MEDICARE B *Update!*

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

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

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

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

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THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

In addition to the above, other sections include:

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

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

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

GA modifier and appeals

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

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

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

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CLAIMS

April 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

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

What you need to know

This article is based on change request (CR) 6819, which provides a reminder for physicians to take note of the quarterly updates to correct coding initiative (CCI) edits. The last quarterly release of the edit module was issued in January 2010.

Background

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

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

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

The latest package of CCI edits, version 16.1, is effective April 1, 2010, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

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

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at *http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf*. The official instruction (CR 6819) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1916CP.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: MM6819
Related Change Request (CR) #: 6819
Related CR Release Date: February 5, 2010
Effective Date: April 1, 2010
Related CR Transmittal #: R1916CP
Implementation Date: April 5, 2010

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Consolidated Billing

Implementation of a new consolidated billing edit

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

Provider types affected

This article is for providers who submit claims to Medicare contractors, i.e., Medicare administrative contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ambulatory surgical center (ASC) payment system.

Provider action needed

This article is based on change request (CR) 6702 which describes a new edit that will be created to prevent separate payment for facility costs billed by ASCs for Medicare beneficiaries in Part A SNF stays. Be sure your billing staff is aware of these changes.

Background

The Balanced Budget Act (BBA) of 1997 required the Centers for Medicare & Medicaid Services (CMS) to implement a Medicare SNF prospective payment system (PPS). Additionally, the BBA of 1997 required consolidated billing (CB) for SNFs. Under the CB provision, an outside supplier must bill and receive payment from the SNF rather than from Medicare for services provided to a beneficiary in a Part A SNF CB stay.

Effective for claims with dates of service on or after January 1, 2008, Medicare will deny claims from an ASC that is enrolled as a provider specialty type 49, where the service has a type of service of F, and the patient is in a Part A SNF CB stay. Also, where Medicare receives a SNF claim for a patient in a Part A SNF CB stay and has previously paid an ASC claim incorrectly due to SNF CB, Medicare will follow current processes to recoup any overpayment from the ASC.

Services excluded from the CB provision include ambulatory surgeries performed at an outpatient hospital. However, this exception does not apply to the facility service provided by a freestanding, (non-hospital), ASC. Physicians' professional services are also excluded from consolidated billing.

Additional information

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

The official instruction (CR 6702) issued to your Medicare MAC and/or carrier is available at *http://www.cms.hhs.gov/Transmittals/downloads/R1911CP.pdf*.

MLN Matters® Number: MM6702
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R1911CP
Related Change Request (CR) #: 6702
Effective Date: January 1, 2008
Implementation Date: July 6, 2010

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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.

Note: This article was rescinded on February 5, 2010, because related change request 6375 was rescinded. This information was previously published in the January 2010 *Medicare B Update!* pages 7-9.

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

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Processing anti-markup services – missing or incomplete information in item 20

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

Note: This article was revised on February 1 to reflect a revised change request (CR) 6670 that was issued on January 29. The CR release date, transmittal number, and the Web address for accessing CR 6670 were revised. All other information remains the same. This information was previously published in the November 2009 *Medicare B Update!* page 5.

Provider types affected

This article is for physicians and other providers submitting claims to Medicare contractors (carriers 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 6670 which provides your Medicare contractor with instructions for processing claims for diagnostic services that are subject to the 'anti-markup payment limitation' and that are billed with missing or incomplete information in item 20 of the CMS-1500 or its electronic equivalent.

Caution -- what you need to know

Prior to the implementation of the anti-markup payment limitation, contractors were instructed to assume none of the services presented on a claim were purchased if item 20 was either not completed or was missing information. CR 6670 gives specific criteria for processing claims with partial information completed in item 20.

Go -- what you need to do

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

Background

The *Medicare Claims Processing Manual* (Chapter 1, Section 80.3.2.1.2) establishes guidelines for processing of claims for diagnostic services when:

- There is no entry for the "Yes/No" indicator in item 20 of the CMS-1500, or
- The ANSI X12 837P electronic claim is missing a claim or line level PS1 segment to indicate whether the diagnostic services were purchased.

Your Medicare contractor is instructed to assume that a diagnostic service was not purchased when there is no "Yes/No" indicator marked in item 20 of the paper claim form or its electronic equivalent. Additionally, the instructions referred to anti-markup as it was formerly known as "purchased diagnostic tests" and applied only to the technical component (TC) of a diagnostic test. (See CR 6122 (Transmittal 1589, Sep. 8, 2008) at http://www.cms.hhs.gov/transmittals/downloads/R1589CP.pdf. An *MLN Matters* article related to that transmittal is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6122.pdf.)

CR 6670 provides instructions for processing claims for diagnostic services that are subject to what is now known as the "anti-markup payment limitation" and that are billed with missing or incomplete information in item 20 of the CMS-1500 or its electronic equivalent.

Medicare contractors will use the following guidelines for determining whether a claim contains a diagnostic service that is subject to the "anti-markup payment limitation": (Note: These guidelines apply to both the CMS-1500 and its electronic equivalent).

- If a "Yes" or "No" is not indicated in item 20 and the associated dollar amount is missing, contractors shall assume the service is not subject to the anti-markup payment limitation and shall process the claim accordingly
- If a "Yes" or "No" is not indicated in item 20 and the associated dollar amount is present, contractors shall return the claim to you as unprocessable
- If the "Yes" box is marked in item 20 and the associated dollar amount is missing, contractors shall return the claim as unprocessable
- If the "No" box is marked in item 20 and the associated dollar amount is present, contractors shall return the claim as unprocessable.

Note: In accordance with the requirements of the "anti-markup payment limitation", Medicare contractors will apply the above logic to both the TC and PC (professional component) of diagnostic tests.

Additional information

The official instruction, CR 6670, issued to your carrier and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1903CP.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: MM6670 *Revised*
Related Change Request (CR) #: 6670
Related CR Release Date: January 29, 2010
Effective Date: April 1, 2010
Related CR Transmittal #: R1903CP
Implementation Date: April 5, 2010

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Drugs and Biologicals

April 2010 quarterly average sales price update and revision to prior files

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

Provider types affected

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors [MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) are affected by this issue.

What you need to know

This article is based on change request (CR) 6804 which instructs Medicare contractors to download and implement the April 2010 average sale price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised January 2010, October 2009, July 2009, and April 2009 files. Medicare will use the April 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 5, 2010, with dates of service April 1, 2009, through June 30, 2010.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions.

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

Files	Effective Dates of Service
April 2010 ASP and NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and NOC files	April 1, 2009, through June 30, 2009

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 6804) issued to your Medicare MAC, carrier, and/or FI may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1899CP.pdf*.

MLN Matters® Number: MM6804
Related Change Request (CR) #: 6804
Related CR Release Date: January 29, 2010
Effective Date: April 1, 2010
Related CR Transmittal #: R1899CP
Implementation Date: April 5, 2010

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Durable Medical Equipment

Compliance standards for consignment closets and stock and bill arrangements

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

Note: This article was rescinded on February 5, 2010, as the related CR 6528 was rescinded on February 4, 2010. This information was previously published in the September 2009 *Medicare B Update!* page 12.

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

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Interim instructions addressing guidelines for prosthetic implants and surgically implanted items

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, producers, and suppliers billing Medicare carriers and Medicare administrative contractors (A/B MACs) for certain durable medical equipment (DME) products provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6762 which provides instructions to Medicare contractors for recouping funds for any payments made to durable medical equipment prosthetics, orthotics and supplies (DMEPOS) suppliers for implanted DME or implanted prosthetics, based on the revised list of HCPCS codes payable as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME provided in CR 6573. Medicare contractors will continue to pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME based on the supplier's location. (See CR 6573 for the revised list of HCPCS codes at *http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf* that may be paid as replacement part, accessory or supply for prosthetic implants and surgically implanted DME under the guidelines established in CR 5917.) Be sure billing staff are aware of these Medicare changes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 6762 in order to augment previously issued CR 6573. CR 6573 instructed contractors to use the revised list to determine the items that may be billed under the guidelines established in CR 5917 which may be reviewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1603CP.pdf*.

CR 6573 clarified that the filing jurisdiction for claims submitted under the guidelines established in CR 5917 is determined by the supplier's location and that the payment for these items is based on the fee schedule amount for the state where the beneficiary maintains their permanent residence.

In CR 5917, CMS instructed Medicare contractors to process and pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME when submitted by suppliers that are enrolled with both the national supplier clearinghouse (NSC) and their local carrier/A/B MAC.

Although CR 5917 reinstated the local carrier and A/B MAC jurisdiction for claims for these items, the instruction was not clear about the claims filing jurisdiction or the payment rules that apply when the beneficiary resides outside of the local carrier or A/B MAC's jurisdiction. In addition, Attachment A of CR 5917 included an excerpt of the 2008 annual jurisdiction list containing Healthcare Common Procedure Coding System (HCPCS) codes, which CMS previously instructed may be billed to the carrier or A/B MAC as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME. It has since come to CMS' attention that this list included codes for implanted devices, which may not be separately billed to the carrier/A/B MAC by DMEPOS suppliers. Attachment A of CR 5917 was replaced by a revised list of HCPCS codes in Attachment A of CR 6573. The Web links to CR 5917 and CR 6573 are listed above.

Key points of CR 6762

- Medicare contractors will pay claims for items subject to the guidelines in CR 5917 based on the supplier's location per the revised list of HCPCS codes included in Attachment A of CR 6573.
- To the extent possible, Medicare contractors will reopen and reprocess claims for implanted DME and or implanted prosthetics for dates of service between October 27, 2008, and December 31, 2009 and they will recoup any overpayments made to DMEPOS suppliers for implanted DME or implanted prosthetics based on using the original list of HCPCS codes included in Attachment A of CR 5917.

