Pinnacle Medicare Providers' News

Serving the Medicare Part B Providers of Arkansas and Louisiana

July 2010

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

July 2010 Update to the Ambulatory Surgical Center (ASC) Payment System

Reference: Trans. 1991, CR #7008, Pub. 100-04, MLN: MM7008

Note: This article was revised to reflect a new Change Request (CR) that was released on June 25, 2010. The new CR added information on the payment indicator adjustment for HCPCS 90670 (page 3) and corrected the Long Descriptor for C9264 (page 4). The transmittal number, CR release date and web address for the CR was also changed. All other information remains the same.

Provider Types Affected

Providers (ASCs) submitting claims payable under the Ambulatory Surgical Center (ASC) Payment System to Medicare contractors (carriers and Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

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

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

Background

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

CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes, as appropriate. CR 7008 provides information on eight newly created HCPCS codes that will be added to the ASC list of covered surgical procedures and seven newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective July 1, 2010.

Billing for Drugs and Biologicals

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

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

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

performed. Instructions for downloading the ASC DRUG file updates are included in the business requirements section below.

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

New HCPCS Codes for Drugs and Biologicals that are Separately Payable under the ASC Payment System Effective July 1, 2010

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

Table 1- New Drugs and Biologicals Separately Payable under the ASC Payment System Effective July 1, 2010

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

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

Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

The payment rates for three HCPCS codes were incorrect in the April 2010 ASC DRUG file. The corrected payment rates are listed in Table 2 below and have been included in the revised April 2010 ASC DRUG file effective for services furnished on April 1, 2010 through implementation of the July 2010 update. Suppliers who think they may have received an incorrect payment between April 1, 2010 and June 30, 2010 may request their Medicare contractor to adjust the previously processed claims.

Table 2-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

HCPCS Code	Short Descriptor	ASC Payment Rate	ASC PI
C9258	Telavancin injection	$2.12	K2
C9262	Fludarabine phosphate, oral	$8.18	K2
J1540	Gamma globulin 9 CC inj	$141.64	K2

Adjustment to Payment Indicator for HCPCS Code 90670 Effective April 1, 2010

Effective April 1, 2010, the payment for HCPCS code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) will change from ASC PI=Y5 (non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to ASC PI=K2 (Drugs and biologicals paid

separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). The payment rate effective April 1, 2010, is $106.70. Suppliers who think they may have received an incorrect payment determination between April 1, 2010, and June 30, 2010, may request contractor adjustment of the previously processed claims.

New Category III Current Procedural Terminology (CPT) Codes that are Separately Payable under the ASC Payment System Effective July 1, 2010

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

Table 3- New Category III CPT Codes that are Separately Payable under the ASC Payment System Effective July 1, 2010

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

*Denotes Temporary Office-Based Status

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

New HCPCS Code that is Separately Payable under the ASC Payment System Effective March 23, 2010

One new HCPCS code has been created for a payable surgical procedure that is payable for dates of service on and after March 23, 2010, as a result of a recent CMS national coverage decision (NCD). For further information on

the NCD, refer to CR 6953. The new HCPCS code, the long descriptor, the short descriptor, and payment indicator is identified in Table 4 below. The new separately payable code and its payment rate are included in the July 2010 ASCFS file.

Table 4- New HCPCS Code that is Separately Payable under the ASC Payment System Effective March 23, 2010

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

*Denotes Temporary Office-Based Status

Additional Information

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

The official instruction issued to your Medicare carrier and/or MAC, regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R1991CP.pdf on the CMS website.

The MLN Matters article for MM7008 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM7008.pdf.

Effective Date: July 1, 2010; Implementation Date: July 6, 2010

Release of the Positive 2.2 Percent Update for the 2010 Medicare Ambulatory Surgical Center Files

Reference: CMS List-Serv Message 071510; JSM CI 6812-10361

The recent enactment of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, §101, resulted in a positive 2.2 percent update in the 2010 Medicare Physician Fee Schedule (MPFS), effective June 1, 2010, through November 30, 2010.

Many payment rates under the Ambulatory Surgical Center (ASC) payment system are controlled by payment rate information in the MPFS. In order to fully comply with this legislation, it is necessary to implement revised MPFS payment rates in the ASC payment system. Therefore, the Centers for Medicare & Medicaid Services (CMS) has provided its contractors with two sets of positive 2.2 percent ASCFS and ASCPI update files to test, and implement. One set of files is for ASC services furnished on or after July 1, 2010, and the second set of files is for ASC services furnished June 1, 2010, through June 30, 2010. Once installed, Medicare contractors shall use these updated payment files to process new ASC claims and shall adjust previously processed ASC claims for dates of service on or after June 1, 2010, that are brought to their attention.

In accordance with the requirements in Change Request (CR) 7008, contractors shall make July 2010 ASCFS fee data for their ASC payment localities available on their websites. The payment rates in the July 2010 ASCFS fee data files mirror the 2.2 percent update payment rates for services June 1, 2010-June 30, 2010 and also contain payment rates for newly established services identified in CR7008 effective July 1, 2010.

An MLN Matters article which explains the requirements in CR 7008 may be found at: http://www.cms.gov/MLNMattersArticles/downloads/MM7008.pdf on the CMS website.

CMS is aware that contractors were unable to implement the revised payment rates by the July 6, 2010 implementation date contained in CR7008 because these files have just become available to contractors for download and testing. Contractors have been directed to have all these ASC update files in production no later than July 28, 2010. This implementation date supersedes the implementation date specified in CR7008.

ASCs who may have received an incorrect payment determination for certain services furnished on or after June 1, 2010 through the implementation of the July 2010 ASCFS may request contractor adjustment of the previously processed claims.

Additional Healthcare Common Procedure Coding System (HCPCS) Codes Subject to Clinical Laboratory Improvement Amendments (CLIA) Edits

Reference: Trans. 720, CR #6985, Pub. 100-20, MLN: MM6985

Provider Types Affected

Clinical Laboratories submitting claims to Medicare Part A/B Medicare Administrative Contractors (A/B MACs) or carriers for laboratory services provided to Medicare beneficiaries are impacted by this issue.

What You Need to Know

Change Request (CR) 6985, from which this article is taken, informs your A/B MAC or carrier about additional new Healthcare Common Procedure Coding System (HCPCS) codes for 2010 that are subject to Clinical Laboratory Improvement Amendments (CLIA) edits. You should make sure that your billing staff is aware of the changes.

Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

Since the HCPCS codes that are considered a laboratory test under CLIA change each year, the Center for Medicare & Medicaid Services (CMS) informs carriers and MACs about the new HCPCS codes that are subject to, and those that are excluded from, CLIA edits. CR 6985, from which this article is taken, announces additional HCPCS codes that are subject to CLIA edits for 200910, but were not mentioned in CR 6812 or CR 6356.

Note: *Please refer to MLN Matters® article MM6812 (Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits), released February 5, 2010; which you can find at* http://www.cms.gov/MLNMattersArticles/downloads/MM6812.pdf *on the CMS website.*

The HCPCS codes listed in the table, below, are new for 2009and subject to CLIA edits, and require a facility to have either:

- A CLIA certificate of registration (certificate type code 9);
- A CLIA certificate of compliance (certificate type code 1); or
- A CLIA certificate of accreditation (certificate type code 3).

A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) cannot be paid for these tests.

HCPCS	Modifier	Description
G0416		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens
G0416	TC	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens
G0416	26	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens
G0417		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens
G0417	TC	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens
G0417	26	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens

G0418		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens
G0418	TC	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens
G0418	26	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens
G0419		Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens
G0419	TC	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens
G0419	26	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens

Please note that your carrier or MAC is not required to search their files to either retract payment for claims already paid or to retroactively pay claims containing these codes, but will adjust such claims that you bring to their attention.

Additional Information

You can find the official instruction, CR6985, issued to your carrier or A/B MAC by visiting http://www.cms.gov/Transmittals/downloads/R720OTN.pdf on the CMS website.

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 on the CMS website.

The MLN Matters article for MM6985 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6985.pdf.

Effective Date: January 1, 2009; Implementation Date: July 19, 2010

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Reference: Trans. 1996, CR #7006, Pub. 100-04, MLN: MM7006

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on Change Request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) website at http://www.cdc.gov/nchs/icd9.htm in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual,* Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims. However, an ICD-9-CM code is not required for ambulance supplier claims.

Additional Information

For complete details regarding this CR, please see the official instruction (CR7006) issued to your Medicare contractor, which may be found at http://www.cms.gov/Transmittals/downloads/R1996CP.pdf on the CMS website.

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

The MLN Matters article for MM7006 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM7006.pdf.

Effective Date: October 1, 2010; Implementation Date: October 4, 2010

Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

Reference: Trans. 122 and 1978, CR #6953, Pub. 100-03 and 100-04, MLN: MM6953

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 Change Request (CR) 6953, which informs Medicare contractors that effective for claims with dates of service on and after March 23, 2010, dermal injections for facial 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 Non-Covered Indications

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

Claims Coding/Pricing Information

Effective with the July 2010 Healthcare Common Procedure Coding System (HCPCS) update, the July Medicare Physician Fee Schedule (MPFS), and the July Integrated Outpatient Code Editor (IOCE):

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

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

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the dermal filler product. This code provides a payment 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 hospital 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 hospital **outpatient claims, hospital institutional non-OPPS claims**, and ASCs, covered dermal injections for treatment of LDS must be billed 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 G0249 with a LIDOS on or after March 23, 2010; and
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

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

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

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

Practitioner Billing Instructions

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

- A date of service (LIDOS) on or after March 23, 2010;
- HCPCS codes Q2026 0r Q2027;
- A line with HCPCS code G0249; 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:

- Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. 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. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- Group Code: Contractual Obligation (CO)

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

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

Additional Information

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

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 on the CMS website.

The MLN Matters article for MM6953 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6953.pdf.

Effective Date: March 23, 2010; Implementation Date: July 6, 2010

Summary of Medicare Reporting and Payment of Services for Alcohol and/or Substance (Other than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services

Reference: SE1013

Provider Types Affected

This article is for physicians, non-physician practitioners, and other providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for certain mental health services provided to Medicare beneficiaries.

Impact on Providers

This article is informational only and does not alter existing Medicare policy nor does it introduce new policy.

Background

This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS), working with the Substance Abuse and Mental Health Services Administration (SAMHSA), to inform Medicare providers about reporting and payment for the appropriate delivery of alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention (SBIRT) services.

SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach is in contrast with the primary focus of specialized treatment of individuals with more severe substance use, or those who have met the criteria for diagnosis of a Substance Use Disorder.

In the 2008 Medicare Physician Fee Schedule (MPFS), Medicare created two Healthcare Common Procedure Coding System (HCPCS) G-codes to allow for the appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services. See MM5895 (related to CR 5895, Transmittal R1423CP, February 1, 2008 (Summary of Policies in the 2008 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount) at http://www.cms.gov/MLNMattersArticles/downloads/MM5895.pdf on the CMS website.

Additionally, these services are paid under the hospital Outpatient Prospective Payment System (OPPS). See the January 2008 Update of the OPPS – Manualization, which includes a summary of the OPPS policies regarding these codes at http://www.cms.gov/MLNMattersArticles/downloads/MM5946.pdf on the CMS website.

These two HCPCS G-codes are:

- G0396 (Alcohol and/or substance (other than tobacco) abuse **structured assessment** (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes), and
- G0397 (Alcohol and/or substance (other than tobacco) abuse **structured assessment** (e.g., AUDIT, DAST) and intervention greater than 30 minutes).

These HCPCS G-codes (G0396 and G0397) allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services, but only those services that are performed for the diagnosis or treatment of illness or injury.

Medicare Contractors will consider payment for HCPCS codes G0396 and G0397 only when medically reasonable, and necessary (i.e., when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) as per the Social Security Act (Section 1862(a)(1)(A)). It is important to remember that Medicare only covers SBIRT services that are reasonable and necessary and meet the requirements of diagnosis or treatment of illness or injury.

Structured Assessment and Brief Intervention (SBIRT) Services

Medicare pays for medically reasonable and necessary SBIRT services when they are delivered in the following settings: physicians' offices and outpatient hospitals. Providers assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment.

General Principles of Medical Record Documentation for Individual Mental Health Services

It is important to remember that all claims for Medicare services must be supported by information in the patient's medical record, and the general principles of medical record documentation for the reporting of SBIRT services for

Medicare payments include the following as applicable to the specific setting/encounter (See CR 2520 (Transmittal AB-03-037) at http://www.cms.gov/Transmittals/downloads/AB03037.pdf on the CMS website):

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
  - Ø Reason for encounter and relevant history,
  - Ø Physical examination findings and prior diagnostic test results,
  - Ø Assessment, clinical impression, and diagnosis,
  - Ø Plan for care,
  - Ø Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Documentation must denote start/stop time or total face-to-face time with the patient, because the SBIRT G-codes are time-based codes;
- Past and present diagnoses should be accessible for the treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- The patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- The CPT and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim should be supported by documentation in the medical record.

Like all providers of services billed to Medicare, it is essential that providers of mental health services document their services fully in the medical record, because if the records are incomplete, the provider is at risk of losing Medicare payments in the event of a claims audit.

Qualifications of Practitioners Providing Mental Health Services that are Covered under Medicare

In order to bill Medicare, providers of mental health services must be qualified to perform the specific mental health services rendered. In order for these services to be covered, mental health professionals must be working within their State Scope of Practice Act, and licensed (or certified) to perform mental health services by the state in which the services are performed. See CR 2520 (Transmittal AB-03-037, March 28, 2003) at http://www.cms.gov/Transmittals/downloads/AB03037.pdf on the CMS website.

Physician

A qualified physician must be legally authorized to practice medicine by the state in which he/she performs his/her services, and perform his/her services within the scope of his/her license as defined by state law.

Clinical Psychologist (CP)

A CP must hold a doctoral degree in psychology; and be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

In general, CP services are covered in the same manner as physician's services. CPs must be legally authorized to perform the services under applicable licensure laws of the state in which they are furnished.

See 42 CFR 410.71 at http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.71.htm on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section160) at http://www.cms.gov/manuals/Downloads/bp102c15.pdf on the CMS website for the covered services of a CP.

Clinical Social Workers (CSW)

A CSW must possess a master's or doctor's degree in social work; have performed at least two years of supervised clinical social work; and be licensed or certified as a clinical social worker by the state in which the services are performed.

In the case of an individual in a state that does not provide for licensure or certification, the individual must be licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed. As well, the CSW must have completed at least 2 years or 3,000 hours of post-master's degree

supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, Skilled Nursing Facility (SNF), or clinic.

See 42 CFR 410.73 at http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.73.htm on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 170) for the covered services of a CSW.

Nurse Practitioner (NP)

An NP must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. They must also be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

NPs who applied to be a Medicare billing supplier for the first time on or after January 1, 2001, and prior to January 1, 2003, must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. As well, they must be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

NPs applying to be a Medicare billing provider for the first time on or after January 1, 2003, must possess a master's degree in nursing or a DNP degree from an accredited institution, be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

See 42 CFR 410.75 at http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.75.htm on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 200) for the covered services of an NP.

Clinical Nurse Specialist (CNS)

A CNS must be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law, have a master's degree in a defined clinical area of nursing from an accredited educational institution, and be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for a CNS. The following organizations are recognized national certifying bodies for CNSs at the advanced practice level:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

See 42 CFR 410.76 at http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.76.htm on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 210) for the covered services of a CNS.

Physician Assistant (PA)

A PA must have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation), or have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and be licensed by the state to practice as a PA.

See 42 CFR 410.74 at http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.74.htm on the Internet and the Medicare Benefits Policy Manual (Chapter 15, Section 190) for the covered services of a PA.

