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.fcso.com/*.

Routing Suggestions:

- ❑ Physician/Provider
- ❑ Office manager
- ❑ Billing/Vendor
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- ❑ 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.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

In addition to the above, other sections include:

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

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

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

GA modifier and appeals

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

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

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

Find out first: Subscribe to FCSO eNews

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

Ambulance

Definition of ambulance services

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

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7058 which updates the *Medicare Benefit Policy Manual* (Chapter 10, Section 30.1.1) to incorporate the application of basic life support (BLS) – emergency; advanced life support level 1 (ALS1), and emergency and advanced life support level 2 (ALS2) information. No new policy is presented but the CR 7058 updates the relevant manual section to reflect current policy. The updated manual section is attached to CR 7058.

Background

CMS issued MM7058 to update the relevant manual sections and provides the following application-based examples to accompany the definitions of BLS, ALS1 and ALS2 as follows:

Basic life support (BLS) emergency
Application: The determination to respond emergently with a BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced life support, level 1 (ALS1) - emergency
Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advance life support, level 2 (ALS2)
Application: Crystalloid fluids include fluids such as five percent dextrose in water, saline and lactated ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

In other words, the administration of 1/3rd of a qualifying dose three times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given three times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal three times X. Thus, if three administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of intravenous (IV) epinephrine in the treatment of pulseless ventricular tachycardia/ventricular fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), advanced cardiac life support (ACLS) protocol, calls for epinephrine to be administered in one mg increments every three to five minutes. Therefore, in order to receive payment for an ALS2 level of service based in part on the administration of epinephrine, three separate administrations of epinephrine in one mg increments must be administered for the treatment of pulseless VF/VT.

A second example that would not qualify for the ALS2 payment level is the use of adenosine in increments of two mg, two mg, and two mg for a total of six mg in the treatment of an adult patient with paroxysmal supraventricular tachycardia (PSVT). According to ACLS guidelines, six mg of adenosine should be given by rapid intravenous push (IVP) over one to two seconds. If the first dose does not result in the elimination of the

Definition of ambulance services (continued)

supraventricular tachycardia within one to two minutes, 12 mg of adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of adenosine can be administered for a total of 30 mg of adenosine. Three separate administrations of the drug adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

Additional information

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

The official instruction, CR 7058, issued to your Medicare A/B MAC, carrier and/or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R130BP.pdf*.

MLN Matters® Number: MM7058
Related Change Request (CR) #: 7058
Related CR Release Date: July 30, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R130BP
Implementation Date: January 3, 2011

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Ambulatory Surgical Center

Ancillary services performed in an ambulatory surgical center by other entities

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

Provider types affected

This article is for physicians and other providers submitting claims to Medicare contractors (carriers and Part A/B Medicare administrative contractors [A/B MAC]) for services on the ambulatory surgical centers fee schedule (ASCFS).

What you need to know

This article is based on change request (CR) 7078, which clarifies a requirement originally created in CR 5680 to ensure consistency among Medicare contractors. CR 7078 directs Medicare contractors:

- To deny the technical component for all ancillary services on the ASCFS list billed by specialties other than ASCs and where such services are provided in an ASC setting, and
- To deny globally billed ancillary services on the ASCFS list billed by specialties other than ASCs provided in an ASC setting.

The professional component is the only payment allowed for ancillary codes billed by physicians and must be billed separately.

Background

CR 7078 clarifies a requirement originally created in CR 5680, which is addressed in the *MLN Matters®* article available at *http://www.cms.gov/MLNMattersArticles/downloads/MM5680.pdf*. The CR is intended to ensure consistency among all Medicare contractors. CR 7078 informs those contractors to deny the technical component for all ancillary services appearing on the ASCFS when billed by specialties other than ASCs (specialty 49) when place of service (POS) is ASC (POS = 24). Since the technical component is also included in the global fee, the global payment must also be denied. The professional component is the only payment paid for ancillary codes billed by specialties other than ASCs when POS is the ASC.

When denying the technical component for all ancillary services on the ASCFS list billed by specialties other than 49 provided in an ASC setting (POS 24), Medicare contractors will use the following messages:

Claim adjustment reason code 171 – Payment is denied when performed/billed by this type of provider in this type of facility. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remittance advice remark code 97 – Not paid to practitioner when provided to patient in this place of service. Payment included in reimbursement issued the facility.

Remittance advice remark code M16 – Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

When denying globally billed ancillary services on the ASCFS list if billed by specialties other than 49 provided in an ASC setting (POS 24), Medicare will use the following messages:

Remittance advice remark code N200 – The professional component must be billed separately

Claim adjustment reason code 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Ancillary services performed in an ambulatory surgical center by other entities (continued)

Additional information

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

The official instruction, CR 7078, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2020CP.pdf*.

MLN Matters® Number: MM7078
Related Change Request (CR) #: 7078
Related CR Release Date: August 6, 2010
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Related CR Transmittal #: R2020CP
Implementation Date: September 7, 2010

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Audiology

Revisions and re-issuance of audiology policies

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

Note: This article was revised on July 26, 2010, to include revised effective and implementation dates, a revised change request (CR) release date, transmittal numbers, and Web addresses for accessing the transmittals. In addition, claim adjustment reason codes and remittance advice remark codes have been added, where appropriate. The Web address for accessing the audiology code list was also revised. All other information is the same. This information was previously published in the June 2010 *Medicare B Update!* pages 11-13.

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 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 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 (ll) (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 by 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) 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/PhysicianFeeSched/50_Audiology.asp* for a listing of

Revisions and re-issuance of audiology policies (continued)

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:

- 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, contra lateral masking, and/or
- 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 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. In denying such claims, Medicare will use:
  - CARC 170 (Payment is denied when performed/billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present), and
  - Remittance advice remark code (RARC) MA102 (Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider).
- 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. Such claims will be denied using claim adjustment reason code (CARC) 170 (Payment is denied when performed/billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present).

Revisions and re-issuance of audiology policies (continued)

- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. In denying claims under this provision, Medicare will use:
  - CARC 185 (The rendering provider is not eligible to perform the service billed. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present), and
  - RARC M136 (Missing/incomplete/invalid indication that the service was supervised or evaluated by 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/PhysicianFeeSched/50_Audiology.asp*).
- 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/PhysicianFeeSched/50_Audiology.asp* 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 also 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/R129BP.pdf*. The other transmittal modifies the *Medicare Claims Processing Manua*l and it is at *http://www.cms.gov/Transmittals/downloads/R2007CP.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*.

MLN Matters® Number: MM6447 *Revised*
Related Change Request (CR) #: 6447
Related CR Release Date: July 23, 2010
Effective Date: August 11, 2010
Related CR Transmittal #: R129BP and R2007CP
Implementation Date: August 11, 2010

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Durable Medical Equipment

October update to the 2010 DMEPOS fee schedule

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs]), and/or regional home health intermediaries [RHHIs]) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider action needed

This article is based on CR 7070, which provides the required quarterly update of the 2010 DMEPOS fee schedule. Be sure billing staffs are aware of the update.

Background

The DMEPOS fee schedule is updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at *https://www.cms.gov/manuals/downloads/clm104c23.pdf*.

Key points of CR 7070

- Per transmittal 686 (change request 6743), the claims filing jurisdiction for HCPCS code L8509 (Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type) is changing from the DME MACs to the A/B MACs/Part B carriers, effective October 1, 2010. To reflect this change, the claims jurisdiction for code L8509 will change in the DMEPOS fee schedule file to local carrier as part of this update.
- As part of this update, the Alaska and Hawaii fee schedule amounts for HCPCS code E0973 (Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each) are being revised in order to correct errors made in the calculation of the fee schedule amounts. Medicare contractors will adjust previously processed claims for code E0973 with dates of service on or after January 1, 2010, if they are resubmitted as adjustments.

Additional information

The official instruction, CR 7070, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2006CP.pdf*.

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

An earlier *MLN Matters*® article, MM6743 on the change in claims filing jurisdiction for tracheo-esophageal voice prostheses Healthcare Common Procedure Coding System (HCPCS) code may be reviewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM6743.pdf*.

MLN Matters® Number: MM7070
Related Change Request (CR) #: 7070
Related CR Release Date: July 23, 2010
Effective Date: January 1, 2010 for codes in effect then, October 1, 2010 for other changes
Related CR Transmittal #: R2006CP
Implementation Date: October 4, 2010

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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.

Surgery

Payment for implantable tissue markers and implantable radiation dosimeters

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 who bill Medicare carriers or Part A/B Medicare administrative contractors (A/B MAC) for providing services for implantable tissue markers or implantable radiation dosimeters to Medicare beneficiaries.

What you need to know

CR 6968, from which this article is taken, clarifies that the Healthcare Common Procedure Coding System (HCPCS) codes for implantable tissue markers (HCPCS A4648 – Tissue marker, implantable, any type, each) and for implantable radiation dosimeters (HCPCS code A4650 – Implantable radiation dosimeter each) are separately billable, and payable, for physicians when used with *Current Procedural Terminology* (*CPT*) codes *19499, 32553, 49411*, and *55876*.

See the *Background* section for details. You should make sure that your billing staffs are aware of this coding requirement.

Background

Under the Medicare hospital outpatient prospective payment system (OPPS) and the ambulatory surgical center (ASC) payment system, carriers and A/B MACS do not pay hospitals or ASCs separately for HCPCS codes A4648 or A4650; rather, payment for these codes is packaged into the payment for the service in which they are used. Similarly, under the Medicare inpatient prospective payment system (IPPS), payment for these services is bundled into the MS-DRG payment.

Note: Hospitals that are not paid under the OPPS or IPPS are paid for HCPCS code A4648 and HCPCS code A4650 under a variety of other payment mechanisms**.**

CR 6968, from which this article is taken, clarifies that these two HCPCS codes, however, are separately billable, and payable, when billed by physicians and when used with one of the following four *CPT* codes:

19499 *Unlisted procedure, breast*

32553 *Placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter), percutaneous intra-thoracic, single or multiple*

49411 *Placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter), percutaneous intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple*

55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, prostate, single or multiple*

Therefore, effective for dates of service on or after November 6, 2010, your carrier or A/B MAC will pay physicians for these HCPCS codes when the implantable tissue markers or implantable radiation dosimeters are used in conjunction with one of these four *CPT* codes, but will deny payment if one of the above *CPT* codes is not paid on the same claim (or in history) with the same date of service.

