Audit Results for J2778 (Injection, Ranibizumab 0.1 mg)

During a recent medical review of procedure code J2778, Ranibizumab 0.1mg, Highmark Medicare Services denied this service 35% of the time because the medical records did not document the dosage or the physician’s signature was stamped.

Please note that when billing for Ranibizumab providers should use the HCPCS code J2778 and bill the number of units as the actual number of mg utilized.

The actual number of mg used should be noted in the medical documentation as well as in Item 19 of the CMS Form 1500 or its electronic equivalent. Additional information is provided in our Billing and Coding Article A49034: [https://www.highmarkmedicareservices.com/articles/mac-ab/a49034-r4.html](https://www.highmarkmedicareservices.com/articles/mac-ab/a49034-r4.html)

Stamped signatures are not acceptable on ANY medical record. This change was effective April 28, 2008 for dates of service September 30, 2007 and after.

Medical Director Message
“Evaluate, Manage…… Observe?” 3

General News

Claim Review of Procedure Codes 99204 and ..99205 (Office or other Outpatient Visit for the Evaluation and Management of a New Patient) ..........................................................4

Professional Provider Telecommunication Network (PTPN) access arriving in the first quarter of 2011..........................................................5

Magnetic Resonance Angiography (MRA) …..5

Common Working File (CWFF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record If there the GHP record was subsequently deleted or Terminated..........................................................6

Payment for Implantable Tissue Markers (Healthcare Common Procedure Coding system (HCPCS) Code A4648) and Implantable Radiation Dosimeters (HCPCS Code A4650)....................................................................................................................7

Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 16.3, effective October 1, 2010.................................................................8

Change Physician Specialty Code 12 to Osteopathic Manipulative Medicine.................8

Revisions and Re-issuance of Audiology Policies.................9

2010 Reminder For Roster Billing and Centralized Billing For Influenza and Pneumococcal Vaccinations..............................................................10

2011 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments ..13

Eligible Physicians and Non-Physician Practitioners who need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries..............................................................................13

Speciality News

ASC
October 2010 Update of the Ambulatory Surgical Center (ASC) Payment System......15

CONSOLIDATED BILLING

DMEPOS
2010 Durable Medical Equipment Prosthetics, Orthotics and Supply (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List ....................................................19

ESRD
End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services.........................20

THERAPY/REHAB
Intensive Cardiac Rehabilitation (ICR) Programs - Dr. Ornish’s Program for Reversing Heart Disease and the Pritikin Program.................24

Physical Therapy Reporting and Documentation Issues............................................25

Reimbursement
Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs ..................................................26

October Update to the 2010 Medicare Physician Fee Schedule Database (MPFSDB) ..........27


January 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and revisions to Prior Quarterly Pricing Files.....29

Coding Guidelines and Claim Reporting
Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home..................................................30

Discarded Drugs and Biologicals Policy at Contractor Discretion .........................31

Beneficiary-Submitted Claims..................................................32

New Waived Tests..................................................33

Coverage Issues

Common Working File (CWFF) Override Edit for Kidney Transplant Donor Claims When the Kidney Recipient is Deceased.............35

Positron Emission Tomography (FDG PET) for Initial Treatment Strategy (PI) in Solid Tumors and Myeloma..................................................35

Counseling to Prevent Tobacco Use..................................................36

Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) for Myelodysplastic Syndrome MDS)..................................................39

EDI News
Updated Taxonomy Codes..................................................41

New PC-ACE Pro32 Version 2.24 Upgrade Available - UPGRADE NOW! !..........................41

Reminder: Diagnosis Code Reporting for Electronic Claims..............................42

Do You REALLY Qualify for an ASCA Waiver?..................................................42

Clearinghouse, Billing Service, and Vendor – Do You Know the Difference?............43


Claim Status Category and Claim Status Codes Update ..............................................45

Medicare Insights Weekly ..................................................46

Education & Training Feedback
Form..................................................47

Request for Education Form..................................................49

Join our Electronic Mailing Lists..................................................50
“Evaluate, Manage…… Observe?”

As with any change in the use of coding conventions, the recent “sundown” of consultation codes and the increased application of the observation status have resulted in anxiety and confusion in the provider community. One particular element of this confusion has been manifest in teaching hospitals. According to traditional CMS expectations, attending physicians have dealt with the need to supplement and countersign work performed in the admission of an inpatient within a reasonable period of time, certainly less than 24 hours. This “window” of expectation, however, now seemingly contradicts language that requires the physician responsible for the patient’s care to personally enter the orders for observational status at the time the decision is made to commit the patient to observation. This may result in clinically competent house staff, however lacking coding, reimbursement or regulatory background, being asked to decide between hospitalization (inpatient) and observation status (outpatient). Highmark Medicare Services, after reviewing the current regulatory and practice landscape recommends that the decision to commit a patient to observational status be discussed with the attending at least by phone within several hours of admission, and that this discussion be noted in the medical record.

This clearly outlined communication will have the secondary benefit of advising practitioners in other specialties that may render care that this patient is in observation status, and that they must use the outpatient E&M service codes for this case. The increased use of the observation status may in fact have contributed to the significant increase in the use of level 4 and level 5 outpatient E&M codes.

Consistent with CMS’ defined contractor responsibility, Highmark Medicare Services recently implemented a service wide review on Procedure Codes 99204 and 99205. A small population (less than 5%) of the 99204 and 99205 services billed to Highmark Medicare Services will be developed to obtain the medical records to support the service billed. Physicians should not send in medical records unless they receive an Additional Documentation Request (ADR) that will explain what is needed and provide instructions on how and when to submit the requested documentation. This review of services is currently ongoing and is an attempt to verify the correctness of both coding and billing of these services.

Although it was hoped that the transition to this new coding convention would be smooth in its implementation, new data suggests that many claims are contributing to the error rate, particularly due to inadequate documentation of the services. Highmark Medicare Services is currently working with its Provider Outreach and Education Department to repeat and update educational programs that had been initiated at the time of this coding transition to address this issue. Please check our Website to find conferences, Webinars and other activities that may be relevant to your practice.

Laurence J. Clark, MD, FACP
Contractor Medical Director
Highmark Medicare Services
Claim Review of Procedure Codes 99204 and 99205 (Office or other Outpatient Visit for the Evaluation and Management of a New Patient)

A recent widespread post-payment audit performed by Highmark Medicare Services' Medical Review Department revealed that 73% of new patient office or outpatient visits, procedure codes 99204 and 99205, were billed incorrectly. While the number one error was incorrectly coding the level of service, other issues were identified. The issues included the lack of an accepted form of provider signature, the documentation did not support incident to guidelines as there was no evidence of the physician initiating the plan of care, and no documentation was received to support the services billed. In order to bill a new patient office or outpatient visit, the patient must not have received any professional service from any physician in the group of the same specialty within the last three years.

As a result of these review findings, a prepayment edit will be implemented on procedure codes 99204 and 99205 for physicians and non-physician practitioners (NPP) of all specialties. A small population (less than 5%) of the 99204 and 99205 services billed to Highmark Medicare Services will be developed to obtain the medical records to support the service billed. Physicians should not send in medical records unless they receive an Additional Documentation Request (ADR) that will explain what is needed and provide instructions on how and when to submit the requested documentation. This review of services is currently ongoing and is an attempt to verify the correctness of both coding and billing of these services.

Medical records will be requested to verify that services billed were rendered, medically necessary and billed appropriately to the Medicare program. If the requested medical record documentation is not made available to support services billed, the service may be denied. For additional information on the medical review process, please refer to the Medicare Part A/B Reference Manual, Chapter 19 found on our website at https://www.highmarkmedicareservices.com.

When reviewing an evaluation and management (E/M) service, Highmark Medicare Services’ Medical Review Department follows the E/M documentation guidelines which identify and describe three key components that determine the level of service. These three components are:

- History;
- Examination; and
- Medical decision making.

To support procedure code 99205 the documentation must include the following:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of high complexity.

To support procedure code 99204 the documentation must include the following:

- A comprehensive history;
- A comprehensive examination; and
- Medical decision making of moderate complexity.

Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or an electronic signature. Stamp signatures are not acceptable. Patient identification, date of service, and provider of the service should be clearly identified on the submitted documentation.

If you question the legibility of your signature, you may submit an attestation statement with the documentation. A suggested format for attestation statements can be found on our website at https://www.highmarkmedicareservices.com. The signature attestation statement must be signed by the provider. If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated.

In order to bill the services of an NPP such as a physician assistant or a nurse practitioner incident to a physician, there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the NPP is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary. If services are rendered to a new patient, there is no course of treatment already initiated by the physician, therefore, the service provided by the NPP may not be billed under the physician's rendering provider number.

The majority of the level of service coding errors were due to the documentation not meeting a comprehensive history and/or a comprehensive examination. When reviewing an E/M service, Highmark Medicare Services’ Medical Review
Department uses a Documentation Worksheet. The Documentation Worksheet used by Highmark Medicare Services to score E/M services, in addition to other valuable references related to E/Ms, can be found on our website at https://www.highmarkmedicareservices.com.

Highmark Medicare Services has updated our website to include an E/M center which contains direct links to many E/M educational tools. The E/M center can be found on the Part B Homepage. To access this site, click on the “Evaluation & Management” link located on the left-hand side of the page. Please refer to this center in order to access the most current information and educational materials regarding E/M services.

Professional Provider Telecommunication Network (PPTN) access arriving in the first quarter of 2011

PPTN is the ability to connect directly into the Part B Medicare Multi-Carrier System (MCS) through an approved third party vendor. Highmark Medicare Services (HMS) will offer access to Medicare Part B providers who submit claims electronically and receive Electronic Remittance Advice (ERA). Through PPTN you will be able to:

- Request in-depth Medicare Beneficiary Eligibility on your patients
- View detailed Claim Status Information
- Get a quick provider summary snapshot of your claim counts and dollar amounts
- View comprehensive check information
- Receive detailed pricing information
- Look up diagnosis and procedure codes

What can you do now to prepare for PPTN? Make sure that you are submitting your claims electronically and receiving ERA. Information on ERA and Electronic Data Interchange (EDI) enrollment is available on our Electronic Billing (EDI) Center at: https://www.highmarkmedicareservices.com/edi/index.html. You must also contract with a third party PPTN vendor in order to use PPTN.

