Medicare B Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC
Cahaba GBA is the J10 A/B Medicare Administrative Contractor

January 2011

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at https://www.cahabagba.com.

News From Cahaba GBA

News From CMS

News From CMS

Key For Icons

All Providers	(E) End Stage Renal Disease (ESRD)	(S) Skilled Nursing Facility (SNF)
(C) Claims	(R) Radiology	

News From CMS continued

Please Route

Remember that this newsletter, and all other Medicare publications, serves as your official notice of Medicare coverage and billing information. If you have any questions about the information included in this newsletter, please call your Provider Contact Center.

This bulletin shall be shared with all health care practitioners and managerial members of your provider staff. Bulletins are available at no cost from our website https://www.cahabagba.com/part_b/education_and_outreach/newsletters/index.htm.

Routing List

- ☐ Provider/Supplier
- ☐ Administrator
- ☐ Office/Clinic Manager
- ☐ Medical Personnel
- ☐ Billing/Insurance Staff
- ☐ Other Additional Staff

General Medicare Questions for Medicare Recipients

Do some of your patients have questions regarding their Medicare benefits and you are not sure how to answer? Medicare recipients should call **1-800-MEDICARE (1-800-633-4227)** for all questions related to Medicare services. Questions regarding specific claims will be automatically routed to the appropriate Medicare contractor's call center for response. **Please do not ask your patients to contact Medicare on a claim that you accepted assignment on.**

Holiday Closure Schedule

Cahaba GBA's Medicare offices in Birmingham, AL; Savannah, GA; Chattanooga, TN; and Des Moines, IA are closed on the following days listed below in 2011. In addition, all Medicare Provider Contact Centers (PCC) close on federal holidays for continuing education training; therefore, customer service representatives will not be available on those days to receive your calls.

Holiday / Date	Closure Schedule
New Year's Day December 31, 2010 Friday	All Offices Closed
Martin Luther King Birthday January 17, 2011 Monday	All Offices Closed
President's Day February 21, 2011 Monday	PCC Closed
Good Friday April 22, 2011 Friday	Birmingham, AL; Savannah, GA; and Chattanooga, TN Offices Closed
Memorial Day May 30, 2011 Monday	All Offices Closed
Independence Day July 4, 2011 Monday	All Offices Closed
Labor Day September 5, 2011 Monday	All Offices Closed
Columbus Day October 10, 2011 Monday	PCC Closed
Veterans Day November 11, 2011 Friday	PCC Closed
Thanksgiving November 24-25, 2011 Thursday/Friday	All Offices Closed
Christmas December 23, 2011 December 26, 2011 Friday/Monday	All Offices Closed

Provider Contact Center– Training Schedule

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the Provider Contact Centers the opportunity to offer training to our Customer Service Representatives (CSRs). Listed below are the dates and times the Provider Contact Center will be closed for training.

CSR Training Dates	Time
Friday, January 7, 2011	9:30 a.m.- 11:30 a.m. CST/10:30 a.m.- 12:30 p.m. EST
Friday, January 28, 2011	9:30 a.m.- 11:30 a.m. CST/10:30 a.m.- 12:30 p.m. EST

Provider Contact Center Telephone Numbers

- Alabama B, Georgia B, and Tennessee B: 877 567-7271
- Mississippi B: 866 419-9454

Our Interactive Voice Response (IVR) system is designed to assist providers in obtaining answers to numerous issues through self-service options. Options on our IVR include information regarding patient eligibility, checks, claims, deductible and other general information. Please note that our Customer Service Representatives (CSRs) are available to answer questions that cannot be answered by the IVR. CSRs are physically located in Birmingham, Alabama and Savannah, Georgia. When your call is received, it is routed to the next available representative. CSRs are available Monday through Friday 8:00 a.m. until 4:00 p.m. in your time zone.

Using the Interactive Voice Response (IVR) System for Claim Status and Eligibility Requests

Cahaba Government Benefit Administrators®, LLC is experiencing a high volume of providers who are opting out of the Interactive Voice Response (IVR) system to speak to a Customer Service Representative (CSR) for information that can be accessed through the IVR.

The Centers for Medicare and Medicaid Services (CMS) *Internet Only Manual (IOM) Chapter 6 Section 50.1* states:

> "Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR because the IVR is not functioning."

If you are requesting whether Cahaba has received a claim or if a claim has finalized, this is considered a claim status request.

In addition, according to IOM Chapter 6 Section 80.3.4, "If a CSR or written inquiry correspondent receives an inquiry about information that can be found on a Remittance Advice (RA), the CSR/correspondent should take the opportunity to educate the inquirer on how to read the RA, in an effort to encourage the use of self-service. The CSR/correspondent should advise the inquirer that the RA is needed in order to answer any questions for which answers are available on the RA. Providers should also be advised that any billing staff or representatives that make inquiries on his/her behalf will need a copy of the RA."

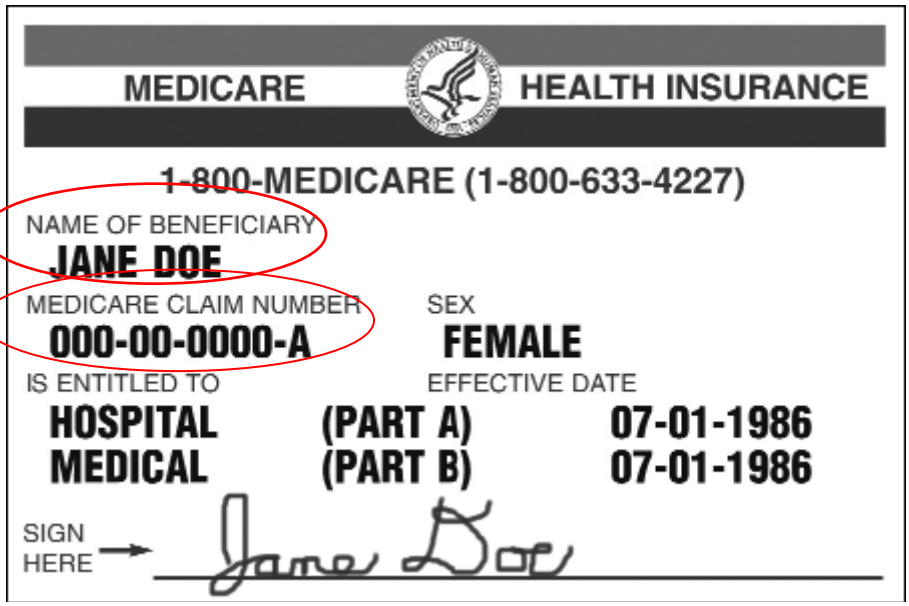
Cahaba CSRs have visibility as to the path the provider takes in the IVR and/or whether they opt out to speak with a representative up front. The CSR will instruct the provider to call back and utilize the IVR if they did not attempt to use this self service option as required by CMS.

Provider Contact Center (PCC)

Medicare Health Insurance Claim (HIC) Number

A Medicare card is issued to every person who is entitled to Medicare benefits and may be identified by its red, white and blue coloring. This card identifies the Medicare beneficiary and includes the following information:

- Name (exactly as it appears on the Social Security records);
- Medicare Health Insurance Claim (HIC) number;
- Beginning date of Medicare entitlement for hospital and/or medical insurance;
- Sex and Beneficiary's signature.



Three of the top five reasons for claim rejection in any given month are for:

- The last name submitted for the beneficiary does not match the last name we have on record for the HIC number on the claim. The beneficiary's last name must include apostrophes, spaces, hyphens, etc., if they appear in the beneficiary's last name on his or her Medicare card.
- The first name submitted for the beneficiary does not match the first name we have on record for the HIC number on the claim. The beneficiary's first name must appear as it does on the beneficiary's Medicare card. This includes spaces, hyphens, apostrophes, etc.
- The HIC number not matching the name we have on record. The Medicare Claim Number must appear on the claim exactly as it does on the beneficiary's card, without the dashes and with no spaces.

It is extremely important that you submit the patient's complete name and HIC number to Medicare or any other health care provider you use (i.e. clinical laboratories, radiology imaging groups, or outpatient therapy providers, etc.). This will ensure that those providers have the correct patient information to file their claims as well.

Cahaba's E-mail Notification Service Subscription Process

Cahaba GBA recently implemented changes that simplify the process in which providers subscribe to our e-mail notification service (Listserv). New members simply provide their name, city, state, zip code, e-mail address, and an optional password. In addition, they can select from 4 different lists to subscribe to:

- J10 Part A News
- J10 Part B News*****
- Home Health News
- Hospice News

Once you are a member, you can edit your profile to:

- unsubscribe from all lists
- subscribe to additional lists
- update your e-mail address
- change your name or address information
- change what Cahaba lists you are subscribed to.

Already a Member?

If you enrolled to Cahaba's Listserv prior to November 1, 2009, you will continue to receive messages. However, depending on the selections you made on the subscription form when you originally enrolled, you may receive messages from more than one Cahaba list. To change the list you are subscribed to, access the "Edit Your E-mail Notification Service Member Profile" Web page to review and edit your profile.

