MEDICARE B *Update!*

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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Vol. 8, No. 10
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The *Medicare B Update!* is published monthly by First Coast Service Options Inc. (FCSO) Provider Outreach and Education Division, to provide timely and useful information to Medicare Part B providers.

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

THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

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

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

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

Who receives the *Update?*

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

In addition to the above, other sections include:

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

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

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

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

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

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

ABN modifiers

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

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

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

GA modifier and appeals

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

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

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

Find out first: Subscribe to FCSO eNews

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

CLAIMS

2011 annual update for the health professional shortage area bonus payments

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in health professional shortage areas (HPSAs).

What you need to know

Change request (CR) 7139, from which this article is taken, alerts providers that the annual HPSA bonus payment file 2011 file will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor on November 15, 2010. This file will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2011, through December 31, 2011.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors by early December of each year.

Additional information

The official instruction (CR 7139) issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2054CP.pdf*. You will find annual HPSA files (as they become available) and other important HPSA information at *http://www.cms.gov/hpsapsaphysicianbonuses/*.

If you have any questions, please contact your 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: MM7139
Related Change Request (CR) #: 7139
Related CR Release Date: September 17, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2054CP
Implementation Date: January 3, 2011

Website Welcome screen – new bookmark feature

Upon entry to either provider website, visitors are asked to indicate their line of business and geographic location before proceeding to the homepage. The purpose of this feature is to allow providers to find the information they need more quickly by focusing content based upon their selections. Since frequent site visitors may prefer not to have to indicate their references at the beginning of every visit, a Bookmark this page link is not only featured on every page of the provider website but also has been added to the site's Welcome pop-up screen. This new feature will allow visitors to save their preferences by bookmarking the homepage. More information is available at *http://medicare.fcso.com/Help/171993.asp*.

Cardiac Services

Intensive cardiac rehabilitation programs – Dr. Ornish's program for reversing heart disease and the Pritikin program

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

Provider types affected

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

What you need to know

CR 7113, from which this article is taken, announces that (through a national coverage determination [NCD]) the Centers for Medicare & Medicaid Services (CMS) has determined that, effective for claims with dates of service on and after August 12, 2010, the Ornish program for reversing heart disease and the Pritikin program each meet the ICR program requirements. As such, both programs have been included on the list of approved ICR programs available at *http://www.cms.gov/MedicareApprovedFacilitie/*. You should make sure that your billing staffs are aware of this new NCD.

Background

ICR refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner than other such programs. As required by Section 1861(eee)(4)(A) of the Social Security Act (the Act), an ICR program must show (in peer-reviewed published research) that it accomplished one or more of the following for its patients: 1) positively affected the progression of coronary heart disease; 2) reduced the need for coronary bypass surgery; and, 3) reduced the need for percutaneous coronary interventions.

In addition, the program must show (also in peer-reviewed literature) that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

- low density lipoprotein
- triglycerides
- body mass index
- systolic blood pressure
- diastolic blood pressure
- the need for cholesterol, blood pressure, and diabetes medications

Individual ICR programs must be approved through the NCD process to ensure they demonstrate the above accomplishments. In order to implement these coverage provisions effective January 1, 2010, CMS added 42 CFR, Part 410.49 through rulemaking in the 2010 Medicare Physician Fee Schedule Final Rule, *Federal Register*, Volume 74, Number 226, pages 61,738 & 61,872, on November 25, 2009. (You may find this information at *http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf*).

The Ornish program for reversing heart disease (also known as the multisite cardiac lifestyle intervention program, the multicenter cardiac lifestyle intervention program, and the lifestyle heart trial program) was initially described in the 1970s and incorporates comprehensive lifestyle modifications including exercise, a low-fat diet, smoking cessation, stress management training, and group support sessions. Over the years, the Ornish program has been refined, but continues to focus on these specific risk factors.

The Pritikin diet was designed and adopted by Nathan Pritikin in 1955. The diet was modeled after the diet of the Tarahumara Indians in Mexico, which consisted of 10 percent fat, 13 percent protein, 75-80 percent carbohydrates, and provided 15-20 grams per day of crude fiber with only 75 mg/day of cholesterol. Over the years, the Pritikin program (also known as the Pritikin longevity program) evolved into a comprehensive program that is provided in a physician's office and incorporates a specific diet (10-15 percent of calories from fat, 15-20 percent from protein, 65-75 percent from complex carbohydrates), exercise, and counseling lasting 21-26 days. An optional residential component is also available for participants.

Please refer to MLN Matters article MM6850 (Cardiac Rehabilitation and Intensive Cardiac Rehabilitation), released on May 21, 2010, to learn more about detailed claims processing, coverage, coding, and payment regarding ICR. You may find this article at *http://www.cms.gov/MLNMattersArticles/downloads/MM6850.pdf*.

Additional information

You may find the official instruction, CR 7113, issued to your carrier, FI, or A/B MAC at *http://www.cms.gov/Transmittals/downloads/R125NCD.pdf*.

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

MLN Matters Number: MM7113
Related Change Request (CR) #: 7113
Related CR Release Date: September 24, 2010
Effective Date: August 12, 2010
Related CR Transmittal #: R125NCD
Implementation Date: October 25, 2010

Chiropractic Services

CMS released chiropractic comparative billing report

The Centers for Medicare & Medicaid Services (CMS) released its second national provider comparative billing report (CBR) in October. This report is centered on chiropractic services. The focus is on the average number of services per beneficiary and the top five diagnosis codes billed compared to the individual chiropractor's state and the nation. The CBRs will be released to approximately 5,000 practitioners nationwide.

The CBRs, produced by SafeGuard Services under contract with CMS, provide comparative data on how an individual health care provider compares to other providers by looking at utilization patterns for services, beneficiaries, and diagnoses billed. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

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

For more information and to review a sample of the chiropractic CBR, please visit CBR Services website located at *http://www.cbrservices.com* or call SafeGuard Services' provider help desk, CBR support team at 530-896-7080.

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

Source: CMS PERL 201010-20

***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.*

Drugs and Biologicals

Fee schedule for administration of influenza and pneumococcal virus vaccines

The allowances for the administration of influenza and pneumococcal virus vaccines, Healthcare Common Procedure Coding System (HCPCS) codes G0008 and G0009 respectively, are not included in the Medicare physician fee schedule (MPFS). However, according to the *Medicare Claims Processing Manual*, Chapter 18 (Preventing and Screening Services), Section 10.2.2.1, reimbursement for HCPCS code G0008 and G0009 on and after March 1, 2003, should be made based upon the rate in the MPFS associated with *CPT* code *90471*. Therefore, to determine the allowance for administration of influenza and pneumococcal virus vaccines, go to the fee schedule lookup page at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp*, select MPFS from the drop-down menu, enter the date of service, locality, procedure code *90471*, and submit.

Source: CR 7124

October 2010 average sales price files are now available

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

All are available for download at: *http://www.cms.gov/McrPartBDrugAvgSalesPrice/*. Year-specific links may be located in left menu section.

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

Source: CMS PERL 201009-33

January 2011 quarterly average sales price update and revision to prior files

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7188 and instructs Medicare contractors to download and implement the January 2011 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2010, July 2010, April 2010, and January 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2011, with dates of service January 1, 2011, through March 31, 2011. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
January 2011 ASP and ASP NOC files	January 1, 2011 through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and ASP NOC files	January 1, 2010, through March 31, 2010

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

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 7188) issued to your Medicare MAC, carrier, and/or FI may be found at *http://www.cms.gov/Transmittals/downloads/R2067CP.pdf*.

MLN Matters® Number: MM7188
Related Change Request (CR) #: 7188
Related CR Release Date: October 15, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2067CP
Implementation Date: January 3, 2011

Find fees faster: Try FCSO's fee schedule lookup

Now you can find the fee schedule information you need faster than ever before with FCSO's redesigned fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp*. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Influenza vaccine payment allowances – annual update for 2010-2011 season

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

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7120 in order to update payment allowances, effective September 1, 2010, for influenza vaccines when payment is based on 95 percent of the average wholesale price (AWP). CR 7120 refers only to the seasonal influenza vaccines. According to CR 6617, only the Level II Healthcare Common Procedure Coding System code G9142 is used to identify the H1N1 vaccine on Medicare claims. Therefore, *Common Procedure Terminology* (*CPT*) codes *90663*, *90664*, *90666*, *90666*, *90667*, and *90668* will not be recognized on Medicare claims for the H1N1 vaccine.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

CR 7120 provides the payment allowances for the following seasonal influenza virus vaccines: CPT codes *90655*, *90656*, *90657*, *90658*, *90660*, and *90662* when payment is based on 95 percent of the AWP. The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year.

The Medicare Part B payment allowance in these situations for:

- *CPT 90655* is $12.398
- *CPT 90656* is $12.375
- *CPT 90657* is $6.297
- *CPT 90658* (for dates of service September 1, 2010 through December 31, 2010) is $11.368

CPT 90660 (FluMist, a nasal influenza vaccine) or *CPT 90662* (Fluzone High-Dose) may be covered if your Medicare claims processing contractor determines the use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance effective September 1, 2010, for *CPT 90660* is $22.316, and for *CPT 90662* is $29.213.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine. The current payment allowances for pneumococcal vaccines may be found on the quarterly drug pricing files.

Additional information

Note that Medicare contractors will not search their files to adjust claims already processed prior to implementation of CR 7120. However they will adjust those claims that you bring to their attention.

The official instruction, CR 7120 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2071CP.pdf*.

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

MLN Matters® Number: MM7120
Related Change Request (CR) #: 7120
Related CR Release Date: October 22, 2010
Effective Date: September 1, 2010
Related CR Transmittal #: R2071CP
Implementation Date: November 24, 2010

2010 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations

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

Provider types affected

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

Provider action needed

This article is for informational purposes and is based on change request (CR) 7124 which serves to remind the Medicare provider community of the requirements to correctly complete roster billing and centralized billing for influenza and pneumococcal immunizations. Be sure billing staffs know of these requirements.

Background

According to the Centers for Disease Control and Prevention, the seasonal vaccine for the 2010-2011 influenza season will protect against the 2009 H1N1 and two other influenza viruses (See *http://www.cdc.gov/flu/protect/keyfacts.htm*) Medicare allows one flu shot per year, and Part B of Medicare pays 100 percent for pneumococcal vaccines and influenza virus vaccines and their administration.

Note: The Part B deductible and coinsurance do not apply for pneumococcal and influenza virus vaccine.

Medicare does not require, for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision. Typically, the pneumococcal vaccine is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received a pneumococcal vaccine within the last five years or are revaccinated because they are unsure of their vaccination status.

When completing a claim for reimbursement, providers are reminded to use the appropriate influenza and pneumococcal (PPV) *Current Procedural Terminology* (*CPT*) codes for the vaccine and the appropriate Healthcare Common Procedure Coding System (HCPCS) codes for the administration as follows:

- G0008 for administration of the seasonal influenza virus vaccine; and
- G0009 for administration of PPV.

Please see *Medicare Claims Processing Manual* (Chapter 18, Section 10) at *http://www.cms.gov/manuals/downloads/clm104c18.pdf* for any additional information regarding reimbursement of influenza and PPV claims.

Providers who only render influenza services may enroll as one of two types of providers:

- A mass immunization roster biller (specialty provider type 73), or
- A centralized biller.

Other facilities that bill Part B of Medicare, including outpatient or inpatient, but do not qualify as type 73, may continue to roster bill.

Providers are responsible for meeting the guidelines for being either a mass immunizer or centralized biller. Additionally, providers (except suppliers) already enrolled in the Medicare program may use their national provider identifier (NPI) to provide influenza vaccinations.

Mass immunization roster billers and centralized billers must enroll in the Medicare program even if mass influenza and/or pneumococcal immunizations are the only service being provided. They must accept assignment on both the vaccine and its administration, bill only for influenza and/or PPV vaccinations, and submit claims using the roster billing process.

Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals. They must be properly licensed in the States in which they plan to operate flu clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors processing claims. Individuals and entities must be properly licensed in the states in which they plan to operate flu and/or pneumococcal clinics. Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier to render influenza vaccination services to Medicare beneficiaries.

Providers and suppliers must enroll using the appropriate CMS 855 Medicare enrollment application. Information on provider enrollment forms may be found at *http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp*. Refer to the *Medicare Claims Processing Manual*, Chapter 18, Sections 10-10.5 at *http://www.cms.gov/manuals/downloads/clm104c18.pdf* for more information on billing requirements.

2010 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations (continued)

Additional Information

The official instruction, CR 7124, issued to your carriers, FIs, and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R774OTN.pdf*. If you have any questions, please contact your carriers, FIs, or A/B MACs at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7124
Related Change Request (CR) #: 7124
Related CR Release Date: September 24, 2010
Effective Date: October 25, 2010
Related CR Transmittal #: R774OTN
Implementation Date: October 25, 2010

Dermal injections for treatment of facial lipodystrophy syndrome

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

Note: This article was revised on October 21, 2010, to correct typographical errors in the original article. Previously, the article referenced HCPCS code G0249 in several places in the billing instructions sections. Instead, the article should have referenced HCPCS code G0429. This information was previously published in the July 2010 *Medicare B Update!* (pages 10-11).

Provider types affected

This article is for physicians, hospitals, and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for facial lipodystrophy syndrome (LDS) provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 6953 which informs Medicare contractors that, effective for claims with dates of service on and after March 23, 2010, dermal injections for facial LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in human immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Background

The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial LDS for human immunodeficiency virus (HIV)-infected Medicare beneficiaries. LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or highly active antiretroviral therapy (HAART). Due to their appearance, patients with LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

Nationally covered indications

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Nationally noncovered indications

- Dermal fillers that are not approved by the FDA for the treatment of LDS, and
- Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

Claims coding/pricing information

Effective with the July 2010 Healthcare Common Procedure Coding System (HCPCS) update, the July Medicare physician fee schedule (MPFS), and the July integrated outpatient code editor (IOCE):

- HCPCS codes Q2026, Q2027, and G0429 will be designated for dermal fillers Sculptra® and Radiesse®
- HCPCS codes Q2026, Q2027, and G0429 are effective for dates of service on or after March 23, 2010
- HCPCS codes Q2026 and Q2027 are contractor-priced under the July MPFS, and
- HCPCS code G0429 is payable under the July MPFS.

However, because HCPCS Q2026, Q2027 and G0429 are not considered valid HCPCS until implementation of the July 2010 HCPCS update, providers will not be able to bill and receive payment for these HCPCS codes prior to July 6, 2010.

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the dermal filler product. This code provides a payment

Dermal injections for treatment of facial lipodystrophy syndrome (continued)

mechanism to hospital outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) providers until average sales price (ASP) or wholesale acquisition cost (WAC) pricing information becomes available. When ASP or WAC pricing information becomes available, the temporary HCPCS code will be deleted and separate payment will be made under the OPPS and ASC payment systems for HCPCS Q2026, Q2027, and G0429.

For institutional non-OPPS claims, Medicare contractors will use current payment methodologies for claims for dermal injections for treatment of LDS.

Hospital and ASC billing instructions

For ASC and hospital outpatient claims, providers must bill covered dermal injections for treatment of LDS by having all the required elements on the claim:

- A line with HCPCS codes Q2026 or Q2027 with a line item date of service (LIDOS) on or after March 23, 2010
- A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010, and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

Medicare will line item deny institutional claims where the LIDOS is prior to March 23, 2010.

Note to OPPS hospitals or ASCs: For line item dates of service on or after March 23, 2010, and until pricing information is made available to price OPPS claims, LDS claims shall contain the temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

Note on all hospital claims: An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

Practitioner billing instructions

Practitioners must bill covered claims for dermal injections for treatment of LDS by having all the required elements on the claim:

- A date of service (LIDOS) on or after March 23, 2010
- HCPCS codes Q2026 or Q2027
- A line with HCPCS code G0429, and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

Note: An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage based on the individual Medicare contractor's policy.

Billing for services prior to Medicare coverage

ASCs and practitioners billing for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following messages upon their Medicare denial:

- **Claim adjustment reason code (CARC) 28:** Coverage not in effect at the time the service was provided.
- **Remittance advice remark code (RARC) N386:** This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- **Group code**: contractual obligation (CO)

Medicare beneficiaries whose provider bills Medicare for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following Medicare summary notice (MSN) message upon the Medicare denial:

- **21.11** - This service was not covered by Medicare at the time you received it.

Billing for services not meeting comorbidity coverage requirements

Hospitals and practitioners billing for dermal injections for treatment of LDS on patients that do not have on the claim both ICD-9-CM diagnosis codes of 042 and 272.6, indicating HIV and lipodystrophy will receive the following messages upon their Medicare claims denial:

- **CARC 50**: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC M386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp* on the CMS website. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- **Group code**: contractual obligation (CO)

Medicare beneficiaries who do not meet Medicare comorbidity requirements of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) and whose provider bills Medicare for dermal injections for treatment of LDS will receive the following MSN message upon the Medicare denial:

- **15.4** - The information provided does not support the need for this service or item.

Additional information

The official instruction, CR 6953, issued to your carrier, FI, and A/B MAC regarding this change via two transmittals. The first transmittal revised the *Medicare NCD Manual* and it may be viewed at *http://www.cms.gov.Transmittals/downloads/R122NCD.pdf*. The second transmittal revises the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Transmittals/downloads/R1978CP.pdf*.

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

Dermal injections for treatment of facial lipodystrophy syndrome (continued)

MLN Matters® Number: MM6953 *Revised*
Related Change Request (CR) #: 6953
Related CR Release Date: June 4, 2010
Effective Date: March 23, 2010
Related CR Transmittal #: R122NCD and R1978CP
Implementation Date: July 6, 2010

Durable Medical Equipment

2010 jurisdiction list for DMEPOS HCPCS codes

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

Provider types affected

Suppliers submitting claims to Medicare contractors (DME Medicare administrative contractors [DME MACs], Part B carriers, and Medicare administrative contractors [A/B MAC]) for DMEPOS services provided to Medicare beneficiaries are affected.

Provider action needed

This article is informational and based on change request (CR) 7110 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2010 jurisdiction list is an Excel® spreadsheet and is available at *http://www.cms.gov/center/dme.asp* on the Centers for Medicare & Medicaid Services (CMS) website.

