there -- learn how to download a webcast recording at *http://medicare.fcso.com/Online_learning/151240.asp*

Take advantage of 24-hour access to free online training

We do our best to provide the Medicare training and information you need -- when it fits into your busy schedule. So, in addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses now offer CEUs.

Learn more on the FCSO Medicare training Web site -- explore our catalog of online courses.

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.

The Medicare Learning Network celebrates its 10th anniversary

The Medicare Learning Network – Celebrating 10 years as your Medicare educational resource

This year marks the 10th anniversary for the *Medicare Learning Network* (*MLN*) – the home for official information for Medicare fee-for-service (FFS) providers. We're located within the Centers for Medicare & Medicaid Services (CMS) and over the past decade, we've been very busy:

- Producing quality educational products designed to meet the needs and learning styles of busy health-care professionals
- Adding continuing education credits to many of our online courses
- Developing new and different ways to make our products accessible and available to the FFS provider community.

Whether you're familiar with the *Medicare Learning Network* or just curious about us, our upcoming marketing campaign will help you to discover or re-discover the features and benefits that so many members of the FFS provider community turn to on a daily basis. So, check your e-mails and join us as we enter our second decade of dedication to providing the Medicare FFS provider community with the education and information resources it needs.

Learn more about the *Medicare Learning Network* right now

Download the *Medicare Learning Network* marketing brochure

View our new marketing brochure online at *http://www.cms.hhs.gov/MLNProducts/downloads/Medicare_Learning_Network_(MLN)_Marketing_Brochure.pdf* to learn what the *Medicare Learning Network* has to offer – print copies of this brochure will soon be available on our product ordering system.

Order the *Medicare Learning Network* DVD – A Good Place to Start

This DVD contains quick and basic information about the *Medicare Learning Network* and its benefits to providers. The DVD is suitable for self instruction, as well as exhibits and training events. National and local provider associations are encouraged to post this product on their Web sites and/or distribute via electronic newsletters or mailing lists. Run time is 7 minutes, 7 seconds.

Visit the *Medicare Learning Network* Product Ordering page (*http://cms.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs*) and scroll down to the "Educational Tool" topic category to find the DVD and place your order. You can also view the video online at *http://www.cms.hhs.gov/MLNGenInfo/Downloads/MLN_Long_Video.zip*.

Stay tuned for more.

Source: CMS PERL 201001-11

Message from the MLN – did you resolve to learn something new this year?

New information is just a click away

The *Medicare Learning Network* (*MLN*) Web-based training courses are the perfect way to make good on that resolution. You may choose from a variety of courses that cover the Medicare program policy topics, ranging from general overviews to specific billing and coding information, as well as important education on new initiatives from the Centers for Medicare & Medicaid Services (CMS).

You do not have to miss a moment in the office because you can access any course 24 hours a day, 7 days a week -- and it is easy to complete the courses at your own pace. Each course is a compact learning opportunity; you gain a significant amount of information in just a short period. Stay on track with CMS' learning management system. The system charts your completed courses and evaluations and even remembers the chapters you have completed if you are not able to finish in one sitting.

Many of the courses offer the benefit of continuing education credits to help you meet academic requirements to obtain or maintain your license or certification.

And, remember -- like all *MLN* products -- our Web-based training courses are free-of-charge.

Resolve to visit the *MLN* Products page today at *http://www.cms.hhs.gov/MLNProducts/*. Find out more information and get started with Web-based training at *http://www.cms.hhs.gov/MLNProducts/03_WebBasedTraining.asp#TopOfPage*.

Source: CMS PERL 201001-20

November 19 ICD-10-CM/PCS conference call transcript summaries

The Centers for Medicare & Medicaid Services (CMS) conducted an ICD-10-CM/PCS Medicare Severity -- Diagnosis Related Group Conversion Project National Provider conference call on November 19. Written and audio transcript summaries of the call are now available for download on the CMS Web site: *http://www.cms.hhs.gov/ICD10/06a_2009_CMS_Sponsored_Calls.asp*.

Source: CMS PERL 201001-01

MLN educational products related to Medicare-covered preventive services

Help keep your Medicare patients healthy in the New Year. The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to encourage their patients with Medicare to take advantage of Medicare-covered preventive services. Medicare covers a wide array of preventive services for eligible beneficiaries, including cancer screenings, glaucoma screenings, an initial preventive physical examination, and certain immunizations.

