MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

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
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- ❑ Other _____

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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Medicare B Update!

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Publications staff

Terri Drury
Millie C. Pérez
Mark Willett
Robert Petty

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

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

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

In addition to the above, other sections include:

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

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

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

GA modifier and appeals

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

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

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

Find out first: Subscribe to FCSO eNews

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Annual *Medicare B Update!* hardcopy/CD-ROM registration form

To receive free editions of the Part B publication in hardcopy, CD-ROM, or e-mail format, you must complete this registration form. To receive a hardcopy or CD-ROM of future issues of the Part B publication, **your form must be faxed to 1-904-361-0723 by May 31, 2010.** Providers currently receiving hardcopy publications must renew by using this form. Providers who do not renew by the May 31 deadline will no longer receive free hardcopy versions after the September 2010 issue. The publication cycle begins every year on October 1 and concludes September 30.

If you miss the registration deadline, you still have the ability to receive a hard copy or CD-ROM through subscription. The annual cost for a hardcopy subscription is $33. The annual cost for a CD-ROM subscription is $55.

Please note that you are not obligated to complete this form to access information contained in the Part B publication. Issues dating back to 1997 are available free on First Coast Service Options' provider Web site: *http://medicare.fcso.com/Publications_B/index.asp*.

Provider/facility name:

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Address:

City, state, ZIP code:

Contact person/title:

Telephone number: Fax number: E-mail address:

Registration type: NEW ❑ RENEWAL ❑

Language preference: English ❑ Español ❑

Rationale for needing a hardcopy:

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Do you have a PC with a CD-ROM drive? YES ❑ NO ❑

Will you accept publications via e-mail? YES ❑ NO ❑

Other technical barrier or reason for needing publications hardcopy or on CD-ROM:

Note: Providers who qualify will receive one copy of each monthly publication.

Fax your completed form to:
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Please share your questions and/or concerns regarding this initiative with us.

Additional questions or concerns may be submitted via the Medicare provider education Web site at http://medicare.fcso.com/Feedback/index.asp. You also may fax your questions or comments to 1-904-361-0723. **Our Provider Contact Center will not be able to respond to inquiries about this form.**

Diagnostic Services

Revision of the Medicare manuals to remove references to purchased diagnostic test

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

Provider types affected

Physicians and independent diagnostic testing facilities (IDTF) submitting claims for diagnostic tests subject to the anti-markup payment limitation to Medicare contractors (carriers and A/B Medicare administrative contractors [A/B MAC]) are affected.

Provider action needed

This article, based on change request (CR) 6627, informs physicians and IDTFs that the Centers for Medicare & Medicaid Services (CMS) will begin to change all references to "purchased diagnostic tests" in Medicare manuals to "anti-markup tests." Until all changes are manualized, you and your billing staffs should consider any reference to a "purchased diagnostic test" to be a reference to an anti-markup test.

Background

CMS is changing references to the term "purchased diagnostic test" in the *Medicare Claims Processing Manual* and the *Medicare Program Integrity Manual* to reflect the new anti-markup payment limitation language. As previously explained in *MLN Matters*® article MM6371, which is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6371.pdf*, CMS established claims processing instructions for diagnostic tests subject to the anti-markup payment limitation and the conditions under which the anti-markup provision applies and advised that related Medicare manuals would be updated at a later date to reflect the new anti-markup language. CMS noted that it would not change all of the references in the manual at one time, but would implement the changes over time. Until all changes are manualized, Medicare contractors will consider the term "purchased diagnostic test" to be obsolete and should instead use the nomenclature associated with the new anti-markup rule.

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*.

The official instruction, CR 6627, issued to your Medicare contractor regarding this change consists of two transmittals, one for the *Medicare Claims Processing Manual*, which is at *http://www.cms.hhs.gov/Transmittals/downloads/R1931CP.pdf*, and one for the *Medicare Program Integrity Manual*, which may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R326PI.pdf*.

MLN Matters® Number: MM6627
Related Change Request (CR) #: 6627
Related CR Release Date: March 12, 2010
Effective Date: June 14, 2010
Related CR Transmittal #: R326PI and R1931CP
Implementation Date: June 14, 2010

Drugs and Biologicals

July 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) 6805 which instructs Medicare contractors to download and implement the July 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised April 2010, January 2010, October 2009, and July 2009 files. Medicare will use the July 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 July 6, 2010, with dates of service July 1, 2010, through September 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 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
July 2010 ASP and NOC files	July 1, 2010, through September 30, 2010
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

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 6805) issued to your Medicare MAC, carrier, and/or FI may be found at *http://www.cms.hhs.gov/Transmittals/downloads/R1922CP.pdf*.

MLN Matters® Number: MM6805
Related Change Request (CR) #: 6805
Related CR Release Date: February 19, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R1922CP
Implementation Date: July 6, 2010

April 2010 average sale price drug file is available

The Centers for Medicare & Medicaid Services (CMS) has posted the April 2010 average sale price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. The ASP pricing files for January 2010, October 2009, July 2009, and April 2009 have also been updated. All are available for download at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

Source: CMS PERL 201003-40

Evaluation and Management

Questions and answers on reporting physician consultation services

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

Provider types affected

This article is for physicians and nonphysician practitioners (NPPs) who perform initial evaluation and management (E/M) services previously reported by *Current Procedural Terminology* (*CPT*) consultation codes for Medicare beneficiaries and submit claims to Medicare carriers and/or Medicare administrative contractors (MACs) for those services. It is also intended for method II critical access hospitals, which bill for the services of those physicians and NPPs who have reassigned their billing rights, and hospices where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice.

This article only applies to the services of physicians and NPPs paid under the Medicare fee-for-service (FFS) program. It does not revise existing policies or rules governing Medicare Advantage or non-Medicare insurers. Physicians, NPPs, method II critical access hospitals, and hospices to which the revised policy applies are subsequently referred to as providers throughout this publication.

Provider action needed

This article pertains to change request (CR) 6740, which alerts providers that effective January 1, 2010, the *CPT* consultation codes (ranges *99241-99245* and *99251-99255*) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should report each E/M service, including visits that could be described by *CPT* consultation codes, with an E/M code payable under the Medicare physician fee schedule (MPFS) that represents **where** the visit occurs and that identifies the **complexity** of the visit performed.

Background

In the calendar year (CY) 2010 MPFS final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the payment of all *CPT* consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation HCPCS G-codes. The change does not increase or decrease Medicare payments. In the case of *CPT* codes for E/M services that may be reported in CY 2010 for E/M services previously paid by the *CPT* consultation codes, CMS increased the work relative value units (RVUs) for new and established office visits, increased the work RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in Publication 100-4, Chapter 12, Section 30.6 of the *Medicare Claims Processing Manual* that pertain to the use of the American Medical Association (AMA) *CPT* consultation codes (ranges *99241-99245* and *99251-99255*) are removed by CR 6740. (The Web address for viewing CR 6740 is in the *Additional information* section of this article.)

Questions and answers

The following questions and answers are offered to address some of the key questions you may have regarding these changes:

Q. When will providers and Medicare contractors stop reporting and paying the *CPT* consultation codes for consultative E/M services that could be described by the *CPT* consultation codes?

A. Medicare ceased recognizing the *CPT* consultation codes for payment effective for services furnished on or after January 1, 2010.

Q. Does this policy apply to other Medicare products, such as Medicare Advantage?

A. This policy applies to providers billing the Medicare fee-for-service program. If a provider is furnishing an E/M service that could be described by a *CPT* consultation code to a Medicare Advantage patient, the provider should contact the Medicare Advantage plan for its policy.

Q. Is CMS going to crosswalk the *CPT* consultation codes that are no longer recognized to the E/M codes for each setting in which an E/M service that could be described by a *CPT* consultation code can be furnished?

A. No, providers must bill the E/M code (other than a *CPT* consultation code) that describes the service they provide in order to be paid for the E/M service furnished. The general guideline is that the provider should report the most appropriate available code to bill Medicare for services that were previously billed using the *CPT* consultation codes. For services that could be described by inpatient consultation *CPT* codes, CMS has stated that providers may bill the initial hospital care service *CPT* codes and the initial nursing facility care *CPT* codes, where those codes appropriately describe the level of service provided. When those codes do not apply, providers should bill the E/M code that most closely describes the service provided.

Q. How should providers bill for services that could be described by *CPT* inpatient consultation codes *99251-99252*, the lowest two of five levels of the inpatient consultation *CPT* codes, when the minimum key component work and/or medical necessity requirements for the initial hospital care codes *99221-99223* are not met?

A. There is not an exact match of the code descriptors of the low level inpatient consultation *CPT* codes to those of the initial hospital care *CPT* codes. For example, one element of inpatient consultation *CPT* codes *99251* and *99252*, respectively, requires “a problem focused history” and “an expanded problem focused history.” In contrast, initial hospital care *CPT* code *99221* requires “a detailed or comprehensive history.”

Questions and answers on reporting physician consultation services (continued)

Providers should consider the following two points in reporting these services. First, CMS reminds providers that *CPT* code *99221* may be reported for an E/M service if the requirements for billing that code, which are greater than *CPT* consultation codes *99251* and *99252*, are met by the service furnished to the patient. Second, CMS notes that subsequent hospital care *CPT* codes *99231* and *99232*, respectively, require "a problem focused interval history" and "an expanded problem focused interval history" and could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by *CPT* consultation code *99251* or *99252*.

Q. How will Medicare contractors handle claims for subsequent hospital care *CPT* codes that report the provider's first E/M service furnished to a patient during the hospital stay?

A. While CMS expects that the *CPT* code reported accurately reflects the service provided, CMS has instructed Medicare contractors to not find fault with providers who report a subsequent hospital care *CPT* code in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Q. How will more reporting of initial hospital care *CPT* codes instead of *CPT* consultation codes affect the review of claims by Medicare contractors?

A. CMS has alerted MAC audit staff as well as Medicare recovery audit contractors of its expectation that physicians may bill more E/M codes for initial hospital care in place of billing inpatient CPT consultation codes. CMS has also alerted contractors to expect a different proportion of various initial hospital care *CPT* codes under the new policy. CMS expects contractors to consider that these may be appropriate changes when making decisions about whether to pursue medical review and other types of claims review.

Q. How should providers bill for E/M services that cannot be described by any *CPT* E/M code that is payable by Medicare?

A. These services should be reported with *CPT* code *99499* (*Unlisted evaluation and management service*). Reporting *CPT* code *99499* requires submission of medical records and contractor manual medical review of the service prior to payment, and CMS expects reporting of this E/M code to be unusual.

Q. Because *CPT* consultation codes are no longer recognized by CMS for payment, is the definition of transfer of care no longer relevant?

A. Yes, CMS agrees that discontinuing recognition of the *CPT* consultation codes for payment renders the issues regarding the definition of what constitutes a transfer of care no longer relevant.

Q. When is it appropriate for providers to report critical care services in the context of furnishing an E/M service that could be described by a *CPT* consultation code?

A. Providers should continue to follow the existing *CPT* guidelines for reporting critical care codes.

Q. What constitutes a new versus an established patient? Can a provider bill an office/outpatient new patient visit code and/or an initial hospital care service code for a patient seen within the past three years but for a new problem?

A. The rules with respect to new and established patient office visits are unchanged. Providers should follow the guidance in Publication 100-04, Chapter 12, Section 30.6.7 of the *Medicare Claims Processing Manual*:

Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a three year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an X-ray or EKG, etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

Q. Will Medicare contractors accept the *CPT* consultation codes when Medicare is the secondary payer?

A. Medicare will also no longer recognize the *CPT* consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, providers must bill an appropriate E/M code for the E/M services previously reported and paid using the *CPT* consultation codes. If the primary payer for the service continues to recognize *CPT* consultation codes for payment, providers billing for these services may either:

- Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or
- Bill the primary payer using a *CPT* consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Q. Can a provider provide an advance beneficiary notice (ABN) to the beneficiary and then bill his or her charge for the consultation after the consultation is billed and denied by Medicare?

A. No, when a *CPT* consultation code is reported to Medicare, the claim is not denied. Instead, the claim is returned to the provider for a different *CPT* code because Medicare recognizes another code for payment of E/M services that may be described by *CPT* consultation codes. Once the claim is resubmitted to report an appropriate, payable E/M code (other than a *CPT* consultation code) for a medically reasonable

Questions and answers on reporting physician consultation services (continued)

and necessary E/M service, the beneficiary can only be billed any applicable Medicare deductible and coinsurance amounts that apply to the covered E/M service.

Q. Can a provider who furnished an E/M service that could be described by a *CPT* consultation code to a Medicare beneficiary bill the beneficiary for his or her charge for the service after providing an ABN?

A. No, an ABN cannot be employed in these circumstances, because ABNs are applicable only where denial of payment is anticipated on grounds of the medical necessity requirement under section 1862(a)(1)(A) of the Social Security Act. E/M services previously reported using CPT consultation codes may be medically reasonable and necessary. *CPT* consultation codes *99241-99245* and *99251-99255* are now assigned status indicator "I," which means that these codes are not valid for Medicare purposes, and explicitly provides that "Medicare uses another code for the reporting of, and payment for these services."

Q. Can providers count floor/unit time toward the time threshold that must be met to bill a prolonged service with direct (face-to-face) patient contact in the inpatient setting?

A. The existing rules for counting time for purposes of meeting the prolonged care threshold times continue to apply. In particular, the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.15.1.C, provides that providers may count only the duration of direct face-to-face contact between the provider and the patient for these purposes and may not include time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient.

Q. Can a new patient office visit *CPT* code be billed to report an E/M service that could be described by a *CPT* consultation code when a patient is seen for a pre-operative consultation at the request of a surgeon, even if the consulting provider has provided a professional service to the beneficiary within the past three years?

A. Publication 100-04, Chapter 12, Section 30.6.7 of the *Medicare Claims Processing Manual* states: "Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a three-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an X-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient."
CMS has not adopted any revisions to the previous policies, regarding the billing of E/M codes as a result of the new policy on *CPT* consultation codes (other than allowing providers who would previously have billed the inpatient *CPT* consultation codes to bill the initial hospital and nursing home visit *CPT* codes where those codes appropriately describe the services furnished). Therefore, the requirements of Publication 100-04, Chapter 12, Section 30.6.7.A of the *Medicare Claims Processing Manual* remain in effect. In the situation where a patient is seen for a pre-operative consultation when the consulting provider has furnished a professional service to the beneficiary in the past three years, that provision precludes the provider from billing a new patient office visit *CPT* code.