Additional information

To see the official instruction (CR 7110) issued to your Medicare DME MAC, carrier, or A/B MAC, visit *http://www.cms.gov/Transmittals/downloads/R2056CP.pdf*. The 2010 jurisdiction list is attached to CR 7110.

If you have any questions, please contact your 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: MM7110
Related Change Request (CR) #: 7110
Related CR Release Date: September 17, 2010
Effective Date: December 22, 2010
Related CR Transmittal #: R2056CP
Implementation Date: December 22, 2010

Website Welcome screen – new bookmark feature

Upon entry to either provider website, visitors are asked to indicate their line of business and geographic location before proceeding to the homepage. The purpose of this feature is to allow providers to find the information they need more quickly by focusing content based upon their selections. Since frequent site visitors may prefer not to have to indicate their references at the beginning of every visit, a Bookmark this page link is not only featured on every page of the provider website but also has been added to the site's Welcome pop-up screen. This new feature will allow visitors to save their preferences by bookmarking the homepage. More information is available at *http://medicare.fcso.com/Help/171993.asp*.

2010 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 7110 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2010 jurisdiction list is attached to CR 7110 at *http://www.cms.gov/Transmittals/downloads/R2056CP.pdf*.

HCPCS	Description	Jurisdiction
A0021-A0999	Ambulance services	Local carrier
A4206-A4209	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other supplies DME MAC.
A4210	Needle free injection device	DME MAC
A4211	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other supplies DME MAC.
A4212	Non coring needle or stylet with or without catheter	Local carrier
A4213-A4215	Medical , surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4216-A4218	Saline	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4220	Refill kit for implantable pump	Local carrier
A4221-A4250	Medical, surgical, and self-administered injection supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4252-A4259	Diabetic supplies	DME MAC
A4261	Cervical cap for contraceptive use	Local carrier
A4262-A4263	Lacrimal duct implants	Local carrier
A4264	**Contraceptive implant**	**Local carrier**
A4265	Paraffin	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4266-A4269	Contraceptives	Local carrier
A4270	Endoscope sheath	Local carrier
A4280	Accessory for breast prosthesis	DME MAC
A4281-A4286	Accessory for breast pump	DME MAC
A4290	Sacral nerve stimulation test lead	Local carrier
A4300-A4301	Implantable catheter	Local carrier
A4305-A4306	Disposable drug delivery system	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4310-A4358	Incontinence supplies/urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A4360-A4434	Urinary supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A4450-**A4456**	Tape; adhesive remover	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4458	Enema bag	DME MAC
A4461-A4463	Surgical dressing holders	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.

2010 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
A4465-**A4466**	Non-elastic binder **and elastic garment**	DME MAC
A4470	Gravlee jet washer	Local carrier
A4480	Vabra aspirator	Local carrier
A4481	Tracheostomy supply	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4483	Moisture exchanger	DME MAC
A4490-A4510	Surgical stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical trays	Local carrier
A4554	Disposable underpads	DME MAC
A4556-A4558	Electrodes; lead wires; conductive paste	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4559	Coupling gel	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4561-A4562	Pessary	Local carrier
A4565	Sling	Local carrier
A4570	Splint	Local carrier
A4575	Topical hyperbaric oxygen chamber, disposable	DME MAC
A4580-A4590	Casting supplies and material	Local carrier
A4595	TENS supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4600	Sleeve for intermittent limb compression device	DME MAC
A4601	Lithium ion battery for non-prosthetic use	DME MAC
A4604	Tubing for positive airway pressure device	DME MAC
A4605	Tracheal suction catheter	DME MAC
A4606	Oxygen probe for oximeter	DME MAC
A4608	Transtracheal oxygen catheter	DME MAC
A4611-A4613	Oxygen equipment batteries and supplies	DME MAC
A4614	Peak flow rate meter	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4615-A4629	Oxygen and tracheostomy supplies	Local carrier if incident to a physician's service (not separately payable). If other DME MAC.
A4630-A4640	DME supplies	DME MAC
A4641-A4642	Imaging agent; contrast material	Local carrier
A4648	Tissue marker, implanted	Local carrier
A4649	Miscellaneous surgical supplies	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A4650	Implantable radiation dosimeter	Local carrier
A4651-A4932	Supplies for ESRD	DME MAC
A5051-A5093	Additional ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.

2010 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
A5102-A5200	Additional incontinence and ostomy supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service and billed to the local carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device and billed to the DME MAC.
A5500-A5513	Therapeutic shoes	DME MAC
A6000	Non-contact wound warming cover	DME MAC
A6010-A6024	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6025	Silicone gel sheet	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6154-A6411	Surgical dressing	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6412	Eye patch	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6413	Adhesive bandage	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6441-A6512	Surgical dressings	Local carrier if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC.
A6513	Compression burn mask	DME MAC
A6530-A6549	Compression gradient stockings	DME MAC
A6550	Supplies for negative pressure wound therapy electrical pump	DME MAC
A7000-A7002	Accessories for suction pumps	DME MAC
A7003-A7039	Accessories for nebulizers, aspirators and ventilators	DME MAC
A7040-A7041	Chest drainage supplies	Local carrier
A7042-A7043	Pleural catheter	Local carrier
A7044-A7046	Respiratory accessories	DME MAC
A7501-A7527	Tracheostomy supplies	DME MAC
A8000-A8004	Protective helmets	DME MAC
A9150	Non-prescription drugs	Local carrier
A9152-A9153	Vitamins	Local carrier
A9155	Artificial saliva	Local carrier
A9180	Lice infestation treatment	Local carrier
A9270	Noncovered items or services	DME MAC
A9274-A9278	Glucose monitoring	DME MAC
A9279	Monitoring feature/device	DME MAC
A9280	Alarm device	DME MAC
A9281	Reaching/grabbing device	DME MAC
A9282	Wig	DME MAC
A9283	Foot off loading device	DME MAC
A9284	Non-electric spirometer	DME MAC
A9300	Exercise equipment	DME MAC
A9500-A9700	Supplies for radiology procedures	Local carrier

2010 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
A9900	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
A9901	Delivery	DME MAC
A9999	Miscellaneous DME supply or accessory	Local carrier if used with implanted DME. If other, DME MAC.
B4034-B9999	Enteral and parenteral therapy	DME MAC
D0120-D9999	Dental procedures	Local carrier
E0100-E0105	Canes	DME MAC
E0110-E0118	Crutches	DME MAC
E0130-E0159	Walkers	DME MAC
E0160-E0175	Commodes	DME MAC
E0181-E0199	Decubitus care equipment	DME MAC
E0200-E0239	Heat/cold applications	DME MAC
E0240-E0248	Bath and toilet aids	DME MAC
E0249	Pad for heating unit	DME MAC
E0250-E0304	Hospital beds	DME MAC
E0305-E0326	Hospital bed accessories	DME MAC
E0328-E0329	Pediatric hospital beds	DME MAC
E0350-E0352	Electronic bowel irrigation system	DME MAC
E0370	Heel pad	DME MAC
E0371-E0373	Decubitus care equipment	DME MAC
E0424-E0484	Oxygen and related respiratory equipment	DME MAC
E0485-E0486	Oral device to reduce airway collapsibility	DME MAC
E0487	Electric spirometer	DME MAC
E0500	IPPB machine	DME MAC
E0550-E0585	Compressors/nebulizers	DME MAC
E0600	Suction pump	DME MAC
E0601	CPAP device	DME MAC
E0602-E0604	Breast pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage board	DME MAC
E0607	Home blood glucose monitor	DME MAC
E0610-E0615	Pacemaker monitor	DME MAC
E0616	Implantable cardiac event recorder	Local carrier
E0617	External defibrillator	DME MAC
E0618-E0619	Apnea monitor	DME MAC
E0620	Skin piercing device	DME MAC
E0621-E0636	Patient lifts	DME MAC
E0637-E0642	Standing devices/lifts	DME MAC
E0650-E0676	Pneumatic compressor and appliances	DME MAC
E0691-E0694	Ultraviolet light therapy systems	DME MAC
E0700	Safety equipment	DME MAC
E0705	Transfer board	DME MAC
E0710	Restraints	DME MAC
E0720-E0745	Electrical nerve stimulators	DME MAC
E0746	EMG device	Local carrier
E0747-E0748	Osteogenic stimulators	DME MAC

2010 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
E0749	Implantable osteogenic stimulators	Local carrier
E0755	Reflex stimulator	DME MAC
E0760	Ultrasonic osteogenic stimulator	DME MAC
E0761	Electromagnetic treatment device	DME MAC
E0762	Electrical joint stimulation device	DME MAC
E0764	Functional neuromuscular stimulator	DME MAC
E0765	Nerve stimulator	DME MAC
E0769	Electrical wound treatment device	DME MAC
E0770	Functional electrical stimulator	DME MAC
E0776	IV pole	DME MAC
E0779-E0780	External infusion pumps	DME MAC
E0781	Ambulatory infusion pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782-E0783	Infusion pumps, implantable	Local carrier
E0784	Infusion pumps, insulin	DME MAC
E0785-E0786	Implantable infusion pump catheter	Local carrier
E0791	Parenteral infusion pump	DME MAC
E0830	Ambulatory traction device	DME MAC
E0840-E0900	Traction equipment	DME MAC
E0910-E0930	Trapeze/fracture frame	DME MAC
E0935-E0936	Passive motion exercise device	DME MAC
E0940	Trapeze equipment	DME MAC
E0941	Traction equipment	DME MAC
E0942-E0945	Orthopedic devices	DME MAC
E0946-E0948	Fracture frame	DME MAC
E0950-E1298	Wheelchairs	DME MAC
E1300-E1310	Whirlpool equipment	DME MAC
E1353-E1392	Additional oxygen related equipment	DME MAC
E1399	Miscellaneous DME	Local carrier if implanted DME. If other, DME MAC.
E1405-E1406	Additional oxygen equipment	DME MAC
E1500-E1699	Artificial kidney machines and accessories	DME MAC
E1700-E1702	TMJ device and supplies	DME MAC
E1800-E1841	Dynamic flexion devices	DME MAC
E1902	Communication board	DME MAC
E2000	Gastric suction pump	DME MAC
E2100-E2101	Blood glucose monitors with special features	DME MAC
E2120	Pulse generator for tympanic treatment of inner ear	DME MAC
E2201-E2397	Wheelchair accessories	DME MAC
E2402	Negative pressure wound therapy pump	DME MAC
E2500-E2599	Speech generating device	DME MAC
E2601-E2621	Wheelchair cushions	DME MAC
E8000-E8002	Gait trainers	DME MAC
G0008-G0329	Misc. professional services	Local carrier

2010 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
G0333	Dispensing fee	DME MAC
G0337-G0365	Misc. professional services	Local carrier
G0372	Misc. professional services	Local carrier
G0378-G9140	Misc. professional services	Local carrier
J0120-J3570	Injection	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified biologicals	Local carrier
J7030-J7130	Miscellaneous drugs and solutions	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7185-J7195	Antihemophilic factor	Local carrier
J7197	Antithrombin III	Local carrier
J7198	Anti-inhibitor; per I.U.	Local carrier
J7199	Other hemophilia clotting factors	Local carrier
J7300-J7307	Intrauterine copper contraceptive	Local carrier
J7308	Aminolevulinic acid HCL	Local carrier
J7310	Ganciclovir, long-acting implant	Local carrier
J7311	Fluocinolone acetonide, intravitreal implant	Local carrier
J7321-J7325	Hyaluronan	Local carrier
J7330	Autologous cultured chondrocytes, implant	Local carrier
J7500-J7599	Immunosuppressive drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7604-J7699	Inhalation solutions	Local carrier if incident to a physician's service. If other, DME MAC.
J7799	NOC, other than inhalation drugs through DME	Local carrier if incident to a physician's service. If other, DME MAC.
J8498	Anti-emetic drug	DME MAC
J8499	Prescription drug, oral, non chemotherapeutic	Local carrier if incident to a physician's service. If other, DME MAC.
J8501-J8999	Oral anti-cancer drugs	DME MAC
J9000-J9999	Chemotherapy drugs	Local carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001-K0108	Wheelchairs	DME MAC
K0195	Elevating leg rests	DME MAC
K0455	Infusion Pump used for uninterrupted administration of epoprostenal	DME MAC
K0462	Loaner equipment	DME MAC
K0552	External infusion pump supplies	DME MAC
K0601-K0605	External infusion pump batteries	DME MAC
K0606-K0609	Defibrillator accessories	DME MAC
K0669	Wheelchair cushion	DME MAC
K0672	Soft interface for orthosis	DME MAC
K0730	Inhalation drug delivery system	DME MAC
K0733	Power wheelchair accessory	DME MAC
K0734-K0737	Power wheelchair seat cushions	DME MAC
K0738	Oxygen equipment	DME MAC
K0739	Repair or nonroutine service for DME	Local carrier if implanted DME. If other, DME MAC.
K0740	Repair or nonroutine service for oxygen equipment	DME MAC

2010 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
K0800-K0899	Power mobility devices	DME MAC
L0112-L2090	Orthotics	DME MAC
L2106-L2116	Orthotics	DME MAC
L2126-L4398	Orthotics	DME MAC
L5000-L5999	Lower limb prosthetics	DME MAC
L6000-L7499	Upper limb prosthetics	DME MAC
L7500-L7520	Repair of prosthetic device	Local carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic donning sleeve	DME MAC
L7900	Vacuum erection system	DME MAC
L8000-L8485	Prosthetics	DME MAC
L8499	Unlisted Procedure for miscellaneous prosthetic services	Local carrier if implanted prosthetic device. If other, DME MAC.
L8500-L8501	Artificial larynx; tracheostomy speaking valve	DME MAC
L8505	Artificial larynx accessory	DME MAC
L8507	Voice prosthesis, **patient inserted**	DME MAC
L8509	**Voice prosthesis, inserted by a licensed health care provider**	**Local carrier for dates of service on or after 10/01/2010, DME MAC for dates of service prior to 10/01/2010**
L8510-L8515	Voice prosthesis	**DME MAC**
L8600-L8699	Prosthetic implants	Local carrier
L9900	Miscellaneous orthotic or prosthetic component or accessory	Local carrier if used with implanted prosthetic device. If other, DME MAC.
M0064-M0301	Medical services	Local carrier
P2028-P9615	Laboratory tests	Local carrier
Q0035	Influenza vaccine; cardio-kymography	Local carrier
Q0081	Infusion therapy	Local carrier
Q0083-Q0085	Chemotherapy administration	Local carrier
Q0091	Smear preparation	Local carrier
Q0092	Portable X-ray setup	Local carrier
Q0111-Q0115	Miscellaneous lab services	Local carrier
Q0138-Q0139	**Ferumoxytol injection**	**Local carrier**
Q0144	Azithromycin dihydrate	Local carrier if incident to a physician's service. If other, DME MAC.
Q0163-Q0181	Anti-emetic	DME MAC
Q0480-Q0506	Ventricular assist devices	Local carrier
Q0510-Q0514	Drug dispensing fees	DME MAC
Q0515	Sermorelin acetate	Local carrier
Q1003-Q1005	New technology IOL	Local carrier
Q2004	Irrigation solution	Local carrier
Q2009	Fosphenytoin	Local carrier
Q2017	Teniposide	Local carrier
Q2025	**Oral chemotherapy drug (effective July 1, 2010)**	**DME MAC**
Q2026-Q2027	**Injectable dermal fillers (effective July 1, 2010)**	**Local carrier**
Q3001	Radio elements for brachytherapy	Local carrier
Q3014	Telehealth originating site facility fee	Local carrier
Q3025-Q3026	Vaccines	Local carrier

2010 DMEPOS jurisdiction listing (continued)

HCPCS	Description	Jurisdiction
Q3031	Collagen skin test	Local carrier
Q4001-Q4051	Splints and casts	Local carrier
Q4074	Inhalation drug	Local carrier if incident to a physician's service. If other, DME MAC.
Q4081	Epoetin	DME MAC for method II home dialysis. If other, local carrier.
Q4082	Drug subject to competitive acquisition program	Local carrier
Q4100-Q4116	Skin substitutes	Local carrier
Q5001-Q5009	Hospice services	Local carrier
Q9951-Q9954	Imaging agents	Local carrier
Q9955-Q9957	Microspheres	Local carrier
Q9958-**Q9968**	Imaging agents	Local carrier
R0070-R0076	Diagnostic radiology services	Local carrier
V2020-V2025	Frames	DME MAC
V2100-V2513	Lenses	DME MAC
V2520-V2523	Hydrophilic contact lenses	Local carrier if incident to a physician's service. If other, DME MAC.
V2530-V2531	Contact lenses, scleral	DME MAC
V2599	Contact lens, other type	Local carrier if incident to a physician's service. If other, DME MAC.
V2600-V2615	Low vision aids	DME MAC
V2623-V2629	Prosthetic eyes	DME MAC
V2630-V2632	Intraocular lenses	Local carrier
V2700-V2780	Miscellaneous vision service	DME MAC
V2781	Progressive lens	DME MAC
V2782-V2784	Lenses	DME MAC
V2785	Processing-corneal tissue	Local carrier
V2786	Lens	DME MAC
V2787-V2788	Intraocular lenses	Local carrier
V2790	Amniotic membrane	Local carrier
V2797	Vision supply	DME MAC
V2799	Miscellaneous vision service	DME MAC
V5008-V5299	Hearing services	Local carrier
V5336	Repair/modification of augmentative communicative system or device	DME MAC
V5362-V5364	Speech screening	Local carrier

Note: Deleted codes are valid for dates of service on or before the date of deletion.
Note: Updated codes are in bold.

Source: CR 7110

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Laboratory/Pathology

Effective date on the procedure status indicator for *CPT* code *80101*

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

Provider types affected

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

Provider action needed

This article is based on CR 7140, which clarifies that the effective date for the change of the procedure status indicator to "I" for *Current Procedure Terminology* (*CPT*) code *80101* has been set to January 1, 2010 for all claims and CR 7140 supersedes all other CRs in relation to this issue. Thus;

- For claims with date of service (DOS) on or after January 1, 2010, the new test code G0431 (Drug Screen, Qualitative; Single Drug Class Method) must be utilized by those clinical laboratories that do not require a Clinical Laboratory Improvement Act (CLIA) certificate of waiver as *CPT* codes *80101* and *80101* QW are not valid on the clinical laboratory fee schedule (CLFS) as of January 1, 2010.
- Clinical laboratories should identify claims that were filed and denied during the period of January 1, 2010 through June 30, 2010, as a result of CPT 80101, and resubmit these claims with HCPCS code G0431. However, do not resubmit such claims if they were paid by Medicare.
- For claims with DOS on or after January 1, 2010, clinical laboratories that do require a CLIA certificate of waiver must utilize the new test code G0431 QW.