Medicare's Outpatient Mental Health Treatment Limitation

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program. This limitation does not apply to payment made to facilities under the OPPS.

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833(c) of the Social Security Act to phase out the outpatient mental health treatment limitation over a 5-year period, from 2010 - 2014. MM6686 (related to CR 6686 - see http://www.cms.gov/MLNMattersArticles/Downloads/MM6686.pdf on the CMS website) alerts providers that CMS is phasing out the outpatient mental health treatment limitation over this 5- year period.

The 62.5 percent limitation will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 – December 31, 2011, the limitation percentage is 68.75%. (Medicare pays 55% and the patient pays 45%).
- January 1, 2012 – December 31, 2012, the limitation percentage is 75%. (Medicare pays 60% and the patient pays 40%).
- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%. (Medicare pays 65% and the patient pays 35%).
- January 1, 2014 – onward, the limitation percentage is 100%. (Medicare pays 80% and the patient pays 20%).

Note: There is no national policy that establishes whether the outpatient mental health treatment limitation (the limitation) applies to these SBIRT services. Therefore, the application of the limitation to the SBIRT services would be made by the local Medicare contractor.

Additional Information

For additional details about the outpatient mental health treatment limitation, please see the Medicare Claims Processing Manual (Publication 100-04; Chapter 5, Section 100.4; Chapter 9, Section 60; and Chapter 12, Section 210 & Section 210.1E) at http://www.cms.gov/Manuals/IOM/list.asp on the CMS website.

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 on the CMS website.

For more information on SBIRT, please visit SAMHSA's website at http://sbirt.samhsa.gov on the Internet.

The MLN Matters article for SE1013 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1013.pdf.

ICD-10 Implementation Information

Reference: SE1019

Provider Types Affected

This issue impacts all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

What You Need to Know

This MLN Matters® special edition article provides information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The first ICD-10-related compliance date is less than 2 years away. On **January 1, 2012**, standards for electronic health transactions change from Version 4010/4010A1 to Version 5010. Unlike Version 4010, Version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

On **October 1, 2013**, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background

ICD-10 Implementation Compliance Date

On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
  - Ø There will be **no** delays.
  - Ø There will be **no** grace period for implementation.

Important, please be aware:

- ***ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.***
- ***ICD-10 codes will not be accepted for services prior to October 1, 2013.***

You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2013, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2013.

Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2013.

Note: Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report CPT and HCPCS codes.

What are the Differences Between the ICD-10-CM/ICD-10-PCS and ICD-9-CM Code Sets?

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

What are Benefits of the ICD-10 Coding System?

The new, up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition
- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

ICD-10-CM Code Use and Structure

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is 3 to 7 characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters 3-7 are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

- A78 – Q fever
- A69.21 – Meningitis due to Lyme disease
- O9A.311 – Physical abuse complicating pregnancy, first trimester
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

1. Laterality (left, right, bilateral)

   For example:
   - C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
   - H16.013 – Central corneal ulcer, bilateral
   - L89.022 – Pressure ulcer of left elbow, stage II
2. Combination codes for certain conditions and common associated symptoms and manifestations

   For example:
   - K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
   - E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
   - I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
3. Combination codes for poisonings and their associated external cause

   For example:
   - T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela
4. Obstetric codes identify trimester instead of episode of care

For example:

- O26.02 – Excessive weight gain in pregnancy, second trimester

5. Character “x” is used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than 6 characters in length requires a 7th character

   For example:

   - T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter
   - T15.02xD – Foreign body in cornea, left eye, subsequent encounter

6. Two types of Excludes notes

   Excludes 1 – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

   For example:

   - Q03 – Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

   Excludes 2 – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).

   For example:

   - L27.2 – Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

7. Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)

   For example:

   - T45.526D – Underdosing of antithrombotic drugs, subsequent encounter
   - Z67.40 – Type O blood, Rh positive
   - Y90.6 – Blood alcohol level of 120–199 mg/100 ml

8. A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)

   For example:

   - E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy
   - F10.182 – Alcohol abuse with alcohol-induced sleep disorder
   - T82.02xA – Displacement of heart valve prosthesis, initial encounter

9. Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders

   For example:

   - D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
   - D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM
- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now 4 weeks rather than 8 weeks)

- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review “Basic Introduction to ICD-10-CM” audio or written transcripts from the March 23, 2010 provider outreach conference call. Go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage on the CMS website. Scroll to the bottom of the web page to the Downloads section and select the 2010 ICD-10 Conference Calls zip file and locate the March 23rd written or audio transcript.

ICD-10-PCS Code Use and Structure

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have 7 characters that can be either alpha (non-case sensitive) or numeric. The numbers 0 - 9 are used (letters O and I are not used to avoid confusion with numbers 0 and 1), and they do not contain decimals.

For example:

- 0FB03ZX - Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ - Repair, upper esophagus, open approach

Help with Converting Codes

The General Equivalence Mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers
- All providers
- Medical researchers
- Informatics professionals
- Coding professionals—to convert large data sets
- Software vendors—to use within their own products;
- Organizations—to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use can be found on the CMS website at http://www.cms.gov/ICD10 (select from the left side of the web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, “ICD-10 Implementation and General Equivalence Mappings”. Go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp, scroll to the bottom of the page, under Downloads select – 2009 ICD-10 Conference Calls to locate the audio and written transcripts.

What to do Now in Preparation for ICD-10 Implementation?

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types

- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims
- Learn about system impact and 5010
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation
- Review and refresh knowledge of medical terminology as needed based on the assessment results
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology)
- Plan to provide intensive coder training approximately 6 -9 months prior to implementation
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much

Additional Information

To find additional information about ICD-10, visit http://www.cms.gov/ICD10 on the CMS website. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page** -This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp and check back regularly for access to ICD-10 implementation information of importance to you. **Note**: Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- **CMS Sponsored National Provider Conference Calls** - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage on the CMS website.
- **Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at http://www.cms.gov/ICD10/, select the **Medicare Fee-for-Service Provider Resources** link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange (WEDI)** http://www.wedi.org*; and*
- **Health Information and Management Systems Society (HIMSS)** http://www.himss.org/icd10 on the Internet.

The MLN Matters article for SE1019 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1019.pdf.

Provisions in the Affordable Care Act of 2010 (ACA)

Reference: SE1023

Provider Types Affected

All providers that bill Medicare for services provided to Medicare beneficiaries

Provider Action Needed

Providers should be aware of these provisions and frequently visit the CMS website for updates on their implementation.

Background

The ACA, signed into law on March 23, 2010, includes a number of provisions designed to help physicians. Some of those changes are reflected in the Notice of Proposed Rule Making (NPRM), CMS-1503-P. (CMS is accepting comments on the proposed rule until August 24, 2010, and will respond to them in a final rule to be issued on or about November 1, 2010, that sets forth the policies and payment rates effective for services furnished to Medicare beneficiaries on or after January 1, 2011.)

Provisions in the ACA

Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

The ACA extends the preventive focus of Medicare coverage, which currently pays for a one-time only initial preventive physical examination (also known as the "Welcome to Medicare Visit"). Medicare will cover annual wellness visits where beneficiaries receive personalized prevention plan services.

Elimination of Deductible and Coinsurance for Most Preventive Services

Effective January 1, 2011, the ACA waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services, specifically for Medicare covered preventive services that have been recommended with a grade of A ("strongly recommends") or B ("recommends") from the U.S. Preventive Services Task Force, as well as the initial preventive physician examination and the annual wellness visit. The ACA also waives the Part B deductible for colorectal cancer screening tests that become diagnostic.

Incentive Payments to Primary Care Practitioners for Primary Care Services

The ACA authorizes CMS to make incentive payments equal to 10 percent of the provider's allowed charges for primary care services furnished by certain physician and non-physician specialties that are designated as primary care practitioners. This provision begins with calendar year 2011. Primary care practitioners are physicians (1) who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's allowed charges under Part B for a prior period as determined by the Secretary of Health and Human Services.

Incentive Payments for General Surgery Services in Rural Areas

The ACA calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the Medicare Physician Fee Schedule – in Health Professional Shortage Areas (HPSAs) between January 1, 2011, and December 31, 2016. To be eligible for the incentive payment, you must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the payment for the surgical services furnished by the general surgeon occurring in a zip code that is located in an area designated as a primary care HPSA.

Revisions to the Practice Expense Geographic Adjustment (PE GPCI) to Assist Rural Providers

The ACA limits recognition of local differences in employee wages and office rents in the PE GPCIs for calendar years 2010 and 2011 as compared to the national average. Localities are held harmless to any decrease in 2010 and 2011 in their PE GPCIs that would result from this alternative methodology. The new law also establishes a permanent 1.0 floor for the PE GPCI for frontier states (Montana, Wyoming, Nevada, North Dakota, and South Dakota), raising the rural area payment for physicians' services to be no less than the national average.

Physician Self-Referral for Certain Imaging Services

The ACA amends the in-office ancillary services exception to the self-referral law as applied to advanced imaging services, such as magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that there are other suppliers of these imaging services, along with a list of other suppliers in the area in which the patient resides.

Misvalued Codes under the Physician Fee Schedule

The ACA requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. Building on this authority, the new rule identifies additional categories of services that may be misvalued, including codes with low work relative value units (RVUs) commonly billed in multiple units per single encounter and codes with high volume and low work RVUs.

Modification of Equipment Utilization Factor for Advanced Imaging Services

The ACA adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment to more consistently reflect the typical actual use of the equipment and, thereby, reduces payment rates for the associated procedures. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the ACA increases the established multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Maximum Period for Submission of Medicare Claims Reduced to Not More than 12 Months

The ACA changes the time frame during which claims may be submitted for physicians' services to one year from the date of service, beginning with services furnished on or after January 1, 2010. This reflects a reduction in the maximum prior timely filing deadline of 15 to 27 months and aims to improve prompt payment and improve program integrity.

Additional Information

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

You can find information (as of June 11, 2010) on CMS published regulations, CMS policy instructions, key implementation dates, and other accomplishments that relate to ACA at https://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf on the CMS website.

Many of the new provisions outlined in the ACA are reflected in the proposed Medicare Physician Fee Schedule regulation, which can be found at http://www.federalregister.gov/inspection.aspx on the Internet.

You can also find a beneficiary brochure that provides information about the services and benefits of the new health care law (Medicare and the New Health Care Law — *What it Means for You)* at http://www.medicare.gov/Publications/Search/Results.asp?PubID=11467&Type=PubID on the Internet.

The MLN Matters article for SE1023 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1023.pdf.

Notice of New Interest Rate for Medicare Overpayments and Underpayments

Reference: Trans. 172, CR #6654, Pub. 100-06

Effective **July 21, 2010**, the interest rate for-overpayments and underpayments will be **11.00 percent**. Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the current value of funds rate (one percent for calendar year 2010) or the private consumer rate (PCR). The Department of the Treasury has notified the Department of Health and Human Services that the PCR rate will be **11.00 percent**.

Magnetic Resonance Angiography (MRA)

Reference: Trans. 1998 and 123, CR #7040, Pub. 100-04 and 100-03, MLN: MM7040

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), carriers, and A/B Medicare Administrative Contractors (MAC)) for Magnetic Resonance Angiography (MRA) services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7040. You need to know that, effective for claims with dates of services on or after June 3, 2010, Medicare contractors will have the discretion to cover or not cover all indications of MRA (and magnetic resonance imaging (MRI)) that are not specifically nationally covered or nationally non-covered. Existing national coverage for both MRI and MRA will be maintained. Please ensure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) in October, 1995, set forth the original conditions under which MRA would be covered. Revisions to the national coverage determination (NCD) policy took place in 1997, 1999, and 2003 to expand coverage for additional indications. Currently covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest. All other uses of MRA are nationally non-covered unless coverage is specifically indicated.

In addition, CMS recently reconsidered the NCD for MRI at section 220.2 of the NCD Manual and removed national non-coverage for MRI for blood flow determination, thereby permitting local Medicare contractors to make local coverage determinations within their respective jurisdictions effective for claims with dates of service on or after June 3, 2010. Such local determinations would apply to all indications of MRA/MRI that are not specifically covered nationally or non-covered nationally.

While reviewing published scientific evidence for the MRI reconsideration, CMS became aware of evidence that may speak to currently non-covered indications for MRA. As a result, CMS initiated this reconsideration to evaluate the current evidence for the non-covered indications for the MRA NCD at section 220.3.C of the NCD Manual.

MRA is a specific application of MRI. CMS believes that the continued existence of separate NCDs is unnecessary, and that the provisions of the MRA NCD at section 220.3 should be merged under the NCD for MRI at section 220.2. Thus, section 220.3, MRA, of the NCD Manual, will no longer appear as a separate NCD.

The effect of this change will maintain existing national coverage for both MRI and MRA, and will eliminate the non-coverage language that currently exists for MRA at section 220.3.C of the NCD Manual, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally non-covered.

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 on the CMS website. The official instruction, CR 7040, was issued to your Medicare contractor via two transmittals. The first transmittal modifies the NCD Manual as discussed above and that transmittal is available at http://www.cms.gov/Transmittals/downloads/R123NCD.pdf on the CMS website. The second transmittal updates the Medicare Claims Processing Manual and that is available at http://www.cms.gov/Transmittals/downloads/R1998CP.pdf on the CMS website.

The MLN Matters article for MM7040 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM7040.pdf.

Effective Date: June 3, 2010; Implementation Date: August 9, 2010

Part B CERT Data Summary

Reference: AR – JMC 071510

The Improper Payments Information Act of 2002 requires agencies to assess every federal program and dollar for improper payment risk, measure the accuracy of payments annually, and initiate program improvements to ensure payment errors are reduced. The CERT Program was developed as an outcome of this payment risk assessment.

Executive Order 13520, *Reducing Improper Payments*, was issued on November 20, 2009, to further intensify efforts to eliminate payment error, waste, fraud, and abuse in the major programs administered by the federal government. The Executive Order also establishes a requirement for a central website that contains improper payments information. Through this interactive website, (http://www.PaymentAccuracy.Gov), information such as current and historic improper payments amounts and rates, improper payments reduction targets, and recovered improper contract payments will be publicly accessible.

The Payment Accuracy website (see link below) lists the Improper Payment Rate for Medicare Fee for Service as 12.4% nationally for the Fiscal Year 2009 totaling $35.4 Billion dollars.

http://paymentaccuracy.gov/content/program-details?programid=23

The current goal or target for the November CERT Report (claims submitted 4/1/2009 – 3/31/2010) is to have a projected Improper Payment rate of 9.5% or less.

The following is a summary of errors received by PBSI during the 3rd quarter of FY 2010 for the Arkansas and Louisiana Part B contractor jurisdictions.

3rd Quarter Summaries

Arkansas	
Error Code 21	16 Errors
Error Code 25	20 Errors
Error Code 31	6 Errors
Error Code 35	1 Error
TOTAL	**43 Errors**

Louisiana	
Error Code 21	44 Errors
Error Code 25	1 Error
Error Code 31	12 Errors
Error Code 41	1 Error
TOTAL	**58 Errors**

Error Code	Description
21	Insufficient documentation
25	Medically unnecessary service or treatment
31	Service incorrectly coded
35	Not covered or unallowable service
41	Services billed were not rendered

The following chart provides some of the most frequent error codes with comments made by the CERT reviewer from the 3rd Quarter FY 2010.