If you are not already contracted with a third party PPTN vendor, you are encouraged to start contacting third party PPTN vendors now to begin the research, selection and contract process. An EDI Approved Vendor List is available on our Electronic Billing (EDI) Center at: https://www.highmarkmedicareservices.com/edi/pdf/vendor_list.pdf.

PPTN is just one of the benefits when becoming an electronic biller; visit our Electronic Billing (EDI) Center at: https://www.highmarkmedicareservices.com/edi/index.html to learn more. Watch our Web site for more information on what PPTN can offer your provider office and how you can get access.

Magnetic Resonance Angiography (MRA)

MLN Matters® Number: MM7040
Related Change Request (CR) #: 7040
Related CR Release Date: July 9, 2010
Effective Date: June 3, 2010
Related CR Transmittal #: R1998CP and R123NCD
Implementation Date: August 9, 2010

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.

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 the Customer Contact Center at 1-877-235-8073.


**Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted or Terminated**

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

**PROVIDER TYPES AFFECTED**

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

**WHAT you need TO knoW**

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

**BACKGROUND**

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

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

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

**ADDITIONAL INFORMATION**

You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting [http://](http://)
Payment for Implantable Tissue Markers (Healthcare Common Procedure Coding System (HCPCS) Code A4648) and Implantable Radiation Dosimeters (HCPCS Code A4650)

MLN Matters® Number: MM6968 Revised
Related Change Request (CR) #: 6968
Related CR Release Date: August 6, 2010
Effective Date: November 6, 2010
Related CR Transmittal #: R745OTN
Implementation Date: November 6, 2010

Note: This article was revised on August 18, 2010, to correct an error in the “What You Need to Know” section on page 1. The HCPCS code of A450 was corrected to show A4650. All other information remains the same.

Provider Types Affected
This article is for physicians who bill Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MAC) for providing services for implantable tissue markers or implantable radiation dosimeters to Medicare beneficiaries.

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

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

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

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

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

1. 19499 (unlisted procedure, breast);
2. 32553 (placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter), percutaneous intra-thoracic, single or multiple);
3. 49411 (placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter), percutaneous intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple); and
4. 55876 (single or multiple((the placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter)), prostate (via needle, any approach)) on a claim for physician services.

Therefore, effective for dates of service on or after November 6, 2010, your carrier or A/B MAC will pay physicians for these HCPCS codes when the implantable tissue markers or implantable radiation dosimeters are used in conjunction with one of these four CPT codes, but will deny payment if one of the above CPT codes is not paid on the same claim (or in history) with the same date of service. When denying your claim for these codes if the qualifying service is not reported on the same date of service, they will use Claim Adjustment Reason Code B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/ adjudicated.).

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

Additional Information
You can find the official instruction, CR6968, issued to your carrier or A/B MAC by visiting http://www.cms.gov/Transmittals/downloads/R745OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.
Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 16.3, effective October 1, 2010

MLN Matters® Number: MM7081
Related Change Request (CR) #: 7081
Related CR Release Date: August 27, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R2036CP
Implementation Date: October 4, 2010

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 7081, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in July 2010.

**Background**

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

- National and local policies and edits,
- Coding guidelines developed by national societies,
- Analysis of standard medical and surgical practice, and by
- Review of current coding practice.

The latest package of CCI edits, Version 16.3, is effective October 1, 2010, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in the following two tables:

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

Additional information about CCI, including the current CCI and MEC edits, is available at [http://www.cms.gov/NationalCorrectCodInitEd](http://www.cms.gov/NationalCorrectCodInitEd) on the CMS website.

**Additional Information**


If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

**Change Physician Specialty Code 12 to Osteopathic Manipulative Medicine**

MLN Matters® Number: MM6890
Related Change Request (CR) #: 6890
Related CR Release Date: August 27, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2035CP
Implementation Date: January 3, 2011

**Provider Types Affected**

This article is for physicians and providers submitting claims to Medicare contractors (carriers and/or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

**What You Need to Know**

Effective January 1, 2011, Medicare claims processing systems will be revised to change the name of physician specialty code 12 from Osteopathic Manipulative Therapy to Osteopathic Manipulative Medicine. Medicare’s Provider Enrollment, Chain and Ownership System (PECOS) will also recognize physician specialty code 12 as a valid specialty code for Osteopathic Manipulative Medicine.
Revisions and Re-issuance of Audiology Policies

MLN Matters® Number: MM6447 Revised
Related Change Request (CR) #: 6447
Related CR Release Date: September 3, 2010
Effective Date: September 30, 2010
Related CR Transmittal #: R132BP and R2044CP
Implementation Date: September 30, 2010

Note: This article was revised on September 7, 2010, to reflect the revised CR 6447 that was issued on September 3. As a result, the article shows revised effective and implementation dates, a revised CR release date, transmittal numbers, and Web addresses for accessing the CR 6447 transmittals. In addition, the Remittance Advice Remark Code referenced at the top of page 5 has been corrected to be consistent with the revised CR. All other information is the same.

Provider Types Affected
This article is for physicians, non-physician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare Administrative Contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6447. The Centers for Medicare & Medicaid Services (CMS) issued CR 6447 to respond to provider requests for clarification of some of the language in CR5717 and CR6061. Special attention is given to clarifying policy concerning services incident to physician services that are paid under the Medicare Physician Fee Schedule (MPFS). See the Key Points section below for the clarifications provided by CR6447. Disclaimer

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

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable State laws.

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

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

See the CMS website at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp for a listing of all CPT codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The MPFS at http://www.cms.gov/PFSlookup/ allows you to search pricing amounts, various payment policy indicators, and other MPFS data.

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

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

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

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

Examples include, but are not limited to:

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

Key Points of CR 6447

- For claims with dates of service on or after October 1, 2008 audiologists are required to be enrolled in the Medicare program and use their National Provider Identifier (NPI) on all claims for services they render in office settings.
- For audiologists who are enrolled and bill independently for services they render, the audiologist’s NPI is required on all claims they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital Outpatient Prospective Payment System (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.
- Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.
- When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the audiologist must submit a claim to Medicare.
- Medicare pays for diagnostic audiological tests under the MPFS when they meet the requirements of audiology services as shown in Chapter 15, Section 80.3 of the Medicare Benefit Policy manual as attached to CR 6447.
- For claims with dates of service on or after October 1, 2008, the NPI of the enrolled audiologist is required on claims in the appropriate rendering and billing fields.
- Medicare will not pay for services performed by audiologists and billed under the NPI of a physician. In denying such claims, Medicare will use:
  - CARC 170 (Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
  - Remittance Advice Remark Code (RARC) N290 (Missing/incomplete/invalid rendering provider primary identifier.)
- Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills. Such claims will be denied using Claim Adjustment Reason Code (CARC) 170 (Payment is denied when performed/billed by this type of provider.
Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. In denying claims under this provision, Medicare will use:
  - CARC 185 (The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.); and
  - RARC M136 (Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.)
- Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audioligists under the designated level of physician supervision for the service and the audiologist is qualified to perform the service. (Once again, the list of audiology services is posted at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp on the CMS website.)
- Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services at http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp and are not “always” therapy services and the audiologist is qualified to perform the service.
- All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
- The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.
- When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
- The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.
- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.
- The “global” service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
- Tests that have no appropriate CPT code may be reported under CPT code 92700 (Unlisted otorhinolaryngological service or procedure).
- Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
- The opt out law does not define “physician” or “practitioner” to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.

**Additional Information**

There are two transmittals related to CR6447, the official instruction issued to your Medicare A/B MAC, FI and/or carrier. The first modifies the Medicare Benefit Policy Manual and that transmittal is at http://www.cms.gov/Transmittals/downloads/R132BP.pdf on the CMS website. The other transmittal modifies the Medicare Claims Processing Manual and it is at http://www.cms.gov/Transmittals/downloads/R2044CP.pdf on the CMS website.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

---

**Medicare Report: December 2010**
2010 Reminder For Roster Billing and Centralized Billing For Influenza and Pneumococcal Vaccinations

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

Provider Types Affected

This article physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for influenza and pneumococcal immunization services provided to Medicare beneficiaries.

Provider Action Needed

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

Background

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

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

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

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

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

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

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

1. A Mass Immunization Roster Biller (specialty provider type 73), or

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

Providers are responsible for meeting the guidelines for being either a Mass Immunizer or Centralized Biller. Additionally, providers (except suppliers) already enrolled in the Medicare program may use their National Provider Identifier (NPI) to provide influenza vaccinations.

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

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

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

Suppliers must enroll as a Mass Immunization Roster Biller (specialty provider type 73) with a carrier to render influenza vaccination services to Medicare beneficiaries.

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

**Additional Information**

The official instruction, CR 7124, issued to your carriers, FIs, and A/B MACs regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R774OTN.pdf](http://www.cms.gov/Transmittals/downloads/R774OTN.pdf) on the CMS website.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

### 2011 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

**MLN Matters® Number:** MM7139  
**Related Change Request (CR) #:** 7139  
**Related CR Release Date:** September 17, 2010  
**Effective Date:** January 1, 2011  
**Related CR Transmittal #:** R2054CP  
**Implementation Date:** January 3, 2011

**Provider Types Affected**

Physicians and other providers who bill Medicare contractors (Carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in health professional shortage areas (HPSAs).

**What You Need to Know**

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

**Background**

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

**Additional Information**


If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

### Eligible Physicians and Non-Physician Practitioners who need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries

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

**Provider Types Affected**

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

**What You Need to Know**

CR 7097, from which this article is taken, announces that physicians and non-physician practitioners will need to enroll in the Medicare program so they can order and refer items and services for Medicare beneficiaries.
The enrollment requirement is applicable to those physician and non-physician practitioners of a profession eligible to order and refer who are:

- Employed by the Department of Veterans Affairs (DVA), Public Health Service (PHS), Department of Defense (DOD) TRICARE, or by Medicare enrolled Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), or Critical Access Hospitals (CAH);
- Physicians in a fellowship; or
- Dentists, including oral surgeons.
- Other employed eligible physicians and non-physician practitioners.

