MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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

TABLE OF CONTENTS

Medicare B Update!

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Publications staff

Terri Drury
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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.

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THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education website, *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 **websites** 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 website 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 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 Websites section of this publication for the address in which to send written appeals requests.

Find out first: Subscribe to FCSO eNews

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options eNews, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Ambulance

Extension of add-on provisions for ambulance services

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). PPACA Sections 3105 and 10311 impact certain ambulance payment provisions. It should be noted that PPACA Section 3105 establishes the implementation date as April 1, 2010. PPACA Section 10311 revises Section 3105 and changes the implementation date retroactive to January 1, 2010.

The PPACA extends increases in the ambulance fee schedules for covered ground ambulance transports that originated in rural areas by three percent and for covered ground ambulance transports that originated in urban areas by two percent retroactive to January 1, 2010, through December 31, 2010. The new law similarly extends the provision for air ambulance services provided in any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for services furnished on December 31, 2006.

Finally, the PPACA extends retroactive to January 1, 2010, and through December 31, 2010, Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which established the super rural bonus.

The Centers for Medicare & Medicaid Services is working to implement these three ambulance provisions of the PPACA expeditiously.

Be on the alert for more information about these ambulance provisions and their impact on your past and future claims.

In addition, be on the alert for more information pertaining to the Patient Protection and Affordable Care Act.

Source: CMS PERL 201004-10

The revised Ambulance Fee Schedule fact sheet is now available

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 print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: CMS PERL 201004-09

Update to the Medicare Claims Processing Manual – ambulance 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 ambulance suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6896 which updates the *Medicare Claims Processing Manual* (Chapter 15 (Ambulance), Section 40 (Medical Conditions List and Instructions).

Caution – what you need to know

Change request (CR) 5442 (Transmittal 1185, February 23, 2007) provided for an update to the ambulance fee schedule medical conditions list and instructions found in the *Medicare Claims Processing Manual*. Subsequently, CR 6347 (Transmittal 1696, March 6, 2009) communicated many revisions and updates to most of Chapter 15 of the *Medicare Claims Processing Manual*. However, the updated Section 40 (Medical Conditions List and Instructions) was not updated properly to reflect the updates made by CR 5442. Therefore, CR 6896 updates Section 40, Chapter 15, of the *Medicare Claims Processing Manual*.

Go – what you need to do

CR 6896 is issued primarily for educational guidance and to help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 6896 is being issued to reflect the updates and revisions to the *Medicare Claims Processing Manual* (Chapter 15 [Ambulance], Section 40 [Medical Conditions List and Instructions]), and the following includes the revised Section 40. These updates and revisions will help ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service.

Ambulance providers and suppliers must retain adequate documentation of dispatch instructions, patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by the Medicare contractor or other oversight authority. Medicare contractors will rely on medical record documentation to justify coverage, not simply the Healthcare Common Procedure Coding System (HCPCS) code or the condition code by themselves. All current Medicare ambulance policies remain in place.

Update to the Medicare Claims Processing Manual – ambulance services (continued)

The Centers for Medicare & Medicaid Services (CMS) issued the medical conditions list as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool. While the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are not precluded from use on ambulance claims, they are currently not required (per Health Insurance Portability and Accountability Act [HIPAA]) on most ambulance claims, and these codes generally do not trigger a payment or a denial of a claim. Some Medicare contractors have local coverage determinations (LCD) in place that cite ICD-9-CM that can be added to the claim to assist in documenting that the services are reasonable and necessary, but this is not common. Since ICD-9-CM codes are not required and are not consistently used, not all carriers or fiscal intermediaries edit on this field, and it is not possible to edit on the narrative field. The ICD-9-CM codes are generally not part of the edit process, although the medical conditions list in CR 6896 is available for those who do find it helpful in justifying that services are reasonable and necessary. (CR 6896 is available at *http://www.cms.gov/Transmittals/downloads/R1942CP.pdf*.

The medical conditions list in CR 6896 is set up with an initial column of primary ICD-9-CM codes, followed by an alternative column of ICD-9-CM codes. The primary ICD-9-CM code column contains general ICD-9-CM codes that fit the transport conditions as described in the subsequent columns. Ambulance crew or billing staff with limited knowledge of ICD-9-CM coding would be expected to choose the one or one of the two ICD-9-CM codes listed in this column to describe the appropriate ambulance transport and then place the ICD-9-CM code in the space on the claim form designated for an ICD-9-CM code. The option to include other information in the narrative field always exists and may be used whenever an ambulance provider or supplier believes that the information may be useful for claims processing purposes. If an ambulance crew or billing staff member has more comprehensive clinical knowledge, then that person may select an ICD-9-CM code from the alternative ICD-9-CM code column. These ICD-9-CM codes are more specific and detailed. An ICD-9-CM code does not need to be selected from both the primary column and the alternative column. However, in several instances in the alternative ICD-9-CM code column, there is a selection of codes and the word "plus." In these instances, the ambulance provider or supplier would select an ICD-9-CM code from the first part of the alternative listing (before the word "plus") and at least one other ICD-9-CM code from the second part of the alternative listing (after the word "plus"). The ambulance claim form does provide space for the use of multiple ICD-9-CM codes.

Example:

The ambulance arrives on the scene. A beneficiary is experiencing the specific abnormal vital sign of elevated blood pressure; however, the beneficiary does not normally suffer from hypertension (ICD-9-CM code 796.2 [from the alternative column on the medical conditions list]). In addition, the beneficiary is extremely dizzy (ICD-9-CM code 780.4 (fits the "plus any other code" requirement when using the alternative list for this condition [abnormal vital signs]). The ambulance crew can list these two ICD-9-CM codes on the claim form, or the general ICD-9-CM code for this condition (796.4 – Other abnormal clinical findings) would work just as well. None of these ICD-9-CM codes will determine whether or not this claim will be paid; they will only assist the Medicare contractor in making a medical review determination provided all other Medicare ambulance coverage policies have been followed.

While the medical conditions/ICD-9-CM code list is intended to be comprehensive, there may be unusual circumstances that warrant the need for ambulance services using ICD-9-CM codes not on this list. During the medical review process contractors may accept other relevant information from the providers or suppliers that will build the appropriate case that justifies the need for ambulance transport for a patient condition not found on the list.

Because it is critical to accurately communicate the condition of the patient during the ambulance transport, most claims will contain only the ICD-9-CM code that most closely informs the Medicare contractor why the patient required the ambulance transport. This code is intended to correspond to the description of the patient's symptoms and condition once the ambulance personnel are at the patient's side. For example, if an advanced life support (ALS) ambulance responds to a condition on the medical conditions list that warrants an ALS-level response and the patient's condition on-scene also corresponds to an ALS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport. (All claims are required to have HCPCS codes on them, and may have modifiers as well.) Similarly, if a basic life support (BLS) ambulance responds to a condition on the medical conditions list that warrants a BLS-level response and the patient's condition on-scene also corresponds to a BLS-level condition, the submitted claim need only include the code that most accurately reflects the on-scene condition of the patient as the reason for transport.

When a request for service is received by ambulance dispatch personnel for a condition that necessitates the skilled assessment of an advanced life support paramedic based upon the medical conditions list, an ALS-level ambulance would be appropriately sent to the scene. If upon arrival of the ambulance the actual condition encountered by the crew corresponds to a BLS-level situation, this claim would require two separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the on-scene condition of the patient. Because in this example, this code corresponds to a BLS condition, a second code that corresponds to the dispatch information would be necessary for inclusion on the claim in order to support payment at the ALS level. In these cases, when medical review is performed, the Medicare contractor will analyze all claim information (including both codes) and other supplemental medical documentation to support the level of service billed on the claim.

Medicare contractors may have (or may develop) individual local policies that indicate that some codes are not appropriate for payment in some circumstances. These continue to remain in effect.

Update to the Medicare Claims Processing Manual – ambulance services (continued)

Information on appropriate use of transportation indicators:

When a claim is submitted for payment, an ICD-9-CM code from the medical conditions list that best describes the patient's condition and the medical necessity for the transport may be chosen. In addition to this code, one of the transportation indicators below may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim.

Air and ground transportation indicators

Transportation indicator C1 indicates an interfacility transport (to a higher level of care) determined necessary by the originating facility based upon the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.

Transportation indicator C2 indicates a patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.

Transportation indicator C3 may be included on claims as a secondary code where a response was made to a major incident or mechanism of injury. All such responses – regardless of the type of patient or patients found once on scene – are appropriately advanced level service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified. Some examples of these types of responses would include patient(s) trapped in machinery, explosions, a building fire with persons reported inside, major incidents involving aircraft, buses, subways, trains, watercraft and victims entrapped in vehicles.

Transportation indicator C4 indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appears to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.

Ground only transportation indicators

Transportation indicator C5 has been added for situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter for any number of reasons, but the ambulance service is informing you that although the patient transported had an ALS-level condition, the actual service rendered was through a BLS-level ambulance in a situation where an ALS-level ambulance was not available.

For example, a BLS ambulance is dispatched at the emergency level to pick up a 76-year old beneficiary who has undergone cataract surgery at the Eye Surgery Center. The patient is weak and dizzy with a history of high blood pressure, myocardial infarction, and insulin-dependent diabetes mellitus. Therefore, the on-scene ICD-9-CM equivalent of the medical condition is 780.02 (unconscious, fainting, syncope, near syncope, weakness, or dizziness – ALS Emergency). In this case, the ICD-9-CM code 780.02 would be entered on the ambulance claim form as well as transportation indicator C5 to provide the further information that the BLS ambulance transported a patient with an ALS-level condition, but there was no intervention by an ALS service. This claim would be paid at the BLS level.

Transportation indicator C6 has been added for situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. If once on scene, the crew determines that the patient requiring transport has a BLS-level condition, this transportation indicator should be included on the claim to indicate why the ALS-level response was indicated based upon the information obtained in the operation's dispatch center. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on-scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS-level response based upon medically appropriate dispatch protocols.

Transportation indicator C7 is for those circumstances where IV medications were required en route. C7 is appropriately used for patients requiring ALS level transport in a non-emergent situation primarily because the patient requires monitoring of ongoing medications administered intravenously. Does not apply to self-administered medications. Does not include administration of crystalloid intravenous fluids (i.e., normal saline, lactate ringers, 5% dextrose in water, etc.). The patient's condition should also be reported on the claim with a code selected from the list.

Air only

All "transportation indicators" imply a clinical benefit to the time saved with transporting a patient by an air ambulance versus a ground or water ambulance.

Transportation indicator D1 long distance: patient's condition requires rapid transportation over a long distance.

Transportation indicator D2: Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.

Transportation indicator D3: Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of hospital time to maximize clinical benefits to the patient.

Update to the Medicare Claims Processing Manual – ambulance services (continued)

Transportation indicator D4: Pick up point not accessible by ground transportation.

The revised *Medicare Claims Processing Manual* (Chapter 15, Section 40) is included as an attachment to CR 6896, and in the attachment you can review the medical conditions list which is set up as a series of tables divided into the following principal sections:

- Emergency conditions – non-traumatic
- Emergency conditions – trauma
- Non-emergency
- Transportation indicators, and
- Air ambulance transportation indicators

Additional information

The official instruction, CR 6896, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1942CP.pdf*.

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

MLN Matters® Number: MM6896
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Related CR Release Date: April 2, 2010
Effective Date: May 3, 2010
Related CR Transmittal #: R1942CP
Implementation Date: May 3, 2010

Ambulatory Surgical Center

April 2010 update to the ambulatory surgical center payment system

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

Provider types affected

Providers who submit claims to Medicare administrative contractors (A/B MACs) and carriers, for services provided to Medicare beneficiaries, which are paid under the ASC payment system, are affected.

Provider action needed

This article is based on change request (CR) 6866 which describes changes to, and billing instructions for, payment policies implemented in the April 2010 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals.

Background

This recurring update notification describes changes to, and billing instructions for, payment policies implemented in the April 2010 ASC payment system update. Final policy under the revised ASC payment system, as set forth in Medicare Program, Revised Payment System Policies for Services Furnished in ASCs, beginning in CY 2008 (72 FR 42470), requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly. Therefore, beginning with CR 5994, issued April 9, 2008, CMS has issued quarterly updates to ASC payment rates for separately paid drugs and biologicals. CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes, as appropriate. CR 6866 provides information on six newly created HCPCS codes that will be added to the ASC list of covered ancillary procedures effective April 1, 2010. You may review CR 5994 at *http://www.cms.gov/MLNMattersArticles/downloads/MM5994.pdf*.

Key points in CR 6866

- ASCs are strongly encouraged to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs billing for these products must make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

April 2010 update to the ambulatory surgical center payment system (continued)

- If two or more drugs and biological products are being mixed together to facilitate their concurrent administration, the ASC should report the quantity of each product (reported by HCPCS codes) that is separately payable in the ASC used in the care of the patient.
- If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.
- The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned. Note: Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product.

New HCPCS drug codes separately payable under the ASC payment system as of April 1, 2010

Six new HCPCS codes have been created effective April 1, 2010. These new HCPCS codes, their descriptors, and ASC payment indicators are listed in Table 1 below.

Table 1

New drugs and biologicals separately payable under the ASC payment system as of April 1, 2010

HCPCS Code	Long Descriptor	Payment Indicator
C9258*	Injection, telavancin, 10 mg	K2
C9259*	Injection, pralatrexate, 1 mg	K2
C9260*	Injection, ofatumumab, 10 mg	K2
C9261*	Injection, ustekinumab, 1 mg	K2
C9262*	Fludarabine phosphate, oral, 1 mg	K2
C9263*	Injection, ecallantide, 1 mg	K2

*Indicates that the HCPCS code is new and effective April 1, 2010

Updated payment rate for HCPCS code J9031, effective January 1, 2009, through March 31, 2009

The payment rate for HCPCS code J9031 was incorrect in the January 2009 ASC DRUG file. The corrected payment rate is listed in Table 2 below and has been included in the revised January 2009 ASC DRUG file effective for services furnished on January 1, 2009 through implementation of the April 2009 update. Suppliers who think they may have received an incorrect payment between January 1, 2009, and March 31, 2009, may request contractor adjustment of the previously processed claims.

Table 2

Updated payment rate for HCPCS code J9031, effective January 1, 2009, through March 31, 2009

HCPCS Code	Payment Indicator	Short Descriptor	Corrected Payment Rate
J9031	K2	Bcg live intravesical vac	$118.96

Updated payment rates for certain HCPCS codes, effective October 1, 2009, through December 31, 2009

The payment rates for four HCPCS codes were incorrect in the October 2009 ASC DRUG file. The corrected payment rates are listed in Table 3 below and have been included in the revised October 2009 ASC DRUG file effective for services furnished on October 1, 2009 through implementation of the January 2010 update. Suppliers who think they may have received an incorrect payment between October 1, 2009, and December 31, 2009, may request contractor adjustment of the previously processed claims.

Table 3

Updated payment rates for certain HCPCS codes, effective October 1, 2009, through December 31, 2009

HCPCS Code	Payment Indicator	Short Descriptor	Corrected Payment Rate
J2278	K2	Ziconotide injection	$6.38
J2323	K2	Natalizumab injection	$7.97
J1458	K2	Galsulfase injection	$333.49
90371	K2	Hep b ig, im	$113.78

Correct reporting of drugs and biologicals when used as implantable devices

When billing for a biological for which the HCPCS code describes a product that is solely surgically implanted or inserted, and that is separately payable under the ASC payment system, the ASC should report the HCPCS code for the product. If the implanted biological is packaged, that is, not eligible for separate payment under the ASC payment system, the ASC should not report the biological product HCPCS code.

April 2010 update to the ambulatory surgical center payment system (continued)

When billing for a biological for which the HCPCS code describes a product that either may be surgically implanted or inserted or otherwise applied in the care of a patient, ASCs should not report the HCPCS code for the product when the biological is used as an implantable device (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the ASC payment system, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items. When using biologicals during surgical procedures as implantable devices, ASCs may include the charges for these items in their charge for the procedure.

Correct reporting of units for drugs

ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

- For example, if the drug's HCPCS code descriptor specifies 6 mg, and 6 mg of the drug were administered to the patient, the units billed should be one.
- As another example, if the drug's HCPCS code descriptor specifies 50 mg, but 200 mg of the drug were administered to the patient, the units billed should be four.
- ASCs should not bill the units based on how the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 10 units should be reported on the bill, even though only one vial was administered.
- HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Note: Providers take note that if your claims were processed prior to the installation of the revised April 2009 ASC Drug file, your Medicare AB/MAC or carrier will adjust, as appropriate, claims you bring to their attention that have dates of service on or after January 1, 2009, through March 31, 2009.

Providers take note that if your claims were processed prior to the installation of the revised January 2010 ASC drug file, your Medicare AB/MAC or carrier will adjust, as appropriate, claims you bring to their attention that have dates of service on or after October 1, 2009, through December 31, 2009.

Additional information

For complete details regarding this CR, please see the official instruction (CR 6866) issued to your Medicare FI or carrier at *http://www.cms.gov/Transmittals/downloads/R1943CP.pdf*.