In order to ensure that you receive your subscription emails and announcements from Cahaba GBA, please add us to your contact lists, adjust your spam settings, or follow the instructions from your email provider on how to prevent our emails from being marked "Spam" or "Junk Mail".

*****Mississippi Medicare Part B providers will choose J10 Part B News for their selection to receive Medicare Part B information.

Cahaba University

Cahaba GBA proudly introduces "Cahaba University," an online self-service training tool for our provider community and their staff.

Cahaba University is an educational program designed to provide a broad variety of Medicare related training to meet the needs of Medicare health care providers and suppliers. It is powered by Centra, a learning management system that will allow registered users to manage their own learning. Cahaba University allows for a blended e-learning environment. Blended means that users are allowed to register for Webinars, teleconferences, as well as assign self-paced learning tracks. It also provides centralized management and access to content created by the Provider Outreach and Education department for the provider community.

Our staff of well-trained professionals wants every provider to be pleased with their learning experience. We know you're just as concerned about your claims being processed for your facility as you are about the quality of care administered to your Medicare patients. That is why we always try to provide additional education and outreach activities to help improve this process.

Cahaba University is located at http://www.cahabagba.com/part_b/education_and_outreach/CahabaUniversity.pdf. All providers are encouraged to create a user profile. Click the "Create a new account" link, and then select either a Part A or Part B account. You must create a username and password to login. Make sure all the appropriate fields are completed. Once the account is created, log in using your new user name and password. Remember, your username and password is case-sensitive!

Alabama Medicare Part B
Top Five EDI Reasons for Claim Rejections for November 2010

Audit trails show which of your claims were accepted by the Cahaba GBA Part B processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See Audit Trail Explanations for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part B EDI Services is providing you with the top five reasons for claim rejections. For the month of **November 2010**, these are:

Claim Rejection	Description	Number of Claims
421	**DIAG CODE (XXXXX) INVALID FOR DATE SVC** The date of service was outside of the effective date range of the diagnosis code used. The invalid diagnosis code will appear inside the parenthesis.	6,130
434	**PROC CODE REQUIRES REFERRING NPI** Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim.	5,683
480	**LINE PAID AMOUNT CANNOT BE GREATER THAN ALLOWED AM** The claim was submitted as a Medicare Secondary Payer claim, and the primary paid amount for the line charge indicated was greater than the primary allowed amount. For help filing MSP claims visit http://www.cahabagba.com/part_b/msp/Providers_Electronic_Billing_Instructions.htm.	4,303
888	**INSTREAM REJECTION** There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred. If you need help locating specific positions in your 4010A1 file here is an article explaining one way you may do this: http://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm	2,391
384	**INVALID NPI/EIN COMBINATION IN LOOP : XXXXXX** The NPI submitted in the indicated loop is not associated with the EIN submitted. If the EIN is the provider's Social Security Number, be sure the qualifier in the REF segment where the NPI is submitted is SY instead of EI.	2,080

Georgia Medicare Part B
Top Five EDI Reasons for Claim Rejections for November 2010

Audit trails show which of your claims were accepted by the Cahaba GBA Part B processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 4:30 p.m. Eastern Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See Audit Trail Explanations for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part B EDI Services is providing you with the top five reasons for claim rejections. For the month of **November 2010**, these are:

Claim Rejection	Description	Number of Claims
421	**DIAG CODE (XXXXX) INVALID FOR DATE SVC** The date of service was outside of the effective date range of the diagnosis code used. The invalid diagnosis code will appear inside the parenthesis.	7,451
434	**PROC CODE REQUIRES REFERRING NPI** Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim.	7,356
224	**INVALID QUAL (SY) IN 2010BA/REF** Qualifier SY (Social Security Number) was used in NM108 as the qualifier for the beneficiary's ID number.	3,732
207	**INVALID HIC NUMBER SUFFIX** The suffix used for the beneficiary's HIC (Medicare) number is not valid. For a list of valid suffixes visit http://www.cahabagba.com/part_b/education_and_outreach/newsletters/2009/2009_01.pdf and go to page 9.	3,609
385	**CLAIM CONTAINS A MEDICARE LEGACY ID IN LOOP : XXXX** Claim was submitted with a PTAN or UPIN, or a REF segment with either a 1C or 1G qualifier, in the indicated loop.	2,545

Tennessee Medicare Part B
Top Five EDI Reasons for Claim Rejections for November 2010

Audit trails show which of your claims were accepted by the Cahaba GBA Part B processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See Audit Trail Explanations for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part B EDI Services is providing you with the top five reasons for claim rejections. For the month of **November 2010**, these are:

Claim Rejection	Description	Number of Claims
434	**PROC CODE REQUIRES REFERRING NPI** Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim.	6,730
421	**DIAG CODE (XXXXX) INVALID FOR DATE SVC** The diagnosis code indicated was not valid on the date-of-service billed.	4,468
888	**INSTREAM REJECTION** There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred. If you need help locating specific positions in your 4010A1 file here is an article explaining one way you may do this: http://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm.	3,643
387	**NPI : XXXXXXXXXX NOT FOUND ON CROSSWALK FILE IN LO** The indicated NPI in the indicated loop was not found on the crosswalk. For help with NPI-related issues contact Provider Enrollment via the Provider Contact Center at (877) 567-7271.	3,576
207	**INVALID HIC NUMBER SUFFIX** The suffix in the beneficiary's Medicare number was not valid. For an explanation of HIC numbers and their suffixes please visit http://www.cahabagba.com./part_b/education_and_outreach/newsletters/2009/2009_01.pdf and go to page 9.	2,698

Mississippi Medicare Part B
Top Five EDI Reasons for Claim Rejections for November 2010

Audit trails show which of your claims were accepted by the Cahaba GBA Part B processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

See Audit Trail Explanations for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part B EDI Services is providing you with the top five reasons for claim rejections. For the month of **November 2010**, these are:

Claim Rejection	Description	Number of Claims
434	**PROC CODE REQUIRES REFERRING NPI** Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim	4,160
458	**LINE ITEM CHARGE MUST BE > 0** The billed amount for the item indicated must be greater than zero.	3,412
888	**INSTREAM REJECTION** There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred. If you need help locating specific positions in your 4010A1 file here is an article explaining one way you may do this: http://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm.	3,278
421	**DIAG CODE (XXXXX) INVALID FOR DATE SVC** The date of service was outside of the effective date range of the diagnosis code used. The invalid diagnosis code will appear inside the parenthesis.	2,380
387	**NPI : XXXXXXXXXX NOT FOUND ON CROSSWALK FILE IN LO** The indicated NPI in the indicated loop was not found on the crosswalk. If the NPI is valid contact Provider Enrollment at (877) 567-7271.	1,836

Local Coverage Determination (LCD) Updates- 2011 CPT/HCPCS Codes

- **J10 MAC B (Alabama, Georgia, Tennessee)**
- **Carrier 00512 (Mississippi)**

Effective: January 1, 2011

Revisions made to Local Coverage Determinations (LCDs) as a result of the Annual CPT/HCPCS Update for 2011 are described below. These codes reflect services which are currently addressed in the LCDs and do not establish any new indications within nor restrict the current coverage. Please make note of these revisions, which will become effective January 1, 2011.

All LCDs can be accessed from the Local Coverage Determinations (LCDs) and Articles page of our website (choose your state and select 'LCDs').

Drugs and Biologicals: Immune Globulin Intravenous (IVIg) (J10 - L30029; 00512 – L30612)

- **J1599** (Injection, Immune Globulin, Intravenous, Non-Lyophilized (e.g. liquid), Not otherwise specified, 500 mg) has been added to the LCD and included in the Indications and Limitations for J1459, J1561, J1566, J1568, J1569, and J1572.
- **C9270** (Injection, Immune Globulin (Gammaplex), Intravenous, Non-Lyophilized (e.g. liquid), 500 mg) has been added to the LCD and included in the Indications and Limitations for J1459, J1561, J1566, J1568, J1569, and J1572. (Note: This code is for use under Hospital OPPS and for Ambulatory Surgery Centers.)

Medicine: Long-Term Electrocardiographic Monitoring (Holter Monitoring) (J10 - L30038; 00512 – L30620)

- **93224, 93225, 93226, 93227**: The descriptions for these codes were revised to include recording up to 48 hours. The LCD Indications and Documentation Requirements were updated accordingly.
- **93230, 93231, 93232, 93233, 93235, 93236, 93237**: These codes are invalid after December 31, 2010 and were removed from the LCD.

Radiology: Computed Tomography of the Abdomen and Pelvis (J10 - L30048; 00512 – L30629)

- **74176, 74177, 74178**: These codes have been added to the LCD.

Surgery: Debridement of Skin Ulcers and Wounds (J10 - L30060; 00512 – L30641)

- **11040, 11041**: These codes are invalid after December 31, 2010 and were removed from the LCD.

- **11045, 11046, 11047**: These codes have been added to the LCD as add-on codes to 11042, 11043 and 11044.

- **97597, 97598**: The descriptions for these codes were revised. 97598 is an add-on code to 97597. The LCD Indications and Limitations were updated accordingly.