**Background**

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

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

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

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

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

Specifically, if you order or refer items or services for Medicare beneficiaries and (1) you are employed by the Department of Veterans Affairs (DVA), the Public Health Service (PHS), the Department of Defense (DOD) TRICARE; or by a Medicare enrolled Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Critical Access Hospital (CAH), (2) you are in a fellowship, or (3) you are a dentist or oral surgeon, you will need to enroll in Medicare using the modified enrollment process described below. (Any provider can enroll for the sole purpose of ordering or referring, regardless of who their employer is.)

**Modified Enrollment Process for Physicians and Non-Physician Practitioners who are Enrolling Solely to Order and Refer**

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

1. Complete the following sections paper of form CMS-855I (“Medicare Enrollment Application for Physicians and Non-Physician Practitioners”):
   - Section 1 – Basic Information (you would be a new enrollee)
• Section 2 – Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K);
• Section 3 – Final Adverse Actions/Convictions;
• Section 13 – Contact Person; and
• Section 15 - Certification Statement (must be signed and dated—blue ink recommended).

2. You must include a cover letter with this enrollment application stating that you are enrolling for the sole purpose of ordering and referring items or services for a Medicare beneficiary and cannot be reimbursed by the Medicare program for services that you may provide to Medicare beneficiaries.

3. Mail the completed enrollment application and cover letter to your designated Medicare enrollment contractor, which you can find at http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

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

Notes: 1) When enrolling, you do not have to complete the CMS 460, Medicare Participating Physician or Supplier Agreement or the CMS 588, Electronic Funds Transfer (EFT) Authorization Agreement, in with the CMS-855I application. Also, license information received from a physician or practitioner employed by DVA or DOD may be active in a state other than the DVA or DVA location.

2) Since the abbreviated application does not require you to complete section 4 and CMS is requiring a cover letter, the Medicare enrollment contractors will reject your application if section 4 is blank and a cover letter is not attached.

3) You are not permitted to be reimbursed by Medicare for services you may furnish to Medicare beneficiaries.

4) If, in the future, you wish to be reimbursed by Medicare for services performed, you must submit the full enrollment application via the paper application(s) (CMS-855) or Internet-based PECOS; the Medicare enrollment contractor will deactivate the current information.

**ADDITIONAL INFORMATION**

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

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

---

**Specialty News**

**ASC**

**OCTOBER 2010 UPDATE OF THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM**

**MLN Matters® Number:** MM7147  
**Related Change Request (CR) #:** 7147  
**Related CR Release Date:** September 10, 2010  
**Effective Date:** October 1, 2010  
**Related CR Transmittal #:** R2045CP  
**Implementation Date:** October 4, 2010

**PROVIDER TYPES AFFECTED**

This article is for ASCs, who submit claims to Medicare Administrative Contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

**PROVIDER ACTION NEEDED**

This article is based on Change Request (CR) 7147 which describes changes to, and billing instructions for, payment policies implemented in the October 2010 ASC update. CR 7147 provides information on one newly created pass-through device Healthcare Common Procedure Coding System (HCPCS) code, five newly created drug HCPCS codes, and six newly created HCPCS codes describing imaging services that will be added to the ASC list of covered ancillary services effective October 1, 2010. Be sure your billing staff is aware of these changes.
**Background**

Final policy under the revised ASC payment system, as set forth in the Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs), beginning in CY 2008 (72 FR 42470), 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.

The key updates effective on October 1, 2010, are as follows:

**New HCPCS Codes for Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2010**

Five new HCPCS codes have been created for drugs that are payable as covered ancillary services for dates of service on and after October 1, 2010. The new HCPCS codes, the short descriptors, the long 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 October 2010 ASC DRUG file.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Short Descriptor</th>
<th>Payment Indicator Effective 10/01/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9269</td>
<td>Injection, C-1 esterase inhibitor (human), Berinert, 10 units</td>
<td>C-1 esterase, berinert</td>
<td>K2</td>
</tr>
<tr>
<td>C9270</td>
<td>Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg</td>
<td>Gammaplex IVIG</td>
<td>K2</td>
</tr>
<tr>
<td>C9271</td>
<td>Injection, velaglucerase alfa, 100 units</td>
<td>Velaglucerase alfa</td>
<td>K2</td>
</tr>
<tr>
<td>C9272</td>
<td>Injection, denosumab, 1 mg</td>
<td>Inj, denosumab</td>
<td>K2</td>
</tr>
<tr>
<td>C9273</td>
<td>Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer’s, including leukapheresis and all other preparatory procedures, per infusion</td>
<td>Sipuleucel-T, per infusion</td>
<td>K2</td>
</tr>
</tbody>
</table>

**Supplemental Information for HCPCS Code C9273**

The Centers for Medicare & Medicaid Services (CMS) has opened a national coverage determination (NCD) analysis for HCPCS code C9273, Provenge (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250mL of Lactated Ringer’s, including leukapheresis and all other preparatory procedures, per infusion). A final decision on coverage is forthcoming in 2011. As with other drugs and biologicals, at this time, local carriers and MACs will retain the discretion to make individual claim determinations for Provenge based on the medical necessity of the service(s) being provided.

Additionally, CMS clarifies that the language given in the long descriptor of Provenge states that “all other preparatory procedures” refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient.

**Updated Payment Rate for HCPCS Code 90476 Effective April 1, 2010 through June 30, 2010**

The payment rate for one HCPCS code was incorrect in the April 2010 ASC DRUG file. That HCPCS code is 90476 (Adenovirus vaccine, type 4). The corrected payment rate is $72.17 with an ASC Payment Indicator (PI) of K2. The corrected code has 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 contractor adjustment of the previously processed claims.

**Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010, through September 30, 2010**

The payment rates for two HCPCS codes were incorrect in the July 2010 ASC DRUG file. The corrected payment rates are listed in Table 2 below and have been included in the revised July 2010 ASC DRUG file effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Suppliers who think they may have received an incorrect payment between July 1, 2010, and September 30, 2010, may request contractor adjustment of the previously processed claims.
Table 2 - Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010, through September 30, 2010

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>ASC Payment Rate</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9264</td>
<td>Paclitaxel protein bound</td>
<td>$9.22</td>
<td>K2</td>
</tr>
<tr>
<td>C9268</td>
<td>Capsaicin patch</td>
<td>$25.55</td>
<td>K2</td>
</tr>
</tbody>
</table>

Payment for Vaccine CPT Code 90670 Effective April 1, 2010

CPT code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) was erroneously assigned ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) in the July 2010 ASC update (CR 7008), effective April 1, 2010. Effective April 1, 2010, the payment for CPT code 90670 will change from ASC PI=K2 to ASC PI=L1 (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made). As a result, CPT code 90670 does not appear in the revised April 2010 and revised July 2010 ASC DRUG files.

Payment for Vaccine CPT Code 90662

CPT code 90662 (Long Descriptor: Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use; Short Descriptor: Flu vacc prsv free inc antig) has been assigned ASC PI=Y5. However, 90662 received approval from the Food and Drug Administration (FDA) on December 23, 2009. Therefore, effective December 23, 2009, CPT code 90662 is assigned ASC PI=L1 (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made).

New Device Pass-Through Category

Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

The OPPS has established one new pass-through device category as of October 1, 2010. The ASC payment system is also establishing the same device pass-through code for separate payment effective October 1, 2010. CMS has determined that it is not able to identify a portion of the OPPS procedure payment amount associated with the cost of the device; therefore, CMS will not reduce the ASC procedure payment to remove the costs of related predecessor devices packaged into the base procedure’s OPPS payment weight. Table 3 provides a listing of new ASC coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C1749 is assigned ASC PI=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

Table 3 - New ASC Device Pass-Through HCPCS Code Effective October 1, 2010

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1749</td>
<td>Endo, colon, retro imaging</td>
<td>Endoscope, retrograde imaging/illumination</td>
<td>J7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>colonoscope device (implantable)</td>
<td></td>
</tr>
</tbody>
</table>

Coding and Payment for Magnetic Resonance Angiography (MRA)

Effective for claims with dates of service on and after June 3, 2010, CMS permits local Medicare contractors to cover (or not cover) all indications of MRA that are not specifically nationally covered or nationally non-covered. CMS has created the six Level II HCPCS codes in Table 4 below to allow ASCs to bill for certain MRA services that were previously non-covered but may now be covered at local Medicare contractor discretion. These HCPCS codes are assigned ASC PI=Z2 (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) with the update to the Medicare Physician Fee Schedule authorized for June 1 through November 30, 2010, under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. The six Level II HCPCS codes must be used in place of existing CPT codes for the previously non-covered MRA procedures due to a statutory requirement that the OPPS provide payment for imaging services provided with contrast and without contrast through separate payment groups. Specifically, HCPCS codes C8931, C8932, and C8933 replace CPT code 72159 (Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)), while HCPCS codes C8934, C8935, and C8936 replace CPT code 73225 (Magnetic resonance angiography, upper extremity, with or without contrast material(s)).

Further information on billing and coverage for MRA is available to contractors in Transmittal 123 (CR7040), issued July 9, 2010.

