

TrailBlazer Bulletin



July 2010



Note: Unless designated differently, all information herein pertains to both Part A and Part B audiences.

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

<http://www.trailblazerhealth.com/Publications/Newsletters/>

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

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From the Desk of the Medical Director
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Inappropriate Hospital Admission Versus Outpatient Observation **R**

TrailBlazer is the Medicare Administrative Contractor (MAC) authorized by the Medicare program to perform comprehensive medical review of acute Prospective Payment System (PPS) hospital and Long-Term Care Hospital (LTCH) claims submitted in Jurisdiction 4. As a result of recent medical reviews, TrailBlazer has become aware that a number of inpatient claims are submitted for reimbursement without physician admission orders. The lack of a physician order indicating the required level of care results in a billing error. Medicare requirements state the inpatient admission begins when the admission order is written. Additionally, all physician orders must have a date and a legible signature.

Only two levels of care may be ordered:

- Inpatient – Billed on bill type 11X.
- Outpatient – Billed on bill type 12X, 13X or 85X.

Inpatient Status

Medicare policies in the Conditions of Participation (CoP) and in Internet-Only Manual (IOM) Pub. 100-04, *Medicare Claims Processing Manual*, indicate the importance of providing supporting documentation for all rendered treatment, services and care. Physician orders, with signature for authentication, are required in order to identify the physician's decision to treat the patient as an outpatient or inpatient. The patient's condition, history and current diagnostic test results, along with the physician's medical judgment, availability of treatment modalities and hospital admission policies, should be considered when making a determination to admit a patient. As indicated in IOM Pub. 100-04, the term "admit" refers to the decision to provide inpatient care. If a physician determines additional information is required in making a medical

decision for inpatient admission, the physician may elect to place the patient in outpatient status for observation services.

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13X or 85X) for medically necessary Medicare Part B services furnished to the beneficiary, provided conditions are met for condition code 44. When the conditions for use of condition code 44 are not met, the hospital may submit a 12X bill type for covered Part B-only services that were furnished to the patient as inpatient services. Additional details may be found in IOM Pub. 100-04, Chapter 1, Section 50.3. When a patient is admitted appropriately and documentation supports inpatient services, the provider may submit an inpatient claim on an 11X bill type for reimbursement. Prior to submitting a claim to Medicare, hospital providers and utilization review committees are encouraged to review documentation for physician orders.

Outpatient Status

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital or Critical Access Hospital (CAH).

Outpatient Status With Observation Services

Observation is covered only when ordered by a physician or another individual authorized to admit patients to the hospital or to order outpatient tests in accordance with state licensure law and hospital staff bylaws.

Observation or monitoring is a type of service. A physician may choose to place a patient under observation. A valid order may read, "Outpatient for observation." Observation is within the scope of services offered at the outpatient level of care. Planned admission following an elective outpatient procedure may be denied for lack of medical necessity when the patient's condition does not warrant an acute inpatient stay. The admission must be related to the patient's condition and documentation must provide a rationale for the medical decision to place the patient in an inpatient status. In addition, monitoring and observation services following an outpatient procedure are not observation services; the recovery, monitoring and medications following the procedure are an inclusive part of the procedure.

Scenario 1:

An inpatient claim is submitted for medical review with the following components:

- The claim is without a written and signed physician order for admission.
- The documentation is without an admit note describing the reason for admission to an inpatient level of care.
- The services rendered could have been rendered in an outpatient setting.
- The screening tool indicates the intensity of services and the severity of the patient's condition as documented did not support the medical necessity for an acute inpatient level of care.
- The claim is submitted on bill type 11X.

Medical Review Determination:

The claim is denied because the documentation does not support the medical necessity for an acute inpatient level of care.

Scenario 2:

An inpatient claim is submitted for medical review with the following components:

- A patient has an elective scheduled outpatient procedure, such as a cardiac catheterization with stent placement, and is kept overnight for recovery.
- The patient is discharged the next morning without documentation of any complications.
- The hospital bills for inpatient services on bill type 11X.
- Medical reviewers assess the submitted documentation and find the chart is without physician orders, an admission note or progress notes describing the medical necessity to admit.

Medical Review Determination:

The claim is denied because documentation does not support the medical necessity for an acute inpatient level of care. Outpatient observation should be billed on bill type 13X. If the patient's condition requires inpatient admission, the physician needs to document an inpatient admission order with a progress note describing the medical decision for the inpatient admission and the intended treatment plan to address the patient's condition.

Physician Orders: Inpatient Versus Outpatient

Examples of valid physician orders for inpatient admission are:

- Admit to inpatient care.
- Admit to Dr. Smith.
- Any set of orders labeled "admission orders."

Some providers have demonstrated confusion associated with billing for observation services. Providers are reminded that observation services are provided on an outpatient basis and should be billed according to observation billing guidelines. (**Note:** Orders for observation services are rendered in an outpatient level of care.) Orders for observation services are not considered to be valid inpatient admission levels of care orders. When billing observation services, the contractor expects the charges associated with those services to be billed as outpatient level of care services.

The following are acceptable examples of orders received for observation services in an outpatient level of care:

- Admit to observation.
- Admit to case management.

Additional information is available in the notice titled "Inpatient Admission Versus Outpatient Observation Following an Outpatient Procedure" at:

<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13067>

Resources:

- IOM Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 50.3.
<http://www.cms.gov/manuals/downloads/clm104c01.pdf>
- IOM Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.2.2.K.
<http://www.cms.gov/manuals/downloads/clm104c03.pdf>