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

MLN Matters Number: MM6866
Related Change Request (CR) #:6866
Related CR Release Date: April 6, 2010
Effective Date: April 1, 2010
Related CR Transmittal #: R1943CP
Implementation Date: April 5, 2010

Cardiac Services

Automatic implantable cardiac defibrillator provided in a clinical study

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

Provider types affected

This article is for all providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for ICD services rendered to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6867 and updates the list of ICD-9-CM diagnosis codes not requiring the modifier Q0 (zero) for ICD services provided in a clinical study. Be sure your billing staff knows of this change.

Key point of CR 6867

ICD-9-CM diagnosis code V12.53 (effective October 1, 2007) does not require a modifier Q0 for payment. The following is a complete list of diagnosis codes that do not require a modifier Q0.

Automatic implantable cardiac defibrillator provided in a clinical study (continued)

Diagnosis codes that do not require either a modifier QR (for dates of service prior to January 1, 2008) or a modifier Q0 (for dates of service on or after January 1, 2008).

ICD-9-CM Code	Secondary Prevention Diagnosis
427.1	Ventricular tachycardia
427.41	Ventricular fibrillation
427.42	Ventricular flutter
427.5	Cardiac arrest
427.9	Cardiac dysrhythmia, unspecified
V12.53	Personal history of sudden cardiac arrest
996.04	Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator
V53.32	Fitting and adjustment of other device, automatic implantable cardiac defibrillator

Further, when any of these codes do appear on an ICD claim, the modifier QR is not required. However, it should be noted that providers are permitted to append the modifier QR for secondary prevention diagnoses if they deem it appropriate, i.e., that data is submitted to a data collection registry.

Background

Requiring reporting of HCPCS modifier QR to identify primary prevention indications for ICDs

On March 8, 2005, CR 3604, Transmittal (TR) 497, was issued to provide instructions to Centers for Medicare & Medicaid Services (CMS) contractors on how to process ICD implantations under newly expanded coverage. Among other specifications, CR 3604 informed CMS contractors that one of the requirements for covering the new indications is that the patient be enrolled in a data collection system.

Currently, CMS identifies claims through the procedure code for defibrillator implantation and the **absence** of five specified arrhythmia codes and two codes often used when the device is being replaced. It has come to CMS' attention that one other code should be included on this list – V12.53, personal history of sudden cardiac arrest, bringing the total number of diagnosis codes to eight.

Replacing of HCPCS modifier QR with Q0 (zero)

CR 5805 was issued on January 18, 2008 (after CR 3604 was issued). Among other things, CR 5805 replaced HCPCS modifier QR with HCPCS modifier Q0, effective for dates of service on or after January 1, 2008. To review the *MLN Matters*® article related to CR 5805 you may go to *http://www.cms.gov/MLNMattersArticles/downloads/MM5805.pdf*.

Providers take note: Effective for claims with dates of service on or after April 1, 2005, for 427.89 and on or after October 1, 2007, for V12.53, your Medicare contractors will adjust as appropriate claims brought to their attention that were denied because the diagnosis code V12.53 and lacked a modifier Q0 for dates of service on or after January 1, 2008, or lacked the modifier QR for dates of service prior to January 1, 2008.

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The official instruction and the revised *Medicare Claims Processing Manual* instruction associated with CR 6867, issued to your Medicare MAC, FI or carrier regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R663OTN.pdf*.

MLN Matters® Number: MM6867
Related Change Request (CR) #: 6867
Related CR Release Date: March 26, 2010
Effective Date: October 1, 2007 for ICD-9-CM V12.53
Related CR Transmittal #: R663OTN
Implementation Date: July 6, 2010

Diabetic Services

Outpatient intravenous insulin treatment

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, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MACs)) for providing outpatient intravenous insulin therapy (OIVIT) to Medicare beneficiaries.

What you need to know

On December 23, 2009, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) announcing the noncoverage decision on the use of outpatient intravenous insulin therapy (OIVIT).

Specifically, CMS has determined (effective for claims with dates of service on or after December 23, 2009) that the evidence does not support a conclusion that OIVIT improve health outcomes in Medicare beneficiaries. Therefore, OIVIT is not reasonable and necessary for any indication under section 1862(a)(1)(A) of the Social Security Act and services comprising an OIVIT regimen are therefore nationally noncovered under Medicare when furnished pursuant to an OIVIT regimen. You should ensure that your billing staffs are aware of this NCD.

Background

On December 23, 2009, CMS issued a national noncoverage decision on the use of OIVIT. CR 6775, from which this article is taken, provides details about this decision.

The term OIVIT refers to an outpatient regimen that integrates pulsatile or continuous intravenous infusion of insulin via any means guided by the results of measuring:

- Respiratory quotient, and/or
- Urine urea nitrogen (UUN), and/or
- Arterial, venous, or capillary glucose, and/or
- Potassium concentration, and
- Performed in scheduled recurring periodic intermittent episodes.

Most commonly delivered in pulses (but sometimes as a more conventional drip solution), the insulin administration is an adjunct to the patient's routine oral agent or insulin-based diabetic (or other disease) management regimen, typically performed on an intermittent basis (often weekly), and frequently performed chronically without duration limits.

Note: OIVIT is also sometimes termed cellular activation therapy (CAT), chronic intermittent intravenous insulin therapy (CIIT), hepatic activation therapy (HAT), intercellular activation therapy (iCAT), metabolic activation therapy (MAT), pulsatile intravenous insulin treatment (PIVIT), pulse insulin therapy (PIT), and pulsatile therapy (PT).

Coding OIVIT

For use with this noncoverage decision, effective April 5, 2010, CMS will create a new HCPCS code (G9147) that is to be implemented with the April 2010 integrated outpatient code editor (IOCE) and Medicare physician fee schedule database (MPFSDB). You should use this new code on claims that you submit for noncovered OIVIT and any services compromising an OIVIT regimen with dates of service on and after December 23, 2009.

Effective April 5, 2010, *Current Procedural Terminology* (*CPT*) code *99199* (*Unlisted Special Service, Procedure, or Report*) should not be used when billing noncovered OIVIT and any services comprising an OIVIT regimen. Your FI, carrier, or A/B MAC will return any such claims that you submit with *99199* unprocessable using the following messages:

Claim adjustment reason code (CARC) 189 (NOS or unlisted procedure code (*CPT*/HCPCS) was billed when there is a specific procedure code for this procedure/service.)

Remittance advice remark code (RARC) N56 (The procedure code billed is not correct/valid for the services billed or the date of service billed.), and

RARC MA66 (Missing/incomplete/invalid principal procedure code).

Also, effective April 5, 2010, *CPT* code *94681* (exhaled air analysis O2/CO2) must not be used on claims billing for noncovered OIVIT and any services comprising an OIVIT regimen or for claims billing diabetes-related conditions 250.00-250.93. Such claims submitted with *CPT* code 94681 will also be returned as unprocessable using the following messages:

CARC 11 (The diagnosis is inconsistent with the procedure.)

RARC N56 (The procedure code billed is not correct/valid for the services billed or the date of service billed.), and

RARC MA66 (Missing/incomplete/invalid principal procedure code.)

Effective April 5, 2010, when HCPCS code G9147 is billed on claims for noncovered OIVIT and any services comprising an OIVIT regimen for dates of service on and after December 23, 2009, Medicare contractors will deny the claim with the following messages:

Medicare summary notice (MSN) 16.10: Medicare does not pay for these item(s) or service(s)

CARC 96: Non-covered charge(s)

CARC M51: Missing/Incomplete /Invalid Procedure Code(s), and

RARC N386: This decision was based on an NCD. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy

Outpatient intravenous insulin treatment (continued)

is available at *http://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Note: Prior to April 5, 2010, noncovered OIVIT claims with dates of service on and after December 23, 2009, should be processed as they currently are now using NOS *CPT* code *99199* and *CPT* code *94681*. On April 5, 2010, these codes should no longer be used for noncovered OIVIT claims and new HCPCS code G9147, created for this purpose, should be used in their place.

Please remember that individual components of OIVIT may have medical uses in conventional treatment regimens for diabetes and other conditions; and in these contexts, coverage may be determined by other local or national Medicare determinations, and do not pertain to OIVIT.

For examples of these uses you might want to look at the *Medicare National Coverage Determinations Manual* Sections 40.2, (Home Glucose Monitors), Section 40.3 (Closed-loop Blood Glucose Control Devices), Section 190.20 (Blood Glucose Testing), and Section 280.14 (Infusion Pumps. You may also want to look at the *Medicare Claims Processing Manual*, Chapter 18, Section 90, on Diabetes Screening. These manuals are available at *http://www.cms.gov/Manuals/IOM/list.asp*.

In addition, you should know that your contractors will not automatically search their files for claims with dates of service between December 23, 2009, and April 5, 2010, but may go back and adjust claims that you bring to their attention.

Additional information

You may find more information about noncoverage of OIVIT by going to CR 6775, which was issued via two transmittals. The first transmittal, located at *http://www.cms.gov/Transmittals/downloads/R117NCD.pdf*, contains the updated *Medicare National Coverage Determinations Manual* sections related to CR 6775. The second transmittal, located at *http://www.cms.gov/Transmittals/downloads/R1930CP.pdf*, contains the updated sections of the *Medicare Claims Processing Manual*.

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

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Related Change Request (CR) #: 6775
Related CR Release Date: March 9, 2010
Effective Date: December 23, 2009
Related CR Transmittal #: R117NCD and R1930CP
Implementation Date: April 5, 2010

Drugs and Biologicals

Safety announcement from the FDA – High-dose Zocor and increased risk of muscle injury

FDA drug safety communication, March 19, 2010: Ongoing safety review of high-dose Zocor (simvastatin) and increased risk of muscle injury

Based on review of data from a large clinical trial and data from other sources, the U.S. Food and Drug Administration (FDA) is informing the public about an increased risk of muscle injury in patients taking the highest approved dose of the cholesterol-lowering medication, Zocor (simvastatin) 80 mg, compared to patients taking lower doses of simvastatin and possibly other drugs in the "statin" class.

The clinical trial data being reviewed is from the Study of the Effectiveness of Additional Reductions in Cholesterol and Homocysteine (SEARCH) trial. The agency is also reviewing data from other clinical trials, observational studies, adverse event reports, and data on prescription use of simvastatin to better understand the relationship between high-dose simvastatin use and muscle injury (see Data Summary below).

The muscle injury, also called myopathy, is a known side effect with all statin medications. Patients with myopathy generally have muscle pain, tenderness or weakness, and an elevation of a muscle enzyme in the blood (creatine kinase). The higher the dose of statin used, the greater the risk of developing myopathy. The risk of myopathy is also increased when simvastatin, especially at the higher doses, is used with certain drugs (see simvastatin dose limitations at *http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm204882.htm#TableofSimvastatinDoseLimitations*).

The most serious form of myopathy is called rhabdomyolysis. It occurs when a protein (myoglobin) is released as muscle fibers break down. Myoglobin can damage the kidneys. Patients with rhabdomyolysis may have dark or red urine and fatigue, in addition to their muscle symptoms. Damage to the kidneys from rhabdomyolysis can be so severe that patients may develop kidney failure, which can be fatal.

Safety announcement from the FDA – High-dose Zocor and increased risk of muscle injury (continued)

Known risk factors for developing rhabdomyolysis include age (> 65 years), low thyroid hormone levels (hypothyroidism), and poor kidney function. Myopathy and rhabdomyolysis are listed as possible side effects in the simvastatin and other statin drug labels.

Healthcare professionals should:

- Understand that rhabdomyolysis is a rare adverse event reported with all statins.
- Be aware of the potential increased risk of muscle injury with the 80 mg dose of simvastatin compared to lower doses of simvastatin and possibly other statin drugs.
- Follow the recommendations in the simvastatin label regarding drugs that may increase the risk for muscle injury when used with simvastatin (see simvastatin dose limitations at *http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/default.htm*.

Patients should:

- Not stop taking simvastatin unless told to by their healthcare professional.
- Talk to their healthcare professional about any questions they have about the use of simvastatin.
- Call their healthcare professional if they experience any of the following: muscle pain, tenderness or weakness, urine that is dark or red-colored, or unexplained tiredness.

This communication is in keeping with FDA's commitment to inform the public about its ongoing safety review of drugs. The agency will update the public as soon as this review is complete.

**Simvastatin is sold as a single-ingredient generic medication and as the brand-name, Zocor. It is also sold in combination with ezetimibe as Vytorin; and niacin as Simcor.*

Additional information for patients

Patients currently using 80 mg simvastatin should:

- Know that rhabdomyolysis is a rare side effect reported with all statin medications.
- Not stop taking simvastatin unless told to by their healthcare professional.
- Review their medical history and current medications with their healthcare professional to determine if they should continue using simvastatin.
- Talk to their healthcare professional about any questions or concerns they have about simvastatin.
- Call their healthcare professional if they have muscle pain, tenderness or weakness, dark or red colored urine, or unexplained tiredness.
- Report any side effects with simvastatin to FDA's MedWatch program using the information at the bottom of the page in the "Contact Us" box.

Additional information for healthcare professionals

FDA recommends that healthcare professionals should:

- Understand that rhabdomyolysis is a rare adverse event reported with all statins.
- Be aware of the potential increased risk of muscle injury with the 80 mg dose of simvastatin compared to lower doses of simvastatin and possibly other statin drugs.
- Review patients' medical history and medications to determine if simvastatin is clinically appropriate.
- Discuss with patients the benefits and risks, including the risk of myopathy and rhabdomyolysis, of simvastatin therapy.
- Be aware of potential drug-drug interactions with simvastatin.
- Report any adverse events associated with the use of simvastatin to FDA's MedWatch program using the information in the "Contact Us" box at the bottom of the page.

Data summary

FDA's review of the SEARCH trial is part of the agency's continuing effort to evaluate the risk of muscle injury with simvastatin; this review includes evaluating data from clinical trials, observational studies, and adverse event reports, as well as data on prescription use of simvastatin.

The SEARCH trial evaluated over 6.7 years the number of major cardiovascular events (heart attack, revascularization, and cardiovascular death) in 6031 patients taking 80 mg of simvastatin compared to 6033 patients taking 20 mg of simvastatin. All patients in the study had previously had a heart attack.

Preliminary SEARCH trial results revealed that more patients in the simvastatin 80 mg group developed myopathy compared to patients in the simvastatin 20 mg group (52 [0.9 percent] cases compared to 1 case [0.2 percent]). Further, FDA's preliminary analyses of the primary data suggest that 11 (0.02 percent) of the patients in the simvastatin 80 mg group developed rhabdomyolysis compared to no patients in the simvastatin 20 mg group.

Safety announcement from the FDA – High-dose Zocor and increased risk of muscle injury (continued)

In 2008, the agency alerted the public about an increased risk of developing rhabdomyolysis when doses greater than 20 mg of simvastatin are given with amiodarone. The agency also included information about this drug interaction in its Summer 2008 issue of the FDA Drug Safety Newsletter (*http://www.fda.gov/Drugs/DrugSafety/DrugSafetyNewsletter/ucm109176.htm*) and in its November 2008 Patient Safety News broadcast (*http://www.accessdata.fda.gov/psn/transcript.cfm?show=81*).

In March 2010, FDA approved a labeling revision for simvastatin based on interim results from an ongoing clinical trial – the Heart Protection Study 2 (HPS2). The revised label states that patients of Chinese descent should not receive simvastatin 80 mg with cholesterol-modifying doses of niacin-containing products. Further, the revised label recommends caution when such patients are treated with simvastatin 40 mg or less in combination with cholesterol-modifying doses of niacin-containing products. The interim HPS2 results showed that the incidence of myopathy was higher in patients of Chinese descent (0.43 percent) compared with patients not of Chinese descent (0.03 percent) taking 40 mg simvastatin plus cholesterol-modifying doses (≥1 g/day) of a niacin-containing product. It is not known if the increased risk for myopathy observed in these patients applies to other patients of Asian descent.

Moreover, FDA has requested that the sponsor of simvastatin change the product labeling to instruct healthcare professionals to avoid prescribing simvastatin doses greater than 40 mg daily when patients are taking the medication diltiazem, due to an increased risk for myopathy.

A 2010 review of prescription drug use data conducted by FDA found that, despite dose limitations and drug-drug interaction precautions included in the simvastatin drug label, patients are continuing to be prescribed higher doses of simvastatin with other medications that are known to increase the risk for rhabdomyolysis.

It is important for healthcare professionals to consider the potential risks and known benefits of simvastatin compared to other cholesterol-lowering therapies when deciding to use simvastatin. Healthcare professionals should also carefully review patients' medications for potential drug-drug interactions before prescribing or dispensing simvastatin.

This communication is in keeping with FDA's commitment to inform the public about its ongoing safety review of drugs. The agency will update the public as soon as this review is complete.

View the following communication on the FDA website at *http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm204882.htm*: FDA drug safety communication: Ongoing safety review of high-dose Zocor (simvastatin) and increased risk of muscle injury.

Source: CMS PERL 201003-48

End-Stage Renal Disease

Validating the billing of end-stage renal disease 50/50 rule modifier

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

Note: This article was revised on March 24 to reflect the revised change request (CR) 6683 that was issued on March 23. The CR release date, transmittal number, and the Web address for accessing CR 6683 were revised in the article. All other information remains the same. This information was previously published in the November 2009 *Medicare B Update!* pages 18-19.

Provider types affected

This article is for physicians, laboratories, and providers billing Medicare contractors (carriers or Medicare administrative contractors [MACs]) for automated multi-channel chemistry (AMCC) end-stage renal disease (ESRD)-related tests provided to Medicare beneficiaries.