Background

The Center for Medicare & Medicaid Services (CMS) has been receiving inquiries on when the Medicare procedure status indicator should be changed to "I" (Not valid for Medicare purposes, Medicare recognizes another code) for *CPT 80101* (*Drug Screen, Qualitative; Single Drug Class Method*). There has been some confusion regarding the compliance between CR 6852 (Transmittal 653) issued on March 19, 2010, which changed the indicator effective April 1, 2010 and CR 6909 (Transmittal 1957) issued on April 28, 2010 which changed the indicator effective date to July 1, 2010, as well as a third source, the CLFS file that is utilized by the Medicare contractors, which changed the indicator effective date to January 1, 2010. CR 7140 clarifies that the effective date for the change of the procedure status indicator to "I" for *CPT* code *80101* has been set to January 1, 2010. This CR supersedes all previous CMS transmittals concerning the indicator change for *CPT* code *80101*.

Beginning January 1, 2010, the new test code G0431 (Drug Screen, Qualitative; Single Drug Class Method) must be used by those clinical laboratories that do not require a CLIA certificate of waiver.

For claims with DOS on or after January 1, 2010, those clinical laboratories that do require a CLIA certificate or waiver must utilize the new test code G0431 QW.

Claims that were filed and denied for the period January 1, 2010, through June 30, 2010, with *CPT* code *80101* should be resubmitted with the Healthcare Common Procedure Coding System (HCPCS) Code G0431.

Additional Information

The official instruction (CR 7140) issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R776OTN.pdf*. If you have any questions, please contact your carrier, FI, and A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7140
Related Change Request (CR) #: 7140
Related CR Release Date: September 24, 2010
Effective Date: October 26, 2010
Related CR Transmittal #: R776OTN
Implementation Date: October 26, 2010

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Medicare Physician Fee Schedule Database

October 2010 Medicare physician fee schedule database update

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

Provider types affected

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

What you need to know

Payment files were issued to Medicare contractors based upon the 2010 Medicare physician fee schedule final rule. This article is based on change request (CR) 7112, which amends those payment files. Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that were processed prior to implementation of CR 7112. However, contractors will adjust claims brought to their attention.

Background

Changes included in the October update to the 2010 Medicare physician fee schedule database (MPFSDB) are as follows:

The following changes are effective for dates of service on and after January 1, 2010:

CPT/HCPCS/modifier	Action
51725 TC	Multiple procedure indicator: 2
51726 TC	Multiple procedure indicator: 2
51727 TC	Multiple procedure indicator: 2
51728 TC	Multiple procedure indicator: 2
51729 TC	Multiple procedure indicator: 2
51736 TC	Multiple procedure indicator: 2
51741 TC	Multiple procedure indicator: 2
51784 TC	Multiple procedure indicator: 2
51785 TC	Multiple procedure indicator: 2
51792 TC	Multiple procedure indicator: 2
54240	Multiple procedure indicator: 0
54240 26	Multiple procedure indicator: 0
54250	Multiple procedure indicator: 0
54250 26	Multiple procedure indicator: 0
59020	Multiple procedure indicator: 0
59020 26	Multiple procedure indicator: 0
59025	Multiple procedure indicator: 0
59025 26	Multiple procedure indicator: 0
76813 TC	Physician supervision diagnostic indicator: 01
76814 TC	Physician supervision diagnostic indicator: 01
G8443	Procedure status: I
G8445	Procedure status: I
G8446	Procedure status: I

Magnetic resonance angiography

On June 3, 2010, the Centers for Medicare & Medicaid Services (CMS) discontinued separate national coverage determinations (NCD) for magnetic resonance angiography (MRA) and magnetic resonance imaging (MRI) and eliminated the noncoverage language that currently exists for MRA in the *NCD Manual*, Section 220.3, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally noncovered. As a result of this change, the procedure status for *CPT* codes *72159* and *73225* has changed from noncovered to restricted. This change is effective for dates of service on or after June 3, 2010.

October 2010 Medicare physician fee schedule database update (continued)

The following changes are effective for dates of service on and after July 1, 2010:

CPT/HCPCS	Action
0223T	Assistant at surgery indicator: 9
0224T	Assistant at surgery indicator: 9
0225T	Assistant at surgery indicator: 9
0226T	Assistant at surgery indicator: 9
0227T	Assistant at surgery indicator: 9
0228T	Assistant at surgery indicator: 9
0229T	Assistant at surgery indicator: 9
0230T	Assistant at surgery indicator: 9
0231T	Assistant at surgery indicator: 9
0232T	Assistant at surgery indicator: 9
0233T	Assistant at surgery indicator: 9

Descriptor changes

The long and/or short descriptor has been revised for the following codes:

HCPCS code	Revised long descriptor	Revised short descriptor
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening	N/A
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening	N/A
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening	Rapid immunoassay HIV-1,2

Additional information

The official instruction, CR 7112 issued to your carrier, FI, or A/B MAC, regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2051CP.pdf*.

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

MLN Matters® Number: MM7112
Related Change Request (CR) #: 7112
Related CR Release Date: September 17, 2010
Effective Date: January 1, 2010, unless otherwise noted
Related CR Transmittal #: R2051CP
Implementation Date: October 4, 2010

Welcome to Medicare

If you're new to the Medicare community or if you just need a review of the basics, please visit our Welcome to Medicare page at *http://medicare.fcso.com/Welcome_to_Medicare/*. You'll find everything you need to build your foundation of Medicare knowledge, from a recommended training curriculum to links to key resources to help you on your way to success as a Medicare provider or biller.

Radiology

FDG-PET for initial treatment strategy in solid tumors and myeloma

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

Provider types affected

This article is for physician, hospitals, and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MAC]) for providing fluorodeoxyglucose positron emission tomography (FDG PET) services to Medicare beneficiaries.

What you need to know

CR 7148, from which this article is taken, announces that on August 4, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum determining that currently restricting the use of only one positron emission tomography (PET) scan for therapeutic purposes in the initial treatment strategy for suspected solid tumors and myeloma is not supported by available evidence.

Therefore, effective August 4, 2010, Medicare will continue to nationally cover one FDG PET scan for these indications; and local Medicare contractors will have discretion to cover (or not cover), within their jurisdictions, any additional FDG PET scans for therapeutic purposes related to the initial treatment strategy. You should make sure that your billing staffs are aware of this national coverage determination (NCD).

Background

Currently, CMS covers only one FDG PET study for beneficiaries who have biopsy-proven solid tumors, or those in whom such tumors are strongly suspected based on other diagnostic testing; when the beneficiary's treating physician determines that the study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to the initial treatment strategy in order to:

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

CMS believes that the usefulness of an additional FDG PET scan in the initial treatment plan for any individual beneficiary might be affected by their specific medical problem, the availability of results of other diagnostic tests, and the expertise of the interpreting physician. CMS does not believe an NCD is the most appropriate way to address coverage for additional FDG PET scans in these situations, but rather believes that the local Medicare contractor should determine the efficacy for these tests for therapeutic purposes related to initial treatment strategy. Effective for claims with dates of service on or after August 4, 2010, CMS issued a final decision memorandum which:

- Removes the current absolute restriction of coverage of only one FDG PET scan to determine the location and/or extent of the tumor for therapeutic purposes related to initial treatment strategy (Medicare will continue to nationally cover one FDG PET scan for these indications), and
- Provides that your local Medicare contractors will have the discretion to cover (or not cover), within their jurisdictions, any additional FDG PET scans for therapeutic purposes related to the initial treatment strategy.

Additional information

You may find more information about the policy that changes the limitation of FDG PET scans for initial treatment strategy in solid tumors and myeloma by going to CR 7148, located at *http://www.cms.gov/Transmittals/downloads/R124NCD.pdf*. You will find the updated *Medicare National Coverage Determinations Manual* Chapter 1 (Chapter 1, Part 4 (Sections 200-310.1) Coverage Determinations, Section 220.6.17 (Positron Emission Tomography [PET] [FDG] for Oncologic Conditions – [Various Effective Dates]) as an attachment to that CR.

You might also want to review the *MLN Matters®* article related to CR 6632 (FDG PET for Solid Tumors and Myeloma), released May 6, 2010 (at *http://www.cms.gov/MLNMattersArticles/downloads/MM6632.pdf*) for existing coding and claims processing requirements.

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: MM7148
Related Change Request (CR) #: 7148
Related CR Release Date: September 24, 2010
Effective Date: August 4, 2010
Related CR Transmittal #: R124NCD
Implementation Date: October 25, 2010

Surgery

Allogeneic hematopoietic stem cell transplantation for myelodysplastic syndrome

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 hospitals billing Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [A/B MACs]) for providing allogeneic hematopoietic stem cell transplantation (HSCT) services to Medicare beneficiaries with myelodysplastic syndrome (MDS).

What you need to know

Change request (CR) 7137, from which this article is taken, announces (through a national coverage determination [NCD]) that, effective for claims with dates of service on and after August 4, 2010, Medicare will cover the use of allogeneic HSCT for treatment of MDS under Section 1862(a)(1)(E) of The Social Security Act (the Act) **only** if provided in the context of a Medicare-approved clinical study meeting specific criteria under coverage with evidence development (CED). The Centers for Medicare & Medicaid Services (CMS), pursuant to the NCD process, has determined that the evidence does not demonstrate the use of allogeneic HSCT improves health outcomes in Medicare beneficiaries with MDS, is not reasonable and necessary under Section 1862(a)(1)(A) of the Act, and is therefore not covered by Medicare **except** when provided in a Medicare-approved clinical study.

Background

MDS refers to a group of diverse blood disorders in which the bone marrow does not produce enough healthy, functioning blood cells. These blood disorders are varied with regard to clinical characteristics, cytologic and pathologic features, and cytogenetics. The abnormal production of blood cells in the bone marrow leads to low blood cell counts, referred to as cytopenias, which are a hallmark feature of MDS along with a dysplastic and hypercellular-appearing bone marrow.

On November 10, 2009, CMS accepted a formal request from several bone marrow and cancer organizations and societies, asking for national coverage of allogeneic HSCT for Medicare beneficiaries "who would either be at high risk for progression to leukemia or be at risk for MDS complications that place them at high risk for death or prevent the future possibility of a transplant."

Coding information

CR 7137 describes, effective for claims with dates of service on and after August 4, 2010, the codes that you will need to supply on your claims for the use of HCST for MDS to help your FI, carrier, or A/B MAC, determine if the treatment was provided pursuant to a Medicare-approved clinical study under CED using existing clinical trial coding conventions described in *MLN Matters*® article MM5790, *Use of an 8-Digit Registry Number on Clinical Trial Claims*, released on January 18, 2008, (found at *http://www.cms.gov/MLNMattersArticles/downloads/MM5790.pdf*).

Effective for claims with discharge dates on or after August 4, 2010, your inpatient claims (type of bill [TOB] 11x) for HSCT for the treatment of MDS in a clinical study must contain:

- ICD-9 diagnosis code V70.7
- Condition code 30
- HSCT-ICD-9-CM procedure codes 41.02, 41.03, 41.05, or 41.08, and
- MDSICD-9-CM diagnosis code 238.75.

Outpatient hospital claims (TOB 13x) for dates of service on or after August 4, 2010, for HSCT for the treatment of MDS in a clinical study must contain:

- HSCT *CPT* code *38240*
- MDS ICD-9-CM diagnosis code 238.75
- Clinical trial ICD-9-CM diagnosis code V70.7, and
- Clinical trial procedure code modifier Q0.

Practitioner claims for dates of service on or after August 4, 2010, billed by a method II critical access hospital on TOB 85x with revenue code 96x, 97x, or 98x, for HSCT for the treatment of MDS must contain:

- HSCT *CPT* code *38240*
- MDS ICD-9-CM diagnosis code 238.75
- Clinical trial ICD-9-CM diagnosis code V70.7, and
- Clinical trial procedure code modifier Q0.

Professional claims for HSCT for the treatment of MDS for dates of service on or after August 4, 2010, for HSCT for the treatment of MDS must contain:

- HSCT *CPT* code *38240*
- MDS ICD-9-CM diagnosis code 238.75
- Clinical trial ICD-9-CM diagnosis code V70.7
- Clinical trial procedure code modifier Q0, and
- Place of service code 21 or 22.

Note that the 8-digit clinical trial number may also appear on the claim, at the discretion of the provider (along with value code D4 for inpatient claims).

Medicare contractors will use the following messages if they deny claims for HSCT for the treatment of MDS that do not contain all of the required coding requirements mentioned above:

October 2010 Medicare physician fee schedule database update (continued)

- **Claim adjustment reason code (CARC) 50** – These are noncovered services because this is not deemed a "medical necessity" by the payer. Note: Refer to the 835 Healthcare policy identification segment (loop 2110 service payment information REF), if present.
- **Remittance advice remark code (RARC) N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** – patient responsibility (PR) if an advance beneficiary notice (ABN) or hospital issued notice of noncoverage (HINN) given to the beneficiary, otherwise contractual obligation (CO).

Finally, you should be aware that for claims with dates of service between August 4, 2010, and the implementation date of CR 7137; your contractor will perform necessary adjustments only when you bring affected claims to their attention.

Additional information

More details are available in the official notice to your Medicare contractor, CR 7137, which was issued in two transmittals. The first transmittal updated the *Medicare NCD Manual*, and it is available at *http://www.cms.gov/Transmittals/downloads/R127NCD.pdf*. The second transmittal updated the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R2062CP.pdf*.

You may also review the entire decision memorandum regarding this NCD at *http://www.cms.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=238&*. Appendix D of that memorandum contains instructions for submission of applications for protocols to address CED as required by an NCD.

If you have 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: MM7137
Related Change Request (CR) #: 7137
Related CR Release Date: October 8, 2010
Effective Date: August 4, 2010
Related CR Transmittal #: R127NCD and R2062CP
Implementation Date: November 10, 2010

General Coverage

CMS updates physician payment information for value-driven health care

The Centers for Medicare & Medicaid Services (CMS) updates the physician payment information for value-driven health care to support the delivery of high-quality, efficient health care and enable consumers to make more informed health-care decisions. In addition, the U.S. Department of Health & Human Services is making cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2007, 2008, and 2009 about the payments it made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

The hospital information is posted on the Hospital Compare website where it may be viewed along with hospital quality information. The Hospital Compare website may be found at *http://www.medicare.gov/*.

On August 20, 2010, Medicare posted an update to the ambulatory surgery center data. The hospital outpatient department payment update was posted on September 29, 2010. The physician update was posted on October 1, 2010. The information is being displayed in the same format as in previous years, updated with calendar year (CY) 2009 data. The posting updates may be found at *http://www.cms.gov/HealthCareConInit/*.

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

Source: CMS PERL 201010-06

Medicare fee-for-service emergency policies and procedures

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

Provider types affected

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

Provider action needed

This article is informational only and advises providers on where to find information regarding Medicare policies related to emergency guidance for the duration of the emergency, such as the H1N1 pandemic.

Background

As part of its preparedness efforts for an influenza pandemic, the Centers for Medicare & Medicaid Services (CMS) developed certain emergency guidance and procedures that may be implemented for the Medicare fee-for-service (FFS) program in the event of a pandemic or disaster.

Additional pandemic-specific preparedness guidance and procedures were issued in prior change requests (CRs). CR 6837 rescinds the CRs implementing selected influenza pandemic-specific guidance and procedures. Specifically, CR 6837 rescinds CRs 5099, 6146, 6164, 6174, 6209, 6256, 6280, 6284, and 6378.

The guidance and procedures (in the form of questions and answers [Qs & As]) previously implemented by the aforementioned CRs will, instead, be made available on the CMS "Emergency" website at *http://www.cms.gov/Emergency/*, and titled:

- "Emergency Qs & As – no 1135 waivers required," and
- "Emergency Qs & As – applicable only when an applicable 1135 waiver has been granted."

Additional information

The official instruction, CR 6837, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R772OTN.pdf*.

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

MLN Matters® Number: MM6837
Related Change Request (CR) #: 6837
Related CR Release Date: September 21, 2010
Effective Date: November 22, 2010
Related CR Transmittal #: R772OTN
Implementation Date: November 22, 2010

Partial code freeze prior to ICD-10 implementation

At the ICD-9-CM Coordination & Maintenance Committee meeting on September 15, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM/PCS codes prior to implementation on October 1, 2013. There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012, there will be only limited code updates to both ICD-9-CM and ICD-10 code sets to capture new technology and new diseases.
- There will be no updates to ICD-9-CM on October 1, 2013, as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

You may view the transcript of the meeting at *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp*. From there, select the September 15-16, 2010 meeting transcript in the *Download* section, and then from the ZIP files, select the 091510_Morning_Transcript file. This section appears on page 4 of the 78-page proceeding.

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

Source: CMS PERL 201010-35

Counseling to prevent tobacco use

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

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for tobacco cessation counseling services provided to Medicare beneficiaries who are outpatients or are hospitalized are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7133 which announces that the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use for outpatient and hospitalized beneficiaries.

Caution – what you need to know

Effective for claims with dates of service on and after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries 1) who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations. The ICD-9 diagnosis codes that should be reported for these individuals are 305.1 (non-dependent tobacco use disorder) or V15.82 (history of tobacco use).

Go – what you need to do

New G codes and C codes are also created for these services. See the *Background* and *Additional information* sections of this article for further details regarding these changes and the use of the new G and C codes.

Background

Medicare Part B (Section 210.4 of the *National Coverage Determination [NCD] Manual*) already covers cessation counseling for individuals who:

1. Use tobacco and have been diagnosed with a recognized tobacco-related disease, or
2. Use tobacco and exhibit symptoms consistent with a tobacco-related disease.

In November 2009, based upon authority to cover "additional preventive services" for Medicare beneficiaries if certain statutory requirements are met, the CMS initiated a new national coverage analysis. This analysis was to evaluate whether the existing evidence on counseling to prevent tobacco use is sufficient to extend national coverage for cessation counseling to those individuals who use tobacco (but do not have signs or symptoms of tobacco-related disease).

One of these statutory requirements is that the service be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the US Preventive Services Task Force (USPSTF).