Front Page News

Updated Online Medicare Fee Schedule Now Available

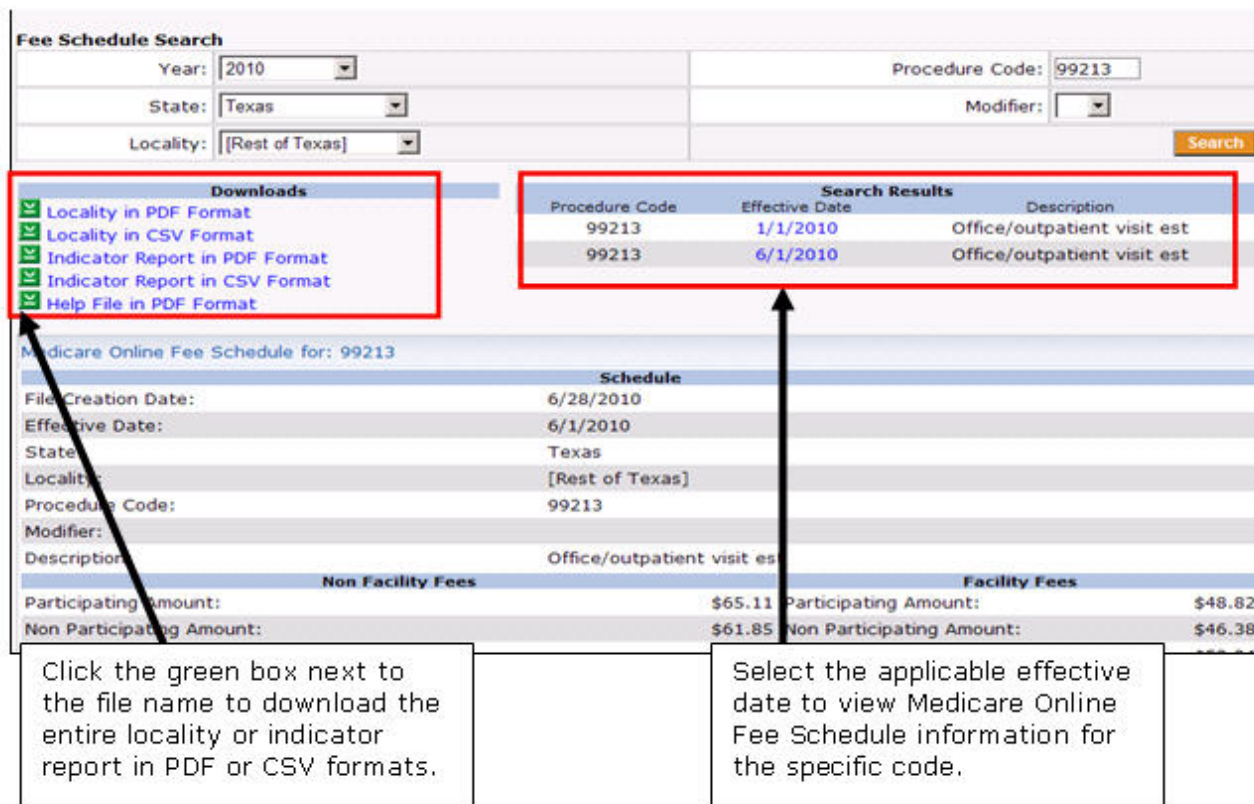
The updated 2010 Medicare Physician Fee Schedule (MPFS) that includes the new 2.2 percent update effective June 1, as well as the updated rates for January 1, 2010 – May 31, 2010, is now available on the Medicare Fee Schedule page.

[http://www.trailblazerhealth.com/Tools/Fee Schedule/MedicareFeeSchedule.aspx](http://www.trailblazerhealth.com/Tools/Fee%20Schedule/MedicareFeeSchedule.aspx)

In addition, updates due to CMS Change Request (CR) 6974, "July 2010 Medicare Physician Fee Schedule Database Update," have been added (<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13770>).

Instructions for Online Fee Schedule Search:

- Select the year, state and locality.
- Downloadable files for the entire locality will display in the Downloads section.*
- To display fee schedule information for a specific code, enter a procedure code and modifier, if applicable, and click **Search**.
- For 2010, the June 1 effective date information is automatically displayed in the Medicare Online Fee Schedule section for most codes. To view fee schedule information effective January 1, 2010 – May 31, 2010, select "**1/1/2010**" in the Search Results section. Codes with July 1, 2010 changes due to CR 6974 will display the 7/1/2010 effective date.



The screenshot shows the 'Fee Schedule Search' interface. At the top, there are dropdown menus for 'Year' (2010), 'State' (Texas), and 'Locality' ([Rest of Texas]), along with input fields for 'Procedure Code' (99213) and 'Modifier'. A 'Search' button is located to the right. Below the search fields, there are two main sections: 'Downloads' and 'Search Results'. The 'Downloads' section lists five items: 'Locality in PDF Format', 'Locality in CSV Format', 'Indicator Report in PDF Format', 'Indicator Report in CSV Format', and 'Help File in PDF Format'. Each item has a green box icon to its left. The 'Search Results' section displays a table with three columns: 'Procedure Code', 'Effective Date', and 'Description'. It shows two rows of results for procedure code 99213, with effective dates of 1/1/2010 and 6/1/2010, both described as 'Office/outpatient visit est'. Below the search results, there is a 'Medicare Online Fee Schedule for: 99213' section. This section includes a 'Schedule' table with fields for 'File Creation Date' (6/28/2010), 'Effective Date' (6/1/2010), 'State' (Texas), 'Locality' ([Rest of Texas]), 'Procedure Code' (99213), and 'Modifier'. Below the schedule table, there are two columns of fees: 'Non Facility Fees' and 'Facility Fees'. The 'Non Facility Fees' column shows 'Participating Amount' (\$65.11) and 'Non Participating Amount' (\$61.85). The 'Facility Fees' column shows 'Participating Amount' (\$48.82) and 'Non Participating Amount' (\$46.38). Two callout boxes with arrows provide instructions: one points to the green box icons in the Downloads section, and the other points to the 'Effective Date' column in the Search Results table.

Click the green box next to the file name to download the entire locality or indicator report in PDF or CSV formats.

Select the applicable effective date to view Medicare Online Fee Schedule information for the specific code.

***Note:** The downloadable file includes all fees effective for 2010 dates of service. The **Notes column** designates the effective date for the code:

- 01 – Effective date for code is 1/1/2010.
- 06 – Effective date for code is 6/1/2010.
- 07 – Effective date for code is 7/1/2010.

Provider News

Education and Training

Medicare Part A Provider Education and Training August – September 2010

TrailBlazer Part A Provider Outreach and Education is offering the following education and training opportunities August – September 2010. There is **no charge** to attend the in-house seminars, Web-based training and teleconference training sessions. Registration and event details are available by clicking the event date below or via the Calendar of Events Web page at:

<http://www.trailblazerhealth.com/Calendar/CalendarofEvents.aspx>

Event Title	Event Date
Beginner’s Guide to Medicare – Part 3 Web-Based Training	<u>August 3, 2010</u>
Outpatient Prospective Payment System (OPPS) Documentation Guidance Web-Based Training	<u>August 10, 2010</u>
Inpatient Return to Provider (RTP) Errors Web-Based Training	<u>August 10, 2010</u>
Electronic Data Interchange Direct Data Entry (EDI DDE) Training	<u>August 11, 2010</u>
Beginner’s Guide to Medicare – Part 4 Web-Based Training	<u>August 17, 2010</u>
Skilled Nursing Facility (SNF) Policy and Billing Web-Based Training	<u>August 17, 2010</u>
Rural Health Clinic (RHC) Documentation and Comprehensive Error Rate Testing (CERT) Web-Based Training	<u>August 24, 2010</u>
Inpatient Documentation Guidance Web-Based Training	<u>August 24, 2010</u>
EDI DDE Training	<u>August 25, 2010</u>
End Stage Renal Disease (ESRD) RTP Errors Web-Based Training	<u>September 7, 2010</u>
Critical Access Hospital (CAH) Policy and Billing Web-Based Training	<u>September 7, 2010</u>
Examining the Medicare Appeals Process Web-Based Training	<u>September 8, 2010</u>