Contractor State	Error Code	Error Comments
AR/LA	21	Received unsigned progress note and lab results but no orders, verbal or written, were submitted to support the laboratory testing billed, therefore not medically necessary.
AR/LA	21	Documentation includes medical necessity, the complete study, documentation of the modes used for the test, and the rationale for performing the study. However, the visit note has no handwritten or electronic signature as required by the PIM on this date of service.
AR/LA	21	Missing attestation of office visit note. Submitted documentation consists in part of a handwritten office visit note dated that has no legible signature.
AR/LA	21	Insufficient documentation. Missing an order for sputum culture and sensitivity study. Received a copy of the lab requisition for date of service but not signed; received a copy of telephone order dated 06/02/2009 and at the bottom of the sheet were initials of unknown person dated 05/05/2009.
AR/LA	21	Missing the physician order or documentation of intent of ordering the billed Prothrombin Time. Received results and unsigned office visits notes that documents check PT/INR in 2 weeks, the note is dated without a signature, but no physician order or documentation that supports the physician intent or plan to order the billed services was submitted. Requested attestation and orders twice from Customer Service Rep Call and received duplicate documentation.
AR/LA	21	Submitted document is missing a legible identifier of the individual who rendered the billed service.
AR/LA	25	Missing the physician order or documentation of intent of ordering the billed procedure. Received only unsigned reports from the billing provider but no physician order or documentation that supports the physician intent or plan to order the billed service. No attestation was submitted after call to the billing physician. Need an attestation Statement of your medical record entry for billed Date of Service that accurately reflects signatures/notations that you made in capacity as the treating physician when you treated the above listed Medicare beneficiary.
AR/LA	25	Submitted documentation includes a transcribed office visit note that listed a plan to have a lipid profile, CHEM 14, TSH, and CBC that has no legible identification of the individual who provided or documented the service. Does not meet the requirement for an order, unable to determine who provided the billed service.
AR/LA	25	Missing the physician order or documentation of intent of ordering the billed Chest X-ray, 2 Views. Received a signed report from the billing provider rendering services.

AR/LA	31	Billed CPT Code 99213 requires 2 of 3 key components (Expanded Problem Focused Hx, Expanded Problem Focused Ex, Low Medical Decision Making). Submitted Documentation supports code change from 99213 to 99212 with Problem Focused Hx, Problem Focused Ex, and Straight Forward MDM.
AR/LA	31	Billed 99204, which requires 3 of 3 components: comprehensive history and exam, moderate complexity MDM. Submitted Documentation supports 99203 with Detailed History and Exam, Moderate Complexity MDM. Notes were electronically signed by the physician.
AR/LA	31	Billed is CPT 99285 that requires 3/3 key components: Comprehensive Hx, Comprehensive Ex, and High Complexity MDM. Submitted documentation supports 99284 with a Detailed Hx, Complex Ex, and High Complexity MDM. 99284 requires 3/3 d Hx, Detailed Ex, and Moderate Complexity MDM. Documentation supports recode to 99284.

Please be sure that submitted documents provide all needed documentation to support the service billed.

October 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Reference: Trans. 1990, CR #7007, Pub. 100-04, MLN: MM7007

Provider Types Affected

This article is for all physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7007 and instructs Medicare contractors to download and implement the October 2010 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised, July 2010, April 2010, January 2010 and October 2009 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

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

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

Files	Effective Dates of Service
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and ASP NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009

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

Additional Information

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

The official instruction (CR7007) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.gov/Transmittals/downloads/R1990CP.pdf on the CMS website.

The MLN Matters article for MM7007 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM7007.pdf.

Effective Date: October 1, 2010; Implementation Date: October 4, 2010

July 2010 Average Sales Price (ASP) Files Are Now Available

Reference: CMS List-Serv Message 062410

The Centers for Medicare and Medicaid Services (CMS) has posted a revised July 2010 ASP Pricing file, which is available for download at: http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ (see left menu for year-specific links).

Durable Medical Equipment National Competitive Bidding Implementation -- Phase 10C: Exception for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan

Reference: Trans. 721, CR #6918, Pub. 100-20, MLN: MM6918

Note: This article was revised on June 21, 2010, to reflect the revised CR 6918 that was issued on June 18, 2010. The article was changed to include a revised first bullet point in the "Key Points of CR 6918" section. Also, the CR release date, transmittal number, and the Web address for accessing CR 6918 were revised. All other information remains the same.

Provider Types Affected

Suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries are impacted by this issue.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6918 to alert providers that under certain circumstances Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) payment will be allowed for grandfathered items for beneficiaries who received services from a DMEPOS supplier while under a Medicare Advantage plan. Those items should be furnished by a non-contract Medicare Advantage (MA) supplier under the DMEPOS Competitive Bidding Program for a beneficiary who resides in a competitive bidding area (CBA) and elects to leave their MA plan or loses his/her coverage under this plan. Such beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program.

However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier; meet the Medicare fee for service (FFS) coverage criteria and documentation requirements; and elect to become a grandfathered supplier.

Key Points of CR6918

- Medicare will pay oxygen claims that qualify for the MA plan grandfathering at the Round One bid amount and will pay capped rental claims that qualify for the MA plan grandfathering at the fee schedule amount during the Round One contract period. The target implementation date for the Round One Rebid is January 1, 2011, and is subject to change.
- The beneficiary must have been enrolled in a MA plan on the day prior to the start date for the Round One Rebid to qualify for the MA plan grandfathering exception.

Background

The Medicare DMEPOS Competitive Bidding Program was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) which amended section 1847 of the Social Security Act (the Act) to require the Secretary of Health and Human Services to establish and implement programs under which competitive bidding areas (CBAs) are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Medicare Part B.

Section 1847(a)(4) requires that in the case of covered DME items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary must establish a "grandfathering" process by which rental agreements for the DME covered items and oxygen are entered into before the start of the competitive bidding program may be continued.

Additional Information

If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website. The official instruction associated with this CR6918, issued to your Medicare DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R721OTN.pdf on the CMS website.

To review the complete listing of links to DME related information you may go to http://www.cms.gov/center/dme.asp on the CMS website.

The MLN Matters article for MM6918 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6918.pdf.

Effective Date: October 1, 2010; Implementation Date: October 4, 2010

July Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Reference: Trans. 1993, CR #6945, Pub. 100-04, MLN: MM6945

Note: This article was revised on July 1, 2010, to reflect changes made by the release of an updated Change Request (CR) 6954. Language on page 2 **in bold** was corrected to state that claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 will be adjusted if brought to the contractor's attention. In addition, the Transmittal number, CR release date, and web address for the CR has been changed. All other material remains the same.

Provider Types Affected

This article is for providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

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

Background

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

Key Points of CR6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 with dates of service on or after January 1, 2010 that have already been processed may be adjusted to reflect the newly established fees if brought to the attention of your Medicare contractor.**
- CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code - A4221 Supplies for Maintenance of Drug Infusion Catheter, Per Week. To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.
- CR6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items. Additionally, the descriptors for RA and RB are being revised, effective April 1, 2010, to read as follows:
  - RA- Replacement of a DME, Orthotic or Prosthetic Item
  - RB- Replacement of a Part of a DME, Orthotic or Prosthetic Item Furnished as Part of a Repair

  Suppliers should continue to use the RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. Likewise,

the RB modifier should continue to be used on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device.)

- Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is 5 years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than 5 years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than 5 years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to 3 months.
- HCPCS code Q0506 Battery, Lithium-Ion, For Use With Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than lithium ion – HCPCS codes Q0496 and Q0503 – remains at 6 months as described in CR3931, Transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA (Replacement of a DME, Orthotic or Prosthetic Item) to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

Additional Information

If you have questions, please contact your Medicare DME MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

The official instruction (CR6945) issued to your Medicare DME MAC may be found at http://www.cms.gov/transmittals/downloads/R1993CP.pdf on the CMS website.

The MLN Matters article for MM6945 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6945.pdf.

Effective Date: January 1, 2010, for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010 for the revisions to the RA & RB modifier descriptors which became effective April 1, 2010; July 1, 2010 for all other changes; Implementation Date: July 6, 2010

Guidance on Implementing Section 3109 of the Patient Protection and Affordable Care Act (ACA)

Reference: Trans. 346, CR #7021, Pub. 100-08, MLN: MM7021

Provider Types Affected

This article is for Durable Medical Equipment Prosthetics and Orthotics Suppliers (DMEPOS).

Provider Action Needed

This article is based on Change Request (CR) 7021, which revises the Medicare Program Integrity Manual (Chapter 15 (Medicare Provider/Supplier Enrollment)) to include Section 38.6.1 (Compliance Standards for Pharmacy Accreditation). This article explains the revised requirements for pharmacies as a result of Section 3109 (a) of the Patient Protection and Affordable Care Act (ACA). That section states that certain pharmacies are not required to have submitted evidence of accreditation to the Secretary of Health and Human services prior to January 1, 2011. See the Background section of this article for complete details.

Background

The Medicare Modernization Act of 2003 (MMA; Section 302) added a new paragraph 1834(a)(20) to the Social Security Act (see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet) that required the Centers for Medicare & Medicaid Services (CMS) to establish and implement quality standards for suppliers of DMEPOS. All DMEPOS suppliers that furnish such items or services identified in Section 1834(a)(20)(D) of the Social Security Act (as CMS determines appropriate) must comply with the quality standards in order to receive Medicare Part B payments and to retain Medicare billing privileges.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA); Section 154(b); (see http://thomas.loc.gov/cgi-bin/bdquery/z?d110:SN03101: on the Internet) added a new subparagraph (F) to Section 1834(a)(20) of the Social Security Act. In implementing quality standards under this paragraph, CMS required suppliers furnishing items and service on or after October 1, 2009, to have submitted evidence of accreditation by an accreditation organization designated by CMS.

The ACA, Section 3109 (a)) amends MIPPAA (subparagraph (F)(i) of Section 154(b)(1)(A)) by not requiring a pharmacy to submit to CMS such evidence of accreditation prior to January 1, 2011.

Also, with respect to items and services furnished on or after January 1, 2011, the ACA (section 3109 (a)) provides that the quality standards and accreditation requirements set forth in MIPPA (Section 1834(a)(20)(F)) will not apply to such pharmacies if the pharmacy meets each of the following:

1. The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the CMS;
2. The pharmacy has been enrolled under Section 1866(j) of the Social Security Act as a supplier of DMEPOS, and has been issued a provider number for at least 5 years;
3. No final adverse action (as defined in Section 424.579a) of title 42, Code of Federal Regulations) has been imposed in the past 5 years;
4. The pharmacy submits an attestation that the pharmacy meets the first three criteria listed above; and
5. The pharmacy agrees to submit materials as requested during the course of an audit conducted on a random sample of pharmacies selected annually.

The National Supplier Clearinghouse (NSC) will not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011. The NSC-Medicare Administrative Contractor (MAC) will determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The NSC-MAC will then send a notice of revocation by January 10, 2011, to all enrolled pharmacies who are not accredited **or who are not exempt from the accreditation requirements**. The NSC-MAC will prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for five calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total DMEPOS billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter will cite that the attestation requires the signature of the authorized or delegated official of

the entity. The authorized and delegated officials are defined in Section 15 of the Medicare Enrollment Application (CMS -855S) and as described in the internet enrollment application version of the Provider Enrollment, Chain and Ownership System (PECOS). The letters should be mailed between October 1, 2010, and October 31, 2010.

For pharmacies with more than one practice location, the letters will cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies will not be considered to have been enrolled for five calendar years. Pharmacies that have had a change of ownership in the prior five years, which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), will not qualify for an attestation accreditation exemption.

The NSC-MAC will review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter will be given an accreditation status of exempt. The NSC will make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The NSC-MAC will send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation will cite that the revocation is for a lack of required accreditation.

Between April 1, 2011, and April 30, 2011, the NSC-MAC will compile a sample listing of at least 10 percent of the pharmacies that have submitted an NSC accepted attestation exempting them from accreditation. The NSC-MAC will develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter will request submission of evidence substantiating the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence will include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods.

The NSC-MAC will determine the acceptability of the replies received in response to the audit verification random sample mailing. The NSC will use DMEPOS billing data for only products and services requiring accreditation to assist in the determination. The NSC will make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications.

By June 30, 2011, the NSC-MAC will send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation will cite that the revocation is for a lack of required accreditation.

Additional Information

The official instruction, CR 7021, issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R346PI.pdf on the CMS website.

If you have any questions, please contact your DME MAC at their toll-free number, which, may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

The MLN Matters article for MM7021 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM7021.pdf.

Effective Date: January 1, 2011; Implementation Date: January 3, 2011

EDI Services – FTP Changes

Reference: AR – KDA 071310

EDI Services currently receives electronic transactions via dial-up or FTP. Our customers have provided suggestions for the submission and receiving of transactions via FTP. Therefore, to better serve our customers EDI Services has developed the means for electronic submitters to transmit and receive electronic transactions via FTP using a third party program of your choice. EDI Services will provide support for connectivity. However, EDI Services will not provide support for any third party programs. Electronic submitters will be solely responsible for the setup and maintenance of their third party programs.

Electronic submitters are not required to use a third party program. Electronic submitters can continue to transmit and receive electronic transactions via FTP using a command line. However, by July 6, 2010, all electronic submitters who have chosen to use a command line or a script will be required to make changes. All electronic submitters, once transitioned, will have an inbound directory, outbound directory, archive directory and changes in the put and get commands. If you are using a command line and running from a script, you will need to contact your vendor so that the necessary changes can be made. Please contact your vendor as soon as possible and allow ample time for them to make the necessary changes. Failure to do so may cause interruption in your transmissions and may cause cash flow issues.

Directory Structure Changes

Inbound Directory – All upload data should be placed in the submitter number inbound folder for FTP users. Any electronic inbound transaction to EDI Services that has not been placed in the inbound directory **will not be processed.**

Outbound Directory – The outbound directory is where all EDI reports, electronic remittance advices, and claim status responses will be placed for FTP users.

Archive Directory – The archive directory is where all EDI reports, electronic remittances advices, and claim status responses will be copied to for users to retrieve when needed. Every outbound transaction from EDI Services that has been placed in your outbound directory will automatically be copied to the archive directory.

Put command – For command line users only, electronic submitters will no longer be required to enter the produp!837P or produp!837I statements. The new command will simply be put filename.ext or the mput command.

Get command – For command line users only, electronic submitters will be able to use the mget command. The mget command can be used for all extensions. The extensions are 835, rpt, txt, h99 and rej.

Timeline

May 1, 2010

Beginning May 1, 2010, EDI Services will begin accepting beta testers who wish to submit and receive electronic transactions via FTP using third party programs. If you would like to be a beta tester, contact EDI Services at (866) 582-3247 or (501) 378-2419 to make arrangements. Beta testers will need to have their third party programs installed and ready for use. Beta testers will be submitting and receiving transactions in production mode on the day of transition. EDI Services will provide support for the telecommunication setup. However, EDI Services will not provide setup and support for third party programs. Setup and maintenance of third party programs will be the sole responsibility of the electronic submitter. EDI Services will assist and monitor inbound submissions of electronic transactions during the first transmission as well as the outbound transactions to the user.

Before July 6, 2010

Before July 6, 2010, FTP users who will continue to use the command line function will need to notify EDI Services at (866) 582-3247 or (501) 378-2419 when you are ready to begin using the new FTP process. EDI Services will change your profile so you can begin using the new command line functions. The change made to your profile will become effective the next day. Script users will need to ensure that their scripts have been changed accordingly prior to contacting EDI Services. EDI Services highly recommends that you provide this document to your vendor, have your vendor contact us for the document or download the document from one of the websites listed below.

www.arkbluecross.com
www.pinnaclemedicare.com

FTP electronic submitters who have not notified EDI Services by July 6, 2010, will be contacted by our office and will be informed of the new changes. New electronic submitters who have opted to send and receive via FTP will automatically be setup with the new profile changes.

July 6, 2010

All electronic submitters will be required to start using the new FTP command line functions or use a third party FTP program of your choice. Failure to do so by July 6, 2010, may cause interruption in your transmissions and may affect your cash flow.