Q. When may initial nursing facility (NF) care codes be reported for E/M services that could be described by CPT consultation codes?

A. Physicians may bill an initial NF care *CPT* code for their first visit during a patient's admission to a NF in lieu of the *CPT* consultation codes these physicians may have previously reported, when the conditions for billing the initial NF care *CPT* code are satisfied. The initial visit in a skilled nursing facility (SNF) and nursing facility must be furnished by a physician except as otherwise permitted as specified in CFR Section 483.40(c)(4).
The initial NF care *CPT* codes *99304-99306* are used to report the initial E/M visit in a SNF or NF that fulfills federally-mandated requirements under Section 483.40(c).

Q. What E/M code should physicians report for an initial E/M service that could be described by a *CPT* consultation code but that does not meet the requirements for reporting an initial NF care *CPT* code?

A. In these cases, physicians and other practitioners may bill a subsequent NF care *CPT* code in lieu of the *CPT* consultation codes they may have previously reported. Otherwise, the subsequent NF care *CPT* codes *99307-99310* are used to report either a federally-mandated periodic visit under Section 483.40(c), or any E/M service prior to and after the initial physician visit that is reasonable and medically necessary to meet the medical needs of the individual resident.

Q. When may NPPs furnish an initial NF E/M service?

A. In the NF setting, an NPP, who is enrolled in the Medicare program and is not employed by the facility, may perform the initial visit when the state law permits this (See this exception in Publication 100–04, Chapter 12, Section 30.6.13.A of the *Medicare Claims Processing Manual*). A NPP who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. As discussed in the CY 2010 MPFS proposed rule (74 FR 33543), the long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.

Q. How should E/M services previously reported by *CPT* consultation codes and provided in a split/shared manner be billed?

Questions and answers on reporting physician consultation services (continued)

A. The split/shared rules applying to E/M services remain in effect, including those cases where services would previously have been reported by *CPT* consultation codes.

Q. Does the policy of no longer recognizing *CPT* consultation codes for the purposes of Medicare billing apply to billing for physicians' services in hospices, where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice?

A. Yes, when hospices bill Part A for the services of physicians, they must use *CPT* codes that are paid under the MPFS. Since the *CPT* consultation codes are no longer recognized for payment under the MPFS, hospices must follow the same guidelines for reporting E/M services as physicians billing Part B. Hospices should use the most appropriate E/M codes to bill for E/M services furnished by physicians that could be described by *CPT* consultation codes.

Q. Will appending modifier A1 (Dressing for one wound) instead of the appropriate modifier AI (Principal physician of record) to the *CPT* code for an initial hospital or nursing home E/M service furnished by the principal physician of record affect payment to the provider for that service?

A. Because modifier AI (not modifier A1) is the appropriate modifier to identify an initial hospital or nursing home E/M service by the patient's principal physician of record, payment to the provider for the E/M service could be affected. Some Medicare contractors may reject an E/M code reported with modifier A1 as an invalid procedure code/modifier combination and, therefore, payment for the E/M service would not be made. In that case, the provider should submit a corrected claim reporting modifier AI appended to the E/M code. If an E/M code with modifier A1 appended has already been submitted and paid, the provider does not need to submit a corrected claim but should report the appropriate modifier AI on future claims for initial hospital or nursing home E/M services when the E/M service is furnished by the principal physician of record. Providers should contact their Medicare contractor for further assistance if necessary.

Q. Do admitting physicians still get paid if they do not report the modifier AI?

A. Yes, the use of the modifier is for informational purposes only.

Q. The transmittal, "Revisions to Consultation Services Payment Policy" (Transmittal # R1875CP, also referred to as CR 6740), indicates that the *CPT* consultation codes are not valid for Medicare. It also states Medicare uses a different code to report the service. However, the *MLN Matters*® article directed to providers states the consult codes are noncovered. When it comes to reporting services, there is a definite difference in these two terms. Please clarify.

A. The question refers to the following passage in the original *MLN Matters*® article:

Physicians who bill a consultation after January 1, 2010 will have the claim returned with a message indicating that Medicare uses another code for the service. The physician must bill another code for the service and may not bill the patient for a noncovered service.

The *MLN Matters*® article is being reissued to clarify this passage, consistent with the answer to the question that follows. The provider may not bill the patient in lieu of billing Medicare and may not have the patient sign an ABN to hold the patient personally responsible for the payment. CMS did not intend for this passage to suggest that E/M services that could be described by *CPT* consultation codes are noncovered. Rather, CMS intended to indicate that providers may not bill the patient for the E/M service that could be described by a *CPT* consultation code as though the E/M service was noncovered, as is now clarified in the reissued article. However, some people have interpreted the passage to suggest that providers cannot bill for an E/M service that could be described by a *CPT* consultation code because it is a noncovered service. The following language may clarify what CMS was trying to say in the cited passage:

Providers who bill an E/M service after January 1, 2010 using one of the *CPT* consultation codes (ranges *99241-99245*, and *99251-99255*) will have the claim returned with a message indicating that Medicare uses another code for reporting and payment of the service. To receive payment for the E/M service, the claim should be resubmitted using the appropriate E/M code as described in this article. Although CMS has eliminated the use of the *CPT* consultation codes for payment of E/M services furnished to Medicare fee-for-service patients, those E/M services themselves continue to be covered services if they are medically reasonable and necessary and, therefore, an ABN is not applicable. Furthermore, the patient may not be billed for the E/M service instead of Medicare.

Q. Does the new policy violate HIPAA rules by requiring providers to bill for E/M services that could be described by *CPT* consultation codes using codes other than the ones designated by *CPT*, which is the adopted code set under the law?

A. The HIPAA regulations place certain requirements on health plans. One of those requirements is that "a health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction." In addition, a health plan must "accept and promptly process any standard transaction that contains code sets that are valid" and *CPT*-4 has been accepted as the standard medical data code set for, among other things, physician services. However, the regulations also state that "all parties [must] accept these codes within their electronic transactions . . . [but does not require] payment for all of these services."

As of January 1, 2010, Medicare will no longer recognize for payment *CPT* consultation codes. Instead, CMS is instructing providers to use the most appropriate office or inpatient E/M code to report E/M services that could be described by *CPT* consultation

Questions and answers on reporting physician consultation services (continued)

codes. This policy change was adopted after going through notice and comment rulemaking and the payment rates for certain E/M services were increased to maintain budget neutrality and to ensure all providers were being paid equivalently for equivalent work. Further, CMS is not changing the definition of any of the existing E/M codes as a result of this policy. Claims with the *CPT* consultation codes are not rejected. Instead, Medicare accepts a claim that reports a *CPT* consultation code, processes it, and returns the claim to the provider to report an E/M code for the service that is recognized by Medicare for payment because CMS does not pay for the *CPT* consultation codes. In other words, accepting claims with *CPT* codes (including consultation codes) from the adopted code set, and then processing (paying, denying, or returning the claim to the provider to report a code that is recognized by Medicare for payment) those claims in accordance with the MPFS ensures that Medicare is fulfilling its obligation to "accept" and "process" standard transactions that contain valid code sets. It is not the intention of CMS to cause confusion or make the Medicare program more administratively complex.

Additional information

If you have questions, please contact your Medicare 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 6740, issued to Medicare MACs and carriers regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1875CP.pdf*.

The related *MLN Matters* article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf*.

Medicare manuals are available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

The E/M documentation guidelines are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*.

MLN Matters® Number: SE1010
Related Change Request (CR) #: 6740
Related CR Release Date: N/A
Effective Date: January 1, 2010
Related CR Transmittal #: N/A
Implementation Date: January 4, 2010

Revisions to consultation services payment policy

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

Note: This article was revised on February 24 to clarify some language and to add a reference to a related special edition article SE1010. All other information remains the same. This information was previously published in the December 2009 *Medicare B Update!* pages 19-22.

Provider types affected

This article is for physicians and nonphysician practitioners (NPPs) who perform the initial evaluation and management (E/M) consultation for Medicare beneficiaries and submit claims to Medicare carriers, fiscal intermediaries (FIs) and/or Medicare administrative contractors (MACs) for those services. It is also intended for Method II critical access hospitals, which bill for the services of those physician and nonphysician practitioners who have reassigned their billing rights.

This article only applies to billing for physician services under the Medicare fee-for-service program. It does not revise existing policies or rules governing Medicare Advantage or non-Medicare insurers.

Provider action needed

This article pertains to change request (CR) 6740, which alerts providers that effective January 1, 2010, the *Current Procedural Terminology* (*CPT*) consultation codes (ranges *99241-99245* and *99251-99255*) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents **where** the visit occurs and that identify the **complexity** of the visit performed. See the *Key points* section of this article for details.

Background

In the calendar year 2010 Medicare physician fee schedule (MPFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation HCPCS G codes.

The change will not increase or decrease Medicare payments. In place of the consultation codes, CMS increased the work relative value units (RVUs) for new and established office visits, increased the work RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6 that pertain to the use of the American Medical Association (AMA) *Current Procedural Terminology* (*CPT*) consultation codes (ranges *99241-99245* and *99251-99255*) are removed by CR 6740. (The Web address for viewing CR 6740 is in the *Additional information* section of this article.)

Key points of CR 6740

- Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA *CPT*

Revisions to consultation services payment policy (continued)

consultation codes (ranges *99241-99245*, and *99251-99255*) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings.

- Effective January 1, 2010, local fiscal intermediaries and/or A/B MACs will no longer recognize American Medical Association (AMA) *CPT* consultation codes (ranges *99241-99245*, and *99251-99255*) for Method II CAHs, when billing for the services of those physician and nonphysician practitioners who have reassigned their billing rights.
- Physicians may employ the 2009 consultation service codes, where appropriate, to bill for consultative services furnished up to and including December 31, 2009.
- Providers who bill an E/M service after January 1, 2010, using one of the *CPT* consultation codes (ranges *99241-99245* and *99251-99255*) will have the claim returned with a message indicating that Medicare uses another code for reporting and payment of the service. To receive payment for the E/M service, the claim should be resubmitted using the appropriate E/M code as described in this article. Although CMS has eliminated the use of the *CPT* consultation codes for payment of E/M services furnished to Medicare fee-for-service patients, those E/M services themselves continue to be covered services if they are medically reasonable and necessary and, therefore, an ABN is not applicable. Furthermore, the patient may not be billed for the E/M service instead of Medicare.
- RHCs and FQHCs will discontinue use of AMA *CPT* consultation codes *99241*-99245 and *99251-99255* and should instead use the E/M codes that most appropriately describe the E/M services that could be described by the *CPT* consultation codes.
- Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.
- In the inpatient hospital setting and nursing facility setting, any physicians and qualified NPPs who perform an initial evaluation may bill an initial hospital care visit code (*CPT* code *99221-99223*) or nursing facility care visit code (*CPT 99304-99306*), where appropriate.
- In all cases, physicians will bill the available code that most appropriately describes the level of the services provided.
- The principal physician of record will append modifier AI (Principal physician of record) to the E/M code when billed. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed.
- However, claims that include the AI modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.
- For patients receiving hospital outpatient observation services who are not subsequently admitted to the hospital as inpatients, physicians should report *CPT* codes *99217-99220*. In the event another physician evaluation is necessary, the physician who provides the additional evaluation bills the office or other outpatient visit codes when they provide services to the patient.

  For example, if an internist orders observation services, furnishes the initial evaluation, and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established patient office or other outpatient visit codes as appropriate.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients and who are discharged on the same date, the physician should report *CPT* codes *99234-99236* (e.g., Code *99234-Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date*). If the patient is an inpatient and another physician evaluation is necessary, the physician would bill the initial hospital day code as appropriate (*99221-99223*). Otherwise, the physician should use the new or established patient office or other outpatient visit codes for a necessary evaluation.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients on the same date, the physician should report only the initial hospital care services codes (codes *99221-99223*). Medicare will pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. When a physician performs a visit that meets the definition of a level five office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code *99221*) for the initial hospital admission. Medicare will pay the office visit as billed and the level one initial hospital care code. The principal physician of record, as previously noted, must append the AI modifier to the claim with the initial hospital care code.
- For patients receiving hospital outpatient observation services or inpatient care services (including admission and discharge services) for whom observation services are initiated or the hospital inpatient admission begins on the same date as the patient's discharge, the ordering physician should report *CPT* codes *99234-99236*.

Revisions to consultation services payment policy (continued)

- Emergency department visits (codes *99281-99288*) – physician billing for emergency department services provided to patient by both the patient's personal physician and emergency department (ED) physician. If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician may not bill.
- If the ED physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.
- Follow-up visits by the physician in the facility setting should be billed as subsequent hospital care visits for hospital inpatients and subsequent nursing facility care visits for patients in nursing facilities, as is the current policy.
- In the office or other outpatient setting where an evaluation is performed, physicians and qualified NPPs should report the *CPT* codes (*99201-99215*) depending on the complexity of the visit and whether the patient is a new or established patient to that physician.
- A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous three years. Examples of where a new patient office is not billable:
  - If the consultant furnishes a pre-operative consultation at the request of a surgeon on a beneficiary and the consultant has provided a professional service to the patient within the past three years, then this situation would not meet the requirements to bill a new patient office visit.
  - The consultant could not bill for a new patient office visit for a consultation furnished to a known beneficiary for a different diagnosis than he or she has previously treated if the patient was seen by the consultant in the prior three years.
  - The consultant furnishes a consultation to a known beneficiary in an outpatient setting different than the office (e.g., emergency department) observation where the patient was seen in the past three years. As the patient has been seen by the consultant within the past three years, a new patient office visit cannot be billed.
- In order for physicians to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a level five new patient visit, the history must meet *CPT's* definition of a comprehensive history).
- Medicare may pay for an inpatient hospital visit or an office or other outpatient visit if one physician or qualified NPP in a group practice requests an evaluation and management service from another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge.
- Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:
  - Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or
  - Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

  We note that the first option may be easier from a billing and claims processing perspective.
- All physicians and qualified NPPs need to follow the E/M documentation guidelines, which are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*.
- Medicare contractors will use the following threshold times to determine if the prolonged services codes *99354* and/or *99355* can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes. Threshold time for prolonged visit codes *99354* and/or *99355* billed with office outpatient visit are as follows (all times in minutes):

Code	Typical time for code	Threshold time to bill code *99354*	Threshold time to bill codes *99354* and *99355*
99201	10	40	85
99202	20	50	95
99203	30	60	105

Revisions to consultation services payment policy (continued)

Code	Typical time for code	Threshold time to bill code *99354*	Threshold time to bill codes *99354* and *99355*
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

- Threshold time for prolonged visit codes *99356* and/or *99357* billed with inpatient setting codes are as follows (all times in minutes):

Code	Typical time for code	Threshold time to bill code *99356*	Threshold time to bill codes *99356* and *99357*
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

- Appropriate documentation is required to support the billing of the prolonged visit codes.
- The existing rules for counting time for purposes of meeting the prolonged care threshold times continue to apply. In particular, the *Medicare Claims Processing Manual*, Chapter 12, 30.6.15.1.C, provides that physicians may count only the duration of direct face-to-face contact between the physician and the patient for these purposes, and may not include time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient.

