

MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

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



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

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

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THE FCSO MEDICARE B UPDATE!

About the FCSO Medicare B Update!

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

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

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education website, <http://medicare.fcsocom>. 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-R131 form 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/MLN MattersArticles/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** (waiver 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.*

CLAIMS

July quarterly update to Correct Coding Initiative edits

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 6930, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in April 2010.

Background

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

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

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

The latest package of CCI edits, version 16.2, is effective July 1, 2010, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

Additional information about CCI, including the current CCI and MEC edits, is available at

<http://www.cms.gov/NationalCorrectCodInitEd>.

Additional information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>. The official instruction (CR 6930) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1971CP.pdf>.

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

MLN Matters® Number: MM6930

Related Change Request (CR) #: 6930

Related CR Release Date: May 21, 2010

Effective Date: July 1, 2010

Related CR Transmittal #: R1971CP

Implementation Date: July 6, 2010

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Ambulance

Extension of add-ons for ambulance services

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

Provider types affected

Ambulance providers submitting claims to Medicare contractors (fiscal intermediaries [FI], carriers and Medicare administrative contractors [MAC]) for ambulance services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6972, which instructs Medicare contractors to adjust the ambulance fee schedule amounts for ground and air ambulance services for claims with dates of service on or after January 1, 2010, through December 31, 2010.

Any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, should be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period beginning January 1, 2010, and ending on December 31, 2010. Please ensure that your staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 amended the Social Security Act with section 1834(l) (13) (A). This section provided increases in payment rates for covered ground ambulance transports which originated in a rural area in the amount of two percent, and for covered ground ambulance transports which originated in a non-rural area by one percent. This provision was effective for the period July 1, 2004 to January 1, 2007.

Section 146(a) of Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) provided for an increase in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by three percent and for covered ground ambulance transports which originated in urban areas by two percent. These increases were only applicable for claims with dates of service July 1, 2008, through December 31, 2009; however, sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act of 2010 (PPACA) reinstate these provisions on or after January 1, 2010, and before January 1, 2011.

Further, section 146(b) (1) of MIPAA amended the designation of rural areas for air ambulance services. The statute specified that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services should continue to be treated as a rural area for purposes of making air ambulance service payments under the ambulance fee schedule. This statute was also applicable for claims with dates of service July 1, 2008 through December 31, 2009; however, Sections 3105(b) and 10311(b) of the PPACA further amends Section 146(b) (1) of MIPAA to reinstate these provisions for claims with dates of service on or after January 1, 2010, and ending December 31, 2010. Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently re-designated as urban, the Centers for Medicare & Medicaid Services (CMS) has re-established the "rural" indicator on the ZIP code file for air ambulance services, effective January 1, 2010.

In addition, section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) specified that, for services furnished during the period July 1, 2004, through December 31, 2009, the payment amount for the ground ambulance base rate was increased where the ambulance transport originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). Approximately half of all rural areas (rural counties plus Goldsmith areas) were required to include 25 percent of the rural population arrayed in order of population density. The amount of this increase was based on the Department of Health and Human Services Secretary's estimate of the ratio of the average cost per trip for the rural areas comprised of the lowest quartile of population arrayed by density compared to the average cost per trip for the rural areas comprised of the highest quartile of population arrayed by density. CMS determined that the amount of this increase was equal to 22.6 percent. Sections 3105(c) and 10311(c) of ACA further amend Section 1834(l) (12) (A) of the Social Security Act to reinstate this provision for claims with dates of service on or after January 1, 2010, and before January 1, 2011, using the percentage increase that was applicable under this provision to ambulance services during 2009.

Additional information

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

The official instruction issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R706OTN.pdf>.

Extension of add-ons for ambulance services (continued)

Florida fees

Code	LOC 99	LOC 03	LOC 04	
A0425	6.87	6.87	6.87	
A0425	6.94	6.94	6.94	*
A0426	251.22	259.84	269.01	
A0426	253.69	262.39	271.64	*
A0427	397.77	411.42	425.93	
A0427	401.67	415.45	430.10	*
A0428	209.35	216.54	224.17	
A0428	211.40	218.66	226.37	*
A0429	334.96	346.46	358.67	
A0429	338.25	349.86	362.19	*
A0430	2802.46	2870.75	2943.30	
A0430	4203.69	4306.12	4414.95	*
A0431	3258.27	3337.66	3422.01	
A0431	4887.41	5006.49	5133.02	*
A0432	366.37	378.94	392.30	
A0432	369.96	382.66	396.15	*
A0433	575.72	595.48	616.47	
A0433	581.36	601.32	622.52	*
A0434	680.39	703.75	728.56	
A0434	687.07	710.65	735.70	*
A0435	8.07	8.07	8.07	
A0435	12.11	12.11	12.11	*
A0436	21.53	21.53	21.53	
A0436	32.30	32.30	32.30	*

* Rural rate

U.S. Virgin Islands fees

Code	Allowance	
A0425	6.87	
A0425	6.94	*
A0426	229.13	
A0426	231.37	*
A0427	362.79	
A0427	366.34	*
A0428	190.94	
A0428	192.81	*
A0429	305.50	
A0429	308.50	*
A0430	2627.49	
A0430	3941.23	*
A0431	3054.84	
A0431	4582.25	*
A0432	334.15	
A0432	337.42	*
A0433	525.09	
A0433	530.23	*
A0434	620.56	
A0434	626.64	*
A0435	8.07	
A0435	12.11	*
A0436	21.53	
A0436	32.30	*

* Rural rate

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 Related CR Transmittal #: R706OTN
 Implementation Date: July 6, 2010

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Ambulatory Surgical Center

Revised payment files for the 2010 ambulatory surgical center payment system

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

Provider types affected

Ambulatory surgical centers (ASC) submitting claims to Medicare contractors (carriers and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7010, which amends those payment files used to pay ASC claims to reflect retroactive provisions of the Affordable Care Act (ACA). Because the ACA payment adjustments are retroactive to January 1, 2010, your Medicare contractor will adjust claims you bring to their attention with dates of service on or after January 1, 2010, that are/were processed before the new payment files are in place. Be sure your billing staffs know of this change.

Background

Many ASC payment rates under the ASC payment system are established using payment rate information in the hospital outpatient prospective payment system (OPPS) and Medicare physician fee schedule (MPFS). CR 7010 directs Medicare contractors to amend payment files to reflect retroactive changes to the calendar year (CY) 2010 OPPS and MPFS payment rates.

CR 7010 also amends those payment files to include changes to the MPFS payment amounts as a result of practice expense (PE) and malpractice relative value unit (RVU) corrections. This requires revised ASC fee schedule (ASCFS) and ASC payment indicator (PI) files, retroactive to January 1, 2010.

Medicare contractors will begin to pay claims using these new files no later than three weeks from the date of issuance of this instruction. Contractors will disclose the new January 2010 ASC payment rates on their websites as soon as possible, but no later than two weeks from the date that the files are available for contractors to download. In addition, contractors will notify providers via their website that the new fees are effective retroactive to January 1, 2010.

Contractors are not required to reprocess ASC claims, but will adjust claims brought to their attention. Contractors will not perform mass adjustments for claims affected by changes in this instruction. Contractors will continue all routine functions, such as redeterminations, re-openings, and appeals.

Key changes of CR 7010

Affordable Care Act changes to the OPPS

The ACA changed the CY 2010 market basket update to the conversion factor and wage index values for certain

hospitals. Due to budget neutrality, these changes effectively change the CY 2010 OPPS payment amount for most ambulatory payment classes (APCs). The ASC payment system uses the OPPS payment amounts in the payment methodology for “office-based” surgical procedures and ancillary radiology services. Further, ASC payment for device-intensive services is established by including the device portion for the OPPS payment, and this amount is based on the revised OPPS payment amount.

Affordable Care Act changes to the Medicare physician fee schedule

As discussed in CR 6973, Section 3111 of the ACA changed several aspects of the MPFS. Of these changes, only changes to the non-facility PE RVUs for bone density tests are ancillary radiology services under the ASC payment system. The ASC payment system uses the MPFS non facility PE payment in the payment methodology for ancillary radiology services.

Corrections to Medicare physician fee schedule calendar year 2010 payment

The revised payment files issued also reflect corrections and revisions to certain PE and malpractice MPFS relative value units (RVU's), including the non-facility practice expense (PE) RVUs included in the ASC payment system, as discussed in CR 6973. The *MLN Matters*® article related to CR 6973 is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM6973.pdf>.

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 carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R711OTN.pdf>.

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 Related Change Request (CR) #: 7010
 Related CR Release Date: May 28, 2010
 Effective Date: January 1, 2010
 Related CR Transmittal #: R711OTN
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July 2010 update to the ambulatory surgical center payment system

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

Provider types affected

Providers (ASCs) submitting claims payable under the ambulatory surgical center (ASC) payment system to Medicare contractors (carriers and Medicare administrative contractors [MAC]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article, based on change request (CR) 7008, which is a recurring update notification that describes changes to, and billing instructions for, payment policies implemented in the July 2010 ASC payment system update. You should note that this instruction provides information on eight newly created Healthcare Common Procedure Coding System (HCPCS) codes that will be added to the ASC list of covered surgical procedures and seven newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective July 1, 2010.

Also, CR 7008 notes that the payment rates for three HCPCS codes (C9258, C9262, and J1540) were incorrect in the April 2010 ASC drug file. Medicare contractors will adjust as appropriate claims for these three HCPCS codes brought to their attention that have dates of service on or after April 1, 2010, through July 1, 2010, and were originally processed prior to the installation of the revised April 2010 ASC Drug file. Ensure that your billing staffs are aware of this update.

Background

CR 7008 describes changes to, and billing instructions for, payment policies implemented in the July 2010 ASC payment system update. Final policy under the revised ASC payment system requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly. Therefore, beginning in April 9, 2008, the Centers for Medicare & Medicaid Services (CMS) has issued quarterly updates to ASC payment rates for separately paid drugs and biologicals.

CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes, as appropriate. CR 7008 provides information on eight newly created HCPCS codes that will

be added to the ASC list of covered surgical procedures and seven newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective July 1, 2010.

Billing for drugs and biologicals

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

ASCs are reminded that, under the ASC payment system, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a “new” drug as regulated by the Food and Drug Administration (FDA) under the new drug application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.

HCPCS payment updates are posted quarterly at http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp.

New HCPCS codes for drugs and biologicals that are separately payable under the ASC payment system effective July 1, 2010

Seven new HCPCS codes have been created for drugs that are payable as covered ancillary services for dates of service on and after July 1, 2010. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in Table 1. The new separately payable drug and biological codes and their payment rates are included in the July 2010 ASC drug file.

Table 1- New drugs and biologicals separately payable under the ASC payment system effective July 1, 2010

HCPCS code	Long descriptor	Short descriptor	Payment indicator effective 7/1/10
C9264	Injection, tocilizumab, 1 mg	Tocilizumab injection	K2
C9265	Injection, romidepsin, 1 mg	Romidepsin injection	K2
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	Collagenase clostridium histo	K2
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	Injection, Wilate	K2
C9268	Capsaicin, patch, 10cm2	Capsaicin patch	K2
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	Endoform Dermal Template	K2
Q2025*	Fludarabine phosphate, oral, 1 mg	Oral Fludarabine phosphate	K2

* C9262 is discontinued after June 30, 2010, and replaced by Q2025 effective July 1, 2010.

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

Updated payment rates for certain HCPCS codes effective April 1, 2010, through June 30, 2010

The payment rates for three HCPCS codes were incorrect in the April 2010 ASC Drug file. The corrected payment rates are listed in Table 2 below and have been included in the revised April 2010 ASC Drug file effective for services furnished on April 1, 2010 through implementation of the July 2010 update.

Suppliers who think they may have received an incorrect payment between April 1, 2010 and June 30, 2010 may request their Medicare contractor to adjust the previously processed claims.

Table 2-Updated payment rates for certain HCPCS codes effective April 1, 2010, through June 30, 2010

HCPCS code	Short descriptor	ASC payment rate	ASC PI
C9258	Telavancin injection	\$2.12	K2
C9262	Fludarabine phosphate, oral	\$8.18	K2
J1540	Gamma globulin 9 CC inj	\$141.64	K2

Adjustment to payment indicator for CPT code 90670 effective April 1, 2010

Effective April 1, 2010, the payment for CPT code 90670 (*Pneumococcal conjugate vaccine, 13 valent, for intramuscular use*) will change from ASC PI=Y5 (non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). The payment rate effective April 1, 2010, is \$106.70. Suppliers who think they may have received an incorrect payment determination between April 1, 2010, and June 30, 2010, may request contractor adjustment of the previously processed claims.

New category III Current Procedural Terminology (CPT) codes separately payable under the ASC payment system effective July 1, 2010

Seven new category III CPT codes have been created for payable surgical procedures that are payable for dates of service on and after July 1, 2010. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in Table 3. The new separately payable codes and their payment rates are included in the July 2010 ASCFS file.

Table 3- New category III CPT codes separately payable under the ASC payment system effective July 1, 2010

CPT code	Long descriptor	Short descriptor	Payment indicator effective 7/1/10
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	Anosc high resol dx +-coll	R2*
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	Anosc high resol dx w/bx	R2*
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	US tfrml edrl inj crv/t 1lvl	G2
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	US tfrml edrl inj crv/t +1vl	G2
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	US tfrml edrl inj l/s 1lvl	G2
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	US tfrml edrl inj l/s +1vl	G2
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	Inj plsm img guid hrvstg&prep	R2*

*Denotes temporary office-based status

Several codes have been identified as having temporary office-based status. CMS will not establish permanent office-based status for these new category III CPT codes until sufficient volume and utilization data become available to assess accurately that each procedure is performed predominantly in physicians' offices. See the CY 2010 OPPS/ASC November 20, 2009 final rule (74 FR 60605), available at <http://edocket.access.gpo.gov/2009/E9-26499.htm> (page 60605) for a more detailed discussion of temporary office-based status.

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

New HCPCS code separately payable under the ASC payment system effective March 23, 2010

One new HCPCS code has been created for a payable surgical procedure that is payable for dates of service on and after March 23, 2010, as a result of a recent CMS national coverage decision (NCD). For further information on the NCD, refer to CR 6953. The new HCPCS code, the long descriptor, the short descriptor, and payment indicator is identified in Table 4. The new separately payable code and its payment rate are included in the July 2010 ASCFS file.

Table 4- New HCPCS code separately payable under the ASC payment system effective March 23, 2010

HCPCS code	Long descriptor	Short descriptor	Payment indicator effective 3/23/10
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	Dermal filler inj px/suppl	R2*

*Denotes temporary office-based status

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 carrier and/or MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R1991CP.pdf>.

MLN Matters® Number: MM7008
 Related Change Request (CR) #: 7008
 Related CR Release Date: June 25, 2010
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 Implementation Date: July 6, 2010

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Audiology Services

Revisions and re-issuance of audiology policies

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, audiologists, and speech-language pathologists submitting claims to Medicare administrative contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6447. The Centers for Medicare & Medicaid Services (CMS) issued CR 6447 to respond to provider requests for clarification of some of the language in CR 5717 and CR 6061. Special attention is given to clarifying policy concerning services incident to physician services that are paid under the Medicare physician fee schedule (MPFS). See the *Key points* section of this article for the clarifications provided by CR 6447.

Background

Key parts of the clarified policy are in the revised Chapter 12, Section 30.3 of the *Medicare Claims Processing Manual* and in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual*. These revised manual sections are attached to CR 6447. As mentioned in these revised sections of the manuals and per Section 1861 (II) (3) of the Social Security Act, “audiology services” are defined as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under state law (or the state regulatory mechanism provided by state law), as would otherwise be covered if furnished by a physician. These hearing and balance assessment services are termed “audiology services,” regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1)

Revisions and re-issuance of audiology policies (continued)

and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable state laws.

Note: References to technicians in CR 6447 and this article apply also to other qualified clinical staff. The qualifications for technicians vary locally and may also depend on the type of test, the patient, and the level of participation of the physician who is directly supervising the test. Therefore, an individual must meet qualifications appropriate to the service furnished as determined by the Medicare contractor to whom the claim is billed. If it is necessary to determine whether the individual who furnished the labor for appropriate audiology services is qualified, contractors may request verification of any relevant education and training that has been completed by the technician, which shall be available in the records of the clinic or facility.

Audiology services, like all other services, should be reported under the most specific HCPCS code that describes the service that was furnished and in accordance with all CPT guidance and Medicare national and local contractor instructions.