Medicare Part B Provider Education and Training August – September 2010

TrailBlazer Part B Provider Outreach and Education is offering the following education and training opportunities August – September 2010. There is **no charge** to attend the Web-based training and teleconference training sessions. Registration and event details are available by clicking the event date below or via the Calendar of Events Web page at:

<http://www.trailblazerhealth.com/Calendar/CalendarofEvents.aspx>

Event Title	Event Date
All TrailBlazer Service Areas	
Psychiatric Services Web-Based Training	August 4, 2010
Beginner's Guide to Medicare – Part 3 Web-Based Training	August 4, 2010
Beginner's Guide to Medicare – Part 4 Web-Based Training	August 18, 2010
Proper Use of the ABN Web-Based Training	August 25, 2010
Examining the Medicare Appeals Process Web-Based Training	September 8, 2010
Beginner's Guide to Medicare – Part 5 Web-Based Training	September 8, 2010
E/M and Surgery Modifiers Web-Based Training	September 15, 2010
Jurisdiction 4	
J4 Neurology/Neurosurgery Policy and Billing Errors Web-Based Training	August 25, 2010
J4 Ask-the-Contractor Teleconference	September 14, 2010
Virginia	
Virginia Ask-the-Contractor Teleconference	September 21, 2010

Local Coverage Determinations

J4 LCD Updates – June 2010

Applies to CO, NM, OK, TX

To keep providers up to date on any revisions to Local Coverage Determinations (LCDs), a list of updated LCDs will be made available on a monthly basis. The following J4 Medicare Administrative Contractor (MAC) LCDs for Medicare Parts A and B were updated in June and can be viewed in their entirety on the LCD Web page at:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx>

Bioengineered Skin Substitutes – 4S-157AB-R2

Update: Per Change Request (CR) 6711, updated language within sections “Product Wastage,” “Coding Drug Wastage JW Modifier” and “Product Wastage Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Botulinum Toxin Types A and B – 4I-84AB-R5

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Chelation Therapy - 4I-85AB-R2

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Colony Stimulating Factors – 4I-86AB-R2

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Per provider request, added ICD–9–CM code V42.82 to the list for limited coverage for CPT/HCPCS codes J1440, J1441, J2505 and J2820. Effective date: 06/07/2010.

Drugs and Biologicals, Non-Chemotherapeutic – 4I-81AB-R16

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Drugs and Biologicals – Chemotherapeutic – 4I-92AB-R16

Update: Per Change Request (CR) 6711, updated language within sections “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Erythropoiesis Stimulating Agents (ESA) – Non-Dialysis – 4I-101AB-R4

Update: Per Change Request (CR) 6711, updated language within sections “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Hyaluronate Polymers – 4I-87AB-R4

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Immunizations – 4I-83AB-R5

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Intravenous Immune Globulin (IVIG) – 4I-82AB-R6

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Intravenous Immune Globulin (IVIG) – 4I-82AB-R7

Update: Per provider request, added ICD-9-CM code V42.82 (Trspl sts-perip stm cell) to the limited coverage list for CPT/HCPCS codes J1459, J1561, J1566, J1568, J1569 and J1572. Effective date: 06/15/2010.

Leucovorin and Levoleucovorin Calcium – 4I-89AB-R2

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Luteinizing Hormone-Releasing Hormone (LHRH) Analogs – 4I-90AB-R4

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Non-Covered Services – 4Z-18AB-R14

Update: Per provider request, revised the CPT/HCPCS Codes section in the LCD to clarify the processing instructions for services that are bundled or packaged under OPPS. Effective date: 06/03/2010.

Photodynamic Therapy with Verteporfin (Visudyne®) – 4O – 56AB-R2

Update: Per Change Request (CR) 6711, updated language within sections “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Therapy Services (PT, OT, SLP) – 4Y-26AB R2

Update: Revised text in the LCD section titled, “Indications and Limitations of Coverage and/or Medical Necessity,” to clarify the paragraph regarding the length of a usual treatment session. Effective date: 05/17/2010.

Thrombolytic Agents – 4I-91AB-R3

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Virginia LCD Updates – June 2010 

Applies to Part B Virginia

To keep providers up to date on any revisions to Local Coverage Determinations (LCDs), a list of updated LCDs will be made available on a monthly basis. The following Part B Virginia LCDs were updated in June and can be viewed in their entirety on the LCD Web page at:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx>

Botulinum Toxin Type A – I-48B-R10

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Colony Stimulating Factors – I-74B-R4

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Per provider request, added ICD–9–CM code V42.82 to the list for limited coverage for CPT/HCPCS codes J1440, J1441, J2505 and J2820. Effective date: 06/07/2010.

Chelation Therapy - I-63B-R5

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Drugs and Biologicals – Chemotherapeutic Drugs J9000–J9999 – I-68B-R54

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Drugs and Biologicals, Non-Chemotherapeutic – I-66B-R49

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Erythropoiesis Stimulating Agents (ESA) – Non-Dialysis – I-102B-R4

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Hyaluronate Polymers – I-73B-R11

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Immunizations – I-80B-R10

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Intravenous Immune Globulin (IVIG) – I-71B-R21

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Leucovorin and Levoleucovorin Calcium – I-75B-R5

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Luteinizing Hormone-Releasing Hormone (LHRH) Analogs – I-79B-R10

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Photodynamic Therapy With Verteporfin (Visudyne®) – O-43B-R8

Update: Per CR 6711, updated language within the sections titled “Drug Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Skin Substitutes/Replacements – S-129B-R13

Update: Per CR 6711, updated language within the sections titled “Product Wastage,” “Coding Drug Wastage JW Modifier” and “Documentation Requirements” of the LCD and article. Effective date: 07/30/2010.

Skin Substitutes/Replacements – S-129B-R14

Update: Per provider request, added indications and limitations criteria under the “Indications and Limitations of Coverage and/or Medical Necessity” section and added limited coverage criteria under the “ICD-9-CM Codes That Support Medical Necessity” section for HCPCS code Q4107 (GraftJacket®). Effective date: 10/15/2009.

Therapy Services (PT, OT, SLP) – Y-18Bva R23

Update: Revised text in the LCD section titled, "Indications and Limitations of Coverage and/or Medical Necessity," to clarify the paragraph regarding the length of a usual treatment session. Effective date: 05/17/2010.

Thrombolytic Agents – I-76B-R8

Update: Per CR 6711, updated language within the sections titled "Drug Wastage," "Coding Drug Wastage JW Modifier" and "Documentation Requirements" of the LCD and article. Effective date: 07/30/2010.

Educational Notices

GENERAL

Part B Echo Exam of Eye and Ophthalmic Biometry

TrailBlazer continues to receive inquiries about the proper coding for CPT codes:

- 76519© Echo exam of the eye.
- 92136© Ophthalmic biometry.

To properly report these codes for services performed on both eyes, separate the codes and report on two separate detail lines for professional and technical components. The fields indicated below apply to the CMS-1500 claim form. Please refer to the Part B Crosswalk to the CMS-1500 Claim Form for equivalent electronic claim fields at:

http://www.trailblazerhealth.com/Publications/Job_Aid/Crosswalkto1500ClaimForm.pdf

Technical Component:

- Item 24d: 76519 TC or 92136 TC.
- Item 24g: 1.

