

MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

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



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Publications staff

Terri Drury
 Millie C. Pérez
 Mark Willett
 Robert Petty

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

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THE FCSO MEDICARE B UPDATE!

About the FCSO Medicare B Update!

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

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

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

Who receives the Update?

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

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

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

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

Publication format

The *Update!* is arranged into distinct sections.

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

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

In addition to the above, other sections include:

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

The Medicare B Update! represents formal notice of coverage policies

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

Quarterly provider update

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

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

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

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

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

Advance beneficiary notices

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

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

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

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131 form as part of the Beneficiary Notices Initiative (BNI). The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

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

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

ABN modifiers

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

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

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

GA modifier and appeals

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

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

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

Find out first: Subscribe to FCSO eNews

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

CLAIMS

Important reminder on the upcoming timely claim filing requirement

The Centers for Medicare & Medicaid Services (CMS) would like to remind Medicare fee-for-service (FFS) physicians, providers, and suppliers submitting claims to Medicare for payment, as a result of the Patient Protection and Affordable Care Act (PPACA), effective immediately, all claims for services furnished on or after January 1, 2010, must be received by your Medicare contractor no later than one calendar year (12 months) from the date of service on the claim or Medicare will deny the claim.

If you have Medicare FFS claims with service dates from October 1, 2009, through December 31, 2009, those claims must be received by December 31, 2010, or Medicare will deny them. Claims with services dates from January 1, 2009, to October 1, 2009, keep their original December 31, 2010, deadline for filing.

In general, the start date for determining the one-year timely filing period is the date of service or “From” date on the claim. For institutional claims that include span dates of service (i.e., a “From” and “Through” date on the claim), the “Through” date on the claim is used for determining the date of service for claims filing timeliness. For claims submitted by physicians and other suppliers that include span dates of service, the line item “From” date is used for

determining the date of service for claims filing timeliness.

For additional information about the new maximum period for claims submission filing dates, contact your Medicare contractor, or review the *MLN Matters* articles listed below related to this subject:

- MM6960 – “Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 – Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months” at <http://www.cms.gov/MLN MattersArticles/downloads/MM6960.pdf>
- MM7080 – “Timely Claims Filing: Additional Instructions” at <http://www.cms.gov/MLN MattersArticles/downloads/MM7080.pdf>

You may also listen to a podcast on this subject by visiting http://www.cms.gov/CMSFeeds/02_listofpodcasts.asp.

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

Source: CMS PERL 201011-56 & 201012-10

Incentive payment program for major surgical procedures furnished in HPSAs

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

Provider types affected

This program is for general surgeons submitting claims to Medicare contractors (carriers and Medicare administrative contractors [MAC]) for major surgical procedures furnished in health professional shortage areas (HPSAs) to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article, based on change request (CR) 7063, explains that Section 5501(b) of the Affordable Care Act (ACA) revises Section 1833(m) of the Social Security Act, referred to as the Act, and authorizes an incentive payment program for major surgical services furnished by general surgeons in HPSAs. This section of the ACA provides for payments on a monthly or quarterly basis in an amount equal to 10 percent of the payment for physicians’ professional services under Medicare Part B.

Caution – what you need to know

This new program will be known as the HPSA Surgical Incentive Payment Program (HSIP). The incentive payment applies to major surgical procedures, defined as 10-day and 90-day global procedures, under the physician fee schedule (PFS) and furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon with a primary specialty code of 02 (general surgery) in an area designated under Section 332(a)(1)(A) of the Public Health Service Act as a HPSA.

Section 5501(b)(4) of the ACA provides payment under the HSIP as an additional payment amount for specified surgical services without regard to any additional payment for the service under Section 1833(m) of the Act. Therefore, a general surgeon may receive both a HPSA physician bonus payment under the established program and an HSIP payment under the new program beginning in CY 2011.

Go – what you need to do

Modifier AQ is to be used to denote claims that were furnished in HPSAs approved by December 31 of the preceding calendar year, but that are not recognized for automatic payment. The modifier must be appended to the surgical procedure for the service to be eligible for the 10 percent additional HSIP payment, unless the services are provided in a ZIP code on the list of HPSA ZIP codes where automatic incentive payments are made. The list of these ZIP codes is available at http://www.cms.gov/HPSAPSAPhysicianBonuses/01_overview.asp. Please ensure that your billing staffs are aware of this change.

Background

Section 5501(b) of the Affordable Care Act revises section 1833(m) of the Act and authorizes an incentive payment program for major surgical services furnished by general surgeons in HPSAs. The section indicates that there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment for physicians’ professional services under Part B.

Incentive payment program for major surgical procedures furnished in HPSAs (continued)

Note: The new HSIP and the new Primary Care Incentive Payment Program (PCIP) will be implemented in conjunction with one another for CY 2011. CMS issued CR 7060 with requirements specific to the PCIP. (The *MLN Matters*® article related to CR 7060 is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7060.pdf>.) The former “special HPSA remittance” will now be known as the “special incentive remittance.”

The incentive payment applies to major surgical procedures, defined as 10-day and 90-day global procedures, under the PFS and furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area designated under section 332(a)(1)(A) of the Public Health Service Act as a HPSA.

HPSA Surgical Incentive Payment Program

For services furnished on or after January 1, 2011, and before January 1, 2016, a 10 percent incentive payment will be paid to general surgeons, identified by their enrollment in Medicare with a primary specialty code of 02 (general surgery), in addition to the amount they would otherwise be paid for their professional services under Part B, when they furnish a major surgical procedure in an area designated by the Secretary of Health and Human Services, as of December 31 of the prior year as a HPSA.

To be consistent with the original Medicare HPSA physician bonus program, HSIP payments will be calculated by Medicare contractors based on the identification criteria for payment discussed below and paid on a quarterly basis on behalf of the qualifying general surgeon, for the qualifying major surgical procedures. The surgeon’s professional services are paid under the PFS based on a claim for professional services.

Identification

Qualifying general surgeons would be identified on a claim in the incentive payment program year for a major surgical procedure based on the primary specialty of 02 of the rendering physician, identified by his or her national provider identifier (NPI). If the claim is submitted by a physician group or practice, the rendering physician’s NPI must be included on the line-item for the major surgical procedure in order for a determination to be made regarding whether or not the procedure is eligible for payment under the HSIP.

Each year, a list of ZIP codes eligible for automatic payment for the established HPSA bonus is published. This list of ZIP codes will be utilized for automatic payments of the incentive payment for eligible services furnished by general surgeons. Modifier AQ is used to identify circumstances when general surgeons furnish services in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of ZIP codes eligible for automatic payment. Modifier AQ should be appended to the major surgical procedure on claims submitted for payment, similar to the current process for payment of the original Medicare HPSA physician bonus when the HPSA is not a HPSA identified for automatic payment.

CMS is defining major surgical procedures as those for which a 10-day or 90-day global period is used for payment under the PFS.

Computation of payment

Medicare contractors will compute the payment and pay general surgeons an additional incentive payment 10 percent of the amount actually paid for the service, not the Medicare approved payment amount. Claim adjustment reason code LE will identify the incentive payment as noted on the special remittance generated with the incentive payment.

Additional information

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

The official instruction, CR 7063, issued to your Medicare carrier and/or MAC regarding this incentive program may be viewed at <http://www.cms.gov/Transmittals/downloads/R2040CP.pdf>.

MLN Matters® Number: MM7063

Related Change Request (CR) #: 7063

Related CR Release Date: August 27, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2040CP

Implementation Date: January 3, 2011

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- Download recorded events

Learn more on FCSO’s Medicare training website

January quarterly update to Correct Coding Initiative edits

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

Provider types affected

Physicians and providers submitting claims to Medicare carriers and/or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries are impacted by this issue.

Provider action needed

This article is based on change request (CR) 7210, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in October 2010.

Background

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

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

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

The latest package of CCI edits, version 17.0, is effective January 1, 2011, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

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

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

Additional Information

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>. The official instruction (CR 7081) issued to your carrier or A/B MAC regarding this change is at <http://www.cms.gov/Transmittals/downloads/R2097CP.pdf>. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7210

Related Change Request (CR) #: 7210

Related CR Release Date: November 19, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2097CP

Implementation Date: January 3, 2011

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Take advantage of FCSO's exclusive PDS report

Did you know that FCSO's exclusive Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Accessible through FCSO's PDS portal at <https://medicare.fcsoc.com/reporting/index.asp>, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specified time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your bottom line.

Ambulance

2011 ambulance inflation factor and productivity adjustment

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

Provider types affected

This article is for providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for those services.

Provider action needed

Change request (CR) 7042, from which this article is taken, provides the ambulance inflation factor (AIF) for CY 2011. The AIF for CY 2011 is -0.1 percent. CR 7042 also includes updates to Chapter 15, Section 20.4 of the *Medicare Benefit Policy Manual* to incorporate a multi-factor productivity adjustment. Be sure billing staff are aware of the changes.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Remember that Part B coinsurance and deductible requirements apply to these services.

Specifically, this section of the Act provides for a 2011 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act (ACA) amended Section 1834(l) (3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The following table displays the AIF for CY 2011 and for the previous eight years.

Ambulance inflation factor by calendar year	
2011	-0.1 percent
2010	0.0 percent
2009	5.0 percent
2008	2.7 percent
2007	4.3 percent
2006	2.5 percent
2005	3.3 percent
2004	2.1 percent
2003	1.1 percent

Additional information

The official instruction, CR 7042, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2104CP.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: MM7042

Related Change Request (CR) #: 7042

Related CR Release Date: November 19, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2104CP

Implementation Date: January 3, 2011

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Fractional mileage amounts submitted on ambulance claims

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

Provider types affected

This article is for providers and suppliers of ambulance services who bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]) for those services.

What you need to know

Change request (CR) 7065, from which this article is taken, provides a new procedure for reporting fractional mileage amounts on ambulance claims, effective for claims for dates of service on or after January 1, 2011. Prior to that date, mileage is reported by rounding the total mileage up to the nearest whole mile. Be sure billing personnel are aware of this change that requires ambulance providers and suppliers to report to the nearest tenth of a mile for total mileage of less than 100 miles on ambulance claims as of January 1, 2011.

Background

Currently, the *Medicare Claims Processing Manual*, Chapter 15, Sections 30.1.2 and 30.2.1 require that ambulance providers and suppliers submitting claims to Medicare contractors use the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. According to these instructions from the Centers for Medicare & Medicaid Services (CMS), providers and suppliers are required to round the total mileage up to the nearest whole mile, including trips of less than one whole mile. For example, if the total number of round trip miles traveled equals 9.5 miles, the provider or supplier enters 10 units on the claim form or the corresponding loop and segment of the ANSI X12N 837 electronic claim. For ambulance suppliers

Fractional mileage amounts submitted on ambulance claims (continued)

submitting claims to the Medicare carriers or A/B MACs, the *Medicare Claims Processing Manual*, Chapter 26, Section 10.4 additionally states that at least one unit must be billed in Item 24G on the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12N 837P electronic claim. Therefore, if a supplier travels less than one mile during a covered trip, the supplier would enter one unit on the claim form with the appropriate HCPCS code for mileage.

In the CY 2011 Medicare physician fee schedule (MPFS) final rule, CMS established a new procedure for reporting fractional mileage amounts on ambulance claims to improve reporting and payment accuracy. The final rule requires that, effective January 1, 2011, all Medicare ambulance providers and suppliers bill mileage that is accurate to a tenth of a mile.

Note: Currently the hardcopy UB-04 form cannot accommodate fractional billing, therefore, hardcopy billers will continue to use previous ambulance billing instructions provided in effect prior to January 1, 2011, that is, providers that are permitted to file paper UB-04 claims will continue to round up to the nearest whole mile until further notice from CMS.

Effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers must report mileage units rounded up to the nearest tenth of a mile for all claims (except hard copy billers that use the UB-04) for mileage totaling less than 100 covered miles. Providers and suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). Medicare contractors will truncate mileage units with fractional amounts reported to greater than one decimal place (e.g., 99.99 will become 99.9 after truncating the hundredths place).

For trips totaling 100 miles and greater, suppliers must continue to report mileage rounded up to the nearest whole number mile (e.g., 999). Medicare contractors will truncate mileage units totaling 100 and greater that are reported with fractional mileage; (e.g., 100.99 will become 100 after truncating the decimal places).

For mileage totaling less than one mile, providers and suppliers must include a "0" prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Medicare contractors will automatically default "0.1" unit when the total mileage units are missing in Item 24G of the CMS-1500 claim form.

Additional information

The official instruction, CR 7065, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2103CP.pdf>.

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

MLN Matters® Number: MM7065

Related Change Request (CR) #: 7065

Related CR Release Date: November 19, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2103CP

Implementation Date: January 3, 2011

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Drugs and Biologicals

New Q codes for 2010-2011 seasonal influenza vaccines

The Centers for Medicare & Medicaid Services has created specific procedure codes and payment rates for Medicare billing purposes for the 2010-2011 influenza season. Effective for claims with dates of service on or after January 1, 2011, procedure code 90658 will no longer be payable by Medicare. Effective for dates of service on or after October 1, 2010, the following new influenza Q codes will be payable by Medicare: Q2035 (Afluria®), Q2036 (Flulaval®), Q2037 (Fluvirin®), Q2038 (Fluzone®), and Q2039 (not otherwise specified flu vaccine).

Physicians, other practitioners, and suppliers may submit their claims with the new influenza Q codes on an individual basis or via the roster billing process. CMS has instructed Medicare contractors to hold all claims containing the influenza Q codes with dates of service on or after October 1, 2010, until their systems are able to accept them for processing. The Medicare contractors' systems will be ready to process claims containing the Q codes no later than February 7, 2011. Physicians, other practitioners, and suppliers also have the option to hold their claims containing the new influenza Q codes until February 7, 2011.

For further information, please see Transmittal 815, change request 7234, issued on November 19, 2010 at <http://www.cms.gov/transmittals/downloads/R815OTN.pdf>.

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 201012-02

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines

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.

Provider action needed

The article is based on change request (CR) 7234 which establishes separate billing codes for each brand-name influenza vaccine product under *Common Procedure Terminology (CPT) code 90658* and describes the process for updating the new specific Healthcare Common Procedure Coding System (HCPCS) codes and their payment allowances for Medicare during the 2010-2011 influenza season.

Background

CMS has created specific HCPCS codes and payment allowances to replace *CPT code 90658* for Medicare billing purposes for the 2010-2011 influenza season.

Key points of CR 7234

The following describes the process for updating these specific HCPCS codes for Medicare payment effective for dates of service on or after October 1, 2010.

Effective for claims with dates of service on or after January 1, 2011, the following *CPT* code will no longer be payable for Medicare:

CPT code	Short description	Long description
90658	Flu vaccine, 3 yrs & >, im	<i>Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use</i>

Effective for claims with dates of service on or after October 1, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short description	Long description
Q2035	Afluria vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	Flulaval vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037	Fluvirin vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	Fluzone vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	NOS flu vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

Note: *CPT 90658* describes the regular dose vaccine that is supplied in a multi-dose vial for use in patients over three years of age. For dates of service on or after October 1, 2010, HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 (as listed in the table above) will replace the *CPT code 90658* for Medicare payment purposes during the 2010-2011 influenza season. However, these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when *CPT code 90658* will no longer be recognized.

This instruction does not affect any other *CPT* codes. It is very important to distinguish between the various *CPT* and HCPCS codes which describe the different formulations of the influenza vaccines (i.e. pediatric dose, regular dose, high dose, preservative free, etc.). As a reference, the quarterly Part B drug pricing files includes a set of National Drug Code (NDC) to HCPCS crosswalks available online at <http://www.cms.gov/McrPartBDrugAvgSalesPrice/>.

Billing

In general, it is inappropriate for a provider to submit two claims for the same service on the same date. For dates of service between October 1, 2010, and December 31, 2010, the *CPT 90658* and the Q-codes will be valid for billing; however, providers may not bill Medicare for both the *CPT 90658* and any of the Q-codes for the same patient for the same date of service. Thus, if a provider vaccinates a beneficiary on any date between October 1, 2010, and December 31, 2010, the provider may either bill Medicare immediately using *CPT 90658*, or hold the claim and wait until January 1, 2011, to bill Medicare using the most appropriate Q-code. If a claim has already been submitted and processed using *CPT 90658*, then there is no need to use the Q-code for that same service.

For dates of service on or after January 1, 2011, providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered.

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines (continued)

Payment

The Medicare Part B payment limits for influenza vaccines are 95 percent of the average wholesale price (AWP) except where the vaccine is furnished in a setting that follows a cost-based or prospective payment system under Medicare. For example, where the vaccine is furnished in the hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC), payment for the vaccine is based on reasonable cost.

For dates of service on or after October 1, 2010, the Medicare Part B payment allowances in other situations are:

HCPCS code	Allowance
Q2036	\$7.439
Q2037	\$13.253
Q2038	\$12.593

No national payment limits are available for Q2035 and Q2039. The payment limits for these two codes will be determined by the local claims processing contractor.

For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for *CPT 90655* is \$14.858.

Important notes

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. 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.

Be aware that Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 7324. However, they will adjust such claims that you bring to their attention.

Additional information

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

For complete details regarding this CR please see the official instruction (CR 7234) issued to your Medicare A/B MAC, carrier or FI. That instruction may be viewed by going to <http://www.cms.gov/Transmittals/downloads/R815OTN.pdf>.

CMS would like providers to be aware that educational products are available through the MLN catalogue free of charge. The MLN catalogue is available at <http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf>. The specific products that may be of interest to providers who use the information in MM7234 are as follows:

The *Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B)* is available at http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf.

The *Adult Immunizations* brochure provides a basic overview of Medicare’s influenza, pneumococcal and hepatitis B vaccine benefits and is available at http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf.

MLN Matters® Number: MM7234

Related Change Request (CR): 7234

Related CR Release Date: November 19, 2010

Effective Date: October 1, 2010 unless otherwise specified

Related CR Transmittal #: R815OTN

Implementation Date: January 3, 2011

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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.

Note: This article was revised on November 26, 2010, to reflect a correction to the payment rate for *Common Procedure Terminology (CPT) 90655*, as announced in change request (CR) 7234, issued on November 19, 2010. The corrected payment rate for 90655, as of September 1, 2010, is \$14.858. All other information is the same. This information was previously published in the **October 2010 Medicare B Update!** page 9.