Enroll with EDI Services

Reference: AR – KDA 071310

Don't risk claim rejection. If Medicare Provider Enrollment has issued you a new PTAN and you have obtained a new NPI, you are required to enroll these new numbers with EDI Services. Medicare Provider Enrollment ***does not*** forward this information to EDI Services. You will need to complete EDI Services paperwork so you can send claims electronically under these new numbers.

You may print the forms from our Web sites www.pinnaclemedicare.com under EDI/download file center. Please complete the EDI Enrollment Form (two pages).

Once you have completed the above form, return it to EDI Services - 4BC/S, PO BOX 2181, LITTLE ROCK, AR 72203; FedEX or UPS: 601 S. Gaines St., Little Rock, AR 72201; Fax (501) 378-2265; or e-mail edi@arkbluecross.com.

Arkansas providers who have AHIN workstations will need to notify AHIN of any changes as well. AHIN personnel will need to update the provider's access information with the new PTAN and NPI combination. AHIN service line is (501) 378-2336; Fax (501) 378-2484.

If you have questions please do not hesitate to call EDI Customer Service at (866) 582-3247 or (501) 378-2419.

Electronic Remittance Advices (ERA)

Reference: AR – KDA 071310

Effective immediately, all **new EDI Submitters** will be set up with Electronic Remittance Advices (ERA) automatically. Due to system limitations, we can only set up one submitter number to receive an ERA. Once a provider has been receiving ERA for Medicare Part B for 45 days, CMS will no longer issue standard paper remittance advices. **If a provider is using a clearinghouse for claims, PBSI by default will return the ERA to that clearinghouse's mailbox.** Should the provider wish to pick up their own ERA they will need to contact EDI Services at edi_enrollment@arkbluecross.com and we will issue a submitter number to that provider. Now, with Medicare Remit Easy Print (MREP) for Medicare Part B, everyone can download their ERA, print, and save them. The provider can download a copy of MREP at http://www.pinnaclemedicare.com/provider/partb/edi/software/default.aspx. If you have any questions regarding the ERA mandate, please email edi_enrollment@arkbluecross.com.

Electronic Prescribing (eRx) Incentive Program 2010 Updates

Reference: SE1021

Provider Types Affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician e-Prescribing (eRx) Incentive Program.

Provider Action Needed

CMS is issuing this Special Edition article to alert providers that it is not too late to start participating in the eRx Incentive Program to potentially qualify to receive a full-year incentive payment. Eligible professionals may begin reporting eRx at any time throughout the 2010 program year of January 1, 2010, through December 31, 2010, to be incentive eligible.

This article also provides updated information about changes to the eRx Incentive Program for 2010 as authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The eRx is a separate incentive program from the Physician Quality Reporting Initiative (PQRI), with different reporting requirements.

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

Be aware that beginning in 2012, eligible professionals who are not successful electronic prescribers will be subject to a PFS payment adjustment, or penalty.

Background

The Medicare eRx began January 1, 2009, and is authorized under the MIPPA. The program provides incentives for eligible professionals who are successful electronic prescribers. A web page dedicated to providing all the latest news on the *eRx Incentive Program* is available at http://www.cms.gov/ERXincentive/ on the CMS website.

For 2010, changes have been made, regarding the eRx measure (numerator) and its reporting requirements, reporting options, reporting mechanisms, and changes to the denominator codes. These are described in detail below.

eRx Incentive Program Eligibility Criteria for 2010

Reporting Requirements

- To be considered a successful eRx prescriber and be eligible to receive an incentive payment, you must generate and report one or more electronic prescriptions associated with an eligible patient visit - a minimum of 25 unique visits per year (see denominator codes below). Each visit must be accompanied by the eRx G-code (numerator code) attesting that during the patient visit at least one prescription was electronically prescribed. (See Report Mechanism Section below)
- Electronically generated refills do not count and faxes do not qualify as eRx. New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum 25 unique Rx events.
- The eligible professional's Medicare Part B PFS allowed charges for services in the eRx measure's denominator should be comprised of 10% or more of the eligible professional's total 2010 estimated allowed charges. (See denominator codes below.)

Qualified Reporting System Requirements

- Eligible professionals must have adopted a "qualified" eRx system.
- There are two types of systems: A system for eRx only (stand-alone) or an electronic health record (EHR) system with eRx functionality.
- Regardless of the type of system used, to be considered "qualified" it must be based on ALL of the following capabilities:
  - Ø Generates a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers if available;

- Ø Selects medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts;
- Ø Provides information related to lower cost, therapeutically appropriate alternatives (if any). The availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2010; and
- Ø Provides information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

Note: For the capabilities listed above, the system must employ the eRx standards adopted by the Secretary of the Department of Health and Human Services for Medicare Part D by virtue of the 2003 Medicare Modernization Act (MMA).

Reporting Mechanisms for 2010

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

- **Claims-based reporting of the eRx measure**. Claims-based reporting involves the addition of a quality-data code (QDC) to claims submitted for services (occurring during the reporting period) when billing Medicare Part B. For 2010, only report one G-code (G8553 - At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.);
- **Registry-based reporting using a CMS-PQRI qualified registry**. EPs have the option of using a qualified registry to assist in collecting eRx measure data and submitting 2010 data to CMS during the first quarter of 2011. The registry will submit this quality data directly to Medicare, eliminating the need for adding the QDC to the Medicare Part B claim; and
- **EHR-based reporting**, using a CMS-PQRI qualified EHR product, submitting 2010 data to CMS during the first quarter of 2011.

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

The option of reporting via the Group Practice Reporting Option (GPRO) is no longer available for the 2010 program year. The group practices have already been selected for 2010.

Note: Only registries and EHR vendors who have been selected by CMS for the 2010 PQRI/eRx and are on the posted list of registries/EHR vendors are eligible to be considered "qualified" for purposes of the 2010 eRx Incentive Program you may go to http://www.cms.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage (Downloads) on the CMS website.

eRx Measure Denominator Codes (Eligible Cases) for 2010

Patient visit during the reporting period (Current Procedural Terminology [CPT] or Healthcare Common Procedure Coding System [HCPCS] G-codes):

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

Summary

If you are routinely using a qualified system (as described above) and expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx Measure Denominator Codes above) to make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may be eligible for an incentive payment equal to two percent of your Medicare Part B PFS allowed charges for services furnished during the reporting period and you should report the eRx measure.

If you are routinely using a qualified system (as described above) but do not expect your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted eRx Measure Denominator Codes above) to make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may not be eligible for the incentive payment. However, CMS encourages you to report the measure. In the event that your Medicare Part

B PFS charges for the codes in the denominator of the measure do make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may be eligible for the incentive payment.

Note: For the years 2012, 2013, and 2014, if an eligible professional is not a successful electronic prescriber for the reporting period for the year, the PFS amount for covered professional services furnished by such professionals during the year will be less than the PFS amount that would otherwise apply over the next several years by: (1) 1.0 percent for 2012; (2) 1.5 percent for 2013; and (3) 2.0 percent for 2014.

The reporting period and criteria CMS will use in 2012 to determine whether an eligible professional (or group practice) is subject to this penalty (including the circumstances under which an eligible professional or group practice could seek a hardship exemption) are addressed in the Medicare PFS proposed rule for 2011.

Additional Information

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

There are two fact sheets that detail the eRx Program for 2010. The *2010 eRx Incentive Program Made Simple Fact Sheet* may be found at http://www.cms.gov/ERxIncentive/Downloads/2010eRxMadeSimpleFS032310f.pdf, and the *2010 eRx Incentive Program Fact Sheet: What's New for 2010 eRx Incentive Program* may be found at http://www.cms.gov/ERxIncentive/Downloads/WhatsNew2010eRxFS032310f.pdf on the CMS website.

Previously issued MLN Matters Articles that outline the specifics of the program are:

- SE0922 - *Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (E-Prescribing) Feedback Reports* at http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf;
- M6394 - *Program Overview: 2009 Physician Quality Reporting Initiative (PQRI) And The 2009 Electronic Prescribing (E-Prescribing) Incentive Program* at http://www.cms.gov/MLNMattersArticles/downloads/MM6394.pdf ; and
- MM6514 - *Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs* at http://www.cms.gov/MLNMattersArticles/downloads/MM6514.pdf on the CMS website.

Eligible professionals may refer to the specification for the reporting method applicable to your practice at:

- Claims- and registry-based at http://www.cms.gov/ERxIncentive/Downloads/2010_eRx_MeasureSpecificationsandReleaseNotes_121709.zip
- EHR-based at http://www.cms.gov/ERxIncentive/Downloads/2010EHRMeasureSpecificationforeRxandReleaseNotes.zip; and
- *Claims-Based Reporting Principles for Electronic Prescribing (eRx) Incentive Program* at http://www.cms.gov/ERxIncentive/Downloads/Claims-BasedReportingPrinciplesforeRx122209.pdf on the CMS website.

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 on the CMS website.

The MLN Matters article for SE1021 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1021.pdf.

Statement on the One Year Anniversary of Obama "Year of Community Living" Initiative

Reference: CMS List-Serv Message 062310

Eleventh Anniversary of Olmstead Supreme Court Ruling Also Observed

In honor of today's one year anniversary of the Obama Administration's "Year of Community Living," Health and Human Services Secretary Kathleen Sebelius announced new funds for states to build innovative systems to link persons with disabilities to affordable housing in their home communities.

This new $3.2 million, three-year contract is designed to create unprecedented collaboration between human services agencies and housing authorities at all levels of government to help persons living in institutions find homes and live more independently. The effort, the Housing Capacity Building Initiative for Community Living, will be led by New Additions Consulting Inc.

Today's announcement will also aide the implementation of the U.S. Supreme Court's decision in Olmstead v. L.C., which was handed down 11 years ago today. In that decision, the court ruled that, under the Americans with Disabilities Act, unnecessarily institutionalizing a person with a disability who, with proper support, can live in the community is discrimination. In its ruling, the Court said that institutionalization severely limits the person's ability to interact with family and friends, to work and to make a life for him or herself.

"The Department is continuing to build on the important efforts launched by the President's Year of Community Living initiative," said Secretary Sebelius "Our efforts are being strengthened with the support and efforts of our colleagues in the Department of Housing and Urban Development and at the Department of Justice."

Secretary Sebelius is promoting partnerships within HHS and with other departments, including the Department of Housing and Urban Development to create a productive collaboration in ensuring that people with disabilities, seniors and individuals with chronic conditions have new opportunities to live as valued members of their communities.

Also today, the Centers for Medicare & Medicaid Services is issuing a letter to state Medicaid directors describing the extension of the Money Follows the Person Demonstration as a result of the Affordable Care Act. This program has been a very successful partnership with states and has resulted in many individuals moving from institutional to community-based settings.

"The implementation of the Affordable Care Act helps advance the civil rights of individuals with disabilities and community living arrangements, building on the important cornerstone in the Olmstead decision," said Henry Claypool, director of the Office on Disability. "Today's announcement is yet another step in HHS' 11-year effort to achieve that goal."

To read more on HHS accomplishments during the Year of Community Living, please visit http://www.hhs.gov/od/topics/community/keyadvances.html. More information about the Money Follows the Person program can be found at http://www.cms.hhs.gov/CommunityServices/20_MFP.asp

`Now Available from CMS - The Audio Transcript of the June 15 ICD-10 Implementation in a 5010 Environment Teleconference

Reference: CMS List-Serv Message 062410

The audio transcript of the June 15, 2010 national provider conference call, "ICD-10 Implementation in a 5010 Environment", hosted by the Centers for Medicare & Medicaid Services (CMS) is now available. To access the transcript, go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp on the CMS website. In the Downloads section select the **June 15, 2010 ICD-10 Conference Call** Zip file. The audio transcript is 1 hour and 51 minutes in length. The written transcript will be available soon.

Something New From the Medicare Learning Network (MLN) for Billing and Coding Professionals

Reference: CMS List-Serv Message 062510

It is important to the Centers for Medicare & Medicaid Services (CMS) that the billing and coding professionals who work with Fee-For-Service (FFS) Providers have the timely and accurate information they need to properly bill the Medicare Program. That is why we developed the ***Medicare Learning Network® Suite of Products and Resources for Billing and Coding Professionals*** – to help billers, coders and other reimbursement specialists submit claims correctly the first time.

Like all MLN products, the Suite has nationally consistent, up-to-date Medicare information prepared by subject-specific experts —and it is available at no cost! The Suite addresses – The Business of Medicare, Medicare Benefits and Services, Special Medicare Initiatives, and General Medicare Program Information and Resources, and offers an uncomplicated way to understand more about the Medicare Program.

It would be great if you could forward the below sample e-mail to your members and any staff who may have the responsibility for developing and submitting claims, e.g., billers, coders, reimbursement specialists and office practice managers. The below sample e-mail contains a hyperlink to a flyer detailing the ***Medicare Learning Network® Suite of Products and Resources for Billing and Coding Professionals.***

Sample E-mail

(Please copy and paste this message into the body of e-mail, then forward to your members.)

E-MAIL SUBJECT LINE

Something New From the Medicare Learning Network (MLN) for Billing and Coding Professionals

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There is information. And then there is information from the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network® (MLN).

As a Billing and Coding Professional, you need Medicare information at your fingertips. That is why CMS experts developed a solution just for you — the **"Medicare Learning Network® Suite of Products and Resources for Billing and Coding Professionals."** The Suite contains easy-to-understand, accessible and ***free*** Medicare Program information developed especially for Medicare FFS Providers.

Please start here http://www.cms.gov/MLNProducts/downloads/Billers_and_Coders_flyer.pdf to access current information you need to submit claims correctly the first time.

Equip yourself today with critical reimbursement solutions from the official source for Medicare Fee-For-Service information. For more details, please visit the Medicare Learning Network @ http://www.cms.gov/MLNGenInfo/

Sincerely,

CMS to Expand Medicare Preventive Services and Improve Access to Primary Care in 2011

Reference: CMS List-Serv Message 062810

Proposals Would Implement Affordable Care Act Benefits

The Centers for Medicare & Medicaid Services (CMS) today issued a proposed rule that would implement key provisions in the Affordable Care Act of 2010 that expand preventive services for Medicare beneficiaries, improve payments for primary care services, and promote access to health care services in rural areas. The proposed policies would apply to payments under the Medicare Physician Fee Schedule for services furnished on or after January 1, 2011.

The proposed rule would implement provisions in the Affordable Care Act that will eliminate out-of-pocket costs for beneficiaries for most preventive services, including the new annual wellness visit. This visit augments the benefits of the Initial Preventive Physical Examination (IPPE or "Welcome to Medicare Visit") with an annual wellness visit that allows the physician and patient to develop a personalized prevention plan that includes not only the preventive services generally available to the Medicare population, but additional services that may be appropriate because of the patient's individual risk factors.

The proposed rule would improve access to primary care services by implementing an incentive payment for primary care services furnished by primary care practitioners that can include physicians, nurse practitioners, clinical nurse specialists and physician assistants. The proposed rule would also implement a payment incentive program for general surgeons performing major surgery in areas designated by the Secretary as Health Professional Shortage Areas (HPSAs), would allow physician assistants to order post-hospital extended care services in skilled nursing facilities, and would pay certified nurse midwives for their services under the Medicare Physician Fee Schedule (MPFS) at the same rates as physicians.

To read the entire CMS Press Release issued today (6/25) click here: http://www.cms.gov/apps/media/press_releases.asp

CMS Issued Fact Sheets (6/25) with additional details at: http://www.cms.gov/apps/media/fact_sheets.asp

The proposed rule is available at: http://www.federalregister.gov/OFRUpload/OFRData/2010-15900_PI.pdf or http://www.federalregister.gov/inspection.aspx#special

CMS will accept comments on the proposed rule until August 24, 2010, and will respond to them in a final rule to be issued on or about November 1, 2010. Except as otherwise specified, the payment policies and rates adopted in the final rule will be effective for services on or after January 1, 2011.