Surgery: Nerve Blocks/Paravertebral Nerve Blocks (J10 - L30063; 00512 – L30644)

- **64479, 64480, 64483, 64484**: The descriptions for these codes were revised to include imaging guidance (fluoroscopy or CT).

- **0228T, 0229T, 0230T, 0231T**: These codes were added to the LCD and describe transforaminal epidural injection under ultrasound guidance.

  The LCD Limitations and Utilization Guidelines were updated accordingly.

Medicare Coverage Database (MCD) Articles: Updates 2011 CPT/HCPCS Codes

- **J10 MAC B (Alabama, Georgia, Tennessee)**
- **Carrier 00512 (Mississippi)**

Effective: January 1, 2011

Revisions made to the Medicare Coverage Database Articles as a result of the Annual CPT/HCPCS Update for 2011 are described below. These codes reflect services which are currently addressed in the Articles and do not establish any new indications within nor restrict the current coverage. Please make note of these revisions, which will become effective January 1, 2011.

All Articles can be accessed from the Local Coverage Determinations (LCDs) and Articles page of our website (choose your state and select 'LCDs').

Drugs and Biologicals - Chemotherapeutic Agents (J10 – A48896; 00512 – A49230)

- **J9350** (Injection, Topotecan, 4 mg) is invalid after December 31, 2010 and is replaced with **J9351** (Injection, Topotecan, 0.1 mg)

Educational Article - CPT 0176T (Transluminal dilation of aqueous outflow canal; without retention of device or stent) and CPT 0177T (Transluminal dilation of aqueous outflow

canal; with retention of device or stent) (J10 – A49422; 00512 - A49423)

- **0176T, 0177T** are invalid after December 31, 2010; this article will be retired.

Educational Article - CPT 0193T (Transurethral, radiofrequency micro-modeling of the female bladder neck and proximal urethra for stress urinary incontinence) (J10 – A49858; 00512 – A49859)

- **0193T** is invalid after December 31, 2010; this article will be retired.

Medicare Coverage Database (MCD) Article: NCD- Sterilization

- **J10 MAC B (Alabama, Georgia, Tennessee) (A50478)**
- **Carrier 00512 (Mississippi) (A50485)**

The article **NCD - Sterilization** is being added to the CMS Medicare Coverage Database with an effective date of December 1, 2010.

The long-standing National Coverage Determination (NCD) for Sterilization, published in the CMS Medicare National Coverage Determinations (NCD) Manual (Pub. 100-03), Chapter 1, Section 230.3, provides a description of the covered and non-covered conditions for sterilization.

Sterilization is not covered when the sterilization is not part of a necessary treatment of an illness or injury. In order to ensure payment is not made for noncovered sterilization, this article lists noncovered CPT codes and ICD-9 code combinations.

Providers are encouraged to review this article to ensure compliance.

The Article can be accessed from the Local Coverage Determinations (LCDs) and Articles page of our website, where you can click on your state for the information you need.

Claim Specific Comprehensive Error Rate Testing (CERT) Errors

- **J10 MAC B (Alabama, Georgia, Tennessee)**
- **Carrier 00512 (Mississippi)**

The Comprehensive Error Rate Testing (CERT) Program was implemented by the Centers for Medicare & Medicaid Services (CMS) to monitor the accuracy of claims processing by Medicare contractors, like Cahaba. Contractors are then notified by CERT of the errors and findings.

We would like to remind you that should you receive an Additional Documentation Request (ADR) such as a request for records to support services that are involved in a CERT review, you should submit the appropriate documentation to support the services billed, including but not limited to progress note(s) to match the DOS billed, lab results, operative reports, diagnostic tests, physician orders, etc. Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.

Providers may appeal unfavorable decisions with additional supporting documentation. For detailed information regarding the Appeals Process, refer to the following link: www.cahabagba.com/part_b/claims/appeals_process.htm.

Please contact the Provider Contact Center for individual questions concerning CERT errors:

- Alabama, Georgia and Tennessee Providers – 1-877-567-7271
- Mississippi Providers – 1-866-419-9454

This summary provides examples of Cahaba's errors identified by CERT. We encourage all providers to review this listing to educate you on common errors. This information will be updated periodically. The intent in providing this information is to prompt you to conduct an internal analysis of Medicare billing and reduce future denials by Medicare.

Medicare Coverage Database (MCD) Article: NCD - Hyperbaric Oxygen Therapy (HBO) - Revision

- J10 MAC B (Alabama, Georgia, Tennessee)
- Carrier 00512 (Mississippi)

Hyperbaric Oxygen Therapy (HBO) use in Diabetic Wounds of the Lower Extremity and Appropriate Medical Record Documentation

CMS' National Coverage Determination (NCD) 20.29 outlines the requirement for coverage of HBO use in Diabetic Wounds of the Lower Extremity as follows:

> **Diabetic wounds of the lower extremities in patients who meet the following three criteria:**
>
> a. **Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;**
> b. **Patient has a wound classified as Wagner grade III or higher; and**
> c. **Patient has failed an adequate course of standard wound therapy.**
>
> **The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 –days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in patients with diabetic wounds includes: assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.**

If documentation is submitted for coverage review, standard wound therapy guidelines in the NCD must be apparent. Also, the qualifying Wagner Stage should be clearly supported by the physical exam and/or diagnostic evidence (e.g. imaging study, bone biopsy, etc.) in the medical record.

The entire NCD for HBO can be found at www.cms.hhs.gov/NCD.

Medicare Fee-For-Service (FFS) Implementation of HIPAA 5010/D.0 – Errata Impacts

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

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

Table 1. Transactions Affected by the Errata - list of Base and Errata versions for 5010 and D.0.

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

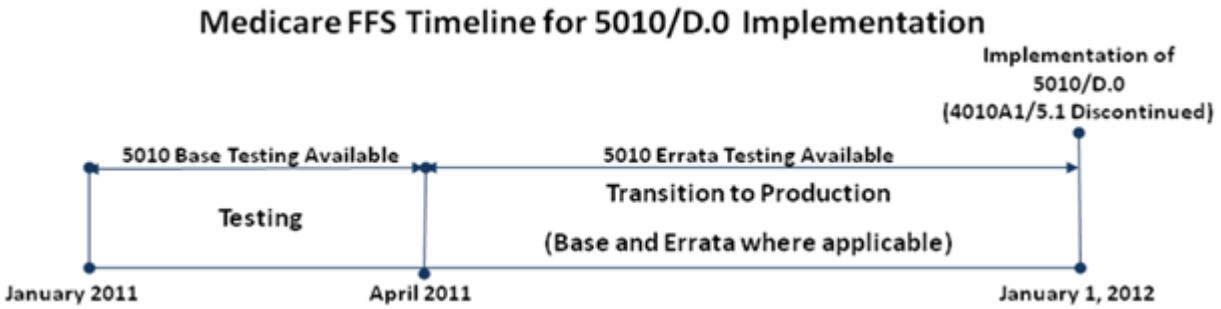
Medicare FFS will implement the Errata versions to meet HIPAA compliance requirements. Also in compliance with the published regulation (RIN 0938-AM50 of 45 CFR Part 162), Medicare FFS testing with external trading partners must begin in January of 2011.

Testing

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

Production

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



Medicare FFS Timeline for 5010/D.O Implementation: 1) Testing on Base Versions to begin in January 2011, 2) Testing and transition to production on Errata version to begin in April 2011, and 3) Implementation of 5010/D.O on January 1, 2012.

HIPAA Version 5010

On January 1, 2012, standards for electronic health care transactions change from Version 4010/4010A1 to Version 5010. These electronic health care transactions include, among others, claims processing, eligibility inquiries, and remittance advice. Unlike the current Version 4010/4010A1, Version 5010 accommodates the International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes, and must be in place first before the changeover to ICD-10. The transition to ICD-10 is dependent on a successful Version 5010 implementation. The Version 5010 change occurs well before the ICD-10 implementation date to allow adequate Version 5010 testing and implementation time. Failure to prepare now for these changes may result in rejection of claims or other transactions and delays in claim reimbursement. Important Dates to Remember:

- **January 1, 2011-** Payers and providers should begin external testing of Version 5010 for electronic claims.
- **April 1, 2011**- Testing and transition to production on Errata version to begin.
- **January 1, 2012-** All electronic claims must use Version 5010
- **October 1, 2013-** Transition to ICD-10-CM (diagnoses codes) and ICD-10-PCS (procedures codes)

Keep Up to Date on Version 5010 and ICD-10. Please visit the websites at http://www.cms.gov/icd10 and http://www.cms.gov/Versions5010andD0/, for the latest news and sign up for Version 5010 and ICD-10 e-mail updates!

ICD-10 Implementation

The Centers for Medicare & Medicaid Services (CMS) has posted on its website 11 new frequently asked questions (FAQ) about the ICD-10 Implementation. To access these FAQs, please visit the CMS ICD-10 webpage at http://www.cms.gov/ICD10/, select the Medicare Fee-for-Service Provider Resources link on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

Remember: The Transition to ICD-10 is Coming October 1, 2013 – there will be no Extension. On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets. ICD-10-CM diagnoses codes will be used by all providers in every health care setting. ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures. The compliance dates are firm and not subject to change. There will be no delays. There will be no grace period for implementation. For more information about ICD-10 Implementation, please read MLN Matters® Special Edition article SE1019 located at http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf on the CMS website.