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 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, *CPT codes 90663, 90664, 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

Influenza vaccine payment allowances - annual update for 2010-2011 season (continued)

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 \$14.858
- CPT 90656 is \$12.375
- CPT 90657 is \$6.297, and
- 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 can 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 *Revised*
 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

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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 November 26, 2010, to reflect a revised change request (CR) 6953, which was issued on November 24, 2010. The CR was revised to clarify billing procedures for services performed in the outpatient hospital setting and to update the claims adjustment reason code for line item denials for relevant services performed prior to March 23, 2010. This article was revised to reflect this clarification and update. This information was previously published in the October 2010 *Medicare B Update!* pages 11-13.

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 services provided to Medicare beneficiaries.

What you need to know

This article is based on CR 6953 which informs Medicare contractors that, effective for claims with dates of service on and after March 23, 2010, dermal injections for facial lipodystrophy syndrome (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 lipodystrophy syndrome (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.

Dermal injections for treatment of facial lipodystrophy syndrome (continued)**Claim 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.

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 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 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 deny line items on institutional claims where the LIDOS is prior to March 23, 2010.

Note to 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.

For outpatient facilities, hospitals should bill:

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

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) 26:** Expenses incurred prior to coverage.
- **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 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.

Dermal injections for treatment of facial lipodystrophy syndrome (continued)

- **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 Claim Processing Manual*

and it is at <http://www.cms.gov/Transmittals/downloads/R2105CP.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: MM6953 *Revised*
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 Related CR Release Date: November 24, 2010
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 Implementation Date: July 6, 2010

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Durable Medical Equipment

Reasonable charge update for 2011 for splints, casts, and certain intraocular lenses

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 billing Medicare contractors (carriers, fiscal intermediaries, [FIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

Provider action needed

Change request (CR) 7225, from which this article is taken, instructs your carriers, FIs, and MACs how to calculate reasonable charges for the payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Make sure your billing staff is aware of these changes.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, and for intraocular lenses implanted (codes V2630, V2631, and V2632) in a physician’s office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Beginning January 1, 2011, reasonable charges will no longer be calculated for payment of home dialysis supplies and equipment for method II end-stage renal disease (ESRD) patients. Section 153 of Medicare Improvements for Patients and Providers Act (MIPPA) amended section 1881(b) of the Act to require the implementation of an ESRD bundled payment system effective January 1, 2011. The ESRD prospective payment will provide an all-inclusive single payment to ESRD facilities (i.e. hospital-based providers of services and renal dialysis facilities) that will cover all the

resources used in providing outpatient dialysis treatment, including dialysis supplies and equipment that are currently separately payable to method II DME suppliers.

CR 7225 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501. The inflation indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the consumer price index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. The 2011 payment limits for splints and casts will be based on the 2010 limits that were announced in CR 6691 last year, increased by 1.1 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2010. The IIC update factor for 2011 is 1.1 percent.

A list of the 2011 payment limits for splints and casts are listed in the table that follows.

Code	Payment limit
A4565	\$7.84
Q4001	\$44.60
Q4002	\$168.58
Q4003	\$32.04
Q4004	\$110.92
Q4005	\$11.81
Q4006	\$26.62
Q4007	\$5.92

Reasonable charge update for 2011 for splints, casts, and certain intraocular lenses (continued)

Code	Payment limit
Q4008	\$13.31
Q4009	\$7.89
Q4010	\$17.75
Q4011	\$3.94
Q4012	\$8.88
Q4013	\$14.36
Q4014	\$24.21
Q4015	\$7.18
Q4016	\$12.10
Q4017	\$8.30
Q4018	\$13.23
Q4019	\$4.16
Q4020	\$6.62
Q4021	\$6.14
Q4022	\$11.08
Q4023	\$3.09
Q4024	\$5.54
Q4025	\$34.44
Q4026	\$107.54
Q4027	\$17.23
Q4028	\$53.78

Code	Payment limit
Q4029	\$26.34
Q4030	\$69.33
Q4031	\$13.17
Q4032	\$34.66
Q4033	\$24.57
Q4034	\$61.10
Q4035	\$12.28
Q4036	\$30.56
Q4037	\$14.99
Q4038	\$37.55
Q4039	\$7.51
Q4040	\$18.76
Q4041	\$18.22
Q4042	\$31.11
Q4043	\$9.12
Q4044	\$15.56
Q4045	\$10.58
Q4046	\$17.02
Q4047	\$5.28
Q4048	\$8.51
Q4049	\$1.93

Additional information

The official instruction, CR 7225 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2100CP.pdf>.

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

MLN Matters® Number: MM7225

Related Change Request (CR) #: 7225

Related CR Release Date: November 19, 2010

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Related CR Transmittal #: R2100CP

Implementation Date: January 3, 2011

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How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at <http://medicare.fcso.com/PDS/>.

End-Stage Renal Disease

End-stage renal disease home dialysis monthly capitation payment

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 and/or A/B Medicare administrative contractors [A/B MACs]) for home dialysis MCP services provided to Medicare ESRD beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7003 which instructs that, effective January 1, 2011, the monthly capitation payment (MCP) physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by *Current Procedure Terminology (CPT)* codes 90963, 90964, 90965, and 90966.

Caution – what you need to know

Physicians and practitioners managing Medicare beneficiaries with ESRD who dialyze at home are paid a single monthly rate based on the age of the beneficiary, and currently, the Centers for Medicare & Medicaid Services (CMS) does not require a frequency of required visits for the home dialysis monthly capitation payment (MCP) service. CR 7003 instructs that, effective January 1, 2011, the MCP physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service. In addition, documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. However, Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist’s notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month. The management of home dialysis patients who remain a home dialysis patient the entire month should be coded using the ESRD-related services for home dialysis patients Healthcare Common Procedure Coding System (HCPCS) codes.

Go – what you need to do

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

Background

In the calendar year (CY) 2004 physician fee schedule (PFS) final rule (68 FR 63216, November 7, 2003; see <http://edocket.access.gpo.gov/2003/pdf/03-27639.pdf>), the CMS established new HCPCS G codes for end stage renal disease (ESRD) monthly capitation payments (MCPs).

For center-based patients, payment for the G codes varied based on the age of the beneficiary and the number of face-to-face visits furnished each month (e.g. 1 visit, 2-3 visits and 4 or more visits). Under this methodology, the lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three

visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD related visits per month. However, payment for the home dialysis MCP only varied by the age of beneficiary. CMS stated that they “will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient.”

Effective January 1, 2009, the American Medical Association’s (AMA’s) *CPT* editorial panel created *CPT* codes to replace the HCPCS G codes for monthly ESRD-related services, and CMS accepted these new codes. The clinical vignettes used for the valuation of the home dialysis MCP services (as described by *CPT* codes 90963 through 90966) include scheduled (and unscheduled) examinations of the ESRD patient.

CR 7003 instructs that, effective January 1, 2011, the MCP physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by *CPT* codes 90963, 90964, 90965, and 90966 shown in the following table. Documentation by the MCP physician (or practitioner) should support at least one face-to-face encounter per month with the home dialysis patient. However, Medicare contractors may waive the requirement for a monthly face-to-face visit for the home dialysis MCP service on a case by case basis; for example, when the nephrologist’s notes indicate that the physician actively and adequately managed the care of the home dialysis patient throughout the month.

CPT code	Descriptor
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older

*End-stage renal disease home dialysis monthly capitation payment (continued)***Additional information**

The official instruction, CR 7003, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R1999CP.pdf>.

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

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 Related CR Transmittal #: R1999CP
 Implementation Date: January 3, 2011

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Evaluation and Management

Expansion of Medicare telehealth services for calendar year 2011

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

Provider types affected

This article is for physicians, nonphysician practitioners (NPP), hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal Intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7049 to alert providers that 14 Healthcare Common Procedure Coding System (HCPCS) codes were added to the list of Medicare telehealth services for:

- Individual and group kidney disease education (KDE) services
- Individual and group diabetes self-management training (DSMT) services
- Group medical nutrition therapy (MNT) services
- Group health and behavior assessment and intervention (HBAI) services, and
- Subsequent hospital care and nursing facility care services.

Make sure your billing staffs are aware of these changes.

Background

As noted in the 2011 Medicare physician fee schedule final rule published on November 29, 2010, CMS is adding 14 codes to the list of Medicare distant site telehealth services for individual and group KDE services, individual and group DSMT services, group MNT services, group

HBAI services, and subsequent hospital care and nursing facility care services. Payment for these services will be made at the applicable physician fee schedule (PFS) payment amount for the service of the physician or practitioner. CR 7049 adds the relevant policy instructions to the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* and those changes may be reviewed by consulting CR 7049 at <http://www.cms.gov/Transmittals/downloads/R2032CP.pdf> and <http://www.cms.gov/Transmittals/downloads/R131BP.pdf>.

Key points of CR 7049

CMS is adding the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services
 - HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour); and
 - HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour).
- Individual and group DSMT services (with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training):
 - HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes), and
 - HCPCS code G0109 (Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes).

Expansion of Medicare telehealth services for calendar year 2011 (continued)

- Group MNT and HBAI services, *Current Procedural Terminology (CPT) codes: 97804 (Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes), 96153 (Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients), and 96154 (Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present))*;
 - Subsequent hospital care services, with the limitation of one telehealth visit every 3 days; *CPT codes*
 - 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit)
 - 99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication)
 - 99233 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit)
 - Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days, *CPT codes*:
 - 99307 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit)
 - 99308 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit)
 - 99309 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit)
 - 99310 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit)
- Note:** The frequency limitations on subsequent hospital care and subsequent nursing facility care delivered through telehealth do not apply to inpatient telehealth consultations. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS codes (G0406, G0407, G0408, G0425, G0426, or G0427) when reporting consultations furnished via telehealth.
- Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or

Expansion of Medicare telehealth services for calendar year 2011 (continued)

practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

- For dates of service (DOS) on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier.
- For dates of service on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ or GT modifier by critical access hospitals (CAHs) that have elected method II on TOB 85x.

Additional information

If you have questions, please contact your Medicare A/B MAC, carrier and/or FI at their toll-free number

which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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Laboratory/Pathology

2011 annual update for clinical laboratory fee schedule and laboratory services

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

Provider types affected

Clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) are affected.

Impact on providers

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6991 which provides instructions for the calendar year (CY) 2011 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

Background

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm), and further amended by Section 3401 of the Affordable Care Act, the annual update to the local clinical laboratory fees for CY 2011 is -1.75 percent. The annual update to local clinical laboratory fees for CY 2011 reflects an additional multi-factor productivity adjustment as described by the Affordable Care Act. The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2011 is 1.1 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Social Security Act (the Act) provides that payment for a clinical laboratory test is the lesser of:

- The actual charge billed for the test
- The local fee, or
- The national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a

national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

Note: The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National minimum payment amounts

For a cervical or vaginal smear test (Pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2011 national minimum payment amount is \$14.87 percent (\$15.13 minus the 1.75 percent update for CY 2011). The affected codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150
88152	88153	88154	88164	88165
88166	88167	88174	88175	G0123
G0144	G0145	G0147	G0148	P3000

National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to data file

Internet access to the CY 2011 clinical laboratory fee schedule data file will be available after November 19,

2011 annual update for clinical laboratory fee schedule and laboratory services (continued)

2010, at <http://www.cms.gov/ClinicalLabFeeSched>. Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2011 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments

On July 22, 2010, CMS hosted a public meeting to solicit input on the payment relationship between CY 2010 codes and new CY 2011 *Current Procedural Terminology (CPT)* codes. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.gov/ClinicalLabFeeSched> on the CMS website. Additional written comments from the public were accepted until October 29, 2010, and a summary of the public comments and the rationale for the final payment determinations are posted on the same CMS website.

Pricing information

The CY 2011 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2011, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2011 clinical laboratory fee schedule also includes codes that have a modifier QW to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

Similar to prior years, the CY 2011 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

- New code 82930 is priced at the same rate as code 82926.
- New code 83861 is priced at the same rate as code 83909.
- New code 84112 is priced at the same rate as code 82731.
- New code 85598 is priced at the same rate as code 85597.
- New code 86481 is priced at the same rate as code 86480.
- New code 86902 is priced at the same rate as code 86905.
- New code 87501 is priced at the sum of the rates of codes 87521 and 83902.
- New code 87502 is priced at the sum of the rates of codes 87801 and 83902.

- New code 87503 is priced at the sum of the rates of codes 83901 and 83896.
- New code 87906 is priced at half of code 87901.
- Healthcare Common Procedure Coding System (HCPCS) Code G0434 is priced at the same rate as code G0430.
- HCPCS Code G9143 is priced at the sum of the rates of codes 83891, 83900, 83901, 83912, three times the rate of code 83896, and three times the rate of code 83908. A two-character modifier indicates that this test's use is limited to a coverage with evidence development (CED) study.
- HCPCS Code G0432 is priced at the same rate as code 86703.
- HCPCS Code G0433 is priced at the same rate as code 86703.
- HCPCS Code G0435 is priced at the same rate as code 87804.
- Reconsidered code 84145 is priced at the same rate as code 82308.
- Reconsidered code 84431 is priced at the same rate as code 84443.
- Reconsidered code 86352 is priced at twice the sum of the rates of codes 86353 and 82397.
- HCPCS Code G0430 is deleted beginning January 1, 2011.
- HCPCS Code G0431 is priced at five times the rate of HCPCS Code G0430.
- New Code 84155QW is priced at the same rate as code 84155 beginning January 1, 2010.
- New Code 87809QW is priced at the same rate as code 87809 beginning January 1, 2008.

For CY 2011, there are no new test codes that need to be gap-filled.

Laboratory costs subject to reasonable charge payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, (see http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr405_01.html) the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1)(see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm). The inflation-indexed update for CY 2011 is 1.1 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8 (see <http://www.cms.gov/manuals/downloads/clm104c23.pdf>). If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. When these services are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual* (Chapter 8, Section 60.3; see <http://www.cms.gov/manuals/downloads/clm104c08.pdf>)

2011 annual update for clinical laboratory fee schedule and laboratory services (continued)

instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system.

Blood products

P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P9033	P9034	P9035	P9036	P9037	P9038
P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, the following codes should be applied to the blood deductible as instructed in the Medicare General Information, Eligibility and Entitlement Manual (Chapter 3, Section 20.5 through 20.54; see

<http://www.cms.gov/Manuals/IOM/list.asp#TopOfPage>):

P9010	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on the Social Security Act (Section 1842(o)). The payment limits based on that provision, including the payment limits for codes P9041, P9043, P9046, P9047 and P9048, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine

86850	86860	86870	86880	86885	86886
86890	86891	86900	86901	86903	86904
86905	86906	86920	86921	86922	86923
86927	86930	86931	86932	86945	86950
86960	86965	86970	86971	86972	86975
86976	86977	86978	86985		

Reproductive medicine procedures

89250	89251	89253	89254	89255	89257
89258	89259	89260	89261	89264	89268
89272	89280	89281	89290	89291	89335
89342	89343	89344	89346	89352	89353
89354	89356				

Additional information

If you have questions, please contact your Medicare A/B MAC, carrier and/or FI at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>. The official instruction associated with this CR 6991, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2106CP.pdf>.

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Editing changes to certain pathology services and new messages

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 billing Medicare contractors (carriers and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 7061, from which this article is taken, instructs your carriers and A/B MACs to modify previously implemented edits that prevent payments to physicians, practitioners, independent diagnostic testing facilities (IDTFs) and independent laboratories for the technical component (TC) portion of the radiology and pathology services furnished to an inpatient or outpatient of a hospital. The CR also revises certain claim adjustment reason code (CARC), remittance advice remark code (RARC), and Medicare summary notice messages for both radiology and pathology because the current codes listed are obsolete. Make sure your billing staff is aware of these changes.

Background

CR 7061 amends CR 5347, issued on April 18, 2007, (see the related MLN Matters® article at <http://www.cms.gov/MLN MattersArticles/downloads/MM5347.pdf>), which implemented edits to prevent payments to physicians, practitioners, IDTFs and independent laboratories for the TC portion of the radiology and pathology services furnished to a hospital inpatient or outpatient. Payment for the TC of physician pathology services provided to a hospital inpatient or outpatient is included in the bundled payment to the hospital. The only exception to this policy is that independent laboratories may bill for the TC of pathology services to an inpatient or outpatient of a hospital according to Section 3104 of the Affordable Care Act.

CR 7061 also implements an edit to prevent payments for the TC of pathology services billed by any entity other than an independent laboratory for dates of service coincident with hospital inpatient and outpatient services.

Editing changes to certain pathology services and new messages (continued)

The Centers for Medicare & Medicaid Services (CMS) will provide your contractors with a file containing physician pathology Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the edit. In addition, CMS will make updates to the file to add and/or delete codes, as needed, in conjunction with the Medicare physician fee schedule database (MPFSDB) quarterly updates.

Payments for independent laboratories are not affected by CR 7061.

Your Medicare contractor will deny the TC or globally billed physician pathology service line items that should be bundled to the hospital. The denied services are the TC or globally billed radiology and physician pathology service line items that fall within the admission and discharge dates, inclusive, of a covered hospital inpatient stay or outpatient service billed on type of bill 11x, 12x, 13x, or 85x (except those billed by specialty code 69 (independent laboratory)). Appeal rights are offered on all denials.

When denying these services/line items, Medicare will use a CARC of 96 (Non-covered Charge(s)) and a RARC of N70 (Consolidated Billing and Payment Applies).

Additional information

For complete details regarding this CR, please see the official instruction (CR 7061) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.gov/Transmittals/downloads/R795OTN.pdf>.

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

MLN Matters Number: MM7061

Related Change Request (CR) #: 7061

Related CR Release Date: October 29, 2010

Effective Date: April 1, 2011

Related CR Transmittal #: R795OTN

Implementation Date: April 4, 2011

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Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

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

Provider types affected

Clinical laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for clinical laboratory services provided to Medicare beneficiaries are affected.

Provider action needed**Stop – impact to you**

This article is based on change request (CR) 7239 which revises the payment of travel allowances, either on a per mileage basis (P9603) or on a flat rate basis (P9604) for calendar year (CY) 2010.

Caution – what you need to know

Note that Medicare contractors will not re-process claims that were processed before the new rates were implemented unless you bring such claims to their attention.

Go – what you need to do

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

Background

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. Also, the travel codes allow for payment of the travel allowance either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604), and payment of the travel allowance is made only if a specimen collection fee is also payable.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the

travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor.

The per flat rate trip basis travel allowance (P9604) for 2010 is \$9.50. The per mile travel allowance (P9603) is \$0.95 cents per mile and is used in situations where the average trip to the patients' home is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the federal mileage rate of \$0.50 per mile plus an additional \$0.45 per mile to cover the technician's time and travel costs. Medicare contractors have the option of establishing a higher per mile rate in excess of the minimum \$0.95 per mile if local conditions warrant it. At no time is a laboratory allowed to bill for more miles than are reasonable or for miles that are not actually traveled by the laboratory technician.