When denying your claim for these codes if the qualifying service is not reported on the same date of service, they will use claim adjustment reason code B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.).

Please note that CR 6968 makes no changes in current payment policies for HCPCS code A4648 or HCPCS code A4650 for inpatient or outpatient hospital services, or to ASCs.

Additional information

You may find the official instruction, CR 6968, issued to your carrier or A/B MAC at *http://www.cms.gov/Transmittals/downloads/R745OTN.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: MM6968
Related Change Request (CR) #: 6968
Related CR Release Date: August 6, 2010
Effective Date: November 6, 2010
Related CR Transmittal #: R745OTN
Implementation Date: November 6, 2010

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Override edit for kidney transplant donor claims when the recipient is deceased

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 carriers, fiscal intermediaries (FIs), RHHIs, or Part A/B Medicare administrative contractors (A/B MACs) for live kidney donor and related services for Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6978 which instructs Medicare contractors to override certain edits on claims for donor expenses when the kidney recipient is deceased. Please make sure your billing staff is aware of these changes.

Background

Medicare instructions allow donor expenses incurred after the death of the kidney recipient to be treated as incurred before the death of the kidney recipient. However, some of these claims are being rejected by Medicare systems. CR 6978 corrects this problem for services performed on or after January1, 2011.

Key points of CR 6978

- All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed.
- All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number). Modifier Q3 (Live kidney donor surgery and related services) must appear on the claim.
- For institutional claims which do not require modifiers, Medicare contractors may process the claim when the donor is receiving institutional services related to the donation of the kidney where the transplant recipient has died and the donor receives those services subsequent to the recipient's death.

Additional information

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

The official instruction (CR 6978) issued to your Medicare MAC, carrier, and/or FI may be found at *http://www.cms.gov/Transmittals/downloads/R2008CP.pdf*.

MLN Matters® Number: MM6978
Related Change Request (CR) #: 6978
Related CR Release Date: July 30, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2008CP
Implementation Date: January 3, 2011

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General Coverage

Revisions to claim processing instructions for services rendered in place of service home

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

Provider types affected

This article is for physicians and other providers who bill Medicare contractors (carriers and Medicare administrative contractors [A/B MAC]) for services provided to Medicare beneficiaries in place of service (POS) home (or any other place of service that Medicare contractors consider to be home).

What you need to know

CR 6947, from which this article is taken, represents no change to payment policy. CR 6947 requires that you now enter the address of where services were performed, including the ZIP code, on claims for anesthesia services and every service payable under the Medicare physician fee schedule (MPFS), for services provided in all places of service, including home. This change will be effective for claims that you submit on the 5010 version of the ANSI X12N 837 P electronic form that are processed by Medicare on or after January 1, 2011, and on the CMS-1500 with dates of service on or after January 1, 2011. (Claims submitted on the 4010A1 electronic form are not impacted by this change.) You should make sure that your billing staffs are aware of this change.

Background

Currently, you are required to submit claims for anesthesia services and for services payable under the MPFS with the address and ZIP code of where the service was performed included on the claim for services provided in all places of service (POS), except when the POS is home. In order to stay consistent with the 5010 version of the ANSI X12 N 837 P format (which is to become effective on January 1, 2011) the exception for POS home will no longer be effective.

Specifically, CR 6947 from which this article is taken, announces that effective for claims that you submit using the 5010 version of the ANSI X12N 827 P electronic claim

Revisions to claims processing instructions for services rendered in place of service home (continued)

form that are processed on or after January 1, 2011, and for paper claims that you submit on the CMS-1500 with dates of service on or after January 1, 2011; you will need to submit the address and 5 digit ZIP code (or the 9-digit code when required per the CMS ZIP Code file) of where the service was provided for services performed in all places of service, including POS home-12, (and any other POS that contractors at their discretion consider to be home). Your carrier or A/B MAC will use that ZIP code to determine the correct payment locality.

Additionally, please remember that you cannot submit the CMS-1500 with more than one POS. Separate CMS-1500 claims must be submitted for each POS. Your carrier or A/B MAC will return as unprocessable such claims if you include more than one POS.

When returning these claims with more than one POS, Medicare contractors will use the following claims adjustment reason code (CARC) and remittance advice remark codes (RARCs):

CARC 16 – Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the NCPCP reject reason code, or remittance advice remark code that is not an ALERT.)

RARC M77 – Missing/incomplete/invalid place of service.

RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

When returning claims for failing to include the address where the service was performed, Medicare contractors will use the following CARC and RARCs:

CARC 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)

RARC MA114 – Missing/incomplete/invalid information on where the services were furnished.

RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note that claims submitted on the 4010A1 version of the electronic claim form are not affected by CR 6947.

Additional information

You may find the official instruction, CR, 6947, issued to your carrier or A/B MAC at *http://www.cms.gov/Transmittals/downloads/R2041CP.pdf*.

You will find the revised *Medicare Claims Processing Manual* Chapter 1 (General Billing Requirements), Sections 10.1.1 (Payment Jurisdiction Among Contractors for Services Paid Under the Physician Fee Schedule and Anesthesia Services), 10.1.1.1 (Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004), and 80.3.2.1.2 (Conditional Data Element Requirements for Carriers and DMERCs) as an attachment to that CR.

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: MM6947
Related Change Request (CR) #: 6947
Related CR Release Date: August 31, 2010
Effective Date: For claims processed on or after January 1, 2011
Related CR Transmittal #: R2041CP
Implementation Date: January 3, 2011

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Electronic Data Interchange

Information and reminders about the upcoming version 5010 and ICD-10 transitions

Have questions about the version 5010 and ICD-10 transition? The Centers for Medicare & Medicaid Services (CMS) is here to help in the transitions to version 5010 and ICD-10. CMS has resources for providers, vendors, and payers to prepare for the transition. Fact sheets available for educating staff and others about the transition include:

- The ICD-10 Transition: An Introduction
- ICD-10 Basics for Medical Practices
- Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices
- Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors

Compliance timelines, materials from CMS-sponsored calls and conferences, and links to resources are available at *http://www.cms.gov/icd10/*. Check back often for the latest information and updates.

Keep up-to-date on version 5010 and ICD-10 Please visit *http://www.cms.gov/icd10/* for the latest news and sign up for version 5010 and ICD-10 e-mail updates.

Version 5010 and ICD-10 are coming. Will you be ready?

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

Source: CMS PERL 201008-17

ICD-10 implementation in a HIPAA version 5010 environment – National provider call

The Centers for Medicare & Medicaid Services will host a follow-up national provider conference call on ICD-10 Implementation in a 5010 Environment. This toll-free teleconference will focus on:

- ICD-10 implementation issues (including proposals to partially freeze code updates)
- Implementation updates for versions 5010 and D.0 (including implemented readiness review)
- How 5010 updates impact ICD-10 implementation
- Advice for providers in moving toward 5010 implementation

Subject matter experts will review basic information on both ICD-10 and 5010 and explain how they are interrelated. A question and answer session will follow the presentations.

Conference call details

Title: ICD-10 Implementation in a 5010 Environment

When: Monday, September 13

Time: Noon-1:30 p.m. ET

Target audience: Medical coders, physician office staff, provider billing staff, health records staff, vendors, educators, system maintainers, and all Medicare fee-for-service providers.

Agendas

ICD-10

- ICD-10 implementation for services provided on and after October 1, 2013
- Differences between ICD-10 and ICD-9-CM codes
- ICD-10-CM basic information for all users
- Tools for converting codes -- general equivalence mappings (GEMs)
- Proposal to freeze ICD-9-CM and ICD-10 code updates except for new technologies and diseases

HIPAA Version 5010

- Compliance dates and timelines (no contingencies)
- 5010 before and after ICD-10 Implementation
- Readiness review for implementing HIPAA version 5010 and D.0.
- What you need to be doing to prepare
- Medicare fee-for-service activities update
- Other issues and considerations

This toll-free teleconference will include a question and answer session. For more information and to register for this informative session, please go to *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*. **Registration will close at noon ET on September 10 or when available space has been filled**. No exceptions will be made. Please register early.

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

Source: CMS PERL 201008-28

Claim adjustment reason code and remittance advice remark code 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 who submit claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], durable medical equipment Medicare administrative contractors [DME MACs]) for services.

Provider action needed

CR 7089, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective October 1, 2010, for Medicare. These are the changes that have been added since CR 6901. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated three times a year – in early March, July, and November although the committee meets every month.

The CARC list is maintained by the Claim Adjustment Status Code Maintenance Committee, and used by all payers. This committee meets three times a year, and this code list also gets updated three times a year – in early March, July and November. Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 7089.

Additional information

To see the official instruction (CR 7089) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to *http://www.cms.gov/Transmittals/downloads/R2019CP.pdf*.

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

New codes – CARC

Code	Current narrative	Effective date per WPC posting
235	Sales Tax.	6/6/2010

Modified codes – CARC

None

Deactivated codes – CARC

None

New codes – RARC

Code	Current narrative	Medicare initiated
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.	No
N534	This is an individual policy, the employer does not participate in plan sponsorship.	No
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.	Yes
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.	No
N537	We have examined claims history and no records of the services have been found.	No
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	No
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.	No

Modified codes – RARC

Code	Modified narrative	Medicare initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	Yes

Claim adjustment reason code and remittance advice remark code update (continued)

Code	Modified narrative	Medicare initiated
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	Yes

Modified codes – RARC

Code	Modified narrative	Medicare Initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	Yes
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	Yes
N386	The 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 www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	No
N528	Patient is entitled to benefits for Institutional Services only.	No
N529	Patient is entitled to benefits for Professional Services only.	No
N530	Not Qualified for Recovery based on enrollment information	No

Deactivated Codes – RARC

Code	Current narrative	Note
M118	Letter to follow containing further information.	Consider using N202
MA101	A skilled nursing facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Consider using N130

MLN Matters® Number: MM7089
Related CR Release Date: August 6, 2010
Related CR Transmittal #: R2019CP

Related Change Request (CR) #: 7089
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

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Medicare Remit Easy Print brochure – revised

The *Medicare Remit Easy Print (revised May 2010)* brochure provides information about free software that enables professional providers and suppliers to view and print remittance information, is now available in print format from the *Medicare Learning Network*.

