MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Enhancements to home health consolidated billing enforcement

Edit criteria related to the consolidated billing provision is being updated. 6

Modifier JW not required – MM6711 does not apply to FCSO

CR 6711 does not modify the previous decision FCSO made not to require modifier JW 11

July 2010 updates to the laboratory national coverage determination edit software

The last quarterly release of the edit module was issued in January 2010. 17

Revised 2010 MPFSDB payment files and other retroactive provisions

Payment files were issued based on the calendar year 2010 MPFS final rule... 18

Signature guidelines – 20-day timeframe for additional documentation requests

FCSO has implemented faxination accounts to assist providers with meeting these requirements. 24

Clinical review judgment

Clinical review staff will use this process when making complex review determinations. 26

Systems changes necessary to implement timely filing limits changes

Revising edit criteria related to the timely filing limits......29

Reminder – Do Not Forward Initiative

Notify Medicare immediately of any change of address. 35

Features

About the *Update!*.....3

Coverage/Reimbursement.....5

Electronic Data Interchange 27

General Information.....29

Local Coverage Determinations (LCDs).....42

Educational Resources.....47

Addresses, Phone Numbers, and Web sites.....50

Order form for Medicare Part B materials.....52

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 websites which may be accessed at: *http://medicare.fcso.com/*.

Routing Suggestions:

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

TABLE OF CONTENTS

In this issue 1
Table of Contents 2

About the Update!
Quarterly provider update 3
Advance beneficiary notices (ABNs) 4
"GA" modifier and appeals 4

Coverage and Reimbursement
Ambulance
Medicare Benefit Policy Manual updated to include ambulance transports with joint responses 5

Consolidated Billing
Enhancements to home health consolidated billing enforcement 6

Diabetic Services
Medicare coverage of blood glucose monitors and testing supplies 7

Drugs and Biologicals
Modifier JW not required – *MLN Matters* article MM6711 does not apply to FCSO 11
Manual update regarding billing for discarded drugs or biologicals 11
Manual update related to determining self-administration of drugs or biologicals 12

Durable Medical Equipment
July update to the 2010 DMEPOS fee schedule 12
Change in claims filing jurisdiction for tracheo-esophageal voice prostheses 14
Billing repair of codes listed in change requests 6573 and 5917 15

Laboratory/Pathology
Screening for the human immunodeficiency virus infection 16
July 2010 updates to the laboratory national coverage determination edit software 17

Medicare Physician Fee Schedule
Revised 2010 MPFSDB payment files and other retroactive provisions 18
Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 19

Radiology
FDG positron emission tomography for solid tumors and myeloma 20

General Coverage
Signature guidelines – 20-day timeframe for additional documentation requests 24
Payment reduction on the technical component of certain diagnostic imaging procedures 25
Clinical review judgment 26

Electronic Data Interchange
Update of remittance advice remark codes and claim adjustment reason including MREP 27
ICD-10/5010 national provider call scheduled for June 15 28

General Information
Systems changes necessary to implement timely filing limits changes 29
Amount in controversy requirement for ALJ hearings and federal district court appeals 30
2010 Physician Quality Reporting Initiative update 30
Update to guidance on standardized Medigap policy 31
Four states and Puerto Rico to receive matching funds for EHR incentive program 33
Beacon communities lead the charge to improve health outcomes 34
Time is running out – have you responded? 35
Reminder – Do Not Forward Initiative 35
Top inquiries, denials, and return unprocessable claims for February–April 36

Local Coverage Determinations
Table of contents 42

Educational Resources
Educational Events
Upcoming provider outreach and education events – June 2010 47

Preventive Services
May 9-15 is National Women's Health Week 48

Other Educational Resources
New resources from the *Medicare Learning Network* 49

Florida addresses, phone numbers, and websites 50

U.S. Virgin Islands addresses, phone numbers, and websites 51

Order form for Medicare Part B materials 52

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

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education 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.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.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.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

Medicare Benefit Policy Manual updated to include ambulance transports with joint responses

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

Provider types affected

This article applies to ambulance suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for ambulance services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6949 which updates the *Medicare Benefit Policy Manual* (Chapter 10, Section 10.5 [Joint Response]) to incorporate information that has been re-organized to include ambulance transports with joint responses. No new policy is presented as this just updates the relevant manual section to reflect current policy.

Background

The Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport.

Basic life support/advanced life support (BLS/ALS) joint responses

In situations where a basic life support (BLS) entity provides the transport of the beneficiary and an advanced life support (ALS) entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, paramedic intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists.

Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their Medicare contractor upon request.

Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

Ground to air ambulance transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided and mileage from the point of pickup to the point of transfer to the air ambulance.

Note: There is no new policy being developed by CR 6949. CR 6949 re-instates language to the *Medicare Benefit Manual* (Publication 100-02, Chapter 10) to incorporate information that has been re-organized to include ambulance transports with joint responses.

Additional information

The official instruction, CR 6949, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R125BP.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: MM6949
Related Change Request (CR) #: 6949
Related CR Release Date: May 14, 2010
Effective Date: January 4, 2010
Related CR Transmittal #: R125BP
Implementation Date: June 15, 2010

Consolidated Billing

Enhancements to home health consolidated billing enforcement

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

Provider types affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries during an episode of home health care.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the home health prospective payment system (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

What you need to know

Consolidated billing edit modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, Chapter 10, Section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both "from" and "to" dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item "from" or "to" date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the "from" date and the date by which the supplies will be used in the "to" date. When this causes the "to" date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the "from" date on the supply line item falls within a HH episode.

A new file of HH certification information

Chapter 10, Section 20.1 of the *Medicare Claims Processing Manual* describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

G0179 Physician re-certification for Medicare-covered home health services under a plan of care

G0180 Physician certification for Medicare-covered home health services under a plan of care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their request for anticipated payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60 percent or 50 percent payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's common working file (CWF) query screens, Medicare systems will display all certification code dates within nine months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within nine months before the current date as the default response.

Enhancements to home health consolidated billing enforcement (continued)

Note: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particular true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40 percent of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Additional information

If you have questions, please contact your Medicare RHHI/MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction (CR 6911) issued to your Medicare RHHI/MAC is available at *http://www.cms.gov/Transmittals/downloads/R1952CP.pdf*.

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Implementation Date: October 4, 2010

Diabetic Services

Medicare coverage of blood glucose monitors and testing supplies

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

Provider types affected

This article is informational for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B MACs, and/or regional home health intermediaries [RHHIs]) for Medicare-covered diabetes benefits provided to Medicare beneficiaries.

What you need to know

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to remind providers what blood glucose self-testing equipment and supplies are covered for Medicare beneficiaries. In addition, prescription/order requirements, quantities and frequency limits of supplies, and documentation requirements for the beneficiary's medical record are detailed. This article reinforces information supplied in *MLN Matters*® article SE0738, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE0738.pdf*. This article is informational only and represents no Medicare policy changes.

Background

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. These supplies include:

- Blood glucose monitors
- Blood glucose test strips
- Lancet devices and lancets, and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies. Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent diabetics based on medical necessity. For more information regarding medical necessity, see the section below titled "Providing Evidence of Medical Necessity."

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions
- A two hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions, or
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

See the *Medicare Benefit Policy Manual*, Chapter 15, at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf* for more information.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit, and the Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

Medicare coverage of blood glucose monitors and testing supplies (continued)

Prescribing/ordering a blood glucose monitor and associated accessories

Provider requirements

For Medicare coverage of a blood glucose monitor and associated accessories, the provider must provide a valid prescription (order) which must state to the supplier:

1. The item(s) to be dispensed
2. The frequency of testing ("as needed" is not acceptable)
3. The physician's signature
4. The signature date, and
5. The start date of the order – only required if the start date is different than the signature date.

For **beneficiaries who are insulin-dependent**, Medicare provides coverage for up to 100 test strips and lancets every month, and one lancet device every six months.

For **beneficiaries who are non-insulin dependent**, Medicare provides coverage for up to 100 test strips and lancets every three months, and one lancet device every six months.

Note: Medicare allows additional test strips and lancets if deemed medically necessary. See the section below titled "Providing Evidence of Medical Necessity." Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers, even if the beneficiary has "authorized" this in advance. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/ shipping date. For subsequent deliveries of refills, the supplier should deliver the item(s) no sooner than approximately five (5) days prior to the end of usage for the current product(s). This includes lancets, test strips, and blood glucose monitors**.**

CR 2363 (Transmittal B-03-004) states that glucose test strips and supplies can be billed for up to three months of supplies at a time. Beginning April 1, 2002, claims for test strips and supplies must be submitted with the appropriate "start" and "end" dates. The "start" and "end" dates for each claim can span across three months. You may find CR 2363 at *http://www.cms.gov/Transmittals/Downloads/B03004.pdf*.

Suppliers may dispense most items of durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) based on a verbal order or preliminary written order from the treating physician. This dispensing order must include: a description of the item, the beneficiary's name, the physician's name and the start date of the order. Suppliers must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available to Medicare contractors upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is non-covered. See the *Medicare Program Integrity Manual*, Chapter 5, at *http://www.cms.gov/manuals/downloads/pim83c05.pdf*.

For verbal orders, the physician must sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation must be reviewed, signed, and dated by the physician. Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing or a change in supplier. Renewal orders must contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC. For more information regarding evidence of medical necessity, see the section below titled "Providing Evidence of Medical Necessity."

Note: CR 5971 (Transmittal 248) was issued to prohibit the use of stamped signatures. In addition, Medicare requires a legible identifier for services provided/ ordered as outlined in CR 6698 (Transmittal R327PI). The method used should be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. You may review *MLN Matters*® articles related to CR 5971 and CR 6698 at *http://www.cms.gov/MLNMattersArticles/downloads/MM5971.pdf* and *http://www.cms.gov/MLNMattersArticles/downloads/mm6698.pdf***.**

Home blood glucose monitors

There are several different types of blood glucose monitors that use reflectance meters to determine blood glucose levels. Medicare coverage of these devices varies, with respect to both the type of device and the medical condition of the patient for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as DME for use in the home because their need for frequent professional re-calibration makes them unsuitable for home use.

However, some types of blood glucose monitors which use a reflectance meter specifically designed for home use by diabetic patients may be covered as DME, subject to the conditions and limitations described below.

Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and (following instructions which may vary with the device used), inserts it into the device to obtain a reading.

Medicare coverage of blood glucose monitors and testing supplies (continued)

Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated.

Home blood glucose monitors enable certain patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment. Studies indicate that the patient's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to patients who must make frequent checks of their blood glucose levels.

Accordingly, coverage of home blood glucose monitors is limited to patients meeting the following conditions:

1. The patient has been diagnosed as having diabetes.
2. The patient's physician states that the patient is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician, and
3. The device is designed for home use rather than clinical use.

There are also blood glucose monitoring systems designed especially for use by those with visual or manual dexterity impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable patients with visual or manual dexterity impairment to use the equipment without assistance.

These special blood glucose monitoring systems are covered under Medicare if the following conditions are met:

- The patient and device meet the three conditions listed above for coverage of standard home blood glucose monitors, and
- The patient's physician certifies that the beneficiary has a visual or manual dexterity impairment severe enough to require use of this special monitoring system. Note: Section 1833(e) of the Social Security Act precludes payment to any provider of services "unless there has been furnished such information as may be necessary in order to determine the amounts due such provider…" See *http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm*.

For more information on home blood glucose monitors, including additional requirements for monitors with special features, see the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1 (Coverage Determinations), Section 40.2 (Home Blood Glucose Monitors) at *http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf* and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at *http://www.cms.gov/mcd/search.asp?from2=search.asp*& (search "Glucose Monitors").

The Health Care Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are shown in the following table:

HCPCS codes for blood glucose self-testing equipment and supplies

HCPCS Code	HCPCS Code Descriptor
A4233	Alkaline battery for glucose monitor
A4234	J-cell battery for glucose monitor
A4235	Lithium battery for glucose monitor
A4236	Silver oxide battery glucose monitor
A4253	50 test strips for a blood glucose monitor
A4256	Calibration solutions
A4258	Spring-powered lancing device
A4259	100 lancets for a blood glucose monitor
E0607	Home blood glucose monitor
E2100	Home blood glucose monitor w voice capability (for visual impairment)
E2101	Home blood glucose monitor w integrated lancing/blood collection (for manual dexterity impairment)

Providing evidence of medical necessity

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies, and
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
- Justification for testing frequency, and
- Evidence of the patient's use of the testing supplies.