CR 7133 instructs that, effective for claims with dates of service on and after August 25, 2010, CMS will cover counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries:

1. Who use tobacco (regardless of whether they have signs or symptoms of tobacco-related disease)
2. Who are competent and alert at the time that counseling is provided, and
3. Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations.

The diagnosis codes that should be reported for these individuals are:

- ICD-9 code 305.1 (non-dependent tobacco use disorder), or
- ICD-9 code V15.82 (history of tobacco use).

The CMS has created two new G codes for billing for tobacco cessation counseling services to prevent tobacco use for dates of service on or after January 1, 2011. These are in addition to the two *CPT* codes *99406* and *99407* that currently are used for tobacco cessation counseling for symptomatic individuals. Medicare will waive the deductible and coinsurance/copayment for counseling and billing with these two new G codes on or after January 1, 2011. The new G codes for use on claims with dates of service on or after January 1, 2011 are:

- **G0436: Long descriptor**: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes. **Short descriptor**: Tobacco-use counsel 3-10 min.
- **G0437: Long descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes. **Short descriptor:** Tobacco-use counsel >10 min.

Medicare will pay claims not paid under the outpatient prospective payment system (OPPS) with dates of service on or after August 25, 2010, through December 31, 2010, but received prior to January 1, 2011, when billed with diagnosis code 305.1 (non-dependent tobacco-use disorder) or V15.82 (history of tobacco use) and unlisted *CPT* code *99199* for counseling to prevent tobacco use services. Code *99199* is Medicare contractor-priced.

However, two new, temporary C codes have been created for facilities paid under the OPPS when billing for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010. (Facilities paid under the OPPS may not bill the unlisted *99199* code.) The two new C codes are:

- **C9801: Long descriptor**: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.

Counseling to prevent tobacco use (continued)

Short descriptor: Tobacco-use counsel 3-10 min.

- **C9802: Long descriptor**: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.
  Short descriptor: Tobacco-use counsel >10 min.

CMS will allow two individual tobacco cessation counseling attempts per year. Each attempt may include a maximum of four intermediate OR intensive sessions, with a total benefit covering up to eight sessions per year per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than three minutes up to 10 minutes) or intensive (more than 10 minutes) cessation counseling sessions for each attempt.

Note: Section 4104 of the Affordable Care Act provided for a waiver of the Medicare coinsurance and Part B deductible requirements for counseling to prevent tobacco use services, codes G0436 and G0437, effective on or after January 1, 2011. No other tobacco cessation codes are eligible for waiver of coinsurance/deductible at this time. Prior to January 1, 2011, this service will be subject to the standard Medicare coinsurance and Part B deductible requirements.

The method of payment to institutional providers for outpatient services is as shown in the following table:

Type of facility	Method of payment
Rural health centers (RHCs)(type of bill (TOB) 71x/federally qualified health centers (FQHCs) (TOB 77x)	All-inclusive rate (AIR) for the encounter
Hospitals (TOBs 12x and 13x)	OPPS for hospitals subject to OPPS Medicare physician fee schedules (MPFS) for hospitals not subject to OPPS
Indian health services (IHS) (TOB 13x)	AIR for the encounter
Skilled nursing facilities (SNFs) (TOBs 22x and 23x)	MPFS
Home health agencies (HHAs) (TOB 34x)	MPFS
Critical access hospitals (CAHs) (TOB 85x), IHS CAHs (TOB 85x)	**Method I:** Technical services are paid at 101 percent of reasonable cost. **Method II:** technical services are paid at 101 percent of reasonable cost, and professional services are paid at 115 percent of the MPFS Based on specific rate
Maryland hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC) that is 94 percent of submitted charges subject to any unmet deductible, coinsurance, and noncovered charges policies.

Note also the following claims processing information from CR 7133:

- Claims submitted with the tobacco cessation counseling codes of G0436 and G0437, but which lack a required diagnosis code (305.1 or V15.82) will be denied with claim adjustment reason Code (CARC) 167 (This (these) diagnosis (es) is (are) not covered. **Note**: Refer to the 835 Health Care Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), remittance advice remarks code (RARC) M64 (Missing/incomplete/invalid other diagnosis), and group code PR assigning financial liability to the beneficiary if a claim is received with a signed advance beneficiary notice (ABN). If no ABN is on file, group code CO is used to assign financial liability to the provider.
- Claims are accepted for G0436 and G0437 with revenue code 0942 on TOB 12x, 13x, 22x, 23x, 34x, and 85x.
- Claims are accepted for G0436 and G0437 with revenue codes 096x, 097x, or 098x when billed on TOB 85x Method II under the MPFS.
- Claims are accepted for G0436 and G0437 with revenue code 052x when billed on TOBs 71x or 77x.
- Claims are accepted for G0436 and G0437 with revenue code 0510 when billed by IHS facilities.
- Institutional claims billed on TOBs other than 12x, 13x, 22x, 23x, 34x, 71x, 77x, or 85x will be returned to the provider.
- When claims are denied for exceeding a combined total of eight sessions within a 12-month period, the claims will be denied using CARC 119 (Benefit maximum for this time period or occurrence has been reached.), RARC N362 (The number of days or units of service exceeds our acceptable maximum.), and group code PR if a signed ABN is on file. A group code of CO is assigned if no ABN is on file.

Note: In calculating a 12-month period, 11 months must pass following the month in which the 1st Medicare covered cessation counseling session was performed.

Counseling to prevent tobacco use (continued)

- Medicare will allow payment for a medically necessary evaluation and management (E/M) service on the same date as tobacco cessation counseling, provided it is clinically appropriate. Such E/M service should be reported with modifier 25 to indicate it is separately identifiable from the tobacco use service.

Additional information

The official instruction, CR 7133, was issued to your carrier, FI, or A/B MACs via two transmittals. The first transmittal modified the *NCD Manual* and it may be viewed at *http://www.cms.gov/Transmittals/downloads/R125NCD.pdf*. The second transmittal modifies the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R2058CP.pdf* on that site.

If you have 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: MM7133
Related Change Request (CR) #: 7133
Related CR Release Date: September 30, 2010
Effective Date: August 25, 2010
Related CR Transmittal #: R125NCD and R2058CP
Implementation Date: January 3, 2011

Eligible practitioners who need to enroll for the sole purpose of ordering and referring

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

Provider types affected

This article is for physicians and nonphysician practitioners who are eligible to order and refer items and services for Medicare beneficiaries and who are enrolling in Medicare for the sole purpose of ordering or referring.

What you need to know

Change request (CR) 7097, from which this article is taken, announces that physicians and nonphysician practitioners will need to enroll in the Medicare program so they can order and refer items and services for Medicare beneficiaries.

The enrollment requirement is applicable to those physician and nonphysician practitioners of a profession eligible to order and refer who are:

- Employed by the Department of Veterans Affairs (DVA), Public Health Service (PHS), Department of Defense (DoD) TRICARE, or by Medicare enrolled federally qualified health centers (FQHC), rural health clinics, (RHC), or critical access hospitals (CAH)
- Physicians in a fellowship
- Dentists, including oral surgeons, or
- Other employed eligible physicians and nonphysician practitioners

Background

On May 5, 2010, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* an interim final rule with comment (IFC) regulation titled, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements." This IFC proposed requirements to implement several of the provisions of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA) (Pub. L. 111-148) designed to support the Administration's efforts to prevent and detect fraud, waste and abuse in the Medicare and Medicaid programs, and to ensure quality care for beneficiaries.

Specifically, this regulation proposed requirements to implement section 6405 of the ACA, which (effective July 6, 2010) requires home health agencies and certain Part B suppliers to include, on a claim, the legal name and national provider identifier (NPI) of the physician or nonphysician practitioner who ordered or referred the billed items or services for the beneficiary.

This action means that Medicare will reimburse claims from providers and suppliers who furnished, ordered, or referred items or services to Medicare beneficiaries only when the ordering/referring provider identified in those claims is of an eligible discipline as noted in the following list, and is also enrolled in the Medicare program (has an enrollment record in the Provider Enrollment, Chain and Ownership System [PECOS]) at the time of the service:

- Doctor of medicine or osteopathy
- Doctor of dental medicine
- Doctor of dental surgery
- Doctor of podiatric medicine
- Doctor of optometry
- Doctor of chiropractic medicine

Counseling to prevent tobacco use (continued)

- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

Further, while most physicians and nonphysician practitioners enroll in the Medicare program to furnish covered services to Medicare beneficiaries, in implementing this section of the ACA, the Centers for Medicare & Medicaid Services (CMS) has become aware of certain physicians and non- physician practitioners who only order or refer items and services for Medicare beneficiaries—the services they furnish to Medicare beneficiaries are not reimbursable by the Medicare program. CR 7097 announces that such physicians and nonphysician practitioners will need to enroll in the Medicare program in order to be able to continue to order or refer items or services for Medicare beneficiaries.

Specifically, if you order or refer items or services for Medicare beneficiaries and (1) you are employed by the DVA, the PHS, DoD TRICARE, or by a Medicare enrolled FQHC, RHC or CAH, (2) you are in a fellowship, or (3) you are a dentist or oral surgeon, you will need to enroll in Medicare using the modified enrollment process described below. (Any provider can enroll for the sole purpose of ordering or referring, regardless of who their employer is.)

Modified enrollment process for physicians and nonphysician practitioners who are enrolling solely to order and refer

To enroll in Medicare for the sole purpose of ordering or referring items or services, you must do the following:

1. Complete the following sections paper of form CMS-855I ("Medicare Enrollment Application for Physicians and Nonphysician Practitioners"):
   - Section 1 – Basic Information (you would be a new enrollee)
   - Section 2 – Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K)
   - Section 3 – Final Adverse Actions/Convictions
   - Section 13 – Contact Person, and
   - Section 15 – Certification Statement (must be signed and dated—blue ink recommended).
2. You must include a cover letter with this enrollment application stating that you are enrolling for the sole purpose of ordering and referring items or services for a Medicare beneficiary and cannot be reimbursed by the Medicare program for services that you may provide to Medicare beneficiaries.
3. Mail the completed enrollment application and cover letter to your designated Medicare enrollment contractor, which you may find at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

Your designated Medicare enrollment contractor will verify that the information you provided on the application meets the Medicare requirements for your profession (supplier type) and, if approved, will enter the data into PECOS. This will place you on the ordering referring file that is available on the Medicare provider/supplier enrollment website (*http://www.cms.gov/MedicareProviderSupEnroll*) and the information will be in the Medicare claims system so that claims for the items or services you ordered or referred can be paid. The designated Medicare contractor will send you a letter notifying you that you are enrolled in the Medicare program for the sole purpose of ordering and referring items or services for Medicare beneficiaries.

Notes:

1) When enrolling, you do not have to complete the CMS 460, Medicare Participating Physician or Supplier Agreement or the CMS 588, Electronic Funds Transfer (EFT) Authorization Agreement, in with the CMS-855I application. Also, license information received from a physician or practitioner employed by DVA or DoD may be active in a state other than the DVA or DVA location.
2) Since the abbreviated application does not require you to complete section 4 and CMS is requiring a cover letter, the Medicare enrollment contractors will reject your application if section 4 is blank and a cover letter is not attached.
3) You are not permitted to be reimbursed by Medicare for services you may furnish to Medicare beneficiaries.
4) If, in the future, you wish to be reimbursed by Medicare for services performed, you must submit the full enrollment application via the paper application(s) (CMS-855) or Internet-based PECOS; the Medicare enrollment contractor will deactivate the current information.

Additional information

You may find more information about enrolling in Medicare for the sole purposes of ordering and referring by going to CR 7097, located at *http://www.cms.gov/Transmittals/downloads/R355PI.pdf*. You will find the updated Medicare Program Integrity Manual, Chapter 15 (Medicare Provider/Supplier Enrollment), Section 16.1 (Ordering/Referring Providers Who Are Not Enrolled in Medicare) as an attachment to that CR.

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

MLN Matters® Number: MM7097
Related Change Request (CR) #: 7097
Related CR Release Date: September 17, 2010
Effective Date: October 18, 2010
Related CR Transmittal #: R355PI
Implementation Date: October 18, 2010

Electronic Data Interchange

HIPAA 5010 requirement for ambulance suppliers

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

Provider types affected

This article is for ambulance suppliers submitting claims in the HIPAA 5010 837P (professional) electronic claim format beginning January 1, 2011, to Medicare carriers or Part A/B Medicare administrative contractors (A/B MAC) for services rendered to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has decided upon early adoption of HIPAA version 5010 of the 837P electronic claim format and will implement it on January 1, 2011. If you are an ambulance supplier who plans early adoption of the new standard, this special edition article tells you how to submit your claims electronically in light of the new 837P, HIPAA version 5010 diagnosis code reporting requirement.

Caution – what you need to know

Effective for claims submitted in the HIPAA version 5010 837P electronic claim format on and after January 1, 2011, ambulance suppliers will have three options for complying with the new diagnosis reporting requirement.

Option 1: Suppliers may choose a code or codes from the medical conditions list provided by CMS that corresponds to the condition of the beneficiary at the time of pickup and report the code(s) in the diagnosis field on the claim. The medical conditions list and instructions for using this list may be found in the *Medicare Claims Processing Manual*, Chapter 15, Section 40, "Medical Conditions List and Instructions," available at *http://www.cms.gov/manuals/downloads/clm104c15.pdf*. The codes in the medical conditions list are taken from the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9CM) diagnosis code set. Suppliers must continue to accurately maintain transport records to support any data reported on the claim.

Option 2: Suppliers may report an ICD-9 (or ICD-10 when appropriate) diagnosis code that is provided to them by the treating physician or other practitioner.

Option 3: Suppliers may report ICD-9 diagnosis code 799.9 (unspecified illness).

Note: Effective October 1, 2013, the new ICD-10 diagnosis code set will be implemented, thus making the ICD-9 code set obsolete.

- Suppliers choosing options 1 or 3 will be given further guidance upon implementation of the new code set.
- Suppliers choosing option 2 should ensure that they are provided with the appropriate ICD-10 diagnosis code for dates of service on and after October 1, 2013.

Go – what you need to do

If you choose to submit claims in the HIPAA version 5010 837P electronic claim format on and after January 1, 2011, you must comply with the requirement to include a diagnosis code. CMS will not be capable of accepting claims submitted under the HIPAA 5010 version of the 837P that do not comply with this requirement. You may continue to use the HIPAA 4010A1 version of the 837P until December 31, 2011.

Background

The Administrative Simplification Compliance Act (ASCA) and its implementing regulation require that all initial claims for payment under Medicare be submitted electronically as of October 16, 2003, unless one of the statutory or regulatory exceptions applies. Electronic claim submissions are required to be in compliance with the claim standards adopted for national use under the Health Insurance Portability and Accountability Act of 1996. Ambulance suppliers currently use the American National Standards Institute (ANSI) 837P (professional), version 4010A1 to submit claims for payment.

The HIPAA 4010A1 version of the 837P electronic claim does not require submission of a diagnosis code from the ICD-9-CM code set in loop 2300, segment HI. Additionally, CMS does not currently require ambulance suppliers to submit a diagnosis code on claims for payment. However, the 5010 version of the 837P, which becomes effective on January 1, 2012, requires that a diagnosis code be present on all 837P electronic claims, including ambulance claims.

Additional information

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: SE1029
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

Claim status category and claim status codes update

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

Provider types affected

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

Provider action needed

This article, based on CR 7158, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 along with the 277 health care claim acknowledgement updated during the October 2010 meeting of the National Code Maintenance Committee and code changes approved at that meeting are to be posted at *http://www.wpc-edi.com/content/view/180/223/* on or about November 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on January 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only claim status codes and claim status category codes approved by the national Code Maintenance Committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (institutional or professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

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

The official instruction (CR 7158) issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2049CP.pdf*.

MLN Matters® Number: MM7158
Related Change Request (CR) #: 7158
Related CR Release Date: September 17, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2049CP
Implementation Date: January 3, 2011

CMS helps in the transitions to HIPAA version 5010 and ICD-10

Have questions about the HIPAA version 5010 and ICD-10 transition? The Centers for Medicare & Medicaid Services (CMS) is here to help.

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 *http://www.cms.gov/ICD10/Downloads/ICD10IntroFactSheet20100409.pdf*
- ICD-10 Basics for Medical Practices *http://www.cms.gov/ICD10/Downloads/ICD10MedicalPracticesBasics20100409.pdf*
- Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices *http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoVendorforMedicalPractices20100409.pdf*
- Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors *http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoCustomersforVendors20100409.pdf*

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 HIPAA version 5010 and ICD-10 e-mail updates.

HIPAA 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 201009-38

Medicare fee-for-service implementation of HIPAA 5010/D.0 – errata impacts

The purpose of this message is to clearly communicate the approach that Medicare fee-for-service (FFS) is taking to ensure compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) new versions of the Accredited Standards Committee (ASC) X12 and the National Council for Prescription Drug Programs (NCPDP) electronic data interchange (EDI) transactions.

The Standards Development Organizations have made corrections to the 5010 and D.0. versions of certain transactions. The Errata versions replace the base versions for HIPAA compliance. Per the *Federal Register* (Vol. 75, No. 197, October 13, 2010, 62684–62686 [2010–25684] found at *http://www.access.gpo.gov/su_docs/aces/fr-cont.html*), HIPAA compliance will require the implementation of the errata versions and the base versions for those transactions not affected by the errata, as listed below. Compliance with the errata must be achieved by the original regulation compliance date of January 2012.

Transactions affected by the errata -- list of base and errata versions for 5010 and D.0.

Transactions affected by the Errata version	Base version	Errata version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) Version D.0 of the Telecom Standard	D.0	D.0 April 2009

Medicare FFS will implement the errata versions to meet HIPAA compliance requirements. Also in compliance with the published regulation (RIN 0938-AM50 of 45 CFR Part 162), Medicare FFS testing with external trading partners must begin in January of 2011.

Testing

Medicare FFS contractors will be ready to test the base versions of all transactions in January 2011, and the 5010/D.0. Errata versions in April 2011. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. See *http://www.cms.gov/ElectronicBillingEDITrans/* under downloads, to find a Medicare FFS contractor in your state.

Production

The errata versions will be available for Medicare FFS production in April 2011. The errata transactions must be tested before using them for production. As a result, Medicare FFS 5010/D.0. test-to-production transition will begin in April 2011.