The Centers for Medicare & Medicaid Services (CMS) reviews the minimum mileage rate and updates it in conjunction with the clinical laboratory fee schedule (CLFS) as needed.

Note: Because of confusion that some laboratories have had regarding the per mile fee basis and the need to claim the minimum distance necessary for a laboratory technician to travel for specimen collection, some Medicare contractors have established local policy to pay based on a flat rate basis only.

*Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens (continued)***Additional information**

The official instruction, CR 7239 issued to your carrier, A/B MAC, or FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2110CP.pdf>.

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

To review examples of scenarios that further clarify the travel allowances you may go to <http://www.cms.gov/MLNMattersArticles/downloads/MM6195.pdf> and read the Additional information section of MM6195.

MLN Matters® Number: MM7239

Related Change Request (CR) #:7239

Related CR Release Date: December 3, 2010

Effective Date: January 1, 2010

Related CR Transmittal #: R2110CP

Implementation Date: January 3, 2011

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Signature on requisitions for clinical diagnostic laboratory tests

In the November 29, 2010, Medicare physician fee schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified nonphysician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective January 1, 2011. A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.

Although many physicians, nonphysician practitioners (NPPs), and clinical diagnostic laboratories may be aware of, and are able to comply with, this policy, CMS is concerned that some physicians, NPPs, and clinical diagnostic laboratories are not aware of, or do not understand, this policy. CMS will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS will post this information on its website at <http://www.cms.gov/ClinicalLabFeeSched> and use other channels to communicate with providers to ensure this information is widely-distributed. Once the first quarter's educational campaign is fully underway, CMS will expect requisitions to be signed.

Source: JSM 11097

*Medicare Physician Fee Schedule***The 'Physician Payment and Therapy Relief Act of 2010' extends 2.2 percent MPFS update**

On Tuesday, November 30, 2010, President Obama signed into law, "The Physician Payment and Therapy Relief Act of 2010." This law extends through Friday, December 31, 2010, the 2.2 percent update to the Medicare physician fee schedule (MPFS) that has been in effect for MPFS claims with dates of service of Tuesday, June 1, 2010, through Tuesday, November 30, 2010. Payments for 2010 services under the MPFS will continue without delay.

Please watch your listservs and your contractor's website for more information, should Congressional action prevent the 2011 negative update from going into effect on Saturday, January 1, 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 201012-06

Preventive Services

Annual wellness visit including personalized prevention plan services

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

Provider types affected

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

Provider action needed

The Affordable Care Act provides for an annual wellness visit (AWV), including personalized prevention plan services (PPPS) for Medicare beneficiaries as of January 1, 2011. Change request (CR) 7079 provides the requirements for the AWV, which are summarized in this article. Make sure billing staff are aware of these services and how to bill for them.

Background

Pursuant to Section 4103 of the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) amended Sections 411.15(a)(1) and 411.15(k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This amendment's expanded coverage is subject to certain eligibility and other limitations that allow payment for an AWV, including PPPS, for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply to the AWV. The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B.

Who is eligible to provide the AWV with PPPS?

- A physician who is a doctor of medicine or osteopathy (as defined in Section 1861(r)(1) of the Social Security Act (the Act)), or
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in Section 1861(aa)(5) of the Act), or
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) of a physician as defined in the first bullet point of this section.

What is included in an initial AWV with PPPS?

The initial AWV providing PPPS provides for the following services to an eligible beneficiary by a health professional:

- Establishment of an individual's medical/family history.
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
- Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.
- Review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
- Establishment of a written screening schedule for the individual, such as a checklist for the next five to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.
- Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

Annual wellness visit including personalized prevention plan services (continued)

- Voluntary advance care planning (as defined in this section) upon agreement with the individual.
- Any other element(s) determined appropriate by the Secretary of Health and Human Services through the national coverage determination (NCD) process.

What would be included in a subsequent AWV/PPPS?

In subsequent AWVs, the following services would be provided to an eligible beneficiary by a health professional:

- An update of the individual's medical/family history.
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS.
- Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- An update to the written screening schedule for the individual as that schedule is defined in this section, which was developed at the first AWV providing PPPS.
- An update to the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWV providing PPPS.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.
- Voluntary advance care planning (as defined in this section) upon agreement with the individual.
- Any other element(s) determined by the Secretary through the NCD process.

Note: Voluntary advanced care planning refers to verbal or written information regarding an individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions and whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

Billing requirements

Two new HCPCS codes will be implemented January 1, 2011, through the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE).

G0438: Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit, (Short descriptor – Annual wellness first)

G0439: Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit, (Short descriptor – Annual wellness subseq)

Effective for services on or after January 1, 2011, Medicare contractors will pay claims containing these codes

provided the requirements for coverage and eligibility are met. Institutional providers need to submit these claims via types of bill (TOB) 12x, 13x, 22x, 23x, 71x, 77x, or 85x. Institutional providers will be paid as follows:

- For services performed on a 12x TOB and 13x TOB, hospital inpatient Part B and hospital outpatient, payment shall be made under the MPFS.
- For TOBs 22x and 23x, skilled nursing facilities will be paid based on the MPFS.
- Rural health clinics (TOB 71x) and federally qualified health centers (TOB 77x) will be paid based on the all-inclusive rate.
- For services performed on an 85x TOB, critical access hospital (CAH), pay based on reasonable cost.
- CAHs claims (submitted on TOB 85x with revenue codes 096x, 097x, and 098x) will be paid based on MPFS.
- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

Other billing requirements

Remember that G0438 is for the first AWV only. Thus, submission of G0438 for a beneficiary for whom a claim with code G0438 has already been paid will result in a denial of the later G0438 with a claim adjustment reason code (CARC) of 149 (Lifetime benefit maximum has been reached for the service/benefit category.) and a remittance advice remarks code (RARC) of N117 (This service is paid only once in a patient's lifetime.).

Remember also that the G0438 or G0439 must not be billed within 12 months of a previous billing of a G0402 (IPPE), G0438, or G0439 for the same beneficiary. Such subsequent claims will be denied with a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) and a RARC of N130 (Consult plan benefit documents/guidelines for information about restrictions for this service).

If a claim for a G0438 or G0439 is submitted within the first 12 months after the effective date of the beneficiary's first Medicare Part B coverage, it will also be denied as that beneficiary is eligible for the IPPE or "Welcome to Medicare" physical. Such claims with G0438 or G0439 will be denied with a CARC of 26 (Expenses incurred prior to coverage) and a RARC of N130.

Additional information

The official instruction, CR 7079, was issued to your carrier, FI, or A/B MAC via two transmittals. The first modified the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Transmittals/downloads/R2109CP.pdf>. The second transmittal updates the *Medicare Benefit Policy Manual*, which is at <http://www.cms.gov/Transmittals/downloads/R134BP.pdf>. See these two transmittals for more complete details regarding this benefit.

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>.

Annual wellness visit including personalized prevention plan services (continued)

MLN Matters® Number: MM7079
 Related Change Request (CR) #: 7079
 Related CR Release Date: December 3, 2010
 Effective Date: January 1, 2011
 Related CR Transmittal #: R134BP and R2109CP
 Implementation Date: April 4, 2011

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Waiver of coinsurance and deductible for preventive services

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

Provider types affected

This article is for physicians, hospitals, and other providers who submit claims to Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MAC) for providing preventive services to Medicare beneficiaries.

What you need to know

Change request (CR) 7012, from which this article is taken, implements the changes in Section 4104 of The Affordable Care Act. The CR announces that (effective for dates of service on or after January 1, 2011) Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the initial preventive physical examination (IPPE), the annual wellness visit (AWV), and for those preventive services that: 1) are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and 2) are appropriate for the individual.

Background

Sections of The Affordable Care Act amend sections of The Social Security Act to require changes in payment (with respect to deductible and

coinsurance/copayment) for identified preventive services: In addition, The Affordable Care Act waives the deductible and coinsurance/copayment for the IPPE and the AWV. The changes apply in all settings in which the services are furnished.

The following preventive services are covered by Medicare:

- Pneumococcal, influenza, and hepatitis B vaccine and administration
- Screening mammography
- Screening pap smear and screening pelvic examination
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training (DSMT)
- Bone mass measurement
- Screening for glaucoma
- Medical nutrition therapy (MNT) services
- Cardiovascular screening blood test
- Diabetes screening tests
- Ultrasound screening for abdominal aortic aneurysm (AAA), and
- Additional preventive services (identified for coverage through the national coverage determination (NCD)

process. Currently, these are limited to human immunodeficiency virus (HIV) testing).

Preventive services that do not have a USPSTF grade A or B

The Affordable Care Act waives the deductible and coinsurance/copayment for many of the preventive services listed above because those services have a recommendation grade of A or B by the USPSTF. In other cases, the deductible and coinsurance are waived because the preventive services are clinical laboratory tests to which the deductible and coinsurance do not apply according to another section of the statute.

Several preventive services covered by Medicare do not have a USPSTF recommendation grade of A or B. These include digital rectal examinations provided as prostate screening tests; glaucoma screening; DSMT services; and barium enemas provided as colorectal cancer screening tests. In the case of a screening barium enema, the deductible is waived under another section of the statute. The deductible continues to apply to the other services and coinsurance/copayment also continues to apply to all of them.

The table in CR 7012 provides a complete list of the Healthcare Common Procedure Coding System (HCPCS) codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the AWV. CR 7012 is available at <http://www.cms.gov/Transmittals/downloads/R739OTN.pdf>.

Extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic or therapeutic

The Affordable Care Act waives the Part B deductible for colorectal cancer screening tests that become diagnostic. The Medicare policy is that the deductible is waived for all surgical procedures (*Current Procedural Terminology (CPT) code range of 10000 to 69999*) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. Modifier "PT" has been created effective January 1, 2011, and providers and practitioners should append the modifier PT to a least one CPT code in the surgical range of 10000 to 69999 on a claim for services furnished in this scenario.

Additional information

You may find more information about the waiver of coinsurance and deductible for preventive services by going to CR 7012, located at <http://www.cms.gov/Transmittals/downloads/R739OTN.pdf>.

Waiver of coinsurance and deductible for preventive services (continued)

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

MLN Matters® Number: MM7012
 Related Change Request (CR) #: 7012
 Related CR Release Date: July 30, 2010
 Effective Date: January 1, 2011
 Related CR Transmittal #: R739OTN
 Implementation Date: January 3, 2011

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Radiology

Billing clarification for positron emission tomography for identifying bone metastasis of cancer in the context of a clinical trial

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7125, which is being issued to clarify a requirement in CR 6861 regarding how these claims should be billed. Specifically, CR 7125 amends instructions for claims submitted for the professional component (PC), technical (TC) or global components. This article explains the specific claims handling instructions for claims submitted for each of these components. Please ensure that your billing staffs are aware of this clarification.

Background

This article explains that CR 7125 clarifies the requirement originally discussed in *MLN Matters*® article MM6861, which may be viewed at <http://www.cms.gov/MLNArticles/downloads/MM6861.pdf>. That requirement is being amended to state that only claims for the TC or global service require the radioactive tracer, Healthcare Common Procedure Coding System (HCPCS) A9580. Claims for the PC do not require HCPCS A9580, but must contain the appropriate modifier (PI or PS), PET/CT HCPCS procedure code, diagnosis code, and the modifier Q0.

CR 7125 also corrects the list of applicable PET or PET with CT CPT codes that can be used for bone metastasis on the claim and to remove CPT 78608 and t8459 as they cannot be paid for bone metastasis with NaF-18. Finally, modifier KX (Requirements specified in the medical policy have been met) will be accepted for PC claims (modifier 26) for PET for

bone metastasis (PET NaF-18) to differentiate these claims from PET for FDG in the context of a clinical trial. This modifier is not required on claims submitted to FIs, nor is it required on claims for the technical or global service.

Key points in CR 7125

- Effective for claims with dates of service on or after February 26, 2010, NaF-18 PET oncologic claims billed with modifier TC or globally to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis that **must** include **all** of the following:
 - Modifier PI or PS
 - PET or PET/CT CPT code (78811, 78812, 78813, 78814, 78815, 78816)
 - ICD-9 cancer diagnosis code
 - Modifier Q0 – Investigational clinical service provided in a clinical research study, are present on the claim.
- Effective for claims with dates of service on or after February 26, 2010, PET oncologic claims billed with modifier 26 and modifier KX to inform the initial treatment strategy or strategy or subsequent treatment strategy for bone metastasis **must** include **all** of the following:
 - Modifier PI or PS
 - PET or PET/CT CPT code (78811, 78812, 78813, 78814, 78815, 78816)
 - ICD-9 cancer diagnosis code
 - Modifier Q0 – Investigational clinical service provided in a clinical research study, are present on the claim.

Billing clarification for positron emission tomography for identifying bone metastasis of..... (continued)

3. Claims failing the requirements stated above will be returned as unprocessable with the following messages:
 - Claim adjustment reason code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.)
 - Remittance advice remark code (RARC) MA-130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.)
 - RARC M16 (Alert: See our website, mailings, or bulletins for more details concerning this policy/procedure/decision.)
 - CARC 167 (This (these) diagnosis(es) is (are) not covered.)
4. Claims billed with modifiers 26 and KX to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis billed with HCPCS A9580 will be returned as unprocessable using CARC 97 (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.).

Additional information

The official instruction, CR 7125, issued to your carrier, FI, or A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2096CP.pdf>.

MLN Matters® Number: MM7125
 Related Change Request (CR) #: 7125
 Related CR Release Date: November 19, 2010
 Effective Date: February 26, 2010
 Related CR Transmittal #: R2096CP
 Implementation Date: February 22, 2011

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Surgery

Ventricular assist devices as destination therapy

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, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for ventricular assist device (VAD) implantation services provided to Medicare beneficiaries.

What you need to know

Effective for claims with dates of service on or after November 9, 2010, The Centers for Medicare & Medicaid Services (CMS) has expanded coverage for VAD implantation as destination therapy as reasonable and necessary when the device has received Food and Drug Administration (FDA) approval for a destination therapy indication and only for patients with New York Heart Association (NYHA) Class IV end-stage ventricular heart failure who are not candidates for a heart transplant and who meet all specific conditions as outlined in the revised *Medicare National Coverage Determinations (NCD) Manual* (Chapter 1, Section 20.9).

Background

A ventricular assist device (VAD) or left ventricular assist device (LVAD) is surgically attached to one or both intact ventricles and is used to assist a damaged or weakened native heart in pumping blood. Medicare currently covers these devices for three general indications:

1. Postcardiotomy

2. Bridge to transplantation
3. Destination therapy.

Destination therapy is for patients who are not candidates for heart transplantation and require permanent mechanical cardiac support. Coverage for destination therapy is currently restricted based on patient selection criteria including:

- New York Heart Association (NYHA) class
- Time on optimal medical management
- Left ventricular ejection fraction, and
- Peak oxygen consumption.

Note: VADs implanted for destination therapy are only covered when performed in a hospital that is Medicare approved to provide this procedure.

CR 7220 instructs that, effective for claims with dates of service on and after November 9, 2010, CMS has determined that the evidence is adequate to conclude that VAD implantation as destination therapy improves health outcomes and is reasonable and necessary when:

- The device has received FDA approval for a destination therapy indication, and only for patients with New York Heart Association (NYHA) class IV end-stage ventricular heart failure who are not candidates for heart transplant, and

Ventricular assist devices as destination therapy (continued)

- Who meet all of the following conditions:
 - Have failed to respond to optimal medical management (including beta-blockers, and Antiotensin-Converting Enzyme (ACE) inhibitors if tolerated) for at least 45 of the last 60 days, or have been balloon pump-dependent for seven days, or IV inotrope-dependent for 14 days
 - Have a left ventricular ejection fraction (LVEF) < 25 percent, and
 - Have demonstrated functional limitation with a peak oxygen consumption of ≤ 14 ml/kg/min unless balloon pump or inotrope dependent or physically unable to perform the test.

Note: There are no changes to existing claims processing requirements/editing for VADs as destination therapy.

Additional Information

The official instruction, CR 7220, issued to your

General Coverage

carriers, FIs, and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R129NCD.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: MM7220
 Related Change Request (CR) #: 7220
 Related CR Release Date: December 8, 2010
 Effective Date: November 9, 2010
 Related CR Transmittal #: R129NCD
 Implementation Date: January 6, 2011

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President Obama signs the Medicare and Medicaid Extenders Act of 2010 New law includes sustainable growth rate fix through December 2011

On Wednesday, December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act of 2010 (MMEA). This new law prevents a scheduled payment cut for physicians who treat Medicare patients from taking effect. The Centers for Medicare & Medicaid Services (CMS) is pleased that this law has addressed key issues for beneficiaries and providers and they are actively engaged in implementing these changes.

CMS is also working to implement several important new provisions for Medicare beneficiaries made possible by the Affordable Care Act – the health reform law. In 2011:

- Beneficiaries who reach the prescription drug coverage gap, known as the donut hole, will receive a 50 percent discount when buying Part D-covered brand-name prescription drugs.
- Virtually all Medicare beneficiaries are eligible to receive many free preventive care services and a free annual wellness visit.

These provisions will improve care for Medicare beneficiaries and we encourage you to share this information with your patients. More information on these Affordable Care Act provisions may be found at

<http://www.medicare.gov/> and at <http://www.healthcare.gov>. Healthcare.gov also contains a timeline and other key information about the new law and a highly praised insurance finder for coverage options in public and private insurance programs, which family members and friends of Medicare beneficiaries may find useful.

Below please find technical summaries of key provisions of the MMEA along with some information about how these changes may affect providers and provider billing.

Physician payment update

Section 101 of the MMEA prevents a payment cut for physicians that would have taken effect on January 1, 2011. While the physician fee schedule update will be zero percent, other changes to the relative value units (RVUs) used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2011. CMS is currently developing the 2011 Medicare physician fee schedule (MPFS) to implement the zero percent update, and we expect all 2011 claims to be processed timely, in compliance with the new legislation.

Extension of Medicare physician work geographic adjustment floor

Current law requires payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 103 of the MMEA extends the existing 1.0 floor on the “physician work” geographic practice cost index, through December 31, 2011. As with the physician payment update, this change will be accomplished through a revised 2011 MPFS.

Extension of physician fee schedule mental health add-on payments

For calendar year 2010, certain mental health services’ payment rates continued to be increased by five percent. Section 107 of the MMEA extends the five percent increase in payments for these mental health services, through December 31, 2011. Similar to the zero percent update and the physician work geographic adjustment floor extension, the five percent increase will be reflected in the revised 2011 MPFS.