Immunize Yourself and Your Staff

Each Office Visit is an Opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. **Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.** Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and http://www.cms.gov/AdultImmunizations on the CMS Web site.

In addition, the "Quick Reference Information, Medicare Immunization Billing" chart, which includes coding, coverage, and billing information for the seasonal influenza, pneumococcal, and hepatitis B vaccines, has been updated and is now available for download, free of charge, from the Medicare Learning Network® at http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf. Additionally, hard copies will be available at a later date.

Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The list of contract suppliers is now available at http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp on the CMS Web site. Visit the CMS Web site at http://www.cms.gov/DMEPOSCompetitiveBid to view additional information on the Round 1 Rebid.

Modification to the HCPCS Code Set

The Centers for Medicare & Medicaid Services (CMS) has released a modification to the Healthcare Common Procedure Coding System (HCPCS) code set. CMS has reinstated codes L3660 "Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment"; L3670 "Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment"; and L3675 "Shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, prefabricated includes fitting and adjustment" with the original language. In making this change, the CY 2011 HCPCS Annual Tape will no longer reflect a termination date of 12/31/10 for these codes. This change has been posted to the 2011 HCPCS Corrections document located on the HCPCS Web page at: http://www.cms.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp.

"Medicare Claim Review Programs: MUE, CCI, CERT, RAC" Booklet Revised

The Medicare Learning Network® has revised the "Medicare Claim Review Programs: MUE, CCI, CERT, RAC" booklet, which is designed to provide education on the different CMS claim-review programs and assist providers in reducing payment errors – in particular, coverage and coding errors. It includes FAQs, resources, and an overview of the various programs, including Medical Review (MR), Recovery Audit Contractor (RAC), and the Comprehensive Error Rate Testing (CERT) Program. This product is suggested for all Medicare Fee-For-Service providers and is available in downloadable format at http://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf. Additionally, please visit the MLN Provider Compliance web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp for additional resources designed to educate FFS providers about the common billing errors and other improper activities identified through these programs.

New Medicare Outpatient Therapy Billing Publication

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

Medicare & Medicaid Electronic Health Record (EHR) Incentive Programs

The Centers for Medicare & Medicare Services (CMS) has launched the official website for the Medicare & Medicaid Electronic Health Record (HER) Incentive Programs. This website provides the most up-to-date, detailed information about the EHR incentive programs. The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals and hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. Bookmark this site and visit http://www.cms.gov/EHRIncentivePrograms/ often to learn about who is eligible for the programs, how to register, meaningful use, upcoming EHR training and events, and much more!

Electronic Health Record (EHR) Incentive Program Tip Sheets

The Medicare Learning Network now has Tip Sheets available with important information on the Electronic Health Record (EHR) incentive programs. One tip sheet provides user friendly information about the factors which impact incentive payment amounts and provides sample payment calculations. Another provides information on how incentive payments are calculated for Critical Access Hospitals (CAHs) and how reimbursement will be reduced for CAHs which have not demonstrated meaningful use of certified EHR technology by 2015. These Tip Sheets are available at http://www.cms.gov/EHRIncentivePrograms on the CMS EHR Incentive Programs website. Select the Hospitals tab on the left, and then scroll to "Downloads."

Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Declare your independence from the paper enrollment process – use Internet-based Provider Enrollment, Chain and Ownership System (PECOS)! Learn how at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the Centers for Medicare & Medicaid website. Internet-based provider enrollment is easy and quick! Submit initial Medicare PECOS applications online up to 50% faster than on paper!

Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)- Revised

Note: This article was revised on **November 26, 2010**, to reflect a revised Change Request (CR) 6953, which was issued on November 24, 2010. CR 6953 was revised to clarify billing procedures for services performed in the outpatient hospital setting and to update the Claims Adjustment Reason Code for line item denials for relevant services performed prior to March 23, 2010. This article was revised to reflect this clarification and update.

Provider Types Affected
This article is for physicians, hospitals, and other providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for Facial Lipodystrophy services provided to Medicare beneficiaries.

What You Need To Know
This article is based on Change Request (CR) 6953 which informs Medicare contractors that, effective for claims with dates of service on and after March 23, 2010, dermal injections for facial Lipodystrophy Syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in Human Immunodeficiency Virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Background
The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial Lipodystrophy Syndrome (LDS) for Human Immunodeficiency Virus (HIV)-infected Medicare beneficiaries. LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or Highly Active Antiretroviral Therapy (HAART). Due to their appearance, patients with LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

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

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

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

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

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

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the dermal filler product. This code provides a payment mechanism to hospital outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) providers until Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC) pricing information becomes available. When ASP or WAC pricing information becomes available, the temporary HCPCS code will be deleted and separate payment will be made under the OPPS and ASC payment systems for HCPCS Q2026, Q2027, and G0429.

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

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

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

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

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

For outpatient facilities, hospitals should bill:

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

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

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

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

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

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

- Claim Adjustment Reason Code (CARC) 26: Expenses incurred prior to coverage.
- Remittance Advice Remark Code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- Group Code: Contractual Obligation (CO)

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

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

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

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

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

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

Additional Information
The official instruction, CR 6953, issued to your carrier, FI, and A/B MAC regarding this change via two transmittals. The first transmittal revised the Medicare NCD Manual and it may be viewed at http://www.cms.gov.Transmittals/downloads/R122NCD.pdf on the CMS website. The second transmittal revises the Medicare Claims Processing Manual and it is at http://www.cms.gov/Transmittals/downloads/R2105CP.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM6953

Calendar Year (CY) 2011 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment- Revised

Note: This article was revised on **December 1, 2010**, to correct the annual update percentage shown for laboratory tests paid on a reasonable charge basis. All other information is the same.

Provider Types Affected
Clinical laboratories billing Medicare Carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) are affected.

Impact On Providers
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6991 which provides instructions for the Calendar Year (CY) 2011 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment.

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

- The actual charge billed for the test;
- The local fee; or
- The National Limitation Amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

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

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

88142	88143	88147	88148	88150	88152
88153	88154	88164	88165	88166	88167

88174	88175	G0123	G0144	G0145	G0147
G0148	P3000				

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

Access to Data File
Internet access to the CY 2011 clinical laboratory fee schedule data file will be available after November 19, 2010, at http://www.cms.hhs.gov/ClinicalLabFeeSched on the CMS website. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the CY 2011 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

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

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

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

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

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

Mapping Information
- New code 82930 is priced at the same rate as code 82926.
- New code 83861 is priced at the same rate as code 83909.
- New code 84112 is priced at the same rate as code 82731.
- New code 85598 is priced at the same rate as code 85597.
- New code 86481 is priced at the same rate as code 86480.

- New code 86902 is priced at the same rate as code 86905.
- New code 87501 is priced at the sum of the rates of codes 87521 and 83902.
- New code 87502 is priced at the sum of the rates of codes 87801 and 83902.
- New code 87503 is priced at the sum of the rates of codes 83901 and 83896.
- New code 87906 is priced at half of code 87901.
- Healthcare Common Procedure Coding System (HCPCS) Code G0434 is priced at the same rate as code G0430.
- HCPCS Code G9143 is priced at the sum of the rates of codes 83891, 83900, 83901, 83912, three times the rate of code 83896, and three times the rate of code 83908. A two-character modifier indicates that this test's use is limited to a Coverage with Evidence Development (CED) study.
- HCPCS Code G0432 is priced at the same rate as code 86703.
- HCPCS Code G0433 is priced at the same rate as code 86703.
- HCPCS Code G0435 is priced at the same rate as code 87804.
- Reconsidered code 84145 is priced at the same rate as code 82308.
- Reconsidered code 84431 is priced at the same rate as code 84443.
- Reconsidered code 86352 is priced at twice the sum of the rates of codes 86353 and 82397.
- HCPCS Code G0430 is deleted beginning January 1, 2011.
- HCPCS Code G0431 is priced at five times the rate of HCPCS Code G0430.
- New Code 84155QW is priced at the same rate as code 84155 beginning January 1, 2010.
- New Code 87809QW is priced at the same rate as code 87809 beginning January 1, 2008.

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

Laboratory Costs Subject to Reasonable Charge Payment in CY 2011

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

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, section 80 through 80.8 (see http://www.cms.gov/manuals/downloads/clm104c23.pdf on the CMS website). If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. When these services are performed for independent dialysis facility patients, the Medicare Claims Processing Manual (Chapter 8, Section 60.3; see http://www.cms.gov/manuals/downloads/clm104c08.pdf) instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system.