Provider action needed

You should be aware that CR 6683 creates the functionality in the Medicare systems to check that claims for AMCC ESRD-related tests for an ESRD beneficiary ordered by a physician from the dialysis facility use the ESRD 50/50 rule modifiers properly. Claims validation will begin with claims processed on or after April 5, 2010.

The *Background* section sets out the billing instructions to be validated. These instructions were discussed in MM3890, available at *http://www.cms.gov/MLNMattersArticles/downloads/MM3890.pdf* and added to the *Medicare Benefit Policy Manual*, Chapter 11, Section 30.2.2 and the *Medicare Claims Processing Manual*, Chapter 16, Section 40.6.1, both available at *http://www.cms.gov/Manuals/IOM/list.asp*. Make sure that your staff is aware of this validation process.

Background

CR 6683, advises that, effective with claims processed on or after April 5, 2010, Medicare will validate claims for AMCC ESRD-related tests provided to a beneficiary who is ESRD eligible to ensure your compliance with billing instructions regarding the use of the ESRD 50/50 rule modifiers CD, CE, and CF.

Validating the billing of end-stage renal disease 50/50 rule modifier (continued)

The payment of certain ESRD laboratory services performed by an independent laboratory is included in the composite rate calculation for ESRD facilities. When billing Medicare for AMCC ESRD-related tests, laboratories must indicate which tests are or are not included within the ESRD facility composite rate to ensure proper reimbursement.

The ESRD 50/50 rule classifies AMCC ESRD-related tests according to the following categories:

1. AMCC test ordered by an ESRD facility (or a physician included in the monthly capitation payment (MCP), i.e., an MCP physician) that is part of the composite rate and is not separately billable.
2. AMCC test ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.
3. AMCC test ordered by an ESRD facility (or MCP physician) that is not part of the composite rate and is separately billable.

When billing for AMCC ESRD-related tests, the laboratory must include the appropriate modifier for each test, as follows:

Modifier CD – AMCC test has been ordered by an ESRD facility (or MCP physician) that is part of the composite rate and is not separately billable.

Modifier CE – AMCC test has been ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity.

Modifier CF – AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable.

The proportion (or percentage) of composite tests to non-composite tests billed is used to determine whether separate payment may be made for all tests performed on the same day for the same beneficiary. The chart attached to CR 6683 identifies the AMCC ESRD-related tests and the Web address for accessing CR 6683 is provided in the *Additional information*" section of this article.

Physicians, providers, and suppliers billing AMCC ESRD-related tests to Medicare must report CD, CE, or CF modifiers for each test. If at least one of the three modifiers is not shown for one of the AMCC ESRD-related test codes, all AMCC ESRD-related tests on the claim will be returned as unprocessable.

When an organ disease panel (i.e., *80076, 80047, 80048, 80053, 80069, 80061*, or *80051* in the chart attached to CR 6683) is billed on a claim regardless of whether CD, CE, or CF modifier is used, the claim will be returned as unprocessable.

If the beneficiary is not ESRD eligible or if the ordering physician is not an MCP physician, then the Medicare contractor will process the claim as acceptable and payable as a non-ESRD claim.

Additional information

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

The official instruction, CR 6683, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R661OTN.pdf*.

The fact sheet, *Outpatient Maintenance Dialysis End-Stage Renal Disease*, provides general information about outpatient maintenance dialysis for ESRD, the composite payment rate system, and separately billable items and services. The fact sheet is available at *http://www.cms.gov/MLNProducts/downloads/ESRDpaymtfctsht08-508.pdf*.

MLN Matters® Number: MM6683 *Revised*
Related Change Request (CR) #: 6683
Related CR Release Date: March 23, 2010
Effective Date: Claims processed on or after April 5, 2010
Related CR Transmittal #: R661OTN
Implementation Date: April 5, 2010

Evaluation and Management

Billing split/shared consultation services

This article is a clarification to a concern expressed by some providers regarding the following question and answer in the special edition *MLN Matters* article SE1010:

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

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.

In a recent open door forum, the Centers for Medicare & Medicaid Services provided the following clarification: Since Medicare no longer recognizes consultation codes, the existing split/shared rules that correspond to the evaluation and management service (E/M) codes that the provider must now use in place of the consultation codes will apply. Therefore, a provider can split/share a consultation-type service when using an applicable split/shared E/M code (such as hospital or office/outpatient E/M codes).

The guidelines regarding split/shared visits may be found in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 12, Sections 30.6.1-30.6.14.

Source: Special edition *MLN Matters* article SE1010

Laboratory/Pathology

Special instructions for specific test codes paid under the clinical laboratory fee schedule

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6852 which provides special instructions for the proper use of *Current Procedural Terminology* (*CPT*) codes *80100, 80101*, and *80101QW*, as well as HCPCS codes G0430, G0430QW, G0431, and G0431QW as of April 1, 2010. Be sure your billing staff is aware of the changes outlined in this article.

Background

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

During calendar year (CY) 2009, effective for January 1, 2010, two new G codes were established: G0430 and G0431. Some providers were incorrectly using *CPT* codes *80100* and *80101*. Therefore, CMS created two new G codes to operate in place of and alongside existing *CPT* codes *80100* and *80101*.

In addition, those clinical laboratories that require a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver had been utilizing *CPT* code *80101QW*. In order to ensure that clinical laboratories that require a CLIA certificate of waiver are also billing correctly whether the drug screen test performed is for a single drug class or multiple drug classes, effective April 1, 2010, two additional G codes were established – G0430QW and G0431QW.

Key points of CR 6852

Each test code discussed in CR 6852 is currently described as follows by the American Medical Association (AMA) (*CPT* codes) and HCPCS (G codes):

80100	*Drug screen, qualitative; multiple drug classes chromatographic method, each procedure*
80101	*Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
80101QW	*Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class*
G0430	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
G0430QW	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure
G0431	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class
G0431QW	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class.

Special instructions for specific test codes paid under the clinical laboratory fee schedule (continued)

For purposes of the CLFS, beginning with dates of service on or after April 1, 2010, when performing a qualitative drug screening test for multiple drug classes that uses chromatographic methods, *CPT* code *80100* is the appropriate code to bill.

New test code G0430 was created to limit the billing to one time per procedure and to remove the limitation of the method (chromatographic) when this method is not being used in the performance of the test. As a result, when a clinical laboratory that does not require a CLIA certificate of waiver performs a qualitative drug screening test for multiple drug classes that does not use chromatographic methods, new test code G0430 is the appropriate code to bill.

When a clinical laboratory that does require a CLIA certificate of waiver performs a qualitative drug screening test for multiple drug classes that does not use chromatographic methods, new test code G0430QW is the appropriate code to bill.

Remember: New test code G0431 is a direct replacement for *CPT* code *80101*. For purposes of the CLFS, effective with dates of service on or after April 1, 2010, new test code G0431 should be utilized by those clinical laboratories that do not require a CLIA certificate of waiver. Those clinical laboratories that do require a CLIA certificate of waiver should utilize new test code G0431QW. Effective April 1, 2010, *CPT* code *80101* will no longer be covered by Medicare, and *CPT* code *80101QW* will be deleted.

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 6852, issued to your Medicare MAC, FI or carrier regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R653OTN.pdf*.

A related article, MM6657 which provides instructions for the CY 2010 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment, may be reviewed at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6657.pdf*.

For additional information regarding the CY 2010 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment see special edition *MLN* article SE1001 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1001.pdf*.

MLN Matters® Number: MM6852
Related Change Request (CR) #: 6852
Related CR Release Date: March 19, 2010
Effective Date: April 1, 2010
Related CR Transmittal #: R653OTN
Implementation Date: April 5, 2010

Medicare travel allowance fees for collection of specimens

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

Provider types affected

This article is for clinical laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for clinical laboratory specimen collection services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 6864 which updates the Medicare travel allowance fees for collection of specimens for calendar year (CY) 2010. The Centers for Medicare & Medicaid Services (CMS) will issue annual updated travel allowance amounts via a recurring update CR. Be sure billing staff knows of these changes.

Background

Under Part B, Medicare covers a specimen collection fee and travel allowance for a laboratory technician who draws a specimen from either a nursing home or homebound patient under the Social Security Act (Section 1833(h)(3), (see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*); and payment is made based on the clinical laboratory fee schedule.

The travel allowance, which is intended to cover the estimated travel costs of collecting a specimen (including the laboratory technician's salary and travel expenses), is made only if a specimen collection fee is also payable. The travel codes allow for such payment either on a per mileage basis (Healthcare Common Procedure Coding System [HCPCS] code P9603 – Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually traveled), or on a flat rate per trip basis (HCPCS code P9604 – Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge).

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor. The 2010 travel allowances are:

Medicare travel allowance fees for collection of specimens (continued)

Per-mile travel allowance (HCPCS Code P9603)

The per-mile travel allowance is to be used when the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated when specimens are also drawn from non-Medicare patients in the same trip. CR 6864 instructs your contractor to pay for HCPCS code P9603, when the average trip to the patients' homes exceeds 20 miles round trip, at a total of $0.95 per mile. This includes:

- The federal mileage rate of $0.50 per mile plus
- An additional $0.45 per mile to cover the technician's time and travel costs.

Your contractor has the option to establish a higher per mile rate for HCPCS code P9603, in excess of the minimum $0.95 per mile, if local conditions warrant it. In addition, the minimum mileage rate will be reviewed and updated in conjunction with the CLFS as needed.

Per flat-rate trip basis travel allowance (HCPCS code P9604)

CR 6864 also instructs your contractor to pay for HCPCS code P9604 on a flat-rate trip basis travel allowance of $9.50 per trip.

Note: At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles that are not actually traveled by the laboratory technician.

Please keep in mind that Medicare allows your contractor to choose either the mileage or flat rate basis for payment, and to also choose how to set each type of allowance. Finally, remember that your contractor will not search their files to either retract payment or retroactively pay claims; however, should adjust claims that you bring to their attention.

Additional information

You may find the official instruction, CR 6864, issued to your carrier, FI, or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R1933CP.pdf*.

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

MLN Matters® Number: MM6864
Related Change Request (CR) #: 6864
Related CR Release Date: March 19, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R1933CP
Implementation Date: April 5, 2010

Legislation to allow billing of technical component by independent laboratory

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

Provider types affected

Independent clinical diagnostic laboratories submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors [A/B MAC]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6813, which directs Medicare contractors to notify independent laboratories eligible to bill for the technical component (TC) of physician pathology services provided in an inpatient or outpatient setting of a hospital that they may continue to do so through December 31, 2010, regardless of the beneficiary's hospitalization status (inpatient or outpatient), in accordance with the Patient Protection and Affordable Care Act. Hospitals and independent laboratories should be sure that their billing staffs are aware of this billing extension.

Background

The Patient Protection and Affordable Care Act was enacted on March 23, 2010. Section 3104 of this statute permits independent clinical laboratories to continue to bill for the TC of physician pathology services for inpatients or outpatients of a hospital. Independent laboratories that qualify to bill under Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA), Section 732 of the Medicare Modernization Act (MMA), Section 104 of the Tax Relief and Health Care Act of 2006 (TRHCA), Section 104 of the Medicare, Medicaid, State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA), and Section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the TC of the physician pathology services may continue to do so effective with date of service January 1, 2010, through December 31, 2010.

Additional information

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

The official instruction issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1945CP.pdf*.

MLN Matters® Number: MM6813
Related Change Request (CR) #: 6813
Related CR Release Date: April 9, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R1945CP
Implementation Date: July 9, 2010

Extension of moratorium on billing for technical component to hospital patients

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which extends the moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to patients in hospitals, effective for claims with dates of service on and after January 1, 2010, through December 31, 2010.

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, the Centers for Medicare & Medicaid Services (CMS) stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. At the request of the industry to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed.

Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the previous extension of the moratorium expired at the end of 2009, Section 3104 of the PPACA restored the moratorium retroactive to January 1, 2010. Therefore, independent laboratories may now submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed.

This policy is effective for claims with dates of service on or after January 1, 2010, through December 31, 2010. If an independent laboratory previously submitted a claim for services covered by this provision and the claim was denied, the laboratory may contact its Medicare contractor for further instructions.

Please be on the alert for more information pertaining to the PPACA.

Source: CMS PERL 201003-56

Medicare Physician Fee Schedule

Zero percent update extended through May 31

President Obama on Thursday signed into law the "Continuing Extension Act of 2010." This law extends through May 31, 2010, the zero percent update to the Medicare physician's fee schedule that was in effect for claims with dates of service January 1-March 31.

The law is retroactive to April 1. As a result, effective immediately, claims with dates of service April 1 and later, which are being held by Medicare contractors, are being released for processing and payment. Please keep in mind that the statutory payment floors still apply and, therefore, clean electronic claims cannot be paid before 14 calendar days after the date they are received by Medicare contractors (29 calendar days for clean paper claims).

Given the uncertainty regarding MPFS claims with dates of service June 1, 2010, and later, please watch your listservs and your contractor's website for more information.

Source: CMS PERL 201004-27

Radiology

Positron emission tomography (NaF-18) to identify bone metastasis of cancer

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

Provider types affected

This article is for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) when providing NaF-18 PET scans to identify bone metastasis of cancer for Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6852 and states that effective for claims with dates of service on and after February 26, 2010, be aware that NaF-18 PET oncologic claims to inform initial treatment strategy (PI) or subsequent treatment strategy (PS) for suspected or biopsy proven bone metastasis **are covered, but only in the context of a clinical study**. All other claims for NaF-18 PET oncology claims are noncovered.

Background

On June 4, 2009, the Centers for Medicare & Medicaid Services (CMS) opened a reconsideration of section 220.6 of the *National Coverage Determinations (NCD) Manual* to review evidence on the use of NaF-18 (sodium fluoride-18) imaging (NaF-18 PET) to identify bone metastasis of cancer. CMS proposes that the evidence is not sufficient to determine that the results of NaF-18 PET imaging to identify bone metastases improve health outcomes of beneficiaries with cancer.

Positron emission tomography (NaF-18) to identify bone metastasis of cancer (continued)

Therefore this use is not reasonable and necessary under Section1862(a)(1)(A) of the Social Security Act (the Act).

However, CMS proposes that the available evidence is sufficient to determine that NaF-18 PET imaging, to identify symptomatic or strongly suspected bone metastasis of cancer to inform the initial antitumor treatment strategy or to guide subsequent antitumor treatment strategy after the completion of initial treatment, is reasonable and necessary under Section 1862(a)(1)(E) through coverage with evidence development (CED) when the beneficiary's treating physician determines that the NaF-18 PET study is needed, and when the beneficiary is enrolled in, and the NaF-18 PET provider is participating in, specific types of prospective clinical studies as outlined in Section 220.6 of the *NCD Manual*.

Key points of CR 6861

NaF-18 PET oncologic claims:

- With dates of service on or after February 26, 2010, Medicare contractors will accept and pay the claims as specified in the revised Section 220.6.19 of the *NCD Manual*, to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven bone metastasis **only in the context of a clinical study**. **Note**: NaF-18 PET also applies to NaF-18 PET/CT.
- With dates of service on or after February 26, 2010, contractors will **return as unprocessable** (professional) or **return to provider** the claims to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis that do not include **all** of the following are present on the claim:
  - Modifier PI or PS
  - PET or PET/CT CPT code (*78608, 78811, 78812, 78813, 78814, 78815, 78816*)
  - ICD-9 cancer diagnosis code
  - HCPCS A9580 (sodium fluoride F-18, diagnostic, per study dose, up to 30 millicuries)
  - Modifier Q0 - Investigational clinical service provided in a clinical research study that is in an approved clinical research study.

Note: For institutional claims, continue to include diagnosis code V70.7 and condition code 30 to denote a clinical study**.**

- Effective for claims with dates of service on or after February 26, 2010, when returning NaF-18 PET claims to providers, they will use the following messages depending on the reason for return:
  - Claims returned for not having the Q0 and either the PI or PS modifier will reflect claim adjustment reason code (CARC) of 4 (The procedure is inconsistent with the modifier used or a required modifier is missing.), remittance advice remark code (RARC) MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.), and RARC M16 (Alert: See our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.)
  - Such claims submitted without HCPCS A9580 will be returned with RARC M20 (Missing/incomplete/invalid HCPCS), and
  - Such claims submitted without an ICD-9 cancer diagnosis code will contain CARC 167 (This (these) diagnosis(es) is (are) not covered).
- Although this coverage decision is effective February 26, 2010, it will not be fully implemented until a clinical study is ready to enroll providers and patients. Medicare will notify providers and beneficiaries where these services can be accessed, as they become available, via the CMS coverage page at *http://www.cms.gov/center/coverage.asp*.

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

The official instruction, CR 6861, was issued to your Medicare MAC, FI or carrier regarding this change via two transmittals. The first modifies the *Medicare NCD Manual* and is at *http://www.cms.gov/Transmittals/downloads/R119NCD.pdf*. The second revises the *Medicare Claims Processing Manual* and it may be viewed at *http://www.cms.gov/Transmittals/downloads/R1937CP.pdf*. Attached to the NCD Transmittal is the revised Section 220.6.19 of the *NCD Manual*.