See the CMS website at <http://www.cms.gov/therapyservices> for a listing of all CPT codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The MPFS at <http://www.cms.gov/PFSlookup/> allows you to search pricing amounts, various payment policy indicators, and other MPFS data.

Qualifications discussion

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable, are appropriate to the test.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to the following:

- Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test.
- Development and modification of the test battery and test protocols.
- Clinical judgment, assessment, evaluation, and decision-making.
- Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes.
- Tests related to implantation of auditory prosthetic devices, central auditory processing, contralateral masking.
- Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss.

Key points of CR 6447

- For claims with dates of service on or after October 1, 2008, audiologists are required to be enrolled in the Medicare program and use their national provider identifier (NPI) on all claims for services they render in office settings.
- For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital outpatient prospective payment system (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.
- Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.
- When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of Section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the audiologist must submit a claim to Medicare.
- Medicare pays for diagnostic audiological tests under the MPFS when they meet the requirements of audiology

Revisions and re-issuance of audiology policies (continued)

services as shown in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual* as attached to CR 6447.

- For claims with dates of service on or after October 1, 2008, the NPI of the enrolled audiologist is required on claims in the appropriate rendering and billing fields.
 - Medicare will not pay for services performed by audiologists and billed under the NPI of a physician.
 - Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills.
 - Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician.
 - Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified to perform the service. (Once again, the list of audiology services is posted at <http://www.cms.gov/therapyservices> on the CMS website.)
 - Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services at <http://www.cms.gov/therapyservices> and are not "always" therapy services and the audiologist is qualified to perform the service.
 - All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
 - The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.
 - When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
 - The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service.
- A physician or NPP may not bill for a PC service furnished by an audiologist.
- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.
 - The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
 - Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure).
 - Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
 - The opt out law does not define "physician" or "practitioner" to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.

Additional information

There are two transmittals related to CR 6447, the official instruction issued to your Medicare A/B MAC, FI and/or carrier. The first modifies the *Medicare Benefit Policy Manual* and that transmittal is at <http://www.cms.gov/Transmittals/downloads/R127BP.pdf>. The other transmittal modifies the *Medicare Claims Processing Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R1975CP.pdf>.

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

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Cardiac Services

Cardiac rehabilitation and intensive cardiac rehabilitation

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

Provider types affected

This article is for physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, and Part A/B Medicare administrative contractors [A/B MAC]) for cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) program services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6850, from which this article is taken, announces that, effective January 1, 2010, Medicare Part B pays for CR and ICR programs, and related items and services if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which it is administered, and the physician administering the program. Please see the *Background* section for details.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for CR and ICR programs. The Centers for Medicare & Medicaid Services (CMS) implemented the MIPPA CR and ICR statutory coverage provisions through rule making, in the calendar year (CY) 2010 physician fee schedule (PFS), by adding Section 410.49 (Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage) to the *Public Health Code of Federal Regulations* (42 CFR).

The regulation at 42 CFR 410.49 includes all coverage provisions for CR and ICR items and services, identifies definitions, covered indications, settings, physician supervision requirements, and physician standards, required CR and ICR components, limitations to the number of sessions covered, and the period of time over which the sessions may be covered.

On October 30, 2009, the CY 2010 PFS final rule with comment was finalized and put on display and is available at <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>. The final rule was published in the *Federal Register* on November 25, 2009, and is available on pages 62004-62005.

ICR services means a physician-supervised program that furnishes the same items/services under the same conditions as a CR program but must also demonstrate through peer-reviewed published research that it improves patients' cardiovascular disease through specific outcome measurements that are described in 42 CFR 410.49(c).

CR 6850 provides specific criteria for CR/ICR programs, outlined as follows:

CR/ICR program beneficiary coverage requirements (effective January 1, 2010)

Medicare Part B covers CR and ICR program services for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months
- A coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- A heart or heart-lung transplant, or
- Other cardiac conditions as specified through a national coverage determination (NCD) (CR only).

CR/ICR program component requirements

Covered CR and ICR programs must include the following components:

- **Physician-prescribed exercise** - This physical activity includes aerobic exercise combined with other types of exercise (i.e., strengthening, stretching) as determined to be appropriate for individual patients by a physician each day CR/ICR items/services are furnished.
- **Cardiac risk factor modification** – This includes education, counseling, and behavioral intervention, tailored to the patients' individual needs.
- **Psychosocial assessment** – This assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation. It should include: (1) an assessment of those aspects of the individual's family and home situation that affects the individual's rehabilitation treatment, and, (2) a psychosocial evaluation of the individual's response to, and rate of progress under, the treatment plan.
- **Outcomes assessment** – These should include: (i) minimally, assessments from the commencement and conclusion of CR/ICR, based on patient-centered outcomes which must be measured by the physician immediately at the beginning and end of the program, and, (ii) objective clinical measures of the effectiveness of the CR/ICR program for the individual patient, including exercise performance and self-reported measures of exertion and behavior.
- **An individualized treatment plan** – This plan should be written and tailored to each individual patient and include (i) a description of the individual's diagnosis; (ii) the type, amount, frequency, and duration of the CR/ICR items/services furnished; and (iii) the goals set for the individual under the plan. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

Cardiac rehabilitation and intensive cardiac rehabilitation (continued)**Frequency limitations**

CR sessions are limited to a maximum of two one-hour sessions per day (up to 36 sessions, over a period of up to 36 weeks), with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under section 1862(a)(1)(A) of the Social Security Act.

ICR sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

CR/ICR program setting requirements

CR/ICR services must be furnished in a physician's office or a hospital outpatient setting (for ICR, the hospital outpatient setting must provide ICR using an approved ICR program). All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items/services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26, and for hospital outpatient services as specified at 42 CFR 410.27.

CR/ICR program physician requirements

Physicians responsible for CR/ICR programs are identified as medical directors who oversee or supervise the CR/ICR program at a particular site. The medical director, in consultation with staff, is involved in directing the progress of individuals in the program. The medical director, as well as physicians acting as the supervising physician, must possess all of the following: (1) expertise in the management of individuals with cardiac pathophysiology, (2) cardiopulmonary training in basic life support or advanced cardiac life support, and (3) license to practice medicine in the state in which the CR/ICR program is offered. Direct physician supervision may be provided by a supervising physician or the medical director.

ICR program approval requirements

All prospective ICR programs must be approved by CMS through the NCD process. To be approved, an ICR program must demonstrate through peer-reviewed, published research that it:

- Accomplished one or more of the following for its patients: (i) positively affected the progression of coronary heart disease, (ii) reduced the need for coronary bypass surgery, or, (iii) reduced the need for percutaneous coronary interventions, and
- Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services: (i) low density lipoprotein, (ii) triglycerides, (iii) body mass index, (iv) systolic blood pressure, (v) diastolic blood pressure, and, (vi) the need for cholesterol, blood pressure, and diabetes medications.

Once an ICR program is approved through the NCD process, all prospective ICR sites that want to furnish ICR items/services via the approved program must enroll with their local Medicare contractor to become an ICR program supplier using the designated forms at 42 CFR 424.510, and report specialty code 31 (single or multi-specialty group practice) in order to be identified as an enrolled ICR supplier.

Note: For purposes of appealing an adverse determination concerning site approval, an ICR site is considered a supplier (or prospective supplier) as defined in 42 CFR 498.2.

A list of approved ICR programs, identified through the NCD process, will be posted to the CMS website and listed in the *Federal Register*.

Claims processing requirements

The following requirements all pertain to claims for CR and/or ICR services with dates of service on and after January 1, 2010.

Your carrier or MAC will pay claims containing the following professional claims containing Healthcare Common Procedure Coding System (HCPCS) codes:

- 93797 *Physician services for outpatient cardiac rehabilitation; without continuous electrocardiographic (ECG) monitoring (per session)*
- 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring [per session]*
- G0422 Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per session
- G0423 Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per session (only when billed with place of service codes 11 [services provided in a physician's office] or 22 [services provided in a hospital outpatient setting]).

All professional claims for CR/ICR services containing any other POS codes will be denied using the following:

Remittance advice remark code (RARC) N428 – “Service/procedure not covered when performed in this place of service”

Claim adjustment reason code (CARC) 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present”

If the claim is received with a modifier GA indicating a signed advance beneficiary notice (ABN) is on file, group code PR (patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN is on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Your FI or MAC will pay institutional claims containing HCPCS 93797, 93798, G0422, and G0423 on types of bill (TOB) 13x under the hospital outpatient prospective payment system (OPPS) and 85x on reasonable cost. They will pay for CR/ICR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis (TOBs 13x) in accordance with the terms of the Maryland waiver. Claims for G0422 and G0423 from Method II critical access hospitals should be billed on TOB 85x with revenue codes 96x, 97x, or 98x.

Cardiac rehabilitation and intensive cardiac rehabilitation (continued)

They will deny claims for CR/ICR services (HCPCS codes 93797, 93798, G0422, and G0423) for services that are provided in other than TOBs 13x and 85x using:

RARC N428 – “Service/procedure not covered when performed in this place of service”

CARC 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 service payment information REF), if present”

If the claim is received with a modifier GA indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN is on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Your contractors will deny both professional and institutional claims for CR services that exceed two units per date of service, or six units per date of service for ICR, using:

CARC 119 – “Benefit maximum for this time period or occurrence has been reached”

RARC N362 – “The number of days or units exceeds our acceptable maximum”

If the claim is received with a modifier GA indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Medicare will pay for HCPCS codes 93797 and 93798 for CR services that exceed 36 sessions when the modifier KX is on the claim. However, Medicare contractors will deny claims for over 36 sessions of CR services without the KX modifier and, in doing so, will use the following:

CARC 151 – “Payment adjusted because the payer deems the information submitted does not support this many/frequency of services”

RARC N435 – “Exceeds number/frequency approved / allowed within time period without support documentation”

If the claim is received with a modifier GA indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Your contractors will deny ICR claims (G0422 and G0423) that exceed 72 sessions within 126 days from the date of the first session unless the modifier KX is on the claim. In denying such claims, they will use:

CARC 119 – “Benefit maximum for this time period or occurrence has been reached”

RARC N435 – “Exceeds number/frequency approved / allowed within time period without support documentation”

If the claim is received with a modifier GA indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Contractors will only pay for ICR services when submitted by providers enrolled as supplier specialty code 31 (intensive cardiac rehabilitation). ICR services submitted by providers enrolled as other than specialty code 31 will be denied using:

CARC 8 – “The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present”

RARC N95 – “This provider type may not bill this service”

If the claim is received with a modifier GA indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Finally, your contractors will not research and adjust any CR or ICR claims (HCPCS 93797, 93798, G0422, and G0423), processed prior to the implementation of CR 6850; however, they will adjust claims that you bring to their attention.

Additional information

You may find more information about CR and ICR services by going to CR 6850, which was issued in four transmittals as follows:

- Transmittal R1974CP modified the *Medicare Claims Processing Manual* and is available at <http://www.cms.gov/Transmittals/downloads/R1974CP.pdf>.
- Transmittal R126BP modified the *Medicare Benefit Policy Manual* at <http://www.cms.gov/Transmittals/downloads/R126BP.pdf>.
- Transmittal R339PI modifies the *Medicare Program Integrity Manual* at <http://www.cms.gov/Transmittals/downloads/R339PI.pdf>.
- Transmittal R170FM modifies the *Medicare Financial Management Manual* at <http://www.cms.gov/Transmittals/downloads/R170FM.pdf>.

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

MLN Matters® Number: MM6850
 Related Change Request (CR) #: 6850
 Related CR Release Date: May 21, 2010
 Effective Date: January 1, 2010
 Related CR Transmittal #: R1974CP, R126BP, R339PI, and R170FM
 Implementation Date: October 4, 2010

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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.

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.

*Enhancements to home health consolidated billing enforcement (continued)***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>.

MLN Matters® Number: MM6911

Related Change Request (CR) #: 6911

Related CR Release Date: April 28, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R1952CP

Implementation Date: October 4, 2010

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Diagnostic Services

Manual correction to reinstate instructions deleted in error

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

Provider types affected

Physicians and suppliers submitting claims for reassigned services to Medicare contractors (carriers and A/B Medicare administrative contractors [A/B MAC]) are affected.

What you need to know

This article is based on change request (CR) 6923, which corrects instructions for reassigned services in the *Medicare Claims Processing Manual*. CR 6923 reinstates Chapter 1, Section 10.1.1.3, regarding payment jurisdiction for reassigned services. This section was deleted in error by CR 6627. This CR also removes an outdated reference in Chapter 35, Section 40, to deleted Chapter 1, Section 30.2.9.1, which was removed by CR 6733.

Background

In CR 6627, the Centers for Medicare & Medicaid Services (CMS) inadvertently changed the billing instructions for reassigned services in a way that is not supported by CMS's systems or Medicare policy. This CR corrects this error and reinstates the instructions in place prior to the implementation of CR 6627. Basically, language was added back to the *Medicare Claims Processing Manual* to show that although a supplier or provider may reassign payment for his services to another entity, suppliers are still required to bill the correct Medicare contractor for reassigned services when they are paid under the Medicare physician fee schedule.

The billing entity must submit claims to the Medicare contractor that has jurisdiction over the geographic area where the services were rendered. Suppliers and providers must also meet current enrollment criteria stated in Chapter 10 of the *Program Integrity Manual* in order to be able to bill for reassigned services.

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 carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1987CP.pdf>.

MLN Matters® Number: MM6923

Related Change Request (CR) #: 6923

Related CR Release Date: June 11, 2010

Effective Date: August 12, 2010

Related CR Transmittal #: R1987CP

Implementation Date: August 12, 2010

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Drugs and Biologicals

July 2010 average sales price files available

The Centers for Medicare & Medicaid Services has posted the **revised** July 2010 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. The ASP pricing files for April 2010, January 2010, October 2009, and July 2009 have also been updated.

All are available for download at: <http://www.cms.gov/McrPartBDrugAvgSalesPrice/> (see left menu for year-specific links).

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

Source: CMS PERL 201006-28 and 201006-41

Durable Medical Equipment

Reprocessing claims for repair codes specified in change request 6573

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

Provider types affected

This article impacts DME suppliers billing Medicare carriers and Part A/B Medicare administrative contractors (A/B MACs) for certain replacement parts, accessories, or supplies for prosthetic implants and surgically implanted DME with dates of service of October 27, 2008, through December 31, 2009.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6970 in order to augment previously issued CR 6573. CMS issued CR 6573, Transmittal 531 on August 14, 2009. That CR included a list of Healthcare Common Procedure Coding System (HCPCS) codes that could be billed as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME according to guidelines established by CR 5917. CR 6970 directs Medicare Contractors to reprocess claims with dates of service October 27, 2008, through December 31, 2009, containing the HCPCS codes found in the attachment to CR 6573, using the guidelines established by CRs 5917 and 6573. That list is an attachment to CR 6573 at <http://www.cms.gov/Transmittals/downloads/R531OTN.pdf>. Make certain your billing staffs are aware of these adjustments that will be processed later this year.

Background

CR 5917, Transmittal 1603, issued on September 26, 2008, "Claims Jurisdiction and Enrollment Procedures for Suppliers of Certain Prosthetics, Durable Medical Equipment (DME) and Replacement Parts, Accessories and Supplies," communicated that entities enrolled with the national supplier clearinghouse (NSC) as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier may enroll with and bill to the carrier/A/B MAC replacement parts, accessories, and supplies for prosthetics implants and surgically implanted DME items that are not required to be billed to the Medicare fiscal intermediary.

Included with CR 5917 was an excerpt of the 2008 annual jurisdiction list containing HCPCS codes, which CMS instructed at the time may be billed to the carrier/MAC as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME.

CR 6573, Transmittal 531, issued on August 14, 2009, clarified the claims filing jurisdiction and payment policies for DMEPOS items submitted under the guidelines established in CR 5917. CR 6573 also provided an updated list of HCPCS codes that may be billed as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME, under these guidelines. CR 6573 was effective for DMEPOS claims with dates of service on and after January 1, 2010.

Key points of CR 6970

- Medicare contractors will reprocess claims with dates of service of October 27, 2008, through December 31, 2009, containing the HCPCS codes found in Attachment A of CR 6573, using the claims processing instructions previously communicated in CRs 5917 and 6573.
- CR 6970 and the billing guidelines for replacement parts, accessories and supplies for implanted devices established in CRs 5917 and 6573 apply only to DMEPOS suppliers enrolled with the NSC and their local carrier/A/B MAC and does not change the existing carrier/A/B MAC billing rules that apply to physicians, facilities, or other entities that are implanting the devices.