*President Obama signs the Medicare and Medicaid Extenders Act of 2010 (continued)***Extension of Medicare Modernization Act
Section 508 Reclassifications**

Section 102 of the MMEA extends Section 508 and special exception hospital reclassifications from October 1, 2010, through September 30, 2011. Effective April 1, 2011, Section 102 also requires removing Section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by Section 102 of the MMEA shall be assigned an individual special wage index effective April 1, 2011. If the Section 508 or special exception hospital's wage index applicable for the period beginning on October 1, 2010, and ending on March 31, 2011, is lower than the period beginning on April 1, 2011, and ending on September 30, 2011, the hospital shall be paid an additional amount that reflects the difference between the wage indices. The provision applies to both inpatient and outpatient hospital payments. For hospital outpatient payments, a special exception hospital's reclassified wage index will be applicable from January 1, 2011, through December 31, 2011.

Extension of exceptions process for Medicare therapy caps

Section 104 of the MMEA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the modifier KX, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,870. For occupational therapy services, the limit is \$1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

Extension of moratorium on independent laboratory billing for the technical component (TC) of physician pathology services furnished to hospital patients

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

Although the previous extension of the moratorium expired at the end of 2010, the MMEA restores the moratorium through 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011, through December 31, 2011.

Extension of ambulance add-on payments

The provisions that were extended by Section 106 of the MMEA are: (1) the three percent increase in the ambulance fee schedule amounts for covered ground

ambulance transports that originate in rural areas and the two percent increase for covered ground ambulance transports that originate in urban areas; (2) the provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services; and (3) the provision relating to payment for ground ambulance services where the base rate is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density.

All of these payment provisions are extended through December 31, 2011.

Extension of outpatient hold harmless provision

Section 108 of the MMEA extends the outpatient hold harmless provision, effective for dates of service on and after January 1, 2011, through December 31, 2011, to rural hospitals with 100 or fewer beds and to all sole community hospitals and essential access community hospitals regardless of bed size.

Extension of Medicare reasonable cost payment for clinical lab tests furnished to hospital patients in certain rural areas

Section 109 of the MMEA extends the reasonable cost payment for clinical lab tests furnished by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2011, through June 30, 2012. This could affect services furnished as late as June 30, 2013.

If your hospital qualifies under Section 109, you do not need to take any action. Your hospital will receive reasonable cost reimbursement for an entire year, starting with the facility cost reporting period beginning on or after July 1, 2011.

Repeal of the delay of RUG-IV

Section 202 of the MMEA repeals the delay of the skilled nursing facility (SNF) prospective payment system (PPS) resource utilization group version IV (RUG-IV) classification system. Therefore, RUG-IV will continue to remain in effect from October 1, 2010, as previously implemented by the final SNF payment regulation for FY 2011. All claims processing activities shall proceed in accordance with the existing instructions.

Please be on the alert for more information pertaining to the Medicare and Medicaid Extenders Act of 2010. Finally, as a reminder, beginning on January 3, 2011, eligible professionals, eligible hospitals, and critical access hospitals can register for the Medicare and Medicaid electronic health records incentive programs. For more information, please visit the website 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 201012-23

National modifier and condition code to identify items or services related to the 2010 oil spill

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, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries related, in whole or in part, to the 2010 oil spill in the Gulf of Mexico.

Provider action needed

This article is based on change request (CR) 7087 which identifies a new modifier and a new condition code that must be used to identify items or services related to the 2010 oil spill in the Gulf of Mexico. Be sure your billing staff is aware of these changes. You should begin to place the modifier or condition code on claims submitted as of January 3, 2011.

Background

As a result of the oil spill in the Gulf of Mexico, the Centers for Medicare & Medicaid Services (CMS) plans to monitor the potential health and cost impacts of the oil spill on Medicare beneficiaries, in both the short and long-term. In order to ensure that such health care services and costs are properly identified, CMS is requiring that every Medicare fee-for-service claim be specifically identified if it is for an item or service furnished to a Medicare beneficiary, where the provision of such item or service is related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico (hereafter referred to as the "Gulf oil spill") and/or circumstances related to such oil spill, including but not limited to subsequent clean-up activities.

Claims from physicians, other practitioners, and suppliers must be annotated with the modifier "CS" for each line item where the item or service is so related. Similarly, claims from institutional billers must be annotated with a condition code of "BP" when the entire claim is so related or with the "CS" modifier for each relevant line item when only certain line items are so related. The modifier and condition code are to be used for claims with dates of service on or after April 20, 2010.

The **long description of the CS modifier** is as follows:

"Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities."

The **short description of the CS modifier** is: "Gulf Oil Spill Related."

The **title of the BP condition code** is "Gulf oil spill related" and its definition is as follows:

"This code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities."

Note: CMS requests provider, physician and supplier assistance in identifying previously processed claims related to an illness, injury or condition caused or exacerbated either directly or indirectly by the 2010 Gulf oil spill. CMS encourages providers, physicians and suppliers to contact their Medicare contractor to identify services or claims – submitted and processed prior to the creation of the Gulf oil spill modifier and condition code – that should have the CS modifier and/or the BP condition code appended.

Additional information

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

The official instruction (CR 7087) issued to your Medicare MAC, carrier and/or FI is available at <http://www.cms.gov/Transmittals/downloads/R2021CP.pdf>.

MLN Matters® Number: MM7087

Related Change Request (CR) #: 7087

Related CR Release Date: August 6, 2010

Effective Date: April 20, 2010

Related CR Transmittal #: R2021CP

Implementation Date: January 3, 2011

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

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.

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

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

Note: This article was revised on November 26, 2010, to include the following statement: The Centers for Medicare & Medicaid Services (CMS) previously announced that, beginning January 3, 2011, if certain Part B billed items and services require an ordering/referring provider and the ordering/referring provider is not in the claim, is not of a profession that is permitted to order/refer, or does not have an enrollment record in the Medicare provider enrollment, chain and ownership system (PECOS), the claim will not be paid. The automated edits will not be turned on effective January 3, 2011. We are working diligently to resolve enrollment backlogs and other system issues and will provide ample advanced notice to the provider and beneficiary communities before we begin any automatic nonpayment actions. This information was previously published in the April 2010 *Medicare B Update!* pages 29-32.

Provider types affected

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

Provider action needed

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

What providers need to know

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

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

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

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

information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

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

Background

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

Below are examples of some of these types of claims:

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

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

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

Questions and answers relating to the edits

1. What will the edits do?

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

*Edits on the ordering/referring providers in Medicare Part B claims (continued)***2. Why did Medicare implement these edits?**

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

3. How and when will these edits be implemented?

These edits are being implemented in two phases:

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

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

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

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

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

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

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

<http://www.cms.gov/MedicareProviderSupEnroll>; click on “Ordering Referring Report” (on the left).

Information about the report will be displayed.

* The informational messages vary depending on the claims processing system.

† DMEPOS suppliers who submit paper claims will not receive an informational message on the remittance advice.

‡ NPIs were added only when the matching criteria verified the NPI.

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

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

1. You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).

- If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
- If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
- If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in six or more years, you do not have an enrollment record in PECOS. You need to take action to establish one. **See the last bullet in this section.**
- If you are not sure, you may: (1) check the ordering referring report previously mentioned, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment Web page about Internet-based PECOS before you begin.
- **If you do not have an enrollment record in PECOS:**
 - You need to submit an enrollment application to Medicare in one of two ways:
 - a. Use Internet-based PECOS to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the certification statement and mail the certification statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the Web-based system before you attempt to use it. Go to <http://www.cms.gov/MedicareProviderSupEnroll>, click on

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

“Internet-based PECOS” on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads section on that page that relate to physicians and nonphysician practitioners. A link to Internet-based PECOS is included on that Web page.

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

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

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

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

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

As the billing provider, you need to ensure that your Medicare claims for items or services that you furnished

based on orders or referrals will pass the two edits on the ordering/referring provider so that you will not receive informational messages in phase 1 and so that your claims will be paid in phase 2.

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

Make sure your claims are properly completed.

Do not use “nicknames” on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., “Dr.”) in a name field. On paper claims (CMS-1500), in item 17, you should enter the ordering/referring provider’s first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or nonphysician practitioner and not to an organization, such as a group practice that employs the physician or nonphysician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, billing providers should contact their local carrier, A/B MAC, or DME MAC.

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

Additional guidance

1. **Orders or referrals by interns or residents.** Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/she may not be identified in a Medicare claim as the ordering/referring provider. The teaching, admitting, or supervising physician is considered the ordering/referring provider when interns and residents order and refer, and that physician’s name and NPI would be reported on the claim as the ordering/referring provider.

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

- 2. Orders or referrals by physicians and nonphysician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare.** These physicians and nonphysician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper certification statement that is generated when submitting a Web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
- 3. Orders or referrals by dentists.** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper certification statement that is generated when submitting a Web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

You may want to review the following related CRs:

- CR 6417 at <http://www.cms.gov/Transmittals/downloads/R642OTN.pdf>
- CR 6421 at <http://www.cms.gov/Transmittals/downloads/R823OTN.pdf>
- CR 6696 at <http://www.cms.gov/Transmittals/downloads/R328PI.pdf>

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

MLN Matters Number: SE1011 *Revised*

Related Change Request (CR) #: 6421, 6417, and 6696

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: R642OTN, R823OTN, and R328PI

Implementation Date: N/A

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

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

Note: This article was revised on December 17, 2010, to reflect the changes in the release of a revised CR 6417 on December 16, 2010. The CR was revised to show that implementation date for phase 2 is being delayed and will not begin on January 3, 2011. A placeholder date of July 5, 2011, has been stated in the revised CR 6417. This placeholder date is being issued to give the Centers for Medicare & Medicaid Services more flexibility to determine the appropriate date for nonpayment of claims that fail the ordering/referring provider edits. This information was previously published in the April 2010 *Medicare B Update!* pages 33-34.

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by physician and nonphysician practitioners who are eligible to order/refer such services.

Physician and nonphysician practitioners who order or refer must be enrolled in the Medicare provider enrollment, chain, and ownership system (PECOS) and must be of the type/specialty who are eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

Background

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

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

or referred must show the name and unique identifier of the ordering/referring provider on the claim.

The providers who can order/refer are:

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

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

Key points

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

provider is not in PECOS, the carrier or Part B MAC will search its claim system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.

- In both phases, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.
- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at <https://pecos.cms.hhs.gov/pecos/login.do>. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp. Once at that site, scroll to the *Download* section of that page and click on the materials that apply to you and your practice.

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

Additional information

You may find the official instruction, CR 6417, issued to your carrier or B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R825OTN.pdf>.

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

MLN Matters® Number: MM6417 *Revised*
 Related Change Request (CR) #: 6417
 Related CR Release Date: December 16, 2010
 Effective Dates: Phase 1: October 5, 2009,
 Related CR Transmittal #: R825OTN
 Implementation Dates: Phase 1: October 5, 2009, Phase 2: July 5, 2011(placeholder)

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Home health face-to-face encounter – a new home health certification requirement

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 certifying Medicare patients' need/eligibility for home health benefits, home health agencies (HHAs), and beneficiaries.

What you need to know

As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed nonphysician practitioner (NPP) has had a face-to-face encounter with the patient. Documentation regarding these encounters must be present on certifications for patients with starts of care on and after January 1, 2011. See the remainder of this article for details.

Background

Since the inception of the benefit, the Social Security Act has required physicians to order and certify the need for Medicare home health services. This new mandate assures that the physician's order is based on current knowledge of the patient's condition.

As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed NPP has had a face-to-face encounter with the patient.

The Affordable Care Act describes NPPs who may perform this face-to-face patient encounter as a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Social Security Act), who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in Section 1861(gg) of the Social Security Act, as authorized by state law), or a physician assistant (as defined in Section 1861(aa)(5) of the Social Security Act), under the supervision of the physician.

Home health prospective payment system final rule implementation provisions

The Centers for Medicare & Medicaid Services (CMS) implemented this provision of the Affordable Care Act via the Home health prospective payment system (HHPPS) calendar year (CY) 2011 rulemaking. In that rule, CMS finalized the following:

- Documentation regarding these face-to-face encounters must be present on certifications for patients with starts of care on and after January 1, 2011.
- As part of the certification form itself, or as an addendum to it, the physician must document when the physician or allowed NPP saw the patient, and document how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.
- The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.
- In situations when a physician orders home health care for the patient based on a new condition that was not

evident during a visit within the 90 days prior to start of care, the certifying physician or NPP must see the patient within 30 days after admission. Specifically:

- If the certifying physician or NPP had not seen the patient in the 90 days prior to the start of care, a visit within 30 days of start of care would be required.
- If a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that accepted standards of practice would preclude the physician from ordering services without the physician or an NPP first examining the patient.

The Affordable Care Act and the final rule include several features to accommodate physician practice:

- In addition to allowing NPPs to conduct the face-to-face encounter, Medicare allows a physician who attended to the patient in an acute or post-acute setting, but does not follow patient in the community (such as a hospitalist) to certify the need for home health care based on their contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then "hand off" the patient's care to his or her community-based physician.
- Medicare will also allow physicians who attended to the patient in an acute or post-acute setting to certify the need for home health care based on their contact with the patient, initiate the orders for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care.
- The law allows the face-to-face encounter to occur via telehealth, in rural areas, in an approved originating site.

Plan of care and certification clarifications

Long-standing regulations have described the distinct content requirements for the plan of care (POC) and certification. The Affordable Care Act requires the face-to-face encounter and corresponding documentation as a certification requirement. Providers have the flexibility to implement the content requirements for both the POC and certification in a manner that best makes sense for them.

Prior to CY 2011, CMS manual guidance required the same physician to sign the certification and the POC. Beginning in CY 2011, CMS will allow additional flexibility associated with the POC when a patient is admitted to home health from an acute or post-acute setting. For such patients, CMS will allow physicians who attend to the patient in acute and post-acute settings to certify the need for home health care based on their face to face contact with the patient (which includes documentation of the face-to-face encounter), initiate the orders (POC) for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care.

Home health face-to-face encounter – a new home health certification requirement (continued)

As described in the final HHPPS regulation, CMS continues to expect that, in most cases, the same physician will certify and establish and sign the POC. But the flexibility exists for HH post-acute patients if needed.

Certain nonphysician practitioners can play an important role in the face to face encounter. For example, an allowed nonphysician practitioner who attends to a patient in an acute setting or emergency room can collaborate with and inform the community certifying physician regarding his/her contact with the patient. The community physician could document the encounter and certify based on this information.

Additional information

Medicare home health plays a vital role in allowing patients to receive care at home as an alternative to extended hospital or nursing home care. Questions and answers regarding this requirement will be available the via Medicare's home health agency Web page at <http://www.cms.gov/center/hha.asp>.

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 Implementation Date: N/A

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

Electronic Data Interchange

How to use and report PLB codes on remittance advice

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 [FIs], regional home health intermediaries [RHHIs], carriers, A/B Medicare administrative contractors [MACs] and durable medical equipment MACs [DME MACs]) for Medicare beneficiaries are affected.

Provider action needed

Change request (CR) 7068 provides instructions to Medicare Carriers, MACs, FIs, and RHHIs about using and reporting PLB codes on the remittance advice (RA). It also includes instruction for DME MACs for reporting RAC recoupment when there is a time difference between the creation of the accounts receivable and actual recoupment of money.

The attachment in CR 7068 provides a list of PLB codes to be reported on the 835 as well as the paper remittance advice and a crosswalk between the HIGLAS PLB codes and the ASC X12 Transaction 835 PLB codes to ensure that PLB code reporting on the RA is consistent and uniform across the board.

Background

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

Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Publication. L.108-173) which amended Title XVIII of the Social Security Act (the Act) has added a new paragraph (f) to Section 1893 of the Act, the Medicare Integrity Program. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment under the provisions of Section 935 of the MMA can begin no earlier than the 41st day (see CR 6183 – Transmittal 141, issued September 12, 2008), and can happen only when a valid request for a redetermination has not been received within that period of time.

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

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

Step II: Report the actual recoupment.

In a previous CR (Transmittal 659, CR 6870), Medicare carriers, FIs and A/B MACs were instructed to provide

enough detail in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step-by-step process, regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done. CR 7068 instructs DME MACs how to report on the RA when an overpayment is identified and also when Medicare actually recoups the overpayment in a future RA.

RAC recoupment reporting – DME claims only

Step I:

Claim level:

The original claim payment is taken back and the new payment is established (reversal and correction).

Provider level:

PLB03-1 – PLB reason code FB (forward balance)

PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: Adjustment CCN#

20-30: HIC#

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

Step II:

Claim level:

No additional information at this step

Provider level:

PLB03-1 – PLB reason code WO (overpayment recovery)

PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: adjustment CCN#

20-30: HIC#

PLB04 shows the actual amount being recouped

A demand letter is also sent to the provider when the accounts receivable (A/R) is created – Step I. This document contains a control number for tracking purpose that is also reported on the RA.

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

Note: CR 7068 instructions, regarding recoupment, apply to both 004010A1 and 005010 versions of ASC X12 Transaction 835 and standard paper remittance (SPR). In some very special cases the HIC # may have to be truncated to be compliant with the 004010A1 Implementation Guide.

How to use and report PLB codes on remittance advice (continued)

PLB code reporting

The RA reports payments and adjustments to payments at 3 levels: a) service, b) claim, and c) provider.

The adjustments at the service and the claim level are reported using 3 sets of codes:

- Group codes
- Claim adjustment reason codes (CARCs), and
- Remittance advice remark codes (RARCs).

Provider level adjustments are reported using the PLB codes. The PLB code list is an internal code list that can be changed only when there is a change in the version.

In version 004010A1, the following PLB codes are available for use: 50, 51, 72, 90, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, AND ZZ. In version 005010, two new codes – AH and HM – have been added, and code ZZ has been deleted. The other change in version 005010 is the way situational field PLB03-2 for reference identification is used.

Field	Version 00401A1	Version 005010
PLB03-1		AH – additional code HM – additional code ZZ – deleted code
PLB03-2	Max: 30 Position 1-2: Medicare intermediaries must enter the applicable Medicare code Position 3-19: Financial control number or the provider level adjustment, number or other pertinent identifier Position 20-30: Health insurance claim (HIC) number	Max: 50 Required when a control, account or tracking number applies to this adjustment as reported in field PLB03-1 No Medicare specific codes.

HIGLAS uses additional PLB codes from the X12 standard that are not in the implementation guide (IG) or technical report (TR) 3. Medicare must use only those codes that are included in the IG/TR3 to report on the 835.

HIGLAS PLB codes and ASC X12 crosswalk

Currently CMS is transitioning to HIGLAS, and some contractors are still not under HIGLAS. CR 7068 applies to both HIGLAS and non-HIGLAS contractors with the goal of uniform and consistent reporting on the 835 across the board. Secondly, CMS is also in the process of implementing version 005010/005010A1. Attachment – 835 PLB code mapping is applicable to version 004010A1 as well as 005010A1.