Medicare FFS timeline for 5010/D.0 implementation

1. Testing on base versions to begin in January 2011
2. Testing and transition to production on errata version to begin in April 2011
3. Implementation of 5010/D.0 on January 1, 2012

Source: CMS PERL 201010-25

Notification of X12 HIPAA version 5010 and version D.0 errata published

On Wednesday, October 13, the Department of Health and Human Services (HHS) published in the *Federal Register* a notification announcing maintenance changes to the standards adopted in the regulation titled "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards," which was published in the *Federal Register* on January 16, 2009. These standards include the ASC X12 5010 (version 5010) HIPAA electronic health care transactions; and the National Council of Prescription Drug Programs (NCPDP) telecommunications version D.0 standard. This notice also instructs interested persons on how to obtain the corrections, and advises HIPAA-covered entities to be sure to use the HIPAA-compliant version of each respective standard that includes these error corrections.

For the complete *Federal Register* notice, please go to *http://edocket.access.gpo.gov/2010/pdf/2010-25684.pdf*.

Source: CMS PERL 201010-26

2010 MCPSS

2010 Medicare contractor provider satisfaction survey – results available

The Centers for Medicare & Medicaid Services (CMS) has completed the administration of the 2010 Medicare contractor provider satisfaction survey (MCPSS). The 2010 results reflect the percentage of provider satisfaction as distributed on the new, fully labeled, five-point scale:

1. Very dissatisfied
2. Dissatisfied
3. Neither satisfied nor dissatisfied
4. Satisfied
5. Very satisfied

A random sample of over 33,000 providers was selected to participate in this year's survey. Providers were asked to rate their satisfaction with services provided by their fee-for-service (FFS) Medicare contractors. Of all providers who responded, more than 69 percent stated they were satisfied or very satisfied with their contractor's overall performance. Approximately 13 percent stated they were dissatisfied or very dissatisfied.

From the results, CMS is able to identify the contractor services that providers value the most as well as areas that need improvement. CMS will use this information to encourage process improvements with the FFS Medicare contractors.

The 2010 MCPSS public report details findings from the survey and may be accessed at *http://www.cms.gov/MCPSS*.

Thank you for your interest in the MCPSS.

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

Source: CMS PERL 201009-37

Results of the 2010 Medicare contractor provider satisfaction survey

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

Provider types affected

This article is informational only for all physicians, providers, and suppliers billing the Medicare program.

Provider action needed

No action is needed. This article is informational only and provides a summary of the findings from the annual Medicare contractor provider satisfaction survey (MCPSS) by the Centers for Medicare & Medicaid Services (CMS) to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]).

Background

The MCPSS offers Medicare fee-for-service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. The MCPSS elicits information from a sample of hospitals, physicians, skilled nursing facilities (SNFs), home health agencies, clinical laboratories, and other providers and suppliers.

Survey questions focus on seven key business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit & reimbursement. The 2010 MCPSS survey questions used a new fully labeled rating scale of 1 to 5, "1" representing "very dissatisfied" and "5" representing "very satisfied".

CMS distributed the 2010 survey to approximately 33,000 randomly selected providers, including physicians and other health care practitioners, suppliers, and institutional facilities that serve Medicare beneficiaries across the country. Those health care providers selected to participate in this year's survey were notified in January.

In January 2011, the next MCPSS will be distributed to a new sample of approximately 33,000 Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2011 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Key points/2010 results

- Of all providers who responded, more than 69 percent stated they were satisfied or very satisfied with their contractor's overall performance and 13 percent were dissatisfied or very dissatisfied with their contractor's overall performance.
- Audit and reimbursement and claim processing business functions were rated with the highest level of provider satisfaction.
- High satisfaction was also expressed by hospices, end-stage renal disease (ESRD) providers, and rural health clinics; while low satisfaction was expressed by licensed practitioners and laboratories.
- Individual results were provided to Medicare contractors for their use in process improvement activities.
- CMS is gradually migrating to a fully Web-based survey. The migration to the Web mode of response this year reached an overall total of 65 percent.
- The public report may be found at *http://www.cms.gov/MCPSS/*.

Results of the 2010 Medicare Contractor Provider Satisfaction Survey (continued)

Additional information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

For more information about the MCPSS, please visit *http://www.cms.gov/MCPSS/*.

MLN Matters® Number: SE1030
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

Electronic Health Records

Electronic health record incentive programs beginning in 2011

Incentive payments totaling as much as $27 billion may be made under the Medicare and Medicaid electronic health record (EHR) incentive programs beginning in 2011. Are you eligible for an incentive? How much can an eligible professional earn? What are the key dates for these programs?

Learn more on the Centers for Medicare & Medicaid Services (CMS) EHR incentive programs website.

Tip sheets for eligible professionals

- **Updated: Medicare EHR incentive programs, Physician Quality Reporting Incentive (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.
- **Updated flow chart: Determine eligibility for Medicare and Medicaid EHR incentive programs**
  Unsure if you are eligible to participate in the Medicare or Medicaid EHR incentive programs? Use this handy flow chart to find out.
- **Medicare EHR incentive payments for eligible professionals**
  Which types of individual practitioners can participate in the Medicare EHR incentive program? This easy tip sheet provides information about incentive payment amounts and describes how payments are calculated for fee for service (FFS) and Medicare Advantage providers. It also describes payment adjustments beginning in 2015 for eligible professionals who are not meaningful users of certified EHR technology.

For the three tip sheets above, go to *http://www.cms.gov/EHRIncentivePrograms*. Select the "Medicare Eligible Professional" tab on the left, and then scroll to "Downloads."

- **NEW: Medicaid EHR incentive payments for eligible professionals**
  Which types of individual practitioners can participate in the Medicaid EHR incentive program? Learn about Medicaid patient volume requirements, payment amounts, and the timeframes for the Medicaid EHR incentive program.
  Go to *http://www.cms.gov/EHRIncentivePrograms*. Select the "Medicaid Eligible Professional" tab on the left, and then scroll to "Downloads."

Important dates

- **NEW: EHR incentive program timeline**
  Find it at *http://www.cms.gov/EHRIncentivePrograms* in the "Downloads" section of the "Overview" tab.

Electronic health record incentives – get the facts from CMS.

***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.*

Source: CMS PERL 201009-42

Act now to earn Medicare electronic health record incentive payments

Eligible professionals must have an enrollment record in the provider enrollment, chain and ownership system (PECOS) in order to receive a Medicare electronic health record (EHR) incentive payment.

Did you know?

You can bill and receive payments from Medicare and not be in the PECOS system. Don't wait.

1. Act now to verify that you have an enrollment record in PECOS.
2. If you do not have an enrollment record in PECOS, establish your enrollment record now.

If you have submitted a Medicare enrollment application within the last 90 days, and your enrollment application has been accepted for processing by the carrier or A/B Medicare administrative carrier (MAC), you need not take any additional actions based on this listserv message. You will be contacted by your carrier or A/B MAC if additional information is needed.

Find out if you have an enrollment record in PECOS. Choose one of the following:

1. Use Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) Go to *Verify PECOS Record* at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf* for more information. If no record is displayed, you do not have an enrollment record in PECOS.
2. Check the ordering referring report on the Centers for Medicare & Medicaid Services (CMS) website. If you are of a specialty permitted to order and refer and you are on that report, you have a current enrollment record in PECOS. Go to *Ordering and Referring Report* at *http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage*.
3. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Contact information is available at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

I don't have an enrollment record. What should I do?

Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see *Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners* at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*. If you encounter problems or have questions as you navigate the system, help is available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf*.

Electronic health record incentives – get the facts from CMS at *http://www.cms.gov/EHRincentiveprograms*.

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

Source: CMS PERL 201010-28

Electronic health records – 33 products certified

The Certification Commission for Health Information Technology (CCHIT®) has announced that it has tested and certified 33 electronic health record (EHR) products under the commission of the Office of the National Coordinator for Health Information Technology as an Authorized Testing and Certification Body (ONC-ATCB) ONC-ATCB program, which certifies that the EHRs are capable of meeting the 2011/2012 criteria supporting Stage 1 meaningful use as approved by the Secretary of Health & Human Services (HHS). Certification is required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act (ARRA). The certifications include 19 complete EHRs, which meet all of the 2011/2012 criteria for either eligible provider or hospital technology, and 14 EHR modules, which meet one or more – but not all – of the criteria.

More news

http://www.cchit.org/media/news/2010/10/commission-announces-first-onc-atcb-20112012-certifications.

On Friday, December 3, the Office of National Coordinator for Health Information Technology (ONC) will host a free day-long public roundtable on:

> Personal Health Records – Understanding the Evolving Landscape
> Friday, December 3, 2010
> FTC Conference Center, 601 New Jersey Avenue, NW, Washington, DC 20001

The roundtable is designed to inform ONC's congressionally mandated report on privacy and security requirements for noncovered entities (non-CEs), with a focus on personal health records (PHRs) and related service providers (Section 13424 of the HITECH Act).

The roundtable will include four panels of prominent researchers, legal scholars, and representatives of consumer, patient, and industry organizations. It will address the current state and evolving nature of PHRs and related technologies (including mobile technologies and social networking), consumer and industry expectations and attitudes toward privacy and security practices, and the pros and cons of different approaches to the requirements that should apply to non-CE PHRs and related technologies.

Mark your calendars now

Registration and additional conference information will be available in October at *http://healthit.hhs.gov/PHRroundtable*.

Two final awardees for the regional extension center (REC) program

The ONC has announced the selection of two final awardees for the regional extension center (REC) program:

- CalOptima Foundation, covering Orange County, California ($4,662,426)

Electronic health records – 33 products certified (continued)

- Massachusetts eHealth Collaborative, covering New Hampshire ($5,105,495) ONC also announced expanded coverage areas for two existing RECs in Florida:
  - Community Health Center Alliances will cover additional areas in Glades and Hendry counties
  - Health Choice Network of Florida will cover additional areas in Indian River, Palm Beach, St. Lucie, Martin and Okeechobee counties

These additional awards complete a nationwide system of RECs that will help providers move from paper-based medical records to electronic health records (EHRs).

For more information about the awards and a complete listing of RECs, visit *http://www.HealthIT.hhs.gov/programs/REC/*.

Learn more about the Medicare and Medicaid EHR incentive programs at *http://www.cms.gov/EHRIncentivePrograms/*.

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

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Source: CMS PERL 201010-04

Additional electronic health record certification bodies named

The Office of the National Coordinator for Health Information Technology (ONC) named InfoGard Laboratories, Inc., San Luis Obispo, Calif., as an ONC-Authorized Testing and Certification Body (ONCATCB).

The addition of InfoGard Laboratories, Inc. as an ONC-ATCB provides more options for EHR vendors to have their products tested and certified for compliance with the standards and certification criteria that were issued by the U. S. Department of Health and Human Services earlier this year.

Certification of EHRs is part of a broad initiative undertaken by Congress and President Obama under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act (ARRA) of 2009. HITECH created new incentive payment programs to help health providers as they transition from paper-based medical records to EHRs. Incentive payments totaling as much as $27 billion may be made under the program. Individual physicians and other eligible professionals can receive up to $44,000 through Medicare and almost $64,000 through Medicaid.

Hospitals can receive millions.

To qualify for the incentive payments offered by the Centers for Medicare & Medicaid Services (CMS) providers must not only adopt, but also demonstrate the meaningful use of, certified EHR systems.

ONC authorized the first two ONC-ATCBs in late August. Additional applications are under review.

For more information about the ONC certification programs visit *http://healthit.hhs.gov/certification*.

To learn more about InfoGard Laboratories, Inc. visit *http://www.infogard.com/*.

Information about the Medicare & Medicaid EHR Incentive Programs may be found at *http://www.cms.gov/EHRIncentivePrograms*.

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Source: CMS PERL 201009-32

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 "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

Electronic Prescribing Initiative

2009 electronic prescribing feedback reports

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce important information about accessing 2009 electronic prescribing (eRx) incentive program feedback reports is posted to the eRx Web page at *http://www.cms.gov/ERXincentive/*.

The 2009 eRx incentive program feedback reports will be available in November 2010 after the 2009 eRx incentive payments are distributed. Feedback reports are compiled at the taxpayer identification number (tax ID number, or TIN) level, with individual-level reporting (by national provider identifier or NPI level) information for each eligible professional (EP) who reported at least one valid eRx quality-data code (QDC) on a claim submitted under that TIN for services furnished during the reporting period. Several new and updated educational resource documents about accessing 2009 eRx incentive program feedback reports are now available on the "Spotlight, 2009 Physician Quality Reporting Initiative (PQRI) program, and eRx Overview" links of the eRx Web page and include the following:

- A downloadable document on accessing 2009 eRx Incentive Program Feedback Reports
- 2009 PQRI Feedback Report User Guide
- 2009 eRx Feedback Report User Guide
- A Guide for Understanding 2009 PQRI Incentive Payment

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

Source: CMS PERL 201010-13

2009 electronic-prescribing incentive program update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the 2009 electronic prescribing (e-Rx) incentive program are being made to eligible professionals who met the criteria for successful reporting.

The 2009 e-Rx incentive payments are currently being processed and distributed by carriers and Medicare administrative contractors (MACs). Distribution of the 2009 e-Rx incentive payments are scheduled to be completed by October 22, 2010.

e-Rx incentives earned by individual participating physicians and other eligible professionals are paid as a lump-sum payment to the taxpayer identification number (TIN) under which the eligible professional's claims were submitted. It is then up to the owner of the TIN to decide how to distribute the incentive within the practice.

Effective January 2010, CMS revised the manner in which incentive payment information is communicated to eligible professionals receiving electronic remittance advices. CMS has instructed Medicare contractors to use a new indicator of LE to indicate incentive payments instead of indicator LS. Indicator LE will appear on the electronic remittance advice. Additionally, the paper remittance advice will read "This is an e-Rx incentive payment." It will not include the year and indicator LE in the paper remittance. In an effort to further clarify the type of incentive payment issued (either PQRI or e-Rx incentive), CMS created a four-digit code to indicate the type of incentive and reporting year. For the 2009 e-Rx incentive payments, the four-digit code is RX09. This code will be displayed on the electronic remittance advice along with indicator LE. For example, eligible professionals will see LE to indicate an incentive payment, along with RX09 to identify that payment as the 2009 e-Rx incentive payment.

2009 electronic prescribing incentive program feedback reports

The 2009 e-Rx feedback reports will be available on the physician and other health care professional quality reporting portal at *http://www.qualitynet.org/pqri*, starting the second week of November. TIN-level reports on the portal require an individual authorized access to CMS computer services (IACS) account. Participants may also contact their carrier or MAC to request individual national provider identifier (NPI)-level reports via an alternate feedback report fulfillment process, please visit *http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf*.

Questions regarding e-Rx incentive payments

If you have questions about the status of your e-Rx incentive payment (during the distribution timeframe), please contact your provider contact center. The contact center directory is available at *http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

Feel free to contact the QualityNet help desk with any of the following:

- PQRI portal password issues
- PQRI/e-Rx feedback report availability and access
- PQRI-IACS registration questions
- PQRI-IACS login issues

The QualityNet help desk is available Monday through Friday from 7:00 a.m.-7:00 p.m. CST at 1-866-288-8912 or via e-mail to:*qnetsupport@sdps.org*. The QualityNet help desk is also available to assist with PQRI and e-Rx measure-specific questions.

Source: CMS PERL 201009-43

2010 electronic prescribing incentive program reminder

It's not too late to start participating in the 2010 electronic prescribing (eRx) incentive program and potentially qualify to receive a full-year incentive payment. Eligible professionals (EPs) may begin reporting eRx at any time throughout the 2010 program year of January 1-December 31, 2010, to be incentive eligible.

The eRx incentive program is an incentive program that is separate from the Physician Quality Reporting Initiative (PQRI) program and has different reporting requirements. **To successfully meet reporting criteria and be considered incentive eligible, individual EPs must report the eRx measure at least 25 times** (for eligible patient encounters), and the Medicare Part B physician fee schedule (PFS) allowed charges for services in the eRx measure's denominator should be comprised of 10 percent or more of the EP's total 2010 estimated allowed charges.

For 2010, eligible professionals who successfully report the eRx measure will become eligible to receive an eRx incentive equal to 2.0 percent of their total Medicare Part B PFS-allowed charges for services performed during the reporting period.

Eligible professionals must have adopted a "qualified" eRx system. There are two types of systems: A system for eRx only (stand-alone) and an electronic health record (EHR system) with eRx functionality. Regardless of which type of system is used, to be considered "qualified," it must be based on all of the following capabilities:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts
- Providing information related to lower cost through therapeutically appropriate alternatives, if available (the availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2010)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available

If you have not yet participated in the eRx program, you can begin by reporting eRx data for January 1-December 31, 2010, using any of the following three options:

- **Claims-based reporting** of the eRx measure (report only one G-code (G8553) for 2010)
- **Registry-based reporting** using a CMS-selected *registry, submitting 2010 data to CMS during the first quarter of 2011
- **EHR-based reporting** using a CMS-selected *electronic health record product, submitting 2010 data to CMS during the first quarter of 2011

*Only registries and EHR vendors who have been selected by CMS for the 2010 PQRI/eRx and are on the posted list of registries/EHR vendors are eligible to be considered "qualified" for purposes of the 2010 Electronic Prescribing Incentive Program (visit *http://www.cms.gov/ERxIncentive/08_Alternative Reporting Mechanism.asp*)

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

Eligible professionals do not need to sign up or pre-register to participate in the 2010 eRx. Reporting one QDC (G8553) for the eRx measure to CMS through claims, or submission via a qualified registry or a qualified EHR will indicate intent to participate.

Although there is no requirement to register prior to submitting the data, EPs should review the educational products CMS has created on how to get started with eRx reporting. To access all available educational resources on eRx please visit *http://www.cms.gov/eRxIncentive*. Eligible professionals are encouraged to check the eRx Web page often for the latest information and downloads.