MLN Matters® Number: MM6861
Related Change Request (CR) #: 6861
Related CR Release Date: March 26, 2010
Effective Date: February 26, 2010
Related CR Transmittal #: R1937CP and R119NCD
Implementation Date: July 6, 2010

Therapy Services

Extension of therapy cap exceptions process

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which extends the exceptions process for outpatient therapy caps (see Section 3103). Outpatient-therapy service providers may continue to submit claims with modifier KX, when an exception is appropriate, for services furnished on or after January 1, 2010, through December 31, 2010.

The therapy caps are determined on a calendar year basis, so all patients began a new cap year on January 1, 2010. For physical therapy and speech-language pathology services combined, the limit on incurred expenses is $1,860. For occupational therapy services, the limit is $1,860. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Please be on the alert for more information pertaining to the PPACA.

Source: CMS PERL 201003-56

Comprehensive outpatient rehabilitation facility coverage

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

Note: This article was revised on March 19, to clarify the language in the "What you need to know" section to refer to the correct types of therapy. All other information remains the same. This information was previously published in the October 2009 *Medicare B Update!* pages 15-17.

Provider types affected

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

What you need to know

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

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

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

Background

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

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

The policy changes that CR 6005 announces are synthesized below.

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

Required services

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

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

   Please be aware that diagnostic or therapeutic services that a CORF (or other) physician provides to a CORF patient are **not** CORF physician services. These

Comprehensive outpatient rehabilitation facility coverage (continued)

services are separately payable to the physician under the MPFS, at the non-facility payment amount billed as if provided in the physician's office.
Remember that to become a CORF patient, a beneficiary must be under the care of a physician who certifies that he/she needs skilled rehabilitation services. If the referring physician does not specify the rehabilitation goals for PT, OT, SLP, or RT services, the CORF physician must established them. Further, either the referring physician or the CORF physician must establish, and sign, a rehabilitation plan of treatment prior to the beginning treatment.
In addition, the CORF physician or the referring physician, must review the treatment plan for respiratory therapy services at least every 60 days; and for physical therapy, occupational therapy, speech-language pathology, and for all other services at least once every 90 days; certifying that the plan is being followed and that the patient is making progress in attaining the established rehabilitation goals.

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

2. Physical therapy services should comprise a clear majority of the total CORF services. To supervise CORF physical therapy services, the physical therapist must be on the CORF premises (or must be available to the physical therapy assistant through direct telecommunications for consultation and assistance) during the CORF's operating hours.
3. Social and psychological services are covered only if the patient's physician (or CORF physician) establishes that the services directly relate to the patients' rehabilitation plan of treatment and are needed to obtain the rehabilitation goals. Social and psychological services include only those services that address the patient's response and adjustment to the rehabilitation treatment plan; rate if improvement and progress towards the rehabilitation goals; or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory plan of treatment.

   Notes: 1) CORF social and psychological services are the same, whether provided by either a qualified social worker or psychologist. Qualifications for individuals providing CORF social and psychological services are a Bachelors of Science for social workers and a Masters-level degree for psychologist; 2) Social and psychological services do not include services for mental health diagnoses.

Optional services

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

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

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

   Please take note that services performed by respiratory therapy technicians are **not** covered because the current medical standards for skilled respiratory therapy services provided to patients in the CORF setting require the educational requirements of respiratory therapists. Examples of specific RT CORF services include the respiratory therapist assessing the patient to determine the appropriateness of pursed lip breathing activity and checking the patient's oxygen saturation level (via pulse oximetry). If appropriate, the respiratory therapist may then provide the initial training in order to ensure that the patient can accurately perform this activity; and again check the patient's oxygen saturation level, or perform peak respiratory flow, or other respiratory parameters.

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

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

   Note: Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary to the treatment of the patient's condition and can usually be given to a patient during the course of treatment by any of the health personnel involved therein, e.g., physician, nurse, respiratory therapist.
4. Prosthetic and orthotic devices are covered, including the testing, fitting, or training in their use.
5. Nursing services (which must be provided by an individual meeting the qualifications of a registered nurse (RN), rather than a licensed practical nurse (LPN)) are provided as an adjunct to the rehabilitation

Comprehensive outpatient rehabilitation facility coverage (continued)

treatment plan of treatment, and must be reasonable and medically necessary. For example, a registered nurse may perform (including patient instruction): the proper procedure of "in and out" urethral catheterization, tracheostomy tube suctioning, or the cleaning for ileostomy or colostomy bags.

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

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

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

7. Supplies and durable medical equipment (DME) – CORFs may not bill for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding *Current Procedural Terminology* code in the 29XXX series.

8. Physical therapy, occupational therapy, and speech-language pathology services may be furnished in the patient's home, as CORF services, when payment for these therapy services is not otherwise made under the Medicare home health benefit, and

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

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

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

Payment rules

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

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

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

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

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

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

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

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

Comprehensive outpatient rehabilitation facility coverage (continued)

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

Additional information

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

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

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

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

General Coverage

Items or services furnished to Medicare beneficiaries in state or local custody

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

Provider types affected

This article applies to physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B MACs) for services provided to Medicare beneficiaries in state or local penal custody.

What you need to know

This article is based on change request (CR) 6880 which updates billing instructions and claims processing requirements to fully implement the policy for Medicare beneficiaries in state or local custody that was outlined in CR 6544. CR 6880 rescinds and fully replaces CR 6544, and revises the *Medicare Claims Processing Manual*, Chapter 1, Section 10.4 and the *Medicare Benefit Policy Manual*, Chapter 17, Section 50.3.3(3). These revisions are included as attachments to CR 6880.

Background

The Medicare program does not pay for services if:

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

Also, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services. See the Social Security Act Section 1862 (a)(2)&(3) at *http://www.socialsecurity.gov/OP_Home/ssact/title18/1862.htm*.

In the fiscal year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule (72 FR 47409 and 47410; see *http://edocket.access.gpo.gov/2007/pdf/07-3820.pdf*), the Centers for Medicare & Medicaid Services (CMS) clarified its regulations at 42 CFR 411.4(b) (see *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr411_main_02.tpl*) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are:

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

42 CFR 411.4(b) describes the special conditions that must be met in order for Medicare to make payment for individuals who are in custody and states:

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

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

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

Note: Your Medicare contractor will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources. In addition, the state or local entity must document its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, your Medicare contractor will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the state or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

The Centers for Medicare & Medicaid Services (CMS) maintains a file of incarcerated beneficiaries, obtained from the Social Security Administration (SSA) that is used to edit claims.

To avoid improper denial of claims, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above should indicate this fact with the use of a the modifier QJ on claims for such services.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals should identify the incarceration period by billing as noncovered all days, services and charges that overlap the incarceration period.

Additional information

The official instruction, CR 6880, was issued to your carrier, FI, A/B MAC, and DME MAC in two transmittals. The first transmittal modifies the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R1944CP.pdf*. The second transmittal is at *http://www.cms.gov/Transmittals/downloads/R122BP.pdf* and it contains the revised portion of the *Medicare Benefit Policy Manual* regarding this change.

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

MLN Matters® Number: MM6880
Related Change Request (CR) #: 6880
Related CR Release Date: April 9, 2010
Effective Date: July 9, 2010
Related CR Transmittal #: R1944CP and R122BP
Implementation Date: July 9, 2010

Signature guidelines for medical review purposes

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

Provider types affected

This article is for physicians, nonphysician practitioners, and suppliers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), carriers, regional home health intermediaries (RHHIs), and/or durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for e-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for reviews conducted on or after the implementation date of April 16, 2010. Please note that all signature requirements in CR 6698 are effective retroactively for comprehensive error rate testing (CERT) for the November 2010 report period.

Background

Those contractors who review Medicare claims include MACs, affiliated contractors (ACs), the CERT contractors, recovery audit contractors (RACs), program safeguard contractors (PSCs), and zone program integrity contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the fee-for-service (FFS) Medicare program.

The previous language in the Program Integrity Manual (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds e-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

Exception 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

Signature guidelines for medical review purposes (continued)

Exception 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

Exception 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature is legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g.MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered. Example: The claim selected for review is for a hospital visit on October 4. The additional documentation request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.
- **Definition of a signature log**: Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- **Definition of an attestation statement**: In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

  "I, _____[print full name of the physician/ practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."
- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

Signature guidelines for medical review purposes (continued)

- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
  - In the situations where the guidelines indicate "signature requirements met," the reviewer will consider the entry.
  - In situations where the guidelines indicate "contact provider and ask a non-standard follow-up question," the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
  - In the situations where the guidelines indicate "signature requirements **not** met," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic prescribing

Electronic prescribing (e-Prescribing) is the transmission of prescription or prescription-related information through electronic media. e-Prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-Prescribing network. With e-Prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. e-Prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified r-Prescribing system. For Medicare Part B medical review purposes, a qualified e-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, 42 CFR 423.160 Standards for Electronic Prescribing, you may go to *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf*.
- When Part B drugs, other than controlled substances, have been ordered through a qualified e-Prescribing system, the reviewer will **not** require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall **not** accept as a valid order any controlled substance drugs that are ordered through any e-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.
- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified e-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified e-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified e-Prescribing system, the reviewer shall **not** require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional information

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

The official instruction, CR 6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R327PI.pdf*.

MLN Matters® Number: MM6698
Related Change Request (CR) #: 6698
Related CR Release Date: March 16, 2010
Effective Date: March 1, 2010
Related CR Transmittal #: R327PI
Implementation Date: April 16, 2010

Ordering/referring providers who are not enrolled in Medicare

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

For the provider education information related to change request (CR) 6696, see the *MLN Matters*® article, SE1011, at *http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf* and following this article.

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Related Change Request (CR) #: 6696
Related CR Release Date: March 19, 2010
Effective Date: April 19, 2010
Related CR Transmittal #: R328PI
Implementation Date: April 19, 2010

Edits on the ordering/referring providers in Medicare Part B claims

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

Provider types affected

Physicians, nonphysician practitioners (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855I). If you reassign your Medicare benefits to a group or clinic, you will also need to complete the CMS-855R.

What providers need to know

Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: Beginning January 3, 2011, Medicare will reject Part B claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment records in PECOS and must be of a specialty that is eligible to order and refer.

Enrolled physicians and nonphysician practitioners who do not have enrollment records in PECOS and who submit enrollment applications in order to get their enrollment information into PECOS should not experience any disruption in Medicare payments, as a result of submitting enrollment applications.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the web, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of phase 2 of the ordering/referring provider edits, which is January 3, 2011.

Background

The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.
Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests
- Claims from imaging centers for ordered imaging procedures
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS, and
- Claims from specialists or specialty groups for referred services.

Only physicians and certain types of nonphysician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, doctor of chiropractic medicine)
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist

Edits on the ordering/referring providers in Medicare Part B claims (continued)

- Certified nurse midwife, and
- Clinical social worker.

Questions and answers relating to the edits

1. What will the edits do?

The edits will determine if the ordering/referring provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e., the enrollment record is in PECOS and it contains the national provider identifier (NPI)), and (2) is of a type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits are being implemented in two phases:

- **Phase 1** began on October 5, 2009, and is scheduled to end on January 2, 2011. In phase 1, if the ordering/referring provider does not pass the edits, the claim will be processed and paid (assuming there are no other problems with the claim) but the billing provider (the provider who furnished the item or service that was ordered or referred) will receive an informational message* from Medicare in the remittance advice†.

  The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication.

  Note: If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.

- **Phase 2** is scheduled to begin on January 3, 2011, and will continue thereafter. In phase 2, if the ordering/referring provider does not pass the edits, the claim will be rejected. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and nonphysician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.‡

On January 28, 2010, CMS made available to the public, via the "Downloads" section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and nonphysician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the ordering referring report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or nonphysician practitioner. To keep the available information up to date, CMS will replace the report on a periodic basis. At any given time, only one report (the most current) will be available for downloading. To learn more about the report, and to download it, go to *http://www.cms.gov/MedicareProviderSupEnroll*; click on "Ordering Referring Report" (on the left). Information about the report will be displayed.

* The informational messages vary depending on the claims processing system.
† DMEPOS suppliers who submit paper claims will not receive an informational message on the remittance advice.
‡ NPIs were added only when the matching criteria verified the NPI.

Effect of edits on providers

A. I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you—the ordering/referring provider—need to ensure that:

1. **You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).**
   - If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in six or more years, you do not have an enrollment record in PECOS. You need to take action to establish one. **See the last bullet in this section**.
   - If you are not sure, you may: (1) check the ordering referring report previously mentioned, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS

Edits on the ordering/referring providers in Medicare Part B claims (continued)

and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.

- **If you do not have an enrollment record in PECOS:**
  - You need to submit an enrollment application to Medicare in one of two ways:

    a. Use Internet-based PECOS to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the certification statement and mail the certification statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to *http://www.cms.gov/MedicareProviderSupEnroll*, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads section on that page that relate to physicians and nonphysician practitioners. A link to Internet-based PECOS is included on that Web page.

Note: For physicians/nonphysician practitioners who reassign all their Medicare benefits to a group/clinic: If you reassign all of your Medicare benefits to a group/clinic, the group/clinic must have an enrollment record in PECOS in order for you to enroll via the Web. You should check with the officials of the group/clinic or with your designated Medicare enrollment contractor if you are not sure if the group/clinic has an enrollment record in PECOS. If the group/clinic does not have an enrollment record in PECOS, you will not be able to use the Web to submit your enrollment application to Medicare. You will need to submit a paper application, as described in the bullet below.

b. Obtain a paper enrollment application (CMS-855I), fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you reassign all your Medicare benefits to a group/clinic, you will also need to fill out, sign and date the CMS-855R, obtain the signature/date signed of the group's authorized official, and mail the CMS-855R, along with the CMS-855I, to the designated Medicare enrollment contractor. Enrollment applications are available for downloading from the CMS forms page (*http://www.cms.gov/cmsforms*) or by contacting your designated Medicare enrollment contractor.

Note about physicians/nonphysician practitioners who have opted-out of Medicare but who order and refer: Physicians and nonphysician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every two years, and the NPI is required on the affidavit). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

2. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty and only the nonphysician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

B. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the ordering/referring provider edits?

As the billing provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the two edits on the ordering/referring provider so that you will not receive informational messages in phase 1 and so that your claims will be paid in phase 2.

You need to use due diligence to ensure that the physicians and nonphysician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have enrollment records in PECOS that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or nonphysician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the ordering referring report described earlier in this article. Ensure you are correctly spelling the ordering/referring provider's name. If you furnished items or services from an order or referral from someone on the ordering referring report, your claim should pass the ordering/referring provider edits. Keep in mind that this ordering referring report will be replaced about once a month to ensure it is as current as practicable. It is possible, therefore, that you may receive an order or a referral from a physician or nonphysician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next report. You may resubmit a claim that did not initially pass the ordering/referring provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the ordering/referring provider's first name first, and last name second (e.g., John Smith).

Edits on the ordering/referring providers in Medicare Part B claims (continued)

Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or nonphysician practitioner and not to an organization, such as a group practice that employs the physician or nonphysician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, billing providers should contact their local carrier, A/B MAC, or DME MAC.

Billing providers should be aware that claims that are rejected because they failed the ordering/referring provider edits are not denials of payment by Medicare that would expose the Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate**.

Additional guidance

1. **Orders or referrals by interns or residents**. Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/she may not be identified in a Medicare claim as the ordering/referring provider. The teaching, admitting, or supervising physician is considered the ordering/referring provider when interns and residents order and refer, and that physician's name and NPI would be reported on the claim as the ordering/referring provider.
2. **Orders or referrals by physicians and nonphysician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare**. These physicians and nonphysician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper certification statement that is generated when submitting a Web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
3. **Orders or referrals by dentists**. Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper certification statement that is generated when submitting a Web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

You may want to review the following related CRs:

- CR 6417 at *http://www.cms.gov/Transmittals/downloads/R642OTN.pdf*
- CR 6421 at *http://www.cms.gov/Transmittals/downloads/R643OTN.pdf*
- CR 6696 at *http://www.cms.gov/Transmittals/downloads/R328PI.pdf*

If you have questions, please contact your Medicare carrier, Part A/B Medicare administrative contractor (A/B MAC), or durable medical equipment Medicare administrative contractor (DME/MAC), at their toll-free numbers, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters Number: SE1011
Related Change Request (CR) #: 6421, 6417, and 6696
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, and R328PI
Implementation Date: N/A

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

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

Note: This article was revised on March 30 to reflect the changes in the release of a new CR 6417 on February 26. The implementation date for some of the requirements of Phase 2 is being changed from April 5, 2010, to January 3, 2011 (see the *Key points* section). The Transmittal number, CR release date, and Web address for accessing the CR has also been changed. All other information remains the same. However, it is extremely important to read *MLN Matters*® special edition article, SE1011, at *http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf* to see important clarifying information regarding this issue. This information was previously published in the December 2009 *Medicare B Update!* pages 29-30.

Provider types affected

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

Provider action needed

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

Background

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

The providers who can order/refer are:

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

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

Key points

- **During Phase 1 (October 5, 2009- January 2, 2011)**: If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. If the ordering/referring provider is not in PECOS the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and the Part B provider or supplier will receive a warning message on the remittance advice. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the remittance advice.
- **During Phase 2, (January 3, 2011, and thereafter)**: If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. Effective January 3, 2011, if the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.
- **In both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system.