Revisions to consultation services payment policy (continued)

Additional information

If you have questions, please contact your Medicare MAC, FI, 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 6740, issued to Medicare MACs and carriers regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf*.

You may also want to review the related article SE1010 (Questions and Answers on Reporting Physician Consultation Services), which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf*.

The E/M documentation guidelines are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*.

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Related Change Request (CR) #: 6740
Related CR Release Date: December 14, 2009
Effective Date: January 1, 2010
Related CR Transmittal #: R1875CP
Implementation Date: January 4, 2010

Physician consultation codes no longer valid for Medicare

In December 2009, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6740 instructing that as of January 1, 2010, *Current Procedural Terminology* (*CPT*) consultation codes *99241-99245* and *99251-99255* are no longer valid for Medicare Part B billing. Because this affects Part A billing as well, CMS will be issuing a separate CR to address Part A billing as it relates to these services. In the interim, hospices should look to CR 6740 for instructions (excluding those related to the use of modifier AI) as to how to bill for these services. CR 6740 is available at *http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf*.

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Source: CMS PERL 201002-42

Laboratory/Pathology

Revised clinical laboratory fee schedule and ZIP code file

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/suppliers submitting reference laboratory claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in Johnson and Wyandote Counties in the state of Kansas.

Provider action needed

This article is based on change request (CR) 6787 which instructs the Medicare contractors to incorporate an additional Kansas payment locality in the clinical laboratory fee schedule (CLFS) into their system to ensure correct pricing for certain laboratory claims submitted with a modifier 90 for services performed in the Kansas payment localities.

Background

The Centers for Medicare & Medicaid Services (CMS) discovered that there is an inconsistency in the payment rates for claims submitted with Kansas ZIP codes in an east Kansas locality for reference laboratory claims. While regular laboratory claims are being paid correctly, reference laboratory claims are not being paid at the correct rate. CR 6787 corrects this deficiency.

During the transition to the A/B MAC, Wisconsin Physician Services (WPS) uses a process to pay in-state clinical laboratory services billed by the performing physician/suppliers in two counties (Johnson and Wyandotte) in Kansas at the Northwest Missouri (NWMO) rates. This unique circumstance is because of a historical contractor configuration. Two payment localities existed prior to contractor consolidation because there were two contractor jurisdictions in the state

Revised clinical laboratory fee schedule and ZIP code file (continued)

of Missouri. The jurisdiction in western Missouri included ZIP codes in both states of Missouri and Kansas, and with consolidation, the Western Missouri area was absorbed by the contractors for Missouri and Kansas. WPS uses a process that accommodates this issue.

However, clinical laboratory reference services billed by independent laboratory suppliers were not allowed at the NWMO rates and are reimbursed at the single Kansas locality rate, which represents the western Kansas region.

Medicare contractors currently use the ZIP Code files to price claims for ambulance, physician, and reference lab services. CR 3090 (Transmittal 85, February 6, 2004) requires contractors to price reference laboratory services based on the ZIP code of the performing laboratory. For reference laboratory services, the ZIP code file associates the ZIP codes in Johnson and Wyandotte counties with Kansas locality 00, not Western Missouri locality 02. The result is that the system allows the Kansas rate and not the Western Missouri rate. You may find the *MLN Matters*® article for CR 3090 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3090.pdf*.

To correct this problem for 2010 and after, CMS has added new payment localities in the 2010 clinical lab fee schedule. The 2010 ZIP code file refers to two Kansas lab localities to correct this inconsistency. This allows reference laboratory services performed in Johnson and Wyandotte counties to be paid at the NWMO rates. For 2010, CMS provided a CLFS which included two payment locality numbers for East and West Kansas as follows:

- Contractor #05202/locality 12 indicates West Kansas, and
- Contractor #05202/locality 15 indicates East Kansas.

The 2010 ZIP code files were also revised to reflect these 2 state codes as "EK" for East Kansas and "WK" for West Kansas.

CR 6787 provides instructions for correcting the inconsistency for dates of service prior to 2010, and instructs claims processing contractors to incorporate the above changes into the CLFS and use the 2010 ZIP code file to process claims with dates of service prior to 2010.

Note: Medicare will adjust, as necessary, claims submitted by providers in the affected localities with dates of service in calendar years 2008 and 2009. If a provider presents a claim prior to calendar year 2008 with a 90 modifier with proof that the claim was paid incorrectly, Medicare Contractors will adjust the claim on a claim by claim basis.

Additional information

The official instruction, CR 6787, issued to your carrier and A/B MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R638OTN.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*.

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Related Change Request (CR) #: 6787
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Effective Date: July 1, 2010
Related CR Transmittal #: R638OTN
Implementation Date: July 6, 2010

Surgery

Percutaneous transluminal angioplasty of the carotid artery concurrent with stenting

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

Provider types affected

Physicians and providers who may wish to submit claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs) for PTA with stenting of the carotid arteries are affected.

Provider action needed

This article is based on change request (CR) 6839 which announces that for claims with dates of service on and after December 9, 2009, contractors will be aware that there is revised language specific to embolic protection devices (EPDs) for percutaneous transluminal angioplasty (PTA) concurrent with carotid artery stenting (CAS) system placement in Food and Drug Administration (FDA)-approved post-approval studies, and PTA Concurrent with CAS system placement in patients at

Percutaneous transluminal angioplasty of the carotid artery concurrent with stenting (continued)

high risk for carotid endarterectomy. The revised language specific to EPDs is located in Pub. 100-03, national coverage determination (NCD) 20.7.B.3 and 20.7.B.4, and Pub. 100-04, Chapter 32, Section 160. Make sure your billing staff is aware of the revised language.

Background

Under the previous NCD policy, patients at high risk for carotid endarterectomy (CEA) who have symptomatic carotid artery stenosis equal to or greater than 70 percent are covered for procedures performed using FDA-approved CAS systems with EPDs in facilities approved by the Centers for Medicare & Medicaid Services (CMS) to perform CAS procedures.

In addition, patients at high risk for CEA with symptomatic carotid artery stenosis between 50 percent and 70 percent and patients at high risk for CEA with asymptomatic carotid artery stenosis equal to or greater than 80 percent are covered in accordance with the Category B investigational device exemption (IDE) clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (*Medicare NCD Manual* 310.1), or in accordance with the NCD on CAS post-approval studies (*Medicare NCD Manual* 20.7B). If deployment of the EPD is not technically possible, then the procedure should be aborted given the risks of CAS without distal embolic protection.

Policy

CMS internally generated a reconsideration of Section 20.7B4 of the *Medicare NCD Manual*. CMS made no changes in the covered patient groups for PTA of the carotid artery concurrent with stenting, but slightly revised the language regarding EPDs. In the final decision, effective December 9, 2009, CMS retained existing coverage for the following with a slight revision to the language regarding EPDs:

- For patients who are at high risk for CEA and who also have symptomatic carotid artery stenosis equal to or greater than 70 percent, coverage is limited to procedures performed using FDA-approved CAS systems and FDA-approved or FDA-cleared EPDs.
- For patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50 percent and 70 percent, in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (*Medicare NCD Manual* 310.1), or in accordance with the NCD on CAS post-approval studies (*Medicare NCD Manual* 20.7B), coverage is limited to procedures performed using FDA-approved CAS systems and FDA-approved or FDA-cleared EPDs. (If deployment of the EPD is not technically possible, and not performed, then the procedure is not covered.), and
- For patients who are at high risk for CEA and have asymptomatic carotid artery stenosis equal to or greater than 80 percent, in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (*Medicare NCD Manual* 310.1), or in accordance with the NCD on CAS post-approval studies (*Medicare NCD Manual* 20.7B), coverage is limited to procedures performed using FDA-approved CAS systems and FDA-approved or FDA-cleared EPDs.

The use of an FDA-approved or cleared EPD is required. If deployment of the EPD is not technically possible and not performed, then Medicare does not cover the procedure.

Note: This CR does not require new or revised claims processing instructions.

Additional information

For complete details regarding this CR, please see the official instruction (CR 6839) issued to your Medicare carrier, FI, or A/B MAC at *http://www.cms.hhs.gov/Transmittals/downloads/R1925CP.pdf*.

The CAS facilities "approved facilities" Web site link in Publication 100-03, The *National Coverage Determinations Manual*, may be found at *http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp*.

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

MLN Matters Number: MM6839
Related Change Request (CR) #: 6839
Related CR Release Date: March 5, 2010
Effective Date: December 9, 2009
Related CR Transmittal #: R1925CP
Implementation Date: April 5, 2010

General Coverage

CPT/HCPCS codes to avoid rejections/denials due to gender/procedure conflict

As a result of transgender and hermaphrodite issues, Medicare Part A and Part B claims have encountered an increase in claims being rejected/denied due to gender specific diagnosis and procedure edits.

Effective for dates of service on and/or after April 1, 2010, change request (CR) 6638 instructs the following:

Part A claims: Institutional providers must report condition code 45 (Ambiguous gender category) on inpatient or outpatient services that may be subjected to gender specific editing (i.e., services that are considered female or male only) for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

Part B claims: Physicians and nonphysician practitioners billing Part B professional claims must bill modifier KX (Requirements specified in the medical policy have been met) on the detail line with any procedure code(s) that are gender specific for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

Gender specific CPT/HCPCS codes

To assist providers in decreasing the number of rejections/denials, First Coast Service Options Inc. has identified gender specific *CPT*/HCPCS codes that the Medicare processing systems will denied/reject for services processed on or after April 5, 2010. The common working file error codes are also indicated:

Mammography (error codes 59x5 and 5361)

76083	*76085*	*76092*	*77052*	*77057*	G0202	G0203

PAP smear (error codes 84x1 and 536a)

G0123	G0124	G0141	G0143	G0144	G0145	G0147
G0148	P3000	P3001	Q0091	Q0060	Q0061	

Pelvic/breast exam (error code 84x4)

G0101

Prostate screen (error codes 84x6 and 5388)

55873	G0102	G0103	G0160	G0161

Source: Publication 100-04, Transmittal 1877, Change request 6638

Medically unlikely edits

Note: Transmittal 617, dated January 8, 2010, has been rescinded and replaced with Transmittal 652, dated March 17, 2010. The new transmittal (1) clarifies the reference to the manual section authorizing medically unlikely edits (MUEs), and (2) clarifies the name of files for the final durable medical equipment (DME) list of MUEs, and provides the denial reason code to be used for MUE denials. This information was previously published in the January 2010 *Medicare B Update!* pages 22-23.

Background

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

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

Medically unlikely edits (continued)

Key points

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

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

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

76 Repeat procedure by same physician
77 Repeat procedure by another physician
91 Repeat clinical diagnostic laboratory test
59 Distinct procedural service

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

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

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

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

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

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

Policy

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

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

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, *Program Integrity Manual (PIM)*, Chapter 3, Section 3.5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

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

Since claim lines are denied, denials may be appealed.

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

Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and contractors will download via the network data mover.

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

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

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

Additional information

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

For complete details regarding CR 6712 please see the official instruction issued to your Medicare FI, carrier or A/B MAC. That instruction may be viewed by going to *http://www.cms.hhs.gov/transmittals/downloads/R652OTN.pdf* on the CMS Web site.

Source: Publication 100-20, Transmittal 652, Change request 6712

Signature requirements for medical review purposes – guidelines for authentication of Medicare services

The Centers for Medicare & Medicaid Services (CMS) requires that any Medicare service provided or ordered must be authenticated by the author **–** the one who provided or ordered that service. Authentication may be accomplished through the provision of a hand-written or an electronic signature; however, stamp signatures are unacceptable.

In addition, any documentation submitted to substantiate the medical necessity for a service billed to Medicare must clearly identify the patient, date of service, and the provider of the service. The purpose of the authentication (signature) requirement is to ensure that the services rendered have been accurately and appropriately documented, reviewed, and authenticated.

Summary of signature guidelines – acceptable forms of authentication

The following methods of authentication have been deemed acceptable by CMS:

- **Handwritten signature** – a mark or a sign placed on a medical document to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services specified in the medical entry. Requirements for this form of authentication are dependent upon whether the signature is considered legible or illegible.
  - **Legible signature** – acceptable forms of presentation:
    - Legible full signature
    - Legible first initial and last name
    - Initials placed above a typed or printed name
    - Initials accompanied by a signature log – lists the typed or printed name of the author associated with initials or an illegible signature. Signature logs may be included on the page where the initials or illegible signature is used, or it may be submitted as a separate document.
    - Initials accompanied by an attestation statement – must be signed and dated by the author of the medical record entry, must be associated with a specific medical entry, and must contain sufficient information to identify the beneficiary.