Professional Component:

- Item 24d: 76519 26 50 or 92136 26 50.
- Item 24g: 1.

The Medicare Physician Fee Schedule Data Base (MPFSDB) displays the following bilateral indicators for these codes:

Bilateral Indicators:

- Total Component (no modifier): 2.
- Technical Component (TC modifier): 2.
- Professional Component (26 modifier): 3.

A bilateral indicator of 2 means the fee schedule amount is already established for bilateral or multiple services, is not valid for a 50 modifier, and should not be billed for more than 1 unit. A bilateral indicator of 3 means the procedure is valid for a 50 modifier. Improper coding can result in incorrect payment or denial of claims.

Note: Commonly, when a patient is diagnosed with bilateral cataracts, the surgeries are performed weeks apart. In this scenario, the professional component is normally done only for the eye for which surgery is planned.

Example: Test is performed on both eyes (TC) but calculation is performed on the right eye only. Report 76519 TC and 76519 26RT. At a later date when surgery is planned and performed on the left eye, report 76519 26LT.

Banking Transition Effective August 2, 2010

CMS recently awarded new banking contracts to U.S. Bank and JP Morgan Chase. Medicare providers do not have to take any action. However, providers should be aware that their Medicare payments may be made by a different bank than in the past because of these new banking contracts.

The following Medicare claims processing contractors will remain with JP Morgan Chase. Providers who bill to these contractors will not experience any change.

- Cahaba Government Benefit Administrators.
- Pinnacle Business Solutions.
- First Coast Service Options (FCSO).
- Palmetto GBA (except for the Jurisdiction 1 (J1) A/B Medicare Administrative Contractor (MAC)).
- Wisconsin Physicians Service (WPS).

August 2, 2010, Transition

The following Medicare claims processing contractor will transition to JP Morgan Chase:

- **TrailBlazer Health Enterprises.**

The following contractors will transition to U.S. Bank:

- CIGNA Government Services.
- Highmark Medicare Services.
- National Government Services (NGS).
- National Heritage Insurance Company (NHIC).
- Noridian Administrative Services (NAS).

Note: Palmetto, the J1 MAC, transitioned to JP Morgan Chase effective June 1, 2010.

(CMS Learn Resource 201004-06, dated April 1, 2010, Joint Signature Memorandum (JSM) 10162, dated March 1, 2010, and JSM 10255, dated May 6, 2010)

Notice to Providers Who Receive Medicare Payments to a Bank of America/Merrill Lynch Account

TrailBlazer currently issues Medicare payments from accounts with Bank of America/Merrill Lynch. Due to CMS mandates, TrailBlazer will begin issuing Medicare payments from JP Morgan Chase Bank, effective August 2, 2010. As a result of this change, if you currently receive Medicare payments by Electronic Funds Transfer (EFT) to an account with Bank of America, you will experience a change in the date that EFT payments are posted to your account.

Currently, because both accounts (TrailBlazer and provider) are with Bank of America, payments are transmitted to provider accounts the same day that TrailBlazer releases payments. When the banking change to JP Morgan Chase is effective, payments will transmit through the Federal Reserve Banking System's clearing process to reach the receiving bank. As a result, payments will not be posted to your account on the same day they are released as you are currently experiencing. This does not mean that the payment is late, but it does mean that payments will no longer be posted to your account as it is currently being done.

IVR Operating Guides Have Been Updated and Duplicate Job Aids Removed

The A/B IVR Operating Guides have been updated to include enhanced descriptions of options available on the Interactive Voice Response (IVR). With these updates completed, we have removed the duplicate IVR job aids to simplify your search process.

- Part A IVR Guide. http://www.trailblazerhealth.com/Publications/Job_Aid/IVRUserGuide.pdf
- Part B IVR Guide. http://www.trailblazerhealth.com/Publications/Job_Aid/IVR_Operating_Guide.pdf

These changes are part of our ongoing commitment to improve our IVR system based on provider feedback because your comments matter! If you have any suggestions to further enhance your IVR experience, please provide us with your feedback by pressing *7 from the eligibility or main menu of the IVR.

CMS Quarterly Provider Update

The CMS Quarterly Provider Update (QPU) is a comprehensive resource that provides a list of non-regulatory changes to Medicare, including new and revised manual instructions and any other instructions that may impact Medicare providers or suppliers.

The QPU is published at the beginning of each quarter and is available on the CMS Quarterly Provider Updates Web page. Providers should bookmark this page and visit often to keep abreast of important Medicare information.

http://www.cms.gov/QuarterlyProviderUpdates/01_Overview.asp

Purpose

- Inform providers about new developments in the Medicare program.
- Assist providers in understanding and complying with Medicare regulations and instructions.
- Announce new or changed Medicare requirements.
- Communicate published information in the *Federal Register*.

CMS QPU Listserv

The CMS QPU listserv mailing list makes it easier for providers to keep track of QPU updates. Providers may join the CMS QPU mailing list by clicking **CMS Quarterly Provider Updates E-mail Updates List** under the "Related Links Inside CMS" section.

New Reporting Requirements for Therapy Services Performed By Persons Other Than Licensed Therapy Professionals

Note: The claims reporting requirements indicated below **do not pertain** to Part A institutional providers; therefore, this notice is being reposted only for Part B providers.

Medicare covers therapy services **personally** performed **only** by one of the following:

- Licensed therapy professionals: licensed Physical Therapists (PTs), Occupational Therapists (OTs) and Speech-Language Pathologists (SLPs).
- Licensed Physical Therapy Assistants (PTAs) when supervised directly by a licensed PT.
- Licensed Occupational Therapy Assistants (OTAs) when supervised directly by a licensed OT.
- Medical Doctors (MDs) and Doctors of Osteopathy (DOs).
- Doctors of Optometry (ODs) and Podiatric Medicine (DPMs) when performing services within their licenses' scope of practice and their training and competency.
- Qualified Non-Physician Practitioners (NPPs), including Advanced Nurse Practitioners (ANPs), Physician Assistants (PAs) or Clinical Nurse Specialists (CNS) when performing services within their licenses' scope of practice and their training and competency (ANP, PA, CNS).
- "Qualified" personnel when directly supervised by a physician (MD, DO, OD, DPM) or qualified NPP, and when all conditions of billing services "incident to" a physician have been met. Qualified personnel have met the educational and degree requirements of a licensed therapy professional (PT, OT, SLP) but are not required to be licensed. **Please note that unless these therapy services are performed by a "qualified" person, the services are not covered and must not be reported for Medicare payment.**

Claims for therapy services personally performed by physicians and qualified NPPs, and reported for Medicare payment on or after July 1, 2010, must contain the name and professional degree of the performing professional.