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

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

Source: CMS PERL 201008-14

General Information

Timely claim filing – additional instructions

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

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7080 to expand the Medicare fee-for-service (FFS) reimbursement instructions outlined in change request (CR) 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. CR 7080 lists the standards for dates of service used to determine the timely filing of claims. Be sure your billing staffs are aware of these changes.

Background

CMS is addressing institutional claims and professional/supplier claims differently with respect to span date claims. Institutions often bill for extended length of stays that exceed a month's (or more) duration. Therefore, it is both less burdensome and more reasonable to use the claim's "through" date rather than the "from" date as the date of service for determining claims filing timeliness.

Conversely, for physicians and other suppliers that bill claims with span dates, these span date services cannot exceed one month. Thus, there is no compelling need to create an extended filing period. CMS also notes that, if the "from" date of these span date services is timely, then those services billed within the span are timely as well, and this will generally ease the administrative burden of the claims processing contractors in their determination of timely filed claims. Therefore, the "from" date standard will be used for determining claims filing timeliness for physicians and other suppliers that bill claims with span date services. With respect to supplies and rental items, they are physically furnished at or near the beginning of the span dates on the claim. Therefore, the "from" date standard reflects more precisely when the supply or item was delivered to the beneficiary, and will be used as the date for determining claims filing timeliness.

Key points of CR 7080

- For institutional claims that include span dates of service (i.e., a "from" and "through" date span on the claim), the "through" date on the claim will be used to determine the date of service for claims filing timeliness.
- For professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item "from" date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).
- Be aware: If a line item "from" date is not timely, but the "to" date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.
- Claims having a date of service of February 29 must be filed by February 28 of the following year to be considered as timely filed. If the date of service is February 29 of any year and is received on or after March 1 of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional information

Remember CR 6960 established that Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

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

You may find the official instruction, CR 7080, issued to your carrier, FI, A/B MAC, or RHHI at *http://www.cms.gov/Transmittals/downloads/R734OTN.pdf*. If you have any questions, please contact your FI, MAC, or RHHI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

To review MM6960, Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months, you may go to *http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf*.

MLN Matters® Number: MM7080
Related Change Request (CR) #: 7080
Related CR Release Date: July 30, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R734OTN
Implementation Date: January 3, 2011

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Reopening certain claims denied when MSP data deleted or terminated

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

Provider types affected

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

What you need to know

CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen group health plan (GHP) Medicare secondary payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the *Background* section for more details.

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

1) Reopen certain MSP claims when certain MSP records are deleted, or

2) Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that MSP data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional information

You may find the official instruction, CR 6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC at *http://www.cms.gov/Transmittals/downloads/R2014CP.pdf*.

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

MLN Matters® Number: MM6625
Related Change Request (CR) #: 6625
Related CR Release Date: July 30, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2014CP
Implementation Date: April 4, 2011

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Listening session regarding feedback reports and value-based payment modifier for physicians

As part of the transition to a value-based purchasing program for services of physicians and certain other professionals, as well as other related provisions under the Patient Protection and Affordable Care Act (known as the Affordable Care Act (ACA)), the Centers for Medicare & Medicaid Services (CMS) will host a listening session on September 24 at CMS headquarters.

The ACA contains provisions that continue and expand the physician feedback program. Beginning in 2015, ACA also requires implementation of a value-based payment modifier to the fee-for-service physician fee schedule. The purpose of the listening session is to solicit comments on approaches being considered as we implement these provisions.

Physicians, physician associations, and all others interested in the use of confidential feedback reports as one means of enhancing quality and efficiency are invited to participate, in person or by calling into the teleconference. The meeting is open to the public, but attendance is limited to space and teleconference lines available.

For the complete *Federal Register* notice, including registration information, visit *http://edocket.access.gpo.gov/2010/pdf/2010-19128.pdf*.

Source: CMS PERL 201008-13

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Physical therapists are first recipients of CMS comparative billing reports

The Centers for Medicare & Medicaid Services (CMS) mailed its first-ever comparative billing reports (CBRs) to as many as 5,000 physical therapists during the week of August 9, according to an August 16 e-mail notice from CMS.

The CBRs, produced by SafeGuard Services LLC and distributed by Livanta LLC under contracts with CMS, compare providers' individual billing practices for specific procedures and services with their peer group. CMS developed the program to reduce improper payments and to educate providers on Medicare billing requirements.

CMS has issued similar reports in the past, including the Program for Evaluating Payment Patterns Electronic Report (PEPPER) sent to inpatient hospitals, and Resource-Based Relative Value Scale (RBRVS) feedback reports sent to physicians, but this is the first time CMS has issued CBRs, agency spokesman Peter Ashkenaz told The Bureau Of National Affairs, Inc. (BNA) August 17.

The initial CBRs apply to outpatient physical therapy services provided by independent physical therapists and are based on 2009 Medicare claims data.

Physical therapists were chosen due to an identified vulnerability in their billing procedures centered on use of the modifier KX. The modifier KX is required to indicate that:

- A service was medically necessary and justified by medical records
- The physical therapy financial limitation cap was met, and
- A patient's condition requires further treatment.

Moving forward, SafeGuard will produce and send new CBRs to Livanta each month for distribution to providers.
By James Swann

Information on the CBR program is at http://www.safeguard-servicesllc.com/cbr/default.asp.

Medicare provider-centered comparative billing report

Last week, the Centers for Medicare & Medicaid Services mailed CBRs to up to 5000 physical therapists across the country. The reports provide comparative data on how an individual health care provider varies from other providers by looking at utilization patterns. We have heard from a number of providers that this kind of information is very helpful to them and have encouraged us to produce more CBRs and make them available to providers.

These reports are not available to anyone but the provider who received them. To ensure privacy, CMS presents only summary billing information. A sample was provided in the communication. No patient or case-specific data is included. These are tools to help providers comply with Medicare billing rules and improve the level of care they furnish to their patients, our beneficiaries.

Provider Help Desk
CBR Support Team: 530-896-7080
CBR Services website: http://www.cbrservices.com

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

Source: CMS PERL 201008-35

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Tip sheets for professionals available on the CMS EHR incentive program website

The following tip sheets for eligible professionals are now available on the Centers for Medicare & Medicaid Services (CMS) electronic health record (EHR) incentive program website http://www.cms.gov/EHRIncentivePrograms:

Medicare EHR Incentive Payments for Eligible Professionals

This tip sheet describes which types of individual practitioners can participate in the Medicare HER incentive program. It provides user friendly information about incentive payment amounts and describes how they are calculated for fee for service and Medicare advantage providers. It also describes payment adjustments beginning in 2015 for EPs who are not meaningful users of certified EHR technology.

Medicare EHR Incentive Program, PQRI and E-Prescribing Comparison

Learn what opportunities are available to Medicare eligible professionals to receive incentive payments for participating in important Medicare initiatives. This fact sheet provides information on eligibility, timeframes, and maximum payments for each program.

On the EHR incentive program website, select the Medicare eligible professional tab on the left, and then scroll to "Downloads."

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

Source: CMS PERL 201007-52

Get the facts on electronic health record incentives

There's a lot of talk right now about electronic health records (EHRs), and how health care professionals and hospitals are going to pay for them.

So you probably have a lot of questions about them as well: Am I eligible to receive incentive payments under the Medicare & Medicaid EHR Incentive Programs? When do the programs begin? How much are the incentive payments? What do I need to participate?

It's important that you have a reliable resource to turn to for accurate information. The Centers for Medicare & Medicaid Services (CMS) is the federal agency establishing these incentive programs. The CMS website is the official federal source for facts about the Medicare & Medicaid EHR Incentive Programs. The site contains up-to-date resources that will give you the insight you need to make educated decisions.

Avoid reading false or misleading information. Get the facts from the federal source – the CMS Medicare & Medicaid EHR Incentive Programs website. Visit *http://www.cms.gov/EHRIncentivePrograms* today.

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

Source: CMS PERL 201008-31

PECOS creates custom applications tailored to your enrollment scenario

Have you tried Internet-based PECOS for your Medicare enrollment actions? Try it today.

Use the convenient Internet-based PECOS (provider enrollment chain and ownership system) to view and change enrollment information, and to track the processing of your enrollment application. And, because Internet-based PECOS creates a custom application tailored to your enrollment scenario, you only supply the information relevant to your application.

Learn how to use the system by selecting the appropriate instructions below based on the type of provider:

Physicians and nonphysician practitioners

Using Internet-based PECOS is easy

Learn how to use the system by visiting the *Medicare Physician and Non-Physician Practitioner Getting Started Guide* at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf*.

And if you encounter problems or have questions as you navigate the system, there are several resources that can help.

Don't wait, set your practice free from paper – start today by using Internet-based PECOS at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*.

Provider and supplier organizations

Using Internet-based PECOS is easy

Learn how to use the system by visiting the *Getting Started Guide for Provider and Supplier Organization* at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf*. Remember, the process by which an organization provider can use Internet-based PECOS may take several weeks. It is recommended that you begin this process (if necessary) well in advance of any upcoming enrollment actions. For more information on this setup process, visit the Provider and Supplier Organization Overview section on the CMS website at *http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Don't wait, set your practice free from paper – start today by using Internet-based PECOS at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*.

Note: Internet-based PECOS is not yet available for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The system will be available for use by DMEPOS suppliers later this year.

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

Source: CMS PERL 201008-23, PERL 201008-24

Handling misdirected mailings from Medicare

As a health care provider subject to the privacy and security requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or under state law, you must safeguard patients' personally identifiable health information. If you receive a remittance advice on a Medicare beneficiary who's not your patient, you should 1) destroy it and 2) report it to your fiscal intermediary, carrier, or Medicare administrative contractor, as appropriate.

Source: CMS PERL 201007-48

Using Internet-based provider enrollment chain and ownership system is easy

The Internet-based provider enrollment chain and ownership system (PECOS) is easy to use and offers a host of advantages over the paper-based enrollment process.

Did you know that you can submit an initial Medicare enrollment application, along with other enrollment actions, using the Internet-based PECOS instead of the traditional paper application?