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

In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.

- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*. Once at that site, scroll to the *Downloads* section of that page and click on the materials that apply to you and your practice.

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

Additional information

You may find the official instruction, CR 6417, issued to your carrier or B MAC by visiting *http://www.cms.gov/Transmittals/downloads/R642OTN.pdf*.
If you have any questions, please contact your carrier or B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6417 *Revised*
Related Change Request (CR) #: 6417
Related CR Release Date: February 26, 2010
Effective Dates: Phase 1: October 5, 2009,
Phase 2: January 3, 2011
Related CR Transmittal #: R642OTN
Implementation Dates: Phase 1: October 5, 2009,
Phase 2: January 3, 2011

Sunset payment of Indian Health Services

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

Note: This article was revised and re-issued on March 31, to reflect the impact of the Patient Protection and Affordable Care Act on these IHS services. In essence, the new Act permanently extends Section 630 of the MMA retroactive to January 1, 2010. See the rest of this article to see how the new law impacts your claims. This information was previously published in the January 2010 *Medicare B Update!* page 31.

Provider types affected

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

Provider action needed

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

However, on March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. Section 2902 of the new law permanently extends Section 630 of the MMA, retroactive to January 1, 2010. The services involved include the following:

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

IHS providers, suppliers, physicians and other practitioners should contact their Medicare contractor for further guidance regarding IHS claims affected by the new law, for dates of service January 1, 2010, and after, which were denied, prior to implementation of the new law.

Note: It will take approximately two weeks for your Medicare contractor to update their systems to be able to pay correctly for these services. You may want to wait until the claims processing system is updated before submitting any new claims containing these IHS services. CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue.

Please be on the alert for more information pertaining to the Patient Protection and Affordable Care Act.

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

Expiration of various payment provisions under the Medicare program

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

Note: This article was revised and re-issued on April 1, 2010, to reflect the impact of the Patient Protection and Affordable Care Act (PPACA) on the therapy caps exceptions process and on billings by independent laboratories for the technical component of physician pathology services furnished to hospital patients. This information was previously published in the January 2010 *Medicare B Update!* page 30.

Provider types affected

All Medicare providers should take note of this article.

Provider action needed

This special edition article is being re-issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected providers that a number of Medicare payment provisions, such as the therapy cap exceptions process and allowing independent laboratories to bill for the Therapy Cap Exceptions Process and Allowing Independent Laboratories to Bill for the Technical Component of Physician Pathology Services Furnished to Hospital Patients, have been extended as a result of the PPACA. Previously, these provisions were to sunset as of December 31, 2009.

Extension of moratorium that allows independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients

On March 23, 2010, President Obama signed into law the PPACA, which extends the moratorium that allows independent laboratories to bill for the TC of physician pathology services furnished to patients in hospitals, effective for claims with dates of service on and after January 1, 2010, through December 31, 2010.

In the final physician fee schedule regulation published in the *Federal Register* on November 2, 1999, CMS stated that it would implement a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. At the request of industry, to allow independent laboratories and hospitals sufficient time to negotiate arrangements, the implementation of this rule was administratively delayed. Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the previous extension of the moratorium expired at the end of 2009, Section 3104 of the PPACA restored the moratorium retroactive to January 1, 2010. Therefore, independent laboratories may now submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2010, through December 31, 2010. If an independent laboratory previously submitted a claim for services covered by this provision and the claim was denied, the laboratory may contact its Medicare contractor for further instructions.

Extension of therapy cap exceptions process

Section 3103 of the PPACA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the modifier KX, when an exception is appropriate, for services furnished on or after January 1, 2010, through December 31, 2010.

Therapy caps are determined on a calendar year basis, so all patients began a new cap year on January 1, 2010. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,860. For occupational therapy services, the limit is $1,860. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Please be on the alert for more information pertaining to the PPACA.

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

Coverage for treating facial lipodystrophy syndrome in people living with HIV

On March 23, 2010, the Centers for Medicare & Medicaid Services (CMS) announced its decision to cover facial injections for Medicare beneficiaries who experience symptoms of depression due to the stigmatizing appearance of severely hollowed cheeks resulting from the drug treatment for human immunodeficiency virus (HIV). This decision is effective immediately.

Facial lipodystrophy syndrome (LDS) is a localized loss of fat from the face, causing an excessively thin appearance in the cheeks. In some cases, facial LDS may be a side effect of certain kinds of medications (antiretroviral therapies) that individuals receive as part of an HIV infection treatment regimen.

The facial LDS may leave people living with HIV looking gaunt and seriously ill, which may stigmatize them as part of their HIV-infection status. Individuals who take these medications and experience facial LDS side effects may suffer psychological effects related to a negative self-image. These effects may lead people living with HIV to discontinue their antiretroviral therapies. The new decision allows for treatment of individuals who experience symptoms of depression due to the appearance changes from facial LDS.

The injections included in this coverage decision are "fillers" that have been approved by the U.S. Food & Drug Administration (FDA) to be injected under the skin in the face to help fill out its appearance specifically for treatment of facial LDS. Data show that these injections can improve patient self-image, relieve symptoms of depression, and may lead to improved compliance with anti-HIV treatment.

Coverage for treating facial lipodystrophy syndrome in people living with HIV (continued)

"Today's decision marks an important milestone in Medicare's coverage for HIV-infection therapies," said Barry M. Straube, M.D., CMS Chief Medical Officer and Director of the Agency's Office of Clinical Standards & Quality. "Helping people living with HIV improve their self-image and comply with anti-HIV treatment can lead to better quality of life and, ultimately, improve the quality of care that beneficiaries receive."

The final decision is posted on the CMS website at *http://www.cms.gov/mcd/viewdecisionmemo.asp?id=234*.

Source: CMS PERL 201003-44

Final 2011 payment policies for Medicare Advantage and prescription drug plans

Background: On April 5, 2010, the Centers for Medicare & Medicaid Services (CMS) announced the capitation rates for Medicare Advantage (MA) plans for 2011. The 2011 rate announcement was accompanied by the final 2011 call letter for Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans.

CMS stated in the 2011 advance notice that, if new legislation was enacted after the advance notice was released, but before the rate announcement was published, changes would be incorporated into the announcement. As required by Section 1102 of the Health Care and Education Reconciliation Act of 2010, the capitation rates for 2011 are the same as the capitation rates for 2010.

In rate announcements from previous years, CMS included final estimates of the national per capital growth percentages (MA growth percentages) as well as tables summarizing the key assumptions that were used to develop the MA growth percentages. The final estimates of the MA growth percentages were used to trend the capitation rates from previous years to the payment year. Given that the capitation rates for 2011 are the same as the capitation rates for 2010, the MA growth percentages have no relevance for the 2011capitation rates.

Therefore, this rate announcement does not include final estimates of the MA growth percentages or the associated key assumptions tables.

The rate announcement also contains the following key changes in response to this new legislation:

- CMS will not implement the new CMS-HCC and CMS-HCC ESRD dialysis and risk adjustment models or the recalibrated frailty factors in 2011.
- CMS will maintain the 2011 state ESRD rates at the 2010 amounts.
- As required by the Patient Protection and Affordable Care Act of 2010, CMS will calculate the government Part D premium subsidy amounts for low-income beneficiaries using the basic Part D premium plans before the premiums are reduced by Part C rebates. This will help ensure that the premium subsidy in each Part D region provides low-income beneficiaries with a sufficient choice of plans for which they would incur no premium liability.

The rate announcement also contains a discussion of the provisions in the health reform legislation that begin to close the Part D coverage gap in 2011 and the effect of these provisions on Part D plan bids.

In addition to changes resulting from new legislation, the following key changes or updates have been made to the advance notice and draft call letter in response to public comments received from beneficiary advocacy groups, associations, congressional agencies, members of the public, and health plans:

- CMS describes the methodology that will be used to adjust the 'default' risk scores for new enrollees to reflect the predicted costs of full risk enrollees in chronic care special need plans.
- CMS notes that for beneficiaries to receive reimbursement for clinical trial services, beneficiaries (or providers acting on their behalf) must notify their plan that they have received clinical trial services and provide documentation of the cost sharing incurred, such as a Medicare summary notice (MSN). CMS will explore ways that this information can be provided to plans in the future to alleviate the potential burden on beneficiaries.
- CMS states that, at this time, low-income beneficiaries who originally chose to enroll in their current plan will not be reassigned, but several methods to make beneficiaries more aware of their options are being considered. CMS will also continue to evaluate the merits of reassigning beneficiaries based on beneficiary drug utilization.
- CMS announces that we intend to issue a regulation proposing to authorize the release of Part C and Part D payment data.

Annual parameter updates to Medicare Part D benefits are unchanged (with the exception of a $10 increase in the initial coverage limit).

Part D Benefit Parameters	2010	2011
Defined Standard Benefit		
Deductible	$310	$310
Initial Coverage Limit	$2,830	$2,840

Final 2011 payment policies for Medicare Advantage and prescription drug plans (continued)

Part D Benefit Parameters	2010	2011
Out-of-Pocket Threshold	$4,550	$4,550
Minimum Cost-sharing for Generic/Preferred Multi-Source Drugs in the Catastrophic Phase	$2.50	$2.50
Minimum Cost-sharing for Other Drugs in the Catastrophic Phase	$6.30	$6.30
Retiree Drug Subsidy		
Cost Threshold	$310	$310
Cost Limit	$6,300	$6,300

Note: The changes from 2010 to 2011 are rounded to the closest appropriate unit.

The final rate announcement and call letter may be viewed at *http://www.cms.gov/MedicareAdvtgSpecRateStats/*.

Source: CMS PERL 201004-14

Let us know your feedback

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

Electronic Data Interchange

Claim status category code and claim status code update

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

Provider types affected

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

Provider action needed

This article, based on change request (CR) 6859, explains that the claim status codes and claim status category codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2010 meeting of the national code maintenance committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on or about March 1. At the January 2010 meeting, the committee also decided to allow the industry six months for implementation of newly added or changed codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on July 6, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national code maintenance committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

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

The official instruction, CR 6859, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1936CP.pdf*.

MLN Matters® Number: MM6859
Related Change Request (CR) #: 6859
Related CR Release Date: March 26, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R1936CP
Implementation Date: July 6, 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.

HIPAA version 5010 – Medicare administrative contractor requirements

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (DME Medicare administrative contractors [DME MACs] and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is informational only for providers. It is based on change request (CR) 6472 which provides Medicare administrative contractors (MACs), and DME MACs, and the DME MACs common electronic data interchange (CEDI) contractor with requirements to prepare their systems to process ASC X12 (also known as ANSI ASC X12) version 005010 (both A/B and DME MACs) transactions and National Council for Prescription Drug Programs (NCPDP) version D.0 (only DME) transactions. While CR 6472 requires no action for providers, you may want to review *MLN Matters*® article SE0904 at *http://www.cms.gov/MLNMattersArticles/downloads/SE0904.pdf*, for an introductory overview of these HIPAA standards.

Background

The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 as the next Health Insurance Portability and Accountability Act (HIPAA) transaction standards for covered entities to exchange HIPAA transactions. The DHHS published the final rule on January 16, 2009, which may be reviewed at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf*. The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing this next version of HIPAA transaction standards.

The purpose of CR 6472 is to provide the MACs and the DME MACs Common Electronic Data Interchange (CEDI) contractor with the necessary requirements to prepare their systems to process ASC X12 version 005010 (both A/B and DME MACs) and NCPDP version D.0 (only DME) transactions.

Note: The DHHS has promulgated in the final rule provisions which permit dual use of existing standards [ASC X12 4010A1 and NCPDP 5.1] and the new standards [ASC X12 version 5010 and NCPDP version D.0] from March 17, 2009 (the effective date) until January 1, 2012 (the compliance date) to facilitate testing (subject to trading partner agreement).

Additional information

The official instruction, CR 6472, issued to your MAC or DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R506OTN.pdf*.

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

MLN Matters® Number: MM6472
Related Change Request (CR) #: 6472
Related CR Release Date: June 19, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R506OTN
Implementation Date: October 5, 2009

General Information

Timely filing requirements for Medicare fee-for-service claims

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which amended the period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

The period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the *Code of Federal Regulations* (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time for submission of all Medicare FFS claims to one calendar year after the date of service.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. In addition, Section 6404 mandates that claims for services furnished before January 1, 2010, must be filed no later than December 31, 2010.

The following rules apply to claims with dates of service prior to January 1, 2010. Claims with dates of service before October 1, 2009, must follow the pre-PPACA timely filing rules. Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.

Section 6404 of the PPACA also permits the Secretary of Health & Human Services to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking.

Please be on the alert for more information pertaining to the PPACA.

Source: CMS PERL 201004-02

The Patient Protection and Affordable Care Act

President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The Centers for Medicare & Medicaid Services (CMS) is working hard to implement expeditiously the new law. Medicare fee-for-service provisions within the law have varying effective dates and our first priority is to address provisions with the earliest effective dates. CMS is committed to assuring Medicare providers are well informed as early as possible. For that reason, CMS is urging you to be on the alert for notices and instructions from CMS and from your Medicare fiscal intermediary, carrier, or Medicare administrative contractor, on forthcoming policy and operational changes as we implement the PPACA.

Source: CMS PERL 201003-54

Change in provider enrollment timeliness standards for certain paper applications

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

Provider types affected

This article is for all physicians, nonphysician practitioners, and other suppliers submitting paper Medicare enrollment applications to carriers and A/B Medicare administrative contractors [A/B MAC]).

Provider action needed

This article, based on change request (CR) 6807, provides you with information regarding the revised provider enrollment processing timeliness standards for certain Medicare enrollment applications. These include: (1) CMS-855I initial application; (2) CMS-855B initial applications; and (3) change requests and reassignments. Timeliness standards for Internet-based Provider Enrollment Chain and Ownership System (PECOS) enrollment applications and Part A providers are not affected by CR 6807. Please be sure that your business office is aware of these changes.

Background

While the Centers for Medicare & Medicaid Services encourages physicians and nonphysician practitioners and other suppliers to submit a complete enrollment application and applicable supporting documentation at the time of filing, the revised processing standards will afford physicians, nonphysician practitioners and other suppliers with additional time to respond to a Medicare contractor development requests.

Below is a summary of the timeliness standards found in CR 6807.

- Medicare contractors shall process 80 percent of all initial CMS-855I applications where no contractor development is needed within 60 calendar days of receipt, and 95 percent of such applications within 90 calendar days of receipt. (Development refers to the need for the Medicare contractor to contact the provider for additional information.) In addition, contractors shall process 80 percent of all initial CMS-855I applications where one development request is made by the contractor within 90 days of receipt; and the contractor shall process 70 percent of all initial MS-855I applications where at least two development request are made by the contractor within 90 calendar days of receipt.

Change in provider enrollment timeliness standards for certain paper applications (continued)

- For 855B initial applications submitted by suppliers other than independent diagnostic testing facilities (IDTFs), Medicare contractors shall process 80 percent of these applications where no contractor development is needed within 60 calendar days of receipt , and 95 percent of such applications within 90 calendar days of receipt. In addition, contractors shall process 80 percent of all initial CMS-855B applications where one development request is made by the contractor within 90 days of receipt; and the contractor shall process 70 percent of all initial CMS-855B applications where at least two development requests are made by the contractor within 90 calendar days of receipt.
- For initial 855B applications submitted by IDTFs, Medicare contractors shall process 70 percent of such applications where no contractor development is needed within 90 calendar days of receipt, 80 percent of such applications within 120 calendar days of receipt, and 95 percent of such applications within 180 calendar days of receipt.

For additional information about provider enrollment processing timeliness standards, see the manual revision attached to CR 6807 and the Web address for accessing that CR is in the next section of this article.

Additional information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

The official instruction, CR 6807, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R329PI.pdf*.

Visit the Medicare provider-supplier enrollment page, designed to provide Medicare enrollment information for providers, physicians, nonphysician practitioners, and other suppliers at *http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage*.

MLN Matters® Number: MM6807
Related Change Request (CR) #: 6807
Related CR Release Date: March 19, 2010
Effective Date: June 21, 2010
Related CR Transmittal #: R329PI
Implementation Date: June 21, 2010

Reporting of recoupment for overpayment on the remittance advice

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries. Change request (CR) 6870 does not apply to suppliers billing durable medical equipment (DME) MACs.

Provider action needed

This article is based on CR 6870 which instructs Medicare system maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national recovery audit contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You can review Section 1893 *http://www.ssa.gov/OP_Home/ssact/title18/1893.htm*. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. (See the MLN Matters® article related to CR 6183 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf*.)

Under the scenario just described, the RAC has to report the actual recoupment in two steps:

- **Step I:** Reversal and correction to report the new payment and negate the original payment (actual recoupment of money does not happen here), and

Reporting of recoupment for overpayment on the remittance advice (continued)

- **Step II:** Report the actual recoupment.

Recovered amounts reduce the total payment and are clearly reported in the remittance advice (RA) to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR 6870 instructs the Medicare System Maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when:

- An overpayment is identified, and
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an internal control number (ICN) or document control number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I
Claim level:
The original payment is taken back and the new payment is established.

Provider level:
PLB03-1 – PLB reason code FB (forward balance)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II
Claim level:
No additional information at this step.