Claims for therapy services reported for Medicare payment by physicians and qualified NPPs, but not personally performed by the physician or NPP, and reported for Medicare payment on or after July 1, 2010, must contain the following information:

- Name and therapy degree of performing therapy professional.
- Name of academic institution having conferred therapy degree.
- Date of graduation.
- Name and professional degree of supervising physician/NPP.

Please include the information above in the comment field of electronic claims and include as an attachment to paper claims.

CLAIM SUBMISSION UPDATES

Duplicate Claims Submissions – A Negative Impact on CERT

TrailBlazer's number one claim denial reason is, and has long been, duplicate claims for the same service. Duplicate claim errors contribute to one of the categories of Medicare claims errors measured by the Comprehensive Error Rate Testing (CERT) program. That error rate is known as the Provider Compliance Error Rate (PCER). The PCER estimates the accuracy of claims as they appear when Medicare receives them, before the claims are subjected to Medicare claim processing system edits and medical review scrutiny. It thus reflects provider understanding of, and compliance with, the Medicare program's payment rules and coverage policies.

Finally, and probably most importantly, submitting useless duplicate claims increases providers' costs unnecessarily. Handling the duplicate claims is also a needless expense for the Medicare Trust Fund and, ultimately, for all U.S. taxpayers.

Monitoring and Educational Initiatives

TrailBlazer actively monitors duplicate claim submissions through numerous avenues including:

- CERT feedback reports.
- Internal TrailBlazer quarterly top denial reason reports.
- Quarterly data identifying providers who most frequently submit duplicate claims.

TrailBlazer maintains the following educational resources for the purpose of reducing unnecessary duplicate claim receipts:

- Posts frequent notices/reminders about duplicate claims on the TrailBlazer Web site.
- Produces a quarterly job aid reflecting the top denial reasons. TrailBlazer sends this job aid to all new J4 and Virginia Part B providers upon their enrollment with the Medicare program and posts this job aid on the TrailBlazer Web site.
- Collaborates with medical societies, organizations and groups to publish information about duplicate claims in their respective periodicals, newsletters, Web sites, etc.
- Provider Outreach and Education (POE) directly contacts those providers who are identified as frequently submitting duplicate claims unnecessarily.

Providers Should Take an Active Role to Limit Unnecessary Duplicate Claims

- Make it a practice to wait at least 30 days from the date of an initial claim submission before considering resubmitting and check the Medicare claim status on the Interactive Voice Response (IVR) prior to filing the claim a second time.
 - J4 – (877) 567-9230.
 - Virginia – (866) 502-9049.
- Many medical office billing software programs automatically generate a duplicate claim sooner than 30 days after the initial claim was submitted. If your office system generates claims sooner than 30 days, check with your software vendor in order to reset the time frame for duplicate submission of unpaid Medicare claims.
- Some third-party billers also submit duplicate unpaid claims sooner than 30 days after the initial claim was submitted. Work with your biller to prevent their premature duplicate claims.
- Be familiar with and use the 76 and 77 modifiers to prevent inappropriate duplicate Medicare claim denials of legitimately repeated services.
- Report appropriate anatomical modifiers (e.g., RT, LT) also to prevent inappropriate duplicate Medicare claim denials of legitimately repeated services.
- For claims containing a combination of some allowed line items or services along with some line items or services that Medicare denied (denied because of incorrect information about the service on the claim), do not resubmit the entire claim. Resubmit a corrected claim with only the previously denied line items or services.

Last But Not Least!

Do not submit additional (duplicate) claims for services previously submitted and currently under medical review by Medicare. Likewise, do not resubmit claims for services previously denied by Medicare upon review of medical records. In both of these circumstances, Medicare will deny the newer claim as a duplicate. Claims involved in the medical review process must be allowed to be adjudicated as submitted. Payment for services denied after medical review will occur only through redetermination (appeal).

DRUGS/BIOLOGICALS

Coverage of Intravenous EMEND® (Fosaprepitant)

Aprepitant is covered by Medicare when provided as an oral drug to certain cancer patients as a part of a regimen to minimize nausea and vomiting related to certain types of chemotherapy. The specifics of this coverage are detailed in National Coverage Determination (NCD) 110.18. This information is available on the CMS Web site at <http://www.cms.gov/>. Payment is made through the Durable Medical Equipment Administrative Contractors (DMACs).

An intravenous (IV) aprepitant product, fosaprepitant dimeglumine, is now available for similar indications of preventing and treating nausea and vomiting related to chemotherapy. Coverage and payment for the IV product is not clear. The IV product should be administered before the chemotherapy is administered, together with both dexamethasone and a 5HT3 receptor antagonist. Monotherapy (IV product alone) should be avoided due to evidence of suboptimal efficacy. On subsequent days, additional oral doses of aprepitant must be administered.

The initial IV dose may be covered under the Medicare Part B "incident to" provisions but is not covered under the DME benefit. For Medicare Part B to cover the IV product, the IV route of administration must be "reasonable and necessary." Pub. 100-02 (*Medicare Benefit Policy Manual*), Chapter 15, Section 50.4.3, bullet number 2 provides the following example of when an injection is not indicated:

- Medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration. For example, the accepted standard of medical practice for the treatment of certain diseases is to initiate therapy with parenteral penicillin and to complete therapy with oral penicillin. Carriers exclude the entire charge for penicillin injections given after the initiation of therapy if oral penicillin is indicated unless there are special medical circumstances that justify additional injections.

If the subsequent oral doses of aprepitant are tolerated by the patient, the medical necessity for the IV route of administration on the initial dose is uncertain. Regardless of whether the initial IV dose is covered under Part B, the subsequent oral doses may be covered under the patient's Part D plan. When the initial dose is administered intravenously, none of the doses are covered through the DME benefit.

TrailBlazer has posted the MLN Matters® article (SE0910) titled "Clarification for Billing Part B Versus Part D for the Anti-emetic Aprepitant (EMEND®)." However, the MLN Matters® article does not supersede a CMS instruction (described above). TrailBlazer continues to review each claim for IV fosaprepitant on a claim-by-claim basis to ensure compliance with this CMS requirement.

Chemotherapy Administration Coding

TrailBlazer's Medical Review staff recently performed a number of audits on several drugs and associated drug administration codes. Findings of the audit indicate the need for review of the proper use of chemotherapy administration CPT codes 96401–96549. The full instructions for the use of these codes are located in two separate documents.

The chemotherapy administration CPT codes (96401–96549):

- Are used to report the administration of certain non-radionuclide drugs when the infusion requires physician work or clinical staff monitoring well beyond that of therapeutic drug agents (CPT codes 96360–96379).
- Apply to parenteral administration of non-radionuclide antineoplastic drugs, antineoplastic agents provided for the treatment of non-cancer diagnoses (e.g., cyclophosphamide for autoimmune conditions), substances such as monoclonal antibody agents and other biologic response modifiers.

Drugs commonly falling in the category of monoclonal antibodies include infliximab, rituximab, alemtuzumb, gemtuzumab and trastuzumab. Drugs commonly falling in the category of hormonal antineoplastics include leuprolide acetate and goserelin acetate. The drugs listed above are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes.