Advanced Beneficiary Notice of Noncoverage (ABN) Booklet

Reference: CMS List-Serv Message 062510

The **Advanced Beneficiary Notice of Noncoverage (ABN) booklet**, which provides information on when provider should use an ABN, ABN policies, how to properly complete an ABN and ABN modifiers, is now available for download on the Medicare Learning Network®. To view the document, please visit http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf on the internet. Hardcopies will be available at a later date.

Healthcare Common Procedure Coding System (HCPCS) Quarterly Update - Other Codes

Reference: CMS List-Serv Message 063010

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS web page at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp. Changes are effective on the date indicated on the update.

CMS Proposes 2011 Medicare Policy, Payment Changes for Services in Hospital Outpatient Departments and Ambulatory Surgical Centers

Reference: CMS List-Serv Message 070210

Medicare beneficiaries would see a decline in their out-of-pocket costs for services they receive in hospital outpatient departments (HOPDs) in calendar year (CY) 2011 under provisions in a proposed rule issued today by the Centers for Medicare & Medicaid Services (CMS). The proposed rule implements changes required by the Affordable Care Act of 2010.

The Affordable Care Act – which was enacted as the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 – waives beneficiary cost-sharing for most Medicare-covered preventive services, including the Initial Preventive Physical Examination (IPPE or "Welcome to Medicare Visit"). This waiver applies not only to the 20 percent coinsurance for the physician's service, but also to any cost-sharing relating to the separate payment to the facility when the service is furnished in an HOPD, as well as those preventive services, such as colonoscopies, that may be furnished in a ambulatory surgical centers (ASC).

For more information on the CY 2011 proposals for the OPPS and ASC payment system, please see www.federalregister.gov/inspection.aspx#special.

Additional information can be found on the CMS website at:

- OPPS: www.cms.gov/HospitalOutpatientPPS/
- ASC payment system: www.cms.gov/ASCPayment/

The News Release and Fact Sheet will be available on www.cms.gov on Tuesday, July 6.

Customer Service Training Program Call Center Closing Times

To better serve the provider community, the Centers for Medicare and Medicaid Services (CMS) is allowing Provider Contact Centers across the nation to conduct customer service training during normal business hours. The Medicare Program is very complex with continuous changes and this initiative will help prepare Provider Customer Service Representatives (CSR's) to give quality answers to substantive Medicare related questions or inquiries.

Pinnacle Business Solutions, Inc. the Medicare Part B Carrier for Arkansas and Louisiana will be participating in this program. We have developed a comprehensive training plan that includes closing our Provider Contact Center for up to eight hours each month. Using Provider Contact Center call distribution data to determine the least possible impact for our customers, we have selected the following closure dates and times for August 2010:

- August 6, 2010 (8:30 a.m. – 10:30 a.m. CST)
- August 13, 2010 (8:30 a.m. – 10:30 a.m. CST)
- August 20, 2010 (9:15 a.m. – 11:15 a.m. CST)
- August 27, 2010 (8:30 a.m. – 10:30 a.m. CST)

Talking About Version 5010 and ICD-10 – Vendors and Providers, Get the Conversation Started

Reference: CMS List-Serv Message 070210

Providers: The first recommended deadline for a successful transition to Version 5010 is only five months away. By December 31, providers should complete their internal testing, and be ready to test with external partners beginning in January 2011.

Now is a great time for providers to check in with your vendors about their transition preparations. Not only is it important for you to make sure that you can count on them during the transition, but they are a great resource to provide you with details about what you need to do to comply with Version 5010 standards and ICD-10.

Vendors: You play a vital role in the Version 5010 and ICD-10 transition. Your customers will be looking to you for guidance to navigate them through the changes. Your products and services will be obsolete if steps are not taken NOW to get ready. Start talking with your customers about preparing for the Version 5010 and ICD-10 transitions.

CMS is here to help you both talk to each other– even help you get the conversation started if you haven't already. Go to our Web site, www.cms.gov/ICD10, for Provider and Vendor Resource pages that includes fact sheets with tips on asking each other the right questions.

Keep Up to Date on Version 5010 and ICD-10

Please visit www.cms.gov/icd10 for the latest news and coming soon: sign up for Version 5010 and ICD-10 e-mail updates!

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

HHS Issues Notice of Proposed Rulemaking to Implement HITECH Act Modifications to the HIPAA Rules

Reference: CMS List-Serv Message 071210

The Department of Health and Human Services (HHS) issued a notice of proposed rulemaking today to modify the Privacy, Security, and Enforcement Rules issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, is designed to promote the widespread adoption and standardization of health information technology, and requires HHS to modify the HIPAA Privacy, Security, and Enforcement Rules to strengthen the privacy and security protections for health information and to improve the workability and effectiveness of the HIPAA Rules.

The proposed modifications to the HIPAA Rules issued today include provisions extending the applicability of certain of the Privacy and Security Rules' requirements to the business associates of covered entities, establishing new limitations on the use and disclosure of protected health information for marketing and fundraising purposes, prohibiting the sale of protected health information, and expanding individuals' rights to access their information and to obtain restrictions on certain disclosures of protected health information to health plans. In addition, the proposed rule adopts provisions designed to strengthen and expand HIPAA's enforcement provisions.

"This proposed rule strengthens the privacy and security of health information, and is an integral piece of the Administration's efforts to broaden the use of health information technology in healthcare today," said Georgina Verdugo, director of the HHS Office for Civil Rights (OCR). These HIPAA Rules are administered and enforced by OCR.

Once it is published in the Federal Register, the notice of proposed rulemaking may be viewed and commented on for 60 days at www.regulations.gov.

In addition to issuing the notice of proposed rulemaking, OCR also updated its breach notification webpage. Breaches of unsecured protected health information affecting 500 or more individuals that are reported to the Secretary are now posted in a new, more accessible format that allows users to search and sort the reported breaches. Additionally, this new format includes brief summaries of the breach cases that OCR has investigated and closed, as well as the names of private practice providers who have reported breaches of unsecured protected health information to the Secretary.

Visit the OCR website for more information about this proposed rule and the updated breach notification webpage: www.hhs.gov/ocr/privacy/.

ICD-9-CM C&M Committee to Meet September 15 on PPACA Requirements for ICD-10 Crosswalk Revisions

Reference: CMS List-Serv Message 071210

The ICD-9-CM Coordination and Maintenance (C&M) Committee will convene on Wednesday and Thursday, September 15-16, 2010. The C&M meeting is a public forum for the presentation of proposed modifications to the International Classification of Diseases, Ninth-Revision, Clinical Modification.

Section 10109(c) of the Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 (PPACA) requires that the C&M Committee convene a meeting before January 1, 2011, to receive stakeholder input regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD-9 and ICD-10, respectively), posted to the CMS website at http://www.cms.gov/ICD10 for the purpose of making appropriate revisions to said crosswalk. Section 10109(c) further requires that any revised crosswalk be treated as a code set for which a standard has been adopted by the Secretary, and that revisions to this crosswalk be posted to the CMS website.

The C&M Committee will use the first half of the first day of the September C&M Committee meeting, 9:00 a.m. to 12:30 p.m., Wednesday, September 15, 2010, to fulfill the above-referenced PPACA requirements for this meeting to be held prior to January 1, 2011, and receive public input regarding the above-referenced crosswalk revisions. Interested parties and other stakeholders should be prepared to submit their written comments and other relevant documentation at the meeting, or no later than November 12, 2010.

For the complete Federal Register notice, please go to http://edocket.access.gpo.gov/2010/pdf/2010-16610.pdf.

Electronic Health Record (EHR) Incentive Program "Meaningful Use" Final Rule (CMS-0033-F)

Reference: CMS List-Serv Message 071310

Today, CMS and ONC jointly announce their final rules for both electronic health record standards for certification and the Medicare and Medicaid EHR incentive programs, including the definition of meaningful use.

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives. One of the two regulations announced today defines the "meaningful use" objectives that providers must meet to qualify for the bonus payments, and the other regulation identifies the technical capabilities required for certified EHR technology.

Announcement of today's regulations marks the completion of multiple steps laying the groundwork for the incentive payments program. With "meaningful use" definitions in place, EHR system vendors can ensure that their systems deliver the required capabilities, providers can be assured that the system they acquire will support achievement of "meaningful use" objectives, and a concentrated five-year national initiative to adopt and use electronic records in health care can begin.

To read the Press Release issued today **(7/13)** click here: http://www.cms.gov/apps/media/press_releases.asp or http://www.hhs.gov/news/press/2010pres/2010.html

Also CMS Issued Fact Sheets **(7/13)** with additional details at: http://www.cms.gov/apps/media/fact_sheets.asp

To learn more about the Medicare and Medicaid EHR incentive programs, visit the CMS-dedicated website to this program, http://www.cms.gov/EHRIncentivePrograms/. Here you'll find information about eligibility, requirements, upcoming events and more. To learn more about electronic health records and certification standards, visit the HHS/ONC-website at http://healthit.hhs.gov/portal/server.pt. This website is the premier place to learn about the benefits of using EHR technology in a meaningful way, local resources to assist in EHR adoption and more.

And, be sure to attend our upcoming joint CMS & ONC training on the EHR incentive programs and certification on July 22 at 2:00 pm EST. More information can be found on the CMS website: http://www.cms.gov/EHRIncentivePrograms/.

Links to Rules via Federal Register:

- http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf
- http://www.ofr.gov/OFRUpload/OFRData/2010-17210_PI.pdf

Now Available from CMS - The Written Transcript of the June 15 ICD-10 Implementation in a 5010 Environment Teleconference

Reference: CMS List-Serv Message 071410

The written transcript of the Centers for Medicare & Medicaid Services' (CMS) June 15, 2010 national provider conference call, "ICD-10 Implementation in a 5010 Environment", is now available. To access the transcript, go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp on the CMS website. In the Downloads section select the "June 15, 2010 ICD-10 Conference Call" Zip file. This Zip file contains the written and audio transcripts, as well as the slide presentation used during the teleconference. **Note:** The length of the audio transcript is 1 hour and 51 minutes.

Mailing To All Individual Practitioners, Medical Groups and Clinics and Independent Diagnostic Testing Facilities (IDTF) Who Are Billing or Have Billed For the Technical Component of Advanced Diagnostic Imaging Services

Reference: Trans. 727, CR #6912, Pub. 100-20, MLN: MM6912

Note: This article was revised on July 12, 2010, to change the implementation date (above). In addition, the CR release date, transmittal number, and the Web address for accessing CR 6912 were revised. All other information remains the same.

Provider Types Affected

Enrolled physicians, non-physician practitioners, including single and multi-specialty clinics, and IDTFs who have billed the Medicare program for the technical component of advanced diagnostic testing services within the preceding six month period and who continue to have Medicare billing privileges with Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MACs)) are affected.

Impact to You

If you have billed the Medicare program for the technical component of advanced diagnostic testing services within the preceding six month period and continue to have Medicare billing privileges with Medicare contractors, you will receive a letter from your Medicare contractor advising you of the need to become accredited by January 1, 2012, in order to continue to provide these services and bill Medicare.

What You Need to Know

You must be accredited by one of the three Centers for Medicare & Medicaid Services (CMS) approved national accreditation organizations by January 1, 2012, in order to be eligible to continue to furnish the technical component of advanced diagnostic testing services to Medicare beneficiaries and submit claims for those services to your Medicare contractor.

What You Need to Do

Look for the instructional letter from your Medicare contractor. Your contractor will be mailing the letter quarterly beginning with July 2010 through July 2011. If necessary, follow the instructions in the letter to become accredited by January 1, 2012, in order to continue billing for the technical component of advance diagnostic imaging services. Make sure that your office staffs are aware of these new accreditation requirements and begin the accreditation process as soon as possible to protect your Medicare billing rights for these services.

Background

Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary, Health and Human Services, to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services.

Definition of advanced diagnostic imaging procedures

MIPPA specifically defines advanced diagnostic imaging procedures as including:

- Diagnostic magnetic resonance imaging (MRI),
- Computed tomography (CT), and
- Nuclear medicine imaging, such as positron emission tomography (PET).

The law also authorized the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

CR 6912 directs Medicare contractors to inform enrolled physicians, non-physician practitioners and independent diagnostic testing facilities (IDTFs) by letter about the need to become accredited in order to continue to furnish the technical component of advanced diagnostic imaging services to Medicare beneficiaries on or after January 1, 2012. Medicare contractors will send the letter once each quarter for 5 times beginning with July 2010 through July 2011.

When more than one physician or non-physician practitioner is operating within a group, such as a single specialty or multispecialty clinic, only the group will receive the letter, not each of the individual physicians or non-physician practitioners working for the group.

The letter will advise you that Medicare records indicate that you have furnished the technical component of advanced diagnostic imaging procedures such as diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET) within the last six months. If you are not accredited by one of the organizations shown below by January 1, 2012, you will not be eligible to bill the Medicare program for advanced diagnostic imaging services. Please note that the accreditation will apply only to the suppliers of the technical component (TC) of advanced diagnostic imaging services and not to the professional component.

CMS urges you take the necessary action to become accredited by the January 1, 2012, deadline. Since CMS expects that it may take as much as nine months from the time you initiate the accreditation process to completion, you should begin the accreditation process for advanced diagnostic imaging services as soon as possible, but not later than March 2011.

Exclusions

MIPPA expressly excludes from the accreditation requirement x-ray, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography, which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

CMS Approved National Accreditation Organizations

CMS approved three national accreditation organizations -- the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission -- to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. **The accreditation will apply only to the suppliers of the images themselves, and not to the physician interpreting the image**. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff.

To obtain additional information about the accreditation process, please contact the accreditation organizations shown below.

American College of Radiology (ACR)
1891 Preston White Drive
Reston, VA 20191-4326
1-800-770-0145
http://www.acr.org

Intersocietal Accreditation Commission (IAC)
6021 University Boulevard, Suite 500
Ellicott City, MD 21043
1-800-838-2110
http://www.intersocietal.org

The Joint Commission (TJC)
Ambulatory Care Accreditation Program
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
1-630-792-5286
www.jointcommission.org/AdvImaging2012

Additional Information

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

The official instruction, CR 6912, issued to your Medicare carrier and/or A/B MAC regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R727OTN.pdf on the CMS website.

The MLN Matters article for MM6912 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6912.pdf.

Effective Date: August 2, 2010; Implementation Date: August 13, 2010

Interactive Voice Response (IVR)

Medicare Interactive Voice Response System – Part B

Pinnacle Business Solutions, Inc. (PBSI) is excited to announce the addition of a new touch-tone option to our Interactive Voice Response (IVR) system for Part B providers. Now you will have a choice on how you interact with and obtain information from the IVR, you may use speech recognition or touch-tone!

The new option is now available. You will continue to dial the toll free number applicable to your specific state and the pleasant voice of the IVR will instruct you in choosing your preferred interaction option. We hope you find this new option beneficial and enjoy the user-friendly interaction. The following is our updated instructions guide that includes the new touch-tone option.

PBSI PART B IVR INSTRUCTIONS

PBSI, Inc has developed an Interactive Voice Response or Voice Recognition (IVR) system to assist actively enrolled providers in obtaining a variety of information through a self-service telephone interface. Our IVR allows you to obtain data through speech interaction or touch-tone keypad input. Information available to providers through our IVR is claims status, eligibility records, and reimbursement checks information. The IVR is available in English and/or Spanish.

When you call into our IVR, you are greeted by a pleasant automated voice, which will ask you for your preferred interaction option, touch-tone keypad option or speech option. **Please keep in mind that once you have selected an input option the IVR will prompt you for your information throughout the entire call in your chosen method of interaction**. Once you have selected an interaction option, the IVR will instruct you on what information to either key via touch-tone or speak to obtain data from our IVR. If you choose, touch-tone the IVR will step you through detailed instructions on entering alpha/numeric characters. The below information will provide you with an overview of the IVR options and supply you with additional facts that will help you to expedite your call.