Additional information

If you have questions, please contact your Medicare carrier or A/B MAC at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. The official instruction (CR 6970) issued to your Medicare carrier or A/B MAC is available at <http://www.cms.gov/Transmittals/downloads/R719OTN.pdf>.

Reprocessing claims for repair codes specified in change request 6573 (continued)

CR 6573 contains the 2008 DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME (Rev. March 2009) and that list is an attachment to CR 6573 at <http://www.cms.gov/Transmittals/downloads/R531OTN.pdf>.

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

MLN Matters® Number: MM6970
 Related Change Request (CR) #: 6970
 Related CR Release Date: June 11, 2010
 Effective Date: October 27, 2008
 Related CR Transmittal #: R719OTN
 Implementation Date: October 4, 2010

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Laboratory/Pathology

New waived tests

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

Provider types affected

Clinical diagnostic laboratories billing Medicare carriers or Part A/B Medicare administrative contractors (MACs) for laboratory tests are impacted by this change.

Provider action needed

Stop – impact to you

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a *Current Procedural Terminology (CPT)* code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The *CPT* codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 6906, from which this article is taken, informs carriers and MACs about the latest new *CPT* codes for 2010 that are subject to CLIA edits.

Go – what you need to do

Make sure that your billing staffs are aware of these CLIA-related changes for 2010 and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The tests are valid as soon as they are approved. The *CPT* codes for the following new tests MUST have the modifier QW to be recognized as a waived test.

CPT code	Effective date	Description
82465QW, 83718QW, 84478QW, 80061QW, 82947QW, 82950QW, 82951QW, 82952QW	December 2, 2009	Infopia USA LipidPro lipid profile and glucose measuring system
82465QW, 83718QW, 84478QW, 80061QW	December 2, 2009	Infopia USA LipidPro lipid profile and glucose measuring system (LipidPro lipid profile test strips)
G0430QW	January 1, 2010	American screening corporation one screen drug test cards
G0430QW	January 1, 2010	American screening corporation one screen drug test cups
G0430QW	January 1, 2010	Express diagnostics international Inc. DrugCheck waive drug test cards

New waived tests (continued)

CPT code	Effective date	Description
G0430QW	January 1, 2010	UCP Biosciences, Inc., UCP home drug screening test cards
G0431QW	January 1, 2010	Phamatech QuickScreen one step amphetamine test
G0431QW	January 1, 2010	Phamatech QuickScreen one Step THC screening test
86308QW	January 4, 2010	Acceava Mono Cassette (for whole blood)
81003QW, 82044QW, 82570QW, 84703QW	January 4, 2010	Siemens, Clinitek Status+ Analyzer
81003QW, 82044QW, 82570QW, 84703QW	January 4, 2010	Siemens, Clinitek Status Connect System
82274QW, G0328QW	January 26, 2010	Care Diagnostics Clarity IFOB test

Other key points of CR 6906

- Only the following tests (*CPT* codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) DO NOT require a QW modifier to be recognized as a waived test.
- Medicare carriers and MACs will not search their files to adjust claims affected by this change, but processed prior to the implementation of CR 6906. They will, however, adjust such claims that you bring to their attention.

Reminder items from CR 6852

Note that CR 6852 [Clinical Laboratory Fee Schedule (CLFS) - Special Instructions for Specific Test Codes (*CPT* code 80100, *CPT* code 80101, *CPT* code 80101QW, G0430, G0430QW, and G0431QW)], provided special instructions for the proper use of *CPT* code 80100, *CPT* code 80101, *CPT* code 80101QW, G0430, G0430QW, G0431, and G0431QW as of April 1, 2010. The *MLN Matters*® article related to CR 6852 is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM6852.pdf>.

CR 6852 also mentioned the following:

- If a laboratory with a CLIA certificate of waiver performs a qualitative drug screening test for multiple drug classes using a non-chromatographic method, then the test code G0430QW would be the appropriate code to bill.
- The test code G0431 is a direct replacement for *CPT* code 80101.
- Clinical laboratories with a CLIA certificate of waiver should utilize new test code G0431QW.
- Effective July 1, 2010, *CPT* code 80101 will no longer be covered by Medicare, and *CPT* code 80101QW was deleted on April 1, 2010.

Additional information

To see the official instruction (CR 6906) issued to your Medicare carrier and/or MAC, see <http://www.cms.gov/Transmittals/downloads/R1968CP.pdf>.

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>.

MLN Matters® Number: MM6906
 Related Change Request (CR) #: 6906
 Related CR Release Date: May 28, 2010
 Effective Date: July 1, 2010
 Related CR Transmittal #: R1968CP
 Implementation Date: July 6, 2010

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Medicare Physician Fee Schedule

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010

The President signs the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 – 2.2 percent Medicare physician fee schedule update for June 1, 2010, through November 30, 2010

On June 25, 2010, President Obama signed into law the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010.” This law establishes a 2.2 percent update to the Medicare physician fee schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010. The Centers for Medicare & Medicaid Services (CMS) has directed Medicare claims administration contractors to discontinue processing claims at the negative update rates and to temporarily hold all claims for services rendered June 1, 2010, and later, until the new 2.2 percent update rates are tested and loaded into the Medicare contractors’ claims processing systems. Effective testing of the new 2.2 percent update will ensure that claims are correctly paid at the new rates. CMS expects contractors to begin processing claims at the new rates no later than July 1, 2010. Claims for services rendered prior to June 1, 2010, will continue to be processed and paid as usual.

Claims containing June 2010 dates of service that have been paid at the negative update rates will be reprocessed as soon as possible. Under current law, Medicare payments to physicians and other providers paid under the MPFS are based upon the lesser of the submitted charge on the claim or the MPFS amount. Claims containing June dates of service that were submitted with charges greater than or equal to the new 2.2 percent update rates will be automatically reprocessed. Affected physicians/providers who submitted claims containing June dates of service with charges less than the 2.2 percent update amount will need to contact their Medicare contractor to request an adjustment. Submitted charges on claims cannot be altered without a request from the physician/provider. Physicians/providers should not resubmit claims already submitted to their Medicare contractor.

Source: CMS PERL 201006-42

Pulmonary Services

Pulmonary rehabilitation services

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6823 which alerts providers that the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added payment and coverage improvements for patients with chronic obstructive pulmonary disease (COPD) and other conditions effective January 1, 2010. As a result, Medicare provides a covered benefit for a comprehensive PR program under Medicare Part B effective for services on or after January 1, 2010. Be certain your billing staffs are aware of these Medicare changes and of the claims processing system changes to handle claims for PR services that must be implemented no later than October 4, 2010.

Background

Pulmonary rehabilitation (PR) is a multi-disciplinary program of care for patients with chronic respiratory impairment who are symptomatic and often have decreased daily life activities.

A PR program is individually tailored and designed to optimize physical and social performance and autonomy. The program must provide an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory impairment. In September 2007, the Centers for Medicare & Medicaid Services (CMS), in its final decision memorandum for PR services, announced there was no basis for a national coverage determination at that time. Specifically, this decision was based on a determination by CMS that the Social Security Act did not expressly define a comprehensive PR program as a Part B benefit, and the evidence was not adequate to draw conclusions on the benefit of the individual components of PR. CMS did (and still does) cover medically reasonable and necessary respiratory treatment services in comprehensive outpatient rehabilitation facilities (CORFs), as well services to patients with respiratory impairments who are not eligible for PR but for whom local contractors determine respiratory treatment services are covered. MIPPA added payment and coverage improvements for patients with COPD and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law authorizes a PR program, which was codified in the physician fee schedule calendar year 2010 final rule at 42 CFR 410.47.

*Pulmonary rehabilitation services (continued)***Key points of CR 6823**

Effective January 1, 2010, MIPPA provisions added a physician-supervised, comprehensive PR program. Medicare will pay for up to two one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of PR. The PR program must include the following mandatory components:

1. Physician-prescribed exercise
2. Education or training
3. Psychosocial assessment
4. Outcomes assessment
5. An individualized treatment plan.

The following bullet points detail Medicare claim processing requirements for PR services furnished on or after January 1, 2010:

- Effective January 1, 2010, Medicare contractors will pay claims containing Healthcare Common procedure Coding System (HCPCS) code G0424 when billing for PR services, including exercise and monitoring, as described in the *Medicare Benefit Policy Manual*, Chapter 15, Section 231, as revised by CR 6823, and the *Medicare Claims Processing Manual*, Chapter 32, Section 140, as revised by CR 6823. These revised documents are attached to CR 6823, which are available at <http://www.cms.gov/Transmittals/downloads/R124BP.pdf> (*Medicare Benefit Policy Manual*) and <http://www.cms.gov/Transmittals/downloads/R1966CP.pdf> (*Medicare Claims Processing Manual*).

Medicare contractors will pay claims for HCPCS code G0424 (PR) only when services are provided in the following places of service (POS): 11 (physician's office) or 22 (hospital outpatient). Medicare will deny claims for HCPCS code G0424 performed in other than, and billed without, POS 11 or 22, using the following:

Claim Adjustment Reason Code (CARC) 58 – “treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

Remittance Advice Remark Code (RARC) N428 – “Service/procedure not covered when performed in this place of service.”

Group Code PR (Patient Responsibility) assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file or **Group Code CO** (Contractual Obligation) assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

- Medicare contractors will pay claims for PR services containing HCPCS code G0424 and revenue code 0948 on types of bill (TOB) 13x and 85x under reasonable cost.
- Contractors will pay for PR services for hospitals in Maryland under the jurisdiction of the Health Services

Cost Review Commission on an outpatient basis, TOB 13x, in accordance with the terms of the Maryland waiver.

- Contractors will deny claims for PR services provided in other than TOB 13x and 85x using the following:

CARC 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

RARC N428 – “Service/procedure not covered when performed in this place of service.”

Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or **Group Code CO** assigning financial liability to the provider if the claim is received with the modifier GZ indicating no signed ABN on file.

- Using the Medicare physician fee schedule, Medicare contractors will also pay for PR services billed with HCPCS code G0424 and revenue code 096x, 097x, or 098x on TOB 85x from Method II critical access hospitals (CAHs).
- Medicare will deny PR services that exceed two units on the same date of service and, in doing so, will use the following:

CARC 119 – “Benefit maximum for this time period or occurrence has been reached.”

RARC N362 – “The number of days or units of service exceeds our acceptable maximum.”

Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or **Group Code CO** assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

- Medicare will normally pay for 36 sessions of PR, but may pay up to 72 sessions when the claim(s) for sessions 37-72 includes a modifier KX. Claims for HCPCS code G0424 which exceed 36 sessions without the modifier KX will be denied using the following:

CARC 151 – “Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.”

Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or **Group Code CO** assigning financial liability to the provider if the claim is received with the modifier GZ indicating no signed ABN on file.

- Medicare contractors will deny claims for HCPCS code G0424 when submitted for more than 72 sessions even where the modifier KX is present. In the denials, contractors will use the following:

CARC B5 – “Coverage/program guidelines were not met or were exceeded.”

Pulmonary rehabilitation services (continued)

Group Code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or **Group Code CO** assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

Additional Information

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

CR 6823 was issued to your Medicare MAC, FI, or carrier in two transmittals. One transmittal modifies the *Medicare Benefit Policy Manual* and that transmittal is available at <http://www.cms.gov/Transmittals/downloads/R124BP.pdf>. The second transmittal modifies the *Medicare Claims Processing Manual* and that transmittal is at <http://www.cms.gov/Transmittals/downloads/R1966CP.pdf>.

For related detailed policy and claims processing instructions issued December 11, 2009, you may review MM6715 at <http://www.cms.gov/MLNMattersArticles/downloads/MM6751.pdf>.

MLN Matters® Number: MM6823

Related Change Request (CR) #: 6823

Related CR Release Date: May 7, 2010

Effective Date: January 1, 2010

Related CR Transmittal #: R124BP and R1966CP

Implementation Date: October 4, 2010

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Surgery

Collagen meniscus implant

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 (NPPs) and facilities that bill Medicare carriers, fiscal intermediaries (FIs), and/or Medicare administrative contractors (MACs) for services related to the collagen meniscus implant procedure for Medicare beneficiaries.

What you need to know

This article pertains to change request (CR) 6903 and announces that claims submitted for a collagen meniscus implant procedure will be denied. Also, effective with the July updates of the Medicare physician fee schedule database (MPFSDB) and the integrated outpatient code editor (I/OCE), a new HCPCS code, G0428 (Collagen or other tissue engineered meniscus knee implant procedure for filling meniscal defects [e.g. collagen scaffold, Menaflex]), will be available for use in noncovering collagen meniscus implant procedure claims with dates of service on and after May 25, 2010.

Background

The Centers for Medicare & Medicaid Services (CMS) concluded that the evidence demonstrates that the collagen meniscus implant does not improve health outcomes. Thus, CMS determined that the collagen meniscus implant is not reasonable and necessary for the treatment of meniscal injury/tear and is noncovered by Medicare, as identified in section 150.12 of the *National Coverage Determination (NCD) Manual*. That section of the NCD manual is available as an attachment to CR 6903.

This is a new NCD as there was no existing NCD on collagen meniscus implants. On August 27, 2009,

CMS initiated a national coverage analysis (NCA) on the collagen meniscus implant. The collagen meniscus implant is manufactured from bovine collagen and is used to fill a meniscal defect that results from a partial meniscectomy. CR 6903 communicates the findings of that analysis. Upon completion of a NCA for the collagen meniscus implant, the decision was made that the collagen meniscus implant is noncovered for Medicare beneficiaries.

Key points of CR 6903

- Effective for dates of service on and after May 25, 2010, claims submitted for a collagen meniscus implant procedure will be denied.
- In denying such claims, Medicare will use claim adjustment reason code 96 (Non-covered charge(s)) and remittance advice remark code N386 (This decision was based on a National Coverage Determination (NCD)). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.gov/mcd/search.asp>. If you do not have access, you may contact the local contractor to request a copy of the NCD.) In addition, Medicare contractors will use group code PR (patient responsibility) assigning financial liability to the beneficiary if a signed advance beneficiary notice (ABN) is on file; otherwise, group code CO (contractual obligation) will be used assigning financial liability to the provider if no signed ABN is on file.

Collagen meniscus implant (continued)

- Your contractor will not search their files to recover payment for claims paid prior to implementing CR 6903.

However, they will adjust such claims that are brought to their attention.

Additional information

If you have questions, please contact your Medicare FI, 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 6903, issued to your Medicare FI, carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R121NCD.pdf> (for the *NCD Manual* revision) and <http://www.cms.gov/Transmittals/downloads/R1977CP.pdf> (for claims processing instructions).

MLN Matters® Number: MM6903
 Related Change Request (CR) #: 6903
 Related CR Release Date: May 28, 2010
 Effective Date: May 25, 2010
 Related CR Transmittal #: R121NCD and R1977CP
 Implementation Date: July 6, 2010

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General Coverage

July 2010 Healthcare Common Procedure Coding System update

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 submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6809 which provides the July 2010 Quarterly Healthcare Common Procedure Coding System (HCPCS) changes. Be sure your billing staff know of these HCPCS code changes as noted below.

Background

The HCPCS code set is updated on a quarterly basis. CR 6809 describes the process for updating these specific HCPCS codes. Effective for claims with dates of service on or after July 1, 2010, the following HCPCS code will be payable for Medicare:

HCPCS code	Short description	Long description	MPFSDB status indicator
Q2025	Oral fludarabine phosphate	Fludarabine phosphate, oral, 1mg	E

Note that suppliers are currently instructed to bill oral anti-cancer drugs to the DME MACs using the appropriate national drug code (NDC).

In addition, the Centers for Medicare & Medicaid Services (CMS) recently concluded that dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration for this purpose, and then only in HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. Consequently, effective for claims with dates of service on or after March 23, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short Description	Long Description	MPFSDB Status Indicator
Q2026	Radiesse injection	Injection, Radiesse, 0.1ml	E
Q2027	Sculptra Injection	Injection, Sculptra, 0.1ml	E

Additional information

Medicare contractors will not search their files to reprocess claims already processed, but will adjust such claims that you bring to their attention. The official instruction, CR 6809, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1972CP.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>.