Interim instructions addressing guidelines for prosthetic implants and surgically implanted items (continued)

- CR 6762 and the billing guidelines for replacement parts, accessories or supplies for implanted devices established in CR 5917 apply only to DMEPOS suppliers enrolled with the NSC and their local carrier or A/B MAC and does not change the existing carrier or A/B MAC billing rules that apply to physicians, facilities, or other entities that are implanting the devices.

Additional information

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

The official instruction, CR 6762, issued to your MAC or carrier regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R636OTN.pdf*.

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

To review MM6573, the MLN Matters® article related to CR 6573, go to *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6573.pdf*.

MLN Matters® Number: MM6762
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Implementation Date: May 5, 2010

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Hospice

Medicare system edit refinements related to hospice services

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

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DME MACs] and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries that have elected the hospice benefit.

Provider action needed

This article is based on change request (CR) 6778 which:

1. Revises existing Medicare standard systems edits to allow Medicare fee for service (FFS) claims to process for beneficiaries in a Medicare Advantage plan on the date of a Medicare hospice election.
2. Adds new edits ensuring the appropriate place of service is reported for hospice general inpatient care (GIP), respite, and continuous home care (CHC).
3. Provides a technical correction to the *Medicare Benefit Policy Manual* regarding the requirement for nursing care related to hospice continuous home care.

Be certain your billing staffs are aware of these Medicare changes.

Background

Claims for Medicare Advantage (MA) plan beneficiaries electing hospice

In an effort to alleviate the often timely process involved for providers to resolve claim disputes on payment responsibility between MA plans and FFS Medicare, the Centers for Medicare & Medicaid Services (CMS) is revising the Medicare hospice and MA enrollment edit(s) for claims submitted on or after July 6, 2010, to allow claims to be processed by FFS Medicare for services occurring on the date of the hospice election. This will prevent services provided on the date of the election from rejecting as MA plan responsibility. Providers that have claims being disputed may resubmit their claims on or after July 6, 2010, to FFS Medicare for payment consideration. Contractors will not be required to provide automated adjustments.

Place of service for general inpatient care (GIP, Respite, and Continuous Home Care CHC)

Medicare hospice patients are able to receive hospice care in a variety of settings. CMS began collecting additional data on hospice claims in January 2007 with CR 5245, available at *http://www.cms.hhs.gov/transmittals/Downloads/R1011CP.pdf*,

Medicare system edit refinements related to hospice services (continued)

which required reporting of a Healthcare Common Procedure Coding System (HCPCS) code on the claim to describe the location where services are provided. Coverage and payment regulations at 42 CFR 418.202 and 418.302 define the locations where certain levels of care can be provided. GIP is described in the regulations at 42 CFR 418.202(e) as "short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or skilled nursing facility (SNF)..." Additionally, the regulations at 42 CFR 418.202(e) require that respite care be furnished in an inpatient setting, as described in 418.108, which limits care settings to a participating Medicare or Medicaid hospital, SNF, hospice facility, or nursing facility (NF). Finally, payment regulations at 42 CFR 418.302(a)(2) define CHC as "a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home." Because CMS now has site-of-service data on hospice claims, they are able to use system edits to ensure more accurate billing of Medicare claims. CMS now edits claims to ensure that the level of care billed, for hospice, was provided at an appropriate site.

To facilitate more accurate billing of Medicare hospice claims, CMS is implementing several edits within the claims processing system to return to providers (RTP), claims submitted on types of bill 81x or 82x for which hospice days are billed for services provided in noncovered settings. Claims for days of GIP care (revenue code 0656) will be RTP'd if HCPCS site of service locations Q5001 (patient's home/residence), Q5002 (assisted living facility), or Q5003 (nursing long term care facility of non-skilled nursing facility) are reported on the same line, as these are not appropriate settings for payment of GIP. GIP may only be provided at Medicare certified hospice facilities, hospitals, or SNFs.

Similarly, claims for respite days (revenue code 0655) will be RTP'd if HCPCS site of service codes Q5001 (patient's home/residence) or Q5002 (assisted living facility) are reported on the same line, as these are not appropriate settings for payment of this level of care. Respite care may only be provided in a Medicare or Medicaid participating hospital, SNF, hospice facility, or NF.

Finally, claims for days of CHC care (revenue code 0652) will be RTP'd if HCPCS site of service locations Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5006 (inpatient hospice), Q5007 (long term care hospital), or Q5008 (inpatient psychiatric facility) are reported on the same line, as these locations are not appropriate settings to bill for payment of CHC. CHC may only be provided in the patient's home, and may not be provided in these types of facilities. We believe these edits will improve the accuracy of Medicare billing and payment for hospice services.

Technical correction

Regulations at 42 CFR 418.204 describe CHC as being provided during periods of crisis as necessary to maintain an individual at home. The regulation requires that care provided on days billed as CHC be "predominantly nursing care". This means that more than half of the time the nurse, aide, or homemaker spends providing care must be nursing hours.

Manual clarification regarding ambulance transport on the date of hospice election

CR 6778 also revises the *Medicare Benefit Policy Manual* to clarify policy regarding payment of ambulance transports on the effective date of hospice election. Hospices do not feel that they are responsible for an ambulance transport which occurs on the effective date of hospice election, if the hospice has not yet conducted their initial assessment.

The deciding factor in determining whether a hospice is financially responsible for an ambulance transport on the effective day of hospice election is when the transport occurred, relative to when all the hospice coverage and eligibility criteria are met. If an ambulance transport occurs on the date of hospice election, but before all the criteria for hospice eligibility and coverage are met (i.e. the initial assessment has been conducted and the plan of care has been developed and includes the ambulance transport), the hospice is not responsible for the transport and the ambulance transport is covered through the ambulance benefit.

Additional information

If you have questions, please contact your MAC, carrier, RHHI 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 6778) was issued to your MAC, carrier, RHHI or FI regarding this change via two transmittals. The first, located at *http://www.cms.hhs.gov/Transmittals/downloads/R121BP.pdf*, contains revisions to the *Medicare Benefit Policy Manual*. The second transmittal at *http://www.cms.hhs.gov/Transmittals/downloads/R1907CP.pdf* contains revisions to the *Medicare Claims Processing Manual*.

MM5245, Instructions for Reporting Hospice Services in Greater Line Item Detail, is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf*. For additional information regarding the Hospice payment system see *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*.

MLN Matters® Number: MM6778
Related Change Request (CR) #: 6778
Related CR Release Date: February 5, 2010
Effective Date: Claims submitted on or after July 6, 2010
Related CR Transmittal #: R121BP and R1907CP
Implementation Date: July 6, 2010

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Laboratory/Pathology

New waived tests

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

Provider types affected

This article is for clinical laboratories and providers that submit claims to Medicare carriers or Medicare administrative contractors (MACs) for laboratory test services provided to Medicare beneficiaries.

Provider action needed

This article, based on change request (CR) 6800, alerts clinical laboratories and providers that the Centers for Medicare & Medicaid Services (CMS) has listed the latest tests approved by the Food and Drug Administration (FDA) as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The tests newly added to the waived tests are in the table in the *Background* section of this article. Be sure your billing staffs are aware of these changes.

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a laboratory facility to be appropriately certified for each test it performs. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

CPT Code	Effective Date	Description
80101QW, G0430QW	July 1, 2009 for 80101QW, January 1, 2010 for G0430QW	Inverness Medical Innovations Signify ER Drug Screen
82274QW, G0328QW	September 9, 2009	Germaine Laboratories AimStep Immunological Fecal Occult Blood Test (iFOBT)
81003QW, *82044QW*, *82570QW*	September 14, 2009	Siemens Clinitek 50 Urine Chemistry Analyzer
87880QW	September 15, 2009	CLIA waived inc Rapid Strep A Test
82044QW	October 26, 2009	Genzyme Diagnostics OSOM ImmunoDip Urinary Albumin Test

CMS identifies waived tests by providing an updated list of waived tests to Medicare contractors on a quarterly basis via a recurring update notification. To be recognized as a waived test, some CLIA waived tests have unique Healthcare Common Procedure Coding System (HCPCS) procedure codes and some must have a modifier QW (CLIA waived test) included with the HCPCS code.

Listed in the table above are the latest tests approved by the FDA as waived tests under CLIA. The *Current Procedural Terminology* (*CPT*) codes for these new tests must have the modifier QW to be recognized as a waived test.

However, please note that the codes for the tests mentioned on the first page of the attachment to CR 6800, at *http://www.cms.hhs.gov/Transmittals/downloads/R1905CP.pdf*, do not require a modifier QW to be recognized as a waived test (i.e., *CPT* codes: *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013*, and *85651*).

Other key points of CR 6800

1. CR 6800 also announces that CMS was informed by Bayer Healthcare that the following tests are no longer manufactured or distributed; Hence, the following tests were removed from the attachment to CR 6800:
   - Bayer Mulitstick Pro 7G reagent strips
   - Bayer Mulitstick Pro 10LS reagent strips
   - Bayer Mulitstick Pro 11 reagent strips
   - Bayer Clinitek 50 urine chemistry analyzer
   - Bayer Clinitek status urine chemistry analyzer
   - Bayer Clinitek 50 urine chemistry analyzer - for microalbumin, creatinine
   - Bayer Diagnostics/ Microalbustix reagent strip, and
   - Bayer Clinitek 50 urine chemistry analyzer - for HCG, urine.
2. Based on a concern received from the laboratory industry on correct coding, the *CPT* code assigned to the following tests has been changed from *83518QW* to *82044QW* with an effective date of April 1, 2010:

New waived tests (continued)

- Beckman Coulter ICON Microalb
- Boehringer Mannheim Chemstrip Micral
- Diagnostic Chemicals ImmunoDip™ urinary albumin test
- Diagnostic Chemicals ImmunoDip™ urinary albumin screen (urine dipstick), and
- Roche Diagnostic Chemstrip Micral (urine dipstick).