Table 4 – Carrier Determination MRA Codes Effective June 3, 2010

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Short Descriptor</th>
<th>Payment Indicator Effective 06/03/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>C8931</td>
<td>Magnetic resonance angiography with contrast, spinal canal and contents</td>
<td>MRA, w/dye, spinal canal</td>
<td>Z2</td>
</tr>
<tr>
<td>C8932</td>
<td>Magnetic resonance angiography without contrast, spinal canal and contents</td>
<td>MRA, w/o dye, spinal canal</td>
<td>Z2</td>
</tr>
<tr>
<td>C8933</td>
<td>Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents</td>
<td>MRA, w/o &amp; w/dye, spinal canal</td>
<td>Z2</td>
</tr>
<tr>
<td>C8934</td>
<td>Magnetic resonance angiography with contrast, upper extremity</td>
<td>MRA, w/dye, upper extremity</td>
<td>Z2</td>
</tr>
<tr>
<td>C8935</td>
<td>Magnetic resonance angiography without contrast, upper extremity</td>
<td>MRA, w/o dye, upper extr</td>
<td>Z2</td>
</tr>
<tr>
<td>C8936</td>
<td>Magnetic resonance angiography without contrast followed by with contrast, upper extremity</td>
<td>MRA, w/o&amp;w/dye, upper extr</td>
<td>Z2</td>
</tr>
</tbody>
</table>

Coverage Determinations
The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Carriers/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, Carriers/MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

**Additional Information**
The official instruction, CR 7147 issued to your carrier and MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R2045CP.pdf](http://www.cms.gov/Transmittals/downloads/R2045CP.pdf) on the CMS website.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

**Consolidated Billing**


**MLN Matters® Number:** MM7159  
**Related Change Request (CR) #:** 7159  
**Related CR Release Date:** September 10, 2010  
**Effective Date:** January 1, 2011  
**Related CR Transmittal #:** R2048CP  
**Implementation Date:** January 3, 2011

**Provider Types Affected**
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered SNF stay.

**Provider Action Needed**
STOP – Impact to You
This article is based on Change Request (CR) 7159 which provides the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the
upate affects edits in Medicare claims processing systems.

**CAUTION – What You Need to Know**

Physicians and providers are advised that, by the first week in December 2010, new code files will be posted at [http://www.cms.hhs.gov/SNFConsolidatedBilling/](http://www.cms.hhs.gov/SNFConsolidatedBilling/) on the Centers for Medicare & Medicaid Services (CMS) website. Note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s FI/A/B MAC update listed at [http://www.cms.hhs.gov/SNFConsolidatedBilling/](http://www.cms.hhs.gov/SNFConsolidatedBilling/) on the CMS website in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

**BACKGROUND**

Medicare’s claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the Medicare Claims Processing Manual (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at [http://www.cms.gov/manuals/downloads/clm104c06.pdf](http://www.cms.gov/manuals/downloads/clm104c06.pdf) on the CMS website. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

**ADDITIONAL INFORMATION**

The official instruction, CR 7159, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed on the CMS website.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

**DMEPOS**

2010 Durable Medical Equipment Prosthetics, Orthotics and Supply (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List

- **MLN Matters® Number:** MM7110
- **Related Change Request (CR) #:** 7110
- **Related CR Release Date:** September 17, 2010
- **Effective Date:** December 22, 2010
- **Related CR Transmittal #:** R2056CP
- **Implementation Date:** December 22, 2010

**SUPPLIER TYPES AFFECTED**

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

**PROVIDER ACTION NEEDED**

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

**ADDITIONAL INFORMATION**

To see the official instruction (CR7110) issued to your Medicare DME MAC, carrier, or A/B MAC, visit [http://www.cms.gov/Transmittals/downloads/R2056CP.pdf](http://www.cms.gov/Transmittals/downloads/R2056CP.pdf) on the CMS website. The 2010 Jurisdiction List is attached to CR 7110.
End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services

MLN Matters® Number: MM7064
Related Change Request (CR) #: 7064
Related CR Release Date: August 20, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2033CP
Implementation Date: January 3, 2011

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for ESRD services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
This article is based on Change Request (CR) 7064 which announces the implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011.

CAUTION – What You Need to Know

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient’s home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a 4-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

GO – What You Need to Do

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the Background and Additional Information Sections of this article for further details regarding the ESRD PPS.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331 on the Internet) requires the Centers for Medicare & Medicaid services (CMS) to implement an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located;
- Patient-level adjustments for case-mix;
- An outlier adjustment (if applicable);
- Facility-level adjustments;
- A training add-on (if applicable); and
- A budget neutrality adjustment during the transition period through 2013.

Patient-level Adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters
for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier Adjustment

ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level Adjustments

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from Core Based Statistical Areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training Add-On

Facilities that are certified to furnish training services will receive a training add-on payment amount of $33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments Specific to Pediatric Patients

The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

ESRD PPS 4-year Phase-in (Transition) Period

The ESRD PPS provides ESRD facilities with a 4-year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Blended Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>75 percent of the old payment methodology, and 25 percent of new PPS payment</td>
</tr>
</tbody>
</table>
### Calendar Year | Blended Rate
--- | ---
2012 | 50 percent of the old payment methodology, and 50 percent of the new PPS payment
2013 | 25 percent of the old payment methodology, and 75 percent of the new PPS payment
2014 | 100 percent of the PPS payment

For Calendar Year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

**The ESRD PPS base rate is $229.63**, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 \((229.63 \times (1 - 0.41737) = 133.79)\).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: Providers wishing to opt out of the transition period blended rate must notify their Medicare Contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

### Three New Adjustments Applicable to the Adult Rate

1. **Comorbid Adjustments**: The new ESRD PPS provides for 3 categories of chronic comorbid conditions and 3 categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The 3 chronic comorbid categories eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia;
   - Monoclonal gammopathy (in the absence of multiple myeloma); and
   - Myelodysplastic syndrome.

   The 3 acute comorbid categories eligible for a payment adjustment are:
   - Bacterial Pneumonia;
   - Gastrointestinal Bleeding; and
   - Pericarditis

2. **Onset of Dialysis Adjustment**: An adjustment will be made for patients that have Medicare ESRD coverage during their first 4 months of dialysis. This adjustment will be determined by the dialysis start date in Medicare’s Common Working File as provided on the CMS Form 2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.

3. **Low-Volume Facility Adjustment**: Providers will receive an adjustment to their ESRD PPS rate when the facility
furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three (3) years preceding the payment year. The 3 years preceding treatment data should be reflected on the last 2 settled cost reports and the most recent must be filed. The provider must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment.

Change in Processing Home Dialysis Claims
For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate.

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility and
- Will be processed as Method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Consolidated Billing
CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary’s ESRD dialysis treatment and such services are billed with the AY modifier.

Other Billing Reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign Group code CO.
- All 72X claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional Information
The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2033CP.pdf on the CMS website. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services;
- Attachment 4, which is a list of DME ESRD Supply HCPCS codes used in for ESRD PPS consolidated billing.
edits;

- Attachment 5, which contains a list of DME ESRD Supply HCPCS codes that are NOT payable to DME suppliers;
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing;
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing; and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

THERAPY/REHAB

Intensive Cardiac Rehabilitation (ICR) Programs - Dr. Ornish’s Program for Reversing Heart Disease and the Pritikin Program

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

**PROVIDER TYPES AFFECTED**

This article is for physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, and Part A/B Medicare Administrative Contractors (A/B MAC)) for Intensive Cardiac Rehabilitation (ICR) program services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

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

**BACKGROUND**

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

In addition, the program must show (also in peer-reviewed literature) that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

1. low density lipoprotein;
2. triglycerides;
3. body mass index;
4. systolic blood pressure;
5. diastolic blood pressure; and
6. the need for cholesterol, blood pressure, and diabetes medications.


The Ornish Program for Reversing Heart Disease (also known as the Multisite Cardiac Lifestyle Intervention Program, the Multicenter Cardiac Lifestyle Intervention Program, and the Lifestyle Heart Trial Program) was initially described in the 1970s and incorporates comprehensive lifestyle modifications including exercise, a low-fat diet, smoking cessation, stress management training, and group support sessions. Over the years, the Ornish program has been refined, but continues to focus on these specific risk factors.

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

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

Additional Information

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

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

Physical Therapy Reporting and Documentation Issues

Recent physical therapy reviews conducted by the Medical Review Part B department have revealed several areas of concern. The issues found during these reviews are as follows:

- When reporting timed therapy codes, the medical records do not clearly document the time spent performing these services;
- Treatment plans are not being followed; and,
- Services are billed under incorrect rendering provider numbers.

Timed Therapy Codes

Several CPT codes for therapy modalities specify that the direct time spent in patient contact is based on each 15 minutes. Providers should report the appropriate procedure codes for therapy services performed on a calendar day using the number of units that correspond to the time spent delivering therapy. For example, when a timed therapy service is rendered for 8 – 22 minutes, one unit would be reported. Please refer to the Internet Only Manual (IOM) 100-04, Chapter 5, Section 20.3 located at http://www.cms.gov/manuals for additional information on reporting timed services. The beginning and ending time of the treatment should be recorded in the patient’s medical record with a note describing the treatment. The total length of the treatment to the minute should be recorded.

Therapy Treatment Plans

Treatment plans of care should document, at a minimum, the following information:

- Diagnoses;
- Long term treatment goals; and
- Type, amount, duration and frequency of therapy services.

The plan of care shall be consistent with the related evaluation. The plan should strive to provide treatment in the most efficient and effective manner, balancing the best achievable outcome with the appropriate resources.

The frequency or duration of the treatment alone may not be used alone to determine medical necessity, but they are considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patients’ goals. For example, it may be clinically appropriate, medically necessary, and most efficient and effective to provide short term intensive treatment or longer term and less frequent treatment depending on the individuals’ needs.

Therapy services provided should be consistent with the current treatment plan. When there is a deviation from the treatment plan (i.e., frequency of services), the documentation must clearly indicate the reasons for the deviations. If necessary, the therapist can make insignificant changes to the treatment plan.

Reporting of Correct Rendering Provider

Highmark Medicare Services conducts data analysis to determine aberrancies in billing or payment patterns to identify potential problems.

Based on the data analysis, claims may be reviewed to validate the hypothesis that such claims are being billed incorrectly. The billing of an incorrect rendering provider may cause such aberrancies and can skew the data. This may be an indication to initiate a review on the rendering provider and/or the billing group.

The reporting of an incorrect rendering provider can cause claims to be denied. To ensure the prompt processing of claims and undue denials please verify that the documentation supports the rendering provider that is being reported and
the rendering physician number is correct prior to submitting the claim.

All providers performing services for a group practice should have an individual active rendering provider number. Providers should enroll in the Medicare program and be assigned to the group practice. For more information on enrolling in Medicare and to obtain the appropriate enrollment forms, please see the Highmark Medicare Services Part A/B Reference Manual, Chapter 3.

---

**Reimbursement**

---

**Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs**

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

**Provider Types Affected**

This article is for physicians and other providers submitting claims to Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MAC)) for services on the Ambulatory Surgical Centers (ASC) Fee Schedule (ASCFS).