July 2010 Healthcare Common Procedure Coding System update (continued)

MLN Matters® Number: MM6809
 Related Change Request (CR) #: 6809
 Related CR Release Date: May 21, 2010
 Effective Date: July 1, 2010 unless otherwise specified
 Related CR Transmittal #: R1972CP
 Implementation Date: July 6, 2010

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Clinical review judgment

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

Note: This article was revised on June 16, 2010, to include an additional reference to Chapter 3 of the *Medicare Program Integrity Manual*. All other information remains the same. This information was previously published in the May 2010 *Medicare B Update!* page 26.

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 [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, fiscal intermediaries [called affiliated contractors or ACs], Medicare administrative contractor [MACs], the comprehensive error rate testing [CERT] contractor, and recovery audit contractor [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.

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, and

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), Section 14 (Clinical Review Judgment) as an attachment to that CR. The original Chapter 3, which contains more information on CMS' medical review processes, is available at <http://www.cms.gov/manuals/downloads/pim83c03.pdf>.

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 *Revised*
 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

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Signature guidelines for medical review purposes

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

Note: This article was revised on June 16, 2010 to include a table from change request (CR) 6698 that summarizes signature requirements. All other information is the same. This information was previously published in the April 2010 *Medicare B Update!* pages 26-28.

Provider types affected

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

Provider action needed

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

Background

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

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

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

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

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

Exception 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for

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

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

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

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

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

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

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

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- Definition of a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.

Example: The claim selected for review is for a hospital visit on October 4. The additional documentation request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated

Signature guidelines for medical review purposes (continued)

October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.

- Definition of a signature log: Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- Definition of an attestation statement: In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

“I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”
- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.
- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or

policy indicate that a signature must be in place prior to a given event or a given date.

- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
 - In the situations where the guidelines indicate “signature requirements met,” the reviewer will consider the entry.
 - In situations where the guidelines indicate “contact provider and ask a non-standard follow up question,” the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20-day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
 - In the situations where the guidelines indicate “signature requirements **not** met,” the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic prescribing

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

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

Signature guidelines for medical review purposes (continued)

- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified e-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified e-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified e-Prescribing system, the reviewer shall **not** require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional information

CR 6698 includes a helpful table that summarizes the situations where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit an attestation statement or signature log. Key portions of that table are as follows:

		Signature requirement met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists three physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and not on letterhead, but the submitted documentation is accompanied by: 1) a signature log, or 2) an attestation statement	X	
6	Illegible signature not over a typed/printed name, not on letterhead and the documentation is UNaccompanied by: a) a signature log, or b) an attestation statement		X
7	Initials over a typed or printed name	X	
8	Initials not over a typed/printed name but accompanied by: a) a signature log, or b) an attestation statement	X	
9	Initials not over a typed/printed name UNaccompanied by: a) a signature log, or b) an attestation statement		X
10	Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

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

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

MLN Matters® Number: MM6698 *Revised*
 Related CR Release Date: March 16, 2010
 Related CR Transmittal #: R327PI

Related Change Request (CR) #: 6698
 Effective Date: March 1, 2010
 Implementation Date: April 16, 2010

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Electronic Data Interchange

Additional instruction – HIPAA version 5010 for transaction 835

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 bill Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and regional home health intermediaries [RHHI]), for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6975 to alert providers that, according to the administrative simplification provisions of HIPAA regulations, the Secretary of the Department of Health and Human Services (DHHS) is required to adopt standard electronic transactions and code sets. CMS is currently in the process of implementing the next version of the HIPAA Transaction 835 standard – referred to as 835v5010 in this document. Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.

Key points of CR 6975

The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective date of the regulation: March 17, 2009
- Level I compliance by: December 31, 2010
- Level II compliance by: December 31, 2011, and
- All covered entities have to be fully compliant on: January 1, 2012.

Background

Level I compliance means “that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing.”

Level II compliance means that a “covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.”

CMS will be fully compliant on January 1, 2012, by completing Level I compliance by December 31, 2010, and level II compliance by December 31, 2011. The transition period when both versions would be allowed in production mode for Medicare will be from January 1, 2011-December 31, 2011. The 835v4010A1 and the current standard paper remittance (SPR) should not be sent on or after January 1, 2012, irrespective of the date of receipt or date of service reported on the electronic or paper claim.

Additional information

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

The official instruction associated with CR 6975, issued to your Medicare carrier, A/B MAC, FI and/or RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R709OTN.pdf>.

MLN Matters® Number: MM6975

Related Change Request (CR) #: 6975

Related CR Release Date: May 21, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R709OTN

Implementation Date: October 4, 2010

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General Information

Solicitation letter to providers who do not have enrollment records in PECOS

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

Provider types affected

Physicians and nonphysician practitioners who are currently enrolled in Medicare but who do not have an established enrollment record in PECOS are affected by this issue.

Provider action needed

Physicians (doctors of medicine or osteopathy, dental medicine, dental surgery, podiatric medicine, optometry, and chiropractic medicine), physician assistants, certified clinical nurse specialists, nurse practitioners, clinical psychologists, certified nurse midwives, or clinical social workers should establish and update a record in the Medicare PECOS if they do not already have a record in that system. This article, based on CR 6842, advises you that your Medicare contractor will be mailing the letter shown in the attachment to CR 6842 if you do not have a record in PECOS. The letter will request that you take the steps to establish such a record and will explain how to do so. It is important that you maintain your enrollment information to ensure you are eligible for future Medicare initiatives and incentives.

Background

The letter will explain that Medicare records indicate you do not have an enrollment record in PECOS because you enrolled in Medicare prior to implementation of PECOS and you have not submitted any updates or changes to your Medicare enrollment information in the past six (or more) years.

You should know that if you do not have an enrollment record in PECOS:

- Your information may not be current and updating your record in PECOS ensures payment accuracy for the services you provide to Medicare patients.
- It is possible that you may not be able to receive incentive payments from Medicare for meaningful use of certified electronic health records. These incentive payments are authorized by the American Recovery and Reinvestment Act of 2009. More information on this initiative, also known as HITECH, is available at http://www.cms.gov/Recovery/11_HealthIT.asp.
- Many physicians and nonphysician practitioners order items or services for Medicare beneficiaries. You need an approved enrollment record in PECOS to continue to refer or order items or services for your Medicare patients.

If you do not have a current and active Medicare enrollment record, it is imperative that you take the necessary action to establish your enrollment record as soon as possible.

You can do this in one of two ways, whichever you prefer:

- Use Internet-based PECOS to complete and send your enrollment application to the Medicare carrier or A/B MAC via the Internet. Before you begin, be sure you have a national provider identifier (NPI) and have created a user ID and password in the National Plan and Provider Enumeration System (NPPES). You will need the NPPES user ID and password in order to access Internet-based PECOS. If you need help creating an NPPES user ID and password, or if you are not sure you ever created them or cannot remember what they are, you may contact the NPI enumerator for assistance at 1-800-465-3203. Visit <http://www.cms.gov/MedicareProviderSupEnroll> to read the documents that are available about Internet-based PECOS on the CMS Provider/Supplier Enrollment Web page. Having that information at hand before you access the system, could avoid the need to contact the CMS End User Services (EUS) Help Desk for assistance after you begin.
- Fill out the appropriate paper Medicare provider enrollment application(s) (CMS-855I and, if appropriate, the CMS-855R as well) and mail the application(s), along with any required additional supplemental documentation, to the Medicare carrier or A/B MAC. These forms are downloadable from the CMS Provider/Supplier Enrollment Web page (shown above) or the CMS forms page <http://www.cms.gov/cmsforms/cmsforms/list.asp>.

Additional information

The official instruction, CR 6842, issued to your Medicare carrier and or MAC regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R712OTN.pdf>.

CMS's proposed rule for incentive payments from Medicare for the meaningful use of certified electronic health records may be viewed at

<http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>.

Additional information about the electronic health records initiative is available at

http://www.cms.gov/Recovery/11_HealthIT.asp.

The *Medicare Learning Network* catalog has three fact sheets explaining provider enrollment responsibilities enrolled in the Medicare program. Go to <http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf> to view these fact sheets which are briefly described as follows:

- **Fee-for-service provider enrollment reporting responsibilities for individual physicians enrolled in the Medicare program** (suggested for physicians)
After enrolling in the Medicare program, all physicians are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. This fact sheet outlines such reportable events for physicians.

Solicitation letter to providers who do not have enrollment records in PECOS (continued)

- **Fee-for-service provider enrollment reporting responsibilities for individual nonphysician practitioners enrolled in the Medicare program** (suggested for nonphysician practitioners)

After enrolling in the Medicare program, all nonphysician practitioners are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. This fact sheet outlines such reportable events for individual nonphysician practitioners.

- **Fee-for-service provider enrollment reporting responsibilities for physician group practices enrolled in the Medicare program** (suggested for physician group practices)

After enrolling in the Medicare program, all physician group practices are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. This fact sheet outlines such reportable events for physician group practices.

MLN Matters® Number: MM6842

Related Change Request (CR) #: 6842

Related CR Release Date: May 28, 2010

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Related CR Transmittal #: R712OTN

Implementation Date: June 28, 2010

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Guidelines for processing appeals via facsimile or via secure Internet portal

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 submitting Medicare fee-for-service (FFS) claim appeal requests 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]).

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6958, which updates the current instructions in the *Medicare Claims Processing Manual*, Chapter 29, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application.

Caution – what you need to know

CR 6958 provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via facsimile and/or via a secure Internet portal/application. At this time, Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must seek approval from the Centers for Medicare & Medicaid Services (CMS) prior to implementation of that portal/application.

Go – what you need to do

Note that, even if your contractor allows submission of appeal requests via facsimile and/or via a secure Internet portal/application, the decision to use those venues is yours. Your contractor may not require you to use those venues. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Several Medicare contractors have requested authority from the CMS to utilize a secure Internet portal/application to receive and process Medicare FFS claim appeal requests. In addition, several Medicare contractors have begun to accept claim appeal requests received in writing via facsimile.

CR 6958 provides guidance regarding appeal requests received in writing via facsimile or via a secure Internet portal/application, and it provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via these mechanisms.

The purpose of CR 6958 is to update the current instructions in the *Medicare Claims Processing Manual*, Chapter 29 (Appeals of Claims Decisions), to allow Medicare contractors to accept appeal requests via facsimile and/or via a secure Internet portal/application.

CMS does not require its contractors to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application is at the discretion of the appellant. Contractors will continue to accept appeal requests in hard copy via mail.

*Guidelines for processing appeals via facsimile or via secure Internet portal (continued)***Key portions of CR 6958****What constitutes a request for redetermination****Written requests for redetermination submitted by a state, provider, physician or other supplier**

States, providers, physicians, or other suppliers with appeal rights must submit written requests via mail, facsimile (if the contractor chooses to receive requests via facsimile), or, where available, secure Internet portal/application indicating what they are appealing and why. The acceptable written ways of doing this are as follows:

- A completed Form CMS-20027 (constitutes a request for redetermination). The contractor supplies these forms upon request by an appellant. “Completed” means that all applicable spaces are filled out and all necessary attachments are included with the request.
- A written request not on Form CMS-20027.

At a minimum, the request shall contain the following information:

- Beneficiary name
- Medicare health insurance claim (HIC) number
- The specific service(s) and/or item(s) for which the redetermination is being requested
- The specific date(s) of the service
- The name and signature of the party or the representative of the party

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either: (1) explicitly asks the contractor to take further action, or (2) indicates dissatisfaction with the contractor’s decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination.

- A secure Internet portal/application. If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall include the required elements for a valid appeal request as outlined under Chapter 29, Section 310.1.B.2.b which is attached to CR 6958.

Note: Some redetermination requests may contain attachments. For example, if the remittance advice (RA) is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Requirements for a valid signature on an appeal request

For appeal purposes, the only acceptable method of documenting the appellant’s signature on the appeal request is by written, digital, digitized, or electronic signature as discussed below:

- A written signature may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- An electronic, digital, and/or digitized signature is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application. The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, “electronically signed by” or “verified/approved by” etc.
- A stamp signature or other indication that a “signature is on file” on the Form CMS 20027 or other documentation (such as a blank claim form) submitted to support the appeal request shall not be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

How contractors will handle multiple requests for redetermination for the same item/service

If a contractor receives multiple timely requests for redetermination for the same item or service from either multiple parties or via multiple venues (i.e., hard copy mail, facsimile, or via a secure Internet portal/application) the contractor acts as follows:

- If a decision or dismissal notice has already been issued or the claim for the item/service at issue has been adjusted/paid in accordance with the redetermination decision and the contractor receives additional redetermination request(s) for the same items/services, the contractors will treat the additional request as an inquiry. Contractors shall not issue a dismissal notice.

Note: In accordance with the *Medicare Claims Processing Manual* (Chapter 29, Section 310.6.3, which is attached to CR 6958), if an appellant requests that the contractor vacates its dismissal action and the contractor determines that it cannot vacate the dismissal; it sends a letter notifying the appellant accordingly. The contractor shall not issue a second dismissal notice to the appellant since a dismissal should only be issued in response to an appeal request.

Guidelines for processing appeals via facsimile or via secure Internet portal (continued)

- If a decision or dismissal notice has not been issued (i.e., the appeal is pending), and the claim for the items/services at issue has not been otherwise adjusted/paid following the redetermination decision, then upon receipt of additional redetermination request(s) for the same items/services, the contractor shall:
 1. Combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with the requirements as outlined in 42 CFR 405.944(c). See http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr405.944.pdf.
 2. When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that multiple requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized) so that it is clear to the appellant that the decision or dismissal was issued timely in accordance with 42 CFR 405.944(c).
 - If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting multiple requests for redetermination via multiple venues, the contractor shall take additional steps to educate the appellant regarding the appeals process.

Timely processing requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of the *Medicare Claims Processing Manual*, Chapter 29, Section 310.4(D) (4), which is attached to CR 6958). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties. Affirmations processed via a CMS-approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application.
2. For partial reversals and full reversals, when all of the following actions have been completed:
 - The decision letter, if applicable, is mailed to the parties (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application), and
 - The actions to initiate the adjustment action in the claims processing system are taken.
3. For withdrawals and dismissals, the date that the dismissal notice is mailed (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application) to the parties.

The redetermination decision

The law requires contractors to conclude and mail and/or otherwise transmit, as noted below, the redetermination within 60 days of receipt of the appellant's request, as indicated in the *Medicare Claims Processing Manual*, Chapter 29, Section 310.4, which is attached to CR 6958. For unfavorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and appointed representative, if applicable).

Contractors shall provide the decision, as required below; in writing via hard copy mail (unless the contractor has submitted a request and received approval for use of secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically). Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism.

Requirements for use of secure Internet portal/application to support appeals activities

Contractors who develop and utilize a secure Internet portal/application for appeals purposes will ensure, at a minimum:

- CMS approves the proposed portal/application and usage prior to development and implementation.
- Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request (the system must include verbiage instructing the appellant not to submit additional redetermination requests for the same item/service via a different venue).
- The secure Internet portal/application includes a formal registration process that validates the signature and requires, at a minimum, use of restricted user IDs and passwords.
- Templates for submission of electronic appeal requests must include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- Contractors utilizing an approved portal/application must provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.
- Contractors must also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.

Guidelines for processing appeals via facsimile or via secure Internet portal (continued)

- Contractors utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.
- Redetermination decision and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements. In addition, contractors shall provide hard copy decision and/or dismissal notices to parties to the appeal and who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).
- Contractors will also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.

Additional information

The official instruction, CR 6958, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1986CP.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>.

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Updated Form CMS-1500 information

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

Provider types affected

This is an informational article for physicians, providers and suppliers who use Form CMS-1500 to submit claims to Medicare contractors (carriers, Part A/B Medicare administrative contractors [A/B MACs], and durable medical equipment Medicare administrative contractors [DME MACs] for services provided to Medicare beneficiaries.

What you need to know

This article, based on change request (CR) 6929, updates Form CMS-1500 information in the *Medicare Claims Processing Manual* by removing language allowing the use of legacy identifiers and making other technical corrections as a result of that change. As part of this update, providers are reminded that they are responsible for purchasing their own CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as the forms follow the specifications approved by the Centers for Medicare & Medicaid Services as developed by the American Medical Association. Photocopies of the Form CMS-1500 are **not** acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. You may purchase forms from the U.S. Government Printing Office by calling 1-202-512-1800.

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 carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1970CP.pdf>.