3. For 2010, the Healthcare Common Procedure Coding System (HCPCS) included the following new codes:
   - G0430 – Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
   - G0431 – Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class

Therefore, the HCPCS code G0430QW was added to the following test systems since they are qualitative drug screening tests for multiple drug classes using a non-chromatographic method:

- Abbott Diagnostics Signify ER drug screen test
- Accu-Stat drugs of abuse home test for marijuana (THC) and cocaine (COC)
- Accu-Stat drugs of abuse home test for marijuana, cocaine, amphetamine, methamphetamines, opiates and phencyclidine
- Accutest multi-drug, multi-line screen test device
- Acon One Step multi-drug, multi-line screen test device (professional use)
- ADC CLIA waived marijuana (THC) and cocaine test
- ADC CLIA waived multiple drug test card
- Advantage Diagnostics Advantage Marijuana (THC) and Cocaine home drug test
- Advantage Diagnostics Corporation ADC multiple drug test card
- Alatex Scientific Peace of Mind multiple drugs of abuse test
- Alfa Scientific Designs, Inc. Instant View multi-drug of abuse urine test
- Alfa Scientific Designs, Inc. Instant View multi-drug of abuse urine cup test
- Amedica Biotech Amedica drug screen test cup
- American Bio Medica Rapid TOX
- Aventir Biotech LLC home check multiple drug test cup
- Aventir Biotech LLC home check multiple drug cup test {professional version}
- Biotechnostix Rapid Response multi-drug, multi-line screen test card with integrated cup
- Biotechnostix Rapid Response One Step multi-drug, multi-line screen test device
- Branan Medical Corporation Fastect II drug screen dipstick test
- Branan Medical Corporation, FasTox multiple drug dipcard
- Branan Medical Corporation, QuickTox drug screen dipcard
- Branan Medical Corporation ToxCup drug screen cup
- BTNX Inc. Know multi-drug One Step screen test panel (urine)
- BTNX Inc. Rapid Response multi-drug One Step screen test panel (urine)
- Drug Detection Devices Ltd. multi-drug multi-line screeners dip drug test with the integrated screeners autosplit KO test cup
- First Check Diagnostics First Check multi-drug cup
- First Check Diagnostics First Check 12 drug test
- Forefront Diagnostics Drugfree@Home THC/COC test kit
- iCassette multi-drug, multi-line screen test device
- Innovacon Integrated E-Z Split Key Cup II {professional use}
- Innovacon multi-clin drug screen test device
- Jant Pharmacal Accutest MultiDrug ER11 drug screen test device

New waived tests (continued)

- 1 Step Detect Associates DTX Drug Test Cup Integrated E-Z Split Key Cup II
- Phamatech at home drug test (model 9150T)
- Quest Diagnostics Incorporated, express results integrated multi-drug screen cup {professional use}
- RediScreen multi-drug, multi-line screen test device
- Redwood Toxicology Laboratory Reditest 6 cassette substance abuse screening device {professional use}
- Syntron Bioresearch Quikscreen multiple drug cup test {professional version}
- Twin Spirit, Inc. DrugSmart Cup
- Wolfe Drug Testing RealityCheck integrated specimen cup
- Worldwide Medical Corporation, First Check® home drug test (THC-COC), and
- Worldwide Medical Corporation, First Check® home drug test panel 4 (THC-COC-OPI-MET)

4. In addition, the HCPCS code G0431QW was added to the following test systems since they are qualitative drug screening tests using a single drug class method:
   - Accu-Stat Drugs of Abuse home test for marijuana (THC)
   - ADC CLIA-waived marijuana (THC) test
   - DyanGen NicCheck II test strips
   - First Check Diagnostics LLC, First Check home drug test marijuana
   - Mossman Associates, Inc. NicCheck I test strips
   - Phamatech at home drug test (model 9068)
   - Phamatech at home drug test (model 9073)
   - Phamatech at home drug test (model 9073T)
   - Phamatech at home drug test (model 9078)
   - Phamatech at home drug test (model 9078T)
   - Phamatech at home drug test (model 9083)
   - Phamatech at home drug test (model 9133)
   - Phamatech QuickScreen one step cocaine screening test
   - Phamatech QuickScreen one step methamphetamine test
   - Phamatech QuickScreen one step opiate screening test
   - Phamatech QuickScreen one step PCP screening test, and
   - Worldwide Medical Corporation, First Check® home drug test (THC)

You should be aware that your carrier or MAC will not search their files to either retract payment or retroactively pay claims processed prior to implementation of CR 6800. However, they should adjust claims that you bring to their attention.

Additional information

You may find the official instruction, CR 6800, issued to your carrier or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1905CP.pdf*. You will find a table containing the tests granted waived status under CLIA as an attachment to that CR.

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*.

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Codes subject to and excluded from Clinical Laboratory Improvement Amendments edits

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

Provider types affected

Clinical laboratories and providers that submit claims to Medicare carriers or Medicare administrative contractors (MACs) for laboratory test services provided to Medicare beneficiaries may be impacted by this issue.

Provider action needed

Change request (CR) 6812, from which this article is taken, informs your carriers and MACs about the new HCPCS codes for 2010 that are subject to and those that are excluded from Clinical Laboratory Improvement Amendments (CLIA) edits. Please see the *Background* section for details.

Background

CLIA regulations require a facility to be appropriately certified for each test it performs; and moreover, to ensure that Medicare & Medicaid only pay for laboratory tests that are performed in certified facilities. HCPCS codes that are considered CLIA laboratory tests are currently edited at the CLIA certificate level.

Since the HCPCS codes that are considered a laboratory test under CLIA change each year, the Center for Medicare & Medicaid Services (CMS) needs to inform carriers and MACs about the new HCPCS codes that are subject to CLIA edits and those that are excluded from CLIA edits. CR 6812 provides this information for 2010.

HCPCS codes subject to CLIA edits

The HCPCS codes listed in the following table are new for 2010 and are subject to CLIA edits. These codes require a facility to have one of the following:

- A CLIA certificate of registration (certificate type code 9)
- A CLIA certificate of compliance (certificate type code 1)
- A CLIA certificate of accreditation (certificate type code 3)

A facility without a valid, current, CLIA certificate, or with a current CLIA certificate of waiver (certificate type code 2) or a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) must not be permitted to be paid for these tests.

The table does not include new HCPCS codes for waived tests or provider-performed procedures.

HCPCS	Description
G0430	Drug screen qualitative; multiple drug classes other than chromographic method, each procedure
G0431	Drug screen qualitative; single drug class method (e.g., immunoassay), each drug class
84145	*Procalcitonin (PCT)*
84431	*Thromboxane metabolite(s), including thromboxane , if performed, urine*
86305	*Human epididymis protein 4 (HE4)*
86352	*Cellular function assay involving stimulation (e.g., mitogen or antigen) and detection of biomarker (e.g., APT)*
86780	*Antibody; Treponema pallidum*
86825	*Human leukocyte antigen (HLA) crossmatch, non-cytoxic (e.g., using flow cytometry); first serum sample or dilution*
86826	*Human leukocyte antigen (HLA) crossmatch, non-cytoxic (e.g., using flow cytometry); each additional serum sample or sample dilution (List separately in addition to primary procedure)*
87150	*Culture, typing; identification by nucleic acid (DNA or RNA) amplified probe technique, per culture or isolate, each organism probed*
87153	*Culture, typing; identification by nucleic acid sequencing method; each isolate (e.g., sequencing of 16S rRNA gene)*
87493	*Infectious agent detection by nucleic acid (DNA or RNA); Clostridium difficile toxin gene(s), amplified probe technique*
88387	*Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (e.g., nucleic acid-based molecular studies); each tissue preparation (e.g., a single lymph node)*
88388	*Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (e.g., nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (e.g., a single lymph node) (list separately in addition to code for primary procedure).*

Codes subject to and excluded from Clinical Laboratory Improvement Amendments edits (continued)

Discontinued HCPCS codes

The following HCPCS codes were discontinued on December 31, 2009:

82307 Calciferol (Vitamin D)

86781 Antibody; Treponema pallidum confirmatory test (e.g., FTA-ABS)

0087T Sperm evaluation, hyaluronan sperm binding test

New codes excluded from CLIA edits

For 2010, the following HCPCS codes are new and excluded from CLIA edits and do not require a facility to have any CLIA certificate:

83987 pH; exhaled breath condensate

88738 Hemoglobin (Hgb), quantitative, transcutaneous

89398 Unlisted reproductive medicine laboratory procedure

Additional information

You should be aware that your carriers or MACs will return (as unprocessable) claims that you submit for the HCPCS codes in the above table (those subject to CLIA edits), if you don't include a CLIA number. Further, while they are not required to search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to implementation of CR 6812, your carrier or MAC will adjust claims that you bring to their attention.

You may find the official instruction, CR 6812, issued to your carrier or MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1912CP.pdf*.

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

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Radiology

Organizations approved to accredit suppliers of advanced imaging services

The Centers for Medicare & Medicaid Services (CMS) is designating the following three national accreditation organizations to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging procedures:

- American College of Radiology (ACR)
- Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC)

The accreditation requirement will apply only to the suppliers furnishing the imaging services, and not to the physician's interpretation of the images.

As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), all suppliers of the TC of advanced imaging will have to become accredited by an accreditation organization designated by the Secretary of Health and Human Services by January 1, 2012. The accreditation requirement applies to physicians, nonphysician practitioners, and physician and nonphysician organizations that are paid for providing the technical component of advanced imaging services under the Medicare physician fee schedule.

MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). The details of the accreditation organization selection process went through notice and comment rulemaking in the calendar year 2010 physician fee schedule rule.

Organizations approved to accredit suppliers of advanced imaging services (continued)

While advanced diagnostic imaging procedures can be useful in identifying health problems that might otherwise require surgery, the rapid growth in their use raises important questions of quality and safety," said Barry Straube, M.D., CMS chief medical officer and director of the CMS Office of Standards and Quality. "The three organizations that will be accrediting suppliers have the expertise and authority to set a standard of excellence industry-wide.