The chemotherapy administration CPT codes (96401–96549) may not be used to report administration of:

- Substances used as diagnostic agents such as radio-opaque dyes.
- Therapeutic radionuclides (use CPT codes 79101, 79403 or 79999).
- Anti-anemia drugs.
- Anti-emetic drugs.
- Hydration fluids.
- Drugs that appear on the “usually self-administered” drug exclusion list.

If performed to facilitate the chemotherapy infusion or injection, the following services and items are included in the payment for CPT codes 96401–96549 and are not separately billable/payable:

- Use of local anesthesia.
- Establishing IV access.
- Access to indwelling IV, subcutaneous catheter or port.
- Flush at conclusion of infusion.
- Standard tubing, syringes and supplies.
- Preparation of chemotherapy agent(s).

If a significant, separately identifiable Evaluation and Management (E/M) service is performed, the appropriate E/M code should be reported utilizing modifier 25 in addition to the chemotherapy code. For an E/M service provided on the same day, a different diagnosis is not required. Additional detailed information is available in the preamble of the CPT codebook and in the Internet-Only Manual (IOM) Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 30.5.D.

ELECTRONIC BILLING

Submitting Electronic Claims Versus Paper Claims

Submitting claims electronically versus paper offers many benefits. Claims processing is faster and reimbursement is sooner, improving providers’ cash flow.

Benefits

- Payment for electronic claims can be released after the 14-day payment floor, while the payment floor for paper claims is 29 days.
- Immediate notification that TrailBlazer has received a provider’s claims.
- Front-end editing notification of critical claim filing errors, allowing providers to correct a claim before it enters the Medicare processing system.
- The ability to correct rejected claims and retransmit if a claim was submitted incorrectly.

Billing Software

The free electronic claims submission software, **PC-ACE Pro32**, is a complete, self-contained electronic processing system for claims submission and management. It can be used in a stand-alone configuration or in conjunction with existing claims management systems.

PC-ACE Pro32 Features

- User-friendly system with extensive help screens.
- Manual with step-by-step instructions.
- No charge when downloaded from the Software and Manuals Web page.
<http://www.trailblazerhealth.com/Electronic Data Interchange/Software - Manuals>
- Nominal charge when requested via CD-ROM.
- Claims transmission via telephone lines with modem speeds ranging from 9600 bps to 56k bps.
- Transmission lines available 24 hours a day, seven days a week.

More Information

- "Benefits of Electronic Data Interchange (EDI)" job aid.
<http://www.trailblazerhealth.com/Publications/Job Aid/BenefitsofEDI.pdf>
- EDI Web page. <http://www.trailblazerhealth.com/Electronic Data Interchange>

PAYMENT/FEE SCHEDULE UPDATES

July 2010 Prompt Payment Interest Rate on Clean Non-PIP Claims Not Paid Timely

Providers should access the U.S. Department of Treasury Prompt Payment Web site for current and past prompt payment interest rates payable when clean non-Periodic Interim Payment (PIP) Medicare claims are not paid in a timely manner by Medicare contractors. **The prompt payment rate effective July 10, 2010, is 3.125.**

<http://fms.treas.gov/prompt/rates.html>

Providers can also access the U.S. Department of Treasury Web site on TrailBlazer's Payment Web page under the Resources heading.

<http://www.trailblazerhealth.com/Payment>

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

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

Many payment rates under the Ambulatory Surgical Center (ASC) payment system are controlled by payment rate information in the MPFS. To fully comply with this legislation, it is necessary to implement revised MPFS payment rates in the ASC payment system. Therefore, CMS has provided its contractors

with two sets of positive 2.2 percent ASC Fee Schedules (ASCFS) and ASC Payment Indicator (ASCPI) update files to test and implement.

- One set of files is for ASC services furnished on or after July 1, 2010.
- The second set of files is for ASC services furnished June 1, 2010, through June 30, 2010.

Once installed, contractors will use these updated payment files to process new ASC claims and adjust previously processed ASC claims for dates of service on or after June 1, 2010, that are brought to their attention.

In accordance with the requirements in Change Request (CR) 7008, contractors will make July 2010 ASCFS fee data for their ASC payment localities available on their Web sites. The payment rates in the July 2010 ASCFS fee data files mirror the 2.2 percent update payment rates for services June 1, 2010 – June 30, 2010, and also contain payment rates for newly established services identified in CR 7008 effective July 1, 2010. Providers may reference MLN Matters® (MM) article MM 7008, which explains the requirements in CR 7008 at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM7008.pdf>

CMS is aware that contractors were unable to implement the revised payment rates by the July 6, 2010, implementation date contained in CR 7008 because these files have just become available for download and testing. Contractors have been directed to have all these ASC update files in production no later than July 28, 2010. This implementation date supersedes the implementation date specified in CR 7008.

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

TrailBlazer Instructions

The updated ASCFS fee data will be available on the ASC Fee Schedule Web page at:

http://www.trailblazerhealth.com/Tools/Fee_Schedule/ASCFeeSchedule.aspx

(CMS Learn Resource 201007-28, dated July 15, 2010)

PROVIDER ENROLLMENT

June Mailing of PECOS Enrollment Letter

Letters were recently sent to physicians and non-physician practitioners who are currently enrolled in Medicare but who do not have an established enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS). Recipients of the letter include physicians and practitioners who not only bill for Medicare services, but who also order and refer services for Medicare patients.

Purpose of the Letter

To encourage the recipient to submit an enrollment application as soon as possible for the following three reasons:

- Ensure correct Medicare payment for services provided to beneficiaries.
- To continue ordering and referring services for Medicare beneficiaries.*

- To be eligible to receive incentive payments for meaningful use of certified electronic health technology.

How to Establish a PECOS Record

- Electronically through Internet-Based PECOS. For information on how to access Internet-Based PECOS, please refer to the information on the Internet-Based PECOS page. http://www.trailblazerhealth.com/Provider_Enrollment/InternetBasedPECOS.aspx
- Mail a paper CMS-855I application. <http://www.cms.gov/CMSforms/downloads/cms855i.pdf>

Note: Applications received via Internet-Based PECOS are given higher priority handling and have shorter processing times than paper applications. Refer to the notice TrailBlazer Average Processing Days for CMS-855 Applications. <http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=12383>

Additional information and resources are available on the Provider Enrollment page. This page includes important notices/articles, publications and links for provider enrollment issues. http://www.trailblazerhealth.com/Provider_Enrollment

***Note:** For claims received on or after January 3, 2011, for services/items requiring a referring/ordering provider, claims processing editing will verify the ordering/referring provider submitted on the claim is of the specialty eligible to order/refer and is either enrolled in PECOS or the contractor's master provider file. If either of those requirements is not met, the billing provider will not receive payment for the ordered/referred services/items billed. This policy was issued by CMS in Change Request 6417 on February 26, 2010. <http://www.cms.gov/transmittals/downloads/R642OTN.pdf>

A copy of the sample letter is available at this link: **PECOS Enrollment Letter.** <http://www.trailblazerhealth.com/Education/Documents/JobAids/PECOSEstablishmentCR6842.pdf>

CMS to Review PECOS Enrollment Process

CMS is working with providers to address concerns about enrollment in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to ensure that Medicare beneficiaries continue to receive the health care services and items they need. PECOS is the electronic system used to enroll physicians and eligible professionals into the Medicare program. For the time being, CMS will not implement changes that would automatically reject claims based on orders, certifications and referrals made by providers who have not yet had their applications approved by July 6, 2010. While more than 800,000 physicians and other health professionals have enrolled and have approved applications in the PECOS system, some providers have encountered problems. CMS is continuing to update and streamline the process, and more providers have been enrolled in the past few days.