**What You Need To Know**

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

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

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

**Background**

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

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

- Claim Adjustment Reason Code 171 - Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code 97 – Not paid to practitioner when provided to patient in this place of service. Payment included in reimbursement issued the facility.
- Remittance Advice Remark Code M16 – Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

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

- Remittance Advice Remark Code N200 – The professional component must be billed separately
- Claim Adjustment Reason Code 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note Refer to the 835 healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
AdditionAl Information
If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.
The official instruction, CR 7078, issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2020CP.pdf on the CMS website.

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

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

Provider Types Affected
Physicians and non-physician practitioners submitting claims to Fiscal Intermediaries (FI), carriers or A/B Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries are affected.

What You Need to Know
Payment files were issued to Medicare contractors based upon the 2010 Medicare Physician Fee Schedule Final Rule. This article is based on Change Request (CR) 7112, which amends those payment files. Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that were processed prior to implementation of CR 7112. However, contractors will adjust claims brought to their attention.

Background
Changes included in the October Update to the 2010 Medicare Physician Fee Schedule Database (MPFSDB) are as follows:

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

<table>
<thead>
<tr>
<th>CPT/HCPCS/Modifier</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>51725 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51726 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51727 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51728 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51729 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51736 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51741 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51784 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51785 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>51792 – TC</td>
<td>Multiple Procedure Indicator: 2</td>
</tr>
<tr>
<td>54240</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>54240 – 26</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>54250</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>54250 – 26</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>59020</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>59020 – 26</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>59025</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>59025 – 26</td>
<td>Multiple Procedure Indicator: 0</td>
</tr>
<tr>
<td>76813 – TC</td>
<td>Physician Supervision Diagnostic Indicator: 01</td>
</tr>
<tr>
<td>76814 – TC</td>
<td>Physician Supervision Diagnostic Indicator: 01</td>
</tr>
<tr>
<td>G8443</td>
<td>Procedure Status: I</td>
</tr>
</tbody>
</table>
Magnetic Resonance Angiography

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

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

Descriptor Changes

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Revised Long Descriptor</th>
<th>Revised Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0432</td>
<td>Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening</td>
<td>N/A</td>
</tr>
<tr>
<td>G0433</td>
<td>Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening</td>
<td>N/A</td>
</tr>
<tr>
<td>G0435</td>
<td>Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening</td>
<td>Rapid immunoassay HIV-1,2</td>
</tr>
</tbody>
</table>

Additional Information


If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.


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

This article is for clinical laboratories billing Medicare Carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs).

**Provider Action Needed**

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

- For claims with Date of Service (DOS) on or after January 1, 2010, the new test code G0431 (Drug Screen, Qualitative; Single Drug Class Method) must be utilized by those clinical laboratories that do not require a Clinical Laboratory Improvement Act (CLIA) certificate of waiver as CPT codes 80101 and 80101QW are not valid on the Clinical Laboratory Fee Schedule as of January 1, 2010.

- Clinical laboratories should identify claims that were filed and denied during the period of January 1, 2010 through June 30, 2010, as a result of CPT 80101, and resubmit these claims with HCPCS code G0431. However, do not resubmit such claims if they were paid by Medicare.

- For claims with DOS on or after January 1, 2010, clinical laboratories that do require a CLIA certificate of waiver must utilize the new test code G0431QW.

**Background**

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

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

For claims with DOS on or after January 1, 2010, those clinical laboratories that do require a CLIA certificate or waiver must utilize the new test code G0431QW.

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

**Additional Information**

The official instruction, CR 7140 issued to your carrier, FI, and A/B MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R776OTN.pdf](http://www.cms.gov/Transmittals/downloads/R776OTN.pdf) on the CMS website.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

**January 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**

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

**Provider Types Affected**

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

**Provider Action Needed**

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

**BACKGROUND**

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

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2011 ASP and ASP NOC files</td>
<td>January 1, 2011 through March 31, 2011</td>
</tr>
<tr>
<td>October 2010 ASP and ASP NOC files</td>
<td>October 1, 2010, through December 31, 2010</td>
</tr>
<tr>
<td>July 2010 ASP and ASP NOC files</td>
<td>July 1, 2010, through September 30, 2010</td>
</tr>
<tr>
<td>April 2010 ASP and ASP NOC files</td>
<td>April 1, 2010, through June 30, 2010</td>
</tr>
<tr>
<td>January 2010 ASP and ASP NOC files</td>
<td>January 1, 2010, through March 31, 2010</td>
</tr>
</tbody>
</table>

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

**ADDITIONAL INFORMATION**

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

The official instruction (CR 7188) issued to your Medicare MAC, carrier, and/or FI may be found at [http://www.cms.gov/Transmittals/downloads/R2067CP.pdf](http://www.cms.gov/Transmittals/downloads/R2067CP.pdf) on the CMS website.

**Coding Guidelines and Claim Reporting**

Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home

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

**Note:** This article was revised on September 1, 2010, to reflect a revised CR 6947, which was re-issued on August 31, 2010. The article was revised to show a new CR release date, transmittal number and Web address for accessing CR 6947. All other information remains the same.

**Provider Types Affected**

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

**What You Need to Know**

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

**BACKGROUND**

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

Specifically, CR 6947 from which this article is taken, announces that effective for claims that you submit using the 5010 version of the ANSI X12N 827 P electronic claim form that are processed on or after January 1, 2011, and for paper claims that you submit on the Form CMS-1500 with dates of service on or after January 1, 2011; you will need to submit the address and 5 digit ZIP code (or the 9-digit code when required per the CMS ZIP Code file) of where the service was provided for services performed in all places of service, including POS home – 12, (and any other POS that contractors at their discretion consider to be home). Your carrier or A/B MAC will use that ZIP code to determine the correct payment locality.

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

When returning these claims with more than one POS, Medicare contractors will use the following Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARCs)

- CARC 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.
- RARC M77 - Missing/incomplete/invalid place of service
- RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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

- CARC 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.
- RARC MA114 - Missing/incomplete/invalid information on where the services were furnished.
- RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

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

Additional Information

You can find the official instruction, CR, 6947, issued to your carrier or A/B MAC by visiting http://www.cms.gov/Transmittals/downloads/R2041CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

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

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

Discarded Drugs and Biologicals Policy at Contractor Discretion

MLN Matters® Number: MM7095
Related Change Request (CR) #: 7095
Related CR Release Date: August 20, 2010
Effective Date: July 30, 2010
Related CR Transmittal #: R758OTN
Implementation Date: September 21, 2010

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs) and/or durable medical equipment (DME) MACs) for drugs or biologicals administered to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7095 which is being issued in response to inquiries related to CR 6711 pertaining to the use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded
drugs and biologicals.

CAUTION – What You Need to Know

CR 7095 instructs that each Medicare contractor 1) has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and 2) will notify their respective providers of such requirements associated with the use of the JW modifier.

GO – What You Need to Do

Your Medicare contractor will provide you with details concerning the use of the JW modifier for discarded drugs and biological. Be sure to follow those requirements.

BACKGROUND

Previously, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6711 (see the MLN Matters® article related to CR 6711 at http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf on the CMS website)) which updated the Medicare Claims Processing Manual (Chapter 17, Section 40) and provided policy on the appropriate use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs or biologicals. After issuing CR 6711, CMS received several inquiries from various providers regarding how the JW modifier is to be used for their Medicare Part B drug claims.

CR 7095 is being issued in response to these inquiries, and it instructs that each Medicare contractor:

- Has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and
- Will notify their respective providers of such requirements associated with the use of the JW modifier.

ADDITIONAL INFORMATION

The official instruction, CR 7095, issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R758OTN.pdf on the CMS website.

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

Beneficiary-Submitted Claims

MLN Matters® Number: MM6874
Related Change Request (CR) #: 6874
Related CR Release Date: August 20, 2010
Effective Date: November 29, 2010
Related CR Transmittal #: R2031CP
Implementation Date: November 29, 2010

PROVIDER TYPES AFFECTED

All physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries are affected by this issue.

PROVIDER ACTION NEEDED

This article, based on CR 6874, clarifies instructions for processing claims by carriers and A/B MACs that are submitted by Medicare beneficiaries. All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, Section 1848 (g)(4)(A) of the Social Security Act requires all providers and suppliers submit claims for services rendered to Medicare beneficiaries. The current manual requirement instructs Medicare contractors how to process claims submitted by Medicare beneficiaries when the provider or supplier refuses to submit claims for services rendered and/or refuses to enroll in Medicare.

Medicare contractors will also provide education to the Medicare beneficiaries on how to submit complete claims, including all supporting documentation. Please inform your billing staffs of these instructions. These requirements apply to all claims received on or after November 29, 2010, without regard to the date of service.

Note: These instructions do not apply to foreign claims or Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims.

BACKGROUND

Medicare contractors will:

1. Process beneficiary-submitted claims for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services; see 42 CFR 411.15 for details at http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr411.15.htm on the Internet), in accordance with its normal processing procedures.

2. Process beneficiary-submitted claims for services that are covered by Medicare when the beneficiary has
submitted a complete claim on Form CMS-1490S, which is available at http://www.cms.hhs.gov/cmsforms/downloads/cms1490s-english.pdf on the Centers for Medicare & Medicaid Services (CMS) website, and all supporting documentation associated with the claim, including an itemized bill with the following information:

- Date of service;
- Place of service;
- Description of illness or injury;
- Description of each surgical or medical service or supply furnished;
- Charge for each service;
- The doctor’s or supplier’s name and address; and
- The provider or supplier’s National Provider Identifier (NPI).

Since there is no place on Form CMS-1490S to insert a provider or supplier’s NPI, claims submitted by the beneficiary without the provider or supplier’s NPI will not be considered incomplete. The contractor will use the NPI registry to locate the provider or supplier’s NPI. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, contractors will follow previously established procedures in order for the claim to be processed and adjudicated through the claims processing system. If an incomplete claim or a claim containing invalid information is submitted, the contractor will return the claim as incomplete with an appropriate letter to the beneficiary that communicates the specific items listed above which were missing or invalid.