What you can do

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

For more information

CMS has developed the following educational products related to Medicare-covered preventive services:

- **The MLN Preventive Services Educational Products Web Page** -- provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff.
- **Quick Reference Information: Medicare Preventive Services** -- this double-sided chart provides coverage and coding information on Medicare-covered preventive services.
- **Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (IPPE)** -- this double-sided chart provides a checklist of services included in the IPPE, as well as additional information on the IPPE benefit.
- **Quick Reference Information: Medicare Part B Immunization Billing** -- this double-sided chart provides coverage and coding information on Medicare-covered immunizations.

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

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

Source: CMS PERL 200912-39

Revised remittance advice WBT now available from *Medicare Learning Network*

The revised Understanding the Remittance Advice (RA) for Professional Providers Web-based training (WBT) course is now available from the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network*.

Available for continuing education credit, this course provides instructions to help fee-for-service Medicare providers and their billing staffs interpret the RA received from Medicare and reconcile it against submitted claims. In addition, it provides guidance on how to read electronic remittance advices (ERAs) and standard paper remittance advices (SPRs), and it offers instructions for balancing an RA. This course also presents an overview of software that Medicare provides free to providers in order to view ERAs. This training may be accessed by visiting *http://www.cms.hhs.gov/MLNgeninfo/*. Scroll down to the *Related Links Inside CMS* section, select *Web Based Training (WBT) Modules*, and then select *Understanding the Remittance Advice for Professional Providers* from the list of training courses provided.

Source: CMS PERL 200912-38

New World of Medicare Web-based training course

Looking for help with the fundamentals of the Medicare program? This new Web-based training (WBT) course from the *Medicare Learning Network* (*MLN*) can help.

The World of Medicare WBT is designed for health care professionals who want to understand the fundamentals of the Medicare program. After completing this course, participants should be able to differentiate between Medicare Part A, Part B, Part C, and Part D and identify Medicare beneficiary health insurance options, eligibility, and enrollment, as well as recognizing how Medigap and Medicaid work with the Medicare program.

This WBT course offers continuing education credits, please see the course description for details. This training may be accessed by visiting *http://www.cms.hhs.gov/MLNgeninfo/*. Scroll down to the *Related Links Inside CMS* section, select *Web Based Training (WBT) Modules*, and then select *World of Medicare* (January 2010) from the list of training courses provided.

Source: CMS PERL 201001-18

New Medicare Learning Network quick reference charts

The *Medicare Learning Network* (*MLN*) has produced the following quick reference charts that provide information on frequently used Centers for Medicare & Medicaid Services (CMS) Web pages:

The Quick Reference: All Medicare Providers (December 2009) -- chart includes a list of CMS Web pages that all Medicare providers use most frequently.

The Quick Reference: New Medicare Provider (December 2009) -- chart includes a list of CMS Web pages that new Medicare providers use most frequently.

These charts may be bookmarked and viewed online or printed and used as references. Both charts may be located at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*. Use search key word "quick" to locate these publications.

Quick reference charts can be handy lists for looking up information.

Source: CMS PERL 201001-17

Revised ASC fee schedule fact sheet now available for download from CMS

The revised *Ambulatory Surgical Center Fee Schedule Fact Sheet* (January 2010), which provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtfctsht508-09.pdf*.

Source: CMS PERL 201001-22

Revised Medicare Physician Guide

The revised *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* (Oct 2009), which offers general information about the Medicare program, how to become a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and fee-for-service appeals, is now available in CD-ROM format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to *Related Links Inside CMS* and select *MLN Product Ordering Page*.

Source: CMS PERL 201001-10

Adult Immunizations brochure

The *Adult Immunizations* brochure, which provides an overview of Medicare's coverage of seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration, is now available in print format. To place your order for the print version, select *MLN Product Ordering Page* in the *Related Links Inside CMS* section on the *Medicare Learning Network* homepage at *http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp*. You may also download at the following address: *http://www.cms.hhs.gov/MLNProducts/downloads/adult_immunization.pdf*.

For more products related to Medicare-covered preventive services, please visit the Centers for Medicare & Medicaid Services (CMS) Preventive Services Educational Products page at: *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*.

Source: CMS PERL 201001-06

Revised Hospice Payment System fact sheet now available in print

The revised Hospice Payment System fact sheet (November 2009) is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. This fact sheet provides general information about the Medicare hospice benefit including coverage of hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and additional reporting required on hospice claims. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, under *Related Links Inside CMS*, select *MLN Product Ordering Page*.

Source: CMS PERL 201001-16

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		
		CD-ROM $6		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