Resources

- *2010 eRx Measure Specification and Release Notes* – EPs should check the eRx measure specification documents for the current program year. (Refer to the specification for the reporting method applicable to your practice.)
  - **Claims- and registry-based** *http://www.cms.gov/ERxIncentive/Downloads/2010_eRx_MeasureSpecificationsandReleaseNotes_121709.zip*
  - **EHR-based** *http://www.cms.gov/ERxIncentive/Downloads/2010EHRMeasureSpecificationforeRxandReleaseNotes.zip*
- *Claims-Based Reporting Principles for Electronic Prescribing (eRx) Incentive Program* *http://www.cms.gov/ERxIncentive/Downloads/Claims-BasedReportingPrinciplesforeRx122209.pdf*
- *2010 eRx Incentive Program Made Simple Fact Sheet* *http://www.cms.gov/ERxIncentive/Downloads/2010eRxMadeSimpleFS032310f.pdf*
- *2010 eRx Incentive Program Fact Sheet: What's New for 2010 eRx Incentive Program* *http://www.cms.gov/ERxIncentive/Downloads/WhatsNew2010eRxFS032310f.pdf*

Additional information

If you have questions on how to get started with eRx, please contact the QualityNet Help Desk at 866-288-8912 from 7:00 a.m.-7:00 p.m. CST or via e-mail at *qnetsupport@sdps.org*.

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

Source: CMS PERL 201010-15

Physician Quality Reporting Initiative

2009 PQRI incentive payment update

Incentive payments for the 2009 Physician Quality Reporting Initiative (PQRI) are available this fall for eligible professionals who met the criteria for successful reporting. Carriers and Medicare administrative contractors (MACs) will begin processing and distributing 2009 PQRI incentive payments on October 25. Distribution of 2009 PQRI incentive payments is scheduled to be completed by November 12.

Remember that PQRI incentives earned by individual participating physicians and other eligible professionals are paid as a lump-sum to the taxpayer identification number (TIN) under which the professional's claims were submitted. It is then up to the TIN to decide how to distribute the incentive within the practice.

Effective January 2010, CMS revised the manner in which incentive payment information is communicated to eligible professionals receiving electronic remittance advices. CMS has instructed Medicare contractors to use a new indicator of LE to indicate incentive payments instead of LS. LE will appear on the electronic remit. In an effort to further clarify the type of incentive payment issued (either PQRI or eRx incentive), CMS created a 4-digit code to indicate the type of incentive and reporting year. For the 2009 PQRI incentive payments, the 4-digit code is PQ09. This code will be displayed on the electronic remittance advice along with the LE indicator. For example, eligible professionals will see LE to indicate an incentive payment, along with PQ09 to identify that payment as the 2009 PQRI incentive payment. Additionally, the paper remittance advice will read, "This is a PQRI incentive payment." The year will not be included in the paper remittance.

2009 PQRI feedback reports will be available on the Physician and Other Health Care Professionals Quality Reporting Portal (*http://www.qualitynet.org/pqri*) starting the second week of November. TIN-level reports on the portal require an Individuals Authorized Access to CMS Computer Services (IACS) account. Participants may also contact their carrier/MAC to request individual NPI-level reports via an alternate feedback report fulfillment process (see *http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf*). Watch for additional feedback report information from CMS.

Contact information

If you have questions about the status of your PQRI incentive payment (during the distribution timeframe), please contact your provider contact center. The contact center directory is available on the CMS website at *http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

Contact the QualityNet Help Desk with any of the following:

- PQRI portal password issues
- PQRI/eRx feedback report availability and access
- PQRI-IACS registration questions
- PQRI-IACS login issues

The QualityNet Help Desk is available Monday through Friday from 7:00 a.m.-7:00 p.m. CT at 1-866-288-8912 or via *qnetsupport@sdps.org*. They can also assist with program and measure-specific questions.

Source: CMS PERL 201010-27

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 "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

2010 PQRI program reminder

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

The 2010 PQRI has two reporting periods:

- 12-month (January 1-December 31, 2010)
- Six-month (July 1-December 31, 2010)

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

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

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

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

Eligible professionals do not need to sign up or pre-register to participate in the 2010 PQRI. Submission of QDCs for individual PQRI measures to CMS through a qualified registry or for a measures group through claims or a qualified registry will indicate intent to participate.

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

Resources

2010 PQRI Implementation Guide
http://www.cms.gov/PQRI/Downloads/2010_PQRI_ImplementationGuide_02-10-2010_FINAL.pdf

Qualified Registries for 2010 PQRI Reporting *http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp*

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

Source: CMS PERL 201010-17

Website survey

We would like to hear your comments and suggestions on the website through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

General Information

New – Medicare self-referral disclosure protocol

Section 6409(a) of the Affordable Care Act (ACA) requires the Secretary of the Department of Health & Human Services, in cooperation with the Inspector General of the Department of Health and Human Services (HHS), to establish a Medicare self-referral disclosure protocol (SRDP) that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of Section 1877 of the Social Security Act (the Act).

The SRDP requires health care providers of services or suppliers to submit all information necessary for the Centers for Medicare & Medicaid Services (CMS), on behalf of the Secretary, to analyze the actual or potential violation of Section 1877 of the Act. Section 6409(b) of the ACA, gives the Secretary of HHS the authority to reduce the amount due and owing for violations of Section 1877. The SRDP is located on the CMS website at *http://www.cms.gov/PhysicianSelfReferral/*.

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

Source: CMS PERL 201009-40

Use Internet-based PECOS for your Medicare enrollment actions

It's easy to use and offers a host of advantages over the paper-based enrollment process.
Learn how to use the system by selecting the appropriate instructions below based on the type of provider:

Do you want to save money and time? The Internet-based provider enrollment, chain and ownership system (PECOS) can help. Internet-based PECOS can be used in lieu of the paper Medicare enrollment application to:

- Submit an initial Medicare enrollment application
- Verify or change your enrollment information
- Track your enrollment application through the Web submission process
- Add or change a reassignment of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate your Medicare enrollment
- Voluntarily withdraw from the Medicare program

Use of this automated, online process results in less staff time and administrative costs to complete and submit enrollment information to Medicare.

Using Internet-based PECOS is easy

Physicians and nonphysician practitioners

Learn how to use the system by reading *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners Fact Sheet*, available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*. And if you encounter problems or have questions as you navigate the system, help is available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf*.

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

Provider and supplier organizations

It's easy to use and offers a host of advantages over the paper-based enrollment process. Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) can now use Internet-based PECOS for Medicare enrollment actions.

Using Internet-based PECOS is easy

Learn how to use the system by reading *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations Fact Sheet*, available at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf*.

Reminder: The process for access to Internet-based PECOS by an organization provider may take several weeks to complete. It is recommended that you begin this process (if you have not already) well in advance of any upcoming enrollment actions. DMEPOS suppliers should visit *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers Fact Sheet* at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf* for more information on how to use the system.

Don't wait, set your organization free from paper -- start using Internet-based PECOS (*http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage*) 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 201010-18

Important reminder regarding the timely filing limits changes

Background

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

Important reminder

Please allow time for mailing as the timeliness is calculated on the contractor receipt date, not the postmark date of when it is mailed. Electronic data interchange (EDI) accepts claims 24/7; however, the cutoff for the date received is 6 p.m. Therefore, any claims received after 6 p.m. or on weekends/holidays would be considered received the next business day.

Additional information

For additional information, please see the related change request at *http://www.cms.gov/Transmittals/downloads/R697OTN.pdf* and *MLN Matters* article MM6960 at *http://www.cms.gov/MLNMattersArticles/downloads/mm6960.pdf*.

Source: CR 6960

Unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

> The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Chapter 5, Section 410.10

Medicare Advantage news – little or no benefit changes in 2011

Medicare Advantage premiums fall, enrollment rises, and benefits similar compared to 2010. In addition, a wide range of Medicare health and drug plan options continues in 2011

The Centers for Medicare & Medicaid Services (CMS) announced today that, on average, Medicare Advantage premiums will be one percent lower in 2011 than today. The majority of Medicare beneficiaries, on average, enrolled in Medicare health and prescription drug plans this year should find little or no change in their benefits in 2011, in addition to seeing more drug plans offering coverage in the prescription drug coverage gap or "donut hole." Medicare Advantage plans project that enrollment will increase by five percent in 2011. And, consistent with the Affordable Care Act, beneficiaries, in most Medicare Advantage plans and original Medicare will gain access to preventive benefits with no out of pocket costs.

Through the new tools provided to Medicare under the Affordable Care Act, and working closely with Medicare Advantage organizations and Prescription Drug Plan, CMS took steps to:

- Protect beneficiaries from excessive increases in premiums and cost sharing through aggressive bid reviews
- Consolidate low enrollment and duplicative plans so beneficiaries have meaningful differences between plans offered by the same organization
- Set limits on out-of-pocket expenses
- Cover preventive services with no cost sharing, and
- Limit plan cost sharing for skilled nursing care, chemotherapy and renal dialysis to the amounts paid by beneficiaries in original Medicare.

The Affordable Care Act also provides some new benefits to Medicare beneficiaries in 2011 like free wellness visits, some new free health screenings, and a 50 percent discount on brand-name drugs for seniors who full into the coverage gap.

CMS is encouraging beneficiaries enrolled in Medicare Advantage and Medicare Prescription Drug plans to review their current health and drug plan coverage for any changes their plans may be making for 2010 before the annual enrollment period begins November 15. In addition to the five-star ratings on the Medicare Plan Finder at *https://www.medicare.gov/find-a-plan/questions/home.aspx*, users will find an icon that shows those plans that had a low overall quality rating the past three years.

Additional resources

- National press release issued 9/21: *http://www.cms.gov/apps/media/press_releases.asp*
- Medicare health and drug plan state-by-state fact sheets: *http://www.cms.gov/center/openenrollment.asp*
- 2011 plan landscape files: *http://www.cms.gov/PrescriptionDrugCovGenIn/*

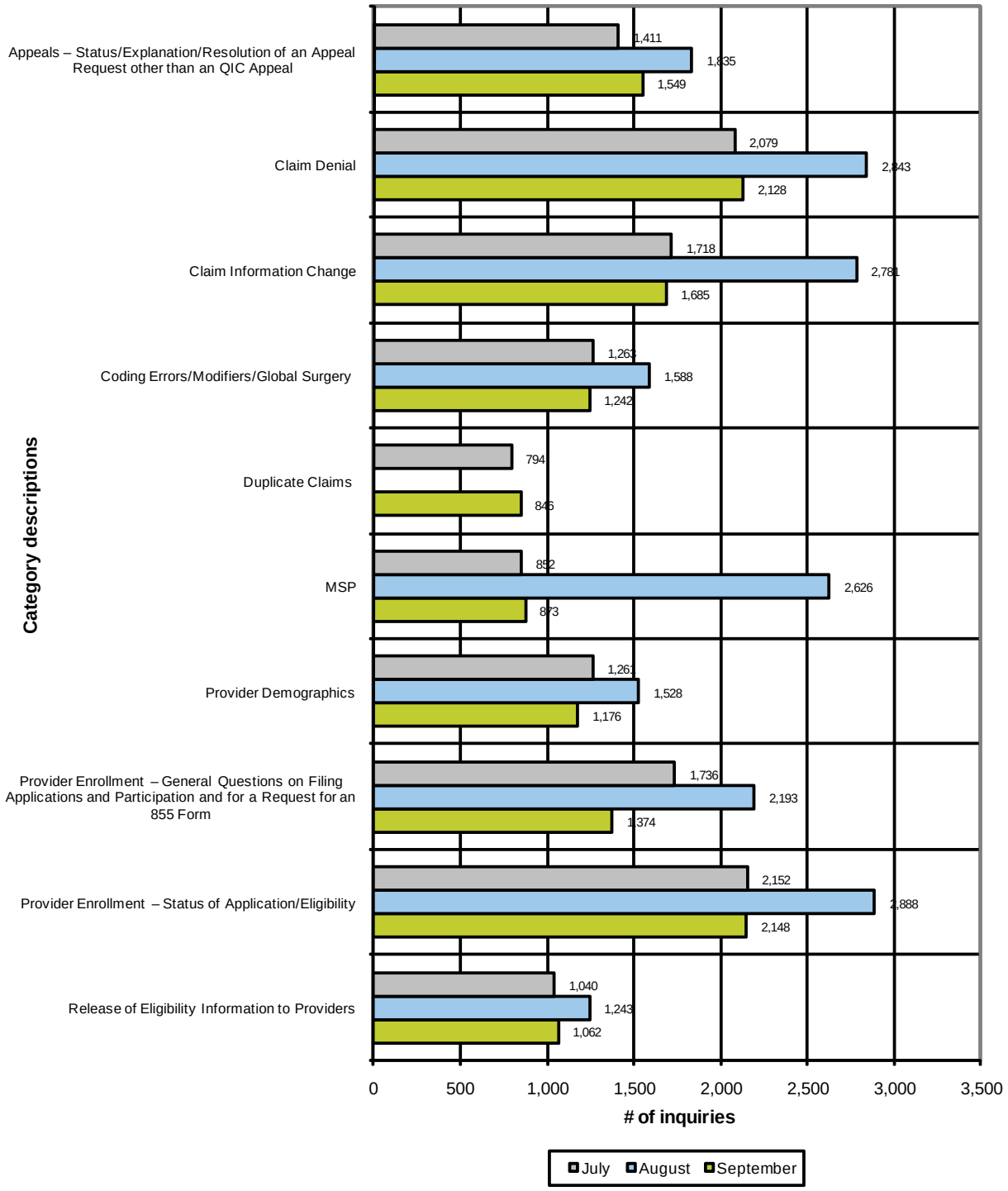
Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201009-39

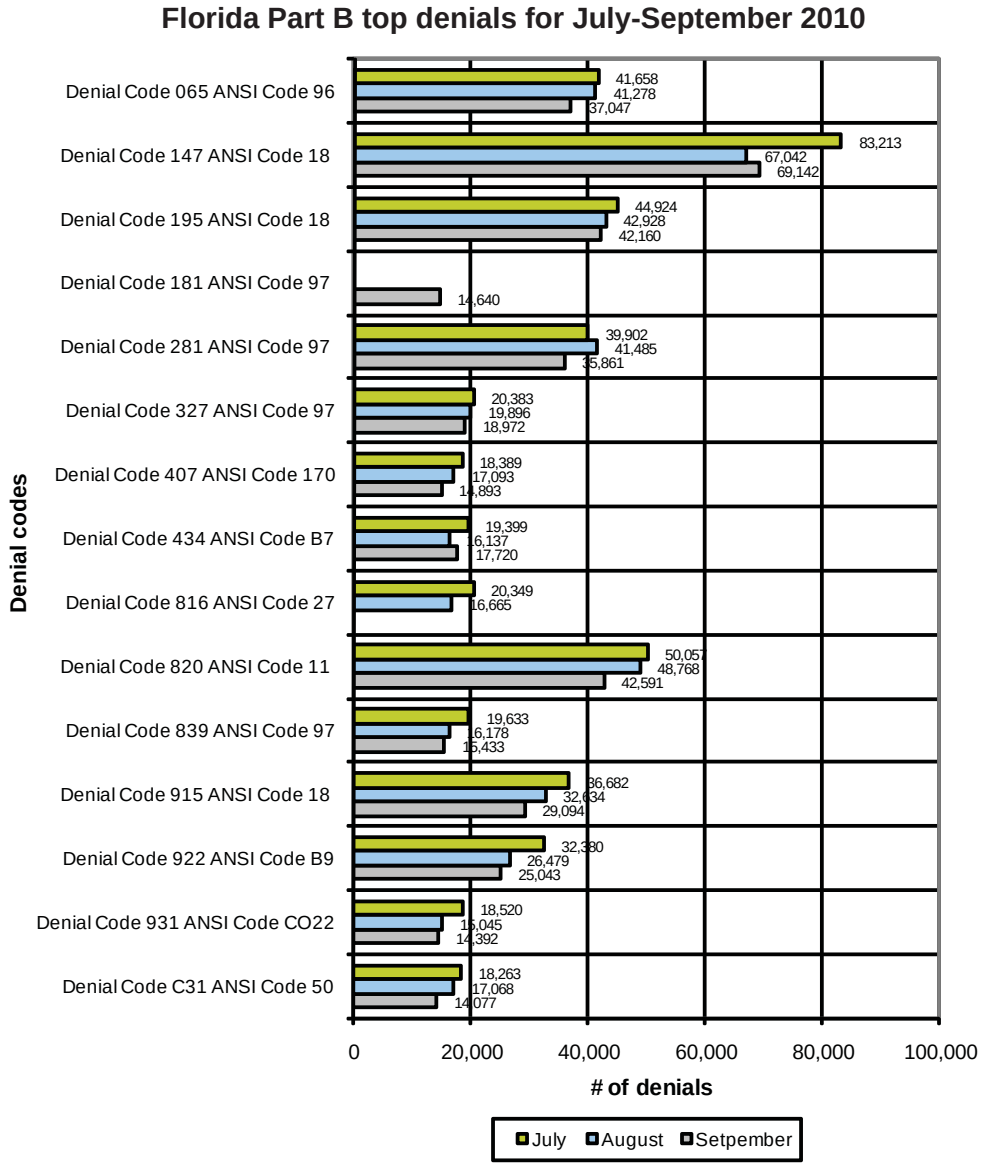
Top inquiries, denials, and return unprocessable claims for July-September

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

Florida Part B top inquiries for July-September 2010



Top inquiries, denials, and return unprocessable claims for July-September 2010 (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.