Blood Products					
P9010	P9011	P9012	P9016	P9017	P9019
P9020	P9021	P9022	P9023	P9031	P9032
P93033	P9034	P93035	P9036	P9037	P9038

P9039	P9040	P9044	P9050	P9051	P9052
P9053	P9054	P9055	P9056	P9057	P9058
P9059	P9060				

Also, the following codes should be applied to the blood deductible as instructed in the Medicare General Information, Eligibility and Entitlement Manual (Chapter 3, Section 20.5 through 20.54; see http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS website):

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

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

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

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

Additional Information

The official instruction associated with this CR6991, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2106CP.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM6991

Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of Certain Diagnostic Imaging Procedures

Provider Types Affected
This article is for physicians, clinical diagnostic laboratories, and other providers who bill Medicare contractors (carriers or Medicare Administrative Contractors (A/B MAC)) for providing diagnostic imaging services to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 6993, from which this article is taken, announces that Medicare is changing the Multiple Procedure Payment Reduction (MPPR) on the Technical Component (TC) of certain diagnostic imaging procedures. You should make sure that your billing staffs are aware of these changes.

Background
Currently, the Multiple Procedure Payment Reduction (MPPR) on diagnostic imaging services applies only to contiguous body parts (that is, within a family of codes, not across families). For example, the reduction does not apply to an MRI of the brain (CPT 70552) in code family 5, when performed during the same session, and on the same day, as an MRI of the neck and spine (CPT 72142) in code family 6.

Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) is consolidating the existing 11 advanced imaging families into a single family. This change applies: 1) When two or more services on the list are furnished to the same patient in a single session; and 2) Only to the Technical Component (TC) portion of global services, not to the Professional Component (PC). Medicare will continue to make the full TC payment for the procedure with the highest priced TC, and at 50 percent each for the TC of each additional procedure on the same patient in the same session.

Additional Information
You will find the complete list of codes subject to the MPPR on diagnostic imaging in Attachment 1 of CR 6993, which is the official instruction issued to your carrier or A/B MAC on this issue. CR 6993 is available at http://www.cms.gov/Transmittals/downloads/R738OTN.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM6993

End Stage Renal Disease (ESRD) Home Dialysis Monthly Capitation Payment (MCP)

Provider Types Affected
This article is for physicians and providers submitting claims to Medicare contractors (carriers and/or A/B Medicare Administrative Contractors (A/B MACs)) for home dialysis Monthly Capitation Payment (MCP) services provided to Medicare End Stage Renal Disease (ESRD) beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7003 which instructs that, effective January 1, 2011, the Monthly Capitation Payment (MCP) physician (or practitioner) must furnish at least one face-to-face patient visit per month for the home dialysis MCP service as described by Current Procedure Terminology (CPT) codes 90963, 90964, 90965, and 90966.

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

What You Need To Do
See the 'Background' and 'Additional Information' sections of this article for further details regarding these changes.

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

For center based patients, payment for the G codes varied based on the age of the beneficiary and the number of face-to-face visits furnished each month (e.g. 1 visit, 2-3 visits and 4 or more visits). Under this methodology, the lowest payment amount applies when a physician provides one visit per month; a higher payment is provided for two to three visits per month. To receive the highest payment amount, a physician would have to provide at least four ESRD related visits per month. However, payment for the home dialysis MCP only varied by the age of beneficiary. CMS stated that they "will not specify the frequency of required visits at this time but expect physicians to provide clinically appropriate care to manage the home dialysis patient."

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

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

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

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7003

Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of The Affordable Care Act, Removal of Barriers to Preventive Services in Medicare

Provider Types Affected
This article is for physicians, hospitals, and other providers who submit claims to Medicare Fiscal Intermediaries (FI), carriers, or Medicare Administrative Contractors (A/B MAC) for providing preventive services to Medicare beneficiaries.

What You Need To Know
Change Request (CR) 7012, from which this article is taken, implements the changes in Section 4104 of The Affordable Care Act. The CR announces that (effective for dates of service on or after January 1, 2011) Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and for those preventive services that: 1) Are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and 2) Are appropriate for the individual.

Background
Sections of The Affordable Care Act amend sections of The Social Security Act to require changes in payment (with respect to deductible and coinsurance/copayment) for identified preventive services: In addition, The Affordable Care Act waives the deductible and coinsurance/copayment for the IPPE and the AWV. The changes apply in all settings in which the services are furnished.

The following preventive services are covered by Medicare:

- Pneumococcal, influenza, and hepatitis B vaccine and administration;
- Screening mammography;
- Screening pap smear and screening pelvic examination;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- Diabetes Outpatient Self-Management Training (DSMT);
- Bone mass measurement;
- Screening for glaucoma;
- Medical Nutrition Therapy (MNT) services;
- Cardiovascular screening blood test;
- Diabetes screening tests;
- Ultrasound screening for Abdominal Aortic Aneurysm (AAA); and
- Additional preventive services (identified for coverage through the National Coverage Determination (NCD) process. Currently, these are limited to Human Immunodeficiency Virus (HIV) testing).

Preventive Services That Do Not Have a USPSTF Grade A or B
The Affordable Care Act waives the deductible and coinsurance/copayment for many of the preventive services listed above because those services have a recommendation grade of A or B by the USPSTF. In other cases, the deductible and coinsurance are waived because the preventive services are clinical

laboratory tests to which the deductible and coinsurance do not apply according to another section of the statute.

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

The table in CR7012 provides a complete list of the Healthcare Common Procedure Coding System (HCPCS) codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the AWV. CR7012 is available at http://www.cms.gov/Transmittals/downloads/R739OTN.pdf Centers for Medicare & Medicaid Services (CMS) website.

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

Additional Information
You can find more information about the waiver of coinsurance and deductible for preventive services by going to CR 7012, located at http://www.cms.gov/Transmittals/downloads/R739OTN.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7012

Ambulance Inflation Factor (AIF) for CY 2011 and Productivity Adjustment

Provider Types Affected
This article is for providers and suppliers of ambulance services who bill Medicare carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for those services.

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

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

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

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

The following table displays the AIF for CY 2011 and for the previous 8 years.

Ambulance Inflation Factor by CY	
2011	**-0.1%**
2010	0.0%
2009	5.0%
2008	2.7%
2007	4.3%
2006	2.5%
2005	3.3$
2004	2.1%
2003	1.1%

Additional Information
The official instruction, CR 7042, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2104CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7042

Expansion of Medicare Telehealth Services for Calendar Year (CY) 2011

Provider Types Affected
This article is for physicians, Non-Physician Practitioners (NPP), hospitals, and Skilled Nursing Facilities (SNFs) submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for telehealth services provided to Medicare beneficiaries.

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

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

Make sure your billing staffs are aware of these changes.

Background
As noted in the 2011 Medicare Physician Fee Schedule Final Rule published on November 29, 2010, CMS is adding14 codes to the list of Medicare distant site telehealth services for individual and group KDE services, individual and group DSMT services, group MNT services, group HBAI services, and subsequent hospital care and nursing facility care services. Payment for these services will be made at the applicable Physician Fee Schedule (PFS) payment amount for the service of the physician or practitioner. CR 7049 adds the relevant policy instructions to the *Medicare Claims Processing Manual* and the *Medicare Benefit Policy Manual* and those changes may be reviewed by consulting CR 7049 at http://www.cms.gov/Transmittals/downloads/R2032CP.pdf and http://www.cms.gov/Transmittals/downloads/R131BP.pdf respectively, on the CMS website.

Key Points of CR 7049
CMS is adding the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services:
  - HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; **individual**, per session, per one hour); and
  - HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; **group**, per session, per one hour).

- Individual and group DSMT services (with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training):

  - HCPCS code G0108 (Diabetes outpatient self-management training services, **individual**, per 30 minutes); and

- HCPCS code G0109 (Diabetes outpatient self-management training services, **group** session (2 or more) per 30 minutes).

- Group MNT and HBAI services, Current Procedural Terminology (CPT) codes: 97804 (Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes), 96153 (Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients), and 96154 (Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present));

- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days; CPT codes:
  - 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit),
  - 99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication), and
  - 99233(Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit); and

- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days, CPT codes:
  - 99307 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility floor or unit),
  - 99308 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit),

- 99309 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit), and
- 99310 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.

Note: The frequency limitations on subsequent hospital care and subsequent nursing facility care delivered through telehealth do not apply to inpatient telehealth consultations. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS codes (G0406, G0407, G0408, G0425, G0426, or G0427) when reporting consultations furnished via telehealth.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

- For Dates Of Service (DOS) on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount **when submitted with a GQ or GT modifier**.

- For dates of service on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted **with a GQ or GT modifier by Critical Access Hospitals (CAHs) that have elected Method II on TOB 85X**.

Additional Information
If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7049

Incentive Payment Program for Primary Care Services, Section 5501(a) of The Affordable Care Act

Provider Types Affected
Physicians and non-physician practitioners submitting claims to Medicare carriers and Part A/B Medicare Administrative Contractors (A/B MAC) for primary care services provided to Medicare beneficiaries are affected.

What You Need To Know
This article, based on Change Request (CR) 7060, explains that Section 5501(a) of The Affordable Care Act provides for an incentive payment for primary care services furnished on or after January 1, 2011 and before January 1, 2016 by a primary care practitioner. The incentive payment will be paid on a monthly or quarterly basis in an amount equal to 10 percent of the payment amount for such services under Part B. See the 'Background' and 'Additional Information' section of this article for further details regarding these changes.