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 Related Change Request (CR) #: 6929
 Related CR Release Date: May 21, 2010
 Effective Date: October 1, 2010
 Related CR Transmittal #: R1970CP
 Implementation Date: October 4, 2010

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There is no ‘one-size-fits-all’ in building a Nationwide Health Information Network

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

Private and secure health information exchange enables information to follow the patient when and where it is needed for better care. The federal government is working to enable a wide range of innovative and complementary approaches that will allow secure and meaningful exchange within and across states, but all of our efforts must be grounded in a common foundation of standards, technical specifications, and policies. Our efforts must also encourage trust among participants and provide assurance to consumers about the security and privacy of their information. This foundation is the essence of the Nationwide Health Information Network (NHIN) (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1142&parentname=CommunityPage&parentid=25&mode=2&in_hi_userid=11113&cached=true).

The NHIN is not a network per se, but rather a set of standards, services, and policies that enable the Internet to be used for the secure exchange of health information to improve health and health care. Different providers and consumers may use the Internet in different ways and at different levels of sophistication. To make meaningful use possible, including the necessary exchange of information, we need to meet providers where they are, and offer approaches that are both feasible for them and support the meaningful use requirements of the Centers for Medicare & Medicaid Services (CMS) electronic health record incentive programs. As with the Internet, it is likely that what is today considered “highly sophisticated” will become common usage. Moreover, users may engage in simpler exchange for some purposes and more complex exchange for others.

Current NHIN exchange capabilities are the result of a broad and sustained collaboration among federal agencies, large provider organizations, and a variety of state and regional health information organizations that all recognized a need for a high level of interoperable health information exchange that avoided “one-off” approaches. Based on this pioneering work, a subset of these organizations (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1407&parentname=CommunityPage&parentid=8&mode=2&in_hi_userid=11113&cached=true) is now actively exchanging information. This smaller group currently includes the Department of Defense, Social Security Administration, Veterans Health Administration, Kaiser Permanente, and MedVirginia. They initially came together to show, on a pilot scale, that this type of highly evolved exchange was possible. Having succeeded, they continue to expand the level of exchange among their group and with their own respective partners in a carefully phased way to demonstrate and learn from these widening patterns of exchange. The robust exchange occurring at this level has several key attributes, including the:

1. Ability to find and access patient information among multiple providers.
2. Support for the exchange of information using common standards.
3. Documented understanding of participants, enabling trust, such as the data use and reciprocal support agreement (DURSA).

Not every organization and provider, however, needs or is ready for this kind of health information exchange today. Nor do the 2011 meaningful use (<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1325&parentname=CommunityPage&parentid=1&mode=2>) requirements set forth by CMS in the recent proposed rule require it. Direct, securely routed information exchange may meet the current needs of some providers for their patients and their practices, such as receiving lab results or sending an electronic prescription.

To enable a wide variety of providers – from small practices to large hospitals – to become meaningful users of electronic health records in 2011, we need to ensure the availability of a reliable and secure “entry level” exchange option that aligns with the long-range information exchange vision we have for our nation. Such an option should balance the need for a consistent level of interoperability and security across the exchange spectrum with the reality that not all users are at the same point on the path to comprehensive interoperability. In an effort to provide the best customer service possible, the Office of the National Coordinator for Health IT (ONC) (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1497&parentname=CommunityPage&parentid=0&mode=2&in_hi_userid=10741&cached=true) will consider what a complete toolkit would be for all providers who want to accomplish meaningful health information exchange.

Broadening the use of the NHIN to include a wider variety of providers and consumers who may have simpler needs for information exchange, or perhaps less technically sophisticated capabilities, is critical to bolstering health information exchange and meeting our initial meaningful use requirements. Building on the solid foundation established through the current exchange group mentioned above and the recommendations of the HIT policy committee (which originated with the committee’s NHIN workgroup [http://healthit.hhs.gov/portal/server.pt?open=512&objID=1476&parentname=CommunityPage&parentid=2&mode=2&in_hi_userid=10741&cached=true]), ONC is exploring this expansion of NHIN capabilities to find solutions that will work across different technologies and exchange models.

The newly launched NHIN Direct project (<http://nhindirect.org/>) is designed to identify the standards and services needed to create a means for direct electronic communication between providers, in support of the 2011 meaningful use requirements. It is meant to enhance, not replace, the capabilities offered by other means of exchange. An example of this type of exchange would be a primary care physician sending a referral and patient care summary to a specialist electronically.

We are on an aggressive timeline to define these specifications and standards and to test them within real-world settings by the end of 2010. Timing is critical so that we may provide this resource to a broader array of participants in health information exchange as a wave of new, meaningful users prepare to qualify for incentives provided for in the HITECH Act and ultimately defined

There is no ‘one-size-fits-all’ in building a Nationwide Health Information Network (continued)

by CMS. This model for exchange will meet current provider needs within the broader health care community, complement existing NHIN exchange capabilities, and strengthen our efforts toward comprehensive interoperability across the nation.

A natural evolution in NHIN capabilities to support a variety of health information exchange needs is being reinforced by trends that are leading us toward widespread multi-point interoperability. The current movement toward consolidation in health care, coupled with health reform’s encouragement of bundled payments for coordinated care, will mean more providers need it. Quality improvement, public health, research, and a learning health care system all require it. Ultimately, simple exchange will be part of a package of broader functions that allows any provider, and ultimately consumers, to exchange information over the Internet, enabled by NHIN standards, services, and policies.

Your continued input will help guide us toward and maintain a direction that is in harmony with the rapid innovations in health IT today. The NHIN Direct project will conduct an open, transparent, and collaborative process throughout its development by using a community wiki, blogs, and open source implementation already available on the project’s website (<http://nhindirect.org>). I encourage you to participate through the website, via public participation at the implementation group meetings, and by deploying and testing the resulting standards and specifications. For those of you who are participants in the current exchange group, I urge you to take every opportunity to share your experiences. Lessons learned from the NHIN direct project and the exchange group will inform the evolution of the NHIN as new uses and users come forward, and as continued innovation occurs to meet the growing needs of our community.

As we head into the next stage in the development of nationwide health information exchange, we should all take a moment to reflect on how far we have come and evaluate our plans for the future. ONC is committed to providing resources and guidance to stakeholders at all levels of exchange through HITECH programs, such as the Health IT regional extension centers (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&parentname=CommunityPage&parentid=58&mode=2&in_hi_userid=11113&cached=true), the national Health IT Research Center, and the State Health Information Exchange Program (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1488&parentname=CommunityPage&parentid=3&mode=2&in_hi_userid=10741&cached=true). As you assess your own needs for exchange, please take advantage of the many federal resources available to you on the ONC website (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1497&parentname=CommunityPage&parentid=14&mode=2&in_hi_userid=10741&cached=true) and the online resources of the programs mentioned above, as well as through the “NHIN University (<http://www.nationalehealth.org/NHIN-U/>)” education program hosted by our public-private partner, the National eHealth Collaborative (<http://www.nationalehealth.org/NHIN-U/>).

We have done a great deal of work in the short period of time since the passage of the HITECH Act. We at ONC appreciate your willingness to stay engaged and involved in every step of our journey, and we look forward to our continuing collaboration to improve the health and well-being of our nation.

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

Source: CMS PERL 201005-35

Banking transition update

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

The following Medicare claim processing contractors will remain with JPMorgan Chase:

- Cahaba Government Benefit Administrators
- Pinnacle Business Solutions
- First Coast Service Options Inc.
- Palmetto GBA (except for A/B Medicare administrative contractor (MAC) for jurisdiction 1)
- Wisconsin Physician Service

Providers that bill to these contractors will not experience any change.

The following Medicare claim processing contractors will transition to JPMorgan Chase on August 2:

- Palmetto A/B MAC for jurisdiction 1
- Trailblazer

The following contractors will transition to U.S. Bank on August 2:

- Noridian Administrative Services
- CIGNA Government Services
- Highmark Medicare Services
- National Government Services
- NHIC, Corp.

Source: CMS PERL 201005-31

New manual for the PQRI and eRx Incentive Program

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

Provider types affected

Physicians and nonphysician practitioners who are eligible professionals (EPs) participating in the Physician Quality Reporting Initiative and/or the E-Prescribing (eRx) Incentive Program and submitting claims to Medicare contractors (carriers and Medicare administrative contractors [MAC]) for services provided to Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 6935, which announces availability of a new Medicare manual describing the Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Incentive Programs. It is important to note that:

- The manual does not establish new requirements for the PQRI and eRx programs, and
- Changes to the programs are described in the annual MPFS legislation.

This new manual titled Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) *Medicare Quality Reporting Incentive Programs Manual* will be Publication 100-22 and will be available at <http://www.cms.gov/manuals/IOM/list.asp>. Chapter 1 of the manual describes current policies for the PQRI initiative and Chapter 2 documents current policies for the eRx program.

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 carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1QRI.pdf>.

For additional information about PQRI and eRx programs, see the *Medicare Learning Network (MLN) Catalog of Products* available at <http://www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf>. This catalog contains a special initiatives section where providers will find topics such as e-Prescribing, and Physician Quality Reporting Initiative (PQRI). Provider and subject indexes help identify products suggested for a specific type of provider or on a specific subject.

MLN Matters® Number: MM6935

Related Change Request (CR) #: 6935

Related CR Release Date: June 11, 2010

Effective Date: September 13, 2010

Related CR Transmittal #: R1QRI

Implementation Date: September 13, 2010

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New additions to the CMS ICD-10 website section

There are two new additions to the “Latest News” page of the Centers for Medicare & Medicaid Services (CMS) ICD-10 website section. The address for the “Latest News” page is http://www.cms.gov/ICD10/02b_Latest_News.asp. Details of these additions are outlined below.

Latest News page watch

This free service enables you to receive e-mail notifications when the information on “CMS’ ICD-10 Latest News” page changes or is updated. If you are interested in receiving this information, please go to the link in the “Related Links Inside CMS” section to subscribe.

Executive summary of CMS’ ICD-10 vendor conference now available

On April 27 at the Capitol Hilton Hotel in Washington D.C., CMS held a free, one-day ICD-10 conference for software vendors, billing services and clearinghouses that support the health care industry. Attendees had the opportunity to openly discuss the ICD-10 and version 5010 transitions, including key implementation issues such as testing, and resources that can help make the transition easier.

Vendor conference highlights

- A presentation by Dr. Douglas Fridsma, Acting Director, Officer of Interoperability and Standards, Office of the National Coordinator, on ICD-10 within the broad scope of health reform initiatives.
- Software vendor, billing services, and clearinghouse panels to discuss their high-level view of industry readiness for version 5010 and ICD-10.
- Breakout sessions to explore readiness, barriers, testing, and other issues specific to these three industry segments.

The executive summary of the ICD-10 vendor conference proceedings is now available in the “Downloads” section at the bottom of the page. A link to a video download of a condensed version of the conference’s plenary session will be made available within the next few weeks.

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

Source: CMS PERL 201005-34

Messages regarding prescription drug coverage for Medicare beneficiaries Medicare helps low-income beneficiaries get big savings on prescription drug costs

Thanks to changes to Medicare's low-income subsidy program (also known as LIS or "extra help") that take effect this year, more Medicare beneficiaries will qualify for "extra help" with their prescription drug costs and will be eligible to pay no more than \$2.50 for generic drugs and \$6.30 for each brand name drug. These changes make it easier than ever for people with Medicare who have limited income to save on their drug costs.

The Centers for Medicare & Medicaid Services (CMS) estimates that "extra help" can save eligible Medicare beneficiaries as much as \$3,900 per year. It is estimated that more than 1.8 million people with Medicare may be eligible for "extra help" but are not currently enrolled to take advantage of these savings.

Changes enacted in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 make it easier for Medicare beneficiaries to qualify for "extra help" by changing the way income and assets are counted in 2010. When determining eligibility for "extra help," the Social Security Administration, who handles enrollment in the program, will no longer count life insurance policies as a resource. In addition, help received from family and friends to pay for household expenses like food, mortgage, rent, and utilities will no longer count as income.

"These changes to the 'extra help' program make it easier for more people to get help paying for their prescription drugs," said Marilyn Tavenner, CMS Principal Deputy Administrator. "Even if you were turned down for 'extra help' before, you should reapply. If you qualify, you will receive help paying for Medicare prescription drug coverage premiums, copayments and deductibles."

To qualify, a Medicare beneficiary's income must be less than \$16,245 a year (or \$21,855 for married couples) and have resources limited to \$12,510 (or \$25,010 for married couples). Resources include bank accounts, stocks, and bonds but do not include houses, cars, or life insurance policies.

There is no cost to apply for "extra help." Medicare beneficiaries, family members, trusted counselors or caregivers can apply online at <http://www.socialsecurity.gov/prescriptionhelp> or call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) and ask for the "Application for Help with Medicare Prescription Drug Plan Costs."

Medicare beneficiaries can also receive assistance in their local communities from their State Health Insurance Assistance Program (SHIP). Local SHIP contact information may be found on the back of the Medicare & You 2010 handbook or online at <http://www.medicare.gov/contacts/staticpages/ships.aspx>. Information given will remain confidential.

Most beneficiaries enrolled in a Part D plan whose income is too high to qualify for the "extra help," but who enter the donut hole in 2010, will receive a one-time, tax-free rebate check of \$250 to help with high prescription drug costs thanks to the Affordable Care Act. The new law contains some important new benefits to help seniors and others who are caught in the coverage gap. To learn more about the Affordable Care Act and these new benefits through Medicare, visit <http://www.medicare.gov/Publications/Pubs/pdf/11467.pdf>.

These \$250 checks will begin to be mailed out to eligible beneficiaries on June 10 and will be sent to beneficiaries soon after they enter the coverage gap. For more information on how to get your rebate check, log on to <http://www.medicare.gov/Publications/Pubs/pdf/11464.pdf>.

The donut hole is the period in the prescription drug benefit in which beneficiaries generally pay 100 percent of the cost of their drugs until they hit the catastrophic coverage. Beneficiaries who qualify for Medicare "extra help" do not have a donut hole.

To learn more about Medicare prescription drug coverage, visit <http://www.medicare.gov>, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Beneficiary information about the \$250 Part D rebate

CMS posted the brochure titled "Closing the Prescription Drug Coverage Gap" at <http://www.medicare.gov> (under "What's New"). This brochure describes details about the tax-free, one-time check for \$250 for people who enter the Part D donut hole and are not eligible for Medicare extra help. The first checks are being mailed June 10 and checks will be mailed monthly after people have entered the coverage gap.

To help fight fraud and protect beneficiaries from potential scams, Medicare is reminding seniors there are no forms to fill out to receive this benefit. Medicare will automatically send a check.

The envelope will have the U.S. Department of Health and Human Services symbol on it and will say "Medicare Part D." Beneficiaries don't need to provide any personal information. They do not need to provide any personal information like Medicare, social security number, or bank account numbers to get the rebate check. They are reminded not to give any personal information to anyone who calls about the \$250 rebate check. People with Medicare should call 1-800-MEDICARE (1-800-633-4227) to report any suspected fraud or scams or with any questions.

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

Source: CMS PERL 201006-10

Fraud prevention education campaign launch

The U.S. Department of Health & Human Services, the Centers for Medicare & Medicaid Services (CMS) and the Administration on Aging launch the Fraud Prevention Education Campaign to ensure Medicare beneficiaries are protected from scams.

The campaign kicks off with a \$1 million national and ethnic radio advertising campaign targeted around the \$250 one time tax-free donut hole rebate check included in the Affordable Care Act.

As eligible seniors who have entered the Medicare Part D donut hole this year begin to receive their tax-free, one time rebate check for \$250, the HHS Secretary Kathleen Sebelius and senior officials from the Administration on Aging and CMS launched a national education effort to ensure that seniors have the information they need to protect themselves from potential scams or fraud when it comes to their Medicare benefits.

The national fraud prevention campaign will include radio, television, and print advertising and outreach efforts.

The campaign will begin with a \$1 million national radio advertising campaign that will run in June through August as \$250 tax-free rebate checks get mailed out to eligible seniors each month. CMS will purchase time in markets with high percentages of Medicare recipients who fall into the donut hole and time on ethnic radio to communicate with groups of seniors who have been particularly targeted by scam artists.

Thirty-second and sixty-second radio spots will be produced in English, Spanish, Korean, and Armenian for the initial radio advertising campaign. English-language spots will begin running in a small number of markets by the end of this week. The number of markets will steadily increase and the national advertising campaign will be completely in place by the end of June.

CMS posted audio files of the English language and Spanish language 60-second spots on the Medicare.gov Web site at <http://www.medicare.gov/>. Scripts for the spots may be found on <http://www.medicare.gov/Default.aspx>.