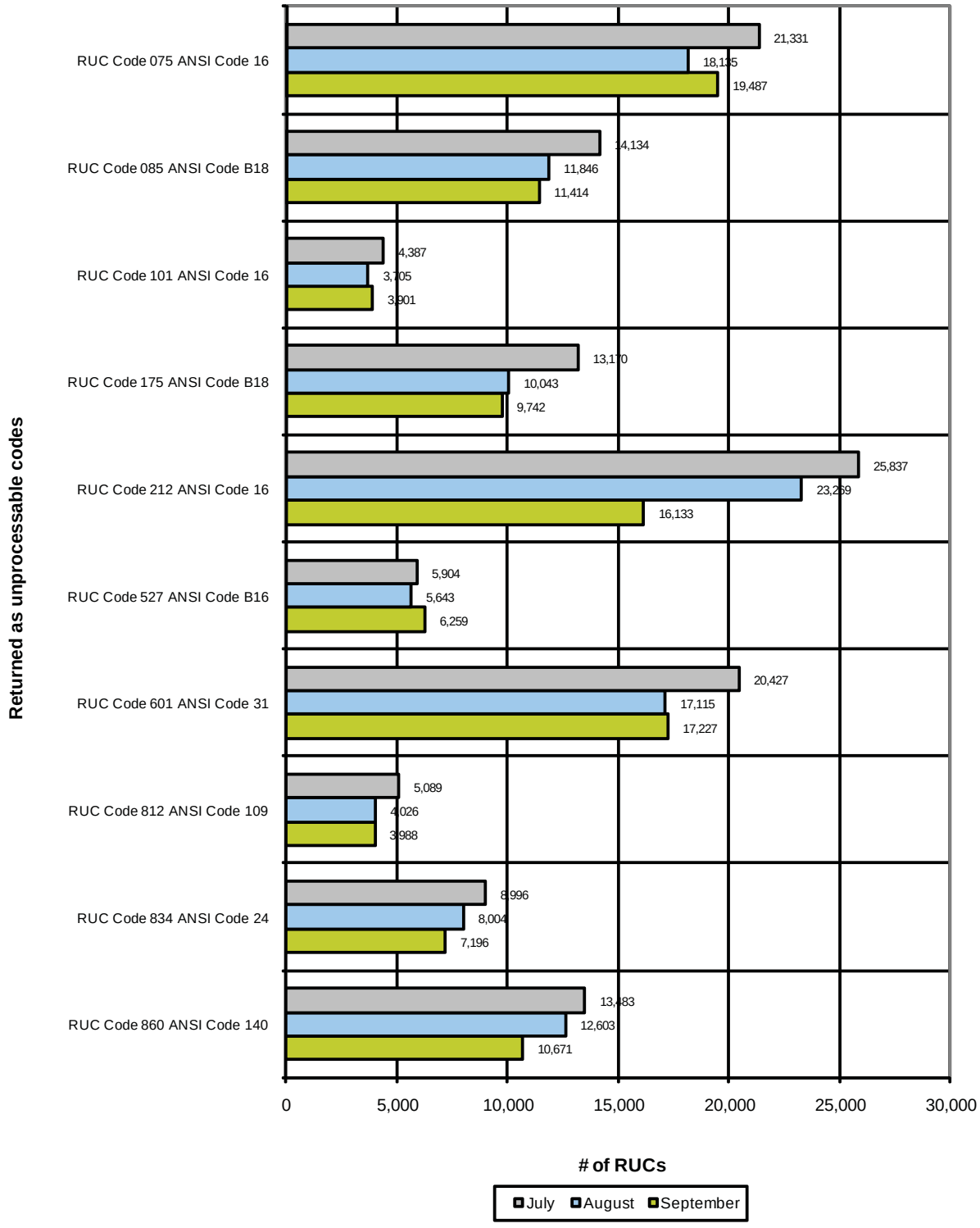
- Only one E/M service may be reported per patient, per day by a physician or by more than one physician of the same specialty in the same group, unless the evaluation and management services are for unrelated problems.
- If more than one face-to-face E/M is provided on the same day to the same patient 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.

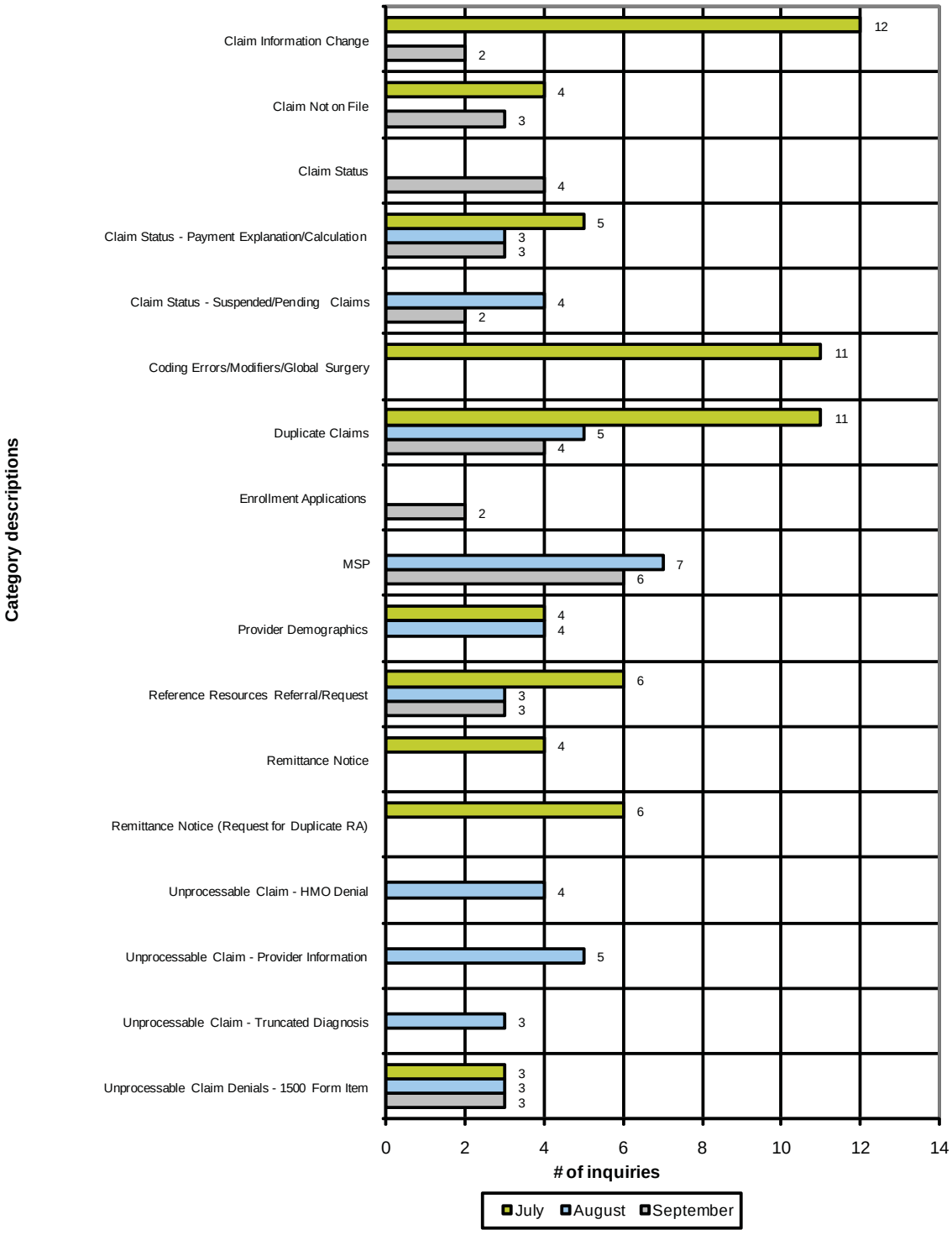
Top inquiries, denials, and return unprocessable claims for July-September 2010 (continued)

Florida Part B top return as unprocessable claims (RUC) for July-September 2010

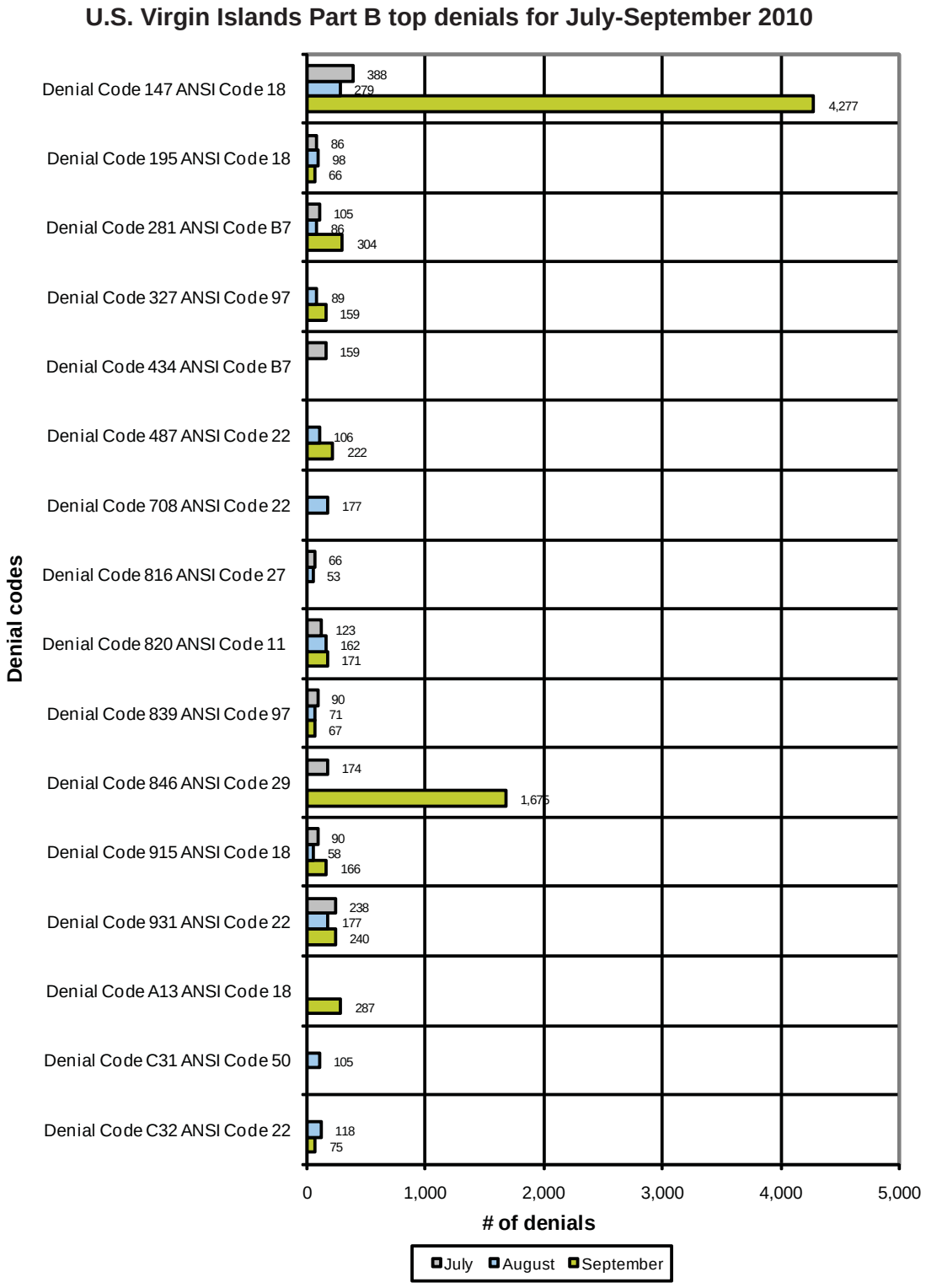


Top inquiries, denials, and return unprocessable claims for July-September 2010 (continued)

U.S. Virgin Islands Part B top inquiries for July-September 2010

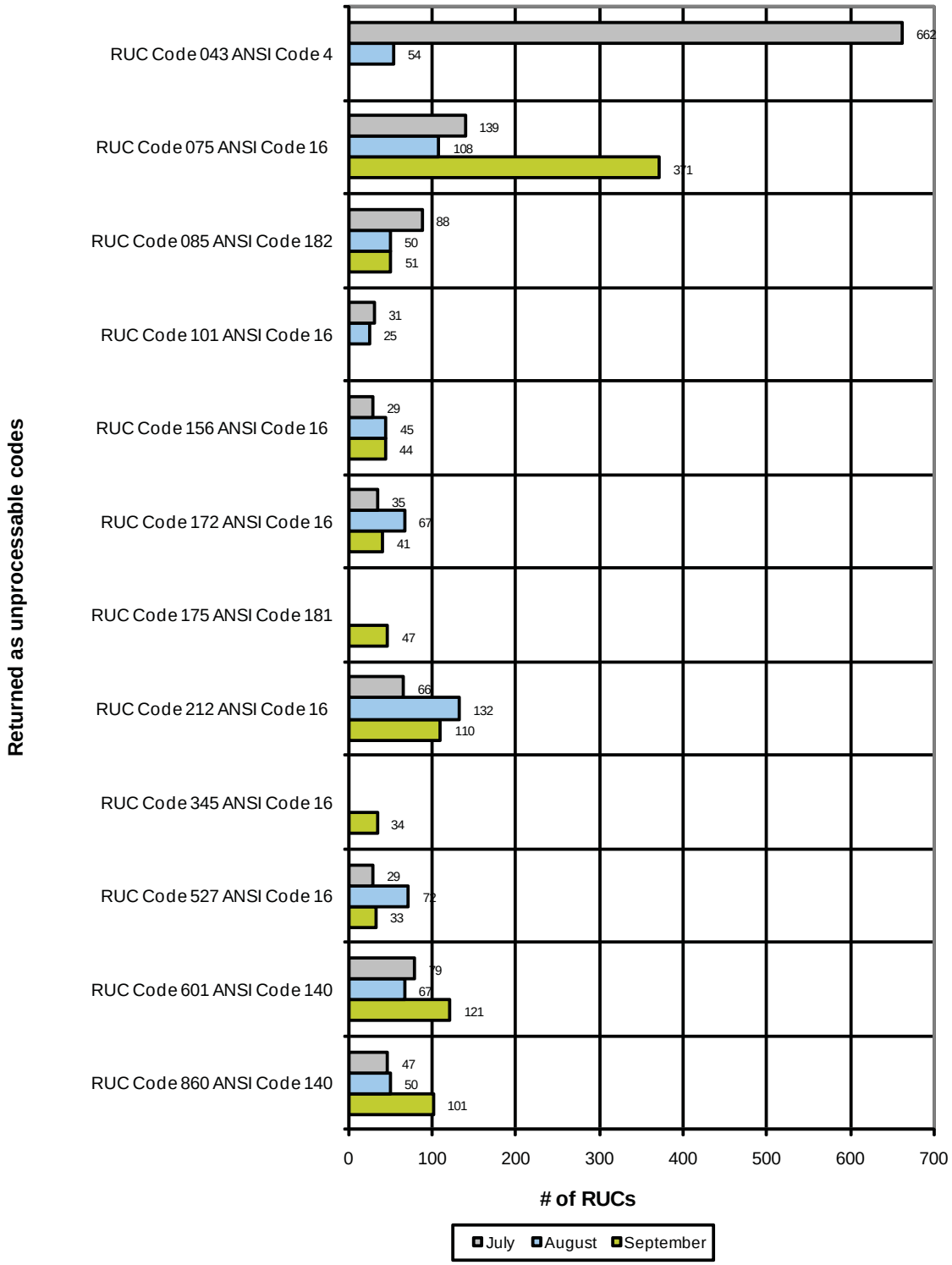


Top inquiries, denials, and return unprocessable claims for July-September 2010 (continued)



Top inquiries, denials, and return unprocessable claims for July-September 2010 (continued)

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



Local Coverage Determinations

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Local Coverage Determinations – Table of Contents

Advance beneficiary notice

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

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

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

Revisions to LCDs

J1459: Intravenous immune globulin – revision to the LCD

LCD ID number: L29205 (Florida)
LCD ID number: L29356 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intravenous immune globulin 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 LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) Transmittal 2045, change request 7147 dated September 10, 2010, to add new HCPCS code C9270 (Injection, immune globulin [Gammaplex], intravenous, non-lyophilized [e.g. liquid], 500 mg) only when billed in an ambulatory surgical center (ASC), under the "CPT/HCPCS Codes" section of the LCD. Gammaplex is an immune globulin intravenous (human) drug approved by the U.S. Food and Drug Administration (FDA) in September 2009, for the replacement therapy of primary immunodeficiency (PI).

Effective date

This LCD revision is effective for claims processed **on or after October 4, 2010**, for services rendered **on or after October 1, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Additional Information

Clarification of modifier use when billing more than one diagnostic test for same procedure on same date of service

When a diagnostic procedure such as *CPT* code *73221* [*Magnetic resonance (eg. proton) imaging, any joint of upper extremity; without contrast material(s)*] is billed for two joints, such as the shoulder and elbow, at the same encounter on the same date of service, *CPT* code *73221* should be billed on two separate detail lines on the claim form. The second procedure should have a modifier 76 [Repeat procedure or service by same physician] appended to allow the technical component (TC) multiple procedures reduction for this service.

The above example represents indications that warrant more than one site for the procedure, such as cases involving trauma affecting more than one area. Multiple procedures would not be expected as routine or when there is insufficient medical necessity to support the additional testing. If three or more repeat services are performed on the same day, they may be subject to medical review at the appeals level.

This information applies to diagnostic procedures that are subject to the TC multiple procedures reduction.

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO's LCD lookup, available at *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

Educational Events

Upcoming provider outreach and educational events
November 2010

HIGLAS transition seminar

When: Wednesday-Friday, November 8-11 (two sessions each day)
Time: 10:00-11:00 a.m. & 2:00-3:00 p.m..
Type of event: Face-to-face
Focus: Florida

Hot Topics Medicare Part B (ACT) (two sessions)

When: Tuesday, November 16
Time: 8:30-10:00 a.m. & 11:30 a.m.-1:00 p.m.

Introduction to the Provider Data Summary report webcast

When: Tuesday, November 16
Time: 9:30-10:30 a.m.

HIGLAS transition seminar

When: Tuesday, November 16 (two sessions)
Time: 1:00-2:00 p.m. & 3:00-4:00 p.m.
Type of event: Face-to-face
Focus: Florida

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

2010-2011 seasonal influenza resources for health care professionals

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

Provider types affected

All Medicare fee-for-service (FFS) physicians, nonphysician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider action needed

- Keep this special edition *MLN Matters* article and refer to it throughout the 2010-2011 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the New Year.
- Don't forget to immunize yourself and your staff.

Introduction

Annual outbreaks of seasonal flu typically occur from the late fall through early spring. Typically, 5 to 20 percent of Americans catch the seasonal flu, with about 36,000 people dying from flu-related causes.[1] Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu vaccine. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Get the flu vaccine, not the flu.

Unlike last flu season patients needed to get both a seasonal vaccine and a separate vaccine for the H1N1 virus, this season, a single seasonal flu vaccine will protect your patients, your staff, and yourself.