And, did you know that Internet-based PECOS can be faster than the paper application process by up to 50-percent (with a 30 to 45-day processing window, versus 60 days for the paper-based process)?

Learn how to use the system by selecting the appropriate instructions below based on the type of provider:

Physicians and nonphysician practitioners

Using Internet-based PECOS is easy

Learn how to use the system by using the *Medicare Physician and Non-Physician Practitioner Getting Started Guide*, available at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf*. And if you encounter problems or have questions as you navigate the system, there are several resources that can help.

Don't wait, set your practice free from paper – start using Internet-based PECOS today at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*.

Provider and supplier organizations

Using Internet-based PECOS is easy

Learn how to use the system by using the *Getting Started Guide for Provider and Supplier Organization*, available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf*. Remember, creating a record in Internet-based PECOS may take several weeks for an organization provider. It is recommended that you begin this process (if necessary) well in advance of any upcoming enrollment actions. For more information on this setup process, visit the Provider and Supplier Organization Overview section at *http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Don't wait, set your organization free from paper – start using Internet-based PECOS today at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*.

Note: Internet-based PECOS is not yet available for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The system will be available for use by DMEPOS suppliers later this year.

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Source: CMS PERL 201007-53, PERL 201007-54

Revised tip sheet regarding national provider identifier

The revised *National Provider Identifier Tip Sheet: Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees (June 2010)* is now available on the CMS website. This resource details the steps an organization that is a health care provider should take when applying for an employee's national provider identifier (NPI), on an individual record-by-record basis. Available in PDF format, the fact sheet may be downloaded or printed from the "Education Resources" section of the NPI Web page at *http://www.cms.gov/NationalProvIdentStand/04_education.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 201008-14

Update to banking transition date

The Centers for Medicare & Medicaid Services 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 the Medicare payments may be made by a different bank than in the past because of these new banking contractors.

Due to issues identified in testing, providers that submit claims to CIGNA Government Services, Highmark Medicare Services, National Government Services, NHIC, and Noridian Administrative Services will experience a delay in the transition to U.S. Bank. **The transition occurred on August 30 instead of August 2.**

Source: CMS PERL 201007-61

Alternative process for individual eligible professionals to access PQRI and e-Prescribing feedback reports

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

Note: This article was revised on July 23, 2010, to update the *Additional information* section with current Web addresses. All other information remains the same. This information was previously published in the October 2009 *Medicare B Update!* pages 35-36.

Provider types affected

Individual eligible professionals (EPs) requesting reports based on their individual national provider identifier (NPI) have an alternative means of accessing those reports. Physicians and other practitioners who qualify as individual EPs under the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) and the 2009 e-Prescribing Incentive Program can request feedback reports through their claims processing contractor. The *MLN Matters* article (MM6394) listing individual EPs under these incentive programs may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6394.pdf*.

What you need to know

- CMS has created an alternative process that individual EPs may use to request 2007 re-run and 2008 PQRI feedback reports based on their individual NPI.
- Based on the nature of your questions (e.g., status of your PQRI incentive payment, measures, coding, or the feedback reports), you may need to contact different entities.
- e-Prescribing feedback reports for data submitted in calendar year 2009 will be available in late 2010. CMS will notify EPs when they can begin requesting these reports using this alternative process.

You should make sure your billing staffs are aware of this information. Please refer to the information below for more details.

Background

In the past, EPs could only access PQRI feedback reports through a secure Web site after first registering in the CMS security system known as Individuals Authorized Access to the CMS Computer Services (IACS). CMS is now offering an alternative feedback report request process which will be available beginning October 19, 2009.

This new process eliminates the need for individual EPs to register in IACS for their feedback report.

Alternative PQRI feedback report request process for individual EPs

Beginning on October 19, 2009, individual EPs can call their respective carrier or A/B MAC provider contact center to request 2007 re-run and 2008 PQRI feedback reports that will contain data based on their individual NPI. This means that EPs who are part of a group practice can get their individual feedback reports as well.

When requesting feedback reports, EPs will be asked to provide an e-mail address. EPs can then expect to receive the e-mailed feedback report within 30 days of the request. If no report is available, the provider will receive an e-mail notification.

EPs requesting reports based on taxpayer identification number for group practice information

EPs who request feedback reports based on taxpayer identification number (TIN) or group practice information will still be required to access their PQRI feedback reports via the PQRI Portal after first registering in IACS. An IACS user identification and password is required to access the PQRI Portal. The PQRI Portal may be found at *http://www.qualitynet.org/pqri*.

Correct contact based on questions

CMS has provided the following resources to answer your questions about the PQRI and e-Prescribing programs, incentive payments, feedback reports, and IACS registration and account issues.

1. A/B MAC and carrier provider contact centers can answer questions concerning incentive payment status, such as:
   - Was my incentive payment sent?
   - What is my incentive payment amount?
   - What does my remittance advice(s) mean?

   To get a list of provider contact centers, see *http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

2. Quality Net Help Desk can provide general PQRI and E-Prescribing information as well as answer questions about PQRI feedback report availability and access, coding, measures, and the feedback reports themselves. Examples of questions they can assist with include:
   - Do I have a PQRI feedback report available for this TIN or NPI?
   - When will my PQRI feedback reports be available?

Electronic prescribing incentive program updates (continued)

- Why am I unable to view my PQRI feedback report on the PQRI Portal?
- Did I qualify for a PQRI incentive payment?
- When will my PQRI incentive payment be available?
- Can you explain a specific part of my PQRI feedback report?

Contact the QualityNet Help Desk Monday-Friday from 7:00 a.m.-7:00 p.m. (CT) at 1-866-288-8912 or by e-mail: *qnetsupport@sdps.org*.

3. External User Services (EUS) can resolve issues concerning IACS registration and account issues such as:
   - I need help registering in IACS
   - I need help accessing my IACS account
   - I need help changing my IACS account, and
   - I need help approving users in my organization.

Contact EUS at 1-866-484-8049 Monday-Friday from 7:00 a.m.-7:00 p.m. (ET) or by e-mail: *EUSsupport@cgi.com*.

Additional information

Please remember that EP and group practice provider enrollment information must be current in the Medicare Provider Enrollment Chain and Ownership System (PECOS) in order to request an IACS account. An IACS account is needed to access the PQRI Portal and view or download TIN-level PQRI feedback reports. See *http://www.cms.gov/MedicareProviderSupEnroll/* for more information, including a link to Internet-based PECOS.

To get a list of Provider Enrollment contact numbers, see *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

For information about IACS, see *http://www.cms.gov/IACS*.

There are other sources where you can find additional information.

- For PQRI Program information and resources, *see http://www.cms.gov/PQRI*.
- To download a copy of the "2007 Re-Run and 2008 PQRI Feedback Report User Guide", see *http://www.cms.gov/PQRI/2008/list.asp#TopOfPage*. On the 2008 PQRI Program Web page, check the following option: "[X] Show only items whose Type is." Then select "Feedback Reports" from the drop down list.
- To download a copy of "A Guide for Understanding the 2008 PQRI Incentive Payment", see *http://www.cms.gov/PQRI/downloads/GuideUnderstanding2008PQRIIncentivePayment072109.pdf*.
- To download a copy of "A Guide for Understanding the 2007 Re-Run PQRI Incentive Payment", see *http://www.cms.hhs.gov/PQRI/Downloads/GuideforUnderstanding2007Re-RunPQRIIncentivePayment063_508.pdf*.
- To access the PQRI Portal and to verify the 2007 Re-Run or 2008 PQRI Feedback Report availability for a TIN or NPI, see *http://www.qualitynet.org/pqri*.
- To download the PQRI Portal User Guide, see the "Downloads" section on *http://www.cms.gov/PQRI/30_EducationalResources.asp*.
- For general E-Prescribing Information, see *http://www.cms.gov/eRxIncentive*.
- For information on the PQRI National Provider Call Schedule and Open Door Forum, see *http://www.cms.gov/PQRI/04_CMSSponsoredCalls.asp*.
- For 2009 PQRI program information, see *http://www.cms.gov/PQRI/2009/list.asp*.
- For a list of Qualified Registries/Qualified EHR Vendors, see *http://www.cms.gov/PQRI/20_alternativereportingmechanisms.asp*.

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Medical record retention and media formats for medical records

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, nonphysician practitioners, suppliers, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [MAC]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is informational in nature. There are no additions or changes to current policies and procedures.

Caution – what you need to know

This article provides guidance for physicians, suppliers, and providers on record retention timeframes.

Go – what you need to do

Review the information in this article and ensure that you are in compliance. Be sure to inform your staff.

Retention periods

State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt state laws if they require shorter periods. Your state may require a longer retention period. The HIPAA requirements are available at 45 CFR 164.316(b)(2) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl*).

While the HIPAA privacy rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. The privacy rule is available at 45 CFR 164.530(c) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl*).

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least five years after the closure of the cost report. This requirement is available at 42 CFR 482.24[b][1] (*http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr482_05.html*).

CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available at 42 CFR 422.504 [d][2][iii] (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=ab240bf0e5f6388a75cbe07cc5cf1d21;rgn=div5;view=text;node=42%3A3.0.1.1.9;idno=42;cc=ecfr*).

Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient. Remember that medical records must be accurately written, promptly completed, accessible, properly filed and retained. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.

The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Providers may want to obtain legal advice concerning record retention after these time periods and medical document format.

Additional information

CMS is currently engaged in a multi-year project to offer incentives to eligible providers that meaningfully use certified electronic health records (EHRs). In close coordination with this incentive program, the Office of the National Coordinator for Health IT (ONC) has developed the initial set of standards and certification requirements for EHRs in order to promote health information exchange and interoperability. You may be eligible to receive incentive payments to assist in implementing certified EHR technology systems.

Use of "certified EHR technology" is a core requirement for physicians and other providers who seek to qualify to receive incentive payments under the Medicare and Medicaid Electronic Health Record Incentive Programs provisions authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Additional information about this initiative may be found at *http://www.cms.gov/EHRIncentivePrograms/*.