3. When returning a beneficiary-submitted claim (Form CMS-1490S) for a Medicare-covered service because the claim is not complete or contains invalid information, the contractor will retain the Form CMS-1490S and supporting documentation for purposes of the timely filing rules in the event that the beneficiary resubmits the claim (see below).

When returning a beneficiary-submitted claim, the contractor will also inform the beneficiary, by letter, that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary’s behalf (for services that would otherwise be payable by Medicare), and/or refused to enroll in Medicare, the beneficiary should:

1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare; and
2) Submit a complete Form CMS-1490S with all supporting documentation.

Medicare contractors will process and pay the beneficiary’s claim if it is for a service that would be payable by Medicare were it not for the provider’s or supplier’s refusal to submit the claim and/or enroll in Medicare. The only exception would be for sanctioned and opt-out providers. Payment may only be made on the first claim submitted for services provided by an excluded/sanctioned or opt-out provider. No further payments will be made for services rendered by such providers after the first claim is paid.

Contractors will maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

**Additional Information**

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

The official instruction, CR 6874, issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2031CP.pdf on the CMS website.

**New Waived Tests**

MLN Matters® Number: MM7084  
Related Change Request (CR) #: 7084  
Related CR Release Date: August 27, 2010  
Effective Date: October 1, 2010  
Related CR Transmittal #: R2038CP  
Implementation Date: October 4, 2010

**Provider Types Affected**

Clinical laboratories and providers submitting claims to Medicare contractors (carriers and Medicare Administrative Contractors (MACs)) for laboratory test services provided to Medicare beneficiaries are affected.

**Provider Action Needed**

This article is based on Change Request (CR) 7084, which informs Medicare contractors of new Clinical Laboratory
Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Be sure your billing staffs are aware of the changes.

**BACKGROUND**

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Medicare and Medicaid programs only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW, defined as CLIA waived test, to be recognized as a waived test. However, the test with CPT code 82962 does not require a QW modifier to be recognized as a waived test.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0430QW</td>
<td>January 1, 2010</td>
<td>Noble medical Inc. Split-Specimen Cup</td>
</tr>
<tr>
<td>82274QW, G0328QW</td>
<td>March 1, 2010</td>
<td>Inverness Medical Clearview iFOBT Complete Fecal Occult Blood Test</td>
</tr>
<tr>
<td>82010QW, 82962 (no QW modifier needed)</td>
<td>March 2, 2010</td>
<td>Nova Biomedical Nova Max Plus Glucose and B-Ketone Monitoring System</td>
</tr>
<tr>
<td>83986QW</td>
<td>April 15, 2010</td>
<td>Common Sense Ltd. VS-Sense Test(qualitative)</td>
</tr>
<tr>
<td>85610QW</td>
<td>April 15, 2010</td>
<td>CoaguSense Self-Test Prothrombin Time/INR Monitoring System (Prescription Home Use)</td>
</tr>
<tr>
<td>G0430QW</td>
<td>April 21, 2010</td>
<td>Redwood Toxicology Laboratory, Inc RediTest Freedom Cup</td>
</tr>
<tr>
<td>G0430QW</td>
<td>April 21, 2010</td>
<td>Noble Medical Inc. NOBLE 1 Step Cup (OTC)</td>
</tr>
<tr>
<td>G0430QW</td>
<td>April 30, 2010</td>
<td>Express Diagnostics, DrugCheck Waive Cup</td>
</tr>
<tr>
<td>G0430QW</td>
<td>April 30, 2010</td>
<td>Express Diagnostics International Inc. DrugCheck Waive Multiple Drug Screen Cups</td>
</tr>
<tr>
<td>81003QW</td>
<td>June 3, 2010</td>
<td>Cole-Taylor Marketing Inc. CTI-120 Urine Strip Analyzer</td>
</tr>
</tbody>
</table>

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims processed prior to implementation of these changes. However, they will adjust such claims that you bring to their attention.

**ADDITIONAL INFORMATION**

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

The official instruction, CR 7084, issued to your Medicare carrier and/or MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R2038CP.pdf](http://www.cms.gov/Transmittals/downloads/R2038CP.pdf) on the CMS website.
**Coverage Issues**

**Common Working File (CWF) Override Edit for Kidney Transplant Donor Claims When the Kidney Recipient is Deceased**

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

**Note:** This article was revised on August 6, 2010, to reflect a revised CR 6978, which was re-issued on August 5, 2010. The article was revised to include Regional Home Health Intermediaries (RHHIs) in the Section listing provider types affected. All other information is the same.

**Provider Types Affected**

This article is for physicians and providers submitting claims to Medicare carriers, fiscal intermediaries (FIs), RHHIs, or Part A/B Medicare Administrative Contractors (A/B MACs) for live kidney donor and related services for Medicare beneficiaries.

**Provider Action Needed**

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

**Background**

Medicare instructions allow donor expenses incurred after the death of the kidney recipient to be treated as incurred before the death of the kidney recipient. However, some of these claims are being rejected by Medicare systems. CR6978 corrects this problem for services performed on or after January 1, 2011.

**Key Points of CR 6978:**

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

**Additional Information**

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.


**Positron Emission Tomography (FDG PET) for Initial Treatment Strategy (PI) in Solid Tumors and Myeloma**

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

**Provider Types Affected**

This article is for physician, hospitals, and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (A/B MAC)) for providing Fluorodeoxyglucose Positron Emission Tomography (FDG PET) services to Medicare beneficiaries.

**What You Need to Know**

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

Therefore, effective August 4, 2010, Medicare will continue to nationally cover one FDG PET scan for these indications; and Local Medicare Contractors will have discretion to cover (or not cover), within their jurisdictions, any additional FDG PET scans for therapeutic purposes related to the initial treatment strategy.

You should make sure that your billing staffs are aware of this National Coverage Determination (NCD)

**BACKGROUND**

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

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

CMS believes that the usefulness of an additional FDG PET scan in the initial treatment plan for any individual beneficiary might be affected by their specific medical problem, the availability of results of other diagnostic tests, and the expertise of the interpreting physician. CMS does not believe an NCD is the most appropriate way to address coverage for additional FDG PET scans in these situations, but rather believes that the local Medicare contractor should determine the efficacy for these tests for therapeutic purposes related to initial treatment strategy.

Effective for claims with dates of service on or after August 4, 2010, CMS issued a final decision memorandum which:

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

**ADDITIONAL INFORMATION**

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

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

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

**Counseling to Prevent Tobacco Use**

**MLN Matters® Number:** MM7133  
**Related Change Request (CR) #:** 7133  
**Related CR Release Date:** September 30, 2010  
**Effective Date:** August 25, 2010  
**Related CR Transmittal #:** R125NCD and R2058CP  
**Implementation Date:** January 3, 2011

**Provider Types Affected**

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for tobacco cessation counseling services provided to Medicare beneficiaries who are outpatients or are hospitalized are affected.

**Provider Action Needed**

STOP – Impact to You

This article is based on Change Request (CR) 7133 which announces that the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use for outpatient and hospitalized beneficiaries.
CAUTION – What You Need to Know

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

GO – What You Need to Do

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

Medicare will pay claims not paid under the Outpatient Prospective Payment System (OPPS) with dates of service on or after August 25, 2010, through December 31, 2010, but received prior to January 1, 2011, when billed with diagnosis code 305.1 (non-dependent tobacco-use disorder) or V15.82 (history of tobacco use) and unlisted HCPCS code 99199 for Counseling to Prevent Tobacco Use Services. Code 99199 is Medicare contractor-priced.

However, two new, temporary C codes have been created for facilities paid under the OPPS when billing for Counseling to Prevent Tobacco Use and Tobacco-Related Disease services during the interim period of August 25, 2010, through December 31, 2010. (Facilities paid under the OPPS may not bill the unlisted 99199 code.) The two new C codes are:

- **C9801**: Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes,
  Short descriptor: Tobacco-use counsel 3-10 min;
• C9802: Long Descriptor: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes,
  Short descriptor: Tobacco-use counsel >10 min.

CMS will allow two individual tobacco cessation counseling attempts per year. Each attempt may include a maximum of four intermediate OR intensive sessions, with a total benefit covering up to 8 sessions per year per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than 3 minutes up to 10 minutes) or intensive (more than 10 minutes) cessation counseling sessions for each attempt.

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

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

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Method of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health Centers (RHCs) (Type of Bill (TOB) 71X)/Federally Qualified Health Centers (FQHCs) (TOB 77X)</td>
<td>All-inclusive rate (AIR) for the encounter</td>
</tr>
<tr>
<td>Hospitals (TOBs 12X and 13X)</td>
<td>OPPS for hospitals subject to OPPS</td>
</tr>
<tr>
<td></td>
<td>Medicare Physician Fee Schedules (MPFS) for hospitals not subject to OPPS</td>
</tr>
<tr>
<td>Indian Health Services (IHS) (TOB 13X)</td>
<td>AIR for the encounter</td>
</tr>
<tr>
<td>Skilled Nursing Facilities (SNFs) (TOBs 22X and 23X)</td>
<td>MPFS</td>
</tr>
<tr>
<td>Home Health Agencies (HHAs) (TOB 34X)</td>
<td>MPFS</td>
</tr>
<tr>
<td>Critical Access Hospitals (CAHs) (TOB 85X), IHS CAHs (TOB 85X)</td>
<td>Method I: Technical services are paid at 101% of reasonable cost. Method II: technical services are paid at 101% of reasonable cost, and Professional services are paid at 115% of the MPFS</td>
</tr>
<tr>
<td></td>
<td>Based on specific rate</td>
</tr>
<tr>
<td>Maryland Hospitals</td>
<td>Payment is based according to the Health Services Cost Review Commission (HSCRC) that is 94% of submitted charges subject to any unmet deductible, coinsurance, and non-covered charges policies.</td>
</tr>
</tbody>
</table>

Note also the following claims processing information from CR 7133:

- Claims submitted with the tobacco cessation counseling codes of G0436 and G0437, but which lack a required diagnosis code (305.1 or V15.82) will be denied with Claim Adjustment reason Code (CARC) 167 (This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Health Care Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), Remittance Advice Remarks Code (RARC) M64 (Missing/incomplete/invalid other diagnosis), and Group Code PR assigning financial liability to the beneficiary if a claim is received with a signed Advance Beneficiary Notice (ABN). If no ABN is on file, Group Code CO is used to assign financial liability to the provider.
- Claims are accepted for G0436 and G0437 with revenue code 0942 on TOB 12X, 13X, 22X, 23X, 34X, and 85X.
- Claims are accepted for G0436 and G0437 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II under the MPFS.
- Claims are accepted for G0436 and G0437 with revenue code 052X when billed on TOBs 71X or 77X.
- Claims are accepted for G0436 and G0437 with revenue code 0510 when billed by IHS facilities.
- Institutional claims billed on TOBs other than 12X, 13X, 22X, 23X, 34X, 71X, 77X, or 85X will be returned to the provider.
- When claims are denied for exceeding a combined total of eight (8) sessions within a 12-month period, the claims will be denied using CARC 119 (Benefit maximum for this time period or occurrence has been reached.), RARC N362 (The number of days or units of service exceeds our acceptable maximum.), and Group code PR if a signed
ABN is on file. A Group Code of CO is assigned if no ABN is on file.