The seasonal flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

MLN Matters seasonal influenza articles

- MM7120: Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season at *http://www.cms.gov/MLNMattersArticles/downloads/MM7120.pdf*
- SE1026: Important News About Flu Shot Frequency for Medicare Beneficiaries at *http://www.cms.gov/MLNMattersArticles/downloads/SE1026.pdf*
- MM7124: 2010 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at *http://www.cms.gov/MLNMattersArticles/downloads/MM7124.pdf*
- MM6608: Influenza Vaccine Payment Allowances – Annual Update for 2009-2010 Season at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6608.pdf*
- MM5511: Update to Medicare Claims Processing Manual, Chapter 18, Section 10 for Part B Influenza Billing at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf*
- MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf*
- MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf*

MLN seasonal influenza related products for health care professionals

- *Quick Reference Information: Medicare Part B Immunization Billing* – this two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF at *http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf*.
- The Medicare Preventive Services Series Part 1 Web-Based Training Course (WBT) – this WBT contains lessons Medicare-covered preventive vaccinations, including the seasonal influenza vaccine. To take the course, visit the Medicare Preventive Services

2010-2011 seasonal influenza resources for health care professionals (continued)

Educational Products page at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*. Scroll down to "Related Links Inside CMS" and choose "Web-Based Training (WBT) Modules."

- *Medicare Preventive Services Adult Immunizations Brochure* – this two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.
- *Medicare Preventive Services Adult Immunizations Brochure* – this two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf*.
- *Quick Reference Information: Medicare Preventive Services* – this two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes seasonal influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file at *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- *MLN Preventive Services Educational Products Web Page* – this *Medicare Learning Network* (*MLN*) Web page provides descriptions of all *MLN* preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp) for easy access*.

Other CMS resources

- CMS Adult Immunizations Web page is at *http://www.cms.hhs.gov/AdultImmunizations*.
- CMS frequently asked questions are available at *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi*.
- *Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2: Immunizations available at *http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf*.
- *Medicare Claims Processing Manual*: Chapter 18, Preventive and Screening Services available at *http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf*.
- Medicare Part B drug average sales price payment amounts influenza and pneumococcal vaccines pricing found at *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01_overview.asp*.

Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009-2010 flu season:

- **Advisory Committee on Immunization Practices** are at *http://www.cdc.gov/vaccines/recs/acip/default.htm*.
- **American Lung Association's Influenza (Flu) Center** is at *http://www.lungusa.org*. This website provides a flu clinic locator at *http://www.flucliniclocator.org*. Individuals can enter their zip code to find a flu clinic in their area. Providers may also obtain information on how to add their flu clinic to this site.

Other sites with helpful information include:

- **Centers for Disease Control and Prevention** - *http://www.cdc.gov/flu*
- **Flu.gov** - *http://www.flu.gov*
- **Food and Drug Administration** - *http://www.fda.gov*
- **Immunization Action Coalition** - *http://www.immunize.org*
- **Indian Health Services** - *http://www.ihs.gov/*
- **National Alliance for Hispanic Health** - *http://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** - *http://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** -*http://www.nlm.nih.gov/medlineplus/immunization.html*
- **National Network for Immunization Information** -*http:/www.immunizationinfo.org*
- **National Vaccine Program** - *http://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Promotion** - *http://odphp.osophs.dhhs.gov*
- **Partnership for Prevention** - *http://www.prevent.org*, and
- **World Health Organization** - *http://www.who.int/en*.

Beneficiary information

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

MLN Matters Number: SE1031
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

1 Flu.gov. 2010. About the Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2010 [cited 16 August 2010]. Available from the World Wide Web: http://www.flu.gov/individualfamily/about/index.html

Flu shot reminder

Vaccination is the best protection against the flu. This year, the Centers for Disease Control and Prevention (CDC) is encouraging everyone six months of age and older to get vaccinated against the seasonal flu. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. And remember, vaccination is particularly important for health-care workers, who may spread the flu to high-risk patients. Don't forget to immunize yourself and your staff. Protect your patients.

Protect your family. Protect yourself. Get your flu vaccine – not the flu.

Remember: Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health-care professionals and their staff, please visit *http://www.cms.gov/AdultImmunizations/*.

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

Source: CMS PERL 201010-20

October is National Breast Cancer Awareness Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered screening mammograms and other preventive services covered by Medicare. Medicare provides coverage for an annual screening mammogram for all female beneficiaries age 40 or older. Medicare also provides coverage for one baseline mammogram for female beneficiaries between the ages of 35 and 39.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered screenings, including screening mammograms that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered screening mammograms. They are all available, free of charge, from the *Medicare Learning Network®*:

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for *Medicare Learning Network®* (*MLN*) educational products for health care professionals related to Medicare-covered preventive services, including screening mammograms. *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings, including screening mammograms. *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including screening mammograms. *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- The Medicare Preventive Services Series: Part 3 Web-Based-Training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including screening mammograms. To access the course, please visit the MLN home page at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules."
- *The Cancer Screenings brochure* – this brochure provides information on coverage for Medicare-covered cancer screenings, including screening mammograms. *http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf*

Please visit the *Medicare Learning Network* at *http://www.cms.gov/MLNGenInfo* for more information on these and other Medicare fee-for-service educational products. For more information on National Breast Cancer Awareness Month, please visit the official website at *http://www.nbcam.org*.

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

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.*

Source: CMS PERL 201010-03

World Osteoporosis Day and National Mammography Day

October 20 is World Osteoporosis Day and October 22 is National Mammography Day. The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered bone mass measurements and screening mammograms.

Medicare provides coverage for bone mass measurements for qualified Medicare patients once every two years. Medicare also provides coverage for an annual screening mammogram for all female beneficiaries age 40 or older, and coverage for one baseline mammogram for female beneficiaries between the ages of 35 and 39.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered screenings, including bone mass measurement and screening mammography that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered bone mass measurements. They are all available, free of charge, from the *Medicare Learning Network*®:

- *The MLN Preventive Services Educational Products Web page* – provides descriptions and ordering information for *MLN* educational products for health care professionals related to Medicare-covered preventive services, including bone mass measurements and screening mammograms. Visit *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings, including bone mass measurements and screening mammograms. Visit *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including bone mass measurements and screening mammograms. Visit *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- *The Medicare Preventive Services Series: Part 3 Web-Based-Training (WBT) course* – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including bone mass measurements and screening mammograms. To access the course, please visit the *MLN* home page at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules."
- *The Bone Mass Measurements brochure* – this brochure provides information on coverage for Medicare-covered bone mass measurements. Visit *http://www.cms.gov/MLNProducts/downloads/bone_mass.pdf*.
- *The Cancer Screenings brochure* – this brochure provides information on coverage for Medicare-covered cancer screenings, including screening mammograms. Visit *http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf*.

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products. For more information on World Osteoporosis Day, please visit the International Osteoporosis Foundation website at *http://www.iofbonehealth.org/about-iof/iof-programs/outreach-education/world-osteoporosis-day.html*. For more information on National Mammography Day, please visit American Cancer Society at *http://www.cancer.org*.

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

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.*

Source: CMS PERL 201010-30

Substance (other than tobacco) abuse and brief intervention service fact sheet

The Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services fact sheet, which provides helpful information for providers that provide SBIRT services to their Medicare patients, is available for download on the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf*. Hard copies will be available at a later date.

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

Source: CMS PERL 201010-20

September 29 is National Women's Health and Fitness Day

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services. Medicare provides coverage for several preventive services to help keep women with Medicare healthy, including bone mass measurements, screening Pap tests, screening pelvic exams, and screening mammograms.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered preventive services that are appropriate for them.

Additional information

CMS has developed several educational products related to Medicare-covered preventive services. They are all available, free of charge, from the *Medicare Learning Network®*:

- The MLN Preventive Services Educational Products Web Page: The page provides descriptions and ordering information for *Medicare Learning Network®* (*MLN*) educational products for health care professionals related to Medicare-covered preventive services. *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*: This guide provides comprehensive coverage and coding information on Medicare-covered preventive services. *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- *The Cancer Screenings brochure*: This brochure provides information on coverage for Medicare-covered cancer screenings, including screening mammograms. *http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf*
- *The Bone Mass Measurements brochure*: This brochure provides information on coverage for Medicare-covered bone mass measurements. *http://www.cms.gov/MLNProducts/downloads/bone_mass.pdf*
- The Medicare Preventive Services Series: Part 3 Web-Based Training Course (WBT): This WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, Pap tests, pelvic exams, and bone mass measurements. To access the WBT, please visit the *MLN* homepage at: *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "WBT Modules".

Please visit the *Medicare Learning Network®* for more information on these and other Medicare fee-for-service educational products. For more information on National Women's Health and Fitness Day, please visit *http://www.fitnessday.com*.

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

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.*

Source: CMS PERL 201009-39

Other Educational Resources

New PECOS enrollment fact sheets from the Medicare Learning Network

If you are a Medicare fee-for-service (FFS) provider or supplier who is currently enrolled or required to enroll in the Medicare program, the *Medicare Learning Network*® (*MLN*) can help you understand and follow the Medicare enrollment process. The *MLN* has released the next in a series of fact sheets designed to educate FFS providers about important Medicare enrollment information, including how to use Internet-based provider enrollment, chain and ownership system (PECOS) to enroll in the Medicare program and maintain your enrollment information. These fact sheets are available in downloadable format on the Centers for Medicare & Medicaid Services (CMS) website at the URLs listed below.

- **The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement**
  Provides general Medicare enrollment information to those physicians who are required to enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries and therefore, are not required to send claims to Medicare contractors for the services they furnish. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_Phys_Infreq_Reimb_FactSheet_ICN006881.pdf*
- **The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners**
  Advises physicians and nonphysician practitioners on how to enroll in the Medicare program and maintain their enrollment information using Internet-based PECOS. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.
- **Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information**
  Provides contact information for technical assistance with Internet-based PECOS. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf*.
- **The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations**
  Advises provider and supplier organizations on how to enroll in the Medicare program and maintain their enrollment information using Internet-based PECOS. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.
- **The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers**
  Explains general Medicare enrollment information specific to physicians and other Part B suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf*.
- **The Basics of Medicare Enrollment for Institutional Providers**
  Provides general Medicare enrollment information specific to institutional providers, such as community mental health centers (CMHCs), home health agencies (HHAs), hospitals, skilled nursing facilities (SNFs), and hospices. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_InstProv_FactSheet_ICN903783.pdf*.
- **The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers**
  Educates DMEPOS suppliers on how to enroll in the Medicare program and maintain their enrollment information using Internet-based PECOS. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf*.

In addition, the *Medicare Learning Network* previously released two fact sheets concerning privacy and protection of Medicare enrollment records that may also be of interest:

- **Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy - Protecting Your Medicare Enrollment Record**
  Advises FFS physicians and nonphysician practitioners on how to ensure their enrollment records are up-to-date and secure. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnrollPrivcy_FactSheet_ICN903765.pdf*.
- **How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)**
  Provides step-by-step instructions to help FFS providers protect their identity while using Internet-based PECOS. This fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf*.

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

Source: CMS PERL 201010-03

September 26 is World Heart Day

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services. Medicare provides coverage for several preventive services to help keep patients with Medicare healthy, including cardiovascular screenings, ultrasound screening for abdominal aortic aneurysms (AAA), and smoking and tobacco-use cessation counseling for eligible beneficiaries.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered preventive services that are appropriate for them.

Additional information

CMS has developed several educational products related to Medicare-covered preventive services. They are all available, free of charge, from the *Medicare Learning Network*®:

- The MLN Preventive Services Educational Products Web Page: The page provides descriptions and ordering information for *Medicare Learning Network*® (*MLN*) educational products for health care professionals related to Medicare-covered preventive services. *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp*
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*: This guide provides comprehensive coverage and coding information on Medicare-covered preventive services. *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- *Quick Reference Information: Medicare Preventive Services*: This chart provides coverage and coding information on Medicare-covered preventive services. *http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- *The Expanded Benefits brochure*: This brochure provides information on coverage for cardiovascular screening blood tests and AAA screening. *http://www.cms.gov/MLNProducts/downloads/Expanded_Benefits.pdf*
- *The Smoking and Tobacco-Use Cessation brochure*: This brochure provides information on coverage for smoking and tobacco-use cessation services. *http://www.cms.gov/MLNProducts/downloads/smoking.pdf*
- The Medicare Preventive Services Series: Part 2 Web-Based Training Course (WBT): This WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including cardiovascular screening blood tests, AAA screening, and smoking and tobacco-use cessation counseling. To access the WBT, please visit the MLN homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "WBT Modules"

Please visit the *Medicare Learning Network*® for more information on these and other Medicare fee-for-service educational products. For more information on World Heart Day, please visit *http://www.worldheart.org*.

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

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Source: CMS PERL 201009-39

Written transcript of the September 13 ICD-10 follow-up conference call

The written transcript is now available for the September 13 Centers for Medicare & Medicaid Services' (CMS) national provider conference call, "ICD-10 Implementation in a 5010 Environment." The written transcript may be accessed at *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*. Scroll to the bottom of the Web page to the *Downloads* section to locate the written transcript PDF file.

October flu shot reminder

Vaccination is the best protection against the flu. The Centers for Disease Control and Prevention (CDC) is encouraging everyone six months of age and older to get vaccinated against the seasonal flu. The risks for complications, hospitalizations and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. And remember, vaccination is particularly important for health care workers, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. Protect your patients, your family, and yourself. Get your flu vaccine – not the flu.

Remember: Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit *http://www.cms.gov/AdultImmunizations*.

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

Source: CMS PERL 201010-19

Updates from the Medicare Learning Network

The *Medicare Learning Network*® has the following Medicare fee-for-service educational products among many other products and tools to assist providers in learning about the Medicare program.

Respiratory Care Week and Lung Health Day

Sunday, October 24 through Saturday, October 30 is Respiratory Care Week and Wednesday, October 27 is Lung Health Day. The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered smoking and tobacco-use cessation counseling services. Medicare provides coverage of two smoking cessation attempts per year for qualified patients. Each attempt may include a maximum of four counseling sessions.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by encouraging them to take advantage of Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services that are appropriate for them.

Additional information

CMS has developed several educational products related to Medicare-covered smoking and tobacco-use cessation counseling services. They are all available, free of charge, from the *Medicare Learning Network*®:

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for *Medicare Learning Network*® (*MLN*) educational products for health care professionals related to Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services. Visit *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings, including smoking and tobacco-use cessation counseling services. Visit *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services. Visit *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- The Medicare Preventive Services Series: Part 2 Web-Based-Training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services. To access the course, please visit the *MLN* home page at *http://www.cms.gov/mlngeninfo/*. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules."
- *The Smoking and Tobacco-Use Cessation Counseling Services brochure* – this brochure provides information on coverage for Medicare-covered smoking and tobacco-use cessation counseling services. Visit *http://www.cms.gov/MLNProducts/downloads/smoking.pdf*.

Hospice payment system fact sheet

The revised *Medicare Learning Network*® publication titled "Hospice Payment System" (September 2010) is now available in downloadable format at *http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*. This publication provides information about the coverage of hospice services, certification requirements, the election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and the hospice option for Medicare Advantage enrollees.

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products.

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

Source: CMS PERL 201010-38

Website Welcome screen – new bookmark feature

Upon entry to either provider website, visitors are asked to indicate their line of business and geographic location before proceeding to the homepage. The purpose of this feature is to allow providers to find the information they need more quickly by focusing content based upon their selections. Since frequent site visitors may prefer not to have to indicate their references at the beginning of every visit, a Bookmark this page link is not only featured on every page of the provider website but also has been added to the site's Welcome pop-up screen. This new feature will allow visitors to save their preferences by bookmarking the homepage. More information is available at *http://medicare.fcso.com/Help/171993.asp*.

The 2010 eRx incentive program fact sheet now available

The 2010 electronic prescribing (e-Rx) incentive program fact sheet *What's New for the 2010 eRx Incentive Program* (revised July 2010) is now available in hardcopy and downloadable format from the *Medicare Learning Network*®. This resource provides an overview of the 2010 e-Rx incentive program, as well as highlighted changes from the 2009 e-Rx program.

To order your copy, free of charge, please visit the *MLN* Products page at *http://www.cms.gov/MLNProducts/01_Overview.asp*. From this page, scroll down to the "Related Links Inside CMS" section and select the "MLN Product Ordering Page" link. To view the online version, please visit *http://www.cms.gov/MLNProducts/downloads/Whats_New_2010_eRx_Fact_Sheet.pdf*.

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

Source: CMS PERL 201010-03

New product titled 'Medicare Outpatient Therapy Billing'

A new publication titled *Medicare Outpatient Therapy Billing* (August 2010) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/Medicare_Outpatient_Therapy_Billing_ICN903663.pdf*. This publication provides information about Medicare outpatient physical therapy, occupational therapy, and speech-language pathology (therapy services) coverage requirements; calendar year 2010 therapy codes and dispositions; and billing measures for therapy services.

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

Source: CMS PERL 201010-30

Medicare quarterly provider compliance newsletter – first edition released

Just a reminder that the *Medicare Learning Network*® (*MLN*) has developed a new educational tool, the *Medicare Quarterly Provider Compliance Newsletter*, to advise physicians, suppliers, and other fee-for-service (FFS) providers about how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. The newsletter will be issued on a quarterly basis and highlight the "top" issues of that particular quarter.

In this first edition, a number of issues that impact a variety of provider types are presented in order to introduce the newsletter to a wide audience of providers. For more information, please read the first edition of the newsletter on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf*.

Please watch for the second edition, which will be released in January 2011.

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

Source: CMS PERL 201010-30

Fact sheet for Medicare secondary payer

The Medicare Secondary Payer Fact Sheet, for Provider, Physician, and Other Supplier Billing Staff (revised May, 2010), is now available in hardcopy from the *Medicare Learning Network*®. This resource provides a general overview of the Medicare secondary payer (MSP) provisions for individuals involved with admission or billing procedures in provider, physician, and other supplier settings. To order your copy, free of charge, please visit the MLN Products page at *http://www.cms.gov/MLNProducts/01_Overview.asp*. From this page, scroll down to the "Related Links Inside CMS" section and select the "MLN Product Ordering Page" link. To view the online version, please visit *http://www.cms.gov/MLNProducts/downloads/MSP_Fact_Sheet.pdf*.

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

Source: CMS PERL 201009-39

Welcome to Medicare

If you're new to the Medicare community or if you just need a review of the basics, please visit our Welcome to Medicare page at *http://medicare.fcso.com/Welcome_to_Medicare/*. You'll find everything you need to build your foundation of Medicare knowledge, from a recommended training curriculum to links to key resources to help you on your way to success as a Medicare provider or biller.

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 2010 through September 2011.	40300260	Hardcopy $33		
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