Medicare coverage of blood glucose monitors and testing supplies (continued)

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
- Names, dosages, and timing of administration of medications used to treat the diabetes.
- Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia.
- Review of beneficiary-maintained log of glucose testing values.
- Changes in the patient's treatment regimen as a result of glucose testing results review.
- Dosage adjustments that the patient should make on their own based on self-testing results.
- Laboratory tests indicating level of glycemic control (e.g., Hemoglobin A1C).
- Other therapeutic interventions and results.
- Documentation by the beneficiary of the actual frequency of testing.
- Logs of self-testing values including the date, time, and results.
- Information about medication dosage adjustments related to the results is also helpful.

Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

For more information regarding evidence of medical necessity, see the *Medicare Program Integrity Manual*, Chapter 5 (Items and Services Having Special DME Review Considerations) at *http://www.cms.gov/manuals/downloads/pim83c05.pdf* and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at *http://www.cms.gov/mcd/search.asp?from2=search.asp&* (search "Glucose Monitors").

Additional information

You may find SE0738, An Overview of Medicare Covered Diabetes Supplies and Services at *http://www.cms.gov/MLNMattersArticles/downloads/SE0738.pdf*.

You may also find *The Guide to Medicare Preventive Services* at *http://www.cms.gov/MLNProducts/downloads/mps_guide_Web-061305.pdf* and the *Medicare Preventive Services Brochure* at *http://www.cms.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.

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

MLN Matters® Number: SE1008
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Drugs and Biologicals

Modifier JW not required – MLN Matters article MM6711 does not apply to FCSO

This article serves as both a reminder and a clarification of the guidelines in the *Medicare Claims Processing Manual* that describes how to use the modifier JW for discarded drugs.

Change request (CR) 5923 provided contractors the option to require or not to require the modifier JW. During implementation of CR 5923, First Coast Service Options Inc. (FCSO) made the decision not to require the modifier JW. CR 6711 does not modify this decision. **Therefore, the new instructions regarding the use of modifier JW, specified in CR 6711, do not apply to claims submitted to FCSO. The instructions in CR 6711 are only applicable to those contractors that require the use of the JW modifier.**

Additional information

Here is the link to the *MLN Matters* article MM5923 *http://www.cms.gov/MLNMattersArticles/downloads/MM5923.pdf*.

Here is the link to the official instruction issued to your Medicare carrier, DME/MAC, FI and/or A/B MAC for CR 5923 *http://www.cms.gov/Transmittals/downloads/R1478CP.pdf*.

Source: CMS Publication 100-04, Chapter 17, Section 40

Manual update regarding billing for discarded drugs or biologicals

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

Provider types affected

Physicians, hospitals, suppliers and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], Part A/B Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for administering or supplying drugs and biologicals should review this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6711 to include in the *Medicare Claims Processing Manual* the updated policy, which describes when to use the modifier JW for discarded drugs.

Background

As a reminder, your Medicare contractor may require its providers to use the modifier JW. If required, when billing Medicare for all drugs except those provided under the Competitive Acquisition Program for Part B drugs and biologicals, use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the discarded drug or biological.

For example, a single use vial labeled to contain 100 units of a drug, where 95 units are used and billed and paid on one line, the remaining five units will be billed and paid on another line using the modifier JW. The modifier JW is only applied to units not used. **Note**: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional information

If you have questions, please contact your Medicare FI, carrier, A/B MAC, 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 6711, issued to your Medicare FI, carrier, A/B MAC, or DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1962CP.pdf*.

MLN Matters® Number: MM6711
Related Change Request (CR) #: 6711
Related CR Release Date: April 30, 2010
Effective Date: July 30, 2010
Related CR Transmittal #: R1962CP
Implementation Date: July 30, 2010

Manual update related to determining self-administration of drugs or biologicals

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

Provider types affected

Physicians, nonphysician practitioners and hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MAC)) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6950, which furnishes Medicare contractors with updates to the *Medicare Benefit Policy Manual* relating to determining self-administration of drug or biological. This update allows for other routes of administration besides injections to be considered as not usually self-administered. Be sure your billing staff is aware of this manual change.

Background

The Medicare program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. FIs, carriers and MACs are instructed to follow the *Benefits Policy Manual* when applying the exclusion for drugs that are usually self-administered by the patient. The term "administered" is discussed in the *Benefits Policy Manual*. Due to recent drugs approved for marketing by the Food and Drug Administration, Chapter 15, Section 50.2, of this manual is being updated to allow for other routes of administration besides injections to be considered as not-usually self-administered.

The term "administered" refers only to the physical process by which the drug enters the patient's body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug). Injectable drugs, including intravenously administered drugs, are typically eligible for inclusion under the "incident to" benefit. With limited exceptions, other routes of administration (including, but not limited to, oral drugs, suppositories, and topical medications) are considered to be usually self-administered by the patient.

Additional information

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

The official instruction issued to your Medicare FI, carrier, and/or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R123BP.pdf*.

MLN Matters® Number: MM6950
Related Change Request (CR) #: 6950
Related CR Release Date: April 30, 2010
Effective Date: July 30, 2010
Related CR Transmittal #: R123BP
Implementation Date: July 30, 2010

Durable Medical Equipment

July update to the 2010 DMEPOS 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 providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for DMEPOS provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6945 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

July update to the 2010 DMEPOS fee schedule (continued)

Key points of CR 6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes with A4336, E1036, L8031, L8032, L8629, and Q0506 with dates of service on or after January 1, 2010, that have already been processed will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.
- CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code A4221 (Supplies for maintenance of drug infusion catheter, per week). To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.
- CR 6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items.

Additionally, the descriptors for modifiers RA and RB are being revised, effective April 1, 2010, to read as follows:

RA Replacement of a DME, orthotic or prosthetic item

RB Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair

Suppliers should continue to use the modifier RA on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. Likewise, the RB modifier should continue to be used on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device.)

- Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is five years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than five years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than five years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR 6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to three months.
- HCPCS code Q0506 (Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only) was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than lithium ion – HCPCS codes Q0496 and Q0503 – remains at six months as described in CR 3931, Transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA (Replacement of a DME, orthotic or prosthetic item) to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR 3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

Additional information

If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
The official instruction (CR 6945) issued to your Medicare DME MAC may be found at *http://www.cms.gov/Transmittals/downloads/R1967CP.pdf*.

MLN Matters® Number: MM6945
Related Change Request (CR) #: 6945
Related CR Release Date: May 7, 2010
Effective Date: January 1, 2010, for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010, for the revisions to the RA & RB modifier descriptors which became effective April 1, 2010; July 1, 2010, for all other changes
Related CR Transmittal #: R1967CP
Implementation Date: July 6, 2010

Change in claims filing jurisdiction for tracheo-esophageal voice prostheses

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 contractors (Medicare administrative contractors [MACs], carriers and/or durable medical equipment Medicare administrative contractors [DME MACs]) for tracheo-esophageal voice prostheses provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6743, which changes the claims filing jurisdiction for Healthcare Common Procedure Coding System (HCPCS) code L8509. HCPCS code L8509 describes a tracheo-esophageal voice prosthesis inserted by a licensed health care provider, any type. This device is inserted in a physician's office or other outpatient setting. Effective for dates of service on or after October 1, 2010, claims for HCPCS code L8509 must be submitted to the A/B MAC or Part B carrier, as applicable, instead of the DME MAC. This jurisdictional policy does not apply to tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting (HCPCS code L8507). The filing jurisdiction for these claims remains with the DME MACs. Be sure billing staff know of this change.

Key points of CR 6743

- Effective for dates of service on or after October 1, 2010, the DME MACs will deny claims containing HCPCS code L8509 as not payable under the contractor's claims jurisdiction area. When Medicare denies such claims, the provider will receive these messages: remark code N418 (Misrouted claim. See the payer's claim submission instructions.) and reason code 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.).
- Effective for dates of service on or after October 1, 2010, the A/B MACs and Part B carriers will accept HCPCS code L8509 for processing.
- The A/B MACs and Part B carriers will cover claims for HCPCS code L8509 as a prosthetic device. The A/B MACs and Part B carriers will base the Medicare allowed payment amount on the lower of the actual charge or the fee schedule amount for HCPCS code L8509.
- Tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting are billed using HCPCS code L8507 (tracheo-esophageal voice prostheses, patient inserted, any type, each) and are eligible for coverage under the prosthetic device benefit. The filing jurisdiction for these claims remains with the DME MACs.
- Medicare does not cover the item if it is shipped or dispensed to the beneficiary, who then takes the item to their physician's office for insertion. The A/B MACs or Part B carriers will deny claims in these instances, as described in Chapter 15, Section 120, in, the *Medicare Benefit Policy Manual*, which states that "Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient's condition."

Additional information

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

The official instruction, CR 6743, issued to your, A/B MAC, carrier and/or DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R686OTN.pdf*.

MLN Matters® Number: MM6743
Related Change Request (CR) #: 6743
Related CR Release Date: April 29, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R686OTN
Implementation Date: October 4, 2010

Billing repair of codes listed in change requests 6573 and 5917

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

Provider types affected

This article applies to suppliers billing Medicare carriers and Medicare administrative contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6914 in order to augment previously issued CR 6573. Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers may bill separately for any of the repair codes listed in the *Key points* section of this article in addition to the codes for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME previously communicated in Attachment A of CR 6573. Your Medicare contractors will reprocess any claims submitted by DMEPOS suppliers for these separately billable repair codes listed below with dates of service of January 1, 2010, through the implementation date of CR 6914 (which is October 4, 2010), according to the guidelines established in CRs 5917 and 6573.

Key points of CR 6914

- The following is the list of the additional separately billable repair codes issued within CR 6914

Code	Description
K0739	Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes
L7500	Repair of prosthetic device, hourly rate
L7510	Repair of prosthetic device, repair or replace minor parts
L7520	Repair prosthetic device, labor component, per 15 minutes
L8627	Cochlear implant, external speech processor, component, replacement
L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device
Q0506	Battery, lithium-ion, for use with electric or electric/pneumatic ventricula r assist device, replacement only

- Medicare contractors will allow suppliers that are dually enrolled with the national supplier clearinghouse (NSC) and with their local carrier or A/B MAC as DMEPOS suppliers to bill separately for any of the above listed DMEPOS repair codes as well as those codes included in Attachment A of CR 6573 when billed under the guidelines established in CRs 5917 and 6573, including items/services furnished to beneficiaries who reside in other states.
- CR 5917 may be reviewed at *http://www.cms.gov/Transmittals/downloads/R1603CP.pdf* and CR 6573 *http://www.cms.gov/Transmittals/downloads/R531OTN.pdf*.

Additional information

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

The official instruction associated with this CR 6914, issued to your Medicare MAC or carrier regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R695OTN.pdf*.

You may review MM6573 (related to CR 6573) at *http://www.cms.gov/MLNMattersArticles/downloads/MM6573.pdf* and MM5917 (related to CR 5917) at *http://www.cms.gov/MLNMattersArticles/downloads/MM5917.pdf*.

MLN Matters® Number: MM6914
Related Change Request (CR) #: 6914
Related CR Release Date: April 30, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R695OTN
Implementation Date: October 4, 2010

Laboratory/Pathology

Screening for the human immunodeficiency virus infection

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, providers, and clinical diagnostic laboratories submitting claims to Medicare contractors (fiscal intermediaries [FI], carriers, and Parts A/B Medicare administrative contractors [A/B MAC]) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has issued a new national coverage determination (NCD) that the evidence is adequate to conclude that screening for human immunodeficiency virus (HIV) infection is reasonable and necessary for prevention or early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Caution – what you need to know

Effective for claims with dates of service on and after December 8, 2009, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries, subject to the criteria in the *National Coverage Determination (NCD) Manual*, Sections 190.14 and 210.7, and the *Medicare Claims Processing Manual (CPM)*, Chapter 18, Section 130. These manual sections are attached to the transmittals, which comprise change request (CR) 6786. This article is based on CR 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.

Go – what you need to do

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

Background

Effective January 1, 2009, the CMS is authorized to add coverage of "additional preventive services" through the NCD process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act (MIPPA). One of those requirements is that the services be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

Consequently, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786. **Note**: 11 full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.
- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

Note: Three tests will be covered for each term of pregnancy beginning with the date of the first test**.**

The USPSTF guideline upon which this policy is based contains eight increased-risk criteria. The first seven require the presence of both diagnosis codes V73.89 (Special screening for other specified viral disease) and V69.8 (Other problems related to lifestyle) for the claim to be paid. The last criterion, which covers persons reporting no increased risk factors, only requires diagnosis code V73.89 for the claim to be paid.

Note: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following three new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 outpatient code editor and the January 2011 clinical laboratory fee schedule (CLFS) updates:

- G0432 - Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening
- G0433 - Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening
- G0435 - Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening

Claims for the annual HIV screening must contain one of the new HCPCS along with a primary diagnosis code of V73.89, and when increased risk factors are reported, a secondary diagnosis code of V69.8. For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030x for claims for HIV screening.

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered.). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached.) will be used.