To be designated, the accrediting organizations had to demonstrate that they were experienced in the advanced diagnostic imaging area, and that their accreditation requirements met or exceeded the standards set out in MIPPA, including requirements for:

- Qualifications of nonphysician personnel performing the imaging
- Qualifications and responsibilities or medical directors and supervising physicians
- Procedures to ensure the safety of the individuals furnishing the imaging procedure and of the persons to whom the services are furnished
- Procedures to ensure the reliability, clarity, and accuracy of the technical quality of the diagnostic images produced by the supplier
- Procedures to assist the beneficiary in obtaining his/her imaging records on request, and
- Procedures to notify CMS of any changes to the imaging modalities subsequent to the accrediting organization's decision.

In addition, the accrediting organizations were required to develop a plan for reducing the burden and cost of accreditation to small and rural suppliers. The accrediting organizations are also required to provide CMS with detailed information about their survey processes.

MIPPA specifically excluded from the accreditation requirement certain imaging services such as x-rays, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography, which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

CMS will issue further guidance to suppliers about meeting the accreditation requirements. CMS plans to undertake a provider education outreach program to ensure that all affected suppliers understand the requirements and are able to comply with them prior to the January 1, 2012, accreditation deadline.

Additional information may be found at: *http://www.cms.hhs.gov/medicareprovidersupenroll*.

Source: CMS PERL 201002-01

General Coverage

Using condition code DR and modifier CR on Medicare fee-for-service claims

As part of its response to the 2005 Katrina hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed condition code "DR" and modifier "CR" to facilitate the processing of claims affected by that emergency. (See Transmittal 184, change request [CR] 4106, issued on October 15, 2005.) Use of these indicators was also authorized for claims affected by subsequent emergencies. The discretionary use of these indicators by a provider or supplier was permitted and such use signified not only that the item or service was affected by an emergency or disaster, but also that the provider or supplier had met all of CMS' requirements related to the furnishing of such item or services during the emergency or disaster.

Subsequently, on July 31, 2009, CMS issued Transmittal 1784 (CR 6451) which, among other things, narrowed the scope of permitted uses of these indicators. In particular, it eliminated the discretionary use of both condition code "DR" and modifier "CR" by providers and suppliers.

For the H1N1 pandemic emergency, CMS has authorized the use of condition code "DR" and modifier "CR" only by providers that have been granted a formal waiver under section 1135 of the Social Security Act and then only for services affected by the emergency and while the waiver remains in effect. No other provider or supplier may use either indicator at this time.

Providers and suppliers who have been annotating their claims with one or both indictors should cease doing so (unless they are operating under a formal 1135 waiver). Processing of claims annotated with these indicators, that are submitted by providers and suppliers that have not been granted an 1135 waiver, may be delayed.

If you have questions or need more information, contact your local CMS regional office. You may also visit the H1N1 Web page at *http://www.cms.hhs.gov/H1N1*.

Source: CMS PERL 201001-30

Electronic Data Interchange

Healthcare provider taxonomy code updates effective April 1, 2010

Effective April 1, 2010, the healthcare provider taxonomy codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of HPTC is available from the Washington Publishing Company Web site at: *http://www.wpc-edi.com/codes/taxonomy*. If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level deletion (rejection) may occur. To ensure you do not receive a claim or file level rejection it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system please contact your software support vendor.

Source: Publication 100-04, Transmittal 1896, change request 6840

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.

General Information

Problem with Medicare claim crossover to supplemental payer

The Centers for Medicare & Medicaid Services (CMS) has identified a problem where claims were not automatically crossing over to supplemental payers even though the provider remittance advice indicated otherwise. This problem began January 5. Part A institutional claims and Part B professional claims, with the exception of supplier claims processed by durable medical equipment Medicare administrative contractors (DME MACs), were impacted by this problem. Claims processed by DME MACs were not impacted.

Part A institutional claims

No action is required by Part A institutional providers. As of February 2, CMS successfully implemented a systems fix to ensure that all Part A institutional claims are crossing over to supplemental payers as indicated on the remittance advice received by providers. As part of the fix, CMS' Medicare contractors were able to identify claims processed between January 5 and February 1 where the provider remittance advice indicated that the affected claims were crossed over to various supplemental payers but were not. On February 2, the affected Medicare contractors began to send the affected claims to the coordination of benefits contractor (COBC) to be crossed over to supplemental payers. This effort is now largely completed. Please allow until March 1 for supplemental payers to receive and process these claims before attempting to balance bill them for any remaining balances after Medicare.

Part B professional claims

Action is required on behalf of Part B professional providers where a remittance advice with an issue date between January 5 and February 12 has two or more service lines for a beneficiary and both of the following apply:

- One service line is 100 percent reimbursable (i.e., the approved amount and amount to be paid are equal)
- One service line where part of or the entire Medicare approved amount is applied to the Part B deductible and/or carries co-insurance amounts.

CMS is not able to forward these beneficiary claims to supplemental payers even though the remittance advice may indicate otherwise. Providers will need to identify these claims by reviewing their remittance advice with an issue date between January 5 and February 12 that contain the criteria noted above. Once identified, providers will need to take action to balance bill the beneficiary's supplemental payer. As of February 12, this system problem was fixed and all claims are crossing over to supplemental payers as indicated on the provider remittance advice.

CMS has already notified supplemental payers of these issues. CMS regrets any inconvenience you may experience related to this Medicare claim supplemental payer crossover problem.

Source: CMS PERL 201002-25

Update on claims processing for ordering/referring providers

The Centers for Medicare & Medicaid Services (CMS) will delay until January 3, 2011, the implementation of phase 2 of change request (CR) 6417 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors [MACs]) and CR 6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS] Supplier Claims Processed by Durable Medical Equipment Medicare Administrative Contractors [DME MACs]).

This delay will give physicians and nonphysician practitioners who order items or services for Medicare beneficiaries or who refer Medicare beneficiaries to other Medicare providers or suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to phase 2 implementation.

Although enrolled in Medicare, many physicians and nonphysician practitioners who are eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare. A current enrollment record is one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and contains the NPI. Under phase 2 of the above referenced CRs, a physician or nonphysician practitioner who orders or refers and who does not have a current enrollment record that contains the NPI will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected.

CMS continues to urge physicians and nonphysician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and nonphysician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

Source: CMS PERL 201002-35

A message of interest regarding national provider identifier and enrollment file

As noted in the Centers for Medicare & Medicaid Services (CMS) provider listserv messages that were sent last fall concerning change requests (CRs) 6417 and 6421, CMS has made available a file that contains the national provider identifier (NPI) and the name (last name, first name) of all physicians and nonphysician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare program and have current enrollment records in Medicare (i.e., they have enrollment records in Provider Enrollment, Chain and Ownership System [PECOS] that contain an NPI). This file is available at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*; select Ordering/Referring Report on the left-hand side.

This file contains approximately 800,000 records. A new file will be made available periodically that will replace the posted file; at any given time, only one file (the most recent) will be available. The file can be viewed online. In addition, it can be downloaded by users with technical expertise and further sorted or manipulated. It can also be used to search for a particular physician or nonphysician practitioner by NPI or by name. Please note the following:

1. Records are in alphabetical order based on the surname of the physician or nonphysician practitioner.
2. Name suffixes (e.g., Jr.), if they exist, are not displayed.
3. There are no "duplicates" in the file. Many physicians or nonphysician practitioners share the same first and last name; their corresponding NPIs are the assurance of uniqueness.
4. Deceased physicians and nonphysician practitioners are not included in the file.
5. If a user is unsure of a physician or nonphysician practitioner's NPI, he or she can look it up in the NPI Registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.

Keep in mind that the record in the NPI Registry is not the Medicare PECOS enrollment record.

Source: CMS PERL 201001-29

Providers randomly selected to participate in the MCPSS urged to respond

The Centers for Medicare & Medicaid Services (CMS) has released a special edition *Medicare Learning Network* (*MLN*) *Matters* article that reminds providers and suppliers that CMS has launched the fifth annual national administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). Providers and suppliers that have received a letter indicating that they were randomly selected to participate in the 2010 MCPSS are urged to take a few minutes to go online and complete this important survey via a secure Internet Web site.

The article, SE1005 -- Providers Randomly Selected to Participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS) Urged to Respond, is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf*.

Source: CMS PERL 201001-23

Verification of legalized status

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

Provider types affected

Physicians and nonphysician practitioners submitting a Medicare enrollment application (the paper-based enrollment application (CMS-855I) or the Internet-based Provider Enrollment, Chain & Ownership System (PECOS) enrollment application) to Medicare carriers and Parts A and B Medicare administrative contractors (A/B MACs) in order to provide Medicare services are affected.

Provider action needed

This article, based on CR 6748, states that a carrier and Part A and Part B Medicare administrative contractor (A/B MAC) must verify that a physician or nonphysician practitioner enrolling, reactivating a deactivated billing number or responding to a contractor request for revalidation must be legally authorized to furnish medical services to Medicare beneficiaries.

Background

Carriers and A/B MACs shall verify that the physician or nonphysician practitioner is: (1) a United States citizen; (2) a permanent resident of the United States, or (3) otherwise legally authorized to work in the United States. **Note**: These requirements are consistent with the requirements for obtaining a social security number.

If the physician or nonphysician practitioner is not eligible to work in the United States, Puerto Rico, or a United States Territory, the contractor must deny the enrollment application pursuant to 42 CFR section 424.530(a)(1).

Additional information

The official instruction, CR 6748, issued to your Medicare carrier or MAC regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R323PI.pdf*. Attached to CR 6748 is the revised language added to the *Medicare Program Integrity Manual* Chapter 10 - Medicare Provider/Supplier Enrollment.

Additional information about Medicare provider and supplier enrollment may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

MLN Matters® Number: MM6748
Related Change Request (CR) #: 6748
Related CR Release Date: January 29, 2010
Effective Date: March 29, 2010
Related CR Transmittal #: R323PI
Implementation Date: March 29, 2010

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

Processing negative CARC adjustment amounts on Medicare secondary payer claims

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

Provider types affected

This article applies to all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 6736, which provides Medicare contractors with processing instructions for claim adjustment reason code (CARC) adjustment amounts that are negative when certain CARCs appear on incoming Medicare secondary payer (MSP) claims.