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

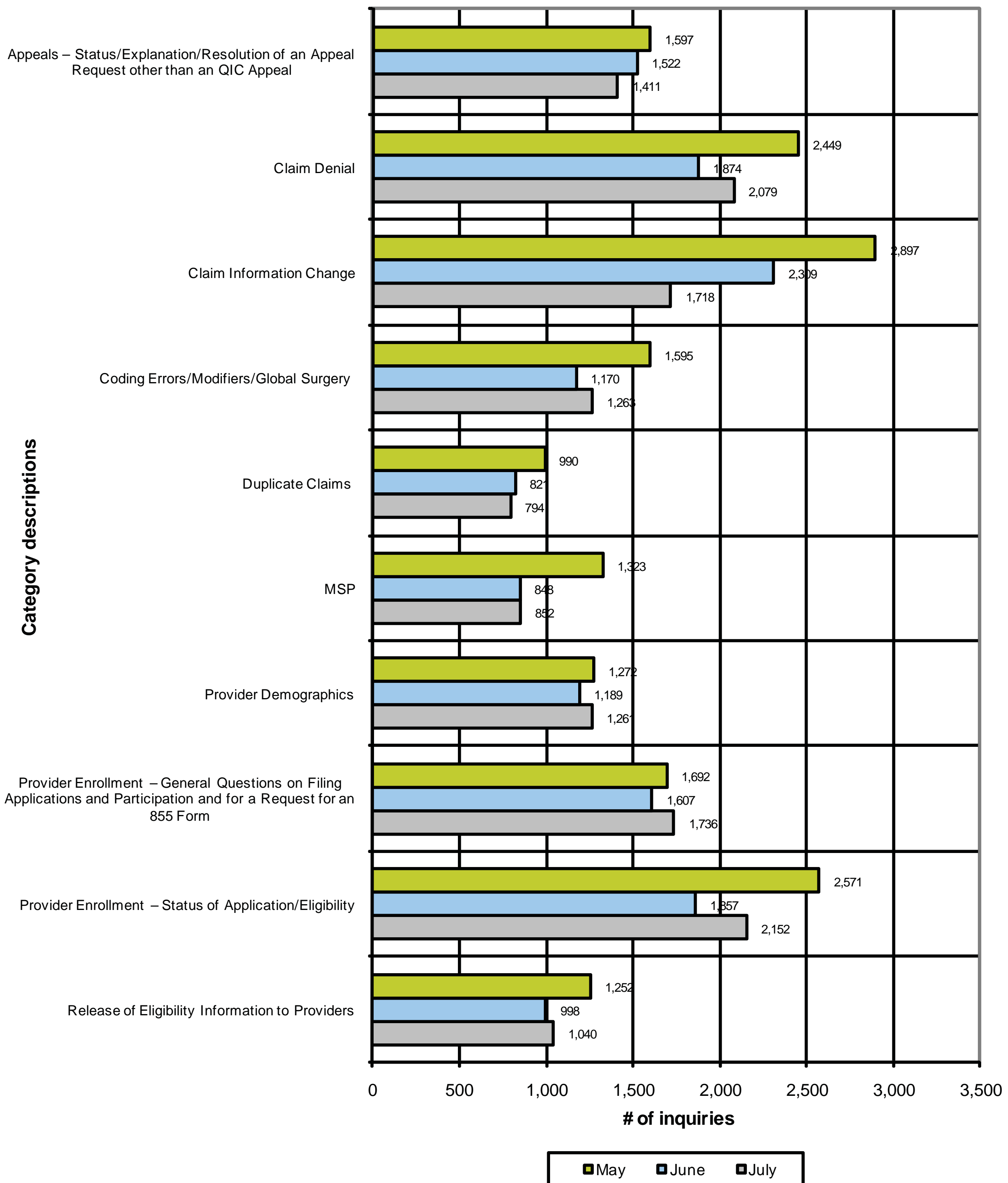
MLN Matters® Number: SE1022
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

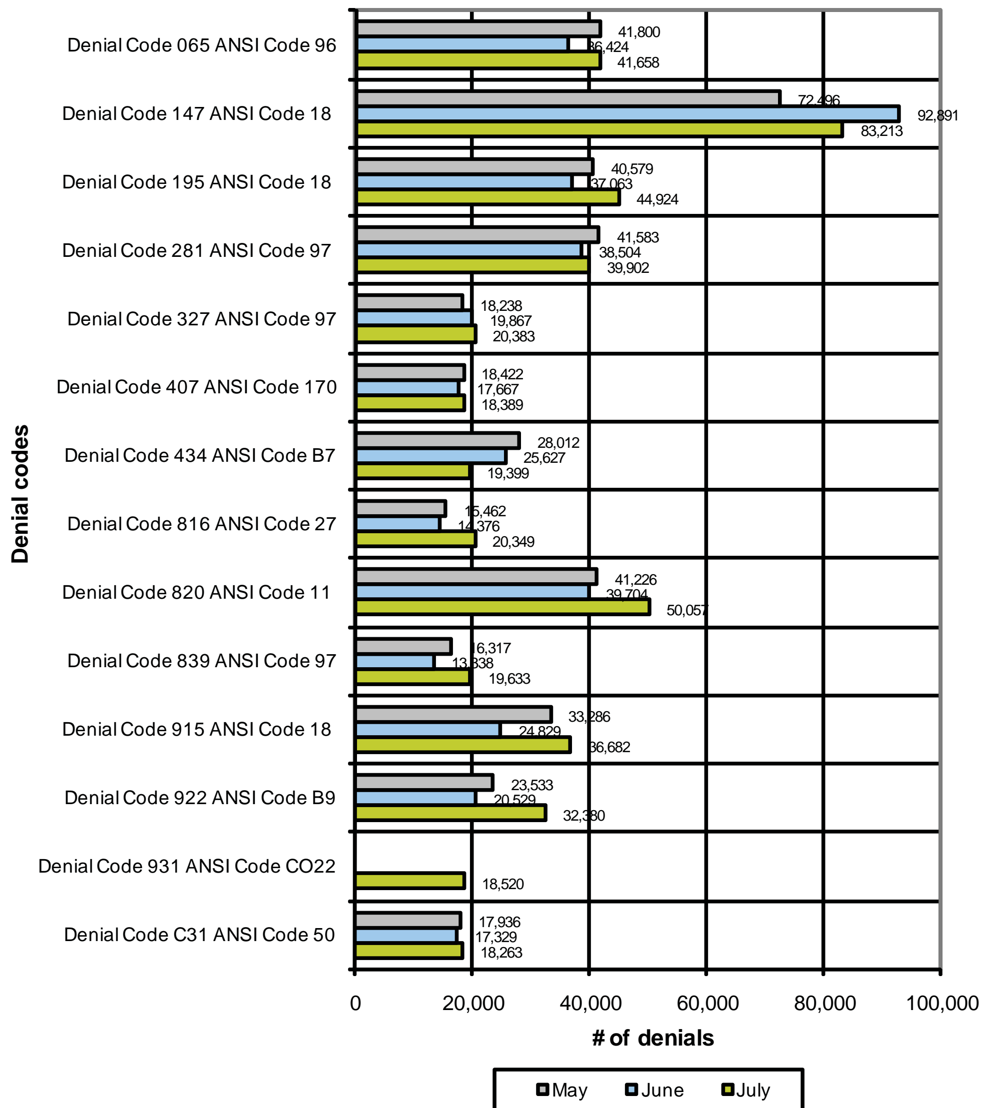
Third-party websites*. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest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

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

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 May-July 2010. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.



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



Tips for avoiding duplicate denials

Before resubmitting a claim, check claims status through the Part B interactive voice response (IVR) system. Do not resubmit an entire claim when partial payment made; when appropriate, resubmit denied lines only. View frequently-asked questions (FAQs) regarding duplicate claims at *http://medicare.fcso.com/FAQs/138013.asp*.

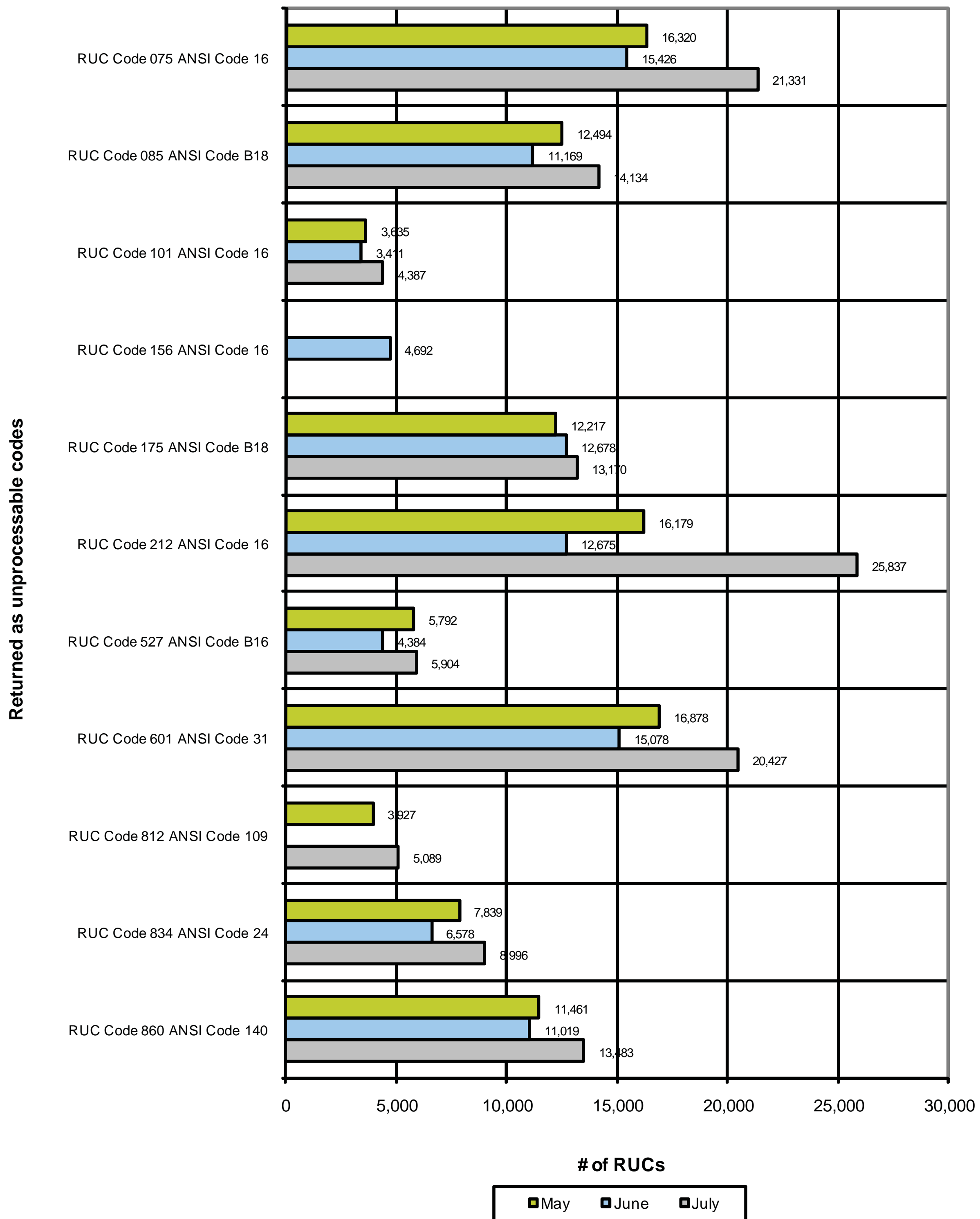
Regarding evaluation and management (E/M) services, physicians in the same group practice of the same specialty must bill and be paid as though they were a single physician.