Screening for the human immunodeficiency virus infection (continued)

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (types of bills 12x, 13x, or 14x) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.

Contractors shall pay for HIV screening tests with HCPCS codes G0432, G0433, or G0435 on TOBs 12x, 13x, 14x, 22x, and 23x, under the clinical laboratory fee schedule as of January 1, 2011. Deductible and coinsurance do not apply.

Prior to inclusion of the new G codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code *87999* may be used when paying for these services.

Note that for HIV screening claims with dates of service on or after December 8, 2009, through July 6, 2010, and processed before CR 6785 is implemented, Medicare will not adjust such claims automatically. However, your Medicare contractor will adjust such claims that you bring to their attention.

Additional information

CR 6786 was issued in two transmittals, one which modifies the *Medicare Claims Processing Manual*, which is at *http://www.cms.gov/Transmittals/downloads/R1935CP.pdf*. The second transmittal revises the *Medicare NCD Manual* and that transmittal is at *http://www.cms.gov/Transmittals/downloads/R113NCD.pdf*.

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

MLN Matters® Number: MM6786
Related Change Request (CR) #: 6786
Related CR Release Date: March 23, 2010
Effective Date: December 8, 2009
Related CR Transmittal #: R1935CP and R113NCD
Implementation Date: July 6, 2010

July 2010 updates to the laboratory national coverage determination edit software

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 carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries may be impacted by this article.

What you need to know

This article is based on change request (CR) 6964 which announces the changes that will be included in the July 2010 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in January 2010.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003.

In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, available at *http://www.cms.gov/manuals/downloads/clm104c16.pdf*, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6964 announces changes to the laboratory edit module for changes in laboratory NCD code lists for July 2010. These changes become effective for services furnished on or after July 1, 2010. The changes that are effective for dates of service on and after July 1, 2010, are as follows:

- ICD-9-CM codes V17.4 and V18.1 have been deleted from the list of noncovered ICD-9-CM codes for all 23 NCDs.
- ICD-9-CM codes V17.41, V17.49, V18.11 and V18.19 have been added to the list of noncovered ICD-9-CM codes for all 23 NCDs.

Additional information

If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction (CR 6964) issued to your Medicare MAC, carrier, and/or FI may be found at *http://www.cms.gov/Transmittals/downloads/R1963CP.pdf*.

MLN Matters® Number: MM6964
Related Change Request (CR) #: 6964
Related CR Release Date: April 30, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R1963CP
Implementation Date: July 6, 2010

Medicare Physician Fee Schedule

Revised 2010 MPFSDB payment files and other retroactive provisions

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

Provider types affected

Physicians, nonphysician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs] for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS) are affected by this article.

Provider action needed

This article is based on change request (CR) 6973, which amends payment files that were issued to contractors to take into account the 2010 MPFS final rule correction notice that went on display at the *Federal Register* on May 5, 2010, and retroactive provisions under the Affordable Care Act.

Background

Payment files were issued to contractors based on the calendar year (CY) 2010 MPFS final rule. Subsequent to the publication of the CY 2010 MPFS final rule:

- The Department of Defense Appropriations Act of 2010 provided a two month zero percent update to the 2010 MPFS, effective for dates of service January 1, 2010, through February 28, 2010.
- The Temporary Extension Act of 2010 extended the zero percent update to the 2010 MPFS for dates of service through March 31 2010.
- The Continuing Extension Act of 2010 extended the zero percent update to the 2010 MPFS for dates of service through May 31, 2010.

CR 6973 includes changes as a result practice expense (PE) and malpractice (MP) relative value unit (RVU) corrections and provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act), as modified by the Health Care and Education Reconciliation Act of 2010, which was signed into law on March 23, 2010, and March 30, 2010, respectively.

The PE and MP RVUs have been revised to align their values with the final CY 2010 MPFS policies for PE and MP RVUs. Although the zero percent (0%) update to the 2010 MPFS has been extended through legislation, the conversion factor (CF) has been revised as a result of the PE and MP RVU corrections. The revised CF used in calculating the payment amounts associated with this instruction is $36.0791.

The Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, also included the extension of several provisions, retroactive to January 1, 2010, that had previously been included in other legislation. The extended provisions include 1) the extension of the work geographic practice cost index (GPCI) floor of 1.0 through December 31, 2010; 2) the extension of the MPFS mental health add-on 3) the extension of the exceptions process for Medicare therapy caps; and 4) the extension of payment for the technical component (TC) of certain physician pathology services. Also included is a revision to the PE GPCIs for CY 2010 and a new provision regarding payment for bone density tests in CY 2010.

Description of provisions

Revisions to CY 2010 work and PE GPCIs

Section 3102 of the Affordable Care Act extends the 1.0 work GPCI floor for services furnished through December 31, 2010. It also revises the PE GPCIs for CY 2010 so that the employee wage and rent portions of the PE GPCI reflect only one-half of the relative cost differences for each locality compared to the national average. Each PFS locality is held harmless under the PE GPCI changes.

These changes are reflected in the revised payment files and are retroactive to January 1, 2010.

Extension of physician fee schedule mental health add-on

Section 138 of the Medicare Improvements for Patients and Providers Act of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extends this provision retroactive to January 1, 2010, through December 31, 2010. The "Psychiatry" *CPT* codes that represent the "specified services" are as follows:

Office or other outpatient facility

- (Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy) *CPT* codes *90804, 90805, 90806, 90807, 90808, 90809*
- (Interactive Psychotherapy) *CPT* codes *90810, 90811, 90812, 90813, 90814, 90815*

Revised 2010 MPFSDB payment files and other retroactive provisions (continued)

Inpatient hospital, partial hospital or residential care facility

- (Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy) *CPT* codes *90816, 90817, 90818, 90819, 90821, 90822*
- (Interactive Psychotherapy) *CPT* codes *90823, 90824, 90826, 90827, 90828, 90829*

CPT	MOD	WRVU	NON-FACILITY PE RVU	FACILITY PE RVU	MALPRACTICE RVU	NON-FACILITY TOTAL	FACILITY TOTAL
77080		0.22	2.35	NA	0.13	2.70	NA
	26	0.22	0.07	0.07	0.01	0.30	0.30
	TC	0.00	2.28	NA	0.12	2.40	NA
77082		0.12	0.59	NA	0.05	0.76	NA
	26	0.12	0.04	0.04	0.01	0.17	0.17
	TC	0.00	0.55	NA	0.04	0.59	NA

The adjusted payment amounts for these codes are included on the revised payment files and are retroactive to January 1, 2010.

Extension of exceptions process for Medicare therapy caps

Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continues the exceptions process through December 31, 2010.

Extension of payment for the TC of certain physician pathology services

Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a Medicare administrative contractor (MAC) for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extends the payment for the TC of certain physician pathology services retroactive to January 1, 2010, through December 31, 2010.

Additional information

The official instruction (CR 6973) issued to your carrier, FI, RHHI or A/B MAC, regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R700OTN.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: MM6973
Related Change Request (CR) #: 6973
Related CR Release Date: May 10, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R700OTN
Implementation Date: No later than June 1, 2010

Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010

On March 23 President Obama signed into law the Patient Protection and Affordable Care Act. One week later, on March 30, the President also signed into law the Health Care and Education Reconciliation Act of 2010. These two new laws have a significant impact on the Medicare program and many of the provisions have effective dates prior to this point in time. Over the past several weeks, the Centers for Medicare & Medicaid Services (CMS) has begun implementing various provisions of the new laws, including those with past effective dates. In addition to implementing these legislative changes, the Medicare physician fee schedule is being updated to include certain corrections, retroactive to January 1, 2010, as prescribed in recently published notices in the *Federal Register*.

Once Medicare contractors have the new payment files in place, per the above, all claims going forward will be processed at the revised rates. However, CMS continues to work on the best way to address the many claims that are paid at the rates that were in place before the current corrections and updates are made. Please be on the alert for further information about how CMS will address past claims. Until then, providers should not resubmit previously-processed claims affected by the payment changes, as it is likely that these resubmissions may be denied as duplicate claims.

Source: CMS PERL 201005-24

Radiology

FDG positron emission tomography for solid tumors and myeloma

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

Note: This article was revised on May 7 to reflect changes made to CR 6632. The CR transmittal number for the national coverage determination (NCD) transmittal and the Web address for accessing that transmittal were updated. All other information remains the same. This information was previously published in the October 2009 *Medicare B Update!* pages 10-13.

Provider types affected

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

What you need to know

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

Background

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

NCD requirements

Initial antitumor treatment strategy

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

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

There are some exceptions to this initial treatment strategy:

- CMS will nationally noncover the use of FDG PET imaging to determine initial treatment strategy in patients with adenocarcinoma of the prostate.
- CMS will continue to cover FDG PET imaging for the initial treatment strategy for male and female breast cancer when used in staging distant metastasis. FDG PET imaging for diagnosis and initial staging of axillary nodes will remain noncovered.
- CMS will continue noncoverage of FDG PET for the evaluation of regional lymph nodes in melanoma.

Other uses to determine initial treatment strategy remain covered.

- CMS will continue to cover FDG PET imaging as an adjunct test for the detection of pre-treatment metastasis (i.e., staging) in newly diagnosed cervical cancers following conventional imaging that is negative for extra-pelvic metastasis. All other uses of FDG PET for the initial treatment strategy for beneficiaries diagnosed with cervical cancer will only continue to be covered through coverage with evidence development (CED).

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

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

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

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

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

Subsequent antitumor treatment strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As exceptions to the *Subsequent treatment strategy* section:

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

Myeloma

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

Further exceptions

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

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

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

The chart below summarizes Section 220.6.1:

Table 1
FDG PET coverage for solid tumors and myeloma

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

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

Notes:

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

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

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

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

Coding and billing requirements

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

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

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

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

Medicare claim processing requirements in CR 6632 are as follows:

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

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

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

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

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

Remittance advice remark code MA-130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remittance advice remark code M16: Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

For claims with dates of service on or after April 3, 2009, Medicare will accept and pay for FDG PET oncologic claims billed for initial or subsequent treatment strategy when performed under CED only when billed with the following:

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

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

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

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

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

Additional information

CR 6632 was issued in two transmittals. One transmittal conveys the revisions to the *Medicare National Coverage Determinations Manual*, and the other conveys the changes to the *Medicare Claims Processing Manual*. These transmittals are at *http://www.cms.gov/Transmittals/downloads/R120NCD.pdf* and *http://www.cms.gov/Transmittals/downloads/R1833CP.pdf*, respectively.

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

MLN Matters® Number: MM6632 *Revised*
Related Change Request (CR) #: 6632
Related CR Release Date: October 16, 2009
Effective Date: April 3, 2009
Related CR Transmittal #: R1833CP and R120NCD
Implementation Date: October 30, 2009

General Coverage

Signature guidelines – 20-day timeframe for additional documentation requests

Medicare claim review contractors, including the comprehensive error rate testing (CERT) contractors and recovery audit contractors, are tasked with measuring, detecting, and correcting improper payments in the Medicare fee-for-service (FFS) program. These contractors review claims and medical documentation submitted by providers.

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. Change request (CR) 6698 updates these requirements and adds e-Prescribing language.

In situations where the guidelines in the PIM indicate for a medical reviewer to contact the billing provider requesting to submit an attestation statement or signature log to authenticate a medical record, the provider must submit the attestation statement or signature log within 20-calendar days.

The 20-day timeframe begins when:

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

Signature log

A signature log lists the typed or printed name of the author associated with initials or an illegible signature. The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document. Medical reviewers will encourage the listing of credentials in the log; however, CMS has instructed reviewers not to deny a claim for a signature log that is missing credentials.

Signature attestation statement

The author of the medical record entry must sign and date the attestation statement in order to be considered valid for Medicare medical review purposes. The attestation statement must contain the appropriate information to identify the beneficiary in question.

Provider assistance

First Coast Service Options (FCSO) has implemented faxination accounts to assist providers with meeting these requirements and expedite this process. FCSO will provide you with these important numbers upon the request for the signature log or attestation statement.

Additional information

Detailed information regarding signature requirements is available at *http://medicare.fcso.com/CERT/166303.asp*.

Source: Pub 100-08, Transmittal 327, Change request 6698

Payment reduction on the technical component of certain diagnostic imaging procedures

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

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers and Medicare administrative contractors [MAC]) for multiple diagnostic imaging procedures provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6965, which directs Medicare contractors to reduce the payment under the Medicare physician fee schedule (MPFS) for the technical component (TC) of certain multiple diagnostic imaging procedures done in a single imaging session from 75 percent to 50 percent. Be sure billing staff know of this change.