Provider level:
PLB03-1 – PLB reason code WO (overpayment recovery)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Additional information

CMS provides more information including an overview of and recent updates for the RAC program at *http://www.cms.gov/RAC/*. You may find the *Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers* at *http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

The official instruction, CR 6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R659OTN.pdf*.

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

MLN Matters® Number: MM6870
Related Change Request (CR) #: 6870
Related CR Release Date: March 19, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R659OTN
Implementation Date: July 6, 2010

New data format for Medicare national correct coding initiative edit files

Beginning with the April 2010 update, the Centers for Medicare & Medicaid Services (CMS) will now post the national correct coding initiative (NCCI) edit files in Excel 2007 and in text formats. Because Excel 2007 can support a larger number of rows, each code range will be contained in one file as opposed to multiple files. This should correct the incompatibility issues that some of our users experienced last quarter with the Excel 2003 files.

Please be aware that Excel 2003 and earlier versions of the software have a maximum row count of 65,536.

Some of the NCCI edit files exceed the maximum row count. If you do not have Excel 2007, please use the text format to import the data into an application that can support larger files.

For more information on NCCI edits, and to download the files, visit the Web page at *http://www.cms.gov/NationalCorrectCodInitEd/*.

Source: CMS PERL 201004-01

Centers for Medicare & Medicaid Services public website address change

The Centers for Medicare & Medicaid Services (CMS) changed its website address from *http://www.cms.hhs.gov* to *http://www.cms.gov/*. Existing bookmarks and links from other websites will continue to work following this address change.

Source: CMS PERL 201004-11

Transition to new CMS banking contracts

The Centers for Medicare & Medicaid Services (CMS) recently awarded new banking contracts to U.S. Bank and JP Morgan Chase. Medicare providers do not have to take any action. However, providers should be aware that the Medicare payments may be made by a different bank than in the past because of these new banking contractors.

The following Medicare claim processing contractors will remain with JP Morgan Chase:

- Cahaba Government Benefit Administrators
- Pinnacle Business Solutions
- First Coast Service Options
- Palmetto GBA (except for A/B MAC Jurisdiction 1)
- Wisconsin Physician Service

Providers that bill to these contractors will not experience any change.
The following Medicare claim processing contractors will transition to JP Morgan Chase on June 1, 2010:

- Palmetto A/B MAC Jurisdiction 1
- Trailblazer

The following contractors will transition to U.S. Bank on June 1, 2010:

- CIGNA Government Services
- Highmark Medicare Services
- National Government Services
- NHIC
- Noridian Administrative Services

Source: CMS PERL 201004-06

Preparing professionals for a nationwide health care transformation

Health Information Technology for Economic and Clinical Health (HITECH) update

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

April 7, 2010

I know that health care providers are concerned about implementing new health information technology and finding professionals who can operate and maintain such systems. I know many clinicians are unsure how they will develop or strengthen their skill set to incorporate using health information technology (IT) efficiently and effectively without jeopardizing their communication with patients during a clinical visit. It seems like a daunting transformation to clinicians themselves and, indeed, for our health are system overall.

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) recognized that the success of this health IT journey depends on people: people who are passionate about improving patient care, and who are supported in making those improvements.

To this end, the Department of Health & Human Services awarded $84 million to 16 institutions of higher education to fund the Health IT Workforce Development Program, which focuses on several key resources required to rapidly expand the availability of health IT professionals who will support broad adoption and use of health IT in the provider community. Those resources include:

- A community college training program to create a workforce that can facilitate the implementation and support of an electronic health care system
- Quality educational materials that institutions of higher education can use to construct core instructional programs
- A competency examination program to evaluate trainee knowledge and skills acquired through nondegree training programs
- Additional university programs to support certificate and advanced degree training

Preparing professionals for a nationwide health care transformation (continued)

The Workforce Development Program is one of the best examples of the depth of thought behind the HITECH Act. We could spend many billions of dollars developing, incentivizing, and implementing health IT solutions, but without an effectively trained workforce, our efforts would fall short of their ultimate goal of improving patient care. These efforts, designed in collaboration with the National Science Foundation, Department of Education, and the Department of Labor, are estimated to reduce the shortfall of qualified health IT professionals by 85 percent.

I congratulate the Workforce Development Program awardees and look forward to working with them on this important initiative. Those who take advantage of professional training in health IT provided through award recipients will find opportunities for interesting, challenging, and important work. Not only do these opportunities represent new jobs, they represent promising careers in a growing sector of our economy.

Sincerely,

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

Source: CMS PERL 201004-17

Six states to receive federal matching funds for electronic health record incentives program

In another key step to further states' role in developing a robust U.S. health information technology (HIT) infrastructure, the Centers for Medicare & Medicaid Services (CMS) recently announced additional federal matching funds for certain state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009 (Recovery Act).

EHRs will improve the quality of health care for the citizens of Vermont and make their care more efficient. The records make it easier for the many providers who may be treating a Medicaid patient to coordinate care. Additionally, EHRs make it easier for patients to access the information they need to make decisions about their health care.

This batch is part of a rolling announcement we began in November 2009. To date, including the new states, we will have awarded a total of $50.16 million to 32 states and territories.

Colorado	$798,000
Mississippi	$1.47 million
North Carolina	$2.29 million
Nevada	$1.05 million
Utah	$396,000
Wyoming	$596,000
Subtotal	$6.60 million

Additional information on implementation of the Medicaid-related provisions of the Recovery Act's EHR incentive payment program may be found at *http://www.cms.gov/Recovery/11_HealthIT.asp*.

The six states' press releases, issued on March 24, 2010, are available at *https://www.cms.gov/apps/media/press_releases.asp*.

Source: CMS PERL 201003-49

Transcripts for the ICD-10-CM national provider conference call now available

The written and oral transcripts of the basic introduction to ICD-10-CM national provider conference call, which was conducted by the Centers for Medicare & Medicaid Services on March 23, 2010, are now available in the *Downloads* section at *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*.

Source: CMS PERL 201004-32

2010 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

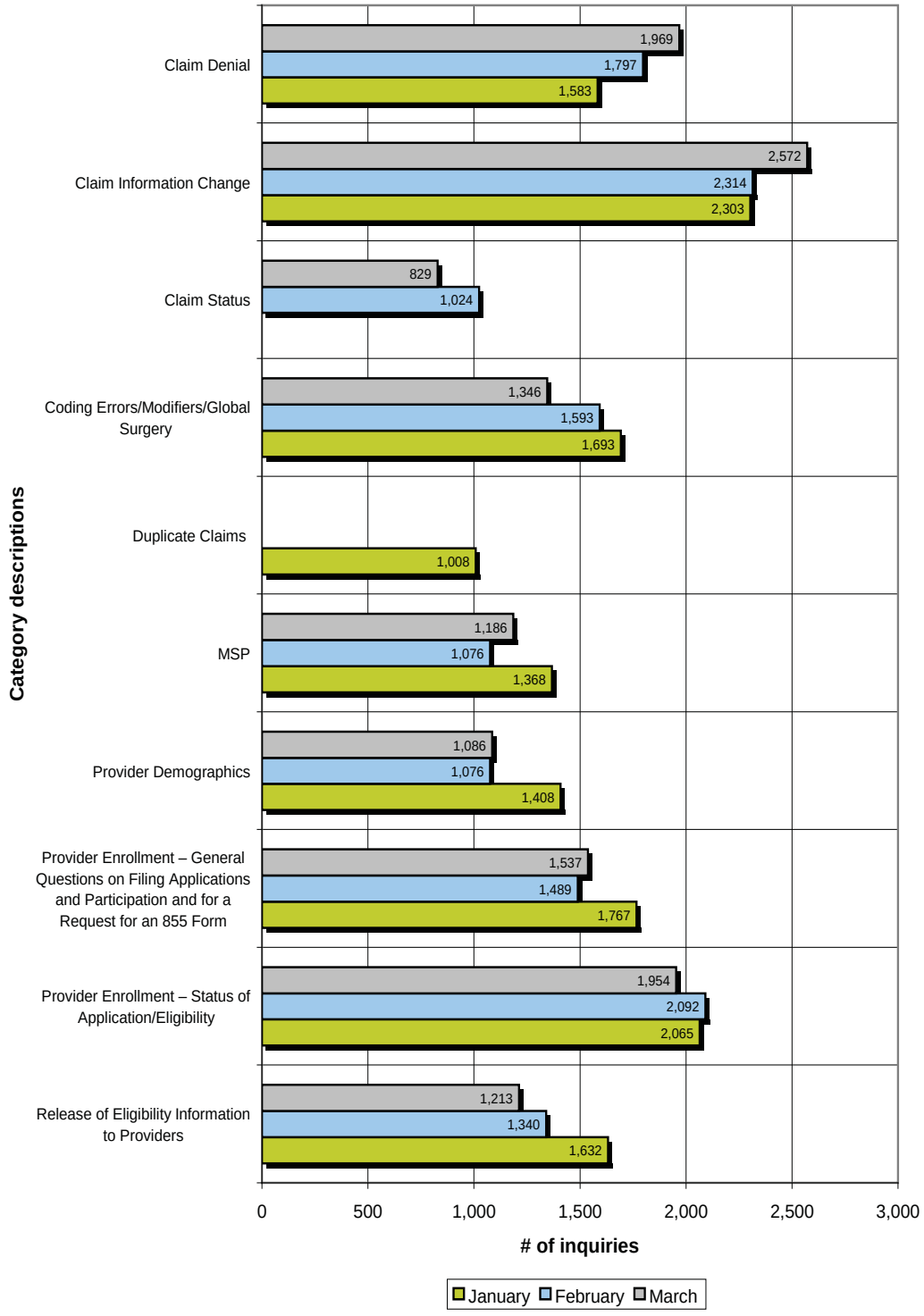
The MEDPARD listing is available on the FCSO Medicare website at *http://medicare.fcso.com/MEDPARD/*.

Source: Pub 100-04, Transmittal 1832, change request 6637

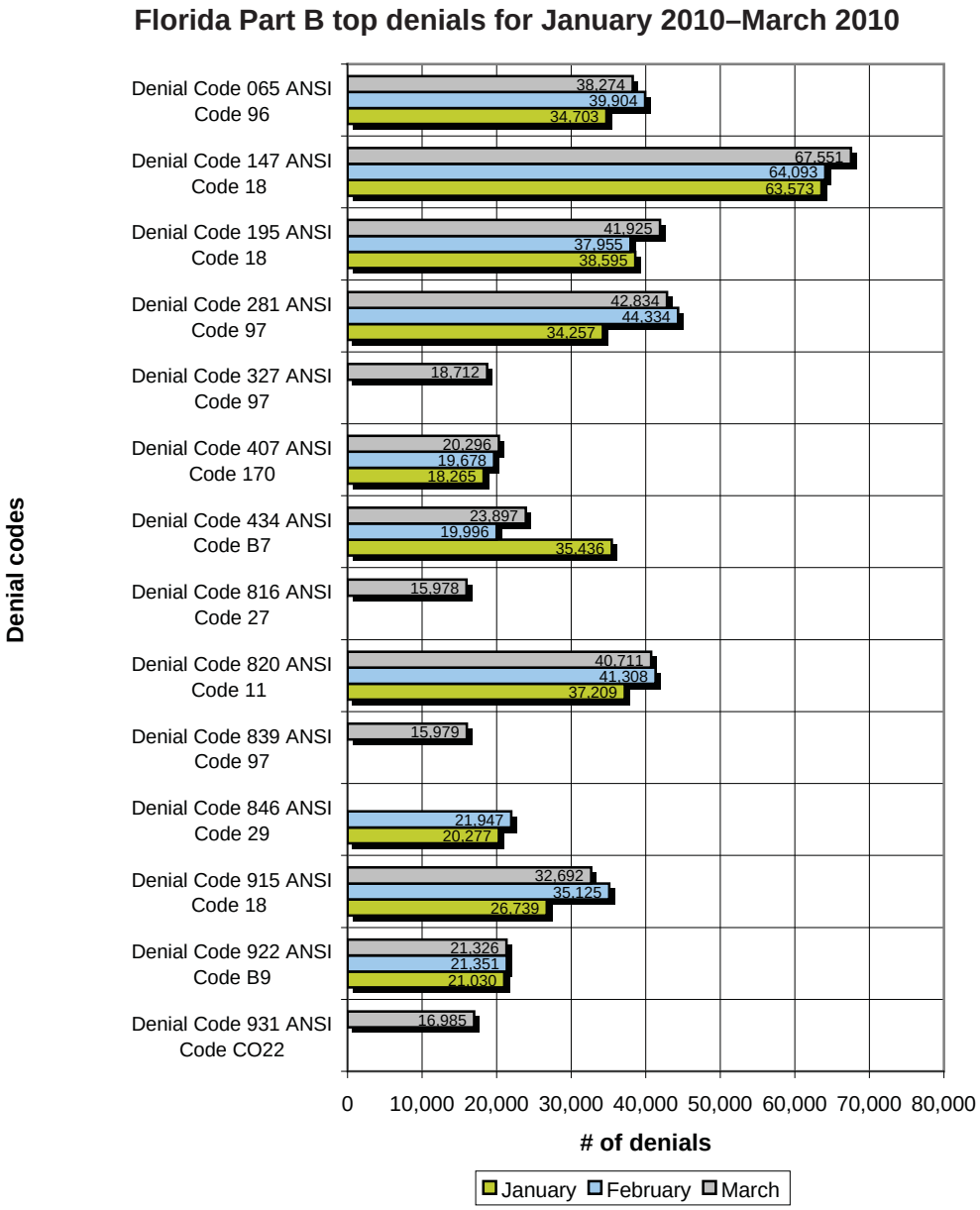
Top inquiries, denials, and return unprocessable claims for January–March

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 January 2010–March 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 website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part B top inquiries for January 2010–March 2010



Top inquiries, denials, and return unprocessable claims for January–March (continued)



Additional information on how to avoid duplicate claim denials

First Coast Service Options Inc. (FCSO) strives to offer providers convenient access to the information and educational tools they need to increase their knowledge of the Medicare program. One way of doing that is offering Web-based training courses that educate providers on a myriad of topics. FCSO offers a free Web-based training (WBT) course specific to duplicate claims.

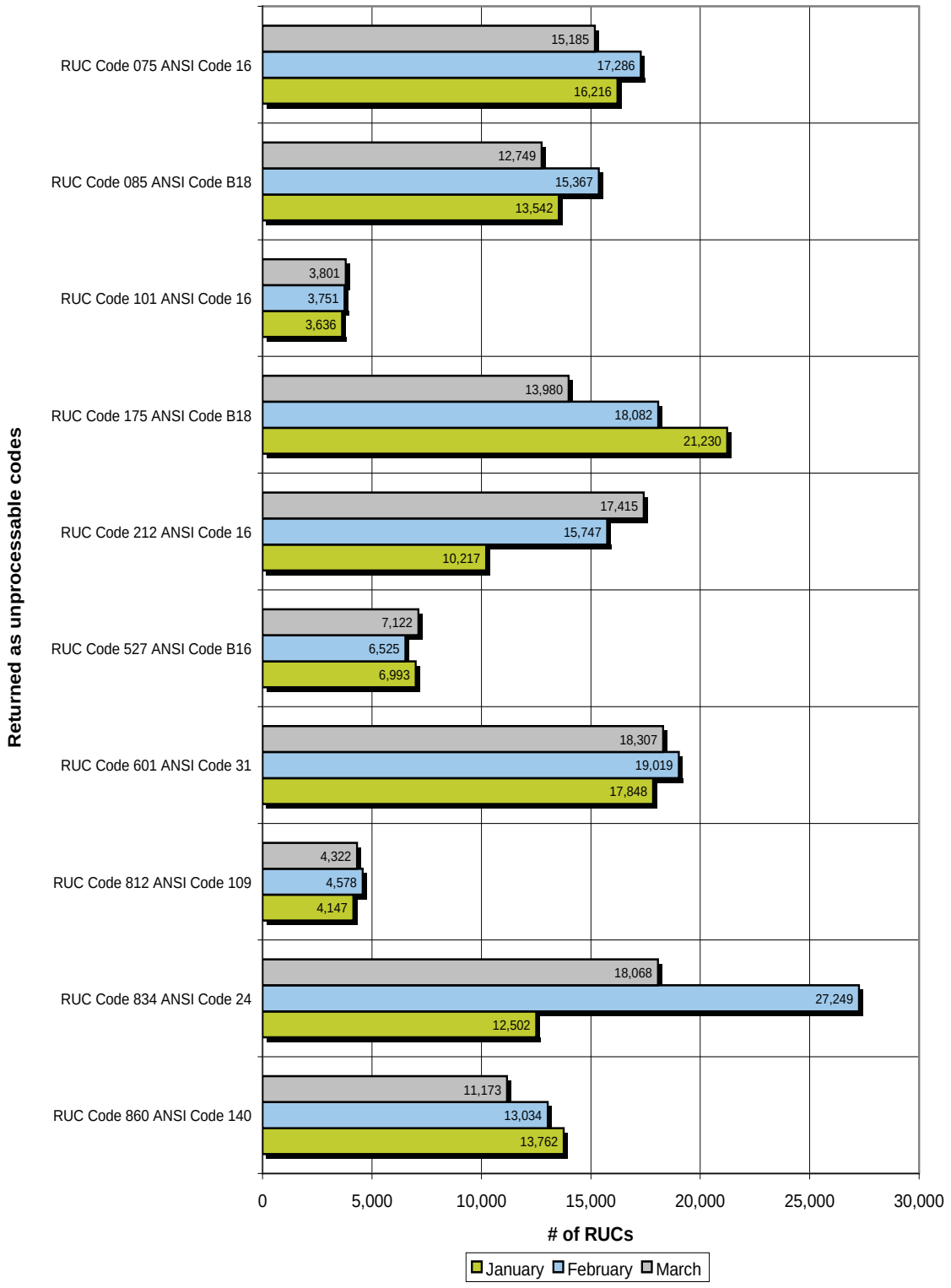
- To access the *Duplicate Claims – Part B WBT*, visit our FCSO Medicare Training website *www.fcsomedicaretraining.com*.