The PLB codes to report on the 835 and HIGLAS and HIPAA PLB crosswalk may be found in the attachment in CR 7068.

Additional information

For complete details regarding this CR, please see the official instruction (Transmittal 812 CR 7068) issued to your Medicare contractor at <http://www.cms.gov/transmittals/downloads/R812OTN.pdf>. You may also want to review the following *MLN Matters*® articles:

- Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments at <http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf>
- Reporting of Recoupment for Overpayment on the Remittance Advice (RA) at <http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf>

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

MLN Matters® Number: MM7068
 Related Change Request (CR) #:7068
 Related CR Release Date: November 12, 2010
 Effective Date: April 1, 2011
 Related CR Transmittal #: R812OTN
 Implementation Date: April 4, 2011; July 5, 2011, for institutional providers and DME suppliers

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Problems with the HIPAA Eligibility Transaction System

On December 4, a new release of the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) was installed. The system had been extensively tested with a number of clearinghouses. Although it performed well in the test environment, the system could not support the production traffic and was backed out on December 6.

The system upgrade was designed to address increasing demands (e.g., volume of transactions) and correct connection problems that have been especially problematic during peak hours (9:00 a.m.-2:00 p.m. ET).

The Centers for Medicare & Medicaid Services (CMS) is aware of the impact of the current performance and connection problems on Medicare providers using this system to get needed beneficiary eligibility information. CMS regrets the inconvenience and want to assure the provider and clearinghouse community that correcting HETS problems is their top priority. Your continued patience is appreciated. HETS status information will be communicated to HETS submitters as information becomes available.

Source: CMS PERL 201012-13

General Information

Update to Medicare deductible, coinsurance and premium rates for 2011

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment 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.

Impact on providers

This article is based on change request (CR) 7224 which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2011.

Background

2011 Part A – Hospital insurance (HI)

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for day 61-90 spent in the hospital.

Note: An individual has 60 lifetime reserve days of coverage, which they may elect to use after day 90 in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for day 21 through 100 of skilled nursing facility (SNF) services furnished during a spell of illness. The 2011 inpatient deductible is \$1,132.00. The coinsurance amounts are shown below in the following table:

Hospital coinsurance		Skilled nursing facility coinsurance
Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
\$283.00	\$566.00	\$141.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for health insurance (HI) benefits without a premium payment. In addition, The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium. Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a two-year 10 percent penalty is assessed for every year they had the

opportunity to (but failed to) enroll in Part A. The 2011 Part A premiums are as follows:

2011 voluntary enrollees Part A premium schedule	
Base premium (BP)	\$450.00 per month
Base Premium with 10 percent surcharge	\$495.00 per month
Base premium with 45 percent reduction (for those with 30-39 quarters of coverage)	\$248.00 (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	\$272.80 per month

2011 Part B – Supplementary medical insurance (SMI)

Under Part B, the Supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2011, the standard premium for SMI services is \$115.40 a month; the deductible is \$162.00 a year; and the coinsurance is 20 percent. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 7224, which is available at

<http://www.cms.gov/Transmittals/downloads/R65GI.pdf>.

Additional information

The official instruction, CR 7224, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R65GI.pdf>.

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

MLN Matters® Number: MM7224

Related Change Request (CR) #: 7224

Related CR Release Date: November 19, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R65GI

Implementation Date: January 3, 2011

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Important update on PECOS and ordering/referring

At this time, the Centers for Medicare & Medicaid Services (CMS) has not turned on the automated edits that would deny claims for services that were ordered or referred by a physician or other eligible professional simply for lack of an approved file in the provider enrollment chain and ownership system (PECOS). CMS is working diligently to resolve backlog and other system issues and will provide ample advance notice to the provider and beneficiary communities before CMS begins any such automatic denials. While there are some rumors that the edits will be turned on in January, CMS wants to reiterate that no date has been announced yet (January 3 or otherwise) as to when ordering/referring edits will be turned on.

Physicians or other eligible professionals not currently enrolled in PECOS should take the initiative to enroll sooner rather than later. There are three ways to verify that you have an enrollment record in PECOS:

- Check the ordering referring report at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp. If you are listed on that report, you have a current enrollment record in PECOS.

- Use Internet-based PECOS to look for your PECOS enrollment record, available at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp. If no record is displayed, you do not have an enrollment record in PECOS.
- Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Visit <http://www.cms.gov/MedicareProviderSupEnroll/> for the “Medicare Fee-For-Service Contact Information” list (in the *Downloads* section).

If you are not yet in PECOS, the best way to submit your application is through internet-based PECOS. For more information, visit

http://questions.cms.gov/app/answers/detail/a_id/10038/.

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

Source: CMS PERL 201011-54

Physicians and nonphysician practitioners excluded from deactivation in Medicare due to inactivity

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

Provider types affected

Physicians and nonphysician practitioners (NPPs) who need to enroll in the Medicare Program for the sole purpose of ordering and referring items and services for Medicare beneficiaries are excluded from the process that would deactivate them after 12 consecutive months of non-billing.

Provider action needed

This article is for certain physicians and NPPs who have the unique enrollment scenarios of enrolling for the sole purpose of ordering and referring items and services for Medicare beneficiaries. These physicians and NPPs do not and will not send claims to a Medicare contractor for the services they furnish and shall be excluded from the 12-month non-billing deactivation process. The supplier types affected are listed in the *Background* section of this article.

Background

The Centers for Medicare & Medicaid Services (CMS) instructs Medicare contractors to deactivate the records of physicians and NPPs who have had no activity in submitting claims to Medicare contractors for 12 consecutive months. However, CMS excludes certain physicians and NPPs from this deactivation process and has instructed Medicare contractors accordingly. The supplier types that are excluded from deactivation for non-billing include the following physicians and NPPs who are employees of Department of Veterans Affairs (DVA), Department of Defense (DOD), or Public Health Service (PHS) and employees of Medicare enrolled federally qualified health center (FQHC), critical access hospital (CAH), and rural health clinic (RHCs):

- Doctor of medicine or osteopathy
- Doctor of dental medicine

- Doctor of dental surgery
- Doctor of podiatric medicine
- Doctor of optometry
- Doctor of chiropractic medicine
- Physician assistant
- Certified clinical nurse specialist
- Nurse practitioner
- Clinical psychologist
- Certified nurse midwife, and
- Clinical social worker.

In addition, the following supplier types, regardless of their employment, are excluded from the deactivation process:

- Pediatric medicine physicians (specialty 37), and
- Oral surgery (dentist only, specialty 19)

Additional information

If you have questions, contact your designated Medicare contractor at its toll free number, which is available at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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Indian Health Service facilities and tribal provider's use of PECOS

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

Note: MLN Matters® article MM7174 was revised on November 30, 2010, to add references to SE0914, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/SE0914.pdf>, and MM6231, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM6231.pdf>, for further information on using Internet-based PECOS. This information was previously published in the November 2010 Medicare B Update! pages 28-29.

Provider types affected

Tribal or Indian Health Service (IHS) providers wanting to enroll or who are currently enrolled in the Medicare program.

Provider action needed

This article is based on change request (CR) 7174, which informs Indian Health Service (IHS) facilities and tribal providers initially enrolling in the Medicare program or submitting changes of enrollment information that they may use the Internet-based provider enrollment, chain and ownership system (PECOS) to do so.

Background

Currently, Indian Health Service (IHS) facilities and tribal providers are permitted to enroll in Medicare Part A and B using the paper enrollment process only. The Internet-based PECOS routes enrollment applications to the correct Medicare contractor based on the provider/supplier type and their practice location, but it is not currently designed to route IHS and tribal enrollment applications to Trailblazer Health Enterprises, LLC (TrailBlazer), the single designated Medicare contractor responsible for enrolling this provider type. For this reason, IHS facilities and tribal providers have not been able to use Internet-based PECOS.

CR 7174 is establishing an interim process to allow IHS facilities and tribal providers to use Internet-based PECOS to initially enroll in the Medicare program or submit changes of information.

If IHS facilities or tribal providers choose to use Internet-based PECOS, they will be responsible for mailing to TrailBlazer the following as part of the interim process:

1. A cover letter to indicate they are seeking to enroll as an IHS facility or tribal provider or updating their current enrollment information;
2. The Internet-based PECOS certification statement; and
3. Any other applicable supporting documentation.

The Trailblazers addresses are as follows:

Part A

Part A Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650458
Dallas, TX 75265-0458

Part B

Part B Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650544
Dallas, TX 75265-0544

This interim process shall remain in effect until PECOS system changes are implemented to route all electronic enrollment applications received from IHS facilities and tribal providers directly to Trailblazers.

Additional information

The official instruction, CR 7174, issued to your carriers, fiscal intermediaries (FIs), and Part A/Part B Medicare administrative contractors (A/B MACs) regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R358PI.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: MM7174 *Revised*
Related Change Request (CR) #: 7174
Related CR Release Date: October 28, 2010
Effective Date: November 29, 2010
Related CR Transmittal #: R358PI
Implementation Date: November 29, 2010

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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.

Recovery audit contractor demonstration high-risk vulnerabilities for physicians

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

This is the fourth in a series of articles that will disseminate information on recovery audit contractor (RAC) demonstration high dollar improper payment vulnerabilities. The purpose of this article is to provide education to physicians on two vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC program nationally, it is essential that physicians understand the lessons learned from the demonstration and implement appropriate corrective actions.

Physician types affected

This article is for all physicians that submit fee-for-service claims to Medicare carriers or Part A/B Medicare administrative contractors (MACs).

Physician action needed

Review the article and take steps, if necessary, to meet Medicare’s billing requirements to avoid unnecessary denial of your claims.

Background

The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. The Centers for Medicare & Medicaid Services (CMS) directed the RAC staff to organize their efforts primarily to attain that goal.

Supplemental goals, such as correcting identified vulnerabilities, were identified after the fact and were not required tasks. CMS did collect improper payment information from the RACs. However, it was on a voluntary basis, and was done at the claim level and focused on the collection. Two high risk vulnerabilities for physician claims are listed in Table 1. These claims were denied because the demonstration RACs determined that either a duplicate claim was billed and paid or the physician reported an incorrect number of units for *Current Procedural Terminology (CPT)* code billed based on the *CPT* code descriptor, reporting instructions in the *CPT* book, and/or other CMS local or national policy.

Table 1 Physician claims

Improper payment amount (pre-appeal)	RAC demonstration findings
\$6,635,558	Other services with excessive units - units billed exceeded the number of units per day based on the <i>CPT</i> code descriptor, reporting instructions in the <i>CPT</i> book, and/or other CMS local or national policy.
\$1,094,751	Duplicate claims - physician billed and was paid for two claims for the same beneficiary, for the same date of service, same <i>CPT</i> code, and same physician.

Note: The two findings identified in Table 1 impacted multiple codes and no specific coding trends were self-reported by the RACs for these categories.

Summary of RAC demonstration findings

The two high risk vulnerabilities for physician claims listed in Table 1 were identified because the demonstration RACs determined that either a duplicate claim was billed and paid or the units billed exceeded the number of units per day according to the *CPT* code descriptor, instructions in the *CPT* book, and/or other CMS local or national policy.

Physician billing and documentation reminders

An overpayment exists when a physician bills and is paid for services that have been previously processed and paid. See the *Medicare Financial Management Manual* Chapter 3, Section 10.2 at

<http://www.cms.gov/manuals/downloads/fin106c03.pdf>.

For more specific information on what criteria constitutes a duplicate claim see the *Medicare Claim Processing Manual*, Chapter 1, Section 120, found at

<http://www.cms.gov/manuals/downloads/clm104c01.pdf>. CMS reminds physicians that routinely submitting duplicate claims to Part B carriers and MACs for a single service encounter is inappropriate. CMS asks physicians to discontinue this practice. For more information on avoiding duplicate billing, please review *Medicare Learning Network (MLN) Matters* article SE0415 found at

<http://www.cms.gov/MLN MattersArticles/downloads/SE0415.pdf>.

CMS guidance requires physicians to bill using the appropriate *CPT* code and to accurately report the units of service. Physicians should ensure that the units billed do not exceed the number of units per day based on the *CPT* code descriptor, reporting instructions in the *CPT* book, and/or other CMS local or national policy.

Additional information

Physicians are also encouraged to visit the CMS RAC website at <http://www.cms.gov/RAC> for updates on the national RAC program. On the website you can register to receive email updates and view current RAC activities nationwide.

MLN Matters® Number: SE1036

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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New physician specialty codes for cardiac electrophysiology and sports medicine

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 bill Medicare carriers and Medicare administrative contractors (A/B MAC) for providing cardiac electrophysiology and sports medicine services to Medicare beneficiaries.

What you need to know

Medicare physician and nonphysician practitioner specialty codes describe the specific/unique types of medicine that physicians and nonphysician practitioners (and certain other suppliers) practice. Specialty codes are used by the Centers for Medicare & Medicaid Services (CMS) for programmatic and claims processing purposes, each code becoming associated with the claims that a physician or nonphysician practitioner submits.

Note: Physicians, who enroll in Medicare, self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based provider enrollment, chain and ownership system; however, nonphysician practitioners are assigned a Medicare specialty code when they enroll.

CR 7209, from which this article is taken, announces that (effective April 1, 2011) CMS will establish new physician specialty codes for cardiac electrophysiology and

sports medicine. These codes are:

- 21 – Cardiac electrophysiology
- 23 – Sports medicine

You should ensure that your billing staffs are aware of these new physician specialty codes.

Additional information

You may find change request (CR) 7209, located at <http://www.cms.gov/Transmittals/downloads/R2098CP.pdf>.

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

MLN Matters® Number: MM7209

Related Change Request (CR) #: 7209

Related CR Release Date: November 19, 2010

Effective Date: April 1, 2011

Related CR Transmittal #: R2098

Implementation Date: April 4, 2011

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Reopening certain claims denied when MSP data deleted or terminated

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

Note: This article was revised on December 6, 2010, to reflect a revision to change request (CR) 6625. The implementation date has been changed to July 5, 2011. The CR release date, transmittal number, and the Web address for accessing CR 6625 has been revised. All other information is the same. This information was previously published in the August 2010 *Medicare B Update!* page 18.

Provider types affected

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

What you need to know

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

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP

record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

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

Basically, where Medicare learns, retroactively, that Medicare secondary payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors

Reopening certain claims denied when MSP data deleted or terminated (continued)

will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional information

You may find the official instruction, CR 6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2112CP.pdf>.

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

MLN Matters® Number: MM6625 *Revised*

Related Change Request (CR) #: 6625

Related CR Release Date: December 3, 2010

Effective Date: April 1, 2011

Related CR Transmittal #: R2112CP

Implementation Date: July 5, 2011

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January 2011 changes to the DMEPOS program

What Medicare-enrolled providers, physicians, treating practitioners, discharge planners, social workers, and pharmacists need to know.

Medicare is phasing in a new program that changes the amount Medicare pays for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and requires Medicare contract suppliers to furnish these items in most cases. Health care providers play a key role in helping their patients understand how they will be affected by this change and what they need to do in order to continue to have Medicare pay for the high-quality equipment and supplies they need.

Effective January 1, 2011, if your patients with original Medicare live in or visit one of the communities listed below, and must obtain any of the equipment or supplies included in the program (also listed below), they will almost always have to use Medicare contract suppliers for Medicare to help pay for the item.

The first nine areas included in the new program are:

1. Charlotte – Gastonia – Concord, NC, SC
2. Cincinnati – Middletown, Ohio, Kentucky, Indiana
3. Cleveland – Elyria – Mentor, Ohio
4. Dallas – Fort Worth – Arlington, Texas
5. Kansas City, Missouri, Kansas
6. Miami – Fort Lauderdale – Pompano Beach, Florida
7. Orlando – Kissimmee, Florida
8. Pittsburgh, Pennsylvania
9. Riverside – San Bernardino – Ontario, California

The products and equipment included in the program are:

- Oxygen, oxygen equipment, and supplies

- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (group 2 only)
- Mail-order diabetic supplies
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Support surfaces (group 2 mattresses and overlays in Miami – Fort Lauderdale – Pompano Beach only)

If your patients currently rent oxygen and oxygen equipment or durable medical equipment, they may be able to continue renting these items from their current supplier when the program takes effect, if the supplier decides to participate in the program as a “grandfathered” supplier.

Medicare has a variety of resources available to help you understand the new program at <http://www.cms.gov/DMEPOSCompetitiveBid/>; DMEPOS Competitive Bidding Program *Medicare Learning Network*® (MLN) fact sheets may be found at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf.

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Source: CMS PERL 201011-55

December 5-11 is National Influenza Vaccination Week

This national health observance was established to highlight the importance of continuing influenza vaccination, as well as fostering greater use of the flu vaccine after the holiday season and into January and beyond. The Centers for Medicare & Medicaid Services (CMS) needs your help to ensure that people with Medicare get their flu vaccine. National Influenza Vaccination Week presents an excellent opportunity for you to place greater emphasis on flu prevention.

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 CDC has designated the following special days:

Monday, December 6 – Family Vaccination Day

Tuesday, December 7 – Chronic Conditions Day

Wednesday, December 8 – Employee Health Day

Thursday, December 9 – Older Adults Vaccination Day

Friday, December 10 – Young Adults Vaccination Day

Please use these designated days to encourage family members, seniors and your staff to get their seasonal flu vaccine. Remember, Medicare pays for the seasonal flu vaccine and its administration for all beneficiaries with no co-pay or deductible. Protect your patients. Protect your family. Protect yourself. Get your flu vaccine – not the flu. More information is available at <http://www.cdc.gov/flu/nivw/>.

More 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, is available at http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and <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.

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Source: CMS PERL 201012-01

2011 Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services is conducting its annual administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). The survey is designed to collect quantifiable data on provider satisfaction with the performance of your Medicare contractor. The MCPSS will be sent to a random sample of approximately 33,000 Medicare fee-for-service providers and suppliers. CMS is listening and wants to hear from you about the services provided by your Medicare contractor. If you are selected to participate, please take a few minutes and complete this important survey. To learn more about the MCPSS, please visit <http://www.cms.gov/mcpss> or <https://www.mcpsstudy.org>.