Background

Section 3135(b) of the Patient Protection and Affordable Care Act of 2009 (PPACA) reduces payment for TC of the second and subsequent procedures from 75 percent to 50 percent of the MPFS amount. Medicare currently applies a multiple procedure payment reduction (MPPR) of 25 percent to the TC of certain diagnostic imaging procedures, i.e.:

- The reduction applies to TC only services, and the TC portion of global services, for the procedures with a multiple surgery value of '4' in the Medicare physician fee schedule database.
- The MPPR does not apply to the professional component (PC) or to the PC portion of global services. The 11 families of imaging codes to which this policy applies are established according to modality (computed tomography (CT), magnetic resonance imaging (MRI), and ultrasound) and body area.
- The reduction applies only to more than one procedure performed in a single imaging session on contiguous body parts, i.e., within a family of codes, not across families. For example, the reduction would not apply to an MRI of the brain (*CPT 70552*) in code family 5 (MRI/MRA head/brain/neck), when performed during the same session, on the same day, as an MRI of the neck and spine (*CPT 72142*) in code family 6 (MRI/MRA spine).

The current payment and payment as of July 1, 2010, are summarized below in the following example:

	Procedure 1	Procedure 2	Current Total Payment	Revised Total Payment
PC	$100	$80	$180 (no reduction)	$180 (no reduction)
TC	$500	$400	$800 ($500 + (.75 x $400))	$700 (($500 + (.5 x $400))
Global	$600	$480	$980 (($600 + ($480-$400)) + (.75 x $400))	$880 (($600 + ($480-$400) + (.5 x $400))

Additional information

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

The official instruction, CR 6965, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R694OTN.pdf*.

MLN Matters® Number: MM6965
Related Change Request (CR) #: 6965
Related CR Release Date: May 7, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R694OTN
Implementation Date: July 6, 2010

Clinical review judgment

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

Provider types affected

This impacts all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

What you need to know

CR 6954, from which this article is taken:

- Adds Section 3.14 (Clinical Review Judgment) to the *Medicare Program Integrity Manual*, clarifying existing language regarding clinical review judgments, and
- Requires that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Background

Medicare claim review contractors (carriers, FIs [called affiliated contractors, or ACs], MACs, the comprehensive error rate testing (CERT) contractor, and recovery audit contractors [RACs]), along with program safeguard contractors (PSC) and zone program integrity contractors (ZPIC) are tasked with measuring, detecting and correcting improper payments in the fee-for-service (FFS) Medicare program.

Change request (CR) 6954, from which this article is taken, updates the *Medicare Program Integrity Manual* by adding a new Section (3.14 – Clinical Review Judgment) which clarifies existing language regarding clinical review judgments; and also requires that Medicare claim review contractors instruct their clinical review staffs to use the clinical review judgment process when making complex review determinations about a claim.

This clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient.
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

Note: Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).

Additional information

You may find more information about clinical review judgment by going to CR 6954, located at *http://www.cms.gov/Transmittals/downloads/R338PI.pdf*. You will find the updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section14 (Clinical Review Judgment) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM6954
Related Change Request (CR) #: 6954
Related CR Release Date: May 14, 2010
Effective Date: April 23, 2010
Related CR Transmittal #: R338PI
Implementation Date: June 15, 2010

Electronic Data Interchange

Update of remittance advice remark codes and claim adjustment reason including Medicare Remit Easy Print

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

Provider types affected

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

Provider action needed

CR 6901, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective July 1, 2010. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC and CARC lists are updated three times a year – in March, July, and November. Both code lists are posted at *http://www.wpc-edi.com/Codes*. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6901.

CR 6901 conveys the following updates:

New codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1/24/2010
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1/24/2010

Modified codes - CARC

None

Deactivated codes - CARC

None

New codes - RARC

Code	Current Narrative	Medicare Initiated
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.	Yes
N524	Based on policy this payment constitutes payment in full.	No
N525	These services are not covered when performed within the global period of another service.	No
N526	Not qualified for recovery based on employer size.	Yes
N527	We processed this claim as the primary payer prior to receiving the recovery demand.	Yes
N528	Patient is entitled to benefits for Institutional Services.	Yes
N529	Patient is entitled to benefits for Professional Services.	Yes
N530	Our records indicate a mismatch in enrollment information for this patient.	Yes
N531	Not qualified for recovery based on direct payment of premium.	Yes
N532	Not qualified for recovery based on disability and working status.	Yes

Update of remittance advice remark codes and claim adjustment reason including Medicare Remit Easy Print (continued)

Modified codes - RARC

Code	Modified Narrative	Medicare Initiated
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package	No
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	No

Deactivated codes - RARC
None

Additional information

To see the official instruction (CR 6901) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC, refer to *http://www.cms.gov/Transmittals/downloads/R1950CP.pdf*.

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

MLN Matters® Number: MM6901
Related Change Request (CR) #: 6901
Related CR Release Date: April 23, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R1950CP
Implementation Date: July 6, 2010

ICD-10/5010 national provider call scheduled for June 15

The Centers for Medicare & Medicaid Services (CMS) will host a national provider conference call on June 15 titled "ICD-10 Implementation in a 5010 Environment." This toll-free teleconference call will include a question and answer session that will give call participants an opportunity to ask questions of CMS subject matter experts. Target audience: Medical coders, physician office staff, provider billing staff, health records staff, vendors, educators, system maintainers and all Medicare fee-for-service (FFS) providers.

Conference call detail

When: Tuesday, June 15, 2010
Time: Noon-2:00 p.m. ET

The presentation will include the following topics:

ICD-10

- Benefits of ICD-10
- Differences between ICD-10 and ICD-9-CM codes
- Tools for converting codes -- general equivalence mappings (GEMs)
- Proposal to freeze ICD-9-CM and ICD-10 code updates except for new technologies and diseases

HIPAA version 5010

- General overview HIPAA version 5010 and D.0 and who is impacted
- Compliance dates
- Benefits
- 5010 scope versus ICD-10 scope
- What you need to do to prepare
- Timelines
- Medicare FFS implementation of HIPAA version 5010 and D.0
- Impact on paper claim forms

Registration information

To register for this informative conference call, please go to the CMS website at *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*. Registration for this call will close at noon ET on June 14 or when available space has been filled. No exceptions will be made. Please register as early as possible.

Additional information

Additional information about ICD-10/5010 may be found at *http://www.cms.gov/ICD10*.

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

Source: CMS PERL 201005-41

General Information

Systems changes necessary to implement timely filing limits changes

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

Provider types affected

This issue impacts all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the timely filing limits for submitting claims for Medicare fee-for-service (FFS) reimbursement. As a result of the PPACA, claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare. Further details follow in this article. Make sure your billing staff is aware of these changes.

Background

Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act as well as the Code of Federal Regulations (CFR), 42 CFR Section 424.44 specify the timely filing limits for submitting claims for Medicare fee-for-service (FFS) reimbursement. Prior to PPACA, the regulations stated the service provider or supplier must submit claims for services furnished during the first nine months of the calendar year on or before December 31 of the following calendar year. For services rendered during the last quarter of the calendar year, the provider or supplier must submit the claim on or before December 31 of the second following year.

Section 6404 of PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010, must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.

What you need to know

Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009, will be subject to pre-PPACA timely filing rules and associated edits.
- Claims with dates of service October 1, 2009, through December 31, 2009, received after December 31, 2010, will be denied as being past the timely filing deadline.
- Claims with dates of service January 1, 2010, and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

Note: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "from" date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify exceptions to the one calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR Section 424.44(b)(1), for "error or misrepresentation" of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

Additional information

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

The official instruction (change request 6960) issued to your Medicare FI, carrier, DME MAC, A/B MAC and/or RHHI is available at *http://www.cms.gov/Transmittals/downloads/R697OTN.pdf*.

MLN Matters® Number: MM6960
Related Change Request (CR) #: 6960
Related CR Release Date: May 7, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R697OTN
Implementation Date: October 4, 2010

Amount in controversy requirement for ALJ hearings and federal district court appeals

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

Provider action needed

This article is based on change request (CR) 6894, which notifies Medicare contractors of the amount in controversy (AIC) required to sustain administrative law judge (ALJ) and federal district court appeal rights beginning January 1, 2010.

- The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2010, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2010, is $130.
- For federal district court review, the amount remaining in controversy goes from $1,220 for requests on or after January 1, 2009, to $1,260 for requests on or after January 1, 2010.

Please ensure that your staff knows of these changes.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6894 modifies the *Medicare Claims Processing Manual*, Chapter 29, Sections 220, 330.1, and 345.1 to update the AIC required for an ALJ hearing or judicial court review. CR 6894 also expands the background information in the Amount in Controversy General Requirements, Principles for Determining Amount in Controversy, and Aggregation of Claims to meet Amount in Controversy sections 250, 250.1, 250.2 and 250.3 in the *Claims Processing Manual*, Chapter 29. The revised portions of the manual are attached to CR 6894.

Additional information

The official instruction (CR 6894) issued to your Medicare carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at *http://www.cms.gov/Transmittals/downloads/R1965CP.pdf*.

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*.

A brochure entitled, The Medicare Appeals Process: Five Levels To Protect Providers, Physicians And Other Suppliers, provides an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process. The brochure is available at *http://www.cms.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf*.

MLN Matters® Number: MM6894
Related Change Request (CR) #: 6894
Related CR Release Date: May 7, 2010
Effective Date: August 9, 2010
Related CR Transmittal #: R1965CP
Implementation Date: August 9, 2010

2010 Physician Quality Reporting Initiative update

It is not too late to start participating in the 2010 Physician Quality Reporting Initiative (PQRI) and potentially qualify to receive incentive payments. A new six-month reporting period begins on July 1, 2010.

The 2010 Physician Quality Reporting Initiative (PQRI) program now has two reporting periods:

- 12-months – January 1-December 31, 2010
- Six-months – July 1-December 31, 2010

For 2010, eligible professionals (EPs) who satisfactorily report PQRI measures for the six-month reporting period will become eligible to receive a PQRI incentive equal to 2.0 percent of their total Medicare Part B allowed charges for services performed during the reporting period.

If you have not previously participated in the PQRI program, you can begin by reporting PQRI data for the time period, July 1-December 31, 2010, and use any of the following four options:

- Claims-based reporting of individual measures for 80 percent or more of applicable patients on at least three individual measures or on each measure (if less than three measures apply).
- Claims-based reporting of one measures group for 80 percent or more of applicable Medicare Part B fee-for-service (FFS) patients of each EP (with a minimum of eight patients).
- Registry-based reporting of at least three individual PQRI measures for 80 percent or more of applicable Medicare Part B FFS patients of each EP.

2010 Physician Quality Reporting Initiative update (continued)

- Registry-based reporting of one measures group for 80 percent or more of applicable Medicare Part B FFS patients of each EP (with a minimum of eight patients).

PQRI claims-based reporting involves the addition of quality-data codes (QDC) to claims submitted for services when billing Medicare Part B. EPs also have the option of using a qualified registry to assist in collecting PQRI measure data. The registry will submit this quality data directly to Medicare, eliminating the need for adding QDCs to the Medicare Part B claim.

Eligible professionals do not need to sign up or pre-register to participate in the 2010 PQRI. Providers may indicate their intent to participate by:

- Submission of QDCs for individual PQRI measures to CMS through a qualified registry
- Submission of QDCs through claims or a qualified registry for a measures group

Although there is no requirement to register prior to submitting the data, EPs should take some preparatory steps prior to undertaking PQRI reporting. CMS has created many educational products that provide information about how to get started with PQRI reporting. You may access all available educational resources on PQRI at *http://www.cms.gov/PQRI/*. Eligible professionals are encouraged to visit the PQRI Web page often for the latest information and downloads on PQRI.

Resources

- 2010 PQRI implementation guide
  http://www.cms.gov/PQRI/Downloads/2010_PQRI_ImplementationGuide_02-10-2010_FINAL.pdf
- Qualified registries for 2010 PQRI reporting
  http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp

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

Source: CMS PERL 201005-26

Update to guidance on standardized Medigap policy

The Centers for Medicare & Medicaid Services (CMS) recently issued guidance on a new standardized Medigap policy (Plan N) that will become effective June 1. Based on inquiries received from the provider community since the guidance was released, CMS has made several clarifying changes, which have resulted in the original guidance being replaced with the following.

Revised questions and answers regarding implementation of Medicare supplement Plan N co-payment, deductible, and coinsurance

Medicare supplement insurance plans and benefits have been updated in accordance with recent revisions to the Medicare Supplement Model Regulation and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 9.1E(11) of the Model provides that new Medicare supplement Plan N will include a co-payment structure. As states and companies are working towards implementation of these new changes (which apply for policies with effective dates on or after June 1), a number of questions have surfaced regarding implementation of the new Plan N co-payment, deductible, and coinsurance requirements.

Plan N requirements

Section 9.1E(11) of NAIC Model Regulation 651 (as published in the *Federal Register* on April 24, 2009 (see page 18823) states:

"(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with copayment s in the following amounts:

(a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists), and

(b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense."