You should know that Medicare contractors will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive claim adjustment segment (CAS) CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as a negative adjustment. Please be sure your billing staffs are aware of these changes.

Background

CRs 6426 and 6427 instruct Medicare contractors to take into consideration the CARCs and the applicable adjustment amounts when processing MSP claims. Business requirements (BRs) 6426.6 and 6427.6 instruct shared systems to add certain CARC adjustment amounts to the paid amounts when these CARCs are received on a claim. There have been rare circumstances where the CARCs found in BR 6426.6 and 6427.6 on incoming MSP claims include a negative adjustment amount and the shared systems mistakenly added the same adjustment amount to the claim based on instructions found in CR 6426 and 6427.

CR 6736 provides instructs Medicare contractors not to add the CARCs when the adjustment amounts on incoming MSP claims are negative. Medicare systems will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive CAS CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as negative adjustment.

Additional information

If you have questions, please contact your Medicare contractor at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
CR 6426 is available at *http://www.cms.hhs.gov/transmittals/downloads/R70MSP.pdf*. CR 6427 is available at *http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf*.

The official instruction, CR 6736, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R73MSP.pdf*. CR 6736 includes the revisions that will be made to the *Medicare Secondary Payer (MSP) Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.5, Effect of Failure to File Proper Claim, as an attachment to that CR.

MLN Matters® Number: MM6736
Related Change Request (CR) #: 6736
Related CR Release Date: February 5, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R73MSP
Implementation Date: July 6, 2010

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

Revision of Medicare Benefit Policy Manual regarding the definition of compendia

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 providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FI], Part A/B Medicare administrative contractors [A/B MAC], or DME Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

What you need to know

CR 6806, from which this article is taken, announces that effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen). This revision requires a publicly transparent process for evaluating therapies and for identifying potential conflicts of interest. Please see the *Background* section for details.

Background

A compendium is defined "as a comprehensive listing of FDA-approved drugs and biologicals (or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment)."

Section 1861(t)(2)(B)(ii)(I) of the Social Security Act (the Act), as amended by section 6001(f)(1) of the Deficit Reduction Act of 2005, Pub. Law 109-171, recognizes three compendia: 1) American Medical Association Drug Evaluations (AMA-DE); 2) United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and 3) American Hospital Formulary Service-Drug Information (AHFS-DI). To date, AHFS-DI, plus other authoritative compendia (found at *http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp#TopOfPage*) that the Secretary of Health and Human Services identifies, serve as sources for you to use in determining the "medically-accepted indication" of drugs and biologicals that are used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia).

In the Medicare physician fee schedule final rule for calendar year 2008, CMS established a process for revising the list of compendia, and also increased the transparency of the process by incorporating a list of desirable compendium characteristics outlined by the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) on March 30, 2006, as criteria for decision-making.

Although the MEDCAC desirable characteristics for compendia included reference to conflict of interest and transparency, section 182(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) amended Section 1861(t)(2)(B) of the Act by adding the following new sentence: "On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests."

CR 6806, from which this article is taken, announces that effective January 1, 2010, CMS is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.5 to include this public transparency requirement.

In this revised definition, a compendium:

1. Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases
2. Is indexed by drug or biological, and
3. Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Additional information

You may find more information about the revised definition of "compendium" by going to CR 6806, located at *http://www.cms.hhs.gov/Transmittals/downloads/R120BP.pdf*.

For more detailed information about the revised definition of "compendium" and the incorporation of MIPPA Section 182 (b) into the compendia review process for current and future statutorily recognized compendia based on this provision, see Issues Related to MIPPA Number 13. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen released in the November 25, 2009 *Federal Register*, which you can find at *http://www.gpo.gov/fdsys/pkg/FR-2009-11-25/pdf/E9-26502.pdf*.

You will find this revised compendium definition in the updated *Medicare Benefit Policy Manual*, Chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen) as an attachment to that CR.

Revision of Medicare Benefit Policy Manual regarding the definition of compendia (continued)

You might also want to read the *MLN Matters*® article titled Compendia as Authoritative Sources for Use in the Determination of a "Medically Accepted Indication" of Drugs and Biologicals Used Off-Label in an Anti-Cancer Chemotherapeutic Regimen, released on October 24, 2008, which you may find at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6191.pdf*.

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

MLN Matters® Number: MM6806
Related Change Request (CR) #: 6806
Related CR Release Date: January 29, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R120BP
Implementation Date: March 1, 2010

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February is American Heart Month

Heart disease is the leading cause of death in the United States for both men and women.[1] Medicare provides coverage for cardiovascular screening blood tests, ultrasound screening for abdominal aortic aneurysms (AAA), and smoking and tobacco-use cessation counseling for qualified beneficiaries.

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 Medicare-covered preventive services that are appropriate for them, including services related to cardiovascular health.

For more information

The Centers for Medicare & Medicaid Services (CMS) has developed several educational products related to Medicare-covered preventive services:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals -- this newly revised comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including cardiovascular screening blood tests, AAA screenings, and smoking and tobacco-use cessation counseling.
http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

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

Quick Reference Information: Medicare Preventive Services --this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including smoking and tobacco-use cessation counseling, and AAA and cardiovascular screenings.
http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

Expanded Benefits brochure -- this brochure provides information on coverage for Medicare-covered cardiovascular blood test and AAA screenings.
http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf

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

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

For more information on American Heart Month, please visit the American Heart Month Web site at: *http://www.americanheart.org/presenter.jhtml?identifier=4441*.

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

[1] Heart Disease, Heart Disease Facts. [online]. Atlanta, GA: The Centers for Disease Control and Prevention, December 21, 2009 [cited 21 January 2010]. Available at *http://www.cdc.gov/heartdisease/facts.htm*.

Source: CMS PERL 201002-06

There's still time to get the seasonal flu shot

Although influenza activity has declined recently, it still may continue for several months.[1] The Centers for Disease Control continues to recommend that patients and health care providers and caregivers be vaccinated against seasonal influenza.

CMS encourages health care providers to use each office visit as an opportunity to talk with Medicare your patients about the importance of getting a seasonal flu shot. And remember, it is also important to immunize yourself and your staff.

Remember: Seasonal influenza vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are not Part D covered drugs.

For information about Medicare's 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*. You will find a variety of resources that explain Medicare coverage and claims 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*.

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

[1] Seasonal Influenza (Flu). [online]. Atlanta, GA: The Centers for Disease Control and Prevention, January 19, 2010 [cited 21 January 2010]. Available at *http://www.cdc.gov/flu*.