Source: JSM 11044

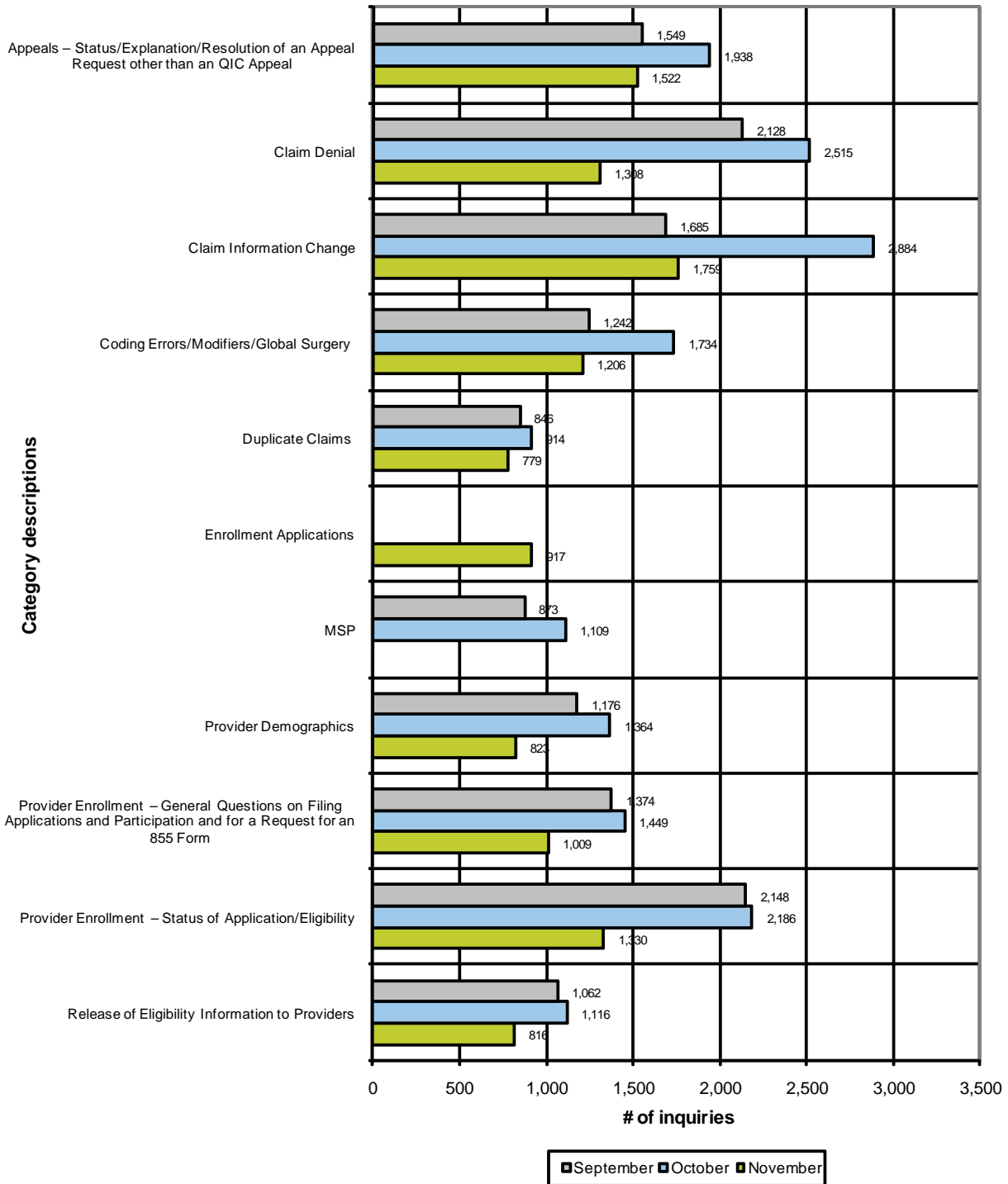
Take advantage of FCSO's exclusive PDS report

Did you know that FCSO's exclusive Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Accessible through FCSO's PDS portal at <https://medicare.fcsso.com/reporting/index.asp>, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specified time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your bottom line.

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

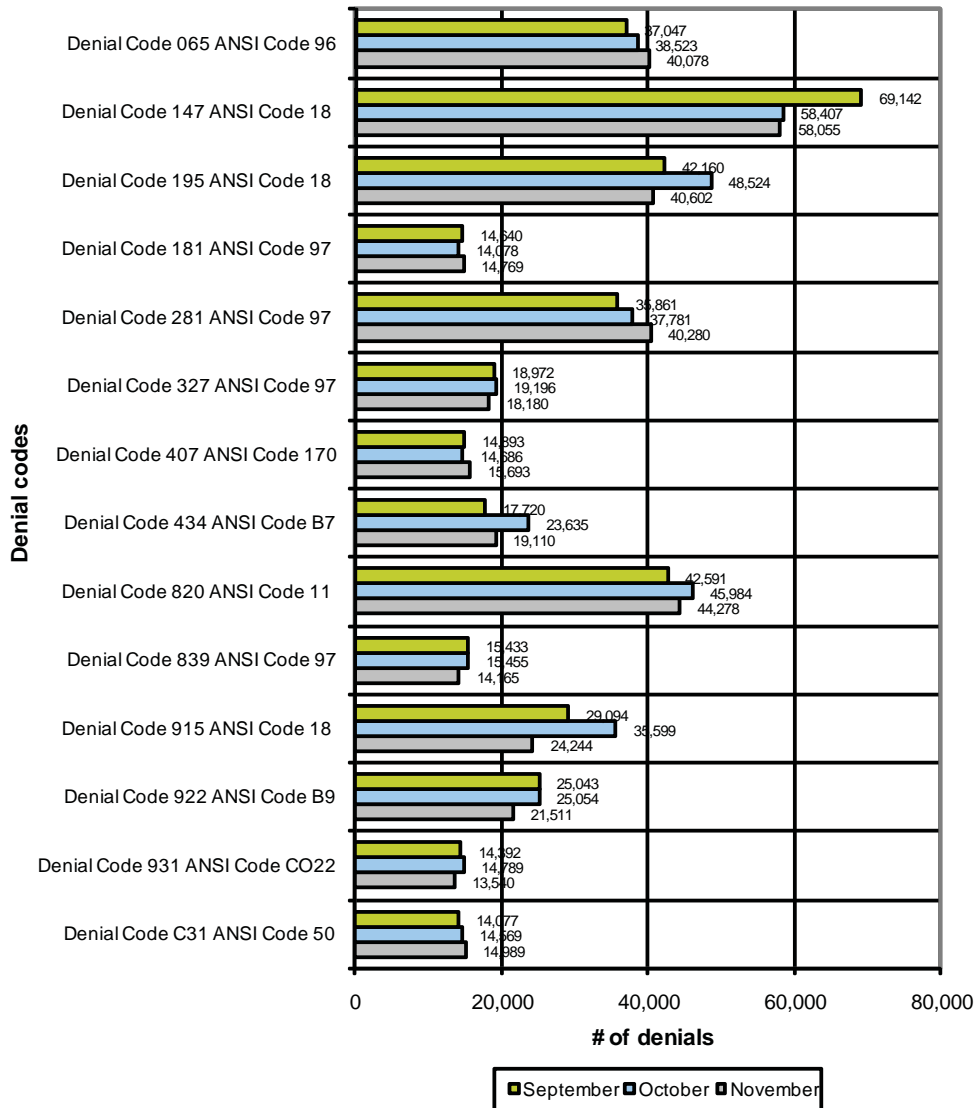
The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during September-November 2010. For tips and resources to help you avoid or reduce the amount of time spent 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 September-November 2010



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

Florida Part B top denials for September-November 2010



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.

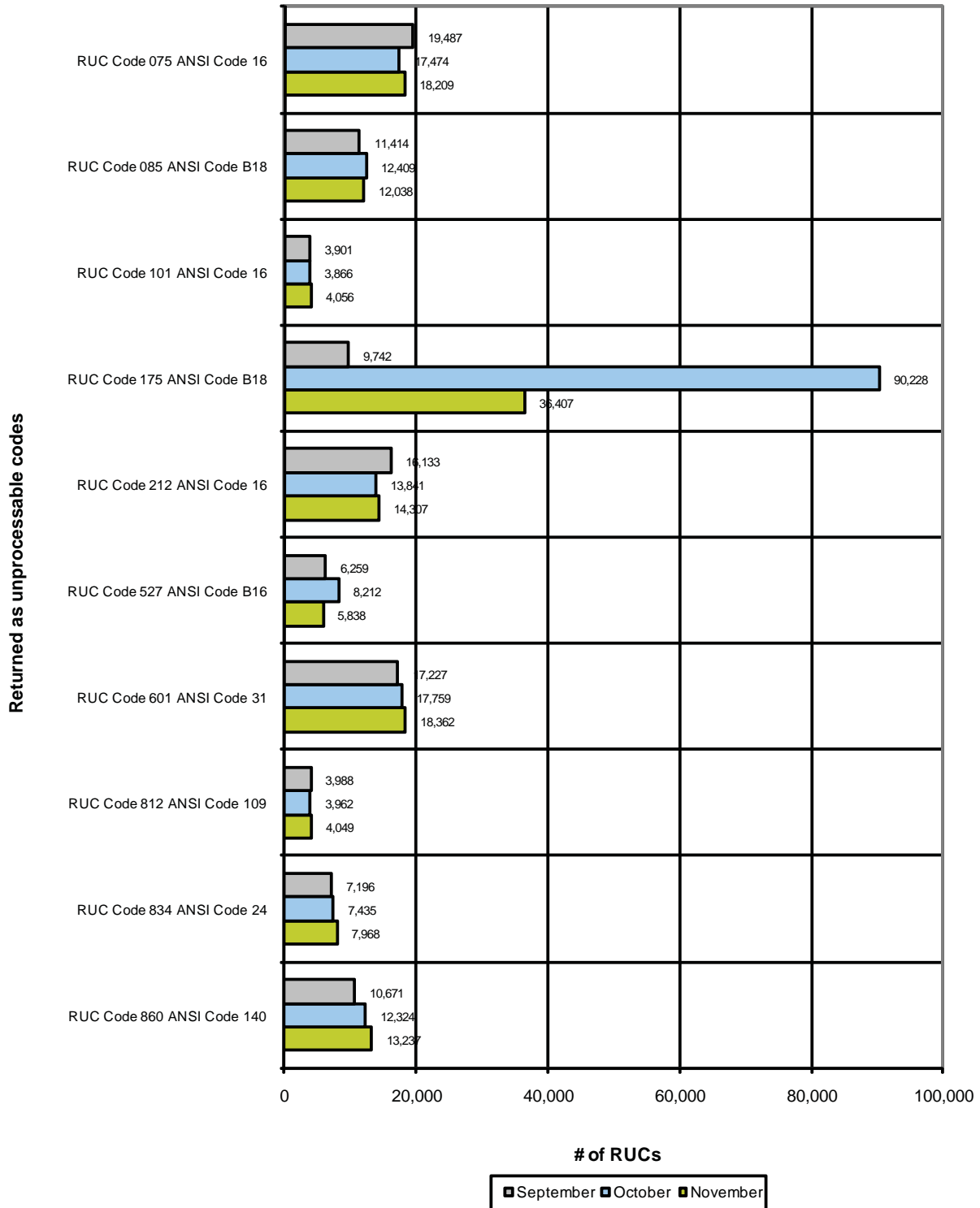
- Only one E/M service may be reported per patient, per day by a physician or by more than one physician of the same specialty in the same group, unless the evaluation and management services are for unrelated problems.
- If more than one face-to-face E/M is provided on the same day to the same patient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

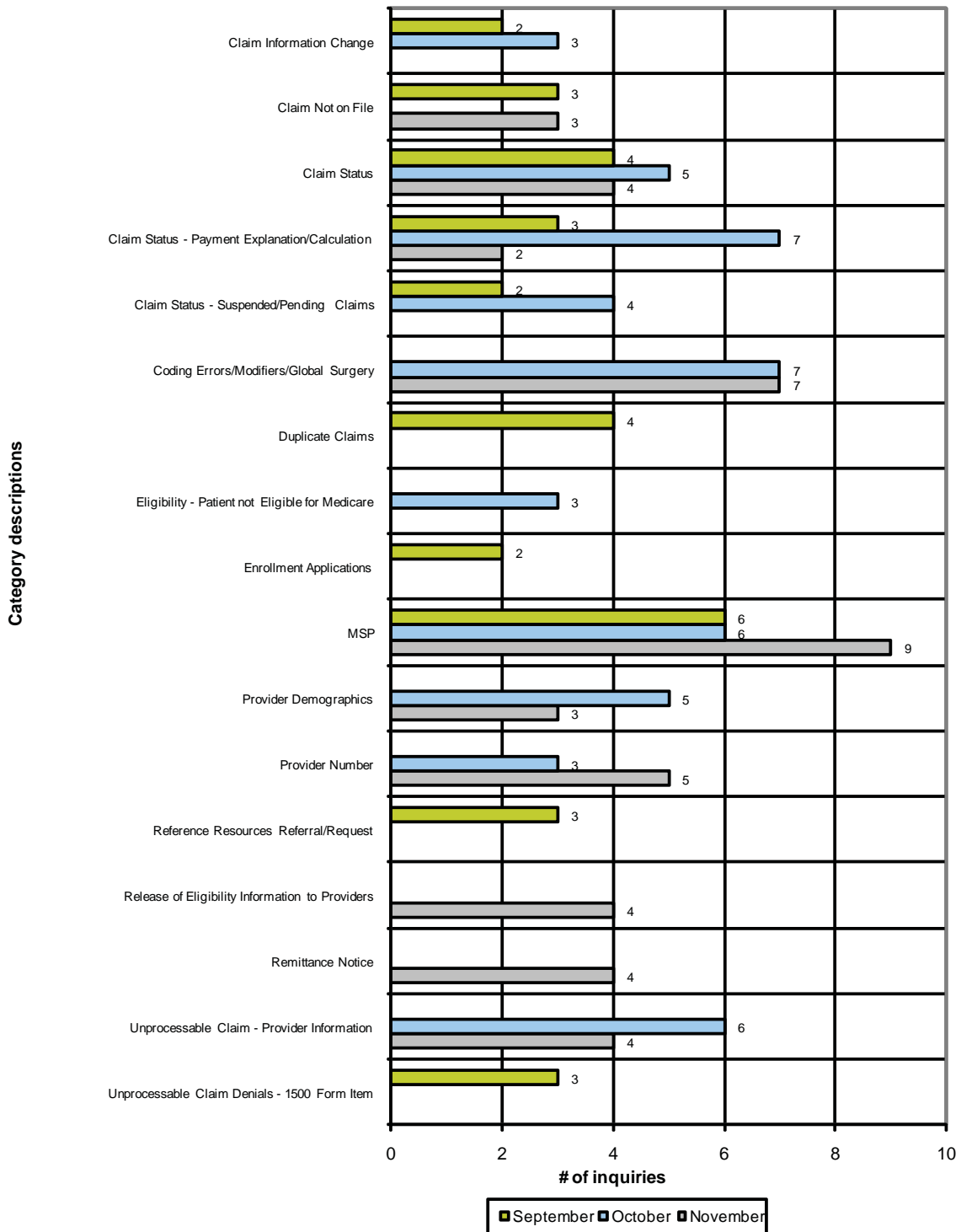
Top inquiries, denials, and return unprocessable claims for September-November 2010 (continued)

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



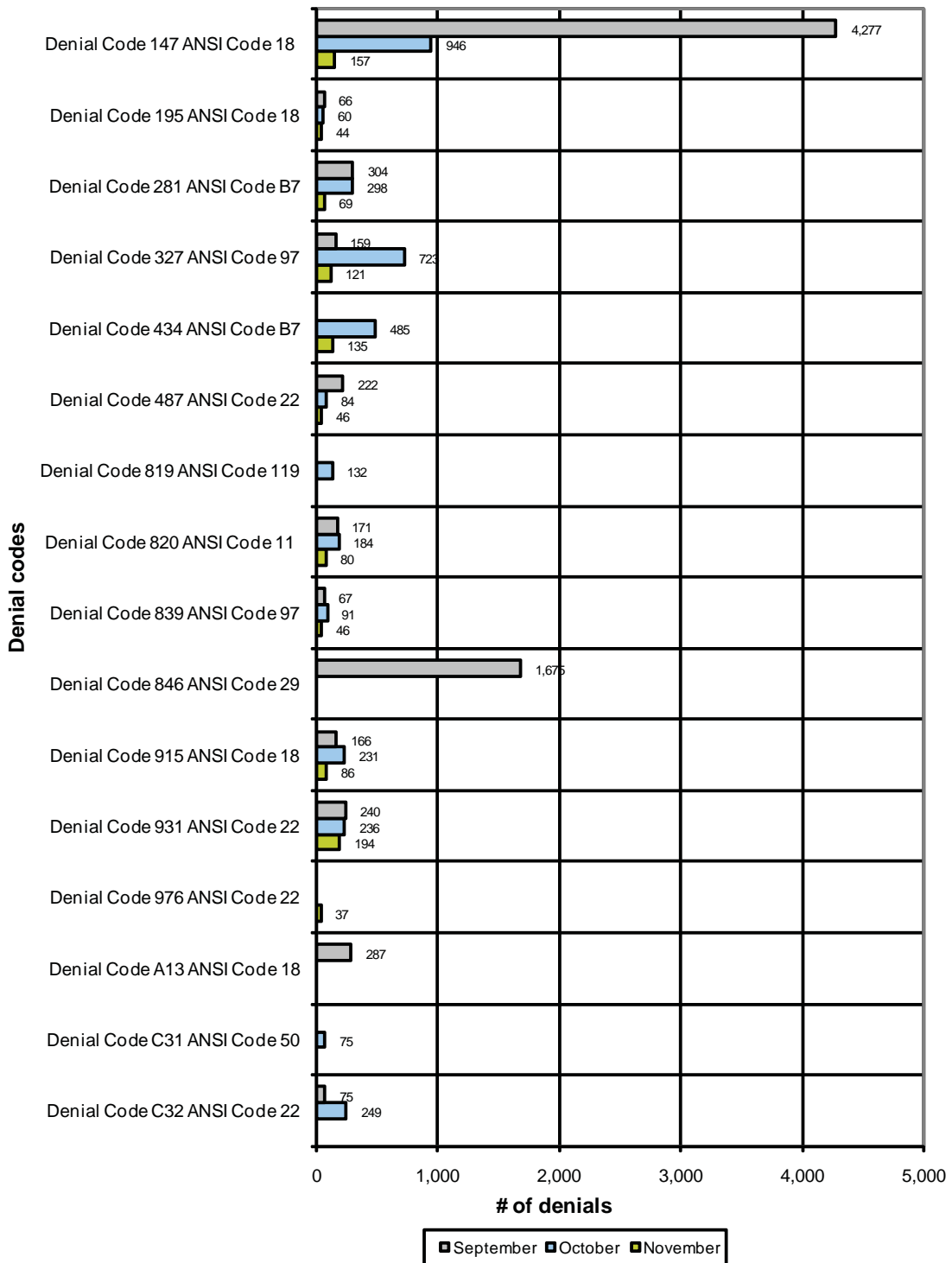
Top inquiries, denials, and return unprocessable claims for September-November (continued)