The press release was posted on June 8, 2010, at http://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 201006-11

Preparing for a transition from an FI/carrier to a Medicare administrative contractor

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

Note: This article, SE0837, has been updated and re-issued as SE1017. You may find the updated article at <http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf>. This information was previously published in the March 2009 *Medicare B Update!* pages 53-57.

MLN Matters® Number: SE0837

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

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

Use the PDS report to improve your Medicare billing operations

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

Preparing for transition to a Medicare administrative contractor

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

Note: This article was initially issued as SE0837 in 2008. It is being re-issued as SE1017 in order to update the content to reflect current experiences with transitions to a MAC.

Provider types affected

All fee-for-service physicians, providers, and suppliers who submit claims to fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), or DME MACs for services provided to Medicare beneficiaries. Providers already billing Medicare administrative contractors (MACs) have already transitioned and need not review this article. However, suppliers billing DME MACs may find the article of value as the Centers for Medicare & Medicaid Services (CMS) recompetes the DME MAC contracts, which could cause a transition from an incumbent DME MAC to a new DME MAC.

Impact on providers

This article is intended to assist all providers that will be affected by MAC implementations (or DME MAC transitions due to recompeting the DME MAC contracts). CMS is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC (or your DME MAC to another DME MAC). Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business. Please note that other Medicare contractors servicing your region will be unaffected by this change, such as the qualified independent contractor (QIC for reconsiderations), recovery audit contractor (RAC), the program safeguard contractor (PSC), and the zone program integrity contractor (ZPIC).

Note to DME suppliers: The remainder of this article focuses on transitions from carriers or FIs to MACs, but suppliers note the information may also pertain to your business if there is a transition from your DME MAC to another DME MAC as those contracts are recompeted.

Background

Medicare contracting reform (or Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B fee-for-service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new MAC authority. Medicare contracting reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare FFS program.

When completed, there will be 15 new MACs processing Part A and Part B claims. Each MAC services a distinct set of contiguous states, also known as a "jurisdiction". Each MAC will handle different volumes of work based upon the geographic breakout of the 15 MACs. Because of this, the MACs will vary in geographic size and the amount of work they handle. Having 15 MACs should result in greater consistency in the interpretation of Medicare policies, which is a key goal of Medicare contracting reform.

MAC implementation milestones/definitions

There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action relative to the milestones defined below:

Award - This is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

Cutover - This is the date on which the carrier or FI work ceases and MAC work begins. Cutover is often done in phases by state-level jurisdictions. Because of the amount of activity involved in a cutover, there may be interrupted services for a day or two.

Outgoing contractor - A Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare contracting reform and whose work will transition to a MAC.

Incoming MAC - The entity that has won a contract under Medicare contracting reform and which will assume the workload that was performed by a carrier or FI.

Pre-award

If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare contracting reform by visiting <http://www.cms.gov/medicarecontractingreform/>.

Post-award

Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

Pay attention to the mail you receive from your outgoing Medicare contractor and your new MAC--you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic funds transfers, appeals, customer service, etc. Focus on necessary actions you must take and the critical due dates assigned, to avoid any disruptions in claims payment.

Preparing for transition to a Medicare administrative contractor (continued)

Sign up for your new MAC's listserv or if you aren't signed up for your current FI or carrier's listserv, please do so immediately. While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Subscribing to the MAC listserv distribution will ensure that you receive news and resource tools as they become available concerning the implementation.

Access and bookmark the MAC's website, particularly any part of the site devoted to information about the MAC transition/implementation) and visit it regularly. The MAC may have a new website that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.

Review the frequently asked questions (FAQs) on the MAC's website.

Participate in the MAC's advisory groups and "Ask the Contractor" teleconferences. (Note that these advisory groups are usually limited in size.) Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC!

Review the MAC's local coverage determinations (LCDs) as they may be different from the outgoing contractor's LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and website for information regarding potential changes to the LCDs.

Two-three months prior to cutover

- **Complete and return your Electronic Funds Transfer (EFT) agreements.** CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC **and, if you are not on EFT, this may be a good opportunity to consider enrollment in EFT.** (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and submit it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. If you fail to submit the CMS-588 form as required, the new MAC will place you in a "Do Not Forward" (DNF) status as required by Chapter 1, Section 80.5 of the *Medicare Claims Processing Manual*. Contact your MAC with any questions concerning the agreement.

The CMS-588 form may be found at <http://www.cms.gov/cmsforms/downloads/CMS588.pdf>.

You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's website. Your current contractor may also provide instructions on its website on accurately completing the form.

- Your new MAC may also request you to execute a new Electronic Data Interchange (EDI) Trading Partner Agreement as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available at <http://www.cms.gov/EducationMaterials/downloads/TradingPartner-8.pdf>.
- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their website for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these submitter IDs and passwords to you in hardcopy or electronically. **You don't need to do anything to get the new IDs;** however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.
- **Contact your claims processing vendor, billing department, and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"
- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.
- Be aware of the last date you can receive and download electronic remittance advices (ERAs) from your outgoing contractor.
- Be aware that some MACs may offer participation in an "early boarding" process for electronic claim submission and/or electronic remittance advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password –watch for and document them for use after cutover to the MAC.

Cutover weekend

Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend (weekend prior to cutover). Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.

Preparing for transition to a Medicare administrative contractor (continued)

Be aware that providers may also experience system [bb] “dark days” [eb] around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to Fiscal Intermediary Standard System (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

Be aware that some interactive voice response (IVR) functionality may also be unavailable during a dark day.

Post-cutover

- The first week or two may be extremely busy at the MAC. The outgoing Medicare contractor will have the “in-process” work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll-free number for use.
- Be prepared that you may experience longer than normal wait times for customer service representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC’s staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Learn how to use the MAC’s IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the customer service representative (CSR) line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.
- Check the MAC’s outreach and education event schedule on the MAC’s and outgoing contractor’s websites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.
- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that there will be changes to PO Boxes and addresses for the submission of requests for redeterminations (appeals), inquiries, and written reopening requests.
- Be aware that the MAC may edit claims differently from your outgoing contractor, so it is important to review your remittance advices (RAs) carefully to identify when this occurs.
- Be aware that you may experience changes in RA coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS post-cutover monitoring

Post-cutover is the CMS-designated period of time beginning with the MAC’s operational date. During the post-cutover period, CMS will monitor the MAC’s operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

Additional assistance

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A is a summary of what you need to do and information you will need;
- Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation, and
- Attachment C may be used to assist you in tracking major MAC milestones.

Additional information

The following **MLN Matters** article provides additional information about the MAC implementation process:

- MM5979: “Assignment of Providers to Medicare Administrative Contractors” located at <http://www.cms.gov/MLNMattersArticles/downloads/mm5979.pdf>.
- MM6207: “Initial Enrollment Assignment for Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs)”, located at <http://www.cms.gov/MLNMattersArticles/downloads/MM6207.pdf>.

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

Preparing for transition to a Medicare administrative contractor (continued)

Attachment A

Timeline and checklist for preparing for MAC implementation

Checklist item	Input
Scheduled Award Date:	
Actual Award Date:	
MAC Contractor:	
MAC Contractor Number:	
MAC Mailing Address:	
MAC Scheduled Dark Days:	
MAC Web site:	
MAC Contact Center Number:	1-800-
MAC EDI Mailing Address:	

90 days before cutover

1. Visit MAC website and bookmark for future use
2. Join the MAC listserv
3. Monitor:
 - LCDs published by the new MAC; compare current LCD's that affect your practice's services.
4. Review:
 - Provider enrollment status for all providers, update as needed.
 - Pay-to address information for practice/providers, update as needed.
5. Contact:
 - Your practice management/billing software vendor to determine if your system will be able to send & receive data to/from the new MAC.
 - Claims clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.
 - Your billing department, vendor, or clearinghouse to be sure they are aware of the changes communicated from the incoming and outgoing contractors. To avoid delays in claims submission and processing and appeals requests submission, effective dates must be communicated to your appropriate provider staff and resources.

75 days before cutover

1. Check the MAC's website and/or Listserv for outreach programs, educational and informational events, FAQs, and conference calls.
2. Check your state's medical society or local provider organization website for MAC transition information, MAC coordinators.

60 days before cutover

1. Submit CMS-588 – EFT form(s) to the new MAC, if needed.
2. Register for electronic remittance advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample remittance advice (RA). RA codes are standard but use of codes may vary across contractors.

45 days before cutover

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

30 days before cutover

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims if you have not done so by now.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of the MAC website and e-mail from the MAC listserv.

15 days before cutover

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational in the new environment.
3. Collect and record all MAC telephone and fax numbers for: general inquiry customer service, provider enrollment, provider relations, EDI and ERA.
4. Become familiar with the MAC IVR query system by taking advantage of educational opportunities as most IVRs are not available until cutover because new outgoing claims/NPI information has not been loaded for accessibility.
5. Continue daily monitoring of e-mail from the MAC listserv and the MAC website.

10 days before cutover

1. Address any existing open items.

Preparing for transition to a Medicare administrative contractor (continued)

- | | |
|---|---|
| <p>2. Continue daily monitoring of e-mail from the MAC listserv and the MAC website.</p> <p>5-10 days after cutover</p> <p>1. Begin submitting claims to the new MAC.</p> <p>2. Continue daily monitoring of the MAC listserv.</p> | <p>3. Monitor and follow up on the MAC open item list.</p> <p>30 days after cutover</p> <p>1. Electronic payments should be arriving by now.</p> <p>2. Payments for paper claims may be arriving by now.</p> |
|---|---|

Attachment B

Schedule of MAC contractor training classes

Scheduled Date	Title of Class	Attendee

Schedule of MAC conferences

Scheduled Date	Conference Subject	Attendee

Attachment C

Important MAC implementation dates

Event	Date
MAC dark days	
Cutoff date for claims submission to the outgoing contractor	
Last date outgoing contractor will make payment	
Last date outgoing contractor will have telephone/customer service	
Last date outgoing contractor will send file to bank	
Last date to retrieve ERAs from outgoing contractor	
Date MAC will accept electronic claims	
Date MAC will accept paper claims	
Date MAC will/claim cycle begins	
Date MAC will accept written appeals requests (redeterminations)	
First anticipated MAC payment date	
Date MAC begins customer service	

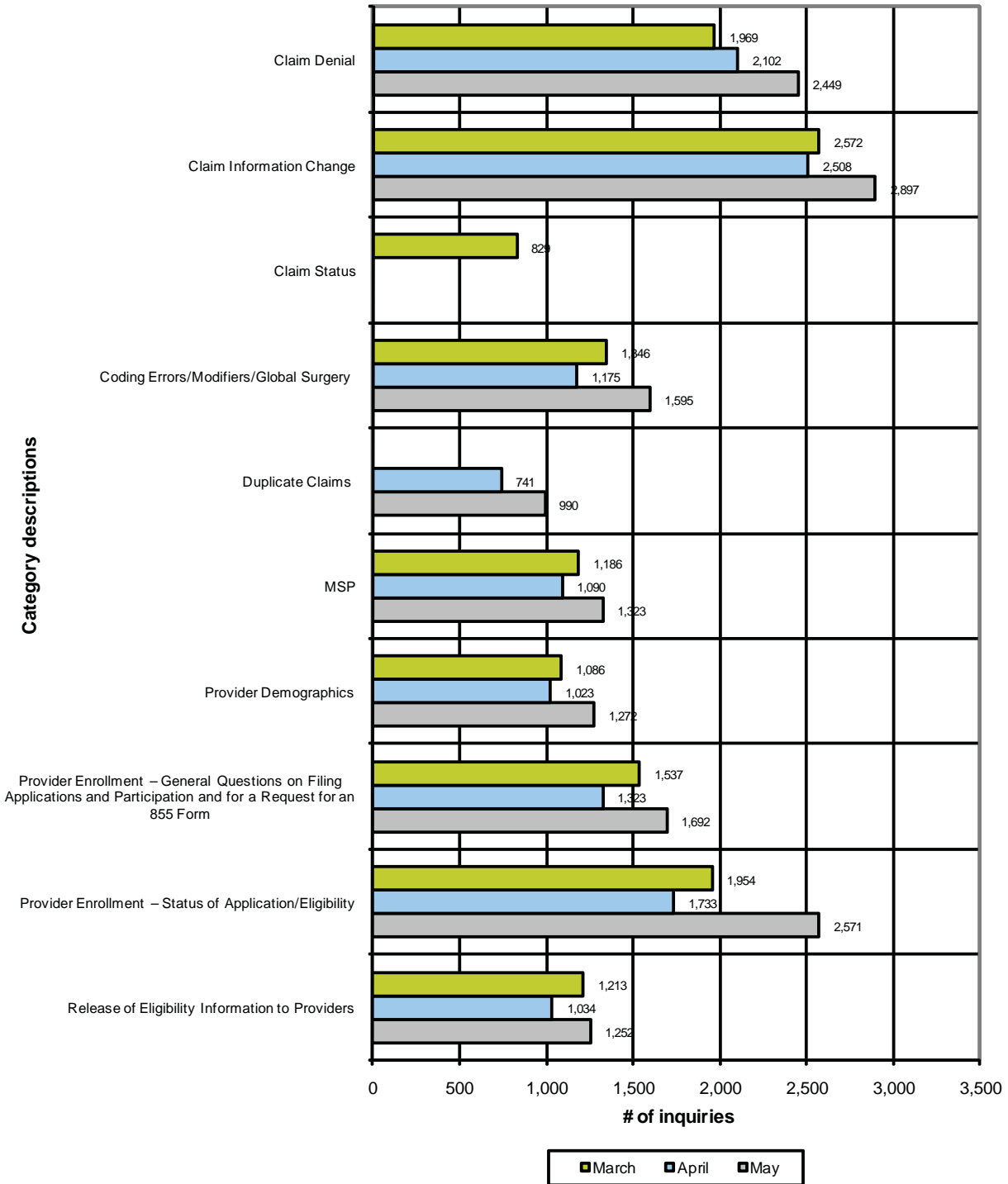
MLN Matters® Number: SE1017
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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Top inquiries, denials, and return unprocessable claims for March-May

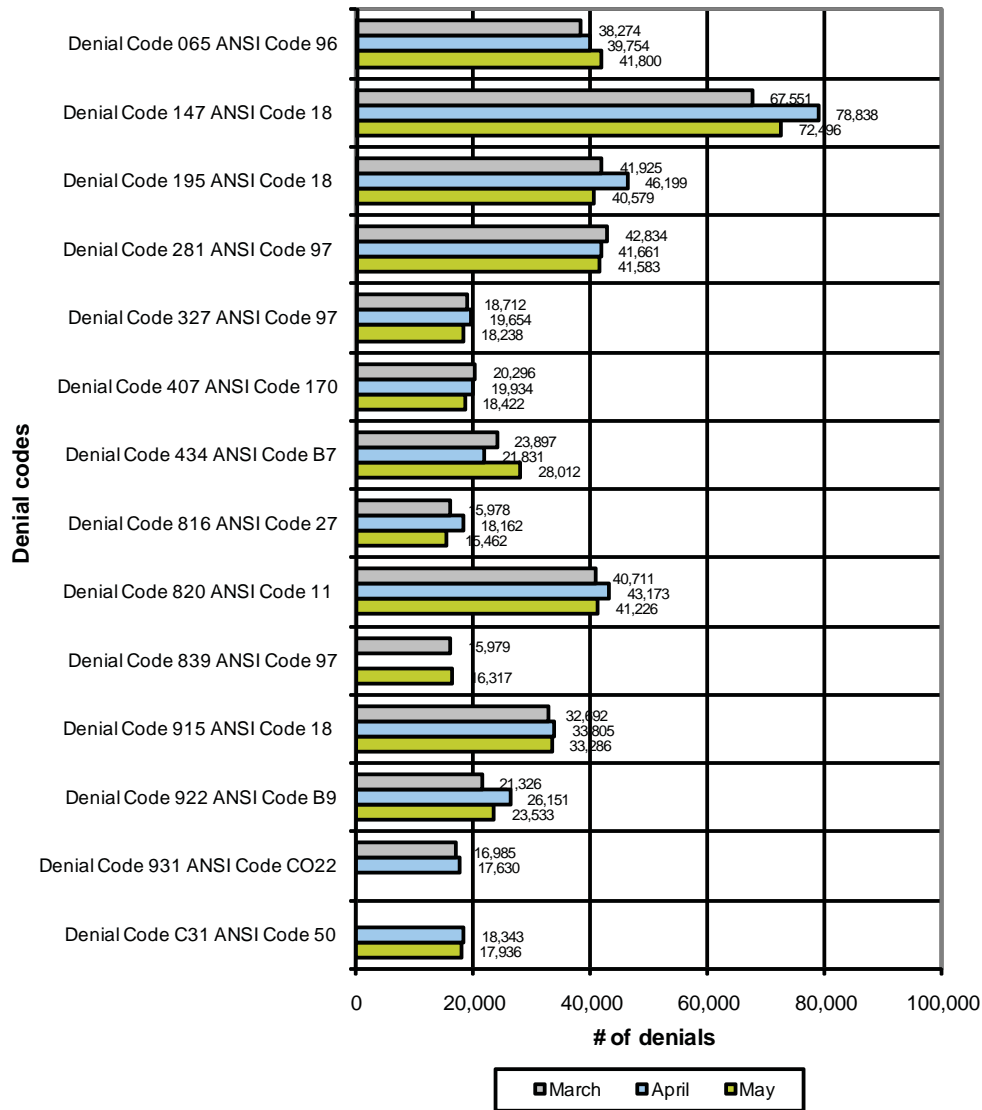
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during March–May 2010. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at http://medicare.fcsom.com/Inquiries_and_denials/index.asp.