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

- Visit the FCSO Events page at *http://medicare.fcso.com/Events/* to learn about upcoming events and link to our online learning system to review encore presentations of webcasts conducted on this topic.

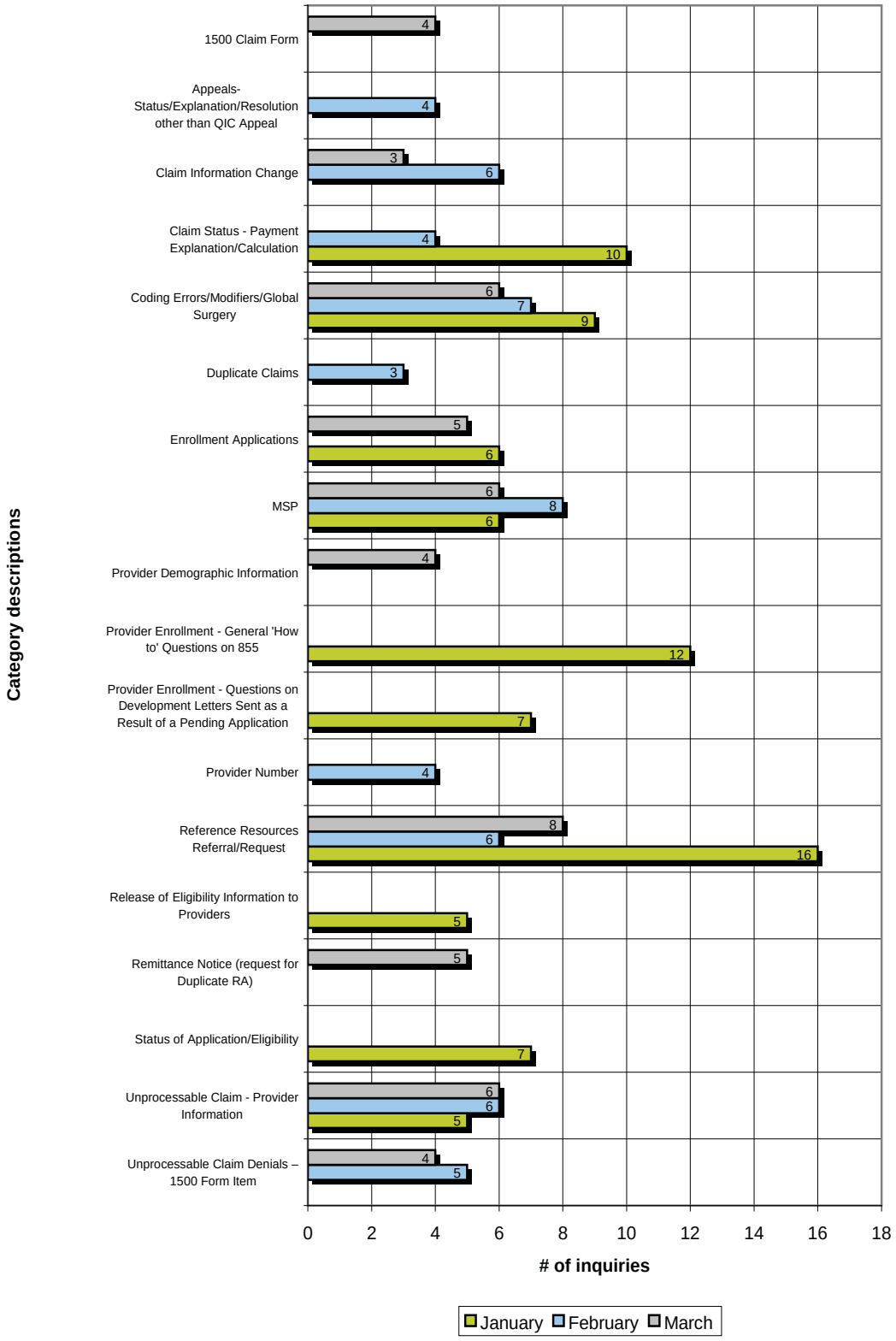
Top inquiries, denials, and return unprocessable claims for January–March (continued)

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

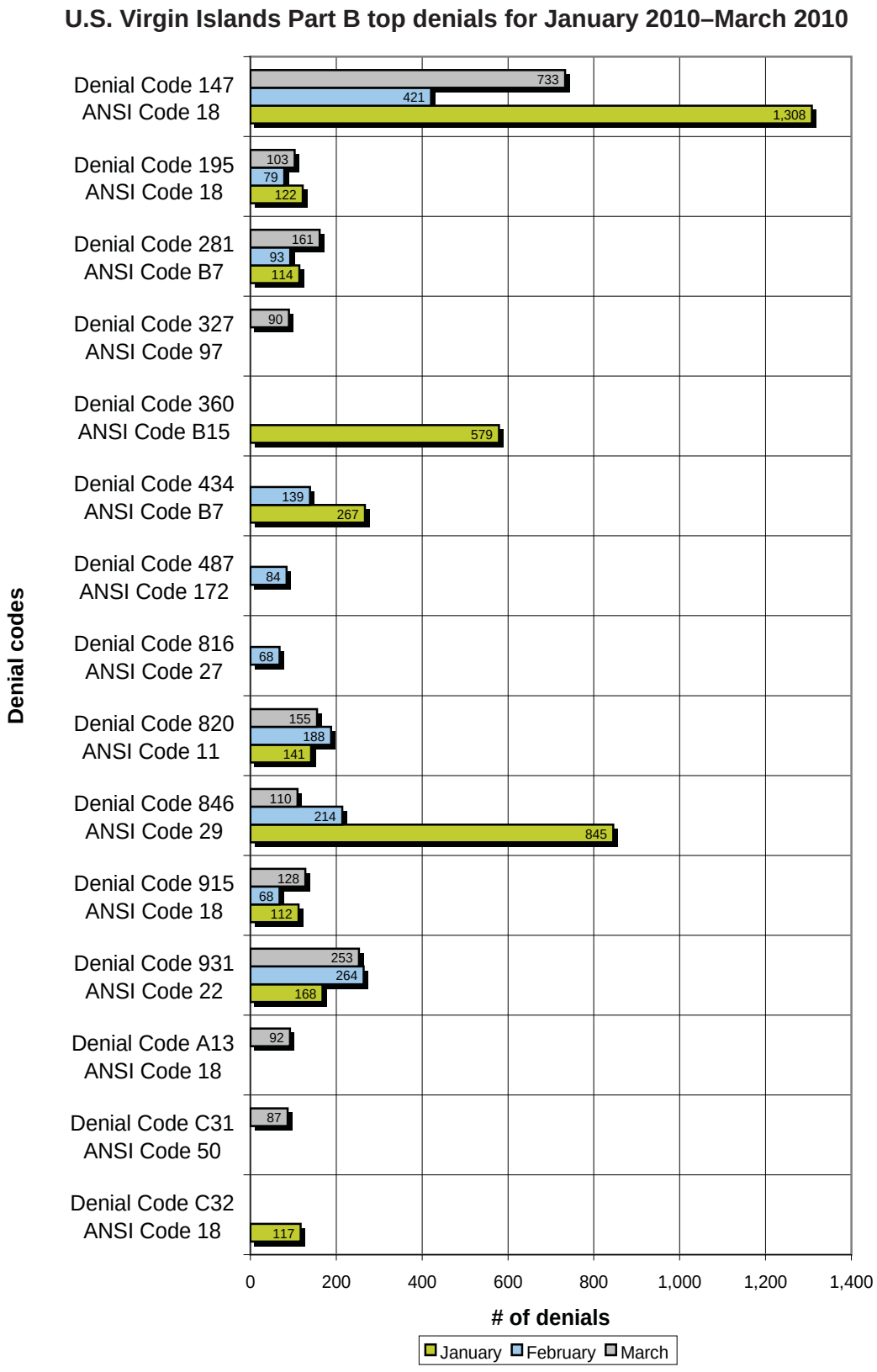


Top inquiries, denials, and return unprocessable claims for January–March (continued)

U.S. Virgin Islands Part B top inquiries for January 2010–March 2010

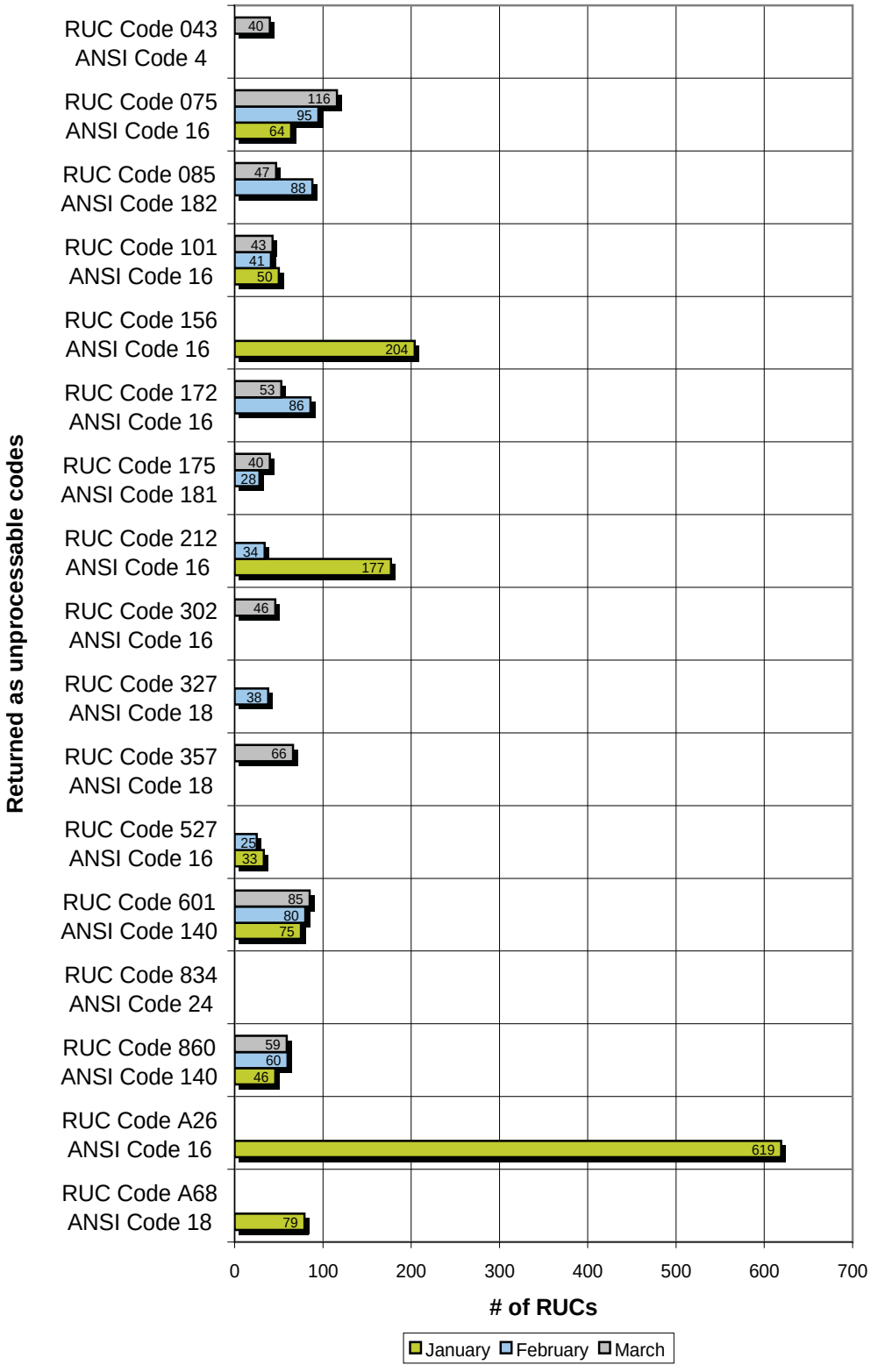


Top inquiries, denials, and return unprocessable claims for January–March (continued)



Top inquiries, denials, and return unprocessable claims for January–March (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for January 2010–March 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.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 website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our website *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.

New LCDs

J2562: Plerixafor (Mozobil®) – new LCD

LCD ID number: L30874 (Florida/Puerto Rico/U.S. Virgin Islands)

The availability of stem cell growth factors has lead to the treatment of certain types of cancers by performing peripheral blood stem cell transplants (PBSCT). Performing PBSCT allows a patient to be treated with higher doses of drugs such as chemotherapy or with radiation therapy. PBSCT is a process by which blood-forming cells that have been destroyed by cancer treatment are replaced after the patient has been treated with chemotherapy or radiation therapy. Two types of cancers commonly treated with PBSCT are non-Hodgkin's lymphoma (NHL) and multiple myeloma (MM). NHL is a type of cancer that forms in the cells that make up the immune system and is either fast or slow growing. MM is a type of cancer that forms in the plasma cells (white blood cells). In order to proceed to the process of performing a PBSCT, the stem cells must be collected through a process called apheresis. To increase the number of stem cells released into the blood stream for collection, the patient may be given a drug called a growth factor (colony stimulating factor).

Plerixafor (Mozobil®) is not a growth factor. It is a reversible inhibitor of the CXCR4 chemokine receptor and blocks binding of its cognate ligand, stomal cell-derived factor-1α (SDF-1α). SDF-1α and CXCR4 are recognized to play a role in the trafficking and homing of human hematopoietic stem cells (HSCs) to the marrow compartment.

Plerixafor (Mozobil®) is a hematopoietic stem cell mobilizer approved by the Food and Drug Administration (FDA) to be used for the following indication:

Mozobil® is indicated to be used in combination with granulocyte-colony stimulating factor (G-CSF) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma.

This local coverage determination (LCD) has been developed to provide indications and limitations, documentation requirements and utilization guidelines. In addition, a "Coding Guidelines" LCD attachment has been developed for this service, which includes information regarding proper coding of diagnosis codes and an outline of a typical treatment regimen since this drug must be given in conjunction with Neupogen®.

Effective date

This new LCD is effective for services rendered **on or after June 7, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

J2796: Romiplostim (Nplate®) – new LCD

LCD ID number: L30878 (Florida/Puerto Rico/U.S. Virgin Islands)

Romiplostim (Nplate®) is an injectable thrombopoietin (TPO) receptor agonist that stimulates bone marrow megakaryocytes to produce platelets. It is used in patients with (idiopathic) thrombocytopenic purpura (ITP), whose degree of thrombocytopenia (i.e., bleeding condition in which the blood doesn't clot as it should due to low platelet counts) and clinical condition increase the risk for bleeding.

Romiplostim (Nplate®) is available only through a restricted distribution program called Nplate® NEXUS (Network of Experts Understanding and Supporting Nplate® and Patients) Program. Under this program, only prescribers and patients registered with the Nplate® NEXUS Program are able to prescribe, administer, and receive romiplostim (Nplate®).

This local coverage determination (LCD) is based upon the U.S. Food and Drug Administration (FDA) approved indication for patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP), ICD-9-CM code 287.31, who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy and are registered (including the prescriber) with the Nplate® NEXUS Program.

The LCD has been developed to outline indications and limitations of coverage, documentation requirements, and utilization guidelines. In addition, a "Coding Guidelines" LCD attachment has been developed for this service.

Effective date

This new LCD is effective for services rendered **on or after June 7, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

46930: Destruction of internal hemorrhoid(s) by infrared coagulation (IRC) – new LCD

LCD ID number: L30862 (Florida/Puerto Rico/U.S. Virgin Islands)

Infrared coagulation (IRC) is one of several non-surgical outpatient therapies for the treatment of internal hemorrhoids without the need for anesthesia. Infrared coagulation involves direct application of infrared waves which penetrates the tissue and converts to heat, promoting coagulation of vessels and fixation of the hemorrhoidal tissue. The amount of tissue destruction depends on the intensity and duration of the application. It is recommended that the infrared probe be applied for 1.5 seconds to the apex of each internal hemorrhoid and be repeated three times on each hemorrhoid. Infrared coagulation involves direct application of infrared waves resulting in protein necrosis, and is considered useful only in the treatment of Stage 1 and Stage II hemorrhoids, without significant prolapse. IRC is associated with high rates of recurrence when substantial prolapse is present. Multiple (two-six) hemorrhoids can be treated at one time using IRC.

This local coverage determination (LCD) has been developed to provide indications and limitations, documentation requirements and utilization guidelines for the destruction of internal hemorrhoid(s) by infrared coagulation (IRC). In addition, a "Coding Guidelines" LCD attachment has been developed for this service, which includes information regarding the 90 day global period and related modifier utilization. A list of procedure codes which should be used to report nonthermal methods of removal and destruction of hemorrhoids has also been included.