- Only one E/M service may be reported per patient, per day by a physician or by more than one physician of the same specialty in the same group, unless the evaluation and management services are for unrelated problems.
- If more than one face-to-face E/M is provided on the same day to the same patient by the same physician or by more than one physician of the same specialty in the same group, instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.
- Physicians in the same group practice but who are in different specialties (e.g., a cardiologist and a general practice physician) may bill and be paid without regard to their membership in the same group.

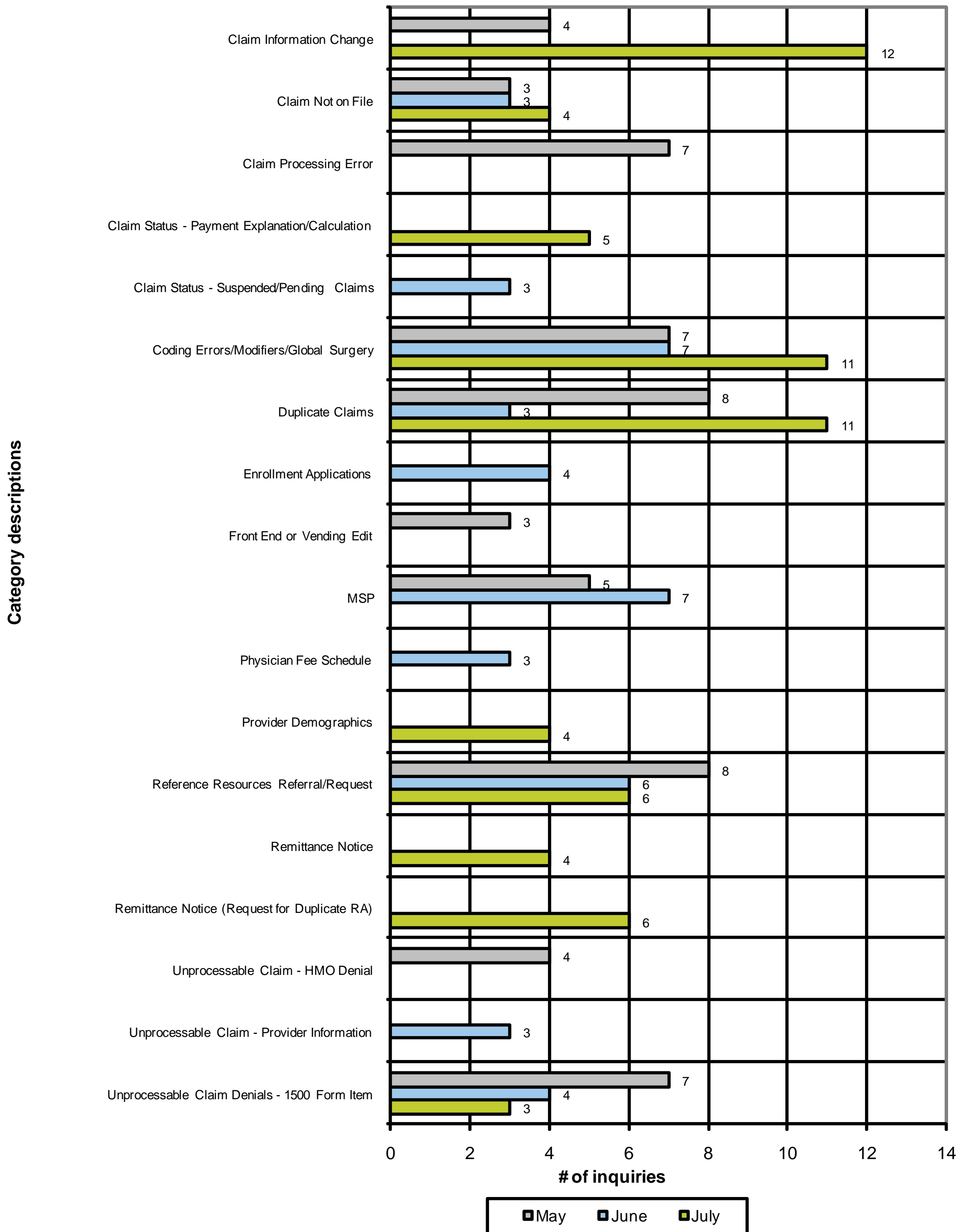
FCSO also offers free educational sessions throughout the year, focused on particular billing issues you may be experiencing. These may include webcasts or seminars on avoiding duplicate claims for Part B.

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

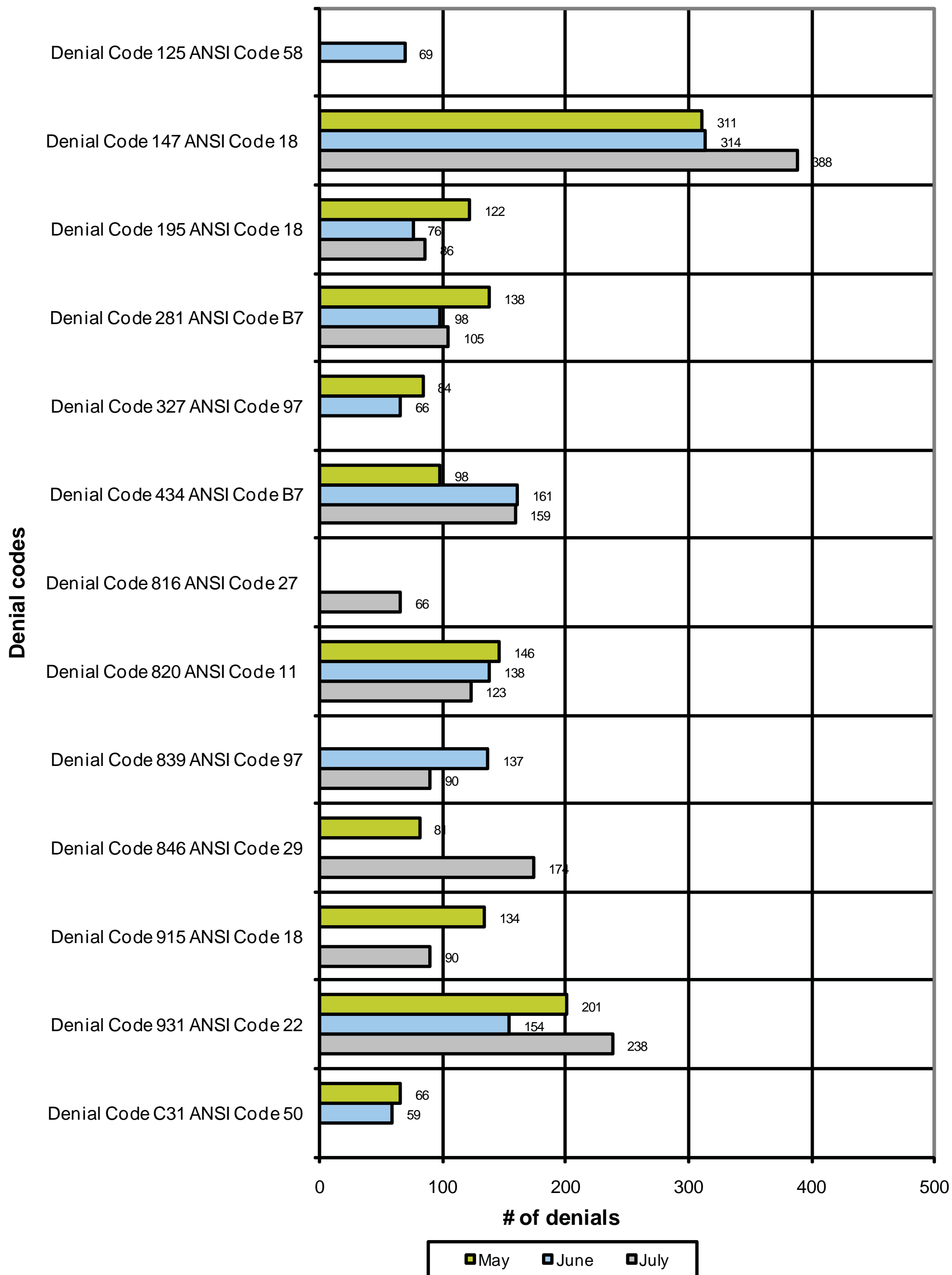
Top inquiries, denials, and return unprocessable claims for May-July (continued)