To reach the Interactive Voice Recognition (IVR) System

- **Arkansas Part B providers should call toll free 877-908-8434**
- **Louisiana Part B providers should call toll free 877-567-7204**

You will begin by dialing your specific number associated with your state. The IVR will answer and you will hear a female voice speaking **"Hi thanks for calling your Medicare Part B Service System".** You will then be given the option to obtain data in Spanish. The system automatically defaults to English if you do not choose the Spanish option. Once you have selected your preferred language you will be offered the option of using touch-tone input or speech input. After you have selected your preferred interaction option, the system will ask you to hold while it accesses Medicare's computers. You will hear a short moment of music and then you will be prompted to touch-tone or speak your National Provider Identifier (NPI*).* Once your NPI has been validated, you will be asked to touch-tone or speak your Provider Transaction Access Number (PTAN) and Tax Identification Number (TIN). The NPI, PTAN, and TIN are used as authentication elements.

To use the IVR system, you must have a valid NPI, PTAN, and TIN. Always use your Group NPI if you are associated with a group practice. To enter the number, you simply touch-tone or speak the number naturally.

Once your NPI, PTAN, and TIN have been validated, you will be given the following options to choose from the **Main Menu** (by using touch-tone or speech): ***Claims Status, Eligibility Information, Reimbursement Checks Status and Other Options.*** When selecting **Eligibility** or **Claims** you will be ask for your patient's Medicare number, please have that information available.

CLAIMS OPTION

- You may **touch-tone #1** or say **Claim** for the status of a claim or claims.
- You will then be asked to touch-tone enter or speak the Medicare number and date of service in question.
- Once your information has been accepted. The IVR will speak back the total amount submitted, deductible applied, payment amount, check number, and allowed amount.

- At this point you can request more detail on the claim by speaking **More Detail or using touch-tone #1**. This feature will give you the date of service, medical procedure code, modifier, billed amount and approved amount or denial message.
- After this you may say **Repeat or touch-tone #8** to repeat the claim information,
- Or you can say **Another Claim or touch-tone #2** to receive data on another claim on same patient, a claim on a different patient, or to switch provider numbers to search for claims under another provider number.
- Or say **Main Menu or touch-tone *** to return to the main menu
- Or speak **I'm Done, touch-tone #9, or simply hang up** if you are finished.

This information can be accessed from 6:00 a.m. to 6:00 p.m. Monday through Friday.

ELIGIBILITY OPTION

You may **touch-tone #2** or say **Eligibility** to receive information on Part A and Part B entitlement, deductible information, and Medicare primary/secondary data, Health Maintenance Organizations on file, Home Health and Hospice information. *When calling about eligibility you must be able to validate the following information about the Beneficiary:*

- *Beneficiary's first and last name*
- *Beneficiary's Health Insurance Claim (HIC) number*
- *Beneficiary's gender and Date of Birth*

This information can be accessed via the IVR 6:00 a.m. to 6:00 p.m. Monday through Friday.

CHECKS OPTION

- You may **touch-tone #3** or say **Checks** to get information on checks or a specific check. You may search by specific check number, a date or range of dates, or status.
- You may **touch-tone #1** or say **Number** to receive information on a specific check number. You must have the check number for this search.
- You may **touch-tone #2** or say **Date** to get information on a specific date or range of dates. You do not need the check number.
- You may **touch-tone #3** or say **Status** to do a search by ***cleared status, outstanding status, stopped status or voided status.***

This information can be accessed via the IVR 6:00 a.m. to 6:00 p.m. Monday through Friday.

OTHER OPTION

You may **touch-tone #4** or say **Other Options** to receive information on Remittance Notice Copies, Customer Service Numbers, Appeals Rights and Seminars.

This information is available 24 hours.

- You may **touch-tone #1** or say **Remittance Notice** to learn how to obtain copies of your notice.
- You may **touch-tone #0** or say **Customer Service Number** to receive information on how to speak with a customer service representative.
- You may **touch-tone #2** or say **Appeals** to learn about the Medicare appeals process.
- You may **touch-tone #3** or say **Seminars** to learn more about Medicare seminars or workshops in your area.

Once you have obtained your information, you may **touch-tone *** or say **Main Menu**, to bring you back to the Main Menu. ***You must have entered a valid NPI, PTAN, and TIN to receive this information.***

Helpful Hints

- You will need to have your provider information and patient information ready when calling the IVR number.
- You cannot reach customer service through the IVR. You can get Customer Service Phone numbers through the Main Menu other options selection.

- Railroad Medicare Numbers have a prefix that begins with a letter. You will need to call Railroad Medicare at 877-288-7600.
- Give the complete Medicare number, using the 9 numeric digits including the suffix.
- When speaking an alpha character do not emphasis by speaking a descriptive word behind the character. (For Example "B" as in Boat or "A" as in Apple). This will confuse the IVR.
- Speak naturally when giving information.
- The IVR is sensitive to background noises and may interpret it as your response. The following situations will cause problems with your call: speaking to others in the office, laughing, coughing, sneezing and loud noises in the background.
- Please listen to the system prompts very carefully. These prompts will let the caller know what the system is expecting to hear from the caller. Once you are familiar with the prompts you can barge ahead.
- When using the touch-tone input method it is not necessary to hit your key pad in a hard manner.

Our staff is happy to offer you the new touch-tone option. We are continuously working to bring you improved and enhanced services through the Interactive Voice Response (IVR) System. We welcome your input and/or suggestions.

Revision to Medicare Documentation Requirements for CPT Codes 90960-90961, MCP for ESRD Visits

Reference: AR – HDM 062310

Recently, Pinnacle Business Solutions, Inc. (PBSI), published documentation requirements for Monthly Capitation Payments (MCP) for CPT 90960-90961. Documentation necessary to pay these services included submission of the care plan. Claims for many of the same beneficiaries are being randomly suspended repeatedly for different months of service. To reduce the burden of submission of documentation on providers, claims will no longer be denied for lack of submission of the care plans. PBSI has determined that when care plans have been submitted, they are sufficient for payment if all other requirements are met. **It is not necessary to continue submitting care plans in response to the Additional Documentation Request (ADR) letters.**

Please send the following documentation when requested for payment of these codes:

- The appropriate number of visits billed with indication that they are face to face visits.
- Legible signatures on visit notes.
- Billing provider performed the monthly comprehensive visit.

It is also not necessary to send the hemodialysis facility treatment notes or lab. Only the required number of face to face visits is necessary to support the MCP code billed.

July Update to the 2010 Medicare Physician Fee Schedule Database (MPFSDB)

Reference: Trans. 1992, CR #6974, Pub. 100-04, MLN: MM6974

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 6974, which amends payment files that were issued to Medicare contractors based on the 2010 Medicare Physician Fee Schedule (MPFS) Final Rule. Be sure your billing staff is aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2010 Medicare Physician Fee Schedule (MPFS) Final Rule. Change Request (CR) 6974 amends those payment files. CR 6974 provides corrections, effective for dates of service on or after January 1, 2010, to those files. These changes include the following:

CPT/HCPCS Code	ACTION
36148	Multiple Procedure Indicator = 0
74261	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
74261 - TC	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
74262	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
74262 - TC	Multiple Procedure Indicator = 4 Diagnostic Family Imaging Indicator = 02
97026	Procedure Status = R

Pharmacogenomic Testing for Warfarin Response

Healthcare Common Procedure Coding System (HCPCS) code G9143 was implemented with the 2010 HCPCS file with an effective date of August 3, 2009. Currently, Medicare contractors have a 2010 MPFSDB record but not a 2009 MPFSDB record. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after August 3, 2009.

CPT Code 90470

CPT code 90470 became effective on September 28, 2009. However, due to an off cycle effective date it was not included on the MPFSDB for 2009. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after September 28, 2009.

Screening for the Human Immunodeficiency Virus (HIV) Infection

On December 8, 2009, CMS issued a non-coverage decision (Transmittal 118, Change Request 6786, dated March 23, 2010) on screening for HIV infection. Medicare contractors were instructed to manually add HCPCS

codes G0432, G0433 and G0435 to the procedure code file and MPFSDB effective for dates of service on or after December 8, 2009.

Outpatient Intravenous Insulin Treatment (OIVIT)

On December 23, 2009, CMS issued a non-coverage decision (Transmittal 114, Change Request 6775, dated February 22, 2010) on the use of OIVIT. Contractors were instructed to manually add HCPCS code G9147 to the procedure code file and MPFSDB effective for dates of service on or after December 23, 2009.

Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

In CR 6974, contractors are being instructed to manually adjust the effective date for HCPCS codes G0429, Q2026, and Q2027 on the procedure code file and the MPFSDB. HCPCS codes G0429 (Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)), Q2026 (Injection, Radiesse, 0.1ml) and Q2027 (Injection, Sculptra, 0.1ml) are effective for dates of service on or after March 23, 2010.

Collagen Meniscus Implant

In CR 6974, contractors are being instructed to manually adjust the effective date for HCPCS code G0428 (Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex) on the procedure code file and the MPFSDB. HCPCS code G0428 is effective for dates of service on or after May 25, 2010.

Other Changes

In addition to the above, Attachment 1 of CR6974 contains numerous adjustments of the MPFSDB for various CPT/HCPCS codes and associated indicators. This attachment to CR 6974 can be viewed at http://www.cms.gov/Transmittals/downloads/R1992cp.pdf on the CMS website.

Additional Information

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that are affected by these changes. However, contractors will adjust such claims that you bring to their attention.

The official instruction, CR 6974, issued to your carrier, FI, RHHI, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1992cp.pdf on the CMS website.

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

The MLN Matters article for MM6974 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6974.pdf.

Effective Date: January 1, 2010; Implementation Date: July 6, 2010

Modifier 22 Clarification

Reference: LA – LLC 063010

Effective 07/21/2010, *all paper (non-EMC)* claims billed with Modifier 22 will be paid at the fee schedule amount if documentation to support a higher allowance does not accompany the claim. This documentation will continue to be requested by the carrier on any EMC claims billed with modifier 22. Please refer to the IOM section 100-04; Chapter 12; Section 40.2; paragraph 10:

Unusual Circumstances

Surgeries for which services performed are significantly greater than usually required may be billed with the "-22" modifier added to the CPT code for the procedure. The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

Modifier "-22" should only be reported with procedure codes that have a global period of 0, 10, or 90 days.

Please do not use generalized statements such as: surgery took extra time; patient was very ill; this was an emergent case; or this was a difficult surgery. These types of statements do not express why the surgery was unusual.

Preventive Services to Help Keep Your Medicare Patients Healthy This Summer

Reference: CMS List-Serv Message 070210

CMS asks the provider community to help keep their Medicare patients healthy this summer by encouraging them to take advantage of Medicare-covered preventive services. Medicare covers a wide variety of preventive services, including screening mammographies, seasonal influenza vaccinations, and screening for certain types of cancer, among other services.

What Can You Do?

Your patients rely upon you as their trusted health-care provider for advice and information to help them live longer, fuller, healthier lives. You can help protect the health of your patients by discussing their risk factors for preventable diseases, and by encouraging them to take advantage of Medicare-covered preventive services for which they qualify.

For More Information

CMS has developed several products to educate providers about Medicare coverage, coding, and claims submission policies related to Medicare-covered preventive services, including:

- **The Medicare Learning Network (MLN) Preventive Services Educational Products Web Page** ~ provides descriptions and ordering information for Medicare Learning Network (MLN) preventive services educational products and resources for health care professionals and their staff. http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** ~ This comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare. http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- **Quick Reference Information: Medicare Preventive Services** ~ This chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy-to-use quick-reference format. http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **The Medicare Preventive Services Series: Part 3 Web-Based Training Course (WBT)** ~ This WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, pap tests, and pelvic exams. To access the WBT, please visit the MLN homepage at: http://www.cms.gov/mlngeninfo Scroll down to "Related Links Inside CMS" and click on "WBT Modules"
- **The Preventive Services Educational Products PDF** ~ This PDF document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more. http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf
- **The Preventive Services Resources CD** ~ This CD Rom contains The Guide to Medicare Preventive Services, 3 quick reference charts, and 7 brochures on one easy to use CD Rom. To order the CD, and other products that are available in hardcopy, please visit the MLN homepage at: http://www.cms.hhs.gov/mlngeninfo in the internet. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page"

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries about the importance of early detection of various diseases by taking advantage of the screenings and other preventive services covered by Medicare.

Louisiana Average Processing Days for CMS-855 Applications

Reference: LA – TEC 071410

Pinnacle Business Solutions, Inc. (PBSI) will now begin sharing monthly average processing days for all initial enrollment applications, change of information, reassignments and PECOS. The June 2010 enrollment data is provided below:

Louisiana Part B – June 2010				
	Initial Applications	Reassignments	Changes of Information	PECOS Web
Average Days to Process	58 days	35 days	48 days	56 days

Arkansas Average Processing Days for CMS-855 Applications

Reference: LA – TEC 071410

Pinnacle Business Solutions, Inc. (PBSI) will now begin sharing monthly average processing days for all initial enrollment applications, change of information, reassignments and PECOS. The June 2010 enrollment data is provided below:

Arkansas Part B – June 2010				
	Initial Applications	Reassignments	Changes of Information	PECOS Web
Average Days to Process	65 days	35 days	47 days	59 days

CMS to Review PECOS Enrollment Process

Reference: CMS List-Serv Message 063010

Medicare Working with Ordering and Referring Providers and Suppliers to Streamline Enrollment Process

The Centers for Medicare & Medicaid Services (CMS) is working with providers to address concerns about enrollment in the Provider Enrollment, Chain and Ownership System (PECOS) to ensure that Medicare beneficiaries continue to receive the health care services and items they need. PECOS is the electronic system used to enroll physicians and eligible professionals into the Medicare program.

As part of those efforts, CMS will, for the time being, not implement changes that would automatically reject claims based on orders, certifications, and referrals made by providers that have not yet had their applications approved by July 6, 2010. While more than 800,000 physicians and other health professionals have enrolled and have approved applications in the PECOS system, some providers have encountered problems. CMS is continuing to update and streamline the process, and more providers have been enrolled in the past few days.

CMS issued an interim final regulation on May 5, 2010 implementing provisions of the Affordable Care Act that permit only a Medicare enrolled physician or eligible professional to certify or order home health services, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and certain items and services under Medicare Part B. The new law applies to orders, referrals and certifications made on or after July 1. The comment period for the regulation closes on July 6, after which the comments will be reviewed and considered before a final regulation is issued.

The Affordable Care Act provisions and the regulation were designed as steps to prevent fraud in Medicare by ensuring that only eligible and identifiable providers and suppliers can order and refer covered items and services to Medicare beneficiaries.

Many physicians and other providers and suppliers have continued to make good faith efforts to comply with the requirements of the law and regulation. These efforts will be a significant factor in determining the procedures and processes that will be incorporated in the final rule.

While the regulation will be effective July 6, 2010, CMS will not implement automatic rejections of claims submitted by providers that have attempted to enroll in PECOS. However, until the automatic rejections are operational, providers should not see any change in the processing of submitted claims, they will continue to be reviewed and paid as they have historically been reviewed and paid.

Additionally, though CMS is taking a more deliberative approach to using the PECOS enrollment system, the agency will employ a contingency plan to meet the ACA requirement that written orders and certifications are only issued by eligible professionals effective July 1.

CMS will continue to send informational notices to providers reminding them of the need to submit or update their enrollment and will work with the provider community to provide guidance on enrollment and will process all applications expeditiously.

Physicians & Non-Physician Practitioners: Declare Your Independence from the Paper Enrollment Process - Use Internet-Based PECOS!