    Note: An unsigned handwritten note may be accepted as authentication when other entries on the same page are in the same handwriting and have been signed.
  - **Illegible signature** – acceptable forms of presentation:
    - Illegible signature placed above a typed or printed name
    - Illegible signature where the letterhead, addressograph, or other information on the page indicates the identity of the individual who signed the entry. For example, the provider's name could be circled to indicate the identity of the individual who signed the entry.
    - Illegible signature accompanied by a signature log – lists the typed or printed name of the author associated with initials or an illegible signature. Signature logs may be included on the page where the initials or illegible signature is used, or it may be submitted as a separate document.
    - Illegible signature accompanied by an attestation statement – must be signed and dated by the author of the medical record entry, must be associated with a specific medical entry, and must contain sufficient information to identify the beneficiary.
  - **Electronic signatures** – an electronic sound, symbol, or process attached to or logically associated with an electronic medical record to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services specified in the medical entry.
    - Electronic signatures must be authenticated, safeguarded against misuse and modification, and should be easily identifiable as electronic, rather than typewritten, signatures.
    - As the individual represented by the electronic signature bears responsibility for the authenticity of the information, physicians are strongly encouraged to check with their attorneys and malpractice insurers regarding the use of alternative signature methods.

Summary of signature guidelines – unacceptable forms of authentication

The following methods of authentication have been deemed **unacceptable** by CMS and may result in a CERT error:

- Unsigned, typed note with provider's typed name.
- Unsigned, typed note without provider's typed name
- Unsigned, handwritten note (only entry on the page)
- Illegible signature that is not placed above a typed or printed name
- Illegible signature that is not identified in a letterhead or addressograph

Signature requirements for medical review purposes – guidelines for authentication of Medicare services (continued)

- Illegible signature that is not accompanied by a signature log or attestation statement
- Stamp signature
- "Signature on file"

Summary of signature guidelines – 20-day timeframe documentation requests

If a claim reviewer requests an attestation statement or a signature log to authenticate a medical record, the organization that billed the claim **must** submit the documentation to the requestor **within 20 calendar days.**

The **20-day timeframe begins when:**

- The reviewer makes actual phone contact with the provider, **or**
- The reviewer's request letter is received by the U.S. post office

Signature requirements – exceptions

- **Certification of terminal illness for hospice** – a facsimile of an original written or electronic signature is an acceptable form of authentication for certification of terminal illness for hospice.
- **Orders for clinical diagnostic tests** – an unsigned order for a clinical diagnostic test that is accompanied by signed medical documentation that demonstrates the treating physician's intent for the test to be performed is an acceptable form of authentication for the test.

Note: Other regulations and CMS instructions regarding signature requirements, such as timeliness standards for particular benefits, take precedence over the guidelines listed above. In cases where the relevant regulation, coverage determination, or CMS manual outlines specific signature requirements (e.g., signatures on plans of care must be signed before those services are rendered), those signature requirements will take precedence.

e-Prescribing (eRx) signature requirements

Electronic prescribing is the transmission of prescription or prescription-related information through electronic media. Health care professionals can electronically transmit new prescriptions as well as responses to renewal requests directly to a pharmacy through a qualified eRx system, which eliminates the necessity for writing or faxing prescriptions for non-controlled substances.

Note: CMS defines a "qualified eRx system" as one that meets the Medicare Part D requirements described in Standards for Electronic Prescribing (42 CFR 423.160, available at *http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms0018ifc.pdf#page=4***).**

- **e-Prescribing for Part B drugs: Non-controlled substances** – if a provider submits an order for a non-controlled substance through a qualified eRx system, the provider is not required to produce a signed hardcopy as evidence to substantiate the drug order.
- **e-Prescribing for Part B drugs: Controlled substances** – the Drug Enforcement Agency (DEA) does not permit the prescribing of controlled substances through e-Prescribing systems; therefore, only a signed (pen and ink) hardcopy of the prescription will be accepted as evidence to substantiate a drug order for controlled substances.

Note: CMS outlines signature requirements for medical documentation as well as exceptions to the guidelines in the *Medicare Program Integrity Manual***,** Chapter 3, Section 3.4.1.1, available at *http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf#page=19***.**

Source: Change request 6698

Electronic Health Records

Electronic health records cooperative agreement awards

The following is a message from Dr. David Blumenthal on advancing health information exchange

The *Health Information Technology Agency* announced on February 12 the first cooperative agreement awards authorized by the *Health Information Technology for Economic and Clinical Health (HITECH) Act*. It marks a major milestone in the journey towards nationwide adoption and meaningful use of health information technology (health IT). One set of awards provides $386 million to 40 states and qualified state-designated entities to rapidly build capacity for exchanging health information across the health care system both within and between states through the *State Health Information Exchange Cooperative Agreement Program* (*http://healthit.hhs.gov/portal/server.pt?open=512&objID=1488&mode=2*). The other awards provide $375 million to create 32 *Health Information Technology Regional Extension Centers* (RECs) (*http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&mode=2*) that will support the efforts of health professionals, starting with priority primary care providers, to become meaningful users of electronic health records (EHRs). Additional awards will be made in both programs over the coming weeks. Together, these programs will help modernize the use of health information, improving the quality and efficiency of care for all Americans.

As part of the State Health Information *Exchange Cooperative Agreement Program*, states will play a leadership role in achieving health information exchange (HIE) to meet health reform goals. The funds awarded will be used to establish and implement plans for statewide HIE by creating the appropriate governance, policies, and technical services required to support HIE. Developing this state-level capability will help us break down the current barriers to HIE and help providers to qualify for Medicare and Medicaid incentives under the HITECH Act. The awards will also strongly encourage states to consider participating in the *Nationwide Health Information Network* as an approach to HIE. This would create a pathway toward seamless, nationwide HIE.

While the state HIE awards will strengthen capacity for health information exchange, the *Health Information Technology Extension Program* (*http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&mode=2*) awards will establish RECs to deliver direct outreach, education, and technical assistance services to health care providers in their regions. Each REC will focus most intensively on the physicians, physician assistants, and nurse practitioners who work as part of individual and small group primary care practices, as well as those who dedicate themselves to providing health care to the underserved. Primary care providers in small practices provide the great majority of such services in the U.S. but have limited resources to implement, meaningfully use, and maintain EHR systems. On-site technical assistance for these priority primary care providers will be a key service offered by the RECs. RECs will assist providers who have not adopted EHRs, as well as those who have but need help progressing to meaningful use. RECs will also help providers keep health information private and secure.

The *Health Information Technology Extension Program* and the *State Health Information Exchange Cooperative Agreement Program* are critical components to the end of a nationwide interoperable, private and secure electronic health information system. I look forward to working in collaboration with each state and REC as they establish their programs, begin work within their communities, and promote the transformation of our health care system. I applaud each awarded entity for its dedication to the mission of improving the quality of health care and for the leadership and guidance it will provide.

Sincerely,

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

The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology.

Source: CMS PERL 201002-37

Proposed rule for the certification programs for health information technology

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

On March 2, 2010, the Secretary of the Department of Health & Human Services (HHS) released a notice of proposed rulemaking (NPRM) outlining the proposed approach for establishing a certification program to test and certify electronic health records (EHRs). The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) mandates the development of a certification program that will give purchasers and users of EHR technology assurances that the technology and products have the necessary functionality and security to help meet meaningful use criteria.

While we are making significant strides toward modernizing our health-care system, these efforts will only succeed if providers and patients are confident that their health information systems are safe and functional.

The proposed rule incorporates two phases of development for the certification program to ensure that eligible professionals and eligible hospitals are able to adopt and implement certified EHR technology in time to qualify for meaningful use incentive payments. The rulemaking process will take time, so this phased approach provides a bridge to detailed guidelines to support an ongoing program of testing and certification of health IT.

The first proposed program creates a temporary certification process under which the national coordinator would authorize organizations to assume many of the responsibilities that will eventually be fulfilled under the permanent certification program. For the permanent certification program, the rule proposes transitioning much of the responsibility for testing and certification to organizations in the private sector.

Publication of the proposed rule on the Establishment of Certification Programs for Health Information Technology is an important first step in bringing structure and cohesion to the evaluation of EHRs, EHR modules, and potentially other types of health IT. The programs will help support end users of certified products, and ultimately serve the interests of each patient by ensuring that their information is securely managed and available where and when it is needed.

Your input is essential to bringing this important process to fruition. We encourage your participation in the open public comment period.

Additional information on both of these programs and how you can comment may be found through the HHS news release and at *http://HealthIT.HHS.Gov*.

The vision of the HITECH Act is unfolding rapidly, and all of us at ONC look forward to continuing to work with you to achieve the meaningful use of EHRs.

Sincerely,

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

Source: CMS PERL 201003-07

General Information

Internet-based PECOS for physicians, nonphysician practitioners, and solely-owned organizations

To assist in protecting, completing, and submitting your Medicare enrollment application via Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the following enrollment reminders and tips are being provided by the Centers for Medicare & Medicaid Services (CMS).

Protect your privacy: Physicians and nonphysician practitioners need to take steps to ensure that their Medicare enrollment information does not get into the hands of people who may use that information to commit fraud. (See the document titled, "Medicare Physicians and Non-Physician Practitioners - Protecting Your Privacy, Protecting Your Medicare Enrollment Record." This document may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/MedPhysPrivacy.pdf*).

Organizations must be enrolled before individuals: Before a physician or nonphysician practitioner can reassign their benefits to a medical group or clinic other than the one they solely own, the medical group or clinic must have an approved enrollment record in PECOS.

Initial enrollment application for an individual: Physicians and nonphysician practitioners who have not enrolled or updated their Medicare enrollment since November 2003 will need to complete an initial enrollment application. PECOS does not contain information for physicians and nonphysician practitioners enrolled before November 2003 who have not updated their enrollment record since that time.

Using Internet-based PECOS: CMS suggests you use Internet-based PECOS because it is faster and more efficient than the paper enrollment application process. Before you begin to use Internet-based PECOS, you should:

Internet-based PECOS for physicians, nonphysician practitioners, and solely-owned organizations (continued)

- Be sure that you have the national provider identifier (NPI) that was assigned to you as an individual and, if you solely own an organization provider, the NPI assigned that was assigned to your organization.
- Review the document titled "Internet-based PECOS -- Getting Started Guide for Physicians and Non-Physician Practitioners." This document may be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf*.

Internet-based PECOS limitations: While Internet-based PECOS supports most Medicare enrollment application actions, there are some limitations. A physician or nonphysician practitioner cannot use Internet-based PECOS for the following:

- Change his/her name or social security number
- Reassign benefits to another supplier if that supplier does not have an approved enrollment record in PECOS
- Change in nonphysician practitioner specialty type, or
- Change an existing business structure. For example:
  - A sole sole proprietorship cannot be changed to a solely-owned professional association, professional owner of an enrolled professional association, professional corporation, or LLC cannot change the business structure to a sole proprietorship, or
  - An enrolled corporation, or LLC.

Finalizing submission and responding to development request: After submitting an enrollment application via Internet-based PECOS, you:

- Must print, sign and date (blue ink recommend) the certification statement(s) and mail the certification statement(s) and supporting documentation to the appropriate Medicare contractor. The Medicare contractor will not begin to process your enrollment application until it receives a signed and dated certification statement.
- May be asked to make corrections or submitted additional documents by the Medicare contractor. In order for your application to be processed, you must submit this information.

Reporting responsibilities: Physicians and nonphysician practitioners enrolled in the Medicare program have reporting responsibilities. See the *Download* section found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* for information about your reporting responsibilities.

More information: For more information about Internet-based PECOS, including contact information for the External User Services (EUS) Help Desk, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll* and select the "Internet-based PECOS" tab on the left side of screen.

EUS Help Desk provides assistance physicians and nonphysician practitioners if they encounter an application navigation or systems problem with Internet-based PECOS. A navigation problem occurs when a practitioner is unable to determine how to use Internet-based PECOS.

Physicians and nonphysician practitioners who have problems with their user IDs or password should contact the NPI enumerator at 1-800-465-3203.

Source: CMS PERL 201003-09

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

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

Note: This article was revised on February 23 to reflect changes made to change request (CR) 6278 on January 29. The article was revised to include the three scenarios in the *Background* section. The CR release date, transmittal number, and the Web address for accessing CR 6278 were also revised. All other information remains the same. This information was previously published in the October 2009 *Medicare B Update!* pages 27-28.

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

Go – what you need to do

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

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

Background

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

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

Medicare contractors will deactivate the billing privileges for the practice locations associated with any provider transaction access number (PTAN) of any letter returned by the post office as undeliverable and the contractor does not already have a change of address enrollment application pending based on the following three scenarios:

- **Scenario 1**: If the provider has one PTAN and multiple practice locations, contractors will deactivate the practice location of the returned letter and mail a revalidation letter to the special payment or correspondence address of the provider/supplier. If the provider/supplier does not respond to the revalidation letter, the Medicare contractor will revoke all practice locations.
- **Scenario 2**: If a provider/supplier has two or more PTANs and multiple practice locations, the contractor will deactivate the practice location of the returned letter(s) and mail a revalidation letter to the provider's special payment or correspondence address. If the provider does not respond for all PTANs, the contractor will revoke all practice locations. If the provider responds for only one of the PTANs, the contractor will deactivate the practice locations of the PTANs for which there was no response.
- **Scenario 3**: If a letter is returned for a provider whose only practice location is a hospital or skilled nursing facility, the contractor will not deactivate that providers' PTAN, but will mail a follow-up letter and revalidation request to the provider's correspondence address.

The follow-up revalidation letter will explain the need to report current address information via a CMS-855 form.

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

Additional information

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

The official instruction, CR 6278, issued to your Medicare carrier or MAC regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R626OTN.pdf*.

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

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

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

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

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

MLN Matters® Number: MM6278 *Revised*
Related Change Request (CR) #: 6278
Related CR Release Date: January 29, 2010
Effective Date: November 2, 2009
Related CR Transmittal #: R626OTN
Implementation Date: November 2, 2009

Medicare contractor provider satisfaction survey information

Attention fee-for-service providers and suppliers, have you responded?

The Centers for Medicare & Medicaid Services (CMS) wants to hear from you about your satisfaction with the services provided by the Medicare fee-for-service (FFS) contractor that processes and pays your Medicare claims.