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



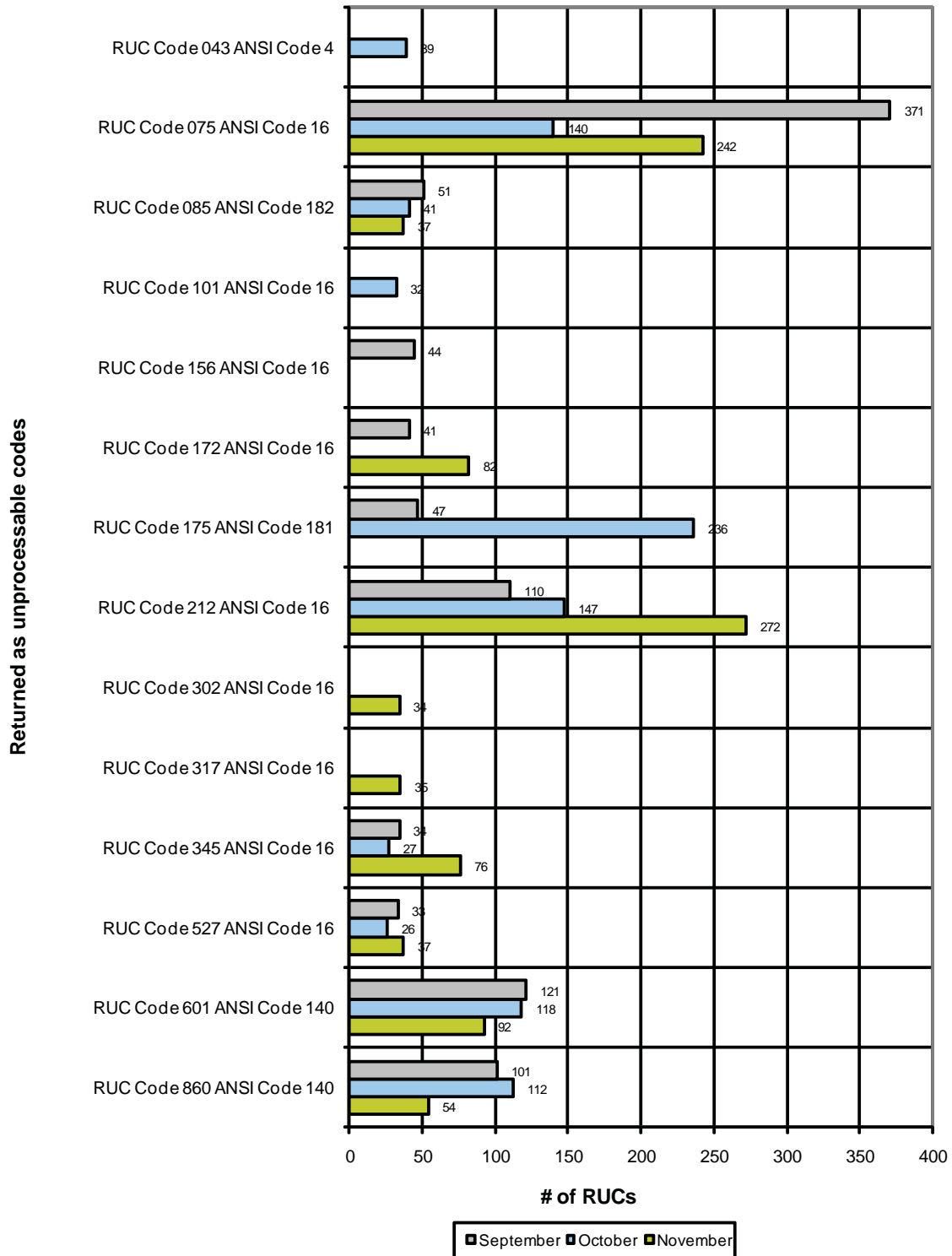
Top inquiries, denials, and return unprocessable claims for September-November 2010 (continued)

U.S. Virgin Islands Part B top denials for September-November 2010



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

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



Local Coverage Determinations

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

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Advance beneficiary notice

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

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

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

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.fcsso.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.

New LCDs

HAE: Selective treatment for HAE with Cinryze™, Berinert®, and ecallantide – new LCD

LCD ID number: L31475 (Florida/Puerto Rico/U.S. Virgin Islands)

Hereditary Angioedema (HAE) is a very rare inherited disease caused by low levels or improper function of a blood protein called C1 inhibitor (C1 – INH). HAE is caused by a genetic defect of chromosome 11. The incidence of HAE is estimated at 1 out of 50,000 individuals. There are three types of HAE. Approximately 85 percent of those diagnosed have Type I HAE, in which the individuals have low levels of normal C1-INH. Type II HAE patients represent approximately 15 percent of those diagnosed with the disease and they have normal or elevated levels of C-1 INH, but it does not function correctly. Type III HAE is extremely rare and is an estrogen dependent form of angioedema and it only occurs in women. HAE affects the blood vessels and can cause the affected individuals to develop rapid swelling and or pain of the hands, feet, limbs, face, intestinal tract, larynx or trachea. The internal swelling of the intestines may cause pain, nausea, and vomiting. The swelling of the airway may cause difficulty in swallowing, change in voice pitch or difficulty breathing and can be potentially life-threatening.

This new local coverage determination (LCD) gives indications and limitations of coverage, documentation requirements, utilization guidelines, and an ICD-9-CM code for the following HCPCS codes:

J0597: Injection, C-1 esterase inhibitor (human), Berinert, 10 units

J0598: Injection, C-1 esterase inhibitor (human), Cinryze, 10 units

J1290: Injection, ecallantide 1 mg

Effective date

This new LCD is effective for services rendered **on or after January 23, 2011**. 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.

77402: Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – new LCD

LCD ID number: L31510 (Florida/Puerto Rico/U.S. Virgin Islands)

There are several treatment options for basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) of the skin including surgical excision and radiation therapy. This local coverage determination (LCD) will focus solely on radiation therapy (RT) for basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) stage T1. Stage T1 lesions are defined as lesions ≤ 2 cm.

Non-melanoma skin cancers (NMSC), also known as basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) are the most common forms of skin cancer. Basal cell carcinoma develops from the deep epidermis skin cells and can most commonly be found on sun exposed areas such as the face, ears, hands and forearms. Basal cell carcinomas are generally slow growing. Squamous cell carcinoma, like basal cell, typically are found on sun exposed areas of the skin, but can also occur on areas of the skin that have had previous trauma (burns, scars) or areas that have inflammatory conditions. Squamous cell carcinoma develops from the middle layer of the epidermis and can be slow or fast growing and can invade surrounding structures.

External beam radiation therapy (EBRT), also known as teletherapy, is therapy aimed at the lesion/tumor from an x-ray source outside the patients’ body, usually a linear accelerator (“linacs”) which produce x-rays (photons) or electrons. Electrons are useful in treating superficial lesions

because the dose is aimed at the surface and dissipates as it goes deeper, thus sparing underlying tissue. Electrons usually have an energy range from 4-25 MV. Therapeutic x-rays (photons) can have energies in the kV range (at least 50 kV or greater) or, more typically, in the MV range. EBRT treatment is usually given over a series of daily treatments called fractions that can span over a few weeks (2-9). There are several methods used to administer EBRT: conventional, 3D conformal, intensity modulated radiation therapy (IMRT), tomographic, and stereotactic radiosurgery.

Brachytherapy unlike EBRT administers radiation therapy within or in contact with the body. Brachytherapy can be low dose rate (LDR) or high dose rate (HDR). LDR involves placing the radiation source directly into or next to the tumor. HDR treatment is delivered with dose rates greater than or equal to 1200 cGy per hour. The high intensity radio elements used in HDR have a radioactivity level high enough that prevents manual handling and loading of the applicator.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines for this service.

77402: Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – new LCD (continued)**Effective date**

This new LCD is effective for services rendered on **or after February 13, 2011**. 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.

95921: Autonomic function tests – new LCD**LCD ID number: L31461 (Florida/Puerto Rico/U.S. Virgin Islands)**

The autonomic nervous system (ANS) is the part of the peripheral nervous system that acts as a control system functioning largely below the level of consciousness, and controls visceral functions. The ANS affects heart rate, digestion, respiration rate, salivation, perspiration, diameter of pupils, maturation, and sexual arousal. It is classically divided into two subsystems: the parasympathetic nervous system and sympathetic nervous system. With regard to function, the ANS is usually divided into sensory (afferent) and motor (efferent) subsystems.

ANS testing checks for imbalances in the part of the body that controls many autonomic processes including heart rate, blood pressure, gastrointestinal function, and sweating.

A local coverage determination (LCD) has been developed for autonomic function tests (AFT) based on review findings of a wide spread probe review. Results of this review showed a majority of ANS testing was used as a screening tool on patients with chronic medical conditions, and had little or no impact on the treatment or care plan of the patients. This LCD gives indications and limitations of coverage, documentation requirements, utilization guidelines, ICD-9-CM codes and coding guidelines for the following CPT codes:

- 95921 – *Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio*
- 95922 – *Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt*
- 95923 – *Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential*

Effective date

This new LCD is effective for services rendered **on or after January 23, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at <http://medicare.fcso.com/PDS/>.

Revisions to LCDs

G0431: Qualitative drug screening – revision to the LCD

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

The most recent revision to local coverage determination (LCD) for qualitative drug screening will be effective January 1, 2011. In addition, a revision was made to the LCD. Under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, verbiage was added to clarify medically reasonable and necessary criteria, and under the “Limitations” section of the LCD as well as the “Coding Guidelines” attachment, verbiage was added to clarify point of service qualitative urine drug screen. In addition, diagnosis code 518.81 (Acute respiratory failure) was added under the “ICD-9 Codes that Support Medical Necessity” section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after February 13, 2011**. 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.

J0470: Chelation therapy – revision to the LCD

LCD ID number: L29098 (Florida)

LCD ID number: L29113 (Puerto Rico/U.S. Virgin Islands)

Chelation therapy is the administration of chelating agents for the removal of heavy metals from the body as treatment for heavy metal poisoning or intoxication. For the purposes of this local coverage determination (LCD), the chelating agents are medications which are administered subcutaneously (SQ), intramuscularly (IM), or intravenously (IV) by the physician or the nonphysician practitioner provided diagnosis criteria are met for toxicity.

Revisions were made to the following sections of the LCD:

Indications and Limitations of Coverage and/or Medical Necessity

Documentation Requirements

Utilization Guidelines

Sources of Information and Basis for Decision

Effective date

This LCD revision is effective for services rendered **on or after February 13, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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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.fcsoc.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.

J9201: Gemcitabine (Gemzar®) – revision to the LCD**LCD ID number: L29182 (Florida)****LCD ID number: L29432 (Puerto Rico/U.S. Virgin Islands)**

This local coverage determination (LCD) for gemcitabine (Gemzar®) was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, under the off-labeled indications portion of the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD, the indication of advanced or recurrent endometrial carcinoma used as a single agent or in combination with other chemotherapy drugs was added. Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, diagnosis code 182.0 (Malignant neoplasm of corpus uteri, except isthmus [Endometrium]) was added. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after December 2, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

NCSVCS: Noncovered services – revision to the LCD**LCD ID number: L29288 (Florida)****LCD ID number: L29398 (Puerto Rico/U.S. Virgin Islands)**

The most recent revision to local coverage determination (LCD) for noncovered services will be effective January 1, 2011. Since that time, a revision was made to the LCD. Two Category III CPT codes from the Medicare & Medicaid Services (CMS) July 2010 *Medicare B Update!*, change request (CR) 6974, CR 6996, and CR 7008 were evaluated and were determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, Category III CPT codes 0226T and 0227T were added to the noncovered services LCD.

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

- 0226T – Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed
- 0227T – Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)

In addition, CPT codes 43499 (*EsophyX® System [transoral incisionless fundoplication TIF®]*) and 64999 (*Minimally invasive lumbar decompression [MILD] procedure*) were added to the LCD under the “CPT/HCPCS Codes – Local Noncoverage Decisions – Procedures” section of the LCD based on an evaluation of these services. CPT code 97139 (*MicroVas® therapy*) was added to the LCD under the “CPT/HCPCS Codes – Local Noncoverage Decisions – Devices” section of the LCD based on an evaluation of this service.

The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has also been revised to update the language to reflect medically reasonable and necessary criteria for coverage at the local level. In addition, the language in the “Documentation Requirements” section of the LCD has also been revised.

Effective date

This LCD revision is effective for services rendered **on or after February 13, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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11000: Wound debridement services – revision to the LCD**LCD ID number: L29128 (Florida)****LCD ID number: L29146 (Puerto Rico/U.S. Virgin Islands)**

This local coverage determination (LCD) for wound debridement services was most recently revised on September 30, 2009. Since that time, a revision was made to the LCD to add additional diagnosis codes based on a reconsideration request.

Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, the following diagnosis code ranges and codes were added:

885.0-885.1: Traumatic amputation of thumb (complete) (partial)

886.0-886.1: Traumatic amputation of other finger(s) (complete) (partial)

887.0-887.7: Traumatic amputation of arm and hand (complete) (partial)

895.0-895.1: Traumatic amputation of toe(s) (complete) (partial)

896.0-896.3: Traumatic amputation of foot (complete) (partial)

897.0-897.7: Traumatic amputation of leg(s) (complete) (partial)

997.60: Amputation stump, unspecified complication

997.62: Amputation stump complication, infection (chronic)

Effective date

This LCD revision is effective for services rendered **on or after January 1, 2011**. 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.

92132: Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the LCD**LCD ID number: L29276 (Florida)****LCD ID number: L29473 (Puerto Rico/U.S. Virgin Islands)**

The most recent revision to local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) will be effective January 1, 2011. In addition, a revision has been made in regard to the National Correct Coding Initiative (CCI) edits which identify fundus photography (CPT code 92250) and scanning computerized ophthalmic diagnostic imaging (SCODI) (CPT code 92133 or 92134) as mutually exclusive of one another when performed on the same day on the same eye.

Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (CPT code 92133 or 92134) are generally mutually exclusive of one another in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier 59 to CPT code 92250. (National Correct Coding Initiative Policy Manual, Chapter 11, Section G, Ophthalmology). The physician is not precluded from performing fundus photography and posterior segment SCODI on the same eye on the same day under appropriate circumstances (i.e., when each service is necessary to evaluate and treat the patient).

The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised to add a new “Limitations” section under the “Indications of Coverage for Posterior Segment SCODI” section to add

language regarding performing fundus photography and scanning computerized ophthalmic diagnostic imaging, posterior segment (SCODI) on the same day on the same eye. A table has also been added to outline diagnoses which will be considered medically reasonable and necessary for fundus photography and posterior segment SCODI (CPT code 92133 or 92134) when performed on the same eye on the same day. The “Documentation Requirements” section has been revised to indicate medical record documentation requirements when fundus photography and posterior segment SCODI are performed on the same eye on the same day.

Effective date

This LCD revision is effective for services rendered **on or after February 13, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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92250: Fundus photography – revision to the LCD**LCD ID number: L29179 (Florida)****LCD ID number: L29341 (Puerto Rico/U.S. Virgin Islands)**

The most recent revision to local coverage determination (LCD) for fundus photography will be effective January 1, 2011. In addition, a revision has been made in regard to the National Correct Coding Initiative (CCI) edits which identify fundus photography (CPT code 92250) and scanning computerized ophthalmic diagnostic imaging (SCODI) (CPT code 92133 or 92134) as mutually exclusive of one another when performed on the same day on the same eye.

Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (CPT code 92133 or 92134) are generally mutually exclusive of one another in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier 59 to CPT code 92250 (National Correct Coding Initiative Policy Manual, Chapter 11, Section G, Ophthalmology). The physician is not precluded from performing fundus photography and posterior segment SCODI on the same eye on the same day under appropriate circumstances (i.e., when each service is necessary to evaluate and treat the patient).

The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised under the “Limitations” section to add language regarding

performing fundus photography and posterior segment SCODI on the same day on the same eye. A table has also been added to outline diagnoses which will be considered medically reasonable and necessary for fundus photography and posterior segment SCODI (CPT code 92133 or 92134) when performed on the same eye on the same day. The LCD “Coding Guidelines” attachment has also been revised to add language to indicate that all services/procedures performed on the same date of service for the same patient by the same provider should be submitted on the same claim.

Effective date

This LCD revision is effective for services rendered **on or after February 13, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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93875: Non-invasive extracranial arterial studies – LCD revision**LCD ID number: L29235 (Florida)****LCD ID number: L29321 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for non-invasive extracranial arterial studies was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised in the “Limitations” section, under the fourth bullet to indicate CPT code 93875 is of limited usefulness and will only be reimbursed when billed to represent ocular pneumoplethysomography (OPG-GEE) in evaluating a patient with ischemic optic neuropathy. The following statement has also been added to this section of the LCD: Performance of both non-invasive extracranial arterial studies (CPT codes 93880 or 93881) and non-invasive evaluation of extremity veins (CPT codes 93965, 93970 or 93971) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available to Medicare upon request.

The “Training Requirements” section of the LCD has been revised in the third paragraph, under the third seriation, regarding a qualified physician to add: ASN: Neuroimaging Subspecialty Certification.

The “ICD-9 Codes that Support Medical Necessity” section of the LCD has been revised to add two new section headers, “The following ICD-9-CM code applies only to CPT code 93875” and “The following ICD-9-CM codes apply only to CPT codes 93880 and 93882”. ICD-9-CM code 377.41 has been moved under “The following ICD-9-CM code applies only to CPT code 93875”.

The “Documentation Requirements” section of the LCD has been revised to add the following statements: The provider is responsible for ensuring the medical necessity of procedures and maintaining the medical record, which must be available to Medicare upon request. Non-invasive vascular studies are medically reasonable and necessary only if the outcome will potentially impact the diagnosis or clinical course of the patient. Providers billing Medicare are encouraged to obtain additional information from referring providers and/or patients or medical records to determine the medical necessity of studies performed. Referring physicians are required to provide appropriate diagnostic information to the performing provider. Performance of both non-invasive extracranial arterial studies (CPT codes 93880 or 93881) and non-invasive evaluation of extremity veins (CPT codes 93965, 93970 or 93971) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter,

93875: Non-invasive extracranial arterial studies – LCD revision (continued)

and be available to Medicare upon request. The “Sources of Information and Basis for Decision” section of the LCD has also been updated.