In order to ensure consistent implementation of this new standardized benefit Plan N, the Centers for Medicare and Medicaid Services (CMS) and the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC), have developed the following guidance. This information will also be provided to Medicare supplement carriers. References to *CPT* codes and Medicare procedures in this document have been reviewed by CMS, but are subject to change as Medicare rules and coding may change.

Update to guidance on standardized Medigap policy (continued)

Deductible
Q1. Will payment of the Medicare Part B deductible by the beneficiary when the beneficiary has a Plan N policy operate the same way as fee-for-service Medicare, in that the beneficiary pays coinsurance or a co-payment for the Medicare-approved amount for services only after meeting the Part B deductible?
A1. Yes, the Plan N subscriber is responsible for meeting the deductible before any coinsurance or co-payment is collected. Once the deductible is met, the subscriber is responsible for up to $20 per office visit and up to $50 for an emergency room visit.

Office visit coinsurance or co-payment
Q2. Under Plan N, what constitutes an "office visit" for purposes of determining whether the subscriber is subject to the Part B coinsurance or co-payment of up to $20?
A2. Services coded as office visits or evaluation and management visits and billed on Part B professional claim forms (CMS-1500 or ASC X12N 837 professional) would be considered "office visits" for purposes of determining whether the subscriber is subject to the Plan N Part B coinsurance or co-payment of up to $20. These include *CPT*-4 codes *99201-99205* and *99211-99215*, as well as *92002, 92004, 92012*, and *92014* (ophthalmology), and *90805* (psychotherapy).

Note: Consultation *CPT*-4 codes have been deleted from the 2010 Medicare physician fee schedule and are no longer payable by Medicare as of January 1, 2010.

Q3. When applying the Plan N physician office co-payment or coinsurance, should the amount be applied only to the office visit charge and not to other charges such as laboratory, x-ray or durable medical equipment (DME)?
A3. Yes, the coinsurance or co-payment should be applied only to *CPT*-4 codes *99201-99205* and 99211-*99215*, which are codes used to bill an office visit.

Q4. If the Plan N subscriber presents for multiple Medicare-covered office visits in one day, is the coinsurance or co-payment applicable to each office visit?
A4. Yes, the coinsurance or co-payment is applicable to each Medicare-covered office visit.

Q5. What are the *CPT*-4 codes applicable to physician specialty office visits for Plan N?
A5. There are no office visit codes used solely for visits to specialists, with the exception of the ophthalmology and psychotherapy codes listed above. *CPT*-4 codes *99201-99205* and *99211-99215*, which apply to nonspecialty office visits, also apply to the Plan N specialty office visit coinsurance or co-payment.

Q6. Would online, telephone, or telehealth services constitute "office visits" for purposes of determining whether a Plan N subscriber is subject to the Part B coinsurance or co-payment of up to $20?
A6. Providers do not code these services as office visits, office consultations or evaluation and management visits in their Part B billings. Therefore, these services would not be subject to the Plan N coinsurance or co-payment.

Q7. Does the Plan N office visit or emergency room co-pay apply to the foreign travel emergency benefit?
A7. No, the Plan N office visit and emergency room co-pays do not apply to the foreign travel emergency benefit. These services will not have a valid NPI attached. Therefore, the claims cannot be crossed over.

Emergency room coinsurance or co-payment
Q8. Does the Plan N emergency room (ER) coinsurance or co-payment apply to the physician professional fee charges, the ER facility fees, or both the ER and the physician office visit coinsurance or co-payment?
A8. The Plan N ER coinsurance or co-payment applies to the total Medicare Part B coinsurance or co-payment patient responsibility amount as shown in the remittance advice. The physician professional fee portion of the charges for ER visits are identified as *CPT*-4 codes *99281-99285*.

Q9. Is a Plan N subscriber subject to both the Plan N physician professional fee charge coinsurance or co-payment of up to $20 and the emergency room facility coinsurance or co-payment of up to $50 as a result of a covered emergency room visit that does not result in an inpatient hospital admission?
A9. No, the beneficiary is subject to one Plan N emergency room coinsurance or co-payment of up to $50 based on the total Part B coinsurance liability.

Q10. When is the Part B emergency room coinsurance or co-payment of up to $50 waived for a Plan N subscriber?
A10. If a Plan N subscriber is admitted to an inpatient facility subsequent to the ER visit, and the care is paid under a Medicare Part A hospital inpatient stay, then the Plan N ER coinsurance or co-payment must be waived. If the emergency room visit, including physician and facility outpatient charges are paid under Part B, as they will be when the subscriber is not admitted to an inpatient facility, then the Plan N Part B coinsurance or co-payment of up to $50 will apply.

Q11. If the Plan N subscriber presents for multiple Medicare-covered ER visits in one day and is not admitted, is the ER coinsurance or co-payment applicable to each visit?
A11. Yes, the Plan N ER coinsurance or co-payment of up to $50 is applicable to each Medicare-covered visit.

Q12. Is the Plan N ER or office visit coinsurance or co-payment applicable to urgent care facilities?
A12. No. Since a visit to an urgent care facility is not coded as either an office visit or an ER visit and has a unique code, the Plan N copayment or coinsurance for either the office visit or ER visit does not apply to visits to an urgent care facility.

Update to guidance on standardized Medigap policy (continued)

Q13. Under Plan N, why is there a greater coinsurance or co-payment for emergency room visits than for office visits?
A13. The intent of having a greater coinsurance or co-payment for emergency room visits is to encourage office visits where they are appropriate and discourage unnecessary emergency room visits.

Additional questions?

If you have any questions, you may contact Jane Sung at the NAIC for matters relating to the NAIC model regulation or related issues at (202) 471-3979 or mailto:*jsung@naic.org*, or Jay Dobbs at CMS for matters relating to Medicare procedures and coding at (410) 786-1182 or mailto:*jay.dobbs2@cms.hhs.gov*.

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

Source: CMS PERL 201005-02

Four states and Puerto Rico to receive matching funds for EHR incentive 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) 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 the recipient states and Puerto Rico 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 CMS began in November 2009. To date, including these latest matching funds, CMS has awarded a total of $58.38 million to 35 states, Puerto Rico, and the U.S. Virgin Islands.

Recipient	Award amount
Missouri	$1.53 million
New Mexico	$405,000
Oregon	$3.53 million
Puerto Rico	$1.80 million
Washington	$967,000
Subtotal	$8.23 million
Total awards to date	$58.38 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 press releases, which were issued on April 26, are available at *https://www.cms.gov/apps/media/press_releases.asp*.

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

Source: CMS PERL 201005-08

Beacon communities lead the charge to improve health outcomes

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

Establishing beacons for nationwide advances in Health Information Technology

Healthcare professionals appreciate opportunities to learn from innovative colleagues and communities – to see what really works, to get "boots-on-the-ground" perspectives, to learn best practices, and to use the experience of other leaders to inform how to improve performance more broadly.

The Beacon Community Cooperative Agreement Program (*http://healthit.gov/portal/server.pt?open=512&objID=1805&parentname=CommunityPage&parentid=2&mode=2&cached=true*), by its very design, was intended to shine a spotlight on health information technology (health IT) innovators, so that we all might learn from them. On May 4, Secretary Sebelius awarded $220 million to establish 15 Beacon communities throughout America. Read the press release at *http://www.gov/news/press/2010pres/05/20100504a.htm*). These community consortia – selected from 130 applicants – have demonstrated leadership in developing advanced health IT solutions to help improve specific health outcomes. They also share a strong conviction in the benefits of health IT as a critical pillar to advance broad and sustainable health system improvement. The average award amount is $15 million over 36 months.

The Beacon community awards recognize collaborative community efforts operating at the cutting edge of health IT and health care delivery system innovation. Beacon Communities will implement a range of care delivery innovations building on existing infrastructure of interoperable health IT and standards-based information exchange, in coordination with the Regional Extension Center Program and State Health Information Exchange Program.

In addition, the program will help Beacon communities plan and develop new initiatives that can ensure the longer-term sustainability of health IT-enabled improvements in health care quality, safety, efficiency, and population health. This includes preparing for future policy changes resulting from enactment of health care reform legislation that will permit providers, states, and regional health care organizations to test new payment methods emphasizing improvements in quality and value.

Like so many other providers who effectively implement health IT, Beacon communities will leverage other existing federal programs and resources to promote health information exchange at the community level. These resources include:

- Department of Defense and the Department of Veterans Affairs Virtual Lifetime Electronic Record (VLER) program, which aims to develop a longitudinal electronic health record for all active duty, Guard and Reserve, retired military personnel, and eligible separated Veterans
- Health Resources and Services Administration (HRSA) programs at federally qualified health centers (FQHCs) and Health Center Controlled Networks (HCCNs) to advance the adoption of certified electronic health records and exchange of health information
- Department of Agriculture and Department of Commerce efforts to extend broadband infrastructure

The partnership with applicable VLER, FQHC, and HCCN sites is particularly important to ensure we realize measurable and tangible results in federally funded, military, and private sector health care settings alike.

I would like to acknowledge and praise the many applicants who were not funded today, but whose experience and commitment suggests our nation has an encouraging foundation of health information exchange to build on. An additional $30.3 million is currently available to fund additional Beacon community cooperative agreement awards. An announcement to apply will be made in the near future.

Especially, I am particularly pleased by the diversity among Beacon awardees (*http://healthit.gov/blog/onc/index.php/2010/05/05/beacon-communities-lead-the-charge-to-improve-health-outcomes/*): geographically, they span the continental United States and reach as far as Hawaii; both urban and rural communities are well represented; and targeted program outcomes span some of America's most pressing health concerns, from reducing medication errors and improving the care of individuals with cardiovascular disease to reducing disparities in access and outcomes for patients with diabetes. Additionally, the programs bring health IT innovation to a variety of underserved populations to address health disparities and improve patient care. The Beacon communities demonstrate that health IT can bring meaningful change to health care for all Americans – not just the healthiest, wealthiest, or best insured.

I extend my sincere congratulations to our 15 Beacon communities. Your work inspires me, and I believe that in the coming months, it will inspire and inform America's medical and health IT communities.

Sincerely,

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

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

Source: CMS PERL 201005-21

Time is running out – have you responded?

Your opportunity to participate in the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) is quickly coming to an end and the Centers for Medicare & Medicaid Services (CMS) still needs your feedback. If you or your office received notification from CMS that you were randomly selected to participate in the 2010 MCPSS – this is your last chance to respond before the survey closes. Your feedback is very important. The MCPSS is your opportunity to tell us about your satisfaction with the services you receive from the Medicare contractor that processes and pays your fee-for-service Medicare claims.

Completion of the survey is quick and easy. It only takes a few minutes of your time. To respond to the survey or to designate a proxy respondent to complete it on your behalf, please call the MCPSS Provider Helpline today, at 1-800-835-7012, or send an e-mail to *mcpss@scimetrika.com*. A representative from the MCPSS team will be happy to assist you.

We assure you we will not provide information that identifies you or your practice or facility to anyone outside the study team, except as required by law.

If you have already responded to the 2010 MCPSS, thank you. If you have not, don't pass up this golden opportunity to let your voice be heard. Time is running out… please respond today!

Please note: Only providers and suppliers who have been randomly selected and notified can participate in the 2010 MCPSS. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

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

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

Source: CMS PERL 201005-15

Reminder – Do Not Forward Initiative

Background

All envelopes containing Medicare checks and remittance advices will contain the words "return service requested". This will prevent the forwarding of Medicare checks to locations other than those recorded on the Medicare provider files and allows the U.S. Postal Service to return to the carrier free of charge. Once returned, the providers number will be flagged as "DNF" and the carrier will stop sending paper checks and remittance advices to the provider. In addition, all electronic fund transfers will be stopped.

Provider Action Needed

It is important that providers notify Medicare immediately of any change of address. The provider must complete a Change of Address form CMS-855C or other written notification. Only upon verification and update of all the provider's addresses will the "DNF" flag be removed. Not only will the "pay to" address be verified, but also all "provider location" addresses will be verified.

Once the DNF flag has been removed, the carrier will release all payments and remittances notices held as a result of the DNF.