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



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

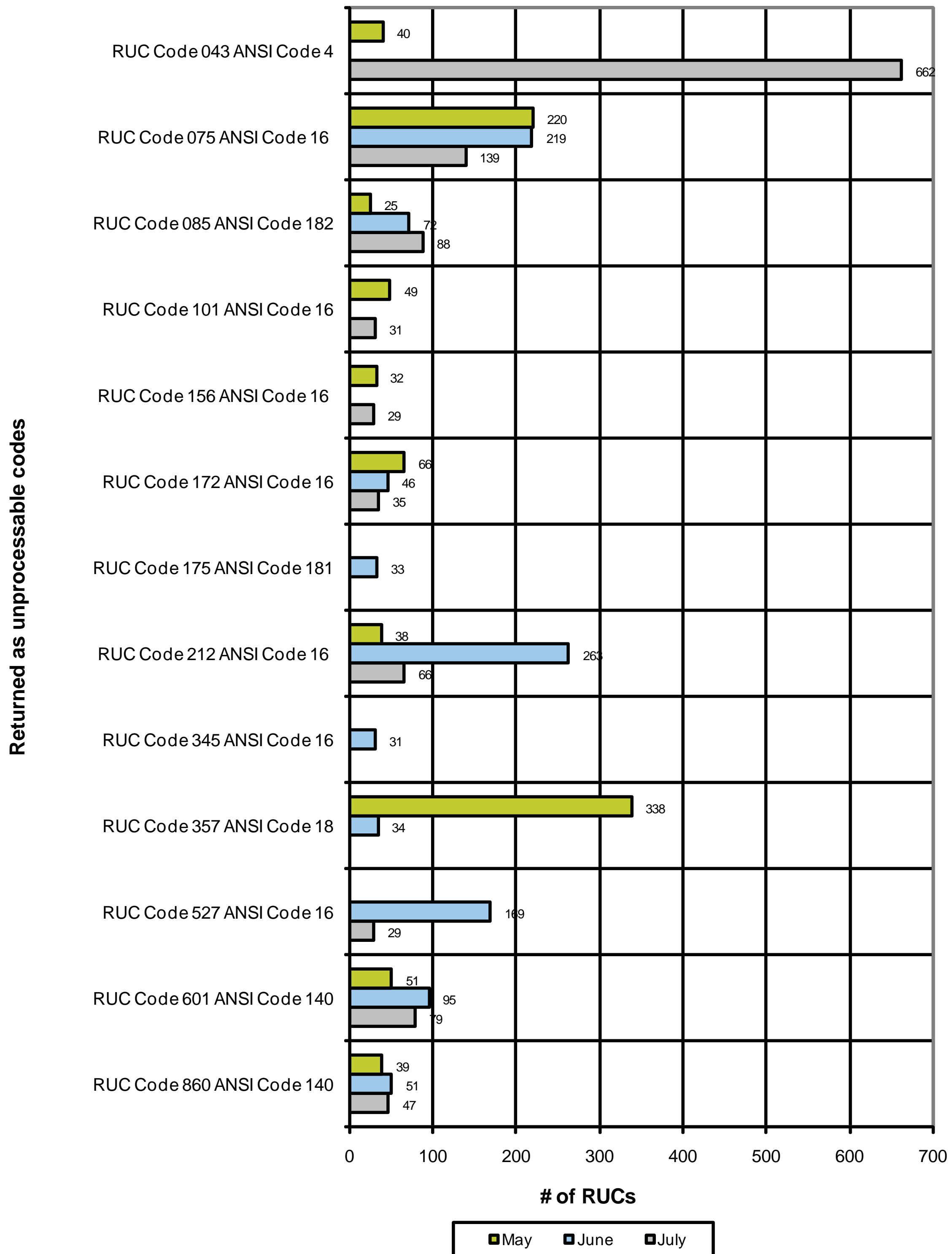


Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare administrative contractor. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education website. It's very easy to do. Simply go to our website *http://medicare.fcso.com*, click on the "***E-mail***" link located on the upper-right-hand corner of the page and follow the prompts.

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

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for May-July 2010



Local Coverage Determinations

This section of the *Medicare B Update!* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and that the carrier's LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), contractors no longer include full text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text of final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date of service (unless otherwise noted in the LCD). Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new LCDs are posted to the website, subscribe to our *FCSO eNews* mailing list. It's very easy to do. Simply go to our website *http://medicare.fcso.com*, click on the "Join eNews" link located on the upper-right-hand corner of the page and follow the instructions.

More information

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

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

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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.

New LCDs

Qutenza: Qutenza® (capsaicin) 8% patch – new LCD
LCD ID number: L31245 (Florida/Puerto Rico/U.S. Virgin Islands)

Postherpetic neuralgia (PHN) is a rare painful complication of shingles (herpes zoster), a result of nerve damage caused by the shingles virus. The pain can persist long after the shingles rash clears up and can disrupt sleep, mood, work, and activities of daily living. Qutenza® is a high concentration capsaicin patch intended to treat neuropathic pain associated with PHN. According to the labeling approved by the Food and Drug Administration (FDA), the patch should be administered only under clinical supervision, with continuous clinical monitoring throughout its administration, and should not be dispensed to patients for self-administration.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. A "Coding Guidelines" LCD attachment has also been developed for this drug, which includes billing information.

Effective date

This new LCD is effective for services rendered **on or after September 30, 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.

Xiaflex: Collagenase clostridium histolyticum (Xiaflex®) – new LCD
LCD ID Number: L31243 (Florida/Puerto Rico/U.S. Virgin Islands)

Dupuytren's contracture affects the palmer fascia of the hands. It is characterized by a thickening of the fibrous tissue underneath the skin of the hand, with resulting nodule and contracture formation. These contractures cause the finger(s) to palmar flex (into the hand). The contractures are usually painless, but they can cause disability of the hand as the disease progresses. The two joints most commonly affected by Dupuytren's contracture are the metacarpophalangeal (MCP) and the proximal interphalangeal (PIP) joints.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. A "Coding Guidelines" attachment has also been developed for this drug, which outlines the specific billing instructions for this drug.

Effective date

This new LCD is effective for services rendered **on or after September 30, 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.

86003: Allergy testing – new LCD
LCD ID Number: L31271 (Florida/Puerto Rico/U.S. Virgin Islands)

The current local coverage determination (LCD) for allergy tests (LCD ID Number: L29057) was most recently revised on January 25, 2010. This revision was made to add tests to the LCD for routine allergy testing that are considered experimental and investigational as they have not been proven to be effective. Since that time, there have been questions of coverage versus non-coverage of procedures not addressed in this LCD. Therefore, this LCD has been revised to such an extent that the current LCD will be retired when the new LCD becomes effective.

Allergy is a form of exaggerated sensitivity or hypersensitivity to a substance that is either inhaled, ingested, injected, or comes in contact with the skin or eye. The term allergy is used to describe situations where hypersensitivity results from heightened or altered reactivity of the immune system in response to external substances. Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any part of the body. The reactions may be acute, subacute, or chronic, immediate or delayed, and may be caused by a variety of offending agents; pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, drugs, etc.

Allergy testing is performed to determine a patient's immunologic sensitivity or reaction to particular allergens for the purpose of identifying the cause of the allergic state, and is based on findings during a complete medical and immunologic history and appropriate physical exam obtained by face-to-face contact with the patient.

86003: Allergy testing – new LCD (continued)

Effective date

LCD ID number L29057 is retired effective for services rendered **on or after September 29, 2010**, and new LCD ID L31271 is effective for services rendered **on or after September 30, 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.

88182: Flow cytometry – new LCD

LCD ID Number: L31247 (Florida/Puerto Rico/U.S. Virgin Islands)

Flow cytometry (FCM) is a procedure which simultaneously measures and analyzes multiple physical characteristics of single cells, as they flow in a fluid stream through a beam of light. The light activates fluorescent molecules, resulting in light scatter, which forms a pattern that can be analyzed for cell characteristics. FCM can be used to analyze blood, body fluids, CSF, bone marrow, lymph node, tonsil, spleen and other solid organs. Information from the analyzed cells may help determine prognosis, aid in the analysis of effusions, urine, or other fluids in which cancer cells may be few or mixed with benign cells, detect metastases in lymph nodes or bone marrow, or to supplement fine needle aspiration.

The flow cytometer is made up of three main systems: fluidics, optics and electronics. The fluidic system transports particles in a stream to the laser beam. The optics system consists of lasers to illuminate the particles in the sample stream and optical filters to direct the resulting light signals to the appropriate detectors. The electronics system converts the detected light signals into electronic signals that can be processed by the computer. Some flow cytometers have a sorting feature which allows the electronic system to initiate sorting decisions to charge and deflect particles.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. A "Coding Guidelines" LCD attachment has also been developed for this service, which includes billing information.

Effective date

This new LCD is effective for services rendered **on or after September 30, 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.

95990: Implantable infusion pump for the treatment of chronic intractable pain – new LCD

LCD ID number: L31254 (Florida/Puerto Rico/U.S. Virgin Islands)

The implantable infusion pump is a drug delivery system that is used to deliver a solution containing parenteral drug(s) under continuous or intermittent infusion with a regulated flow rate. Its purpose is to deliver a therapeutic level of a drug to a specific site within the body.

This new LCD has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT* codes, documentation requirements, and utilization guidelines for implantable infusion pump for the treatment of chronic intractable pain.

In addition, a "Coding Guidelines" LCD attachment has been developed for this service which includes information regarding coding and billing for compounded drugs.

Effective date

This new LCD is effective for services rendered **on or after September 30, 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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Revisions to LCDs

J2778: Ranibizumab (Lucentis®) – revision to the LCD

LCD ID number: L29266 (Florida)
LCD ID number: L29383 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands, as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to add language regarding the approval of ranibizumab by the Food and Drug Administration (FDA) on June 22, 2010, for the treatment of patients with macular edema following retinal vein occlusion (RVO). The recommended dosage and frequency of treatment is 0.5 mg/0.05 mL (10mg/mL), administered by intravitreal injection once a month (approximately 28 days) for six months.

Ranibizumab (Lucentis®) is supplied as a preservative-free, sterile solution in a single-use glass vial designed to provide 0.05 mL of 10 mg/mL solution for intravitreal injection. Each vial should only be used for the treatment of a single eye. If the contralateral eye requires treatment, a new vial should be used.

The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add the following ICD-9-CM codes: 362.07, 362.35, 362.36, 362.53 and 362.83. The following language was also added to this section of the LCD:

Macular edema following retinal vein occlusion (RVO) should be reported as follows:

- Report macular edema with one of the following ICD-9-CM codes: 362.07*, 362.53 or 362.83; and
- Report retinal vein occlusion (RVO) with one of the following ICD-9-CM codes: 362.35 or 362.36.