Background
Section 5501(a) of The Affordable Care Act revises section 1833 of The Social Security Act by adding new paragraph (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Social Security Act states that, in the case of primary care services furnished on or after January 1, 2011 and before January 1, 2016 by a primary care practitioner, there also will be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under Part B.

Specifically, the incentive payments will be made on a quarterly basis and will equal 10 percent of the amount paid for primary care services under the Medicare Physician Fee Schedule for those services furnished during the bonus payment year. (For bonus payments to Critical Access Hospitals paid under the optional method, see Chapter 4, Section 250.12 of the *Medicare Claims Processing Manual* at http://www.cms.gov/manuals/downloads/clm104c04.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

NOTE: The new Health Professional Shortage Area (HPSA) Surgical Incentive Payment Program (HSIP) and the new Primary Care Incentive Payment Program (PCIP) will be implemented in conjunction with one another for CY 2011. A separate article will be available at http://www.cms.gov/MLNMattersArticles/downloads/MM7063.pdf upon release of CR 7063 CR for HSIP. The former "special HPSA remittance" will now be known as the "special incentive remittance". This change is necessary as the PCIP is open to all eligible primary care providers regardless of the geographic location in which the primary care services are being furnished.

Primary Care Practitioner Defined
Section 5501(a)(2)(A) of The Affordable Care Act defines a primary care practitioner as:

- A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
- A nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under the Physician Fee Schedule (PFS) for

the practitioner in a prior period as determined appropriate by the Secretary of Health and Human services.

Primary Care Services Defined

Section 5501(a)(2)(B) of The Affordable Care Act defines primary care services as those services identified by the following Current Procedure Terminology (CPT) codes as of January 1, 2009 (and as subsequently modified by the Secretary of Health and Human Services, as applicable):

- 99201 through 99215 for new and established patient office or other outpatient Evaluation and Management (E/M) visits;
- 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (e.g., boarding home), or custodial care E/M services; and domiciliary, rest home (e.g., assisted living facility), or home care plan oversight services; and
- 99341 through 99350 for new and established patient home E/M visits.

These codes are displayed in the following table. All of these codes remain active in Calendar Year (CY) 2011 and there are no other codes used to describe these services.

Primary Care Services Eligible for Primary Care Incentive Payments in CY 2011

CPT Code	Description
99201	Level 1 new patient office or other outpatient visit
99202	Level 2 new patient office or other outpatient visit
99203	Level 3 new patient office or other outpatient visit
99204	Level 4 new patient office or other outpatient visit
99205	Level 5 new patient office or other outpatient visit
99211	Level 1 established patient office or other outpatient visit
99212	Level 2 established patient office or other outpatient visit
99213	Level 3 established patient office or other outpatient visit
99214	Level 4 established patient office or other outpatient visit
99215	Level 5 established patient office or other outpatient visit
99304	Level 1 initial nursing facility care
99305	Level 2 initial nursing facility care
99306	Level 3 initial nursing facility care
99307	Level 1 subsequent nursing facility care
99308	Level 2 subsequent nursing facility care
99309	Level 3 subsequent nursing facility care
99310	Level 4 subsequent nursing facility care
99315	Nursing facility discharge day management; 30 minutes
99316	Nursing facility discharge day management; more than 30 minutes
99318	Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment.
99324	Level 1 new patient domiciliary, rest home, or custodial care visit
99325	Level 2 new patient domiciliary, rest home, or custodial care visit
99326	Level 3 new patient domiciliary, rest home, or custodial care visit f
99327	Level 4 new patient domiciliary, rest home, or custodial care visit
99328	Level 5 new patient domiciliary, rest home, or custodial care visit
99334	Level 1 established patient domiciliary, rest home, or custodial care visit

99335	Level 2 established patient domiciliary, rest home, or custodial care visit
99336	Level 3 established patient domiciliary, rest home, or custodial care visit
99337	Level 4 established patient domiciliary, rest home, or custodial care visit
99339	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes
99340	Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more
99341	Level 1 new patient home visit
99342	Level 2 new patient home visit
99343	Level 3 new patient home visit
99344	Level 4 new patient home visit
99345	Level 5 new patient home visit
99347	Level 1 established patient home visit
99348	Level 2 established patient home visit
99349	Level 3 established patient home visit
99350	Level 4 established patient home visit

Primary Care Incentive Payment Program (PCIP)

For primary care services furnished on or after January 1, 2011 and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of non-physician practitioners, enrolled in Medicare with a primary care specialty designation of 50-Nurse Practitioner, 89-certified Clinical Nurse Specialist, or 97-Physician Assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charges under the PFS for such practitioner during the time period that has been specified by the Secretary.

CMS will provide Medicare contractors with a list of the National Provider Identifiers (NPIs) of the primary care practitioners eligible to receive the incentive payments.

Eligible practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner or group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in the above table) in order for a determination to be made regarding whether or not the service is eligible for payment under the PCIP. In order to be eligible for the PCIP, Physician Assistants, Clinical Nurse Specialists, and Nurse Practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, these specific non-physician practitioners are eligible for the PCIP based on their profession and historical percentage of allowed charges as primary care services that equals or exceeds the 60 percent threshold.

Beginning in CY 2011, primary care practitioners will be identified based on their primary specialty of enrollment in Medicare and percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold from Medicare claims data 2 years prior to the bonus payment year. A provision to accommodate newly enrolled Medicare providers will be released in 2011.

Coordination with Other Payments
Section 5501(a)(3) of The Affordable Care Act provides payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under section 1833(m) of The Social Security Act. Therefore, an eligible primary care physician furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011.

Additional Information
The official instruction, CR 7060, issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2039CP.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7060

Edit to Deny Payment to Physicians and Other Suppliers for the Technical Component (TC) of Pathology Services Furnished on Same Date as Inpatient and Outpatient Services and Implements New Messages

Provider Types Affected
This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

What You Need To Know
Change Request (CR) 7061, from which this article is taken, instructs your carriers and A/B MACs to modify previously implemented edits that prevent payments to physicians, practitioners, Independent Diagnostic Testing Facilities (IDTFs) and independent laboratories for the Technical Component (TC) portion of the radiology and pathology services furnished to an inpatient or outpatient of a hospital. The CR also revises certain Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Summary Notice messages for both radiology and pathology because the current codes listed are obsolete. Make sure your billing staff is aware of these changes.

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

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

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

Payments for independent laboratories are not affected by CR 7061.

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

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

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7061

Section 5501(b) Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas under the Affordable Care Act (the Affordable Care Act)

Provider Types Affected
This program is for general surgeons submitting claims to Medicare contractors (carriers and Medicare Administrative Contractors (MAC)) for major surgical procedures furnished in Health Professional Shortage Areas (HPSAs) to Medicare beneficiaries.

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

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

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

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

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

Note: The new HPSA Surgical Incentive Payment Program (HSIP) and the new Primary Care Incentive Payment Program (PCIP) will be implemented in conjunction with one another for CY 2011. CMS issued CR 7060 with requirements specific to the PCIP. (The MLN Matters® article related to CR 7060 is

available at http://www.cms.gov/MLNMattersArticles/downloads/MM7060.pdf on the CMS website.) The former "special HPSA remittance" will now be known as the "special incentive remittance."

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

HPSA Surgical Incentive Payment Program (HSIP)
For services furnished on or after January 1, 2011 and before January 1, 2016, a 10 percent incentive payment will be paid to general surgeons, identified by their enrollment in Medicare with a primary specialty code of 02 (General Surgery), in addition to the amount they would otherwise be paid for their professional services under Part B, when they furnish a major surgical procedure in an area designated by the Secretary of Health and Human Services, as of December 31 of the prior year as a HPSA.
To be consistent with the original Medicare HPSA physician bonus program, HSIP payments will be calculated by Medicare contractors based on the identification criteria for payment discussed below and paid on a quarterly basis on behalf of the qualifying general surgeon, for the qualifying major surgical procedures. The surgeon's professional services are paid under the PFS based on a claim for professional services.

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

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

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

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

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7063

Fractional Mileage Amounts Submitted on Ambulance Claims

Provider Types Affected
This article is for providers and suppliers of ambulance services who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs)) for those services.

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

Background
Currently, the *Medicare Claims Processing Manual*, Chapter 15, Sections 30.1.2 and 30.2.1 require that ambulance providers and suppliers submitting claims to Medicare contractors use the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. According to these instructions from the Centers for Medicare & Medicaid Services (CMS), providers and suppliers are required to round the total mileage up to the nearest whole mile, including trips of less than one whole mile. For example, if the total number of round trip miles traveled equals 9.5 miles, the provider or supplier enters 10 units on the claim form or the corresponding loop and segment of the ANSI X12N 837 electronic claim. For ambulance suppliers submitting claims to the Medicare carriers or A/B MACs, the Medicare Claims Processing Manual, Chapter 26, Section10.4 additionally states that at least one (1) unit must be billed in Item 24G on the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12N 837P electronic claim. Therefore, if a supplier travels less than one mile during a covered trip, the supplier would enter 1 unit on the claim form with the appropriate HCPCS code for mileage.

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

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

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

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

For mileage totaling less than 1 mile, providers and suppliers must include a "0" prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Medicare contractors will automatically default "0.1" unit when the total mileage units are missing in Item 24G of the CMS-1500 claim form.