The LCD “Coding Guidelines” attachment has also been revised to add the following statements: *CPT* code 93875 is of limited usefulness and will only be reimbursed when billed to represent ocular pneumoplethysomography (OPG-GEE) in evaluating a patient with ischemic optic neuropathy. Performance of both non-invasive extracranial arterial studies (*CPT* codes 93880 or 93881) and non-invasive evaluation of extremity veins (*CPT* codes 93965, 93970 or 93971) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). When an uninterpretable study results in performing another type of study, only the successful study should be billed.

Effective date

This LCD revision is effective for services rendered **on or after January 23, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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93965: Non-invasive evaluation of extremity veins – revision to the LCD

LCD ID number: L29234 (Florida)

LCD ID number: L29369 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for non-invasive evaluation of extremity veins was most recently revised on October 1, 2010. Since that time, the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has been revised under the “Indications” section, in the fourth bullet, to state the following:

Evaluation of patient with symptomatic varicose veins such as stasis ulcer of the lower leg, significant pain and significant edema that interferes with activities of daily living that have not resolved following three months of conservative therapy, and symptoms are suspected to be secondary to venous insufficiency, and testing is performed to confirm this diagnosis by documenting venous valvular incompetence prior to an invasive therapeutic intervention, which meets criteria for medical necessity as outlined in FCSO Medicare LCD Treatment of varicose veins of the lower extremity.

The “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD has also been revised to add a “Limitations” section, which includes the following:

- Performance of both physiological testing (*CPT* code 93965) and duplex scanning (*CPT* codes 93970 or 93971) of extremity veins during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available to Medicare upon request. Note: Reimbursement of physiologic testing will not be allowed after a duplex scanning has been performed.
- Since the signs and symptoms of arterial occlusive disease and venous disease are so divergent, the performance of simultaneous arterial and venous studies during the same encounter should be rare. Consequently, documentation must clearly support the medical necessity of both procedures if performed during the same encounter, and be available to Medicare upon request.

- Non-invasive vascular studies are considered medically necessary only if the outcome will potentially impact the clinical course of the patient. For example, if a patient is (or is not) proceeding on to other diagnostic and/or therapeutic procedures regardless of the outcome of non-invasive studies, and non-invasive vascular procedures will not provide any unique diagnostic information that would impact patient management, then the non-invasive procedures are not medically necessary. If it is obvious from the findings of the history and physical examination that the patient is going to proceed to angiography, then non-invasive vascular studies are not medically necessary.
- Performance of both non-invasive extracranial arterial studies (*CPT* codes 93880 or 93881) and non-invasive evaluation of extremity veins (*CPT* codes 93965, 93970 or 93971) during the same encounter is not appropriate as a general practice or standing protocol, and therefore, would not generally be expected (American College of Radiology, 2010). Consequently, documentation must clearly support the medical necessity if both procedures are performed during the same encounter, and be available to Medicare upon request.
- When an uninterpretable study results in performing another type of study, only the successful study should be billed. For example, when an uninterpretable non-invasive physiologic study (*CPT* code 93965) is performed which results in performing a duplex scan (*CPT* codes 93970 or 93971), only the duplex scan should be billed.
- It is not considered medically reasonable and necessary to study asymptomatic varicose veins.

The “Training Requirements” section of the LCD has been revised to add an additional example of certification in vascular technology for nonphysician personnel, “Registered Phlebology Sonographer (RPhS)”, which is provided by “Cardiovascular Credentialing International (CCI)”. The “ICD-9 Codes that Support Medical Necessity” section of the LCD has been revised to add

93965: Non-invasive evaluation of extremity veins – revision to the LCD (continued) (continued)

ICD-9-CM codes 453.75, 453.76, 453.85, and 453.86. The “Documentation Requirements” section of the LCD has also been revised to add language regarding services billed by providers other than the ordering provider; documentation requirements when performing both physiologic studies and duplex scanning during the same encounter, when performing arterial and venous studies during the same encounter, and when performing non-invasive extracranial arterial studies and non-invasive evaluation of extremity veins during the same encounter.

The LCD “Coding Guidelines” attachment has also been revised to add language regarding the performance of both physiological testing and duplex scanning during the same encounter; to add language regarding performing non-invasive extracranial arterial studies and non-invasive evaluation of extremity veins during the same encounter; and to add language to indicate that all services/procedures

performed on the same date of service for the same patient by the same provider should be submitted on the same claim.

Effective date

This LCD revision is effective for services rendered **on or after January 23, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/mcd/overview.asp>. Coding Guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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2011 HCPCS local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2011 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD Title	Changes
G0104 Colorectal Cancer Screening (Coding Guidelines only)	Added verbiage related to modifier PT (Colorectal cancer screening test; converted to diagnostic test or other procedure)
G0430 Qualitative Drug Screening	Deleted HCPCS code G0430 Deleted CPT code 80100 (Change Request 7300) Added HCPCS code G0434 Descriptor change for HCPCS codes G0431 Changed “Contractor’s Determination Number” to G0431
IDTF Independent Diagnostic Testing Facility (IDTF)	Deleted CPT codes 76150, 76350, 76880, 91000, 91011, 91012, 91052, 91055, 92135, 93012, 93014, 93230, 93231, 93232, 93233, 93235, 93236, 93237, 93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93555, and 93556 from the “Coding Guidelines” attachment Added CPT codes 43754, 43755, 74176, 74177, 74178, 76881, 76882, 91013, 92132, 92133, 92134, 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, and 93461 to the “Coding Guidelines” attachment. Deleted CPT codes 93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93555 and 93556 from the LCD. Added CPT codes 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, and 93462 to the LCD
J0128 Abarelix for the Treatment of Prostate Cancer	Retired Local Coverage Determination as HCPCS code J0128 was deleted. The drug was withdrawn from the United States market.
J0205 CEREDASE/CEREZYME	Deleted HCPCS code J1785 Added HCPCS codes J1786
J2503 Macugen (pegaptanib sodium injection)	Deleted CPT code 92135 Added CPT code 92134

2011 HCPCS local coverage determination changes (continued)

LCD Title	Changes
J7187 Hemophilia Clotting Factors	Deleted HCPCS code C9267 Added HCPCS code J7184 Changed “Contractor’s Determination Number” to J7184
J9280 Mitomycin (Mutamycin [®] , Mitomycin-C)	Deleted HCPCS codes J9290 and J9291
J9350 Topotecan Hydrochloride (Hycamtin [®])	Deleted HCPCS code J9350 Added HCPCS code J9351 Changed “Contractor’s Determination Number” to J9351
NCSVCS Noncovered Services	Descriptor change for CPT codes 0184T, 0191T, 0208T, 0209T, 0210T, 0211T, 0212T, 0219T, 0220T, 0221T, and 0222T Deleted CPT codes 0016T (replaced with CPT code 67299), 0017T (replaced with CPT code 67299), 0060T (not related to 2011 HCPCS Update – replaced with CPT code 76499), 0104T (replaced with CPT code 93799), 0105T (replaced with CPT code 93799), 0130T (replaced with CPT code 99199), 0140T (replaced with CPT code 83987), 0160T (replaced with new CPT code 90867), 0161T (replaced with new CPT code 90868) Removed CPT codes 90663, 90670, and 89420 (replaced with new CPT codes 0058T and 0059T) Added CPT codes 90644, 90664, 90666, 90667, 90668, 92227 and 92228
Qutenza [®] Qutenza [®] (capsaicin) 8% patch	Changed HCPCS code J3490 to HCPCS code J7335 Deleted HCPCS code C9268 from the “Coding Guidelines” attachment and replaced with HCPCS code J7335
SKINSUB Skin Substitutes	Deleted HCPCS code Q4109 Added HCPCS codes Q4117-Q4121 to the “Non-Covered Products” section of the LCD Descriptor change for HCPCS codes Q4101-Q4108, Q4110-Q4113, and Q4115 Verbiage was revised in the “Coding Guidelines” attachment to reflect code description changes for CPT codes 97597 and 97598 Verbiage was added in the “Coding Guidelines” attachment to reflect new HCPCS codes G0440 and G0441
THERSVCS Therapy and Rehabilitation Services	Added information related to status indicator change from “I” to “A” for CPT code 95992 Added information related to therapy cap (Change Request 7300)
Xiaflex [®] Collagenase clostridium histolyticum (Xiaflex [®])	Changed HCPCS code J3590 to HCPCS code J0775 Deleted HCPCS code C9266 from the “Coding Guidelines” attachment and replaced with HCPCS code J0775
01991 Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services (Coding Guidelines only)	Descriptor change for CPT codes 64479, 64480, 64483, and 64484
11000 Wound Debridement Services	Deleted CPT codes 11040 and 11041 Added CPT codes 11045, 11046, and 11047 Descriptor change for CPT codes 11042, 11043, 11044, 97597 and 97598
17311 Mohs Micrographic Surgery (MMS) (Coding Guidelines only)	Descriptor change for CPT code 88332

LOCAL COVERAGE DETERMINATIONS

2011 HCPCS local coverage determination changes (continued)

LCD Title	Changes
27096 Sacroiliac Joint Injection	Descriptor change for CPT code 77003
43644 Surgical Management of Morbid Obesity	Removed CPT code 43775 as this code is Nationally Noncovered
61885 Vagal Nerve Stimulation (VNS) for Intractable Depression	Deleted CPT code 64573 Added CPT codes 64568, 64569, and 64570
62310 Epidural	Descriptor change for CPT codes 64479, 64480, 64483, and 64484 Added verbiage to the “Coding Guidelines” attachment to indicate that imaging guidance (fluoroscopy or CT) and any injection of contrast are inclusive components of CPT codes 64479-64484. Imaging guidance and localization are required for the performance of CPT codes 64479-64484.
64702 Surgical Decompression for Peripheral Polyneuropathy	Descriptor change for CPT codes 64708, 64712, and 64714
66761 Iridotomy by Laser Surgery	Descriptor change for CPT code 66761 Retired the “Coding Guidelines” attachment as it is no longer applicable based on the new descriptor for CPT code 66761
72192 Computed Tomography of the Abdomen and Pelvis	Added CPT codes 74176, 74177, and 74178
77371 Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (Coding Guidelines only)	Deleted CPT code 61795
86294 Urinary Tumor Markers for Bladder Cancer	Removed CPT codes 88367 and 88368 Added CPT codes 88120 and 88121
92135 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	Deleted CPT codes 92135 and 0187T Added CPT codes 92132, 92133, and 92134 Changed “Contractor’s Determination Number” to 92132
92250 Fundus Photography	Added CPT codes 92227 and 92228 as not meeting Medicare’s reasonableness and necessity criteria for fundus photography
93224 Electrocardiographic Monitoring for 24 hours (Holter Monitoring)	Descriptor change for CPT codes 93224, 93225, 93226, and 93227 Deleted CPT codes 93230, 93231, 93232, 93233, 93235, 93236, and 93237 Changed “LCD Title” to “External Electrocardiographic Recording”
93268 Patient Demand Single or Multiple Event Recorder	Deleted CPT codes 93012 and 93014 Descriptor change for CPT codes 93268, 93270, 93271, and 93272
93501 Cardiac Catheterization	Deleted CPT codes 93501, 93510, 93511, 93514, 93524, 93526, 93527, 93528, and 93529 Added CPT codes 93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, and 93461 Changed “Contractor’s Determination Number” to 93451
93922 Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries	Descriptor change for CPT codes 93922, 93923, and 93924

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Educational Events

Upcoming provider outreach and educational events January – February 2011

Hot Topics: Bimonthly Medicare Part B ACT: Medicare data and CMS initiatives

When: Wednesday, January 19
Time: 2:00 p.m.-3:30 p.m.

Hot Topics: HIGLAS transition webcast

When: Tuesday, January 25
Time: 2:00 p.m.-3:00 p.m.

Hot Topics: Virtual Medifest 2011

When: February 21-25
Time: 8:00 a.m.-5:00 p.m.

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, medicare.fcsso.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.

Note: This article was revised on November 29, 2010, to include a reference to *MLN Matters*® article MM7234 (New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines). All other information is the same. This information was previously published in the October 2010 *Medicare B Update!* pages 55-56.

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.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.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.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.gov/MLNMattersArticles/downloads/MM5037.pdf>
- MM7234: New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines at <http://www.cms.gov/MLNMattersArticles/downloads/MM7234.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,

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

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.gov/MLNProducts/downloads/qr_immun_bill.pdf.

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Third Edition* – this updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file at http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.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 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.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.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.gov/MLNProducts/35_PreventiveServices.asp for easy access.

Other CMS resources

- CMS Adult Immunizations Web page is at <http://www.cms.gov/AdultImmunizations>.
- CMS frequently asked questions are available at http://questions.cms.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.gov/manuals/downloads/bp102c15.pdf>.
- *Medicare Claims Processing Manual*: Chapter 18, Preventive and Screening Services available at <http://www.cms.gov/manuals/downloads/clm104c18.pdf>.
- Medicare Part B drug average sales price payment amounts influenza and pneumococcal vaccines pricing found at http://www.cms.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>.

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

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

MLN Matters Number: SE1031 *Revised*

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Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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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.

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>

Have a healthy holiday season by taking advantage of Medicare-covered preventive services

The Centers for Medicare & Medicaid Services asks the provider community to help their patients with Medicare have a healthy holiday season by encouraging eligible patients to take advantage of Medicare-covered preventive services. Medicare provides coverage of a variety of preventive services and screenings to help providers detect illnesses early, when treatment works best.

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, during the holiday season and into the New Year.

For more 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 – 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
- *MLN Matters Provider Educational Articles Related to Medicare-covered Preventive Benefits* – provides links to educational articles with the latest information on changes to Medicare-covered preventive services, including the latest coverage and coding information,

and changes due to the Affordable Care Act.

<http://www.cms.gov/MLNProducts/Downloads/MLNPrevArticles.pdf>

- *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. Available as a downloadable PDF only. http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- *Quick Reference Information: Medicare Immunization Billing* – this newly-updated chart provides coding, coverage, and billing information on the seasonal influenza virus, pneumococcal, and hepatitis B vaccines. http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services. http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

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 201012-16

Quick reference chart available for immunization billing

The Medicare Preventive Services Quick Reference Information: Medicare Immunization Billing chart, which includes coding, coverage, and billing information for the seasonal influenza, pneumococcal, and hepatitis B vaccines, has been updated and is available for download, free of charge, from the *Medicare Learning Network*[®] at http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf. Additionally, 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 201012-16

Other Educational Resources

The MLN can help you find answers to your Medicare claim questions

The *Medicare Learning Network*® (MLN) provides plenty of accurate answers to your Medicare questions. As a billing or coding professional, you need Medicare information at your fingertips. That is why experts developed the *Medicare Learning Network Suite of Products and Resources for Billing and Coding Professionals* just for you. The suite contains easy-to-understand, accessible, and free Medicare program information.

To access a detailed listing of all of the products you need to correctly submit claims the first time, visit the MLN Educational Web Guides page at <http://www.cms.gov/MLNEdWebGuide>. On the left-hand side of the page, click on the *Medicare Learning Network Suite of Products and Resources for Billing and Coding Professionals*. Equip yourself today with critical reimbursement solutions from the official source for Medicare fee-for-service provider information.

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

Source: CMS PERL 201011-51

'Medicare Claim Review Programs: MR, NCCI Edits, CERT, and RAC' booklet revised

The *Medicare Learning Network*® (MLN) has revised the *Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC* booklet, which is designed to provide education on the different Centers for Medicare & Medicaid Services (CMS) claim-review programs and assist providers in reducing payment errors -- in particular, coverage and coding errors. It includes frequently asked questions (FAQs), resources, and an overview of the various programs, including medical review (MR), national correct coding initiative (NCCI), recovery audit contractor (RAC), and the comprehensive error rate testing (CERT) program. This product is suggested for all Medicare fee-for-service (FFS) providers and is available in downloadable format at http://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf.

Additionally, please visit the MLN Provider Compliance Web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp for additional resources designed to educate Medicare FFS providers about the common billing errors and other improper activities identified through these programs.

Source: CMS PERL 201012-08

Booklet for advanced practice nurses and physician assistants is available in hardcopy

The new *Medicare Learning Network*® booklet titled *Medicare Information for Advanced Practice Nurses and Physician Assistants* (September 2010) is now available in print format from the *Medicare Learning Network*. This publication provides information about required qualifications, coverage criteria, billing, and payment for Medicare services furnished by advanced practice nurses, anesthesiologist assistants, and physician assistants. To place your order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." Additionally, an errata sheet, which provides corrections or changes that have been identified since implementation of the publication, is available at <http://www.cms.gov/MLNProducts/downloads/Errata.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 201012-16

New PQRI and electronic prescribing fact sheets

These following Physician Quality Reporting Initiative (PQRI) and electronic prescribing (eRx) fact sheets are available in a downloadable format:

- *Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (eRx) and Medicare Advantage (MA) Plans* – provides PQRI and eRx Incentive Program payment information to eligible professionals (physicians/nonphysicians) who provide Medicare services to beneficiaries enrolled in Medicare Advantage (MA) plans. <http://www.cms.gov/MLNProducts/downloads/wPQRIMAPLansTS.pdf>
- *Physician Quality Reporting Initiative (PQRI) Reporting periods for 2010* – designed to provide information for 2010 eligible professionals who satisfactorily report PQRI measures for the two reporting periods. This fact sheet also describes the incentive for eligible professionals who meet the requirements for the six-month reporting period. <http://www.cms.gov/MLNProducts/downloads/PQRI904323.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 201012-16

**Mail directory
Claims submissions**

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

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

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

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

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

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

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

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

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

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

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

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

**Durable medical
equipment (DME)
DME, orthotic or prosthetic claims**
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

**Electronic media claims (EMC)
Claims, agreements and inquiries**
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

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

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

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

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

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

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

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

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

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

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

**Phone numbers
Providers**

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

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

E-mail address: AskFloridaB@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/prevaling charges or fee schedule:

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

Education event registration:

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services

www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

E-mail address: AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE

Hearing Impaired:

1-800-754-7820

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

Education event registration

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:

1-866-270-4909

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications_B/ (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2010 through September 2011.	40300260	Hardcopy \$33		
		CD-ROM \$55		
2011 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 11, 2011, are available free of charge online at http://medicare.fcso.com/Data_files/ (English) or http://medicareespanol.fcso.com/Fichero_de_datos/ (Español). Additional copies or a CD-ROM are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy \$12		
		CD-ROM \$6		

Language preference: **English** [] **Español** []

<i>Please write legibly</i>	Subtotal	\$
	Tax (add % for your area)	\$
	Total	\$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

◆ ATTENTION BILLING MANAGER ◆