CMS is now conducting the fifth national administration of the Medicare contractor provider satisfaction survey (MCPSS). The results of this annual survey are used by CMS to monitor trends, improve contractor oversight, and increase efficiency of the Medicare program. The MCPSS provides contractors with more insight into their provider communities and allows them to make process improvements based on provider feedback.

In January, CMS notified approximately 30,000 Medicare FFS providers and suppliers that they were randomly selected to participate in the 2010 study. CMS urges all selected health care providers and suppliers to take a few minutes to complete and return this important survey.

CMS recognizes that each provider and supplier's time is limited; therefore, if you have been notified that you were selected to participate in this study and have not yet done so, we welcome you to designate a proxy who you believe to be the most knowledgeable person in your practice to answer the survey questions on your behalf. This person may be your management or billing personnel or other knowledgeable designee. You may designate a proxy to respond on your behalf by e-mailing the designated proxy's name, telephone number, mailing and e-mail addresses to SciMetrika (*mcpss@scimetrika.com*), the public health consulting firm, contracted by CMS to administer the MCPSS study. SciMetrika will then send survey instructions to the designee to facilitate a quick completion of the survey without interrupting your day-to-day operations.

If you prefer to personally respond to the survey questions yourself and no longer have your online survey tool access information or need help accessing the survey tool, please call the MCPSS Provider Helpline at 1-800-835-7012 or send an e-mail to *mcpss@scimetrika.com*. Someone on the MCPSS team will be happy to assist you.

The views of every health care professional asked to participate in the 2010 study are very important to the success of this study, as each one of you represents many other organizations that are similar in size, practice type, and geographical location. Please complete and return your survey today. CMS is waiting to hear from you.

Please note: Only providers and suppliers already notified that they have been randomly selected to take part in the 2010 MCPSS may participate in this study. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

For more information about the MCPSS, please visit the CMS MCPSS Web site at *http://www.cms.hhs.gov/mcpss*, or read the CMS *MLN Matters* special edition article SE1005 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf* featuring the survey.

Source: CMS PERL 201003-30

The Centers for Medicare & Medicaid Services needs your feedback

The Centers for Medicare & Medicaid Services (CMS) is conducting the fifth national administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey is designed to collect quantifiable data on providers' satisfaction with the performance of the Medicare fee-for-service (FFS) contractors that process and pay their Medicare claims. CMS conducts the MCPSS on an annual basis and uses the results for Medicare contractor oversight and process improvement initiatives.

In January, CMS notified approximately 30,000 Medicare FFS providers and suppliers that they had been randomly selected to participate in the 2010 MCPSS study. As representatives of the more than 1.5 million providers nationwide who serve Medicare beneficiaries across the country, these providers and suppliers have an opportunity to give CMS valuable feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor.

If you have been notified that you were selected to participate in this study and have not yet done so, CMS is listening and wants to hear from you. Please take a few minutes to go online and complete your survey via a secure online Internet survey tool. Responding online is a convenient, easy, and quick way to provide CMS with your feedback. Survey questionnaires may also be submitted by mail, secure fax, and over the telephone.

The survey takes approximately 20 minutes to complete.

CMS has contracted with SciMetrika, a public health consulting firm, to administer this important survey and report statistical data to CMS. If you received notification that you were selected to participate in the MCPSS study and you no longer have your online survey tool access information or need help accessing the survey tool, please call the MCPSS Provider Helpline at 1-800-835-7012 or send an e-mail to *MCPSS@scimetrika.com*.

Note: Only providers and suppliers notified that they have been randomly selected to take part in the 2010 MCPSS may participate in this study. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

For more information about the MCPSS, please visit the CMS MCPSS Web site at *http://www.cms.hhs.gov/mcpss*, or read the CMS *MLN Matters* special edition article at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf* featuring the survey.

CMS urges you to please take a few moments to complete your survey today.

Source: CMS PERL 201002-43

Medicare terminates drug plan contract with Fox Insurance Co.

Members will be provided access to drugs while transitioning to new plans

The Centers for Medicare & Medicaid Services (CMS) has terminated its contract with Fox Insurance Co. After an onsite review of the plan and its services, CMS determined that the plan's significant deficiencies of not meeting Medicare's requirements to provide enrollees with prescription drugs according to recognized standards of care jeopardized the health and safety of Fox enrollees. CMS found that Fox committed a series of violations, including improperly denying its enrollees coverage of critical HIV, cancer, and seizure medications. The termination of the contract is effective immediately.

The immediate termination will not impact or delay access to drugs for the more than 123,000 Medicare beneficiaries currently enrolled in Fox plans. All enrollees will obtain their drugs through LI-NET, a program run by Medicare and administered by Humana, to ensure that beneficiaries receive their Medicare prescription drugs. Fox enrollees will be able to choose a new Medicare prescription drug plan through May 1, 2010. Current enrollees who do not choose a plan will be enrolled into a new plan by Medicare.

"The immediate termination of Fox as a Medicare prescription drug plan demonstrates our commitment to protecting the health of some of their most vulnerable enrollees from getting necessary drugs, in some cases life-sustaining medicines. CMS's immediate action was essential to protect members' health and safety - an integral part of our contract with all Medicare beneficiaries," said Jonathan Blum, acting director of CMS' Center for Drug and Health Plan Choices. "Fox enrollees also need to know that they are not losing their drug coverage and will continue to have access to needed medicines. We will be sending letters explaining the steps we are taking to ensure they continue to get their medicines. They may also call 1-800-MEDICARE or their local state health insurance assistance programs if they have questions."

CMS issued an enrollment and marketing sanction to Fox on Feb. 26, 2010, because the organization was not following Medicare's rules for providing prescription drug coverage to its enrollees. After an onsite audit, which ran between March 2 and March 4, CMS found Fox's problems persisted and it continued to subject its enrollees to obstacles in getting needed and, in many cases, life-sustaining medicines. CMS also found that many of the obstacles were in place to limit access to high-cost drugs, which could have led to enrollees' clinical needs not being met. In many cases, Fox enrollees were required to have unnecessary and invasive medical procedures before they were able to obtain drugs. Fox was unable to satisfactorily address these compliance concerns and furnish medicines to its Medicare enrollees.

Among the audit findings CMS found include:

- Failing to provide access to Medicare prescription drugs benefits by imposing unapproved prior authorization and step therapy criteria that made it more difficult for beneficiaries to get drugs that are protected by law.
- Not meeting the plan's appeals deadlines.
- Not complying with Medicare regulations requiring enrollees to be transitioned to new drugs at the beginning of the new plan year.
- Failing to notify enrollees about prior authorization and step therapy determinations as required by Medicare.

According to CMS auditors, Fox was unable to satisfactorily address compliance concerns cited in the enrollment and marketing sanction and meet contractual obligations to provide medicines to Medicare beneficiaries enrolled in their plans.

We take our oversight role of Medicare prescription drug plans seriously," said Blum. "We review and take action on all complaints received about Medicare health and drug plans and will take appropriate and immediate actions wherever necessary.

CMS encourages Medicare prescription drug plan enrollees having concerns with access to drug coverage to contact 1-800-MEDICARE (1-800-633-4227) or the state health insurance assistance program (SHIP) to help get them resolved. Medicare enrollees, their families and their caregivers can contact a SHIP near them by visiting *http://www.medicare.gov/Contacts/staticpages/ships.aspx*.

Note: States in which the Fox plan was available were: Arkansas, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Louisiana, Maryland, Missouri, North Carolina, New Jersey, New York, Nevada, Ohio, Pennsylvania, South Carolina, Texas, and West Virginia.

Source: CMS PERL 201003-23

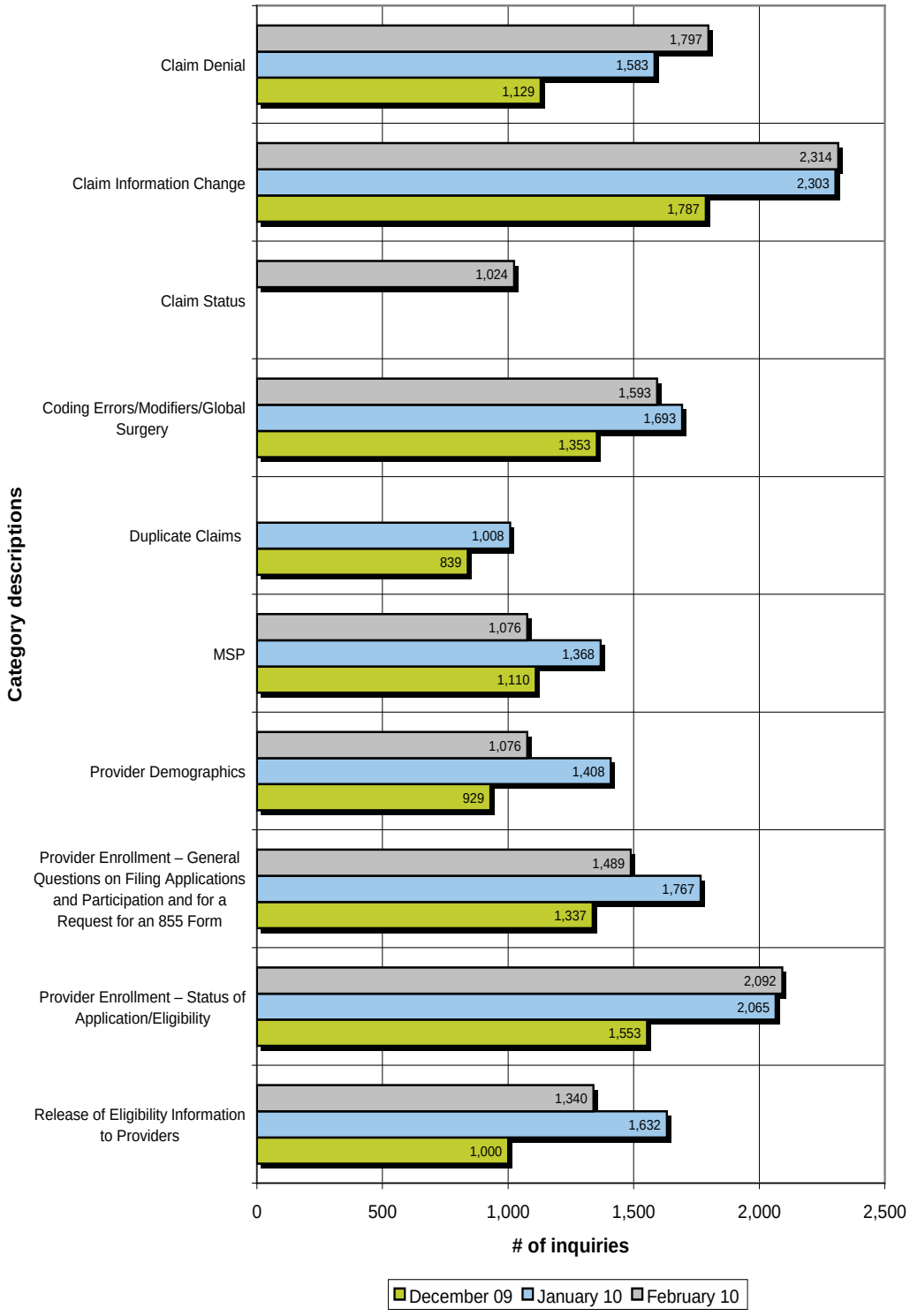
Web site survey

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 December 2009–February 2010

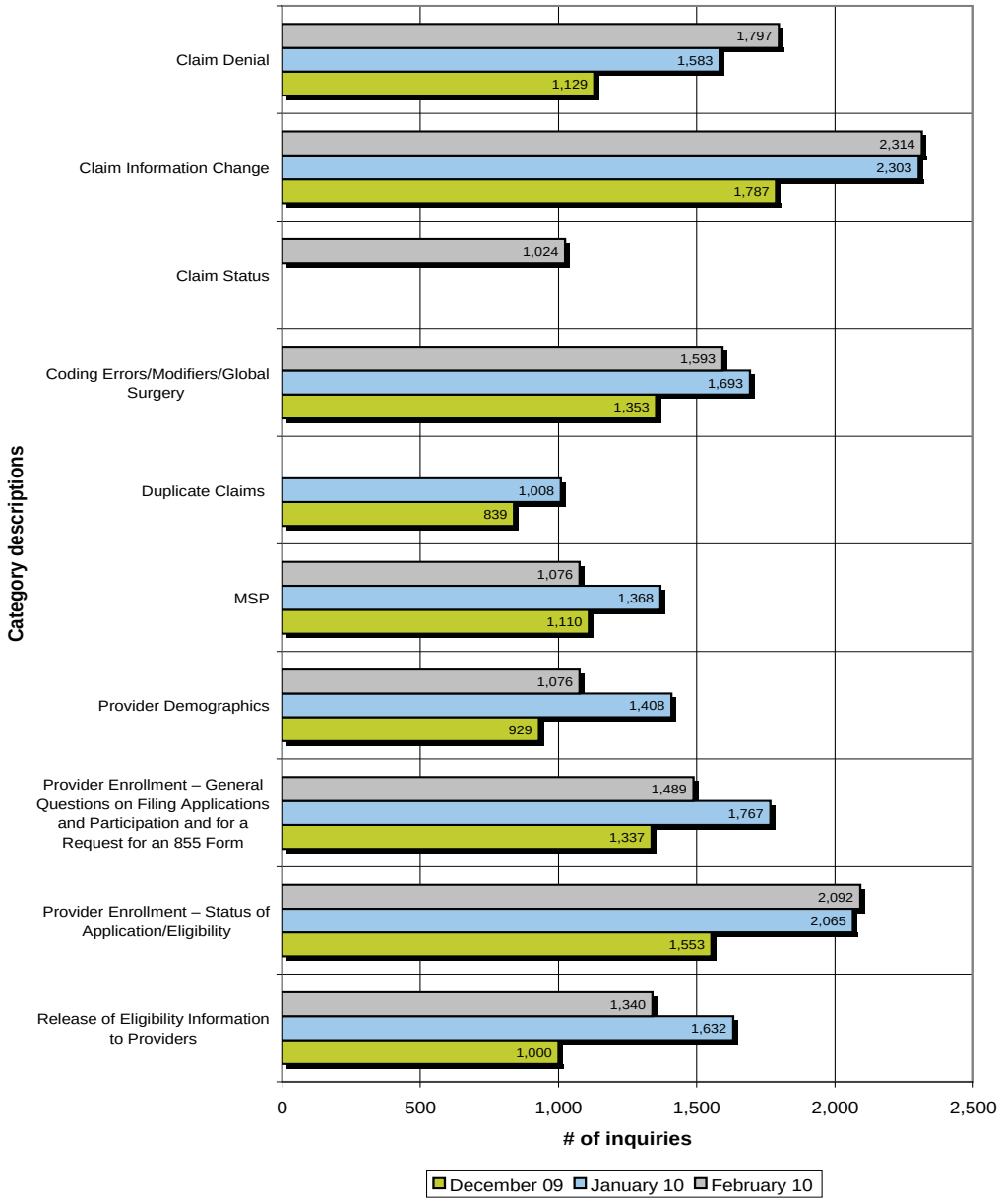
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during December 2009–February 2010. For tips and resources to help you avoid or reduce the amount of time 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 December 2009–February 2010