Additional Information
The official instruction, CR 7065, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2103CP.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7065

Instructions for PLB code reporting on Remittance Advice, a Crosswalk between the HIGLAS PLB codes and ASC X12 Transaction 835 PLB codes, and RAC Recoupment Reporting on Remittance Advice for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Claims

Provider Types Affected
All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed
Change Request (CR) 7068 provides instructions to Medicare Carriers, MACs, FIs, and RHHIs about using and reporting PLB codes on the Remittance Advice (RA). It also includes instruction for DME MACs for reporting RAC recoupment when there is a time difference between the creation of the Accounts Receivable and actual recoupment of money.

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

Background
In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractors (RAC) program to be in place by January 1, 2010. The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and can go back 3 years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

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

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

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

> **Step I:** Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here)
>
> **Step II:** Report the actual recoupment.

In a previous CR (Transmittal 659, CR6870), Medicare Carriers, FIs and A/B MACs were instructed to provide enough detail in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step-by-step process, regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done. CR7068 instructs DME MACs how to report on the RA when an overpayment is identified and also when Medicare actually recoups the overpayment in a future RA.

RAC Recoupment Reporting – DME Claims Only

Step I: Claim Level:

The original claim payment is taken back and the new payment is established (Reversal and Correction).

Provider Level:

PLB03-1 – PLB reason code FB (Forward Balance)

PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: Adjustment CCN#

20-30: HIC#

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

Step II: Claim Level:

No additional information at this step

Provider Level:

PLB03-1 – PLB reason code WO (Overpayment Recovery)

PLB 03-2 shows the detail:

PLB-03-2

1-2: 00

3-19: Adjustment CCN#

20-30: HIC#

PLB04 shows the actual amount being recouped

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

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

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

PLB Code Reporting

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

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

- Group Codes,

- Claim Adjustment Reason Codes (CARCs), and
- Remittance Advice Remark Codes (RARCs).

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

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

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

HIGLAS uses additional PLB codes from the X12 Standard that are not in the Implementation Guide (IG) or Technical Report (TR) 3. **Medicare must use only those codes that are included in the IG/TR3 to report on the 835**.

HIGLAS PLB Codes and ASC X12 Crosswalk
Currently CMS is transitioning to HIGLAS, and some contractors are still not under HIGLAS. CR 7068 applies to both HIGLAS and Non-HIGLAS contractors with the goal of uniform and consistent reporting on the 835 across the board. Secondly, CMS is also in the process of implementing version 005010/005010A1. Attachment – 835 PLB Code Mapping is applicable to Version 004010A1 as well as 005010A1.

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

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (Transmittal 812/CR 7068) issued to your Medicare contractor at

http://www.cms.gov/transmittals/downloads/R812OTN.pdf on the CMS website.
You may also want to review the following MLN Matters® articles:

- Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments at http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf, and

- Reporting of Recoupment for Overpayment on the Remittance Advice (RA) at http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7068

National Modifier and Condition Code to Identify Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries related, in whole or in part, to the 2010 oil spill in the Gulf of Mexico.

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

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

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

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

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

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

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

Additional Information

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7087

Billing Clarification for Positron Emission Tomography (NaF-18) PET for Identifying Bone Metastasis of Cancer in the Context of a Clinical Trial

Provider Types Affected
This article is for physicians, providers and suppliers who bill Medicare carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for providing Positron Emission Tomography (NaF-18) PET scans to identify bone metastasis of cancer for Medicare beneficiaries.

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

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

CR 7125 also corrects the list of applicable PET or PET with CT CPT codes that can be used for bone metastasis on the claim and to remove HCPCS 78608 and t8459 as they cannot be paid for bone metastasis with NaF-18. Finally, modifier KX (Requirements specified in the medical policy have been met) will be accepted for PC claims (modifier 26) for PET for bone metastasis (PET NaF-18) to differentiate these claims from PET for FDG in the context of a clinical trial. This modifier is not required on claims submitted to FIs, nor is it required on claims for the technical or global service.

Key Points in CR 7125

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

2. Effective for claims with dates of service on or after February 26, 2010, PET oncologic claims billed with modifier 26 and modifier KX to inform the initial treatment strategy or strategy or subsequent treatment strategy for bone metastasis MUST include ALL of the following:
   - -PI or –PS modifier AND

- PET or PET/CT CPT code (78811, 78812, 78813, 78814, 78815, 78816) AND
- ICD-9 cancer diagnosis code AND
- Q0 modifier – Investigational clinical service provided in a clinical research study, are present on the claim.

3. Claims failing the requirements stated above will be returned as unprocessable with the following messages:
   - Claim Adjustment Reason Code 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing.);
   - Remittance Advice Remark Code MA-130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.);
   - Remittance Advice Remark Code M16 (Alert: See our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.); and/or
   - Claim Adjustment Reason Code 167 (This (these) diagnosis(es) is (are) not covered.)

4. Claims billed with modifiers 26 and KX to inform the initial treatment strategy or subsequent treatment strategy for bone metastasis billed with HCPCS A9580 will be returned as unprocessable using Claim Adjustment Reason Code 97 (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.).

Additional Information

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7125

Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas (HPSAs), Section 5501(b) of The Affordable Care Act, Payment to a Critical Access Hospital (CAH) Paid under the Optional Method

Provider Types Affected
This article is for general surgeons and Critical Access Hospitals (CAHs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided in HPSAs to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7146 regarding the new HPSA Surgical Incentive Payment Program (HSIP) and the new Primary Care Incentive Payment Program (PCIP) that will be implemented in conjunction with one another for Calendar Year (CY) 2011.

What You Need To Know
Change Request (CR) 7115 gives specific requirements for the PCIP, and CR 7146 includes the business requirements for the actions and costs associated with these incentive payments. Once CR 7115 is released, a related MLN Matters® article will be available at http://www.cms.gov/MLNMattersArticles/downloads/MM7115.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

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

Background
The Affordable Care Act (Section 5501(b)) (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ148.111.pdf) revises The Social Security Act (Section 1833(m); http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) and authorizes an incentive payment program for major surgical services furnished by general surgeons in Health Professional Shortage Areas (HPSAs). The section provides for additional payments (on a monthly or quarterly basis) in an amount equal to 10 percent of the payment for physicians' professional services under Part B.

The incentive payment also applies to surgical procedures (defined as 10 - and 90 - day global procedures on the Payment Policy Indicator File) furnished in an area designated as a HPSA (on or after January 1, 2011 and before January 1, 2016) by an 02-general surgeon who has reassigned their billing rights to a Critical Access Hospital (CAH) paid under the optional method.

The HPSA areas are those ZIP codes designated as such by The Secretary of Health and Human Services as of December 31 of the prior year. This list of ZIP codes is also utilized for automatic payments under the HSIP program.

Modifier AQ should be appended to the 10 - or 90 - day global surgical procedure on claims submitted for payment, similar to the current process for payment of the Medicare HPSA physician bonus when the HPSA is not a HPSA identified for automatic payment.

Medicare Contractors will use the existing HPSA modifier (AQ) submitted on claims along with the physician specialty code 02 to identify circumstances when general surgeons furnish services in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of ZIP codes eligible for automatic payment.

Information regarding the Payment Policy Indicator File and other aspects of the Medicare Physician Fee Schedule is available at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx on the CMS website.

To be consistent with the Medicare HPSA physician bonus program, HSIP payments are calculated by Medicare contractors based on the identification criteria for payment discussed below and paid on a quarterly basis to CAHs, on behalf of the qualifying general surgeon for the qualifying surgical procedures.

The additional HSIP payment will be combined, as appropriate, with the HPSA physician bonus payment. The special remittance advice for the incentive payments to CAHs will be revised to inform CAHS as to the type(s) of incentive payments, i.e., the HPSA physician, HSIP, or PCIP. In addition the remittance for the optional method CAHs will identify the NPI of the surgeon in the "operating provider" field.

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

NOTE: The current HPSA physician bonus program requirements for contractors will remain intact. The additions mentioned in the requirements below are for the HSIP and are based on The Affordable Care Act.

Payment to Critical Access Hospitals (CAHs)
Physicians and non-physician practitioners billing on Type of Bill (TOB) 85X (CAH) for professional services rendered in a CAH paid under the optional method have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to CAHs paid under the optional method, payment is made for professional services (revenue codes (RC) 96X, 97X or 98X).

For major surgical services furnished on January 1, 2011 and before January 1, 2016, CAHs paid under the optional method will be paid an additional 10 percent incentive based on the amount actually paid for those services when furnished by general surgeons in HPSAs. Quarterly incentive payments will be made to CAHs paid under the optional method on behalf of physicians.

Additional Information
The official instruction, CR 7146, issued to your FIs and/or A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2078CP.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7146

New Waived Tests

Provider Types Affected
This article is for clinical diagnostic laboratories billing Medicare Carriers or Part A/B Medicare Administrative Contractors (MACs) for laboratory tests.