Florida Part B top inquiries for March-May 2010



Top inquiries, denials, and return unprocessable claims for March-May (continued)

Florida Part B top denials for March-May 2010



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.

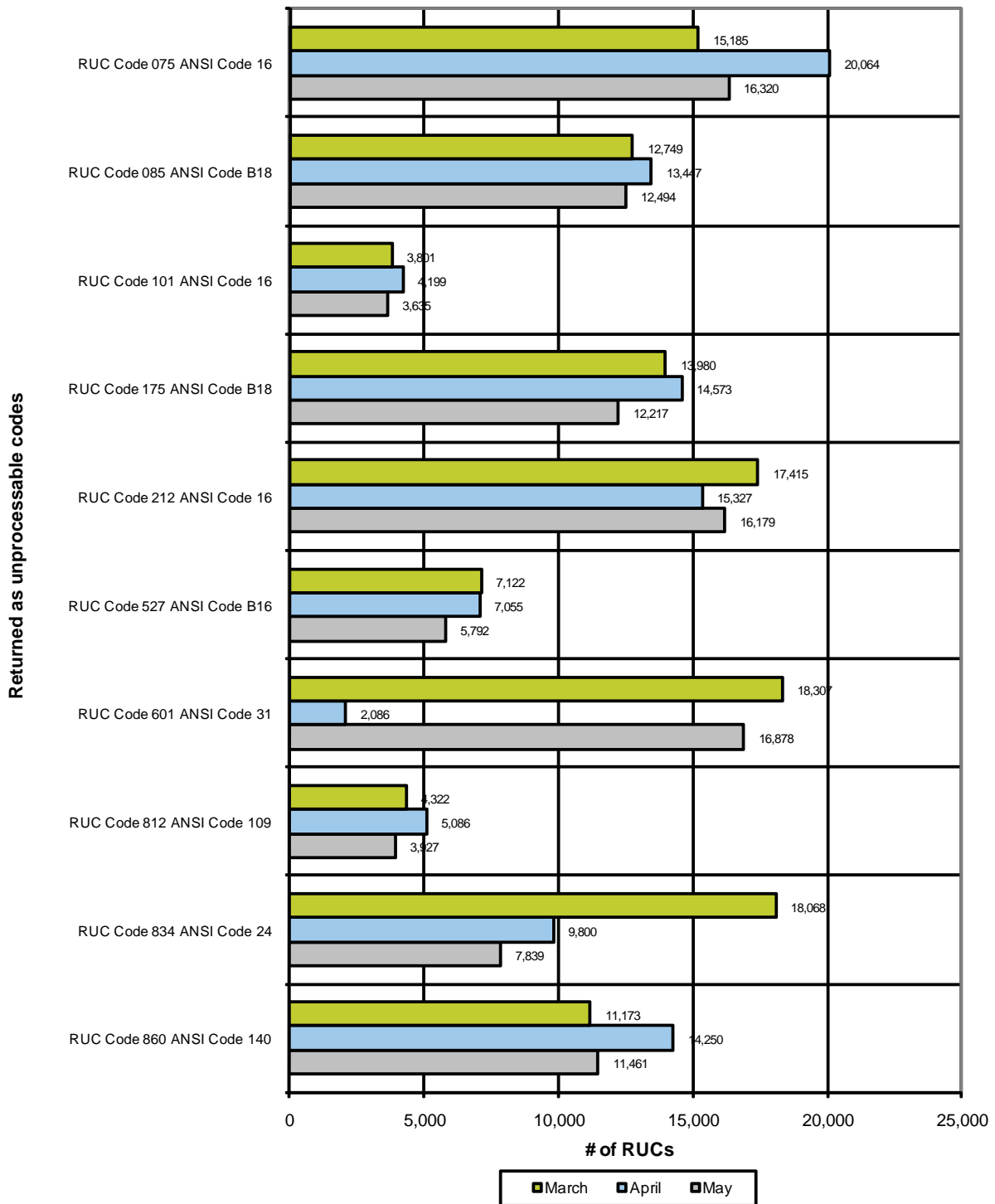
- To access the *Duplicate Claims – Part B WBT*, visit our FCSO Medicare Training website www.fcsomedicaretraining.com.

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.fcsoc.com/Events/> to learn about upcoming events and link to our online learning system to review encore presentations of webcasts conducted on this topic.

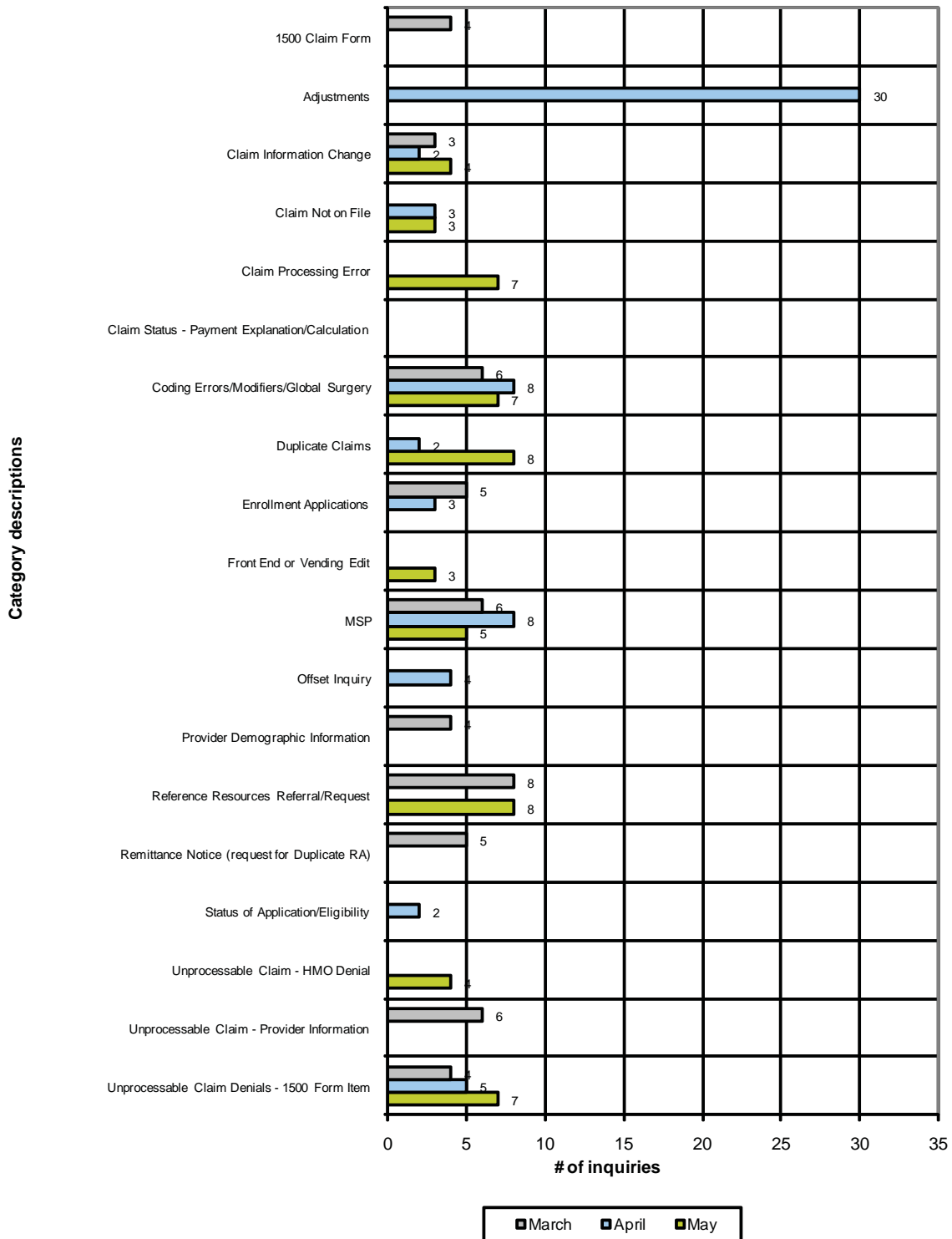
Top inquiries, denials, and return unprocessable claims for March-May (continued)

Florida Part B top return as unprocessable claims (RUC) for March-May 2010



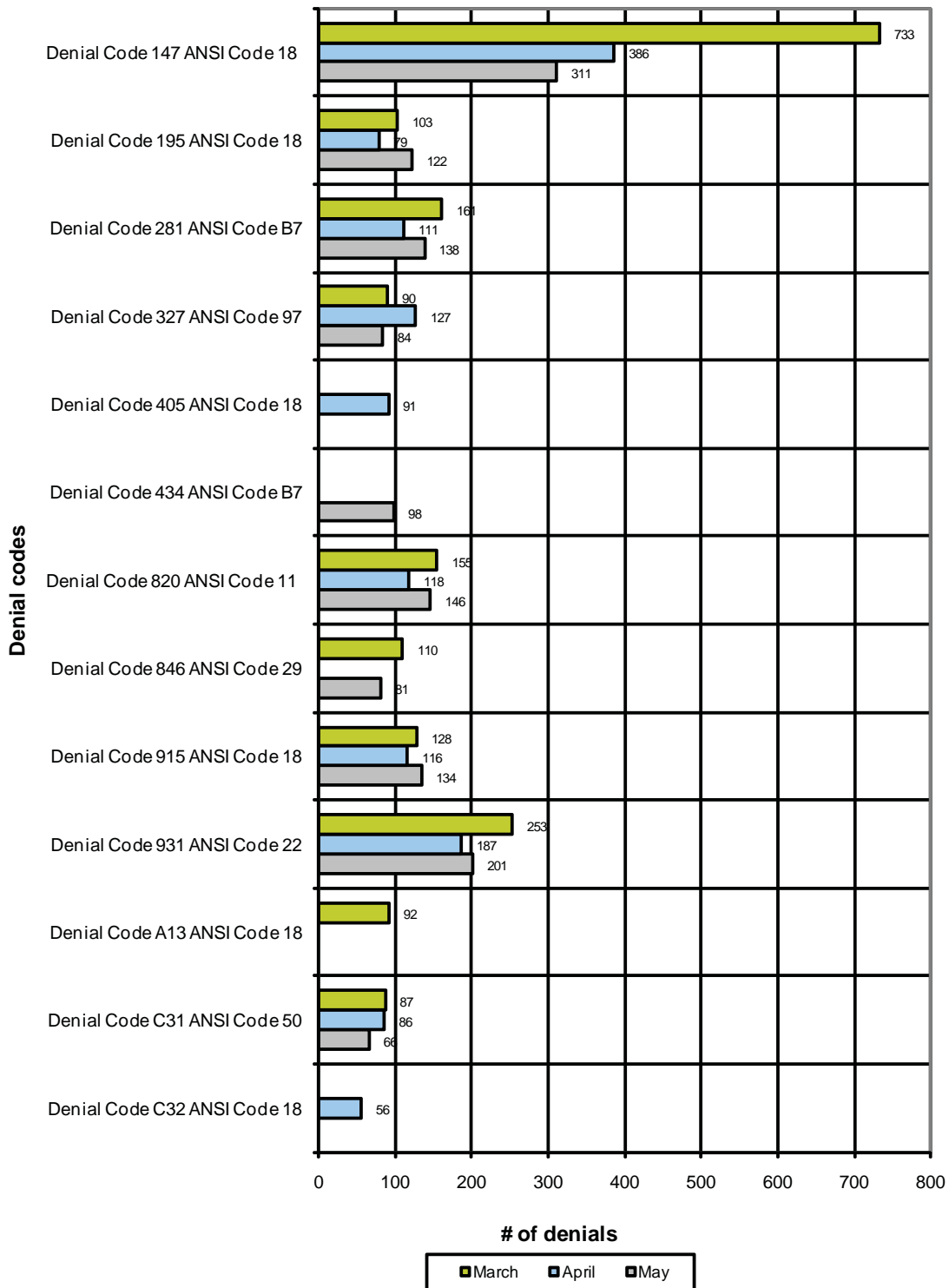
Top inquiries, denials, and return unprocessable claims for March-May (continued)

U.S. Virgin Islands Part B top inquiries for March-May 2010



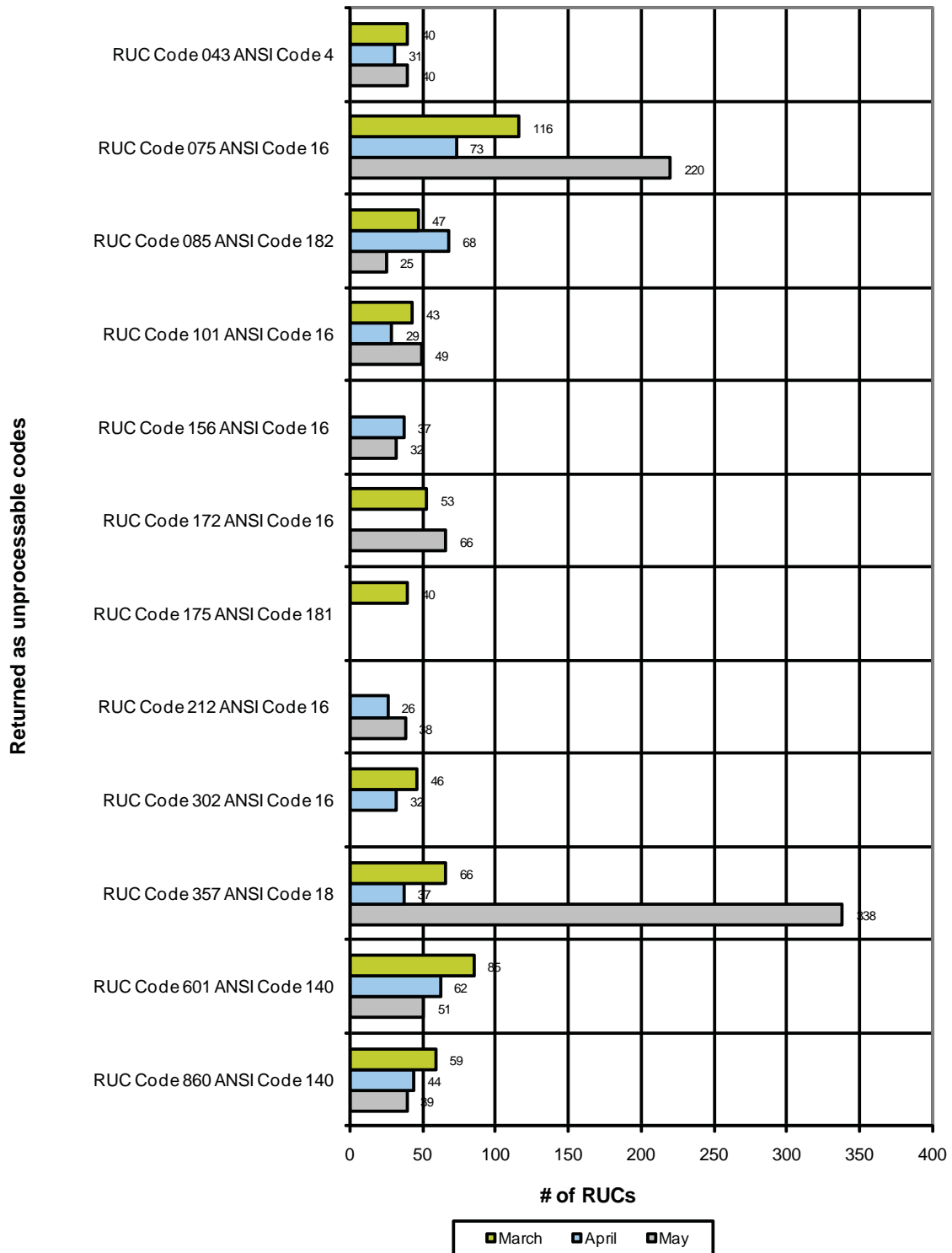
Top inquiries, denials, and return unprocessable claims for March-May (continued)

U.S. Virgin Islands Part B top denials for March-May 2010



Top inquiries, denials, and return unprocessable claims for March-May (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for March-May 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.fcsso.com>, click on the “Join eNews” link located on the upper-right-hand corner of the page and follow the instructions.