Top inquiries, denials, and return unprocessable claims for December 2009–February 2010 (continued)

Florida Part B top denials for December 2009–February 2010

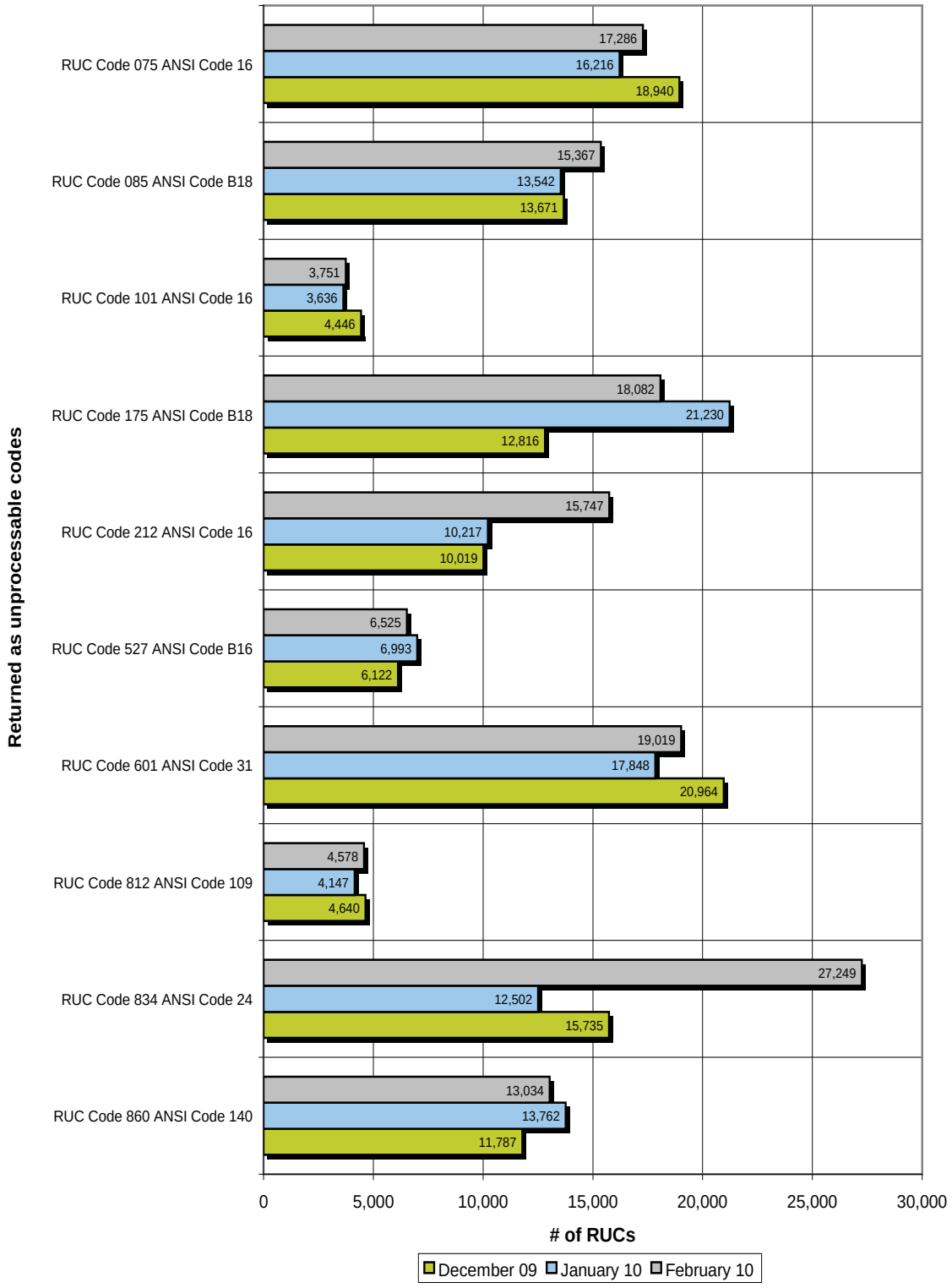


Use the PDS report to improve your Medicare billing operations

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

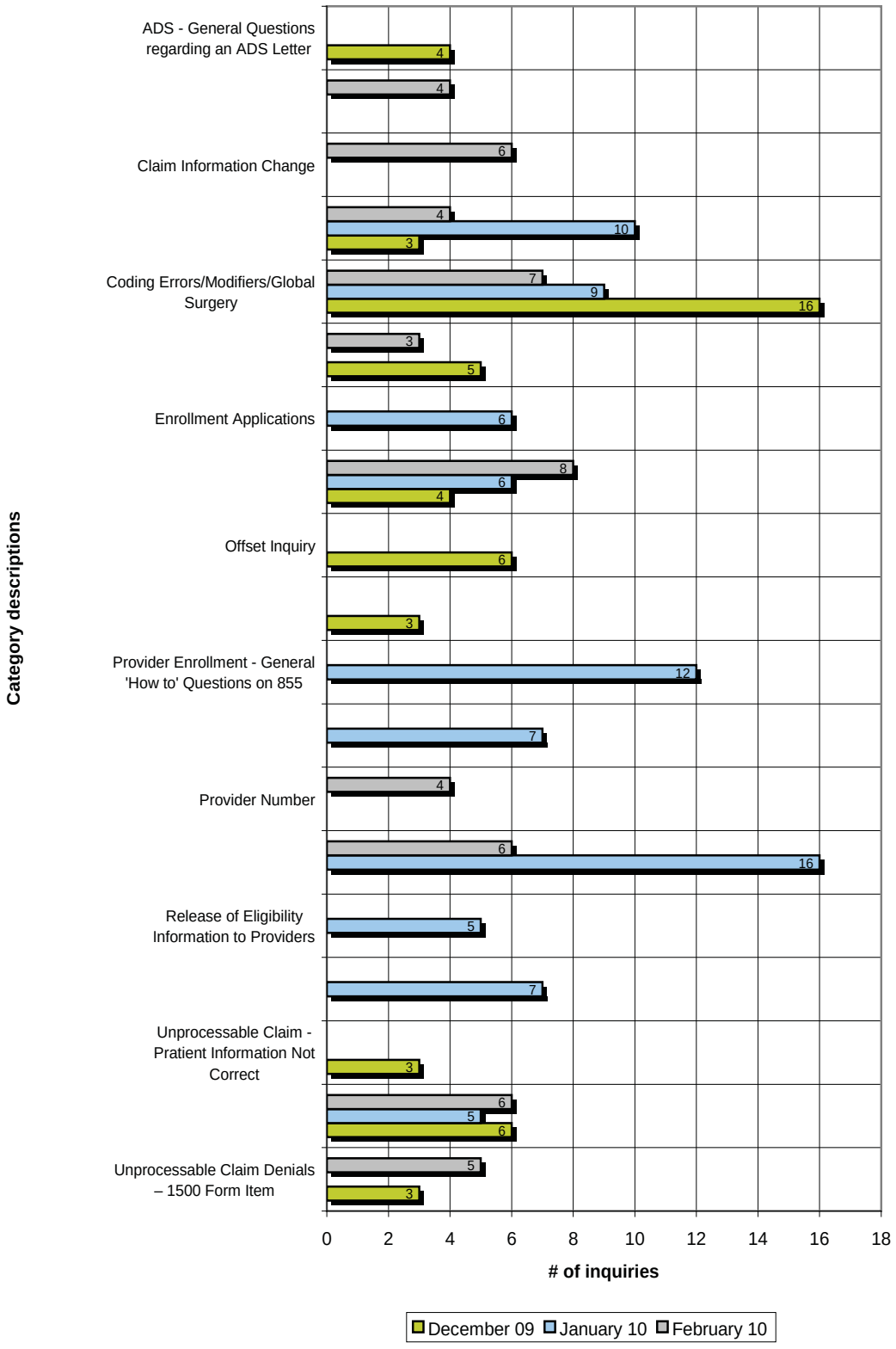
Top inquiries, denials, and return unprocessable claims for December 2009–February 2010 (continued)

Florida Part B top return as unprocessable claims (RUC) for December 2009–February 2010



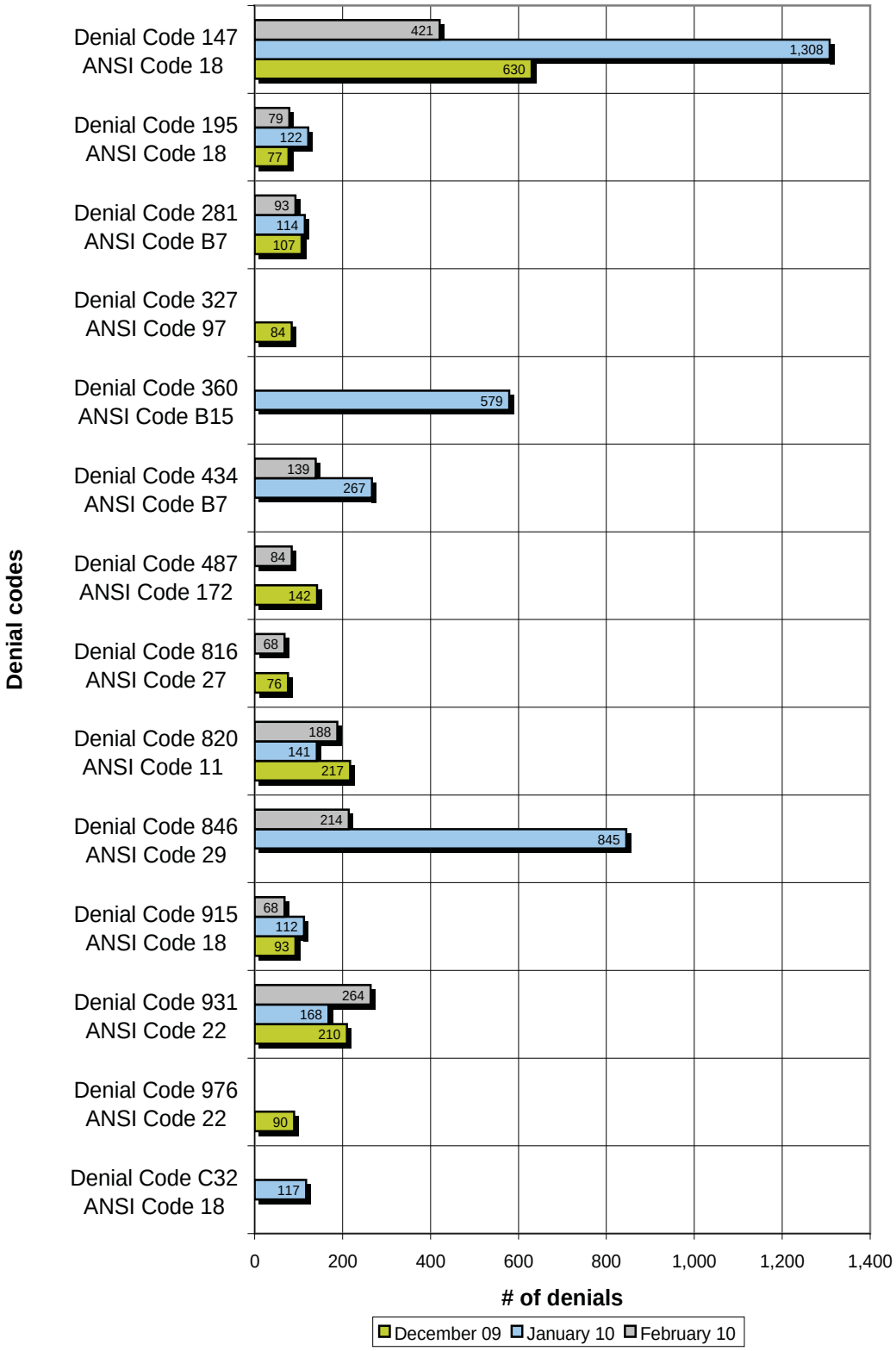
Top inquiries, denials, and return unprocessable claims for December 2009–February 2010 (continued)