Additional Information

Additional information is available in the following chapters of Publication 100-04:

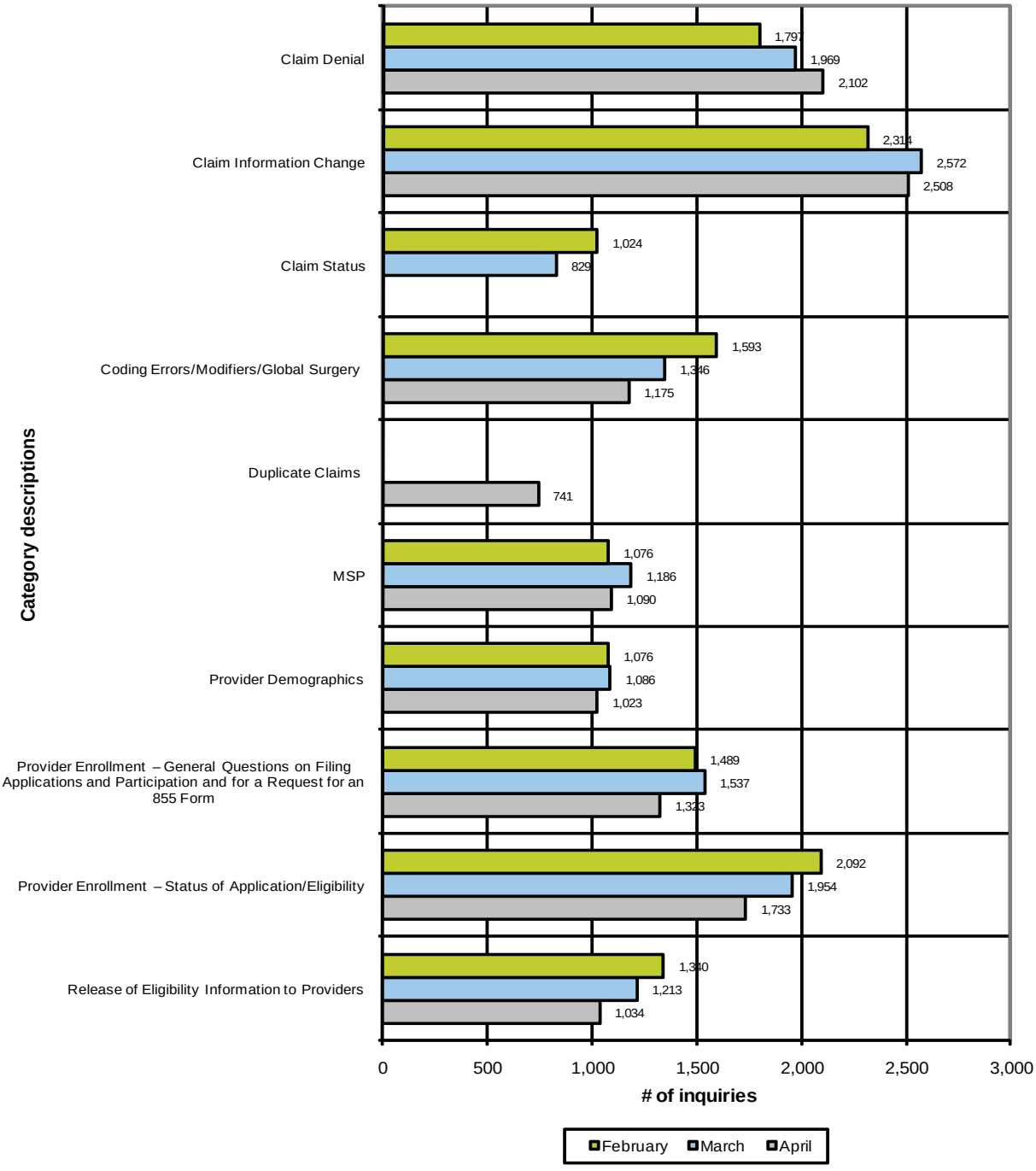
Chapter 1, Section 80.5
Chapter 22, Section 50.1

Source: Publication 100-04, Chapter 22, Section 50.1

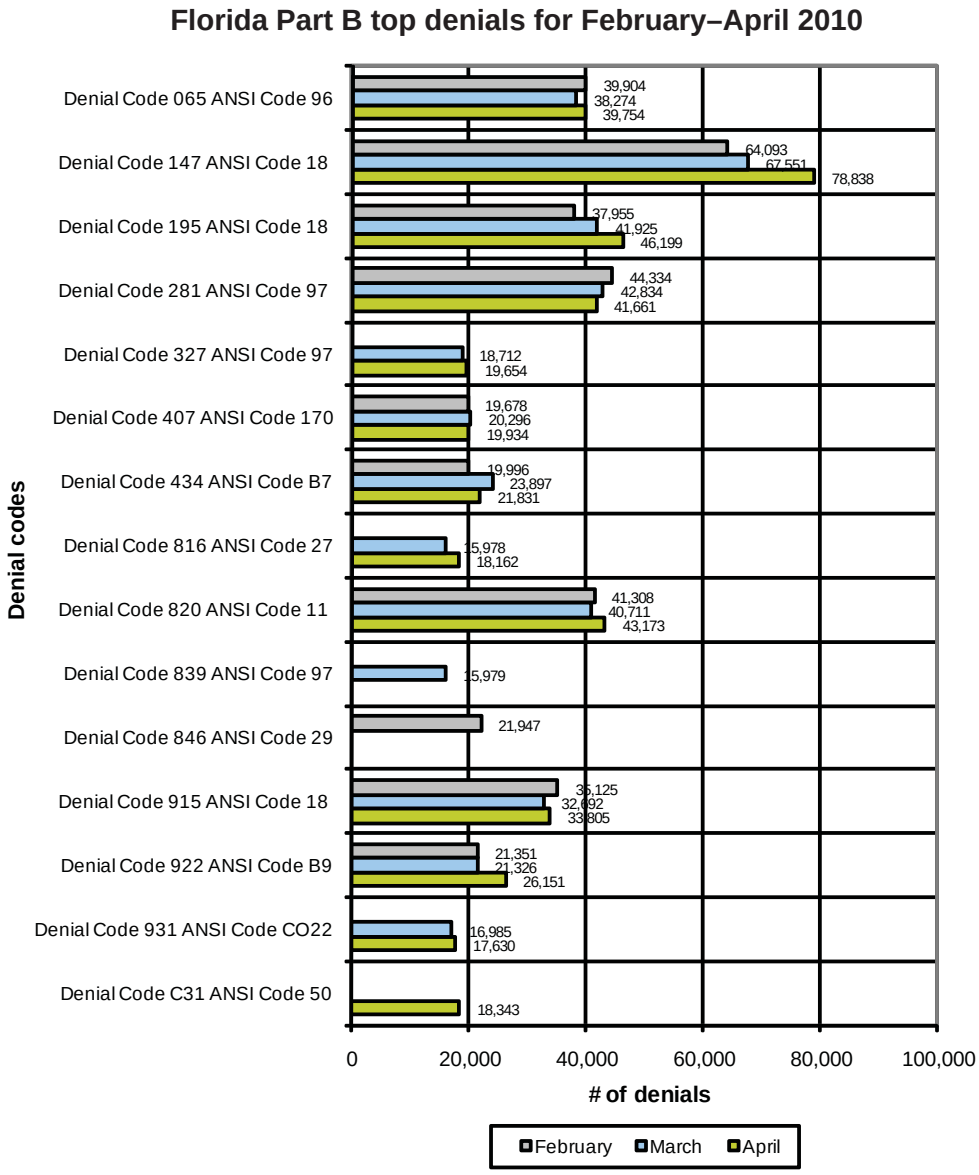
Top inquiries, denials, and return unprocessable claims for February–April

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 February–April 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 February–April 2010



Top inquiries, denials, and return unprocessable claims for February–April (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.

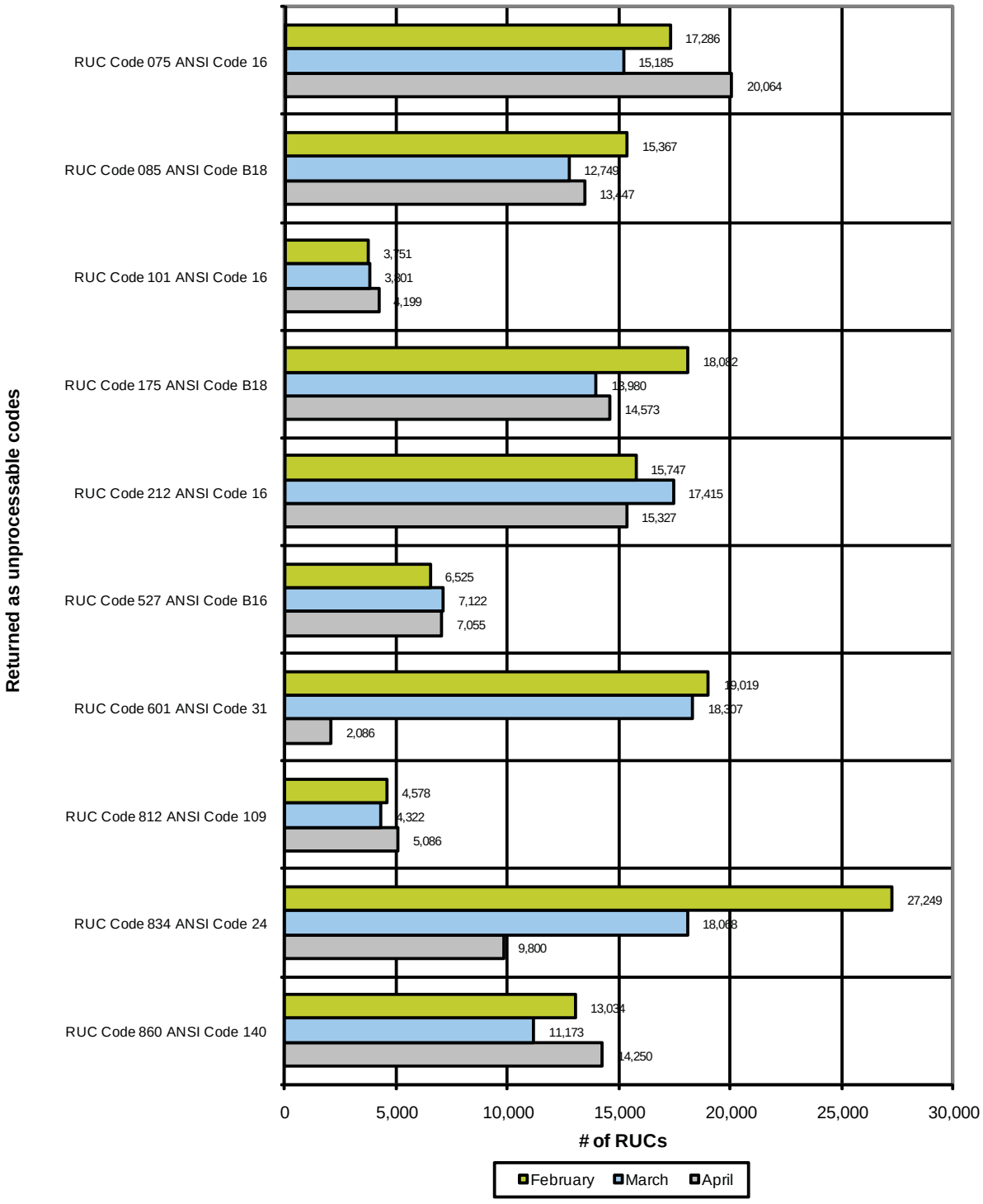
- To access the *Duplicate Claims – Part B WBT*, visit our FCSO Medicare Training website *www.fcsomedicaretraining.com*.

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.