Reference: CMS List-Serv Message 070810

The Internet-based Provider Enrollment, Chain and Ownership System (Internet-based PECOS) can be used in lieu of the Medicare enrollment application (i.e., paper CMS-855) to:

- Submit an initial Medicare enrollment application
- View or change your enrollment information
- Track your enrollment application through the web submission process
- Add or change a reassignment of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate an existing enrollment record
- Withdraw from the Medicare Program

Advantages of Internet-based PECOS

- Faster than paper-based enrollment (45 day processing time in most cases, vs. 60 days for paper)
- Tailored application process means you only supply information relevant to YOUR application
- Gives you more control over your enrollment information, including reassignments
- Easy to check and update your information for accuracy
- Less staff time and administrative costs to complete and submit enrollment to Medicare

Using Internet-based PECOS Is Easy!

Learn how to use the system by visiting the Medicare Physician and Non-Physician Practitioner Getting Started Guide. And if you encounter problems or have questions as you navigate the system, there are several resources that can help.

So, don't wait, set your practice free from paper - Start using Internet-based PECOS today!

Provider & Supplier Organizations: Declare Your Independence from the Paper Enrollment Process - Use Internet-Based PECOS!

Reference: CMS List-Serv Message 070810

The Internet-based Provider Enrollment, Chain and Ownership System (Internet-based PECOS) can be used in lieu of the Medicare enrollment application (i.e., paper CMS-855) to:

- Submit an initial Medicare enrollment application
- View or change your enrollment information
- Track your enrollment application through the web submission process
- Add or change a reassignment of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate an existing enrollment record
- Withdraw from the Medicare Program

Note: Internet-based PECOS will be made available for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) later this year.

Advantages of Internet-based PECOS

- Faster than paper-based enrollment (45 day processing time in most cases, vs. 60 days for paper)
- Tailored application process means you only supply information relevant to YOUR application
- Gives you more control over your enrollment information, including reassignments
- Easy to check and update your information for accuracy
- Less staff time and administrative costs to complete and submit enrollment to Medicare

Using Internet-based PECOS Is Easy!

Learn how to use the system by visiting the Getting Started Guide for Provider and Supplier Organizations. Remember, creating a record in Internet-based PECOS can take several weeks for an organization provider. It is recommended that you begin this process (if necessary) well in advance of any upcoming enrollment actions. For more information on this setup process, visit our Provider and Supplier Organization Overview.

So, don't wait, set your organization free from paper – Start using Internet-based PECOS today!

Medicare Enrollment Guidance for Physicians that Infrequently Receive Reimbursement from the Medicare Program

Reference: CMS List-Serv Message 071410

Traditionally, most physicians have enrolled in the Medicare program to furnish covered services to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, some physicians will need to enroll in the Medicare program for the sole purpose of certifying or ordering services for Medicare beneficiaries. These physicians do not send claims to a Medicare contractor for the services they furnish.

In the process of implementing the provisions contained in the Affordable Care Act, CMS has become aware of several unique enrollment issues for certain types of physicians or practitioners. Specifically, CMS modified the process of enrollment to accommodate the special circumstances of the following individual physicians and practitioners:

- Physicians employed by the Department of Veterans Affairs
- Physicians employed by the Public Health Service
- Physicians employed by the Department of Defense Tricare program
- Physicians employed by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Critical Access Hospitals (CAHs)
- Physicians in a Fellowship
- Dentists, including oral surgeons

For details on the modifications to the enrollment process for these special circumstances, visit the Special Enrollment Fact Sheet for Physicians with Infrequent Reimbursements on the CMS website.

Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted

Reference: SE1024

This is the first in a series of articles that will disseminate information on RAC high dollar improper payment vulnerabilities. The purpose of this article is to provide education regarding RAC demonstration-identified vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC Program and the initiation of complex medical review (coding and medical necessity) in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Note: This article was revised on July 14, 2010, to correct the subcontractor information for Diversified Collection Services on page 4. All other information is the same.

Provider Types Affected

This article is for all Inpatient Hospital and Skilled Nursing Facility providers that submit fee-for-service claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs).

Provider Action Needed

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

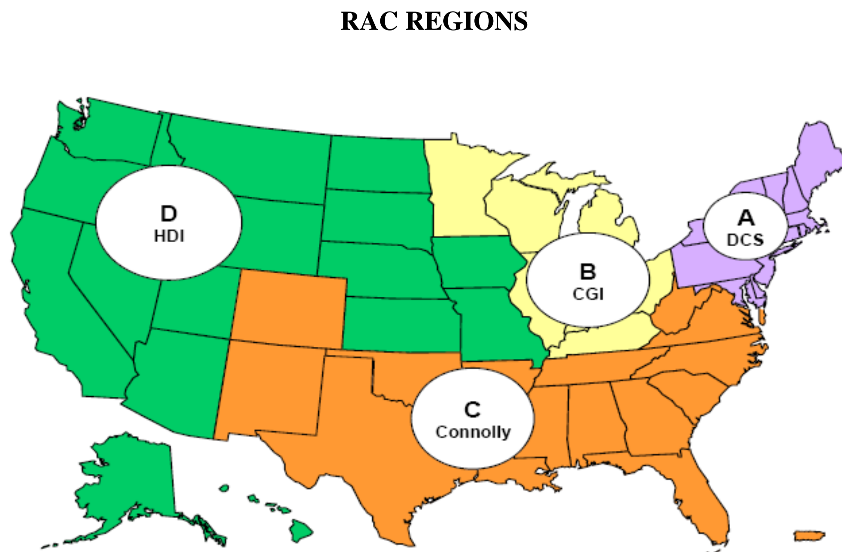
Background

The *Medicare Modernization Act of 2003* (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) establish the Recovery Audit Contractor (RAC) program as a three-year demonstration. The demonstration began March 2005 in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008. The success of the demonstration resulted in the passage of legislation in the *Tax Relief and Healthcare Act of 2006, Section 302,* which required CMS to establish a National RAC Program by January 1, 2010.

CMS uses four RACs to implement the National RAC program. Each RAC is responsible for identifying overpayments and underpayments in approximately one quarter of the country. Figure 1 displays each of the four RAC regions and identifies the RAC responsible for recovery activities in that region.

Figure 1:

RAC REGIONS



The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. While the demonstration proved recovery auditing was successful identifying and correcting improper payments in Medicare, it also provided best practices for developing a national program and allowed CMS to identify high risk vulnerabilities. Two of the high risk vulnerabilities identified during the RAC demonstration include:

- Provider non-compliance with timely submission of requested medical documentation; and
- Insufficient documentation that did not justify that the services billed were covered, medically necessary, or correctly coded.

Medical Documentation Reminders

CMS reminds providers that medical documentation must be submitted within 45 days of the date of the Additional Documentation Request (ADR) letter. Medicare contractors, including RACs, have the legal authority to review any information, including medical records, pertaining to a Medicare claim. If a provider fails to submit documentation, there is no justification for the services or the level of care billed. Failure to submit medical records (unless an extension has been granted) results in denial of the claim.

Submission of incomplete or illegible medical records can also result in denial of payment for services billed. Claim payment decisions that result from a medical review of records are based on the documentation that Medicare contractors received. For a Medicare claim to be paid, there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment and the provider may be requested to repay the claim paid amount to Medicare.

Actions to Assist Providers

The following requirements have been developed to assist providers in ensuring the timely submission of sufficient documentation to justify the services billed:

- RACs must clearly indicate deadlines for submission of medical records in ADR letters;
- RACs must initiate one additional contact with the provider before issuing a denial for a failure to submit documentation;
- RACs must accept and review extensions requests if providers are unable to submit documentation timely;
- RACs must clearly indicate in ADR letters suggested documentation that will assist them in adjudicating the claim;
- RACs must allow providers to submit medical records on CD/DVD or to fax the needed medical records;
- RACs must implement the RAC look back date of 3 years with a maximum look back date of October 1, 2007;
- RACs must limit the number of medical records requests every 45 days;
- RACs must indicate the status of a provider's additional documentation requests on their claim status websites;
- RACs must establish a provider web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters; and
- RACs must post all approved issues under review on their websites.

Preparing for RAC Audits

CMS recommends providers implement a plan of action for responding to RAC ADR letters. This could involve developing a RAC team to coordinate all RAC activities that may include tracking audit and appeal findings, identifying patterns of error, implementing corrective actions, etc. Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters. Providers should tell the RAC the precise address and contact person to use when sending ADR letters. Providers may submit this information to the RAC. Additional information on how to identify a point of contact can be found on the individual RAC web pages listed at the end of this article. Providers can also check the status of the submitted documentation by accessing the applicable RAC website. This allows providers to track whether the RAC received the documentation. Providers should consult the individual RAC web pages to determine the proper method for accessing this information. Providers should also consider monitoring their RAC websites for updates

on approved new issues. This will assist providers in better understanding what audits are taking place so they can prepare to respond to ADR letters.

CMS RAC Website Information

The following list identifies information unique to each of the four RACs, the States they cover, their subcontractor(s), and includes website information to assist providers in preparing for RAC audits:

RAC Region A- Diversified Collection Services (DCS), Inc. of Livermore, California:

- **States in Region:** Maryland (MD), Washington, D.C., Delaware (DE), New Jersey (NJ), Pennsylvania (PA), New York (NY), Maine (ME), Vermont (VT), New Hampshire (NH), Massachusetts (MA), Connecticut (CT), and Rhode Island (RI).
- **Subcontractors:** PRGX (formerly PRG Schultz), Federal Review Services, and iHealth Technologies
- **Email:** Info@dcsrac.com
- **Website:** http://www.dcsrac.com/portal.html

RAC Region B- CGI Technologies and Solutions, Inc. of Fairfax, Virginia:

- **States in Region:** Michigan (MI), Minnesota (MN), Wisconsin (WI), Illinois (IL), Indiana (IN), Kentucky (KY), and Ohio (OH).
- **Subcontractor:** PRGX
- **Email:** racb@cgi.com
- **Website:** http://racb.cgi.com/

RAC Region C- Connolly, Inc. of Philadelphia, Pennsylvania:

- **States in Region:** Colorado (CO), New Mexico (NM), Texas (TX), Oklahoma (OK), Arkansas (AR), Louisiana (LA), Mississippi (MS), Tennessee (TN), Alabama (AL), Georgia (GA), North Carolina (NC), South Carolina (SC), West Virginia (WV), Virginia (VA), Florida (FL), US Virgin Islands (VI) and Puerto Rico (PR).
- **Subcontractor:** Viant
- **Email:** racinfo@connollyhealthcare.com
- **Website:** http://www.connollyhealthcare.com/RAC/

RAC Region D- HealthDataInsights (HDI), Inc. of Las Vegas, Nevada

- **States in Region:** Washington (WA), Oregon (OR), California (CA), Alaska (AK), Hawaii (HI), Nevada (NV), Idaho (ID), Montana (MT), Utah (UT), Arizona (AZ), Wyoming (WY), North Dakota (ND), South Dakota (SD), Nebraska (NE), Kansas (KS), Iowa (IA), and Missouri (MO).
- **Subcontractor:** PRGX
- **Email:** racinfo@emailhdi.com
- **Website:** https://racinfo.healthdatainsights.com/

Additional Information

Providers are also encouraged to visit the CMS RAC website at http://www.cms.gov/RAC for updates on the National RAC Program. On that website, you can register to receive email updates and view current RAC activities nationwide.

The MLN Matters article for SE1024 in its entirety is available on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1024.pdf.

Recovery Audit Contractor (RAC) Audit Issues Posted

Reference: AR – GPH 071210

Connolly Healthcare, the Medicare Recovery Audit Contractor (RAC) for Region C, recently posted a new CMS-approved audit issue for RAC review. The new CMS-approved audit issue, which apply to Arkansas, Louisiana, and Mississippi, is listed below:

- Inpatient Admissions without a Physician's Inpatient Admit Order

More information is available at www.connollyhealthcare.com/rac and www.cms.gov/rac.

Outpatient Therapy Code Modifiers – June 2010

Reference: AR –AGP/DLH 070210

Pinnacle Business Solutions, Inc. (PBSI) as a Medicare carrier and intermediary has identified that outpatient therapy codes are not being billed with the appropriate modifiers. Outpatient therapy includes speech, occupational, and physical therapy. When billing HCPCS codes for outpatient therapy, one of the following modifiers must be appended to the claim to identify which branch of therapy provided the services:

- **GN -** Services delivered under an outpatient speech-language pathology plan of care;
- **GO -** Services delivered under an outpatient occupational therapy plan of care; or
- **GP -** Services delivered under an outpatient physical therapy plan of care

These modifiers do not allow providers to deliver services for which they are not qualified and recognized by Medicare to perform.

The exception to this is: Claims from physicians (all specialty codes) and non-physician practitioners, including specialty codes "50," "89," and "97," may be processed without therapy modifiers for sometimes only therapy codes found in the "Medicare Claims Processing Manual, Chapter 5, §20."

When submitting documentation please include the following:

1. Physician's order for therapy
2. Therapy initial evaluation/re-evaluation
3. Plan of care or treatment plan
4. Physician/NPP Certification/Re-certification
5. Treatment encounter notes for every treatment day and every therapy service including the following:
    a. Date of treatment
    b. The name of the treatment, intervention, or activity provided
    c. Type of equipment used
    d. Time spent in services represented by timed codes
    e. Total treatment time (including the untimed service codes)
    f. Signature and professional identity of qualified professional who furnished the service(s) or
    g. Supervised and list of each person contributing to treatment during that encounter
    h. Record and justification of any changes:
        - If treatment is added
        - If treatment changed
        - Between the interval progress reports
6. Progress Reports
7. Interpretation of abbreviations used in therapy notes
8. Initial date of service

If there is any question as to the legibility of a signature on any of the documentation, a signature verification form with a signed and printed name may be obtained and submitted with the Additional Documentation Response (ADR) letter. If a signature is missing from any documentation, an attestation statement may be obtained and submitted with the ADR letter. If a signature is missing or illegible, the reviewer will conduct the review without considering the documentation with the missing or illegible signature.

Please review the LCD for Physical Medicine and Rehabilitation on the state specific website for any further documentation guidelines.

This applies to all claims from physicians, NPPs, PTPPs, OTPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services. Modifiers only refer to

services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used for codes that are not on the list of applicable therapy services. Claims submitted with applicable HCPCS codes that do not have the appropriate modifiers will be denied as inappropriately billed.

For a complete list of applicable therapy HCPCS/CPT codes, refer to the following CMS Web site: http://www.cms.gov/therapyservices/05_annual_therapy_update.asp. Information can also be obtained in Local Coverage Determination (LCD) ARA-02-059 (L18739) or American Medical Association (AMA) Current Procedural Terminology (CPT) Professional Edition 2010, which may be found on the state specific Medicare Web site.

References:

- Medicare Claims Processing Manual, Chapter 5, §20-20.1
- LCD ARA-02-059 (L18739)
- American Medical Association (AMA) Current Procedural Terminology (CPT) Professional Edition 2010
- Physical Medicine and Rehabilitation LCD:

    Part B (LCD AC-02-059) or

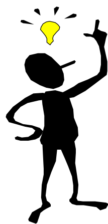
    Part A (LCD ARA-02-059)

    For services performed on or after 08/01/2010 refer to the PBSI merged policy PBSI-A-10-060

Web Site Satisfaction Survey

Pinnacle Business Solutions, Inc. (PBSI) is asking that you please take a few minutes and fill out our Web Site Satisfaction Survey that may pop up while you are browsing the PBSI web site. We want to know how well the entire site and specific site elements address your needs.

As our web site is constantly changing, we would appreciate your input every six weeks or so. It is your feedback that makes changes possible.



Medicare Web-Based Training

Q: How can I learn more about Medicare?