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

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

**AdditionAl Information**


If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.

**Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) for Myelodysplastic Syndrome (MDS)**

MLN Matters® Number: MM7137
Related Change Request (CR) #: 7137
Related CR Release Date: October 8, 2010
Effective Date: August 4, 2010
Related CR Transmittal #: R127NCD and R2062CP
Implementation Date: November 10, 2010

**Provider Types Affected**

This article is for physicians, providers, and hospitals billing Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (A/B MACs)) for providing Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) services to Medicare beneficiaries with Myelodysplastic Syndrome (MDS).

**What You Need To Know**

Change Request (CR) 7137, from which this article is taken, announces (through a National Coverage Determination (NCD)) that, effective for claims with dates of service on and after August 4, 2010, Medicare will cover the use of Allogeneic HSCT for treatment of MDS under section 1862(a)(1)(E) of The Social Security Act (the Act) ONLY if provided in the context of a Medicare-approved clinical study meeting specific criteria under Coverage with Evidence Development (CED). The Centers for Medicare & Medicaid Services (CMS), pursuant to the NCD process, has determined that the evidence does not demonstrate the use of Allogeneic HSCT improves health outcomes in Medicare beneficiaries with MDS, is not reasonable and necessary under section 1862(a)(1)(A) of the Act, and is therefore not covered by Medicare EXCEPT when provided in a Medicare-approved clinical study.

**Background**

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

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

**Coding Information**

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

Effective for claims with discharge dates on or after August 4, 2010, your Inpatient claims (Type of Bill (TOB) 11X)) for HSCT for the treatment of MDS in a clinical study must contain:

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

Outpatient hospital claims (TOB13X) for dates of service on or after August 4, 2010, for HSCT for the treatment of MDS in a clinical study must contain:
• HSCT CPT code 38240;
• MDS ICD-9-CM diagnosis code 238.75;
• Clinical Trial ICD-9-CM diagnosis code V70.7; and
• Clinical Trial Procedure Code Modifier Q0.

Practitioner claims for dates of service on or after August 4, 2010, billed by a Method II Critical Access Hospital on TOB 85X with Revenue Code 96X, 97X, or 98X, for HSCT for the treatment of MDS must contain:
• HSCT CPT code 38240;
• MDS ICD-9-CM diagnosis code 238.75;
• Clinical Trial ICD-9-CM diagnosis code V70.7; and
• Clinical Trial Procedure Code Modifier Q0.

Professional claims for HSCT for the treatment of MDS for dates of service on or after August 4, 2010, for HSCT for the treatment of MDS must contain
• HSCT CPT code 38240;
• MDS ICD-9-CM diagnosis code 238.75;
• Clinical Trial ICD-9-CM diagnosis code V70.7;
• Clinical Trial Procedure Code Modifier Q0; and
• Place of Service Code 21 or 22.

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

Medicare Contractors will use the following messages if they deny claims for HSCT for the treatment of MDS that do not contain all of the required coding requirements mentioned above:
• Claim Adjustment Reason Code (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.
• Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
• Group Code - Patient Responsibility (PR) if an Advance Beneficiary Notice (ABN) or Hospital Issued Notice of Non-coverage (HINN) given to the beneficiary, otherwise Contractual Obligation (CO).

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

ADDITIONAL INFORMATION

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

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

If you have any questions, please contact the Customer Contact Center at 1-877-235-8073.
Updated Taxonomy Codes

The Healthcare Provider Taxonomy Codes (HPTC) have been updated. The effective date for the new codes is January 1, 2011. The HPTC is a Provider Classification System, which codifies provider types and areas for all medical-related providers. The new version of HPTC is available from the Washington Publishing Company at http://www.wpc-edi.com/codes/taxonomy.

If a HPTC is reported to Medicare, it must be a valid code or a claim level deletion (rejection) will occur on your MCS Edit Report. To avoid this type of claim level deletion (rejection), you need to verify that the HPTC entered in your software program is still valid by comparing the HPTC entered in your software to the new list of valid HPTCs. For help changing the HPTCs in your system, please contact your software vendor.

For your reference, the new, deleted, and changed codes effective January 1, 2011, are listed below.

<table>
<thead>
<tr>
<th>New Codes</th>
<th>Inactive Codes</th>
<th>Modified Code Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>174200000X</td>
<td>103GC07000X</td>
<td>177F00000X</td>
</tr>
<tr>
<td>224900000X</td>
<td>103TE10000X</td>
<td>222Z00000X</td>
</tr>
<tr>
<td>224L00000X</td>
<td>103TM17000X</td>
<td>224P00000X</td>
</tr>
<tr>
<td></td>
<td>103TP27000X</td>
<td>225A00000X</td>
</tr>
<tr>
<td>103TW01000X</td>
<td>225000000X</td>
<td></td>
</tr>
<tr>
<td>1835G0000X</td>
<td>333300000X</td>
<td></td>
</tr>
<tr>
<td>213EG0000X</td>
<td>335E00000X</td>
<td></td>
</tr>
<tr>
<td>287300000X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2865C1500X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>317400000X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NEW PC-ACE Pro32 VERSION 2.24 UPGRADE AVAILABLE - UPGRADE NOW!**

PC-ACE Pro32 is a software program that enables electronic billing for both Medicare Part A and Part B claims in a HIPAA-compliant format. To provide the most up-to-date information within PC-ACE Pro32, the software program is updated quarterly. The most current upgrade, which is **PC-ACE Pro32 version 2.24, was released on October 1, 2010. Please take time now to upgrade immediately.**

To streamline the distribution process for software program upgrades, the PC-ACE Pro32 software program is available via Internet download from our Web page located at: https://www.highmarkmedicareservices.com/edi/download-pcace.html. Please note: the installation password is required to install the PC-ACE Pro32 software. This password was provided to you in previous upgrade letters or your initial enrollment letter.

Notification of the upgrade was sent to all customers that are signed up for the PC-ACE Pro32 electronic mailing list. If you are a PC-ACE Pro32 customer and have not signed up for the electronic mailing list, please go to: https://www.highmarkmedicareservices.com/mailinglists.html to subscribe.

If upgrading via CD-ROM, there is a non-refundable service fee of $25 for postage and handling for each quarterly update totaling $100 annually, paid annually. To request the CD-ROM, complete the PC-ACE Pro32 CD-ROM Request form located on our Web site: https://www.highmarkmedicareservices.com/edi/pc-ace/index.html. Mail the PC-ACE Pro32 CD-ROM Request form with the required $100 annual payment to the address shown on the form. To save time and money for you and the Medicare program, we strongly encourage you to download this program via the Internet when enrolling or upgrading.

New With This Release

A reminder message will pop-up when you open the PC-ACE Pro32 software program if you forget to upgrade within two weeks of all future upgrades.

If you would like more information about PC-ACE Pro32 or would like to enroll to begin using this software program, please visit our Web site at: http://www.highmarkmedicareservices.com/edi/index.html

If you have questions or require additional assistance, please contact an EDI Analyst at: 1-866-488-0546.

Reminder: Diagnosis Code Reporting for Electronic Claims

When reporting diagnosis information for electronic claims, eight diagnosis codes may be submitted per claim. However, for each line of service on the electronic claim, only four diagnosis code pointers may be indicated.

At the line of service, report the diagnosis code pointer of the primary diagnosis in the first diagnosis code pointer field. Use the remaining three diagnosis code pointers in declining level of importance to the service. The acceptable values for the diagnosis code pointers are 1 through 8. If more than four diagnosis code pointers are reported on the service line, the claim file will reject at the 997 Functional Acknowledgement level.

Technically speaking, when reporting diagnosis code information, the diagnosis codes and diagnosis code pointers are reported as follows:

<table>
<thead>
<tr>
<th>Loop</th>
<th>Segment</th>
<th>Data Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>HI01-2 through HI08-2</td>
<td>Diagnosis Code – 8 codes</td>
</tr>
<tr>
<td>2400</td>
<td>SV1-07</td>
<td>Diagnosis Code Pointer – 4 pointers</td>
</tr>
</tbody>
</table>

Always confirm the diagnosis code pointer for the primary diagnosis code is reported in the first diagnosis code pointer field. If you are billing more than four diagnosis code pointers or have questions whether the diagnosis pointers are correctly reported on your electronic claims, please contact your software vendor.

Do You REALLY Qualify for an ASCA Waiver?

The Administrative Simplification Compliance Act (ASCA) requires that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. Medicare will not cover claims submitted on paper that do not meet the limited exception criteria. ASCA provides exceptions as stated in Chapter 24, section 90 of the Medicare Claims Processing Manual on the Centers for Medicare & Medicaid Services’ (CMS) Web site. Refer to this documentation for complete instructions at: http://www.cms.gov/manuals/downloads/clm104c24.pdf

Medicare contractors are required to monitor and enforce the ASCA regulations. Highmark Medicare Services conducts quarterly analysis of paper claim receipts. Following the analysis, a letter is mailed to the providers who submitted a high volume of paper claims the previous quarter. This letter requests a response and explains the possible exceptions and what accompanying documentation is needed to support these exceptions. If a response to the letter is not received with acceptable evidence to substantiate eligibility to submit paper claims, all paper claims will begin to reject the 91st day after the date of the letter. This decision cannot be appealed.