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

Many physicians and other providers and suppliers have continued to make good-faith efforts to comply with the requirements of the law and regulation. These efforts will be a significant factor in determining the procedures and processes that will be incorporated in the Final Rule. While the regulation will be effective July 6, 2010, CMS will not implement automatic rejections of claims submitted by providers who

have attempted to enroll in PECOS. However, until the automatic rejections are operational, providers should not see any change in the processing of submitted claims; they will continue to be reviewed and paid as they have been historically.

Although CMS is taking a more deliberative approach to using the PECOS enrollment system, the agency will employ a contingency plan to meet the ACA requirement that written orders and certifications are only issued by eligible professionals effective July 1. CMS will continue to send informational notices to providers reminding them of the need to submit or update their enrollment, will work with the provider community to provide guidance on enrollment and will process all applications expeditiously.

(CMS Learn Resource 201006-57)

Options for Verifying PECOS Status

Due to requirements of Change Requests (CRs) 6417 and 6421, it has become important for providers to be able to verify their enrollment in Medicare (i.e., enrollment records in the Provider Enrollment, Chain and Ownership System (PECOS) that contain a National Provider Identifier (NPI)). Providers have three options for PECOS verification:

1. **TrailBlazer Interactive Voice Response (IVR)** – Providers may check to see if their own NPI is in PECOS by calling the TrailBlazer IVR. Instructions are available in the article titled “NPI Status Now Available By Calling the IVR.”
<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13519>
2. **CMS Ordering/Referring File** – CMS has posted a file that contains the NPI and the name (last name, first name) of all physicians and non-physician practitioners who are eligible to order/refer in the Medicare program and who have current enrollment records in Medicare. Providers can access this file on the CMS Ordering Referring Report Web page by clicking **Ordering/Referring File** under Downloads.
http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage
3. **Internet-Based PECOS** – Providers may view or update existing enrollment information by accessing Internet-based PECOS. Information about how to log on to the system is available at:
<https://pecos.cms.hhs.gov/pecos/login.do>.

Please refer to the following articles in reference to CRs 6417 and 6421 for more information about these requirements:

- Expanded Editing of Ordering/Referring Providers – CMS CR 6417.
<http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13079>
- Editing of Ordering/Referring Providers for DMEPOS Suppliers' Claims Processed by DME MACs – CMS CR 6421. <http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13377>
- June Mailing of PECOS Enrollment Letter.
<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13772>
- CMS to Review PECOS Enrollment Process.
<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13773>
- Clarification Regarding Date All Referring/Ordering Providers Must Be Enrolled in PECOS.
<http://www.trailblazerhealth.com/Tools/Notices.aspx?DomainID=1&ID=13763>

Additional information and any updates to the NPI requirements for ordering/referring providers will be posted in the Provider Enrollment section of the Web site at:

http://www.trailblazerhealth.com/Provider_Enrollment

Physicians and Non-Physician Practitioners: Declare Your Independence From the Paper Enrollment Process – Use Internet-Based PECOS!

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

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

Advantages of Internet-based PECOS:

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

Using Internet-Based PECOS Is Easy!

Learn how to use the system by visiting the Medicare Physician and Non-Physician Practitioner Getting Started Guide at:

<http://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf>

And if you encounter problems or have questions as you navigate the system, there are several resources that can help at:

<http://www.cms.gov/MedicareProviderSupEnroll/Downloads/ContactInformation.pdf>

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

(CMS Learn Resource 201007-13)

Provider and Supplier Organizations: Declare Your Independence From the Paper Enrollment Process – Use Internet-Based PECOS!

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

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

Note: Internet-based PECOS will be made available for suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) later this year.

Advantages of Internet-based PECOS:

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

Using Internet-Based PECOS Is Easy!

Learn how to use the system by visiting the Getting Started Guide for Provider and Supplier Organizations at:

<http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf>

Remember, creating a record in Internet-based PECOS can take several weeks for an organization provider. It is recommended that you begin this process (if necessary) well in advance of any upcoming enrollment actions. For more information on this setup process, visit our Provider and Supplier Organization Overview at:

<http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationOverview.pdf>

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

(CMS Learn Resource 201007-14)

Medicare Enrollment Guidance for Physicians That Infrequently Receive Reimbursement From the Medicare Program

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

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

- Physicians employed by the Department of Veterans Affairs.
- Physicians employed by the Public Health Service.
- Physicians employed by the Department of Defense TRICARE program.
- Physicians employed by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Critical Access Hospitals (CAHs).

- Physicians in a fellowship.
- Dentists, including oral surgeons.

For details on the modifications to the enrollment process for these special circumstances, view the Special Enrollment Fact Sheet for Physicians With Infrequent Reimbursements on the CMS Web site at:

<http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SpecialEnrollmentFactsheetInfrequentPhysicianReimbursement.pdf>

(CMS Learn Resource 201007-25)

Internet-Based PECOS Certification Statement Issue

CMS has become aware of instances when a provider or supplier has entered an application online via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and is unable to print the certification/signature page during the submission process.

Medicare contractors **cannot accept** a paper certification statement when the application has been completed via Internet-based PECOS. The paper certification statement will be **rejected and returned** to the provider or supplier.

To prevent any problems with generating and printing the certification/signature pages during the submission process, providers and suppliers should be using Internet Explorer version 5.5 or 6 and have the most current version of Adobe Acrobat Reader installed on their system when accessing Internet-based PECOS. CMS will continue to monitor this issue. Providers and suppliers experiencing this issue should contact the External User Services (EUS) Help Desk at the telephone number or e-mail address below:

EUS Help Desk
(866) 484-8049
EUSupport@cgi.com

WEB UPDATES

June 2010 Web Site Improvements

TrailBlazer continues to update and enhance our Web site based on valuable feedback from our users. The latest updates are outlined below:

Timely Filing Calculator – The Timely Filing Calculator has been updated to include new time limits for filing claims as a result of Change Request 6960, and is available at: <http://www.trailblazerhealth.com/Tools/TimelyFilingCalculator.aspx>. Access the calculator and other tools from the Self-Service Tools page at: http://www.trailblazerhealth.com/Customer_Service/Self-Service_Tools.