Source: CMS PERL 201002-08

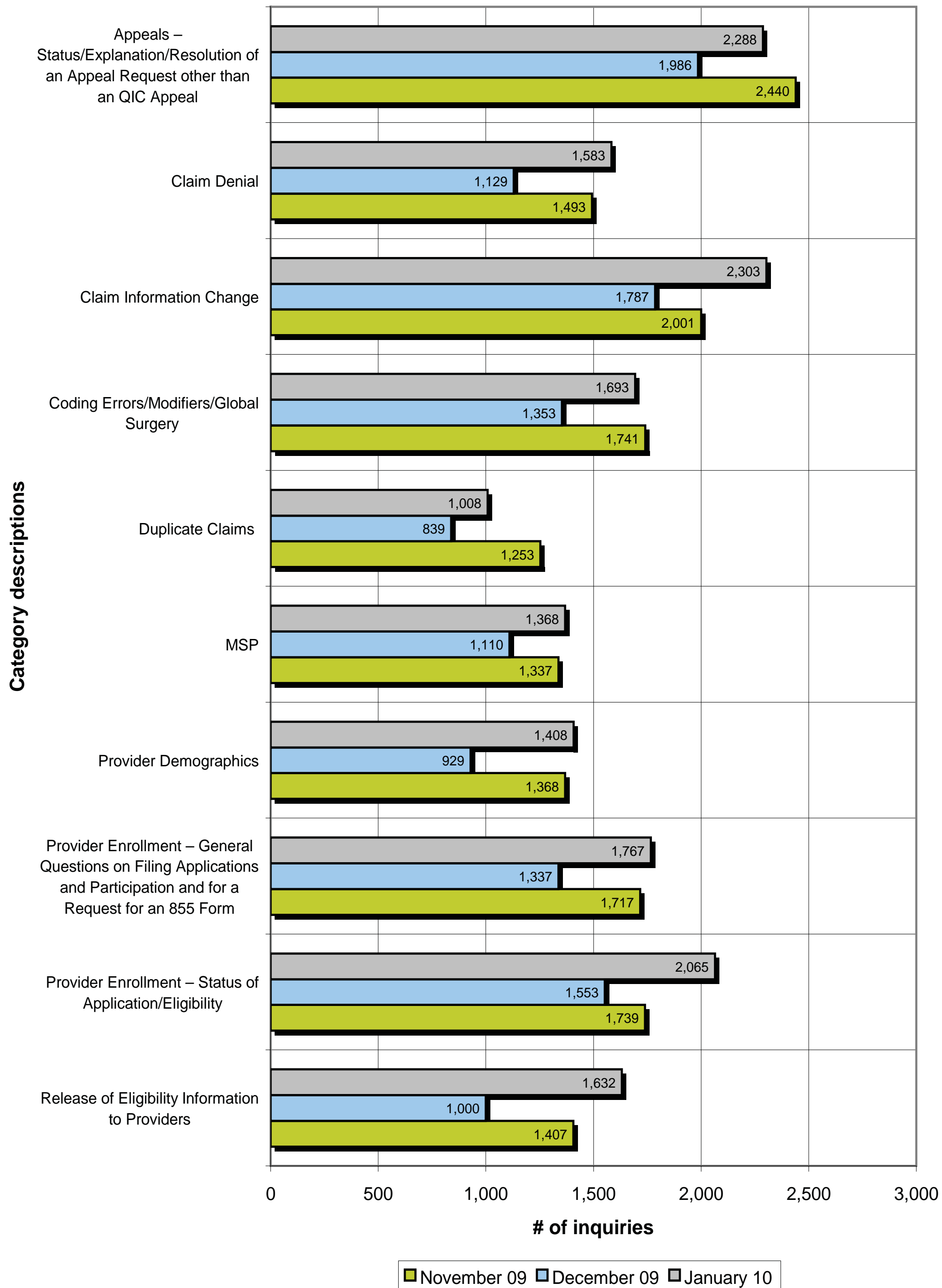
Web site survey

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

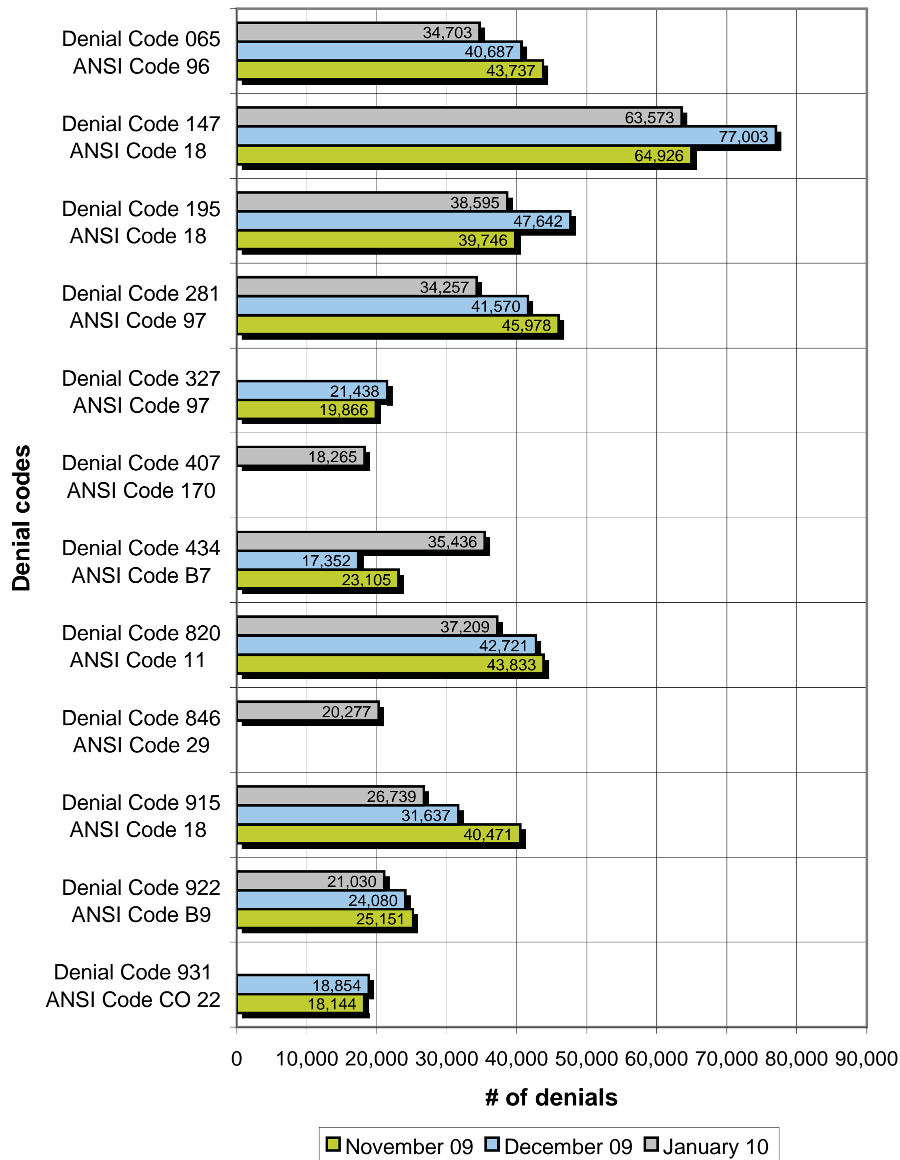
Top inquiries, denials, and return unprocessable claims for November 2009–January 2010

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 November 2009–January 2010. 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 November 2009–January 2010



Top inquiries, denials, and return unprocessable claims for November 2009–January 2010 (continued)

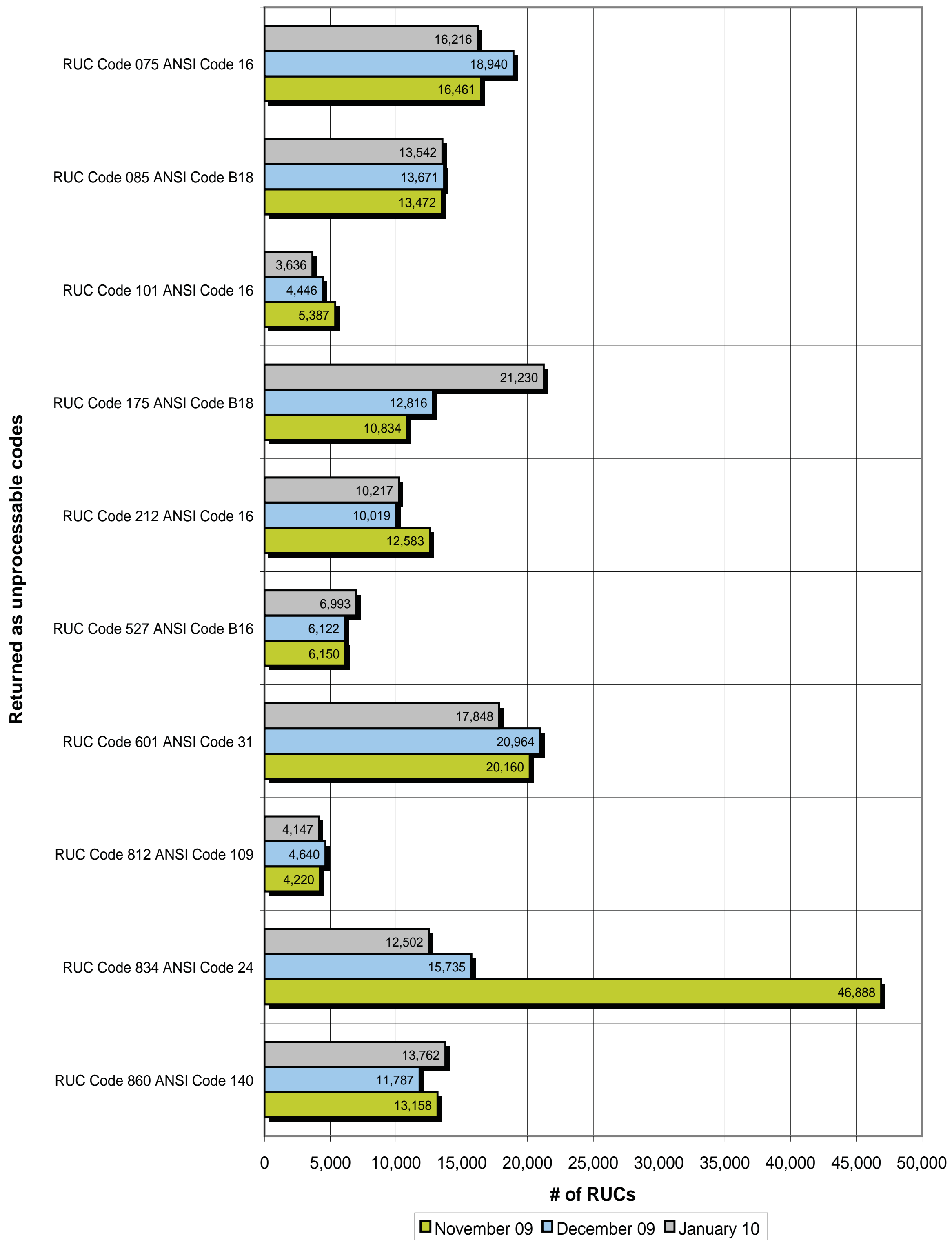


Use the PDS report to improve your Medicare billing operations

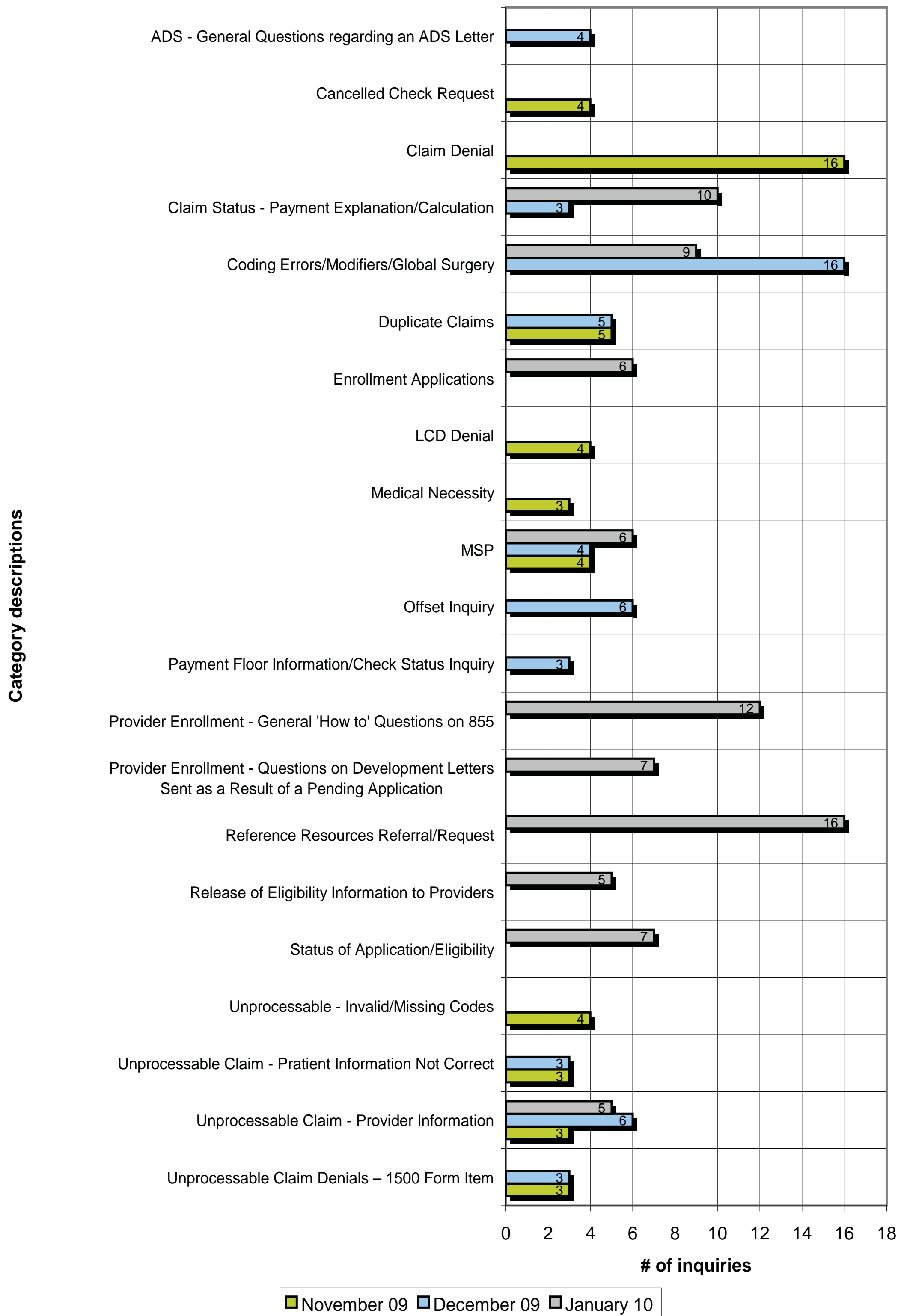
Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified 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 November 2009–January 2010 (continued)