Exceptions to the electronic claim submission requirement include:

- A small provider - a facility (Medicare Part A) that has fewer than 25 Full-Time Equivalent employees (FTEs), or a physician, practitioner, or supplier (Medicare Part B) with fewer than 10 FTEs;
- A dentist;
- A participant in a Medicare demonstration project in which paper claim filing is required;
- A provider that conducts mass immunizations, such as flu injections, and may be permitted to submit paper roster bills;
- A provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment;
- A provider that only furnishes services outside of the United States;
- A provider experiencing a disruption in electricity and communication connections that are beyond its control; and
- A provider that can establish an “unusual circumstance” exists that precludes submission of claims electronically.

The inability to submit claims electronically to Medicare when Medicare is the Secondary payer is not a qualifying reason...
for a waiver. Software is available to submit MSP claims electronically. This exception applies only when there is more than one payer primary to Medicare.

A condensed version of the ASCA is available in Medicare Learning Network (MLN) Matters articles at:


The EDI Help Desk is available at 1-866-488-0546 to answer any additional questions.

**Clearinghouse, Billing Service, and Vendor – Do You Know the Difference?**

Clearinghouse, billing service, and vendor are terms that are frequently used in the Electronic Billing (EDI) environment. They are all third party entities that interface with EDI. It’s important to know the differences between them to aid you in filling out required Block J of the Setup Requirements form (8276) and to help you determine if you will also need to submit Section 8 of the CMS-855 form.

Clearinghouses transfer EDI transactions for a provider. They translate the provider data into the required format. A clearinghouse accepts multiple types of claims and sends them to various payers including Medicare. They also accept EDI transactions from payers for routing to and/or reformatting for providers. Clearinghouses perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider. Clearinghouses frequently reformat data files to submit to various payers and manage response reports including acknowledgements, edit reports, and remittance advices.

A billing service collects the providers’ claim information and creates the electronic claim to bill to the appropriate insurance companies, including Medicare. It may provide claims billing services only or provide full financial accounting and/or other services. Billing services may also view beneficiary or provider data to perform their obligations to the provider, if the provider designates them for that access. To qualify as a billing service, the entity must submit initial claims on the provider’s behalf.

Vendors provide hardware, software and/or ongoing support for total office automation for submission of EDI transactions directly to individual insurance companies.

Highmark Medicare Services’ EDI department has a Vendor List (https://www.highmarkmedicareservices.com/edi/pdf/vendor_list.pdf) which contains contact information for software vendors, billing services and clearinghouses who supply systems or services capable of transmitting electronic claims and receiving electronic reports to Medicare. The Vendor List is located on the Electronic Billing (EDI) Center, in the EDI Enrollment section (https://www.highmarkmedicareservices.com/edi/index.html).

For additional information, please contact the EDI Help Desk at 1-866-488-0546.

MLN Matters® Number: MM6975
Related Change Request (CR) #: 6975
Related CR Release Date: May 21, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R709OTN
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, providers and suppliers who bill Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Regional Home Health Intermediaries (RHHI)), for services provided to Medicare beneficiaries.

Provider Action Needed

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

Key Points of CR6975

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

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

Background

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

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

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

Additional Information

For additional information, please contact the EDI Help Desk at 1-866-488-0546.

The official instruction associated with this CR6975, issued to your Medicare Carrier, A/B MAC, FI and/or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R709OTN.pdf on the CMS website.
**Claim Status Category and Claim Status Codes Update**

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

**Provider Types Affected**

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Part A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected by this article.

**Provider Action Needed**

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

**Background**

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

**Additional Information**

For additional information, please contact the EDI Help Desk at 1-866-488-0546. The official instruction, (CR 7158), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2049CP.pdf on the CMS website.
**Medicare Insights Weekly**

**What is A Podcast?**

According to Wikipedia, the Free Encyclopedia:

A podcast (or non-streamed webcast) is a series of digital media files (either audio or video) that are released episodically and often downloaded through web syndication. The word usurped webcast in common vernacular, due to rising popularity of the iPod and the innovation of web feeds.

The mode of delivery differentiates podcasting from other means of accessing media files over the Internet, such as direct download, or streamed webcasting. A list of all the audio or video files currently associated with a given series is maintained centrally on the distributor’s server as a web feed, and the listener or viewer employs special client application software known as a podcatcher that can access this web feed, check it for updates, and download any new files in the series. This process can be automated so that new files are downloaded automatically. Files are stored locally on the user’s computer or other device ready for offline use, giving simple and convenient access to episodic content.

Don’t have time to keep up with Medicare changes? Missing an important change or instruction can mean denied or delayed claims! Don’t miss another Medicare update! Subscribe to our new free podcast, Medicare Insights Weekly. Medicare Insights Weekly will present important Medicare updates in a concise audio program you can listen to while you work, in the car or at home! Download this free program to your MP3 player or computer and never miss another update.

Visit our website at [https://www.highmarkmedicareservices.com/podcasts](https://www.highmarkmedicareservices.com/podcasts) for more information.
Education & Training Feedback Form

In order to determine the effectiveness of our efforts, we need feedback from you. Tell us how we are doing and what we can do better. Your comments can make a difference in how we design our programs and publications. We would very much appreciate you taking the time to answer a few questions to let us know how you really feel.

Medicare Report
1. Do you always read it?
   - □ Always  □ Occasionally  □ Never
2. Do you read the paper copy or the electronic copy on our website?
   - □ Paper  □ Website
3. How satisfied are you with the Medicare Report?
   - □ Very  □ Somewhat  □ Not at all
4. Are the articles clear and easy to read and understand?
   - □ Mostly  □ Sometimes  □ Never
5. Which topics in the Medicare Report are the most important to you? (Check all that apply)
   - □ Medical Director Column  □ General News  □ Specialty News
   - □ Reimbursement News  □ Coding Guidelines/Claim Reporting
   - □ Coverage Issues  □ EDI News  □ Medical Policy
6. What topics would you like to have included in the Medicare Report?

Educational Opportunities
1. How useful do you find our web-based training modules in developing a better understanding of that topic?
   - □ Very  □ Somewhat  □ Not at all
2. If you have attended any of our workshops, teleconferences or webinars, how helpful did you find them?
   - □ Very helpful  □ Somewhat helpful  □ Not at all helpful
3. Who from your office generally attends our events?
   - □ Healthcare Practitioner/Professional  □ Office Staff  □ Other ____________________
4. What other workshops, teleconferences, or webinar topics would you find helpful?
A/B Reference Manual

1. How often do you use the Medicare A/B Reference Manual?
   - Often   - Occasionally   - Never

2. What information are you looking for when using the Medicare A/B Reference Manual?
   - Appeals   - Coding   - Completion of a Claim Form
   - Coverage Issues   - Diagnosis Coding   - EDI Services
   - Enrollment   - Medigap   - Patient Eligibility
   - Reimbursement   - Secondary Payer   - Other ________________

Specialty Guides

1. Do you refer to any of our online specialty guidelines?
   - Yes   - No

2. If yes, which guides do you utilize?
   - Ambulance   - ASC   - Anesthesia   - Clinical Lab
   - Flu & Pneumonia   - Podiatry   - Therapy Services

3. How helpful do you find the Specialty Guides?
   - Very helpful   - Somewhat helpful   - Not at all helpful

Please provide any additional comments and/or suggestions you have

Contact Information (This is optional)

Name: ____________________________  PTAN: ____________________________
Practice Name: ____________________________  Phone #: ____________________________
Email Address: ____________________________

Please mail or fax this form to:
   Outreach & Education Dept;
   PO Box 890089; Camp Hill, PA 17089-0089
   412-544-1971
**Request for Education Form**

Training and education is paramount to the overall success of administering the Medicare program. Our objectives are to inform and educate our customers through workshops, teleconferences, webinars and web based training modules. We are committed to educating healthcare professionals and their staff about:

- Comprehensive Error Rate Testing (CERT) Program
- Fundamentals of E/M Coding
- Coding of Consultation Services
- Coding of Hospital Visits
- Significant changes to the Medicare program

**Highmark Medicare Services will bring the program to you!**

An education specialist will bring the program to you when you provide the facility with at least 25 attendees. To request such education, please complete the information below and mail or fax to:

Highmark Medicare Services  
Outreach & Education  
PO Box 890089  
Camp Hill, PA 17089-0089  
Fax: 717-302-3658

Name: _______________________________________________

Office Name: __________________________________________________________

PTAN: ________________________________ Phone #: ___________________________________

Email address (print clearly): ____________________________________________________

Topic Requested for Education: ______________________________________________________

You can also visit our website and send us your request electronically at [https://www.highmarkmedicareservices.com/partb/outreach/request-edu.html](https://www.highmarkmedicareservices.com/partb/outreach/request-edu.html)
Join our Electronic Mailing Lists

In these hectic times, it is tough enough to keep on top of all the changes taking place. Why not take advantage of subscribing to our Electronic Mailing List? Subscribing will allow us to send emails to everyone who joins them. The messages may be about things we need to tell you in a hurry (i.e., system outages, updates to an educational event you might be attending that day, etc.) or just general updates to our website.

Partb-outreach subscribers will receive an email once a day (unless we need to send more than one). This gives us a way to notify you of important changes to the Medicare Program.

Provide your email address and select the list(s) that you would like to join. You will receive a confirmation email asking for you to reply to confirm your subscription.

- Part B General Education (receives all updates, except EDI)
- Part B Electronic Billers (EDI)
- Part A & B PC-ACE Pro32 Users (EDI)

Email Address: ________________________________

(Please PRINT Clearly)

Mail or Fax to:
Highmark Medicare Services
Outreach & Education
120 Fifth Avenue Place
Suite P5103
Pittsburgh, PA 15222
Fax: 412-544-1971

You can also visit our website and join our Electronic Mailing List electronically at https://www.highmarkmedicareservices.com/mailinglists.html.
This page was left blank intentionally