A: Medicare Web-Based Training!

Top Five Reasons You Should Utilize Web-Based Training Is:

1. **Flexible** Medicare Web-based training is available 24 hours a day, 7 days a week.
2. **Cost-effective** The training is free.
3. **Time Saver** Complete courses in the comfort of your home or office.
4. **Interactive** Utilizes a multi-sensory approach to engage the learner.
5. **In Demand** Over 95% of learners report they are very satisfied with the quality of the courses.

As your Medicare Carrier, we are constantly seeking innovative ways to keep you informed and knowledgeable regarding Medicare policies and procedures. With that in mind, we now offer web-based training to the provider community at no charge.

Current Topics

- Introduction to Medicare
- Modifiers
- Interpreting the Remittance Advice
- Understanding the '97 Evaluation & Management Guidelines

Continuing Education Units (CEUs) and Continuing Medical Education (CME) credit will not be issued for these courses any longer.

For more information visit your Medicare Carrier's website:

http://www.pinnaclemedicare.com/provider/partb/education/wbt/default.aspx

Pinnacle Medicare Services Seminar Registration

Medicare workshops will be FREE this year! Pre-registration is required and seating is limited so do not delay. Early birds are welcome. Registering for Medicare seminars has become easier. You can register online, by fax or by mail for Medicare seminars presented by each office within the Pinnacle consortium. If you are not able to register online, please complete all of the requested information and fax or mail thisform to the address indicated below:

Note: To register for webinars, please access our website events and seminars section

FAX TO: (225) 231-2276

Pinnacle Medicare Services
Attn: Provider Education Specialist
P.O. Box 83760
Baton Rouge, LA 70884-3760

Seminar Number:__________ Date:__________ Location:__________

Medicare Workshops are FREE to all attendees this year!

Attendee Name(s):__________

How many full time employees are employed at your facility?__________

Office/Physician's Name:__________

Contact Name(s):__________ Provider Number:__________

Mailing Address:__________

City:__________

State:__________ Zip:__________

Phone Number:__________

Fax Number:__________

Email Address:__________

Please keep a copy of this form for your records

If you are not able to register on-line, you may register by faxing this form to (225) 231-2276.

Have a Question?

Your questions are important to us! In our continuing effort to expand the communication between Medicare and the Part B providers, we have established an "And The Answer Is……." column for our providers. If you have a question about Medicare Part B policies and regulations, you may use the form shown below. We will print the most commonly asked questions with their answers. Questions not printed in the newsletter will be addressed through written or telephone response, so be sure to include your name, address and telephone number.

"Did You Know?" Question Submission Form

Provider/Group Name:____

Address:____

City:____________________ State:__________ Zip:____________

Provider Number:________________ Contact Name:__________________

Telephone Number:(_____)__________________________________

Question:____

____

____

____

Question submission forms should be sent to:

Pinnacle Medicare Communications
Attn: Monica Bohannon
515 West Pershing Blvd.
North Little Rock, AR 72114

Your Feedback is Greatly Appreciated!

We would like to take this opportunity to ask you for your input about our service to you and how you think we can improve. Please take a few moments to answer the questions below. Your response will help us serve you better in the future. All comments, concerns and suggestions are welcome.

We suggest you make a copy of this form so that you may use it after any contact with our office (good or bad) on which you would like to comment. After completing the form, mail it to the Pinnacle Medicare Service office you had contact with. Here are the addresses to mail this form:

Arkansas
Pinnacle Medicare Services
Attn: Greg Hart
P.O. Box 1418
Little Rock, AR 72203

Louisiana
Pinnacle Medicare Services
Attn: Greg Hart
P.O. Box 1418
Little Rock, AR 72203

Medicare Program:

Every day our staff makes numerous contacts with the provider community. Please comment on any contact you have had with our office that you would like us to know about. We appreciate being notified of any contact with an employee that meets your standard of excellence or any employee that falls below that standard.

Date of contact: ______________________ Contact was made: In person ______ By telephone ________

Name of Pinnacle employee that assisted you: ____
(Employees should answer with their name.)

Provide us with a general description of the topic discussed or question(s) you asked.

____

____

Was our response clear and easy to understand? ____

Was our staff member friendly and helpful? (If not, what happened?) ___________________________

____

____

General comments: ____

____

Interactive Voice Response Unit:

Do you use the IVR regularly? (If not, why not?) ____

____

Do you find the IVR to be an effective tool for you and your staff? (Why or why not?)

____

____

What features do you feel you and your staff would use which are not available?
(Please remember, we cannot verify entitlement or deductible status through the IVR.)

____

____

(continued on next page)

Seminars:
Medicare seminars are designed to meet your needs. How can we improve our service to you?

_______ More frequent _______ Longer seminars _______ Specialty workshops

If you desire a specialty workshop, please indicate your specialty **and** topics to be addressed.

____

____

Website:
Have your ever visited our website? _______Yes _______No

If yes, how often do you visit our website?____________________

Do you find the website easy to navigate? _______Yes _______No

Our websites are for your benefit. Please indicate suggestions/improvements below:

____

____

____

Thank you for your time and cooperation in responding to these questions. We value your input and constructive suggestions to help us better serve the medical community. Mail all completed forms to the carrier that services your state. Please do not forget to give us your name and telephone number.

____________________________________ (   )______________________________
Name Telephone Number

____
Street Address

____
City/State/Zip Code

2010 Arkansas Allowables for Vaccine Administration

Effective for Dates of Services 01-01-10 thru 05-31-10

Pinnacle Medicare Services has updated the allowables for the below vaccines effective January 1, 2010 thru May 31, 2010. These allowables are listed below. Please remember that these prices are subject to change.

CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply."

CPT Code	Description	PAR Amount	NON-PAR Amount	Limiting Charge
G0008	Administration of Influenza Virus Vaccine	$19.95	$18.95	$21.79
G0009	Administration of Pneumococcal Vaccine	$19.95	$18.95	$21.79
G0010	Administration of Hepatitis B Vaccine	$19.95	$18.95	$21.79
G9141	Administration of H1N1 Vaccine	$19.95	$18.95	$21.79

2010 Arkansas Allowables for Vaccine Administration

Effective for Dates of Services 06-01-10 thru 11-30-10

Pinnacle Medicare Services has updated the allowables for the below vaccines effective June 1, 2010 thru November 30, 2010. These allowables are listed below. Please remember that these prices are subject to change.

CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply."

CPT Code	Description	PAR Amount	NON-PAR Amount	Limiting Charge
G0008	Administration of Influenza Virus Vaccine	$20.39	$19.37	$22.28
G0009	Administration of Pneumococcal Vaccine	$20.39	$19.37	$22.28
G0010	Administration of Hepatitis B Vaccine	$20.39	$19.37	$22.28
G9141	Administration of H1N1 Vaccine	$20.39	$19.37	$22.28

2010 Arkansas Chiropractic Fee Schedule

Effective for Dates of Services 01-01-10 thru 05-31-10

NOTE	PROCEDURE CODE	PAR AMOUNT	NONPAR AMOUNT	LIMITING CHARGE
	98940	23.58	22.40	25.76
*	98940	19.98	18.98	21.83
	98941	32.76	31.12	35.79
*	98941	29.17	27.71	31.87
	98942	42.83	40.69	46.79
*	98942	39.24	37.28	42.87

*These fees apply when service is performed in a facility setting.

Limiting Charge applies to unassigned claims by non-participating providers.

All CPT codes and descriptors copyrighted by the American Medical Association.

2010 Arkansas Chiropractic Fee Schedule

Effective for Dates of Services 06-01-10 thru 11-30-10

NOTE	PROCEDURE CODE	PAR AMOUNT	NONPAR AMOUNT	LIMITING CHARGE
	98940	24.10	22.90	26.34
*	98940	20.42	19.40	22.31
	98941	33.49	31.82	36.59
*	98941	29.81	28.32	32.57
	98942	43.77	41.58	47.82
*	98942	40.10	38.10	43.82

*These fees apply when service is performed in a facility setting.

Limiting Charge applies to unassigned claims by non-participating providers.

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2010 Arkansas Ambulance Fee Schedule Revised

The following payment allowances have been established effective 01/01/2010:

Code	Urban – Base Rate & Mileage	Rural – Base Rate & Mileage
A0425	$6.87	$6.94
A0426	$242.78	$245.16
A0427	$384.40	$388.17
A0428	$202.32	$204.30
A0429	$323.71	$326.88
A0430	$2,735.60	$4,103.40
A0431	$3,180.54	$4,770.80
A0432	$354.05	$357.53
A0433	$556.37	$561.83
A0434	$657.53	$663.98
A0435	$8.07	$12.11
A0436	$21.53	$32.30

2010 Arkansas Anesthesia Conversion Factors

The anesthesia conversion factors and limiting charge effective for services rendered June 1, 2010, and after are as follows:

Par Fee	Non-par Fee	Limiting Charge
$20.57	$19.54	$22.47

2010 Louisiana Allowables for Vaccine Administration

Effective for Dates of Services 01-01-10 thru 05-31-10

Pinnacle Medicare Services has updated the allowables for the below vaccines effective January 1, 2010 thru May 31, 2010. These allowables are listed below. Please remember that these prices are subject to change.

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CPT Code	Description	PAR Amount	NON-PAR Amount	Limiting Charge
G0008	Administration of Influenza Virus Vaccine	$21.92 – Area 01 $20.35 – Area 99	$20.82 – Area 01 $19.33 – Area 99	$23.94 – Area 01 $22.23 – Area 99
G0009	Administration of Pneumococcal Vaccine	$21.92 – Area 01 $20.35 – Area 99	$20.82 – Area 01 $19.33 – Area 99	$23.94 – Area 01 $22.23 – Area 99
G0010	Administration of Hepatitis B Vaccine	$21.92 – Area 01 $20.35 – Area 99	$20.82 – Area 01 $19.33 – Area 99	$23.94 – Area 01 $22.23 – Area 99
G9141	Administration of H1N1 Vaccine	$21.92 – Area 01 $20.35 – Area 99	$20.82 – Area 01 $19.33 – Area 99	$23.94 – Area 01 $22.23 – Area 99

2010 Louisiana Allowables for Vaccine Administration

Effective for Dates of Services 06-01-10 thru 11-30-10

Pinnacle Medicare Services has updated the allowables for the below vaccines effective June 1, 2010 thru November 30, 2010. These allowables are listed below. Please remember that these prices are subject to change.

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CPT Code	Description	PAR Amount	NON-PAR Amount	Limiting Charge
G0008	Administration of Influenza Virus Vaccine	$22.40 – Area 01 $20.79 – Area 99	$21.28 – Area 01 $19.75 – Area 99	$24.47 – Area 01 $22.71 – Area 99
G0009	Administration of Pneumococcal Vaccine	$22.40 – Area 01 $20.79 – Area 99	$21.28 – Area 01 $19.75 – Area 99	$24.47 – Area 01 $22.71 – Area 99
G0010	Administration of Hepatitis B Vaccine	$22.40 – Area 01 $20.79 – Area 99	$21.28 – Area 01 $19.75 – Area 99	$24.47 – Area 01 $22.71 – Area 99
G9141	Administration of H1N1 Vaccine	$22.40 – Area 01 $20.79 – Area 99	$21.28 – Area 01 $19.75 – Area 99	$24.47 – Area 01 $22.71 – Area 99

2010 Louisiana Area 01 Chiropractic Fee Schedule

Effective for Dates of Services 01-01-10 thru 05-31-10

NOTE	PROCEDURE CODE	PAR AMOUNT	NONPAR AMOUNT	LIMITING CHARGE
	98940	24.74	23.50	27.03
*	98940	20.68	19.65	22.60
	98941	34.36	32.64	37.54
*	98941	30.30	28.79	33.10
	98942	44.73	42.49	48.86
*	98942	40.67	38.64	44.43

*These fees apply when service is performed in a facility setting.

Limiting Charge applies to unassigned claims by non-participating providers.

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2010 Louisiana Area 01 Chiropractic Fee Schedule

Effective for Dates of Services 06-01-10 thru 11-30-10

NOTE	PROCEDURE CODE	PAR AMOUNT	NONPAR AMOUNT	LIMITING CHARGE
	98940	25.28	24.02	27.62
*	98940	21.13	20.07	23.08
	98941	35.12	33.36	38.37
*	98941	30.97	29.42	33.83
	98942	45.71	43.42	49.93
*	98942	41.56	39.48	45.40

*These fees apply when service is performed in a facility setting.

Limiting Charge applies to unassigned claims by non-participating providers.

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2010 Louisiana Area 99 Chiropractic Fee Schedule

Effective for Dates of Services 01-01-10 thru 05-31-10

NOTE	PROCEDURE CODE	PAR AMOUNT	NONPAR AMOUNT	LIMITING CHARGE
	98940	23.86	22.67	26.07
*	98940	20.21	19.20	22.08
	98941	33.24	31.58	36.31
*	98941	29.59	28.11	32.33
	98942	43.35	41.18	47.36
*	98942	39.69	37.71	43.36

*These fees apply when service is performed in a facility setting.

Limiting Charge applies to unassigned claims by non-participating providers.

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2010 Louisiana Area 99 Chiropractic Fee Schedule

Effective for Dates of Services 06-01-10 thru 11-30-10

NOTE	PROCEDURE CODE	PAR AMOUNT	NONPAR AMOUNT	LIMITING CHARGE
	98940	24.39	23.17	26.65
*	98940	20.66	19.63	22.57
	98941	33.98	32.28	37.12
*	98941	30.24	28.73	33.04
	98942	44.30	42.09	48.40
*	98942	40.56	38.53	44.31

*These fees apply when service is performed in a facility setting.

Limiting Charge applies to unassigned claims by non-participating providers.

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2010 Louisiana Ambulance Fee Schedule - Locality 01 - Revised

The following payment allowances have been established effective 01/01/2010:

Code	Urban – Base Rate & Mileage	Rural – Base Rate & Mileage
A0425	$6.87	$6.94
A0426	$264.52	$267.11
A0427	$418.82	$422.92
A0428	$220.43	$222.59
A0429	$352.69	$356.14
A0430	$2,907.73	$4,361.60
A0431	$3,380.66	$5,071.00
A0432	$385.75	$389.53
A0433	$606.18	$612.12
A0434	$716.40	$723.42
A0435	$8.07	$12.11
A0436	$21.53	$32.30

2010 Louisiana Ambulance Fee Schedule - Locality 99 - Revised

The following payment allowances have been established effective 01/01/2010:

Code	Urban – Base Rate & Mileage	Rural – Base Rate & Mileage
A0425	$6.87	$6.94
A0426	$245.65	$248.06
A0427	$388.95	$392.77
A0428	$204.71	$206.72
A0429	$327.54	$330.75
A0430	$2,758.36	$4,137.54
A0431	$3,207.00	$4,810.50
A0432	$358.25	$361.76
A0433	$562.96	$568.48
A0434	$665.31	$671.84
A0435	$8.07	$12.11
A0436	$21.53	$32.30

2010 Louisiana Anesthesia Conversion Factors

The anesthesia conversion factors and limiting charge effective for services rendered June 1, 2010, and after are as follows:

Louisiana Area 01		
Par Fee	**Non-par Fee**	**Limiting Charge**
$21.60	$20.52	$23.60

Louisiana Area 99		
Par Fee	**Non-par Fee**	**Limiting Charge**
$21.27	$20.21	$23.24

Important Information from Your Medicare Part B Carrier

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Additional copies of this and all newsletters are available at no cost from your state's web site listed below. Remember that this newsletter, as well as all other Medicare publications, serves as your official notice of Medicare coverage and billing information. Here is a list of phone numbers to call with questions about the information included in this newsletter. You must call the Customer Service area in the state where you are a Medicare provider. Be sure to check our web site for the most up-to-date information:

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