Provider Action Needed
If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare Carrier or A/B MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the Centers for Medicare & Medicaid Services (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 7184, from which this article is taken, informs carriers and MACs about the latest new CPT codes that are subject to CLIA edits

What You Need To Know
Make sure that your billing staffs are aware of these CLIA-related changes for 2010 and that you remain current with certification requirements.

Background
Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The tests are valid as soon as they are approved. The CPT codes for the following new tests MUST have the modifier QW to be recognized as a waived test. Note, however, that the tests mentioned on the first page of the list attached to CR 7184 (i.e., CPT codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

CPT Code	Effective Date	Description
G0430QW	January 1, 2010	American Screening Corporation OneScreen Drug Test Cups
84443QW	March 2, 2010	Aventir Biotech LLC, Forsure TSH Test {Whole Blood}
84443QW	March 4, 2010	BTNX, Inc Rapid Response Thyroid Stimulating Hormone (TSH) Test Cassette
G0430QW	April 21,2010	CLIAwaived, Inc. Rapid Drug Test Cup {OTC}
G0430QW	April 21, 2010	Millennium Laboratories Clinical Supply, Inc Multi-Drug Pain Med Screen Cup
G0430QW	May 10, 2010	US Diagnostics ProScreen Drugs of Abuse Cup {OTC}
G0430QW	July 1, 2010	Ameditech, Inc ImmuTest Drug Screen Cup
G0430QW	July 4, 2010	Quik Test USA, Inc. Multi-Drug of Abuse Urine Test
G0430QW	July4, 2010	Screen Tox Multi-Drug of Abuse Urine Test
82274QW,	July 8, 2010	Consult Diagnostics Immunochemical Fecal

G0328QW		Occult Blood Test (iFOBT)
G0430QW	July 19, 2010	Alfa Scientific Designs, Inc. Instant-View Drug of Abuse Urine Cassette Test
G0430QW	July 19, 2010	Alfa Scientific Designs, Inc. Instant-View Drug of Abuse Urine Cup Test
G0430QW	August 18, 2010	American Screening Corporation Reveal Multi-Drug Testing Cups
87880QW	August 18, 2010	PSS Consult Diagnostics Strep A Dipstick

Additional Information

The official instruction, CR 7184 issued to your carrier or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2084CP.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7184

Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 17.0, Effective January 1, 2011

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

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

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

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

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

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

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

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

Additional Information
The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which is available at http://www.cms.gov/manuals/downloads/clm104c23.pdf on the CMS website. The official instruction (CR 7081) issued to your carrier or A/B MAC regarding this change is at http://www.cms.gov/Transmittals/downloads/R2097CP.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7210

Ventricular Assist Devices (VADs) as Destination Therapy- Revised

Note: This article was revised on **December 9, 2010**, to reflect the revised Change Request (CR) 7220 released on December 8, 2010. The CR release date, transmittal number, and the Web address for accessing CR were revised. All other information is the same.

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for Ventricular Assist Device (VAD) implantation services provided to Medicare beneficiaries.

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

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

1. Postcardiotomy,
2. Bridge to transplantation, and
3. Destination therapy.

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

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

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

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

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

- Who meet all of the following conditions:

    - Have failed to respond to optimal medical management (including beta-blockers, and Antiotensin-Converting Enzyme (ACE) inhibitors if tolerated) for at least 45 of the last 60 days, or have been balloon pump-dependent for 7 days, or IV inotrope-dependent for 14 days;

    - Have a Left Ventricular Ejection Fraction (LVEF) < 25%; and,

    - Have demonstrated functional limitation with a peak oxygen consumption of ≤14 ml/kg/min unless balloon pump ot inotrope dependent or physicially unable to perform the test.

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

Additional Information

The official instruction, CR 7220, issued to your carriers, FIs, and A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R129NCD.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7220

Update to Medicare Deductible, Coinsurance and Premium Rates for 2011

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Impact on Providers
This article is based on Change Request (CR) 7224 which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2011.

Background

2011 Part A - Hospital Insurance (HI)
A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a spell of illness.

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

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

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

Hospital Coinsurance		**Skilled Nursing Facility Coinsurance**
Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
$283.00	$566.00	$141.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium. Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2011 Part A premiums are as follows:

Voluntary Enrollees Part A Premium Schedule for 2011	
Base Premium (BP)	$450.00 per month
Base Premium with 10% Surcharge	$495.00 per month
Base premium with 45% Reduction (for those with 30-39 quarters of coverage)	$248.00 (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$272.80 per month

2011 Part B - Supplementary Medical Insurance (SMI)
Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2011, the standard premium for SMI services is **$115.40** a month; the deductible is **$162.00** a year; and the coinsurance is 20%. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 7224, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R65GI.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information
The official instruction, CR 7224, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R65GI.pdf on the CMS website.

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7224

Reasonable Charge Update for 2011 for Splints, Casts, and Certain Intraocular Lenses

Provider Types Affected
This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

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

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

Beginning January 1, 2011, reasonable charges will no longer be calculated for payment of home dialysis supplies and equipment for Method II End Stage Renal Disease (ESRD) patients. Section 153 of Medicare Improvements for Patients and Providers Act (MIPPA) amended section 1881(b) of the Act to require the implementation of an ESRD bundled payment system effective January 1, 2011. The ESRD prospective payment will provide an all-inclusive single payment to ESRD facilities (i.e. hospital-based providers of services and renal dialysis facilities) that will cover all the resources used in providing outpatient dialysis treatment, including dialysis supplies and equipment that are currently separately payable to Method II DME suppliers.

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

A list of the 2011 payment limits for splints and casts are as follows:

HCPCS Code	2011 Allowance
A4565	$7.84
Q4001	$44.60
Q4002	$168.58

Q4003	$32.04
Q4004	$110.92
Q4005	$11.81
Q4006	$26.62
Q4007	$5.92
Q4008	$13.31
Q4009	$7.89
Q4010	$17.75
Q4011	$3.94
Q4012	$8.88
Q4013	$14.36
Q4014	$24.21
Q4015	$7.18
Q4016	$12.10
Q4017	$8.30
Q4018	$13.23
Q4019	$4.16
Q4020	$6.62
Q4021	$6.14
Q4022	$11.08
Q4023	$3.09
Q4024	$5.54
Q4025	$34.44
Q4026	$107.54
Q4027	$17.23
Q4028	$53.78
Q4029	$26.34
Q4030	$69.33
Q4031	$13.17
Q4032	$34.66
Q4033	$24.57
Q4034	$61.10
Q4035	$12.28
Q4036	$30.56
Q4037	$14.99
Q4038	$37.55
Q4039	$7.51
Q4040	$18.76
Q4041	$18.22
Q4042	$31.11
Q4043	$9.12
Q4044	$15.56
Q4045	$10.58
Q4046	$17.02
Q4047	$5.28
Q4048	$8.51
Q4049	$1.93

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7225

New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines

Provider Types Affected
This article is for physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for influenza vaccines provided to Medicare beneficiaries.

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

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

Key Points of CR7234
The following describes the process for updating these specific HCPCS codes for Medicare payment effective for dates of service on or after October 1, 2010.

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

CPT Code	Short Description	Long Description
90658	Flu vaccine, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use

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

CPT Code	Short Description	Long Description
Q2035	Afluria vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	Flulaval vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037	Fluvirin vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	Fluzone vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	NOS vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age

		and older, for intramuscular use (Not Otherwise Specified)

Take Note: CPT 90658 describes the regular dose vaccine that is supplied in a multi-dose vial for use in patients over 3 years of age. For dates of service on or after October 1, 2010, HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 (as listed in the table above) will replace the CPT code 90658 for Medicare payment purposes during the 2010 – 2011 influenza season. **However, these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when CPT code 90658 will no longer be recognized.**

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

Billing

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

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

Payment

The Medicare Part B payment limits for influenza vaccines are 95 percent of the Average Wholesale Price (AWP) except where the vaccine is furnished in a setting that follows a cost-based or prospective payment system under Medicare. For example, where the vaccine is furnished in the hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC), payment for the vaccine is based on reasonable cost.

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

HCPCS Code	Allowance
Q2036	$7.439
Q2037	$13.253
Q2038	$12.593

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

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

Important Notes:

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

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

Additional Information

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

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

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

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7234

Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

Provider Types Affected
Clinical laboratories submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for clinical laboratory services provided to Medicare beneficiaries are affected.

Provider Action Needed
This article is based on Change Request (CR) 7239 which revises the payment of travel allowances, either on a per mileage basis (P9603) or on a flat rate basis (P9604) for Calendar Year (CY) 2010. Note that Medicare contractors will not re-process claims that were processed before the new rates were implemented unless you bring such claims to their attention.

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

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

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor.

The per flat rate trip basis travel allowance (P9604) for 2011 is $9.50. The per mile travel allowance (P9603) is $0.95 cents per mile and is used in situations where the average trip to the patients' home is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

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

The Centers for Medicare & Medicaid Services (CMS) reviews the minimum mileage rate and updates it in conjunction with the Clinical Laboratory Fee Schedule (CLFS) as needed.

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

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

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

If you have any questions regarding this issue, refer to the "Contact Us" page of our Web site to call the Provider Contact Center.

MLN Matters® MM7239

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2. **Organization and layout of the information.**

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