*In addition, when reporting ICD-9-CM code 362.07: Per the ICD-9-CM coding manual, ICD-9-CM code 362.07 requires a dual diagnosis. Therefore, ICD-9-CM code 362.07 must be used with a code for diabetic retinopathy (ICD-9-CM codes 362.01-362.06).

The LCD "Coding Guidelines" attachment has been revised to add coding and billing information in reporting ranibizumab for the treatment of exudative senile macular degeneration and macular edema following retinal vein occlusion (RVO).

As a reminder, when performing an injection on both eyes, modifier 50 should be used and modifier RT or LT should be used for unilateral services.

Effective date

This LCD revision is effective for claims processed on or after October 3, 2010, for services rendered on or after June 22, 2010. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

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

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on July 1, 2010. Since that time, a revision was made to add Category III *CPT* codes *0223T, 0224T, 0225T; 0228T, 0229T, 0230T, 0231T, 0232T*, and *0233T* to the LCD based on an evaluation of these services.

Under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD, the following Category III *CPT* codes were added:

0223T *Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report*

0224T *Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; multiple, including serial trended analysis and limited reprogramming of device parameter – AV or VV delays only, with interpretation and report*

0225T *Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; multiple, including serial trended analysis and limited reprogramming of device parameter – AV and VV delays, with interpretation and report*

0228T *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level*

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

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)

0230T Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level

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)

0232T Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed

0233T Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy

In addition, *CPT* code *46999* for transanal radiofrequency therapy for fecal incontinence (e.g., Secca® System) and *CPT* code *93799* for noninvasive assessment of central blood pressure (e.g., SphygmoCor System/Device) were added to the LCD under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section based on an evaluation of these services.

The title of the LCD has also been changed from "the list of Medicare noncovered services" to "noncovered services."

Effective date

This LCD revision is effective for services rendered **on or after September 30, 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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70450: Computed tomography scans of the head or brain – revision to the LCD

LCD ID number: L29121 (Florida)
LCD ID number: L29139 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomography scans of the head or brain was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Documentation Requirements" section of the LCD has been revised and updated with the Centers for Medicare & Medicaid (CMS) language regarding rules for different or additional tests. In addition, references were updated under "The CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections of the LCD.

Effective date

This LCD revision is effective for services rendered on or after August 17, 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.

72192: Computed tomography of the abdomen and pelvis – revision to the LCD

LCD ID number: L29119 (Florida)
LCD ID number: L29137 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomography of the abdomen and pelvis was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, the Centers for Medicare & Medicaid (CMS) language was removed regarding diagnostic testing and updated CMS language was added under the "Documentation Requirements" section of the LCD. In addition, references were updated under "The CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections of the LCD.

Effective date

This LCD revision is effective for services rendered on or after August 17, 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.

Educational Events

Upcoming provider outreach and educational events September 2010

Hot Topics: Medicare Part B

When: Wednesday, September 15
Time: 11:30 a.m. – 1:00 p.m.

Medicare's claim edits for ordering/referring providers (CR 6417)

When: Tuesday, September 21
Time: 2:00 p.m. – 3:30 p.m.

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

Two easy ways to register

Online – Visit our provider training website at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: ________________________________
Registrant's Title: ________________________________
Provider's Name: ________________________________
Telephone Number: ________________ Fax Number: ________________
E-mail Address: ________________________________
Provider Address: ________________________________
City, State, ZIP Code: ________________________________

Keep checking our Web site, *www.medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

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, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

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 and explore our catalog of online courses.

Preventive Services

Web-based training – Medicare preventive service

Did you know that the *Medicare Preventive Services Series Part 2 Web-based training course (WBT)* is currently available free of charge, on the Centers for Medicare & Medicaid Services (CMS) website?

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

- The initial preventive physical exam (IPPE)
- Ultrasound screening for abdominal aortic aneurysms (AAA)
- Colorectal cancer screening
- Cardiovascular screening blood tests
- Diabetes screening tests
- Supplies and other services for beneficiaries with diabetes
- Diabetes self-management training and medical nutritional therapy
- Smoking and tobacco-use cessation counseling services

Taking this online course will help you and your staff understands Medicare rules surrounding these important benefits. Not only that, but if you pass this course, you can earn continuing education credit. You can take 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 201008-14

August is National Immunization Awareness Month

This annual health observance is a great opportunity to educate seniors and other people with Medicare about the importance of disease control and prevention through immunization. Vaccine-preventable disease levels are at or near record lows. Yet, many adults remain under-immunized, missing opportunities to protect themselves against diseases such as hepatitis B, seasonal influenza, and pneumococcal disease.

The Centers for Medicare & Medicaid Services (CMS) ask all health-care providers who provide care to Medicare patients to join CMS during National Immunization Awareness Month to help protect your Medicare patients from vaccine-preventable diseases by checking to make sure their immunizations are up-to-date and encouraging utilization of Medicare-covered immunizations that are appropriate for them.

Medicare Part B immunization benefits

Medicare provides coverage for seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration, under Medicare Part B, for qualified beneficiaries as preventive immunizations. Providers who accept the Medicare-approved payment amount for these services are reimbursed under Medicare Part B.

Seasonal influenza immunization

Medicare provides payment for the seasonal influenza vaccine and its administration for all people with Medicare, once per influenza season, in the fall or winter. Medicare may cover additional influenza vaccinations, if medically necessary.

Note: According to the Centers for Disease Control and Prevention, the 2010-2011 influenza vaccine will protect against the 2009 H1N1, and two other influenza viruses *http://www.cdc.gov/flu/about/disease/*.

Pneumococcal immunization

Medicare provides payment for the pneumococcal vaccine and its administration for all beneficiaries, generally once in a lifetime. Medicare may cover additional vaccinations based on risk.

Hepatitis B immunization

Medicare provides payment for the hepatitis B vaccine and its administration for beneficiaries at medium to high risk of contracting hepatitis B.

For more information

CMS Adult Immunizations Web page

http://www.cms.gov/AdultImmunizations/

Please note: The "Immunizers' Question & Answer Guide to Medicare Coverage of Seasonal Influenza and Pneumococcal Vaccinations", which provides administration and flu vaccine payment rates for use by mass immunizers and physician practices, will be updated and posted to this site sometime in early October, 2010.

August is National Immunization Awareness Month (continued)

CMS *Medicare Learning Network* (*MLN*) Preventive Services Educational Products Web page

This site provides access to *MLN* educational resources developed by CMS for fee-for-service providers related to Medicare-covered preventive services, including adult immunizations.
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage

For information about National Immunization Awareness Month, please visit the Centers for Disease Control and Prevention website at *http://www.cdc.gov/vaccines/events/niam/default.htm*.

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

Source: CMS PERL 201008-12

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

Other Educational Resources

Medicare Learning Network is now podcasting

A podcast is a multimedia version of a really simple syndication (RSS) feed that allows you to receive audio or video content from the Centers for Medicare & Medicaid Services (CMS) website whenever new information is added.

Podcasting is a new feature on the CMS website. You can subscribe to a wide variety of podcasts including speeches, testimonies, and other informative episodes. You have the option to subscribe to the entire podcast series using software on your personal computer.

Just released

The CMS premier production of "New Maximum Period for the Submission of Medicare Claims," reminding Medicare fee-for-service providers of the current claims submission deadlines, is now available. To access the podcast, go to *http://www.cms.gov/CMSFeeds/02_listofpodcasts.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 201008-14

Updates from the Medicare Learning Network on social media

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

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

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

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

Source: CMS PERL 201008-26

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New resources from the Medicare Learning Network

Web-based training courses

Need to know the Medicare basics? The *Medicare Learning Network* (*MLN*) offers a series of Web-based training (WBT) courses to teach health care professionals the fundamentals of the Medicare program. The first in the series, the World of Medicare, offers a basic introduction to Medicare. The second in the series, Your Office in the World of Medicare, focuses on Medicare knowledge required by health care professionals and their office personnel. Both activities now offer continuing education and are available from the *MLN* at *http://www.cms.gov/MLNproducts/* by scrolling to the bottom of the page and selecting "Web-based Training Modules" from the "Related Links Inside CMS" section.

How to Use the National Correct Coding Initiative (NCCI) Tools

Get the new *How to Use the National Correct Coding Initiative (NCCI) Tools* booklet from the *MLN* and learn how to navigate the CMS NCCI Web page. This new *MLN* product explains how to look up Medicare code pair edits and medically unlikely edits (MUEs). NCCI tools can help providers avoid coding and billing errors and subsequent payment denials. If you want to become familiar with the *National Correct Coding Initiative Policy Manual* and the tools on the NCCI Web page, this is your best resource. Go to *http://www.cms.gov/MLNProducts/MPUB/list.asp* and enter "How to" to find this and other *MLN* "How to" series publications.

We Heard the Bells: The Influenza of 1918

The Spanish language version of "We Heard the Bells: The Influenza of 1918, a documentary that explores the experiences of Americans during the influenza pandemic of 1918, is now available to order, free of charge, on DVD. The documentary features stories from survivors of the influenza pandemic that swept the United States in 1918. These stories serve to frame the key questions that apply to the current H1N1 pandemic. Award-winning actress S. Epatha Merkerson (Law & Order) narrates the documentary that includes information about seasonal vs. pandemic influenza, symptoms, immunizations, treatment, and research. To order a copy of the DVD in either English or Spanish, please visit the *MLN* page at *http://www.cms.gov/MLNProducts/*, then click on "MLN Product Ordering Page" under the "Related Links Inside CMS" section.

Source: CMS PERL 201007-48

Try our E/M interactive worksheet

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

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

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

Miscellaneous

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

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

Provider education

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

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

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

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

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

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

Phone numbers

Providers

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

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

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

FAX: 1-904-361-0696

Beneficiary

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

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

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

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

Flu rosters

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

Electronic data interchange (EDI)

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

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

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

Provider enrollment

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

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

and

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

Redeterminations

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

Redetermination overpayment

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

Freedom of Information Act requests (FOIA)

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

Congressional inquiries

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

Provider education

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)
1-877-847-4992

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

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
Hearing Impaired:
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 Schedules, effective for services rendered January 1 through May 31, 2010, and June 1 through November 30, 2010, are 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 schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy $12		
		CD-ROM $6		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: ____________________

Provider/Office Name: ____________________

Phone: ____________________

Mailing Address: ____________________

City: ______________ State: ______________ ZIP: ______________

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