U.S. Virgin Islands Part B top inquiries for December 2009–February 2010



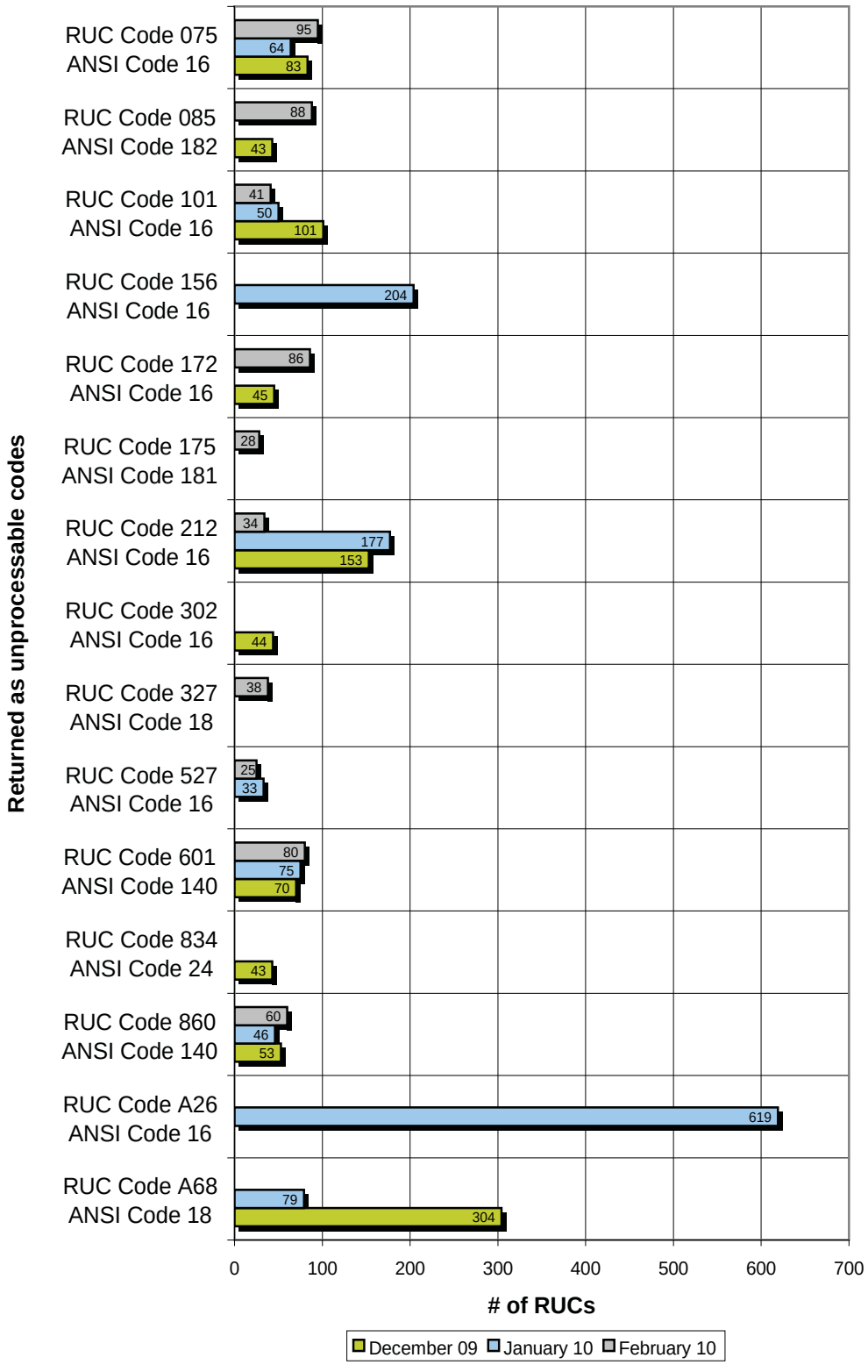
Top inquiries, denials, and return unprocessable claims for December 2009–February 2010 (continued)

U.S. Virgin Islands Part B top denials for December 2009–February 2010



Top inquiries, denials, and return unprocessable claims for December 2009–February 2010 (continued)

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

Local Coverage Determinations – Table of Contents

Advance beneficiary notice

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

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

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

Revisions to LCDs

22523: Kyphoplasty – revision to the LCD

LCD ID number: L29209 (Florida)
LCD ID number: L29454 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for kyphoplasty was most recently revised on January 1, 2010. Since that time, the LCD has been revised to replace all references to "kyphoplasty" and "balloon kyphoplasty" with the term "percutaneous vertebral augmentation/vertebral augmentation". The title of the LCD has also been changed from "kyphoplasty" to "percutaneous vertebral augmentation (vertebral augmentation) (formerly Kyphoplasty)". Additionally, the "Sources of Information" section of the LCD has been updated.

Effective date

This LCD revision is effective for services rendered **on or after March 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.

Additional Information

Self-administered drug (SAD) list

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after May 1, 2010, the following drugs have been added to the MAC J9 Part B SAD list.

- J3590 liraglutide (Victoza®)
- J3490 golimimab (Simponi®)

The evaluation of drugs for addition to the SAD list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

First Coast Service Options Inc.'s (FCSO) SAD lists are available at *http://medicare.fcso.com/Self-administered_drugs/*.

93042: Rhythm ECG, 1-3 leads; interpretation and report only

A review of utilization data of *CPT* code *93042* (*Rhythm ECG, 1-3 leads;interpretation and report only*) has revealed that providers are billing interpretation of ECG rhythm strips obtained from telemetry or cardiac monitoring equipment within hospitals or other facilities.

Electrocardiography (ECG) is the graphic representation of electrical activity within the heart. Electrodes placed on the body in predetermined locations sense this electrical activity, which is then recorded for review and interpretation. The ECG tracing is appropriately billed when performed as a stand-alone test, on a dedicated machine specifically for the purpose of the diagnosis of an arrhythmia or during its treatment.

Interpretation and/or performance of a rhythm strip performed as a separate service from continuous cardiac or telemetry monitoring with the result being an official interpretation and written report would be considered for Medicare reimbursement. The appropriate rhythm strip *CPT* codes (*93040-93042*) should be used and the documentation should support the medical necessity of the service.

Interpretation of a rhythm strip from cardiac monitoring equipment in settings including, but not limited to, inpatient hospital, emergency room and ambulance is not separately allowable. It is included as part of the medical decision portion of a physician's evaluation and management (E/M) services. Simply signing the report printed out by the ECG monitoring equipment is not acceptable documentation for billing and interpretation of a rhythm strip.

Reimbursement for A9552

If you are providing PET imaging in a freestanding or physician-office based PET center in Puerto Rico or the U.S. Virgin Islands, effective for claims processed on or after May 1, 2009, First Coast Service Options Inc. (FCSO) has been requesting and reimbursing fluorodeoxyglucose F-18 (FDG) according to invoice.

Diagnostic radiopharmaceuticals are typically paid at 95 percent average wholesale price (AWP) or when an AWP is not available by carrier price, which is typically invoice. The Centers for Medicare & Medicaid Services (CMS) has advised FCSO that payment for FDG cannot be made according to invoice because it has an AWP available. Therefore, effective for claims processed on or after December 4, 2009, FCSO will be reimbursing FDG at 95 percent of the AWP for Puerto Rico and the U.S. Virgin Islands.

To receive this separate reimbursement amount, FDG must be billed using HCPCS code A9552 – Fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries.

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*.

Educational Events

Upcoming provider outreach and education event
April 2010

Hot Topics: Provider Enrollment webcast
When: April 14
Time: 11:30 a.m.-1:00 p.m.

Hot Topics: 2010 E/M series
When: April 20
Time: 11:00 a.m.-12:30 p.m.

Hot Topics: 2010 E/M series
When: April 22
Time: 2:00 p.m.-3:30 p.m.

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, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands

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.

Preventive Services

March 23 is Diabetes Alert Day

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of the diabetes-related preventive services covered by Medicare.

Medicare coverage of diabetes-related preventive services

Medicare provides coverage of the following diabetes-related services for qualified Medicare beneficiaries:

- Diabetes screening tests
- Diabetes self-management training (DSMT)
- Medical nutrition therapy (MNT)
- Glaucoma screening (e.g. dilated eye exam with an intraocular pressure (IOP) measurement)
- Diabetes supplies (e.g. glucose monitoring equipment and therapeutic shoes) and other services (e.g., foot care).

What can you do?

As a trusted source of health care information, your patients rely on your recommendations. CMS requests your help to ensure that all of your eligible patients take advantage of diabetes-related preventive services covered by Medicare.

For more information

The *Medicare Learning Network* (MLN) has developed several educational products related to diabetes-related preventive services covered by Medicare:

- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals:** This comprehensive resource, available at *http//www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*, provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including diabetes-related services.
- **The MLN Preventive Services Educational Products Web Page**: This Web site, available at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*, provides descriptions and ordering information for MLN preventive services educational products and resources, including diabetes-related services.
- **Quick Reference Information: Medicare Preventive Services**: This chart, available at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*, provides coverage and coding information on Medicare-covered preventive services, including diabetes-related services.
- **Diabetes-Related Services Brochure:** This brochure, available at *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*, provides an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes.
- **Glaucoma Screening Brochure**: This brochure, available at *http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf*, provides an overview of Medicare's coverage of glaucoma screening tests, including the dilated eye exam with an IOP measurement.

To order hardcopies of available Medicare preventive services products, including the brochures mentioned above, click on "MLN Product Ordering" in the "Related Links Inside CMS" section of the MLN Preventive Services Educational Products Web Page listed above.

Additional resources

- **National Diabetes Education Program (NDEP)**: This Web site, available at *http://ndep.nih.gov/index.aspx*, offers numerous resources to help your patients delay or prevent the development of type 2 diabetes, as well as resources to help your patients manage diabetes to prevent serious complications. Check out "Your GAME PLAN to Prevent Type 2 Diabetes: Information for Patients," a three-page booklet to help people assess their risk for developing diabetes and take steps to prevent diabetes (*http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=71*). For patients with diabetes, "The Power to Control Diabetes is in Your Hands", contains information about diabetes and related Medicare benefits, which is available at *http://ndep.nih.gov/publications/OnlineVersion.aspx?NdepId=NDEP-38*.
- **DiabetesAtWork.org**: This Web site, available at *http://www.diabetesatwork.org*, contains information for employers to help them reduce health care costs and improve productivity by keeping employees healthy.
- **American Diabetes Association**: This Web site, available at *http://www.diabetes.org*, contains a wealth of information about diabetes, treatment, and prevention.

Thank you for your support in helping CMS spread the word about the benefits diabetes-related preventive services covered by Medicare.

Source: CMS PERL 201003-38

March is National Nutrition Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of nutrition, healthful eating and the medical nutrition therapy (MNT) benefit covered by Medicare. More than 13.7 million Americans at least 60 years or older are diagnosed with diabetes or chronic kidney disease[1]. MNT provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management and other health outcomes and may help delay disease progression.

Medicare coverage

Medicare provides coverage of medical nutrition therapy (MNT) for beneficiaries diagnosed with diabetes and/or renal disease (except for those receiving dialysis) and post renal transplant when provided by a registered dietitian or nutrition professional who meets the provider qualifications requirement. A referral by the beneficiary's treating physician indicating a diagnosis of diabetes or renal disease is required. Medicare provides coverage for three hours of MNT in the first year and two hours in subsequent years, and additional hours in certain situations.

Note: For the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [glomerular filtration rate (GFR) 13-50 ml/min/1.73m2].

What can you do?

As a trusted source of health-care information, your patients rely on their physician's or other health-care professional's recommendations. CMS requests your help to ensure that all eligible people with Medicare take full advantage of the medical nutrition therapy benefit. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT and encourage them to make an appointment with a registered dietitian or nutrition professional qualified to provide MNT services covered by Medicare.

For more information

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 medical nutrition therapy and other services for Medicare beneficiaries with diabetes. *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 medical nutrition therapy. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- **Diabetes-related services brochure** – this tri-fold brochure provides health-care professionals with an overview of Medicare coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf*
- The CMS Web site provides additional information about the MNT benefit at *http://www.cms.hhs.gov/MedicalNutritionTherapy.*

To order copies of Medicare Preventive Services products, select the link for "MLN Product Ordering Page" on the MLN Products page at *http://www.cms.hhs.gov/MLNProducts/01_Overview.asp*.

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

For more information about National Nutrition Month®, or to "Find a Registered Dietitian" consumers and health-care professionals may visit the American Dietetic Association's Web site at *http://www.eatright.org* to locate downloadable nutrition information for handouts and presentations.

For more information on diabetes, including additional publications to help educate your patients about diabetes prevention and treatment, please visit the National Diabetes Education Program Web site at *http://www.ndep.nih.gov*.

Thank you for your support in helping CMS spread the word about the benefits of good nutrition, healthful eating and the medical nutrition therapy benefit covered by Medicare that may help people with Medicare learn to control and manage their medical conditions.

[1] Department of Health & Human Services. Centers for Disease Control and Prevention, "2007 National Diabetes Fact Sheet," accessed at *http://apps.nccd.cdc.gov/ddtstrs/FactSheet.aspx*. The United States Renal Data System, "2008 USRDS Annual Data Report (ADR) Atlas," accessed at *http://www.usrds.org/2008/pdf/V1_Precis_2008.pdf*.

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

Source: CMS PERL 201003-14

National Colorectal Cancer Awareness Month – 'Dress in Blue Day'

March is National Colorectal Cancer Awareness month. The Colon Cancer Alliance has the first Friday in March as "Dress in Blue Day" to promote awareness about colorectal cancer and to encourage people to get screened. In addition, the entire month of March has been designated as National Colorectal Cancer Awareness Month.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for certain colorectal cancer screenings. Screening can help prevent and detect colorectal cancer in its earliest stages when outcomes are most favorable.

Medicare-covered colorectal cancer screenings

Medicare provides coverage of colorectal cancer screenings for the early detection of colorectal cancer. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema rendered in place of the screening colonoscopy.

Medicare provides coverage for the following colorectal cancer screenings subject to certain coverage, frequency, and payment limitations:

- Screening fecal occult blood test (FOBT)
- Screening colonoscopy
- Screening sigmoidoscopy
- Screen barium enema (as an alternative to a covered screening flexible sigmoidoscopy or screening colonoscopy)

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for all preventive services covered by Medicare.

- **The Medicare Learning Network (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
- **Cancer Screenings brochure** – this tri-fold brochure provides health care professionals with an overview of cancer screenings covered by Medicare, including colorectal cancer screening services.
  http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare, including colorectal cancer screening.
  http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- **Quick Reference Information: Medicare Preventive Services** – this double-sided chart contains coverage, coding, and payment information for the many preventive services covered by Medicare, including colorectal cancer screening, in an easy-to-use quick-reference format.
  http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- To order hard copies of certain *MLN* products, including the *Cancer Screenings* brochure, visit the *MLN* homepage at *http://www.cms.hhs.gov/mlngeninfo*; scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page."