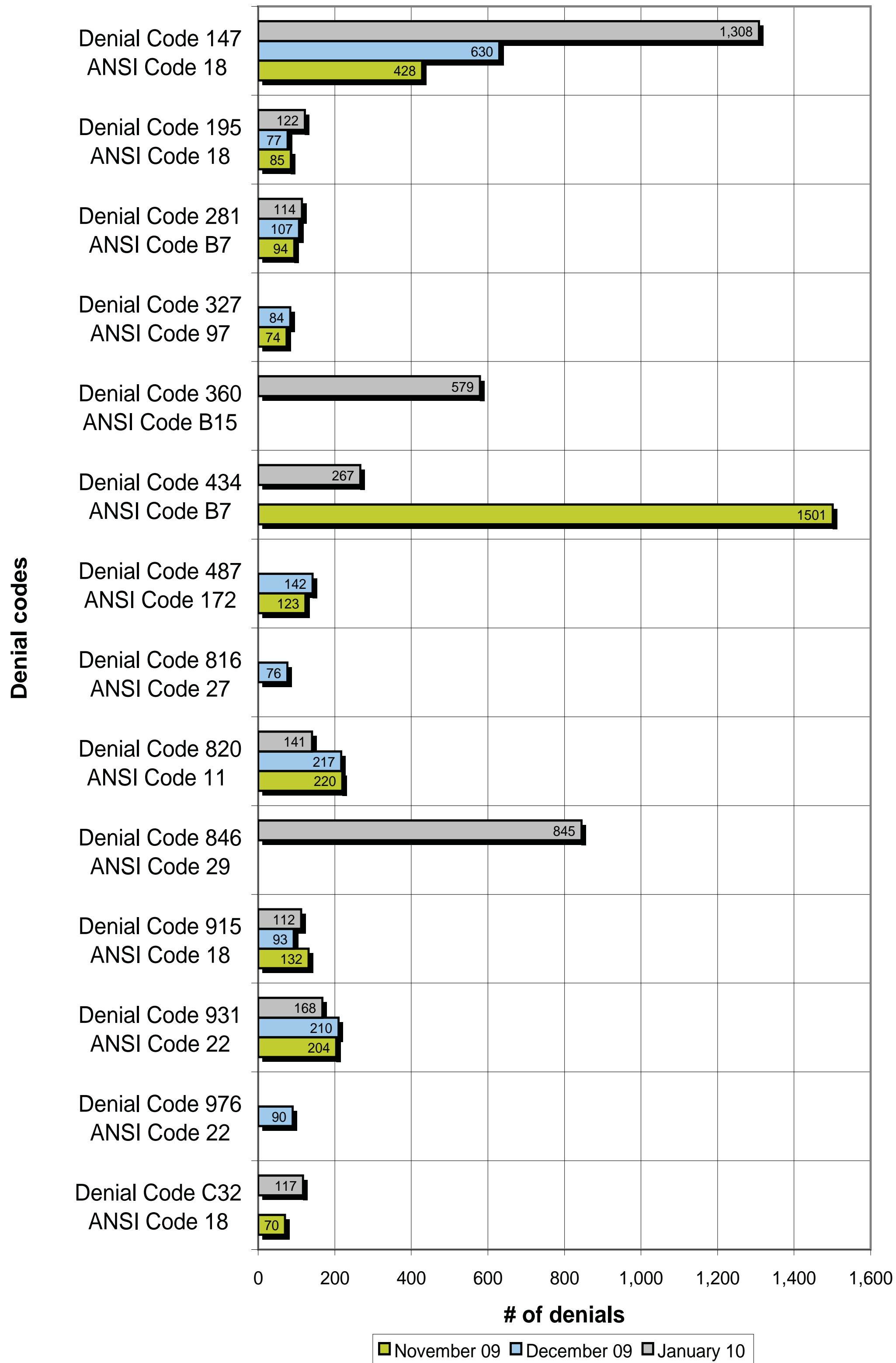
Florida Part B top return as unprocessable claims (RUC) for November 2009–January 2010



Top inquiries, denials, and return unprocessable claims for November 2009–January 2010 (continued)

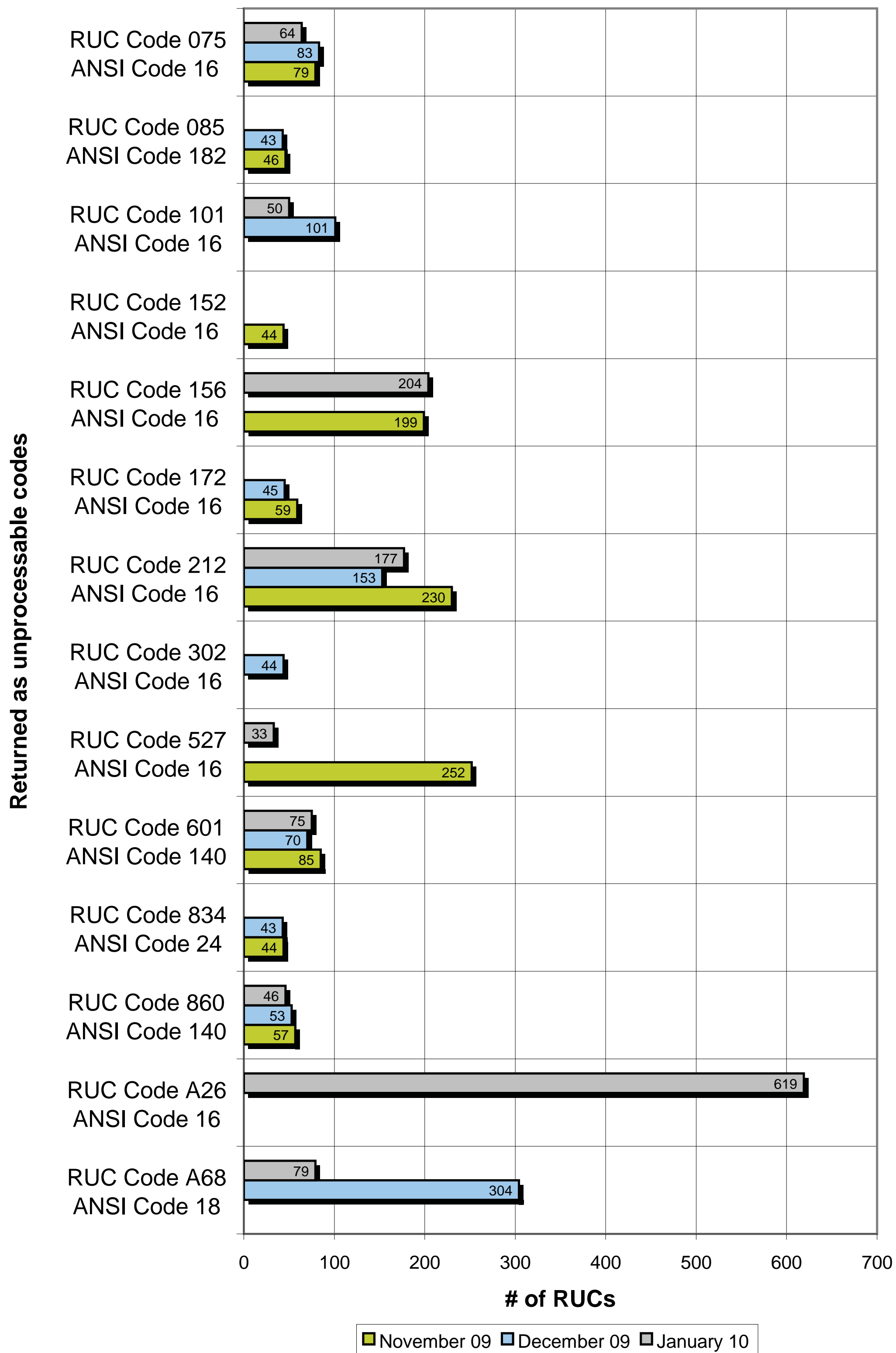


Top inquiries, denials, and return unprocessable claims for November 2009–January 2010 (continued)



Top inquiries, denials, and return unprocessable claims for November 2009–January 2010 (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for November 2009–January 2010



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

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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

J9305: Pemetrexed -- revision to the LCD

LCD ID number: L29255 (Florida)

LCD ID number: L29464 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pemetrexed was most recently revised on April 7, 2009. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to update the Food and Drug Administration (FDA) approved indications for pemetrexed. Additionally, the off-label indication for thymic malignances when used as a second-line chemotherapy regimen has been included for coverage. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been updated with the addition of ICD-9-CM codes 164.0 and 212.6. Dosage and frequency of administration has been removed from the "Utilization Guidelines" section of the LCD, and the "Sources of Information and Basis for Decision" section of the LCD has been updated.