Local Coverage Determination (LCD) Page – To provide better assistance to providers searching for LCDs, the information on the Local Coverage Determinations page was reorganized and simplified to provide better search instructions on the page. Links are provided for supplemental information such as the LCD reconsideration and development process, and the J4 implementation date of service chart. <http://www.trailblazerhealth.com/Tools/LCDs.aspx>

Any suggestions for additional resources or improvements that would benefit the provider community, or feedback about these changes, are welcome and can be e-mailed to:

provider.feedback@trailblazerhealth.com

CMS Notices

President Signs the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 – 2.2 Percent MPFS Update for June 1 – November 30, 2010

On June 25, 2010, President Obama signed into law the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. This law establishes a 2.2 percent update to the Medicare Physician Fee Schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010. CMS has directed Medicare claims administration contractors to discontinue processing claims at the negative update rates and to temporarily hold all claims for services rendered on or after June 1, 2010, until the new 2.2 percent update rates are tested and loaded into the Medicare contractors' claims processing systems. Effective testing of the new 2.2 percent update will ensure that claims are correctly paid at the new rates. CMS expects to begin processing claims at the new rates no later than July 1, 2010. Claims for services rendered prior to June 1, 2010, will continue to be processed and paid as usual.

Claims containing June 2010 dates of service that have been paid at the negative update rates will be reprocessed as soon as possible. Under current law, Medicare payments to physicians and other providers paid under the MPFS are based upon the lesser of the submitted charge on the claim or the MPFS amount. Claims containing June dates of service that were submitted with charges greater than or equal to the new 2.2 percent update rates will be automatically reprocessed. Affected physicians/providers who submitted claims containing June dates of service with charges less than the 2.2 percent update amount will need to contact their local Medicare contractor to request an adjustment. Submitted charges on claims cannot be altered without a request from the physician/provider.

Note: Physicians/providers should not resubmit claims already submitted to their Medicare contractor.

TrailBlazer Instructions

Physicians/providers should wait until after July 1 to request a correction to the billed amount for affected claims.

(CMS Learn Resource 201006-42)

Medicare Mammography Services Claims Processing Issue

CMS has identified a Medicare claims processing issue where adjustments submitted against original bills containing mammography services were incorrectly receiving reason code 36440, preventing the claims from finalizing. Claim adjustments receiving reason code 36440 were being held until the correction of this issue. This issue has been corrected and the held claims will now be released for processing. We apologize for any inconvenience you may experience related to this issue.

TrailBlazer Instructions

Affected adjustment claims were suspended in **location SMFHL4 with reason code 36440**. Claims will be released for processing.

CMS MLN Matters® Articles

General Information

ICD-10 Implementation Information – CMS SE 1019

Special Edition (SE) 1019 provides information about the implementation of the ICD-10-CM/ICD-10-PCS code sets to help providers better understand (and prepare for) the U.S. health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding. The first ICD-10-related compliance date is less than two years away.

January 1, 2012 – Standards for electronic health transactions change from Version 4010/4010A1 to Version 5010. Unlike Version 4010, Version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

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

Important Dates

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

The article, titled "ICD-10 Implementation Information," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/SE1019.pdf>

Affordable Care Act of 2010 Provisions – CMS SE 1023

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

Special Edition (SE) 1023 provides an overview of the following provisions:

- Coverage of annual wellness visit providing a personalized prevention plan.
- Elimination of deductible and coinsurance for most preventive services.
- Incentive payments to primary care practitioners for primary care services.
- Incentive payments for general surgery services in rural areas.
- Revisions to the practice expense geographic adjustment to assist rural providers.

- Physician self-referral for certain imaging services.
- Misvalued codes under the Physician Fee Schedule (PFS).
- Modification of equipment utilization factor for advanced imaging services.
- Maximum period for submission of Medicare claims reduced to not more than 12 months.

Providers should be aware of these provisions and frequently visit the CMS Web site for updates on their implementation. More information (as of June 11, 2010) regarding CMS published regulations, policy instructions, key implementation dates and other accomplishments that relate to ACA is available at:

<https://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf>

The article, titled "Provisions in the Affordable Care Act of 2010 (ACA)," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/SE1023.pdf>

Dermal Injections for Treatment of Facial Lipodystrophy Syndrome – CMS CR 6953

Effective for claims with dates of service on or 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 only in Human Immunodeficiency Virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

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

Temporary HCPCS code C9800 was created to describe both the injection procedure and the dermal filler product and provides a payment mechanism to hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical 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 codes Q2026, Q2027 and G0429.

Hospital Outpatient, Non-OPPS and ASC Billing Instructions

Claims must include the following:

- HCPCS codes Q2026 or Q2027 with a Line Item Date of Service (LIDOS) on or after March 23, 2010.
- HCPCS code G0249 with a LIDOS on or after March 23, 2010.
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (lipodystrophy).
- For LIDOS on or after March 23, 2010, and until pricing information is made available, use temporary HCPCS code C9800 instead of HCPCS codes Q2026, Q2027 and G0429.

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

Practitioner Billing Instructions

Claims must include the following:

- An LIDOS on or after March 23, 2010.
- HCPCS codes Q2026 or Q2027.
- A line with HCPCS code G0249.
- 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.

Effective: March 23, 2010

Implementation: July 6, 2010

The article, titled "Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM6953.pdf>

Providers may reference [Change Request \(CR\) 6953](#), Transmittal 1978, dated June 4, 2010.

Alcohol and/or Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention Services – CMS SE 1013

Special Edition (SE) 1013 informs Medicare providers about reporting and payment for the appropriate delivery of alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention services (Screening, Brief Intervention and Referral to Treatment (SBIRT)).

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

The two HCPCS codes for reporting are:

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

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

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

The article, titled "Summary of Medicare Reporting and Payment of Services for Alcohol and/or Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/SE1013.pdf>

RAC Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted – CMS SE 1024

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

Providers are encouraged to review Special Edition (SE) 1024 and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of claims.

The article, titled "Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities – No Documentation or Insufficient Documentation Submitted," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/SE1024.pdf>

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

Magnetic Resonance Angiography – CMS CR 7040

Effective for claims with dates of services on or after June 3, 2010, Medicare contractors will have the discretion to cover or not cover all indications of Magnetic Resonance Angiography (MRA) (and Magnetic Resonance Imaging (MRI)) that are not specifically nationally covered or nationally non-covered. Existing national coverage for both MRI and MRA will be maintained.

MRA is a specific application of MRI. CMS believes that the continued existence of separate National Coverage Determinations (NCDs) is unnecessary, and that the provisions of the MRA NCD at Section 220.3 should be merged under the NCD for MRI at Section 220.2. Therefore, Section 220.3, "Magnetic Resonance Angiography," of the *NCD Manual*, will no longer appear as a separate NCD.

Effective: June 3, 2010

Implementation: August 9, 2010