- For information to share with your Medicare patients, visit *http://www.medicare.gov*.
- The American Cancer Society offers free materials to help clinicians continue encouraging colorectal cancer screening among patients 50 and older: *http://www.cancer.org/docroot/PRO/PRO_4_ColonMD.asp*.
- The *National Colorectal Cancer Roundtable*, which is convened by the Centers for Disease Control and Prevention (CDC) and the American Cancer Society, provides resources for providers, including a guide for primary care physicians. *http://www.nccrt.org/*
- For more information about colorectal cancer, please visit the Prevent Cancer Foundation at *http://www.preventcancer.org/education3c.aspx?id=1036*.
- For more information about Dress in Blue Day, please visit the Colon Cancer Alliance at *http://www.ccalliance.org/news_events_dress-in-blue.html*.

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

Source: CMS PERL 201003-05

Medicare preventive services quick reference information charts

The Medicare preventive services quick reference information charts have been updated and are now available in downloadable format. This includes the following charts:

- **Quick Reference Information: Medicare Preventive Services**: This two-sided reference chart provides health care providers with coverage, coding, and payment information on the many preventive services covered by Medicare.
- **Quick Reference Information: Medicare Immunization Billing**: This two-sided reference chart provides coverage, coding and payment information on seasonal influenza, pneumococcal, and hepatitis B vaccinations covered by Medicare.
- **Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (IPPE)**: This two-sided reference chart provides a checklist of the elements of an IPPE, as well as coding information and frequently asked questions.

To view the revised charts, please visit the *Preventive Services Educational Products* page at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* and select the *Educational Products* link in the *Downloads* section.

Hard copies of all three charts will be available in the near future.

Source: CMS PERL 201003-14

'We Heard the Bells: The Influenza of 1918' DVD now available

We Heard the Bells: The Influenza of 1918, a documentary that explores the experiences of Americans during the influenza pandemic of 1918, is now available to order, free of charge, on DVD.

The documentary features stories from survivors of the influenza pandemic that swept the United States in 1918. These stories serve to frame the key questions that apply to the current H1N1 pandemic. Award winning actress S. Epatha Merkerson (Law & Order) narrates the documentary that includes information about seasonal versus pandemic influenza, symptoms, immunizations, treatment, and research.

To order a copy of the DVD, please visit our product ordering Web site by first visiting our *Medicare Learning Network* page at *http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp*, then click on "MLN Product Ordering Page" in the "Related Links Inside CMS" section.

This product will also be available in a Spanish language translation at a later date.

Source: CMS PERL 201002-38

Other Educational Resources

2010 Physician Quality Reporting Initiative and EHR educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the following updated 2010 Physician Quality Reporting Initiative (PQRI) educational products to the PQRI Web page at *http://www.cms.hhs.gov/PQRI*.

2010 PQRI educational resource documents

Several new educational resource documents for 2010 PQRI are available on the "Educational Resources" link of the PQRI Web page and include the following:

- **2010 PQRI Electronic Health Record (EHR) Reporting Made Simple**
  http://www.cms.hhs.gov/PQRI/Downloads/2010EHRMadeSimpleTipSheet_021810_FINAL.pdf
- **2010 PQRI Tip Sheet: Satisfactorily Reporting 2010 PQRI Measures**
  http://www.cms.hhs.gov/PQRI/Downloads/2010PQRISatisfactorilyReportingFactSheet_021810_FINAL.pdf
- **2010 PQRI Program Tip Sheet: PQRI Made Simple -- Reporting the Preventive Care Measures Group**
  http://www.cms.hhs.gov/PQRI/downloads/2010PQRIMadeSimpleFS020310f_022210_FINAL.pdf
- **2010 PQRI Fact Sheet: What's New for the 2010 PQRI**
  http://www.cms.hhs.gov/PQRI/Downloads/WhatsNew2010PQRIFS020310f_022210_FINAL.pdf

2010 electronic health record (EHR)-based reporting documents

Several documents related to EHR-based reporting for 2010 PQRI have been updated and are available on the "Alternative Reporting Mechanisms" page of the PQRI Web page, which include the following:

- 2010 EHR Measure Specifications
- Updated 2010 EHR Measure Specification Release Notes

2010 Physician Quality Reporting Initiative and EHR educational products (continued)

- Updated 2010 EHR Downloadable Resource Table
- Updated EHR Data Submission Specifications Utilizing QRDA Release Notes
- Updated EHR Data Submission Specifications Utilizing QRDA Header Errors and Edits
- Updated EHR Data Submission Specifications Utilizing QRDA Body Errors and Edits

2010 PQRI measures documents

Several documents related to reporting PQRI measures for 2010 have been updated and are available on the "Measures Codes" page of the PQRI Web page, which include the following:

- 2010 Getting Started with Reporting of PQRI Measures Groups
- 2010 PQRI Implementation Guide
- 2010 PQRI QDC Categories
- 2010 PQRI Single Source Master Code Table
- 2010 PQRI Measures Specifications – Release Notes

Qualified registries for 2010 PQRI and electronic prescribing (eRx) reporting

An updated list of registries that have become "qualified" to submit quality data to CMS on behalf of their eligible professionals for 2010 PQRI and eRx reporting is available on the "Alternative Reporting Mechanisms" page of the PQRI Web page.

Qualified EHR vendors for the 2010 PQRI and Electronic Prescribing Incentive Programs

An updated list of EHR vendors and their programs that have been "qualified" to submit quality data to CMS by eligible professionals for 2010 PQRI reporting is available on the "Alternative Reporting Mechanisms" page of the PQRI Web page.

Source: CMS PERL 201003-33

2010 electronic prescribing educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the following updated 2010 Electronic Prescribing (eRx) Incentive Program educational products to the eRx Web page at *http://www.cms.hhs.gov/ERxIncentive*.

2010 eRx educational resource documents

Several new educational resource documents for 2010 eRx are available on the "Educational Resources" link of the eRx Web page and include the following:

- 2010 eRx Incentive Program Fact Sheet: What's New for the 2010 eRx Incentive Program
  http://www.cms.hhs.gov/ERxIncentive/Downloads/WhatsNew2010eRxFS020310f_022210_FINAL.pdf
- 2010 eRx Incentive Program Made Simple Fact Sheet
  http://www.cms.hhs.gov/ERxIncentive/Downloads/2010eRxMadeSimpleFS020310f_022210_FINAL.pdf

2010 electronic health record (EHR)-based reporting documents

Several documents related to EHR-based reporting for 2010 eRx have been updated and are now available on the "Alternative Reporting Mechanism" page of the eRx Web page, which include the following:

- 2010 EHR downloadable resource
  http://www.cms.hhs.gov/ERxIncentive/Downloads/2010_EHR_Downloadable_Resource_012810_FINAL.zip
- Qualified registries for 2010 PQRI and eRx reporting
  http://www.cms.hhs.gov/ERxIncentive/Downloads/QualifiedRegistriesPhase1eRx020110.pdf
- Qualified electronic health record (EHR) vendors for the 2010 Physician Quality Reporting Initiative (PQRI) and eRx Incentive Programs
  http://www.cms.hhs.gov/ERxIncentive/Downloads/QualifiedEHRVendorsRvsd02022010.pdf

Source: CMS PERL 201003-33

The Medicare Appeals Process brochure now available

The revised *Medicare Appeals Process brochure* (January 2010), which provides an overview of the Medicare Part A and Part B administrative appeal process, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf*.

This brochure is available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, and it provides details on where to obtain more information about this appeals process.

Source: CMS PERL 201002-38

New fact sheet on the health professional shortage area payment system

The new *Health Professional Shortage Area (HPSA) Fact Sheet* (March 2010) is now available in downloadable format from the Centers for Medicare & Medicaid Services' *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/HPSAfctsht.pdf*. This fact sheet provides general requirements and an overview of the health professional shortage area (HPSA) payment system.

Source: CMS PERL 201003-17

Revised fact sheets from the Medicare Learning Network

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

- **The Hospital Outpatient Prospective Payment System Fact Sheet (January 2010)** – provides general information about the hospital outpatient prospective payment system, ambulatory payment classifications, and how payment rates are set.
- **The Home Health Prospective Payment System Fact Sheet (January 2010)** – provides information about coverage of home health services and elements of the home health prospective payment system.
- **The Outpatient Maintenance Dialysis - End-Stage Renal Disease Fact Sheet (January 2010)** – provides information about the bundled end-stage renal disease (ESRD) prospective payment system for Medicare outpatient ESRD facilities that will replace the current basic case-mix adjusted composite payment system beginning January 1, 2011, the basic case-mix adjusted composite payment rate system, and separately billable items and services.
- **The Ambulatory Surgical Center Fee Schedule Fact Sheet (January 2010)** – provides general information about the ambulatory surgical center (ASC) fee schedule, ASC payments, and how ASC payment amounts are determined.

To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: CMS PERL 201003-27

Revised facilitator's kit for facilitators, trainers, educators, and physicians

The revised *Medicare Resident, Practicing Physician, and Other Health Care Professional Training Facilitator's Kit* (October 2009), includes all the information and instructions necessary to prepare for and present a Medicare resident, practicing physician, and other health care professional training program. The kit, now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*, includes instructions for facilitators, customization guide, a PowerPoint® presentation with speaker notes, pre and post-assessments, master assessment answer keys, and a course evaluation tool.

This kit contains the following materials:

- Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (CD-Rom format)
- Facilitator's Guide (CD-Rom format)
- Medicare Resident, Practicing Physician, and Other Health Care Professional Training: An Introduction Video (DVD format).

To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: CMS PERL 201003-32

Special news from the Medicare Learning Network

The Centers for Medicare & Medicaid Services (CMS) continues to break new ground to enhance the Medicare fee-for-service outreach efforts. CMS is now using the following social media outlets to get information out to the Medicare audience as fast as possible.

- LinkedIn: Join the CMS group at *http://www.linkedin.com/in/CMSGov*.
- YouTube: Log on to the official CMS YouTube channel at *http://www.YouTube.com/CMSHHSGov* to view several videos currently available and more to come in the upcoming months.
- Twitter: Follow CMS' two accounts to get the latest updates on information you need know about CMS (including *Medicare Learning Network* updates) and Insure Kids Now.

    1. For CMS & *Medicare Learning Network* updates, visit *http://www.twitter.com/CMSGov* (Twitter handle = @CMSGov)
    2. For Insure Kids Now updates, visit *http://www.twitter.com/IKNGov* (Twitter handle = @IKNGov)

    Log on to see the latest.

    The CMS Website Wheel has been revised and can now be ordered through the *Medicare Learning Network*.

The CMS Website Wheel is an informational resource that provides a variety of CMS Medicare related Web sites. To place an order, go to *http://www.cms.hhs.gov/MLNProducts/*, scroll to the downloads section of the page and select MLN Product Ordering Page, then select the CMS Website Wheel.

Source: CMS PERL 201003-25

Revised educational booklets that make up the Guided Pathways curricula

The revised *Guided Pathways to Medicare* booklets (1st Quarter 2010) are available from the Centers for Medicare & Medicaid Services' (CMS) *Medicare Learning Network*. Guided Pathways leads Medicare fee-for-service (FFS) providers through a variety of resources organized by topic. Quickly explore these three easy-to-navigate online guides to learn important Medicare policy and requirements. Guided Pathways information is available at *http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp*.

For all Medicare providers

Guided Pathways Basic Booklet January 2010 [PDF, 831KB]: Includes updated information on Medicare resources that provide a fundamental overview of the Medicare program.
http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Intermediate_PartB_Booklet.pdf

For Medicare FFS health care providers who enroll in Medicare using the 855A form

Guided Pathways Intermediate Part A Booklet January 2010 [PDF, 898KB]: Includes updated information on Medicare institutional requirements, reimbursement and coverage, Medicare services such as clinical trials, health care cost report information, MedPAC, Medicare approved facilities, demonstrations, enrollment reports, FFS statistics, the Medicare-Medicaid relationship, program rates and statistics, sustainable growth rates and conversion factors, and telehealth.
http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Intermediate_PartA_Booklet.pdf

For Medicare FFS health care professionals and suppliers who enroll in Medicare using the 855B, 855I or 855S forms

Guided Pathways Intermediate Part B Booklet January 2010 [PDF, 1MB]: Includes updated information on Medicare professional/practitioner/supplier requirements, coverage and reimbursement, services by other practitioners, services by suppliers, coding, billing and reimbursement, durable medical equipment, prosthetics, orthotics, and supplies, independent diagnostic testing facility, and quality.
http://www.cms.hhs.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Intermediate_PartA_Booklet.pdf

Source: CMS PERL 201003-35

Revised fact sheet regarding the Medicare physician fee schedule

The *Medicare Physician Fee Schedule Fact Sheet* (March 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 for dates of service January 1, 2010, through March 31, 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 201003-15

Revised ambulance fee schedule fact sheet

The revised *Ambulance Fee Schedule fact sheet* (January 2010), which provides general information about the ambulance fee schedule including how payment rates are set for ground and air ambulance services, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf*.

Source: CMS PERL 201003-03

Revised clinical laboratory fee schedule fact sheet

The revised *Clinical Laboratory Fee Schedule fact sheet* (January 2010), which provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at

http://www.cms.hhs.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf.

If you are unable to open the fact sheet, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201003-24

Revised fact sheet for Medicare fraud and abuse

The revised *Medicare Fraud & Abuse* fact sheet (February 2010), available from the Centers for Medicare & Medicaid Services' (CMS) *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf*, directs you to a number of sources of information pertaining to Medicare fraud and abuse and helps you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse.

Source: CMS PERL 201003-36

New fact sheet available on DMEPOS Competitive Bidding program

A new fact sheet titled *The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program– A Better Way for Medicare to Pay for Medical Equipment (February 2010)*, is now available in downloadable format on the DMEPOS Competitive Bidding Web site. This fact sheet gives providers and suppliers an overview of the DMEPOS Competitive Bidding program as well as useful information regarding the benefits and inherent qualities of the program. The fact sheet may be downloaded from the following Web page *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp*.

Source: CMS PERL 201003-14

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

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

Miscellaneous

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

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

Provider education

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

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

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

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

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

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

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):
1-877-847-4992

E-mail address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Medicare Web sites

Provider

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

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

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

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

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

and

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare Web sites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

E-mail address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary customer service

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

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

Education event registration

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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
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