Effective date

This LCD revision is effective for services rendered **on or after February 4, 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.

SKINSUB: Skin substitutes -- revision to the LCD

LCD ID number: L29279 (Florida)

LCD ID number: L29393 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was most recently revised on July 1, 2009. Since that time, a revision was made to delete/add verbiage under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

The following sentence regarding noncoverage in the last paragraph of the above mentioned section of the LCD was deleted:

> All other such products, unless they are specifically FDA labeled as "Skin substitutes" and for use in the types of ulcers considered in this LCD, will be denied coverage under this LCD.

In addition, the word "other" was added to "All such products" in the next sentence of this section of the LCD to read "All other such products."

Effective date

This LCD revision is effective for services rendered **on or after February 9, 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.

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*.

Retired LCDs

93798: Cardiac rehabilitation programs -- retired LCD

LCD ID number: L29092 (Florida)
LCD ID number: L29108 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cardiac rehabilitation programs was effective for services rendered on or after February 2, 2009, for Florida, and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) Joint Signature Memorandum (JSM/TDL) 10087, dated December 17, 2009, the decision was made to retire the LCD.

JSM/TDL 10087 refers to the amendment to the *Code of Federal Regulations* (CFR), published on November 25, 2009, Section 410.49, which outlines the Medicare coverage of the cardiac rehabilitation program and the intensive cardiac rehabilitation program.

Effective January 1, 2010, Section 20.10, the national coverage determination (NCD) for cardiac rehabilitation programs, was repealed from the *Medicare National Coverage Determination (NCD) Manual* (Pub. 100-03).

Effective date

This LCD retirement 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.

Additional Information

Billing for compounded drugs

Background

Compounded medications created/processed by a pharmacist in accordance with the Federal Food, Drug, and Cosmetic Act may be covered under Medicare when their use meets all other criteria for services incident to a physician's service. Since the compounded medications do not have an individual NDC number, the specific HCPCS Level II "J" codes may not be used. Instead, providers should use J3490 (unclassified drug) as appropriate for reimbursement of the drug (s). The use of compounded medications has been especially prevalent in the filling of implantable infusion pumps, (*CPT* codes *95990* or *95991*). Whether a single agent or a combination of agents is used, the compounded medication must be billed under HCPCS code J3490 with the modifier KD even though the compound was similar to a specific HCPCS code (e.g., J2275 for preservative free morphine). Of course, providers who document and use the true "off-the-shelf" product from their office supply may continue to use the specific HCPCS code.

Definition

Compounded drug: A compounded drug is a blend of drugs mixed (compounded) by a pharmacist. This mixture is delivered to the physician or qualified non-physician provider ready to instill into an implantable pump. At times, the pharmacist may reconstitute only one substance and deliver it to the provider in a ready to instill form. An example of reconstituting is adding saline solution to a medication that is supplied as a powder and then turning it into a liquid. For purposes of this billing instruction, a drug that is reconstituted outside the provider's office and is delivered to her/him for instillation into an implantable pump is a compounded drug. In summary, any agent that has been processed by a pharmacist outside the provider's office is a compounded drug.

Of note, drug compounding by the physician and/or office staff should be billed with the unlisted code (J3490) given that the compound drug does not have a unique NDC number. Also, compounding or reconstituting of drugs by the physician and/or office staff solely for economic gain is not medically necessary or reasonable.

Procedure codes

J3490 Unclassified drugs
95990 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural), or brain (intraventricular).*
95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician.*

Billing for compound drugs (continued)

EMC and paper claims

The following information should be reported in item 19 of the CMS-1500 or the electronic equivalent field for EMC claim submitters:

- Name(s) and dose (s) of drug(s) administered into the implantable pump
- Volume of refill in ml
- Pump reservoir size (ml)
- Exact invoice price for that individual patient claim for infusion drugs furnished via implanted DME, with dates of service on or after January 1, 2004, shall be identified using the modifier KD. Units billed should be one in the days/units field (item 24G) on CMS-1500.

Note: If any of the above information is omitted from the initial claim, the claim will have to be developed. In that situation, First Coast Service Options Inc. (FCSO) will request specific documentation by means of an additional documentation request (ADR) letter. This will slow down processing and payment.

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology. CPT* codes, descriptions and other data only are copyrighted 2009 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.

Claims for procedure code J7325 denied in error

Claims submitted for HCPCS code J7325 (Hyaluronan or derivative, Synvisc or Synvisc-One, for intra-articular) for services rendered on or after January 1, 2010, may have been denied incorrectly as not being deemed medically necessary by First Coast Service Options Inc. (FCSO). This error was corrected **on February 4, 2010**. Claims processed on or after February 5, 2010, were adjudicated correctly.

No action required by providers

Providers, whose claims were denied incorrectly due to this error, do not need to take any action. FCSO will perform adjustments to correct the error on all affected claims.

We apologize for any inconvenience this may have caused.

Claims for procedure code 20610 denied in error

Claims submitted for *CPT* code *20610* (*Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa*) for claims processed on or after January 1, 2010, may have been denied incorrectly as not receiving/adjudicating a qualifying other service/procedure. This error was corrected **on January 27, 2010**. Claims processed on or after January 28, 2010, were adjudicated correctly.

No action required by providers

Providers whose claims were denied incorrectly due to this error do not need to take any actions. First Coast Service Options Inc. (FCSO) will perform adjustments to correct the error on all the affected claims.

We apologize for any inconvenience this may have caused.

Italicized and/or quoted material is excerpted from the American Medical Association *Current Procedural Terminology. CPT* codes, descriptions and other data only are copyrighted 2009 American Medical Association (or other such date of publication of *CPT*). All rights reserved. Applicable FARS/DFARS apply.

Web site survey

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

Educational Resources

Upcoming provider outreach and education event

March 2010 – April 2010

Hot Topics: Medicare Part B (ACT)

When: March 10
Time: 10:30 a.m.-12:00 p.m.
Focus: Florida, Puerto Rico, and the U.S. Virgin Islands

Hot Topics: 2010 E/M series

When: April 20
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.

MLN -- quality you can trust

There is information -- and then there is quality information you can trust from the *Medicare Learning Network*. All *Medicare Learning Network* products are thoroughly researched and cleared by the experts at CMS.

What this mean to you

It means there is official Medicare fee-for-service (FFS) program information that is always available for your immediate use to assist with your business needs. The *Medicare Learning Network* knows how to translate complex language into easier to understand language and in various formats, e.g., guides, booklets, Web-based training courses, brochures, national articles, and fact sheets.

Test the quality of our products for yourself and begin obtaining information regarding billing and Medicare coverage and payment -- or even basic information such as office management. Visit the *MLN* Publications page on the CMS Web site to view downloadable publications or click on the Product Ordering Page to see what is available in hard copy.

Remember: There's never a charge for *Medicare Learning Network* products.

Source: CMS PERL 201002-33

Redesigned indexes for 2007-2009 *MLN Matters* articles

The indexes for 2007 through 2009 *MLN Matters* articles have been redesigned. These redesigned indexes are much more user friendly and are available in the *Downloads* section at *http://www.cms.hhs.gov/MLNMattersArticles/*. Use the new indexes to find relevant articles needed to explain and support transmittals from the Centers for Medicare & Medicaid Services (CMS) -- zero in on the article needed to get the information you want now.

Source: CMS PERL 201002-02

Free educational products and free shipping from the *MLN*

The high quality *Medicare Learning Network* products you depend on are always free. Did you know that shipment to your office or home is also free?

Go to the *MLN Product Ordering* page for a listing of products available in hard copy, and then add the products to your shopping cart. Your order will be processed for delivery and shipped right to your door.

Need multiple copies? When you checkout, just increase the quantity and follow the system prompts. Make sure to include your e-mail address in case we need to contact you to process your order.

Visit the *MLN Products* page at *http://www.cms.hhs.gov/mlnproducts/*, and select *MLN Products Ordering Page* to start learning today.

Source: CMS PERL 201002-12

New fact sheet for speech-language pathologist in private practice

The new *Medicare Billing for Speech-Language Pathologists in Private Practice Fact Sheet* (January 2010), which provides general information and guidance to speech-language pathologists (SLPs) on enrollment and billing procedures, is now available in downloadable format from the Centers for Medicare & Medicaid Services' *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/SpeechLangPathfctsht.pdf* on the CMS Web site.

Source: CMS PERL 201002-02

New NPI booklet available

The *National Provider Identifier (NPI): What You Need to Know* booklet is available for download. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of a standard, unique health identifier for each health care provider. The NPI final rule, published on January 23, 2004, established the NPI as this standard. Covered entities under HIPAA are required by regulation to use NPIs to identify health care providers in HIPAA standard transactions. This booklet contains information previously available in NPI fact sheet and tip sheets and is available at *http://www.cms.hhs.gov/MLNProducts/downloads/NPIBooklet.pdf*.

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

Source: CMS PERL 201002-24

Revised fact sheet for the Medicare physician fee schedule

The *Medicare Physician Fee Schedule Fact Sheet* (February 2010) has been revised to include information about the two month zero percent (0 percent) update to the 2010 Medicare physician fee schedule (MPFS), effective only for dates of service January 1, 2010, through February 28, 2010. This fact sheet, which also provides information about MPFS payment rates and the MPFS payment rates formula, is available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.

Source: CMS PERL 201002-05

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

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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 ♦