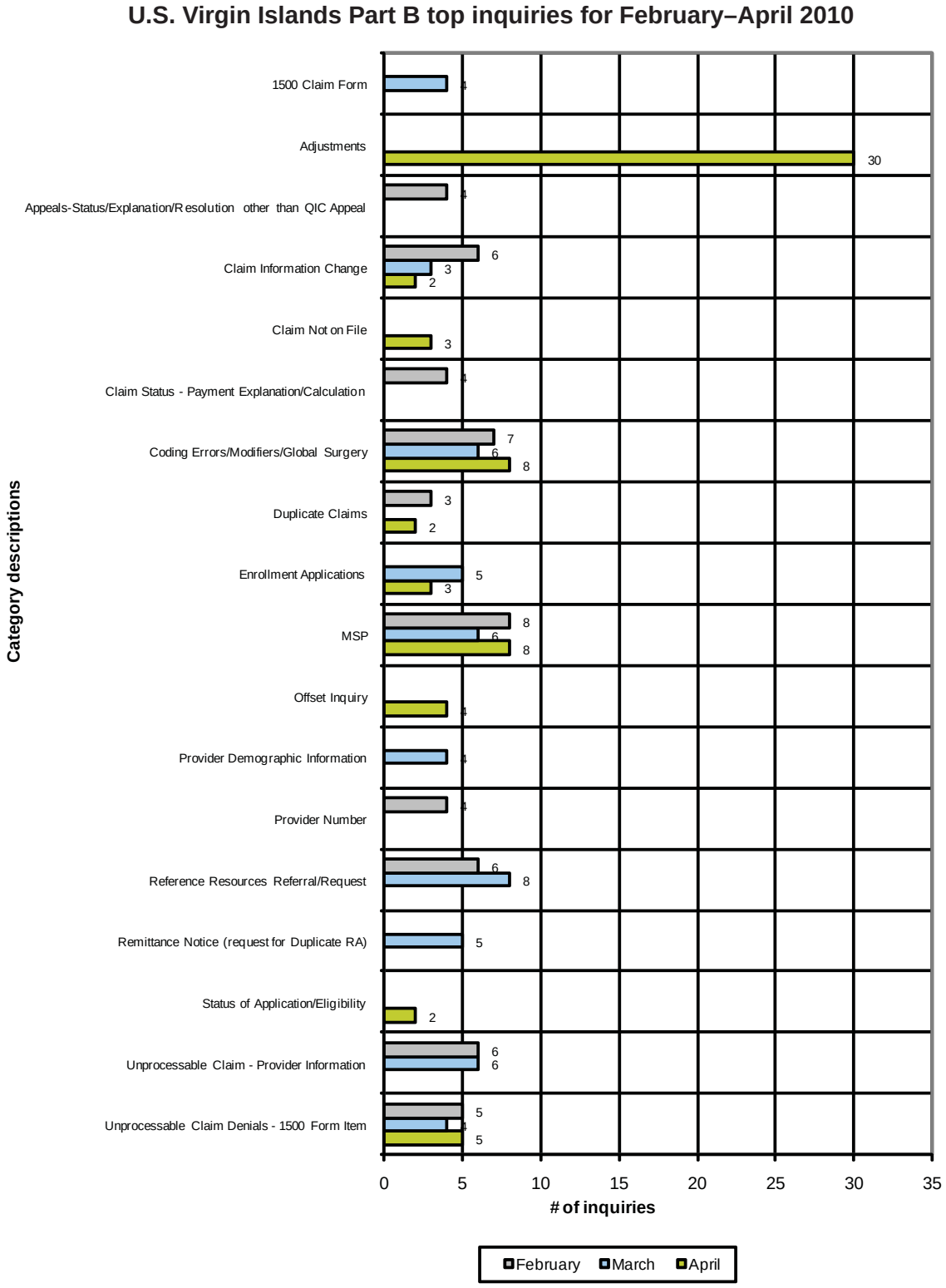
- Visit the FCSO Events page at *http://medicare.fcso.com/Events/* to learn about upcoming events and link to our online learning system to review encore presentations of webcasts conducted on this topic.

Top inquiries, denials, and return unprocessable claims for February–April (continued)

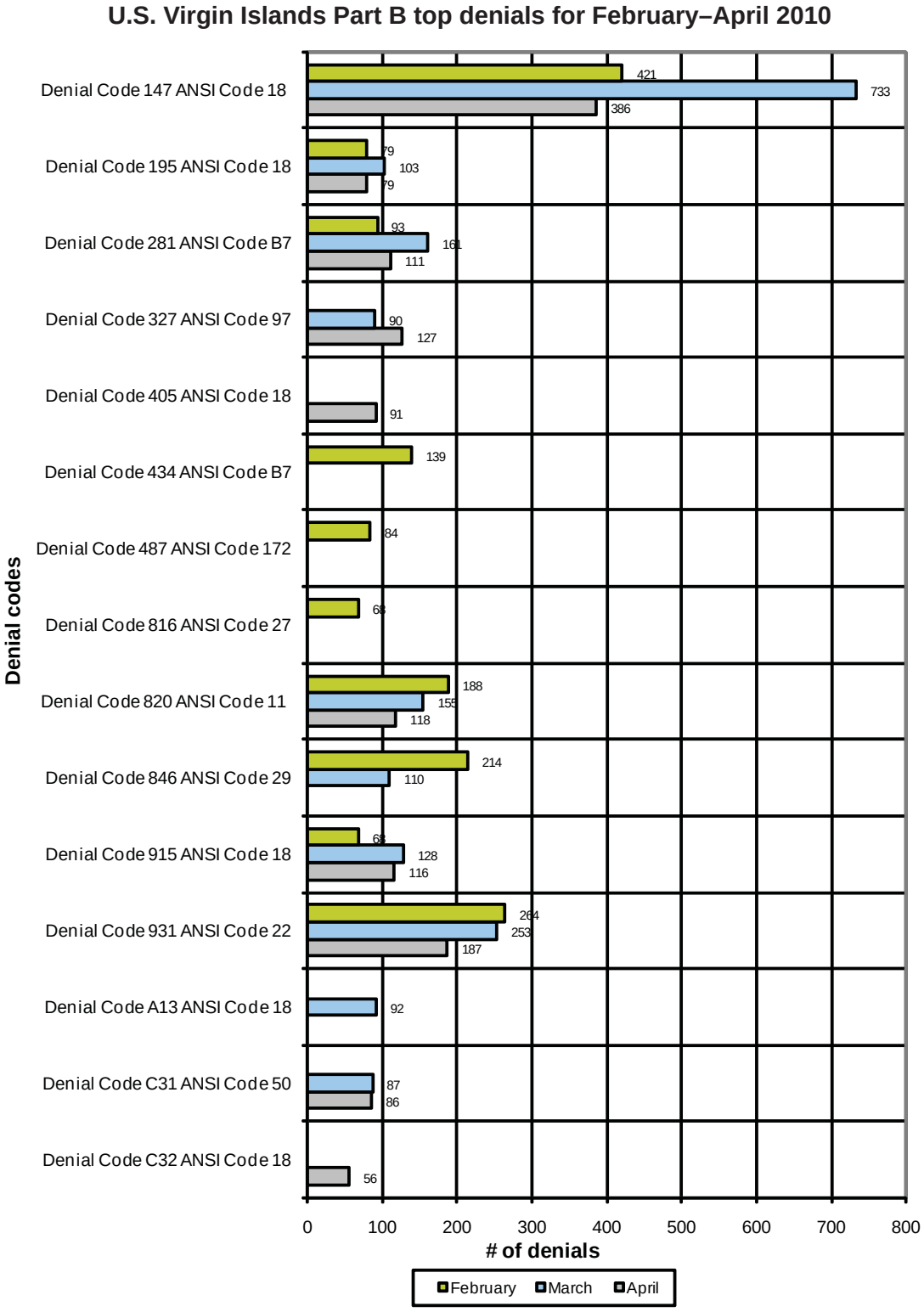
Florida Part B top return as unprocessable claims (RUC) for February–April 2010



Top inquiries, denials, and return unprocessable claims for February–April (continued)

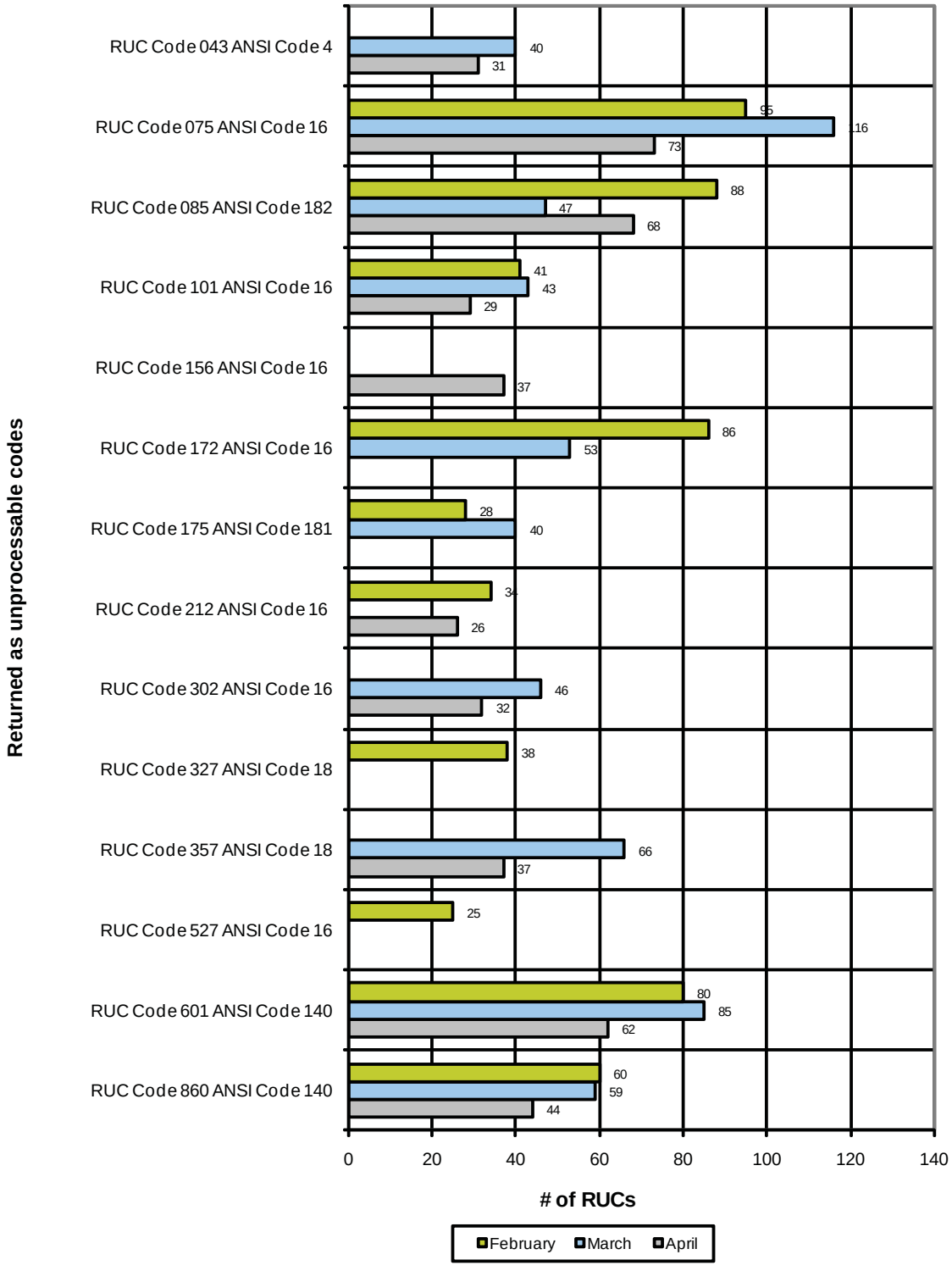


Top inquiries, denials, and return unprocessable claims for February–April (continued)



Top inquiries, denials, and return unprocessable claims for February–April (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for February–April 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 notice statement 42

Revisions to LCDs

J1950: Luteinizing hormone-releasing hormone (LHRH) analogs 43
J2503: Macugen (pegaptanib sodium injection) 43
51784: Anorectal manometry and EMG of the urinary and anal sphincters 43
95805: Polysomnography and sleep testing 44

Additional Information

Improper billing of blood platelet grafts 44
Medicare coverage of Qutenza® patch for treatment of postherpetic neuralgia 44
Authentication requests for missing or illegible signatures 45
Widespread probe review: Autonomic function testing – 95921 46

Advance beneficiary notice

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

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

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

Revisions to LCDs

J1950: Luteinizing hormone-releasing hormone (LHRH) analogs – revision to the LCD

LCD ID number: L29215 (Florida)
LCD ID number: L29360 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs was most recently revised on February 2, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Based on guidance from the Centers for Medicare & Medicaid Services (CMS), the LCD for LHRH analogs is being revised to remove all language pertaining to provisions for the least costly alternative policy (LCA) mentioned throughout the LCD. All other coverage requirements in the LCD remain in effect. In addition, all language pertaining to the LCA policy has been removed from the "Coding Guidelines" attachment of the LCD.

Effective date

This LCD revision is effective for services processed **on or after May 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.

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

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

The local coverage determination (LCD) for Macugen (pegaptanib sodium injection) was most recently revised on October 13, 2009. Since that time, the LCD has been revised in the "ICD-9 Codes that Support Medical Necessity" section of the LCD under the list of ICD-9-CM codes to indicate: *Per the ICD-9-CM coding manual, ICD-9-CM code 362.07 requires a dual diagnosis. ICD-9-CM code 362.07 must be used with a code for diabetic retinopathy (ICD-9-CM codes 362.01-362.06).

Effective date

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

51784: Anorectal manometry and EMG of the urinary and anal sphincters – revision to the LCD

LCD ID number: L29060 (Florida)
LCD ID number: L29078 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for anorectal manometry and EMG of the urinary and anal sphincters was most recently revised on February 2, 2009, for Florida and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a request was received asking that the list of ICD-9-CM codes for *CPT* code *91122* (*Anorectal manometry*) be revised to include ICD-9-CM code 787.6 (Incontinence of feces). A review of the supporting literature submitted with the request supports the request for the revision. Therefore, the list of diagnosis codes for *CPT* code *91122* has been revised to now include ICD-9-CM code 787.6.

Effective date

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

95805: Polysomnography and sleep testing – revision to the LCD

LCD ID number: L29949 (Florida)
LCD ID number: L29951 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for polysomnography and sleep testing was most recently revised on July 21, 2009. Since that time, a request was received asking that a diplomate of the American Board of Family Medicine (ABFM) with a certificate of added qualifications (CAQ) in sleep medicine be added to the list of physician training/certification requirements. A review of available literature supported this request. Therefore the "Indications and Limitations" and "Documentation Requirements" sections of the LCD have been revised to now list a diplomate of the ABFM with a CAQ in sleep medicine as acceptable.

Effective date

This LCD revision is effective for services rendered **on or after May 18, 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

Improper billing of blood platelet grafts

Providers have been improperly associating blood platelet grafts with *CPT* code *20926* (*Tissue grafts, other (eg, paratenon, fat, dermis*). The Centers for Medicare & Medicaid Services (CMS) currently has a national coverage determination (Publication 100-03, NCD 270.3) supporting noncoverage of this service.

Autologous blood derived products for chronic, non-healing wounds includes both: (1) platelet derived growth factor (PDGF) products (such as Procuren) and (2) platelet-rich plasma (PRP). These services are nationally noncovered under NCD 270.3 for the treatment of chronic non-healing, cutaneous wounds (cutaneous is further defined in the national coverage analysis to include superficial and deeper wounds).

Effective March 19, 2008, this service is nationally noncovered for the treatment of acute surgical wounds when the autologous PRP is applied directly to the closed incision, or for dehiscent wounds. Additionally, any services directly related are also noncovered.

Providers are encouraged to audit their records to determine if services were incorrectly billed to the Medicare program. In situations where providers may have inappropriately billed and were incorrectly paid for *CPT* code *20926* for grafting techniques using platelet-rich plasma, it would be expected that a voluntary reimbursement of the overpayment be sent to the First Coast Service Options Inc. (FCSO) Medicare program in order to proactively take action and/or address the identified error. The appropriate form along with instructions and mailing address for submitting a voluntary refund may be found at *http://medicare.fcso.com/Forms/138379.pdf*.

Medicare coverage of Qutenza® patch for treatment of postherpetic neuralgia

Shingles or herpes zoster rash is a painful viral infection caused by a reactivation of the varicella-zoster virus (human herpesvirus, type 3) that causes chickenpox. Approximately one million people in the United States develop shingles each year. It is estimated that up to one in five people with shingles will experience prolonged pain after shingles, known as postherpetic neuralgia (PHN). The pain can persist long after the shingles rash clears up and can disrupt sleep, mood, work, and the person's activities of daily living.

Qutenza® is a high concentration capsaicin patch that was approved by the Food and Drug Administration (FDA) in November 2009 for the management of neuropathic pain associated with PHN. Based on the FDA label, administration, warnings and precautions for this drug include the following:

- Qutenza® should only be administered by physicians or health care professionals under the close supervision of a physician.
- A topical anesthetic is applied prior to the application of Qutenza®.
- Qutenza® is applied for 60 minutes.
- Qutenza® should not be used near eyes or mucous membranes. Qutenza® should not be applied to the face or scalp to avoid risk of exposure to the eyes or mucous membranes.

Medicare coverage of Qutenza® patch for treatment of postherpetic neuralgia (continued)

- The patient's blood pressure should be monitored during and following the treatment procedure.
- Patients with unstable or poorly controlled hypertension, a recent history of cardiovascular or cerebrovascular events may be at an increased risk of adverse cardiovascular effects.

First Coast Service Options Inc. (FCSO) Medicare will cover Qutenza® (capsaicin) 8 percent patch for the FDA-approved indications and administration. See the FDA drug label for full prescribing information regarding this drug.

Since there is currently no HCPCS code for Qutenza® (capsaicin) 8 percent patch, providers should bill the unlisted HCPCS code J3490 (Unclassified drugs) for this drug. In addition, *CPT* code *64999* (*Unlisted procedure, nervous system*) should be billed for the application/preparation of this drug. An evaluation and management (E/M) service may be billed if there was a significant, separately identifiable evaluation and management service performed by the same physician on the same day of this procedure. If the patient is seen for an E/M visit and it is decided to administer the patch at that visit, the E/M visit is allowed. However, if the patient returns to the office on another date for the only purpose of having the patch applied, an E/M visit would not be allowed on the same date of the patch application.

Note: Providers must bill HCPCS code J3490 and *CPT* code *64999* on the same claim. *CPT* code *64999* is not a covered service for the ambulatory surgical centers (ASCs); therefore, FCSO will not be allowing this service to be billed by an ASC at this time**.**

Authentication requests for missing or illegible signatures

The Centers for Medicare & Medicaid Services' (CMS) change request (CR) 6698 (Signature Guidelines for Medical Review Purposes) clarifies Medicare signature requirements for all medical record documentation subject to medical review. This CR also requires contractors to implement a process for contacting the provider of services when previously submitted documentation does not contain the required appropriate signature(s).

Effective for all medical review decisions made on or after April 16, 2010, contractors are required to authenticate medical records when the signatures are missing or illegible. The signature for each entry must be legible and should include the practitioner's first and last name. For clarification purposes, First Coast Service Options Inc. (FCSO) also encourages the inclusion of the practitioner's credentials (e.g., Dr. John Smith, M.D. or Mary Jones, A.R.N.P.).

ADR letters for missing or illegible signatures: 20-day timeframe

If it is determined, upon review of medical record documentation, that CMS' signature requirements have not been met, FCSO will send an additional development request (ADR) letter to the provider. This second development request letter will require the provider to submit either a signed attestation statement for a missing signature or a signature log for an illegible signature. Unlike the standard process for requesting medical records (which allows providers 30 days to respond), the second development request will allow providers only 20 days to respond.

Note: For this process only, providers will be permitted to fax their response to the second development request. The appropriate fax numbers will be provided in the ADR letter. In order for the response to be applied appropriately, the ADR letter must be attached to the response.

Electronic or digital signatures

In addition to hand-written signatures, electronic or digital signatures may also be used to satisfy the signature requirements outlined in CR 6698. An electronic or digital signature is typically generated by specially encrypted software that allows use only by the intended user. The responsibility and authorship related to the signature should be clearly defined in the medical record.

Note: FCSO will consider electronic or digital signatures as acceptable only when accompanied by one of the following:

- Electronically-signed or e-signed signature
- Computerized signature
- Digitally signed or digital signature
- Confirmed by, released by, signed by, or reviewed by
- Authorized by, authenticated by, or verified by

FCSO encourages all facilities, physicians, and other providers who bill services to Medicare to review and implement the changes necessary to be compliant with signature requirements. Providers should conduct internal review of all medical record documentation prior to submission to Medicare to ensure documents are complete and appropriately signed. This will not only reduce the necessity for a second ADR for signature attestation/signature log, it will also reduce the number of other billing/coding inconsistencies and omissions.

Additional information

Additional information regarding signature requirements was previously published on pages 21-22 of the March 2010 *Medicare B Update!*

The official instruction regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R327PI.pdf*.

The *MLN Matters* article related to this change may be viewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf*.

Source: Publication 100-08, Transmittal 327, CR 6698

Widespread probe review: Autonomic function testing – 95921

CPT code *95921*(*Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio*) was identified as aberrant for Florida during FY 2008 based on the July through December 2008 data. This data revealed a Florida to nation ratio of allowed dollars per 1,000 enrollees of 2.05.

Based on the conclusion of findings by the comprehensive data analysis team through the Program Safeguards Communication Group, a recommendation was made to perform a widespread probe for *CPT* code *95921* and include the top 20 performing providers. The purpose of the review was to evaluate how the test results were utilized in clinical decision making, and determine if the services billed to Medicare were medically necessary, appropriately coded, and documented as having been performed. A decision would also be made whether development of a local coverage determination (LCD) was warranted.

A widespread probe review was performed on a sample of 100 claims, encompassing 100 beneficiaries for *CPT* code *95921*. Since *CPT* code *95922* (*Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt*) and *CPT* code *95923* (*Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential*) are also part of the autonomic nervous system (ANS) function testing, and one or both of these codes are generally billed with *CPT* code *95921*, these services were also reviewed when billed with *CPT* code *95921* on the same claim for the same date of service.

It was noted during the review that several providers billed some of the following *CPT* codes with the modifier 59 on the same claim for the same date of service that are included in the ANS function testing codes, and should not have been billed when performed as part of this testing:

93005 *Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report*

93010 *Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only*

93040 *Rhythm ECG, 1-3 leads; with interpretation and report*

Of the 100 claims reviewed for 20 providers for *CPT* code *95921* performed in the office setting, 43 services were allowed in part or complete, and 57 services were denied because there was no supporting documentation showing medical necessity or that the service was performed. Whenever *CPT* code *95921* was allowed, *CPT* codes *95922* and/or *95923* were also allowed. In contrast, if *CPT* code *95921* was denied, *CPT* codes *95922* and/or *95923* were also denied. Five percent of the total services billed also billed *CPT* codes *93005* and *93010* along with the ANS testing on the same date of service, and 30 percent of the services billed *CPT* code *93040* along with the ANS testing on the same date of service. These codes were denied because they are included in the ANS testing and the documentation did not show the EKG codes were independent from this testing.

Reviewed documentation for the majority of ANS testing showed it was used as a screening tool on patients with chronic medical conditions, and had little or no impact on the treatment or care plan of the patients. Based on the review findings, development of an LCD for ANS testing was recommended.

Educational Events

Upcoming provider outreach and education events

June 2010

Evaluation and Management (E/M) Series: Workshops covering the E/M services of a typical patient – Session 6
When: June 22
Time: 11:00 a.m.-12:30 p.m.

Evaluation and Management (E/M) Series: Workshops covering the E/M services of a typical patient – Session 6
When: June 24
Time: 2:00 p.m.-3:30 p.m.

Two easy ways to register

Note: Unless otherwise indicated, all FCSO educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands

Online: Simply log on to your account on our provider training 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

May 9-15 is National Women's Health Week

In the spirit of National Women's Health week, the Centers for Medicare & Medicaid Services asks providers to help keep women with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services.

Medicare covers a wide range of preventive services that can help women with Medicare live longer, healthier lives. The preventive services Medicare covers for eligible beneficiaries include the following:

- Screening mammograms
- Bone mass measurements
- Screening pap tests
- Screening pelvic exams

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 Medicare-covered preventive services.

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 Bone Mass Measurements Brochure – this brochure provides coverage, coding, and billing information on Medicare-covered bone mass measurements.
http://www.cms.gov/MLNProducts/downloads/bone_mass.pdf

The Bone Cancer Screenings Brochure – this brochure provides coverage, coding, and billing information on Medicare-covered cancer screenings, including screening mammographies, pap tests, and pelvic exams.
http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf

The Medicare Preventive Services Series: Part 3 Web-Based Training Course (WBT) – this WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, pap tests, pelvic exams, and bone mass measurements. 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."

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

To order hard copies of certain MLN products, including brochures 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 Women's Health Week, please visit the Office on Women's Health website at *http://www.womenshealth.gov/whw*.

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

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

Source: CMS PERL 201005-18

Other Educational Resources

New resources from the Medicare Learning Network

The April 2010 edition of the *Medicare Learning Network* (*MLN*) *Catalog of Products* is now available and may be accessed at *http://www.cms.gov/MLNproducts*. The *MLN* Catalog of Products is an interactive downloadable document that lists all *Medicare Learning Network* products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All product titles and the word "download" when selected, will link you to the online version of the product. The words "hard copy" when selected, will automatically link you to the *MLN* Product Ordering page. To access the catalog, click on the link called *MLN* Product Catalog.

- The revised *Rehabilitation Therapy Information Resource for Medicare Fact Sheet* (April 2010) is now available in downloadable format from the Centers for Medicare & Medicaid Services' *Medicare Learning Network* at *http://www.cms.gov/MLNProducts/downloads/Rehab_Therapy_Fact_Sheet.pdf*. This fact sheet provides guidance and resources related to rehabilitation therapy services, coverage requirements, and payment systems.
- The revised *Clinical Laboratory Fee Schedule Fact Sheet* (January 2010) 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." This fact sheet provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set.

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

Source: CMS PERL 201005-03

Try our E/M interactive worksheet

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our Web site feedback form, available at *http://medicare.fcso.com/Feedback/160958.asp*.

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:
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Education event registration

1-904-791-8103

Electronic data interchange (EDI)

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Option 1 -Transaction support

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Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO Account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2009 through September 2010.	40300260	Hardcopy $33		
		CD-ROM $55		
2010 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedule, effective for services rendered January 1, 2010, through December 31, 2010, is available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies or a CD-ROM are available for purchase. The fee schedule contains calendar year 2010 payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy $12		
		CD-ROM $6		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