More information

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

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

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Advance beneficiary notice

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

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

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

Revisions to LCDs

G0430: Qualitative drug screening – revision to the LCD

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

The local coverage determination (LCD) for qualitative drug screening was most recently revised on April 1, 2010. Since that time, a revision was made to the “Indications” section of the LCD. Under the “Indications” section of the LCD, the statement “For management of chronic pain patients when there is a high pre-test suspicion of non-adherence to the prescribed drug regimen as documented in the patient’s medical record” was deleted. Additionally, the statements “The management of patients with chronic pain in which there is a significant pre-test probability of non-adherence to the prescribed drug regimen as documented in the patient’s medical record” and “The management of patients with chronic pain in a designated pain management clinic where this select population has a significant pretest probability of drug interactions and side effects” were added under the “Indications” section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after June 1, 2010**, for services rendered **on or after January 25, 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.

J7187: Hemophilia clotting factors – revision to the LCD

LCD ID number: L29187 (Florida)

LCD ID number: L29345 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hemophilia clotting factors was most recently revised on January 1, 2010. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) Transmittal 1984, change request 7008, dated June 11, 2010, to add HCPCS code C9267 to the “CPT/HCPCS Codes” section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 6, 2010**, for services rendered **on or after July 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.

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

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

LCD ID number: L29288 (Florida)

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

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on June 7, 2010. Since that time, a revision was made to the LCD to remove CPT code 50593 (*Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy*) based on review of peer-reviewed literature that was submitted with a reconsideration request along with additional researched literature that supports coverage for this service.

Currently, First Coast Service Options Inc. (FCSO) does not have a local coverage determination (LCD) outlining coverage criteria for this service. Therefore, it is expected that claims for this service would be medically reasonable and necessary for the patient and performed according to standards of care. In order for a service to be considered medically reasonable and necessary, all of the following criteria must be met (CMS Internet-only Manual, Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.1):

- Not experimental or investigational
- The duration and frequency considered appropriate for the service
- Furnished in accordance with accepted standards of medical practice for the treatment of the patient’s condition
- Furnished in a setting appropriate to the patient’s medical needs and condition
- Ordered and furnished by qualified personnel, and
- Meets but does not exceed the patient’s medical need.

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

Medical records must be made available to FCSO Medicare upon request.

Effective date

This LCD revision is effective for services rendered **on or after June 7, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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70544: Magnetic resonance angiography (MRA) – revision to the LCD

LCD ID number: L29218 (Florida)

LCD ID number: L29447 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for magnetic resonance angiography (MRA) was most recently revised on October 1, 2009. Since that time, the LCD has been revised in the “Indications and Limitations of Coverage and/or Medical Necessity”, “CPT/HCPCS Codes” and “ICD-9 Codes that Support Medical Necessity” sections of the LCD to add the following HCPCS codes for ambulatory surgical centers (ASCs) only: C8900, C8901, C8902, C8909, C8910, C8911, C8912, C8913, C8914, C8918, C8919 and C8920.

Effective date

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

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

Additional Information

84295: Serum sodium – update to previous billing instructions**82435: Chloride; blood**

An article published in the January 2010 *Medicare B Update!* (page 51) of the publication may have led providers to a misunderstanding regarding the correct use of modifier CB (Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD (end-stage renal disease) beneficiary’s dialysis benefit, is not part of the composite rate, and is separately reimbursable). The purpose of the article was to advise providers that a correction had been made regarding incorrect denials of CPT code 84295 (*Sodium, serum, plasma or whole blood*), when billed with the appropriate modifier to indicate that the services are outside of the ESRD composite rate. The article instructed providers to append at least modifier CB to the line item for CPT code 84295 in order to prevent the test from denying as part of the composite rate payment.

Modifier CB is a valid modifier and used for ESRD purposes. It does not, however, prevent a test from denying as being included in the ESRD composite rate. There are three modifiers:

- CD** AMCC (automated multi-channel chemistry) test has been ordered by an ESRD facility or MCP (monthly capitation payment) physician that is part of the composite rate and is not separately billable
- CE** AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity
- CF** AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable) used to identify the various payment situations for ESRD AAMC tests. Modifier CF is used on AMCC tests to indicate that services are ordered by an ESRD facility or MCP physician, and are not part of the composite rate.

Modifier CB is used on claims for diagnostic services related to the dialysis treatment for ESRD beneficiaries in a skilled nursing facility Part A stay. It is used to prevent claims from denying as part of consolidated billing. Although CMS removed the requirement for facilities to verify whether a patient is in a skilled nursing facility Part A stay, modifier CB is only used when it has been determined that the beneficiary has ESRD entitlement, the tests are related to dialysis treatment and not included in the dialysis facility’s composite rate payment, and that the ordering physician is providing care in the dialysis facility.

84295: Serum sodium -- update to previous billing instructions (continued)

The Centers for Medicare & Medicaid Services (CMS), Publication 100-02, Chapter 11, Section 30.2.2 lists *CPT* code 84295 as excluded from the composite rate for hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemofiltration patients. This same section also lists *CPT* code 82435 (*Chloride; blood*) as excluded from the composite rate for CAPD (Continuous ambulatory peritoneal dialysis) patients. Therefore, providers who are billing for the scenario outlined in the section above for *CPT* codes 84295 and/or 82435 with ICD-9-CM code 585.6 **should begin appending the modifier CF** for claims processed **on or after July 15, 2010**, for services rendered **on or after October 1, 2006**.

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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>.

Educational Events

Upcoming provider outreach and education events July 2010

Hot Topics: Medicare Part B

When: July 14

Time: 11:30 a.m.-1:00 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 <http://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 <http://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.fcsso.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.fcsso.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 26 is National Senior Health and Fitness Day

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

Medicare-covered preventive services

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

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

For more information

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

The Medicare Learning Network (MLN) Preventive Services Educational Products Web Page: This page provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff.

http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals: This comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare.

http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Quick Reference Information: Medicare Preventive Services: This chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy-to-use quick-reference format.

http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

The Preventive Services Educational Products PDF: This PDF document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more.

http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf

To order hard copies of certain MLN products, please visit the MLN homepage at <http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “MLN Product Ordering Page.”

For more information about National Senior Health and Fitness Day, please visit the official website at <http://www.fitnessday.com/senior/index.htm>.

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

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

Source: CMS PERL 201005-36

June 14-20 is National Men's Health Week and June 20 is Father's Day

In the spirit of National Men's Health Week and Father's Day, the Centers for Medicare & Medicaid Services (CMS) asks providers to help keep men with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services.

What you can do

Medicare provides coverage for a variety of preventive services for eligible Medicare beneficiaries. As a trusted source of health care information, you are in a unique position to encourage your patients with Medicare to get covered screenings to detect certain conditions early, when treatment works best.

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 preventive services and screenings covered by Medicare.

- **The Medicare Learning Network (MLN) Preventive Services Educational Products Web page** – provides descriptions and ordering information for *Medicare Learning Network (MLN)* preventive services educational products and resources for health care professionals and their staff.
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare.
http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- **Quick Reference Information: Medicare Preventive Services** – this chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy-to-use quick-reference format.
http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **The Preventive Services Educational Products PDF** – this PDF document contains links to downloadable versions of the many products the *MLN* has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more.
http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf

To order hard copies of certain *MLN* products, please visit the *MLN* homepage at <http://www.cms.gov/mlnngeninfo>. Scroll down to “Related Links Inside CMS” and click on “MLN Product Ordering Page”

For more information about National Men's Health Week, please visit the official website at <http://www.menshealthmonth.org/week>.

Source: CMS PERL 201006-18

Web-based training for Medicare preventive services

The Centers for Medicare & Medicaid Services (CMS) would like to remind you that the Medicare Preventive Services Series Part 3 Web-based training course (WBT) is currently available for free.

This course includes coverage, coding, and billing information for Medicare coverage of the following preventive services:

- Screening mammography
- Screening pap tests and pelvic examinations
- Colorectal cancer screening
- Bone mass measurements
- Glaucoma screening

Taking this online course will help you and your staff understand Medicare rules surrounding these important benefits. Not only that, but if you pass this course, you can earn continuing education credit. You can access this course, free of charge, at any time, by visiting the “Preventive Services Educational Products” page at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp. Scroll down to the “Related Links Inside CMS” section and click on “Web Based Training Modules” to take the course.

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

Source: CMS PERL 201005-42

June 6 is National Cancer Survivors Day

In the spirit of National Cancer Survivors Day, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for a variety of preventive services, including certain cancer screenings. By encouraging your patients with Medicare to take advantage of covered screenings, you can help them lead healthier lives.

Medicare-covered cancer screenings

Medicare provides coverage for the following cancer screenings for eligible Medicare beneficiaries:

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

Additional information

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

- **The Medicare Learning Network (MLN) Preventive Services Educational Products Web page** – this page provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff. http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- **Cancer Screenings brochure** – this brochure provides coverage information on the Medicare-covered cancer screenings previously listed. http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare, including cancer screenings. http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

- **Quick Reference Information: Medicare Preventive Services** – this chart contains coverage, coding, and payment information for the many preventive services covered by Medicare, including cancer screenings, in an easy-to-use quick-reference format.

http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

- **The Medicare Preventive Services Series: Part 3** – this Web-based training (WBT) includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, pap tests, and pelvic exams. 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 “Web Based Training (WBT) Modules.”
- **Preventive Services Educational Products** – this PDF document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more. http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf

To order hard copies of certain MLN products, please visit the MLN homepage at <http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “MLN Product Ordering Page.”

For more information about National Cancer Survivors Day, please visit the official website at <http://www.ncsdf.org>.

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

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

Source: CMS PERL 201006-03

New from the Medicare Learning Network

The Medicare Preventive Services Resources CD (ICN #6640), which contains PDF (portable document file) format of the Centers for Medicare & Medicaid Services (CMS) Medicare preventive service educational products on a single convenient CD-ROM, is now available for order through the *Medicare Learning Network* – free of charge.

The CD includes the following products:

- The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals
- All three quick reference billing charts (Medicare Preventive Services, The ABCs of Providing the Initial Preventive Physical Examination, and Medicare Immunization Billing)

All seven brochures (Adult Immunization, Bone Mass Measurements, Cancer Screenings, Diabetes-Related Services, Expanded Benefits, Glaucoma Screening, and Smoking and Tobacco-Use Cessation Counseling Services).

To order a free copy of the CD, please visit the Preventive Services Educational Products page on the CMS website at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp. Scroll down to the “Related Links Inside CMS” section and click on “MLN Product Ordering.”

Source: CMS PERL 201006-04

Other Educational Resources

Medicare educating beneficiaries on the Affordable Care Act

Medicare beneficiaries will soon receive important information in the mail about the immediate benefits they may see from the enactment of the Affordable Care Act.

The mailing from the Centers for Medicare & Medicaid Services (CMS), which will be available in both English and Spanish, outlines key provisions of the Affordable Care Act that are important for people with Medicare as well as members of their families.

Medicare mails the Medicare & You handbook to all beneficiary households every fall to provide people with Medicare the most up to date information about changes in Medicare. These annual mailings have from time to time been supplemented with additional mailings that inform beneficiaries about major changes in the law that significantly affect Medicare.

“It’s important that our Medicare beneficiaries get facts about this important new law timely so they can learn what stays the same and what will change and improve in terms of their benefits,” said Marilyn Tavenner, acting CMS administrator. “As a trusted resource for beneficiaries and their families, we believe that this information will help to inform them about the Affordable Care Act and remind them to be on the alert for any scams asking for personal information. CMS has learned from implementing previous major pieces of health reform legislation like Medicare Part D that unfortunately new opportunities for Medicare beneficiaries also bring new opportunities for scam artists to try and defraud seniors.”

“The new law not only strengthens Medicare, but also ensures the guaranteed benefits that beneficiaries have come to rely upon don’t change,” said Tavenner. “CMS is viewed by beneficiaries as the official and trusted source of information, so it is critical that we reach out quickly to ensure beneficiaries understand their Medicare coverage and how it will improve.”

The first benefit that several million Medicare beneficiaries will receive as a result of the passage of the new law is a one-time check for \$250, if they enter the Part D donut hole and are not eligible for Medicare extra help. The donut hole is the period in the prescription drug benefit in which the beneficiary pays 100 percent of the cost of their drugs until they hit the catastrophic coverage.

“The \$250 check that some beneficiaries will soon see in the mail following the brochure for all Medicare beneficiaries is the first step towards the closing of the coverage gap,” said Tavenner. “Next year, all beneficiaries who enter the gap will get a 50 percent discount for covered brand name Part D drugs, and by 2020 will no longer have a gap in coverage.”

In addition to the rebate check, the new mailing to beneficiaries outlines other benefits available under the Affordable Care Act. Beginning next year, the Affordable Care Act ensures that Medicare beneficiaries will get preventive care services like colorectal cancer screening and mammograms without cost-sharing, in addition to an annual “wellness visit.” The law also includes new tools to help fight fraud by helping Medicare crack down on criminals who are seeking to scam seniors and steal taxpayer dollars.

Because Medicare is a trusted resource for beneficiaries and their family members, the mailing encourages them to log on to <http://www.medicare.gov/> or call 1-800-MEDICARE to get their questions about Medicare or the Affordable Care Act answered.

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

Source: CMS PERL 201005-37

EHR incentive programs Web page now available

The Centers for Medicare & Medicaid Services (CMS) has launched the official Web page for the Medicare & Medicaid Electronic Health Record (EHR) Incentive Programs, available at <http://www.cms.gov/EHRIncentivePrograms/>. This page provides the most up-to-date, detailed information about the EHR incentive programs.

The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Bookmark this site and visit often to learn about who is eligible for the programs, how to register, meaningful use, upcoming EHR training and events, and much more.

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

Source: CMS PERL 201006-21

New booklet for using the Medicare coverage database

Do you ever wonder about how to utilize search tools in selected areas of the Centers for Medicare & Medicaid Services website? The searchable Medicare coverage database (MCD) contains all Medicare national coverage determinations, national coverage analyses, local coverage determinations, and local policy articles. The *Medicare Learning Network (MLN)* has produced a “how to” booklet (2.5 MB) that provides an overview of the MCD and teaches users how to use the search, index, report and download features. The revised *How to Use The Medicare Coverage Database* booklet may be located at <http://www.cms.gov/MLNProducts/MPUB/itemdetail.asp> on the MLN Publications page. Use search key words “how to” to locate this publication quickly. Understanding the search tool is the best way to find the information for which you are looking.

Source: CMS PERL 201005-42

Revised – MLN Guided Pathways to Medicare Resources

Feeling lost in your search for Medicare knowledge? Let MLN Guided Pathways get you back on track. With the revised (April 2010) Guided Pathways to Medicare Resources, available at http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp, finding Medicare information has never been so easy.

Guided Pathways leads Medicare fee-for-service providers through a variety of resources that are organized by important topics such as billing, coverage, and reimbursement, and are offered in basic, intermediate, and advanced levels. Explore these easy-to-navigate online guides to quickly find the information you need on important Medicare policy and requirements.

Source: CMS PERL 201005-42

New ICD-10 FAQs from CMS

The Centers for Medicare & Medicaid Services (CMS) has posted 11 new frequently asked questions (FAQs) about the ICD-10 implementation. To access these FAQs, please visit the CMS ICD-10 Web page at <http://www.cms.gov/ICD10/>. Select the “Medicare Fee-for-Service Provider Resources” link on the left side of the page, scroll down the page to the “Related Links Inside CMS” section, and select “ICD-10 FAQs.”

Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

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

Source: CMS PERL 201005-40

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/prevaling 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@fcsso.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.fcsso.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/prevaling charges or fee schedule:

Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

E-mail address: AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:

1-866-270-4909

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 []				
<i>Please write legibly</i>			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 ◆