Effective date

This new LCD is effective for services rendered **on or after June 7, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

82306: Vitamin D; 25 hydroxy, includes fraction(s), if performed – new LCD

LCD ID number: L30868 (Florida/Puerto Rico/U.S. Virgin Islands)

Vitamin D, a group of fat-soluble prohormones, is an essential vitamin. There are two major types of Vitamin D (Vitamin D2 and Vitamin D3) which are collectively known as calciferol. They are essential for promoting calcium absorption and maintaining adequate serum calcium and phosphate concentrations to enable mineralization of bone and prevent hypocalcemic conditions. Vitamin D2 (ergocalciferol) is obtained from foods of plant origin and vitamin D3 (cholecalciferol) is obtained from foods of animal origin and ultraviolet light-stimulated conversion of 7-dehydrocholestral in the skin. Vitamin D is stored in the human body as calcidiol (25-hydroxyvitamin D). Serum concentration of 25(OH) D is the best indicator of vitamin D status.

Vitamin D deficiencies are the result of dietary inadequacy, impaired absorption and use, increased requirement, or increased excretion. Vitamin D deficiency can occur when usual intake is lower than recommended levels over a period of time, or when exposure to sunlight is limited. Vitamin D deficiency can also result from the inability of the kidneys to convert the vitamin D to its active form. Vitamin D toxicity can cause symptoms including nausea, vomiting, poor appetite, constipation, weakness, and weight loss as well as elevation in the blood level of calcium which in turn can lead to mental status changes, and heart rhythm abnormalities.

This local coverage determination (LCD) has been developed to provide indications and limitations, documentation requirements and utilization guidelines for this service.

Effective date

This new LCD is effective for services rendered **on or after June 7, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

93980: Duplex scan for erectile dysfunction – new LCD

LCD ID number: L30870 (Florida/Puerto Rico/U.S. Virgin Islands)

Duplex scan is used to evaluate blood flow, venous leak, signs of atherosclerosis, and scarring or calcification of erectile tissue. Erection is induced by injecting prostaglandin, a hormone-like stimulator produced in the body. Ultrasound is then used to visualize vascular dilation and measure penile blood pressure (which may also be measured with a special cuff).

A basic diagnostic evaluation is the first step in erectile dysfunction assessment and is applied for the majority of men, whereas a specific diagnostic procedure is implemented in a smaller subset of patients. Vascular evaluation and imaging of the penile vessels may be indicated in patients with arterial/arteriolar dysfunction, veno-occlusive disorder, Peyronie's disease, high -flow priapism, penile trauma (fracture) and patients without symptomatic peripheral vascular disease presenting with erectile dysfunction.

This local coverage determination (LCD) has been developed to identify indications and limitations of coverage, documentation requirements, utilization guidelines, and ICD-9-CM codes.

Effective date

This new LCD is effective for services rendered **on or after June 7, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

Revisions to LCDs

G0430: Qualitative drug screening – revision to the LCD

LCD ID number: L30574 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for qualitative drug screening was implemented January 25, 2010. Since that time, a revision was made to the LCD based on change request 6852, transmittal 653, dated March 19, 2010. *CPT* code *80100* (*Drug screen, qualitative; multiple drug classes chromatographic method, each procedure*) and *CPT* code *80101* (*Drug screen, qualitative; single drug class method (e.g.,immunoassay, enzyme assay*), *each drug class*) were added under the "Indications" and "*CPT*/HCPCS Codes" sections of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 1, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

IDTF: Independent diagnostic testing facility – coding guidelines revision

LCD ID number: L29195 (Florida)
LCD ID number: L29330 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for independent diagnostic testing facility (IDTF) was most recently revised on December 8, 2009. The "Credentialing Matrix" in the "Coding Guidelines" attachment was last revised January 1, 2010. Since that time, the "Credentialing Matrix" in the "Coding Guidelines" attachment has been revised for the "Supervising Physician and Interpreting Physician Qualification Requirements" as follows:

Board Certified (ABMS) neurologist or physiatrist has been added for *CPT* codes *51784*, *51785* and *51792*; and ABMS physiatrist has been added for *CPT* codes *92265*, *92585*, *92586*, *95860*, *95861*, *95863*, *95864*, *95867*, *95868*, *95869*, *95870*, *95872*, *95875*, *95900*, *95903*, *95904*, *95905*, *95921*, *95922*, *95923*, *95925*, *95926*, *95927*, *95928*, *95929*, *95930*, *95933*, *95934*, *95936*, and *95937*.

Effective date

The revision to the LCD "Coding Guidelines" attachment is effective for services rendered **on or after March 23, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

J3420: Vitamin B12 injections – revision to the LCD

LCD ID number: L29309 (Florida)
LCD ID number: L29488 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for vitamin B12 injections was most recently revised on February 2, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. A reconsideration request was received asking First Coast Service Options Inc. (FCSO) to revise the indications to allow for coverage of Folotyn™ in addition to the already covered drug Alimta®. In addition the request asked for a revision to the documentation requirements to include the use of Folotyn™. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to include coverage criteria for vitamin B12 injections when administering Folotyn™. Also, the "Documentation Requirements" section of the LCD has been revised to include Folotyn™ within the requirements listed.

Effective date

This LCD revision is effective for services rendered **on or after April 06, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

J9310: Rituximab (Rituxan®) – revision to the LCD

LCD ID number: L29271 (Florida)
LCD ID number: L29472 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was most recently revised on February 2, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. A reconsideration request was received asking First Coast Service Options Inc. (FCSO) to revise the LCD to include the new Food and Drug Administration (FDA) indication approved on February 18, 2010. The new indication allows Rituxan® to be administered for chronic lymphocytic leukemia (CLL) in combination with fludarabine and cyclophosphamide (Fc), for the treatment of patients with previously untreated and previously treated CD20-positive CLL. Previously FCSO covered the CLL as an off-label indication. The LCD has been revised to include CLL as an FDA approved indication and has removed CLL from the off-label list of covered indications, under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

This revision to the LCD is effective for services rendered **on or after February 18, 2010**, for claims processed **on or after April 6, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

NCSVCS: The list of Medicare noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on January 1, 2010. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS), transmittals 117 and 1930, change request 6775, dated March 9, 2010. In this regard, *CPT* code *99199* used for Pulsatile intravenous insulin therapy (pivit) has been deleted from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions, Procedures" section of the LCD.

Effective date

This revision is effective for claims processed **on or after April 14, 2010**, for services rendered **on or after December 23, 2009**.

HCPCS code G9147 (Outpatient intravenous insulin treatment (oivit) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (uun); and/or, arterial, venous or capillary glucose; and/or potassium concentration) is to be used on claims with dates of service on or after December 23, 2009, billing for noncovered oivit and any services comprising an oivit regimen.

As stated in the CMS transmittals referenced above, effective December 23, 2009, CMS determines that the evidence does not support a conclusion that oivit improves health outcomes in Medicare beneficiaries. Therefore, oivit is not reasonable and necessary for any indication under section 1862(a)(1)(A) of the Social Security Act, and services comprising an oivit regimen are nationally noncovered under Medicare when furnished pursuant to an oivit regimen.

OIVIT is also referred to as cellular activation therapy (cat), Chronic intermittent intravenous insulin therapy (ciiit), Hepatic activation therapy (hat), Intercellular activation therapy (icat), Metabolic activation therapy (mat), Pulsatile intravenous insulin treatment (pivit), Pulse insulin therapy (pit) and Pulsatile therapy (pt).

NCSVCS: The list of Medicare noncovered services – revision to the LCD (continued)

This is a revision to a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries (contractors with the federal government that review and/or adjudicate claims, determinations, and/or decisions), quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4)(2005)).

First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

NCSVCS: The list of Medicare noncovered services – revision to the LCD

LCD ID number: L29288 (Florida)
LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on April 14, 2010. Since that time, a revision was made to add *CPT* category III code *0206T* to the LCD based on an evaluation.

Under the "Local Noncoverage Decisions - Procedures" section of the LCD, *CPT* code *0206T* (*Algorithmic analysis, remote, of electrocardiographic-derived data with computer probability assessment, including report*) was added.

Effective date

This revision is effective for services rendered **on or after June 7, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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.

ZEVALIN: Ibritumomab tiuxetan (Zevalin®) therapy – revision to the LCD

LCD ID number: L29193 (Florida)
LCD ID number: L29348 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ibritumomab tiuxetan (Zevalin®) therapy was most recently revised on February 2, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. A reconsideration request was received asking First Coast Service Options Inc. (FCSO) to revise the LCD to include the new Food and Drug Administration (FDA) indication approved on September 3, 2009. The new indication allows Zevalin® to be administered for patients with previously untreated follicular non-Hodgkin's lymphoma (NHL) who achieve a partial or complete response to first-line chemotherapy. The LCD has been revised to include this new FDA indication under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after September 3, 2009**, for claims processed **on or after April 6, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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

Xiaflex™ (collagenase clostridium histolyticum) – coding instructions

Xiaflex™ is approved by the Food and Drug Administration (FDA) for the treatment of adult patients with Dupuytren's contracture with a palpable cord. Xiaflex™ should only be administered by a healthcare provider who is experienced in injection procedures of the hand and in the treatment of Dupuytren's contracture. Xiaflex™ should only be injected into palpable cords with contractures of a metacarpophalangeal (MP) joint or a proximal interphalangeal (PIP) joint. The dose for each palpable cord is 0.58 mg. The patient returns approximately 24 hours after the injection so the physician can perform the stretching of the cord and splint application. Injection and finger extension procedures may be done at approximately 4 week intervals for a maximum of three injections per cord. Only one cord may be injected at a time. Other palpable cords may be injected in sequential order.

Because of the specific training requirements needed to identify and inject the cords, First Coast Service Options Inc (FCSO) only expects to see Xiaflex™ administered by physicians with specialized training in treating and injecting Dupuytren's contracture. There must be evidence of proper training maintained in the medical record and available to Medicare upon request. FCSO would also expect to only see ICD-9-CM code 728.6 (Contracture of palmar fascia) billed on claims for Xiaflex™.

Coding day 1

Providers are instructed to bill *CPT* code *26989* (*Unlisted procedure, hands or fingers*) and HCPCS code J3590 (Unclassified biologics) (Part B providers) or HCPCS code C9399 (Unclassified drugs or biologicals) (Part A providers). This represents the injection of the cord and the use of Xiaflex™.

Coding day 2

Providers are instructed to bill *CPT* code *26989*, which will represent the stretching of the cord and application of the splint.

Note: Providers must bill day one and day two on the same claim. Providers should not bill a separate E&M code or procedure code for splint application on claims for this drug and procedure. *CPT* code *26989* is currently not a covered service for ambulatory surgical centers (ASCs), therefore FCSO will not be allowing this service to be billed by an ASC at this time.

Find LCDs faster on our medical coverage page

Looking for an LCD? Try the integrated-search features on our medical coverage page. You may 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 events

May – June 2010

Hot Topics: Hot Topics: Medicare Part B
When: May 12
Time: 11:30 a.m.-1:00 p.m.

Hot Topics: Medifest 2010
Type: In-person seminar
When: June 8-9
Time: 8:00 a.m.-4:30 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 website 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 website 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 website -- 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 website, *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

April 5-11 is National Public Health Week and April 7 is World Health Day

In the spirit of National Public Health Week and World Health Day, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for a variety of preventive services. By encouraging your Medicare patients to take advantage of covered preventive services, you can help them lead longer, fuller, healthier lives.

Medicare covered preventive services

Medicare provides coverage for the following preventive services for eligible Medicare beneficiaries:

- Abdominal aortic aneurysm screening
- Adult immunizations
- Bone mass measurements
- Cancer screenings
- Cardiovascular screenings
- Diabetes-related services and screenings
- Glaucoma screenings
- Smoking and tobacco-use cessation counseling
- Initial preventive physical examination

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 the many preventive services and screenings 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.gov/MLNProducts/35_PreventiveServices.asp
- **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.
  http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- **Quick Reference Information: Medicare Preventive Services** – this chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy-to-use quick-reference format.
  http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **The Preventive Services Educational Products PDF** – this PDF (document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more.
  http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf
- To order hard copies of certain *MLN* products, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page"

For more information about World Health Day, please visit the World Health Organization's website at *http://www.who.int/world-health-day/en*.

For more information about National Public Health Week, please visit the American Public Health Association's website at *http://www.nphw.org/nphw10/home1.htm*.

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

Source: CMS PERL 201004-08

April is National Cancer Control Month

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

Medicare covered cancer screenings

- Screening mammographies
- Screening pap tests
- Screening pelvic examination
- Colorectal cancer screening
- Prostate cancer screening

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 cancer screenings 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.gov/MLNProducts/35_PreventiveServices.asp*
- **Cancer Screenings Brochure** – this brochure provides health care professionals with an overview of cancer screenings covered by Medicare. *http://www.cms.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 cancer screenings. *http://www.cms.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 cancer screenings, in an easy-to-use quick-reference format. *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- **The Medicare Preventive Services Series: Part 3 Web-based training course (WBT)** – this WBT includes lessons on coverage, coding, and billing for Medicare-covered cancer screenings. To access the WBT, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "WBT Modules."

To order hard copies of certain *MLN* products, including the Cancer Screenings brochure and the quick reference information chart, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page"

For more information about National Cancer Control Month, please visit the American Cancer Society homepage at *http://www.cancer.org*.

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 cancer screening services and other preventive services covered by Medicare.

Source: CMS PERL 201004-16

***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.*

Other Educational Resources

Revised Web-based training course on fraud and abuse

The Medicare Fraud and Abuse Web-based training (WBT) course has been revised and is now available. The course provides information helpful for Medicare providers and suppliers involved in providing and billing for services to people with Medicare. This activity provides information that will increase awareness of Medicare fraud and abuse, provide information regarding correct billing practices, and help Medicare providers, suppliers, and staff to file claims correctly. The course offers continuing education credits; please see the course description page for details.

To access the course, go to the MLN Products page at *http://www.cms.gov/MLNProducts/*, and select the Web-based training modules link in the "Related Links Inside CMS" section. Once the Web-based training courses page is displayed, select the Medicare Fraud and Abuse WBT from the list provided.

Source: CMS PERL 201004-25

New educational materials from the Medicare Learning Network

The following are educational materials and other helpful resources now available from the Centers for Medicare & Medicaid Services *Medicare Learning Network*:

- The *Medicare Learning Network* video is now on YouTube
  Watch the *Medicare Learning Network* video now playing on the YouTube channel at *http://www.youtube.com/watch?v=GOzh7kpAwUo*.

This information video provides you with information on what the *Medicare Learning Network* has to offer you in your Medicare business practices as well as other helpful resources that CMS offers to Medicare fee-for-service providers.

Don't forget, you can also order your copy of this video on DVD today; visit *http://www.cms.gov/MLNGenInfo*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." It's a great conference presentation.

- The Medicare preventive services quick reference information charts, which include (1) *Quick Reference Information: Medicare Preventive Services*, (2) *Quick Reference Information: Medicare Immunization Billing*, and (3) *Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination*, have been updated and are now available in hardcopy format.

To order copies of these products, please visit the "Preventive Services Educational Products" page at: *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp* and select "MLN Product Ordering" in the "Related Links Inside CMS" section.

Source: CMS PERL 201003-50

***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.*

New products from the Medicare Learning Network

The *Medicare Learning Network* (*MLN*) marketing brochure is available in print format at *http://www.cms.gov/MLNProducts/downloads/Medicare_Learning_Network_(MLN)_Marketing_Brochure.pdf*. Do you want to be "in the know" when it comes to the *Medicare Learning Network*? Would you like to let your colleagues and employees in on a valuable secret that can help them with their Medicare fee-for-service business transactions? Then make sure to have plenty of print copies of the *MLN* marketing brochure on hand. This brochure details the various *MLN* products and is now available in print format.

The fact sheet titled *Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance* (February 2010) is available to download at *http://www.cms.gov/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance*.pdf. This fact sheet provides general information and education for providers on how to bill when a beneficiary has both Medicare and Medicaid coverage.

To order a hard copy of these and other resources, *visit http://www.cms.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Source: CMS PERL 201003-43

HCPCS public meeting agendas for drugs, biologicals and radiopharmaceuticals

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of the May 4-5, 2010, HCPCS public meeting agendas for drugs, biologicals and radiopharmaceuticals.
These documents and the link for the corresponding public meeting registrations are located at *http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp*.

Source: CMS PERL 201004-12

2010 Part D symposium

The Centers for Medicare & Medicaid Services (CMS) would like to cordially thank you for attending the 2010 Part D symposium on March 18, 2010. We received very positive feedback from participants and presenters. The Part D symposium presentations are now available online under the *Download* section at *http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp*.

We hope you found the symposium a valuable opportunity to discuss Medicare Part D trends and experiences with the community.

Source: CMS PERL 201004-18

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 websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.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 websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

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

FAX: 1-904-361-0696

Beneficiary customer service

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

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

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		CD-ROM $55		
2010 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2010, through December 31, 2010, is available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies or a CD-ROM are available for purchase. The fee schedule contains calendar year 2010 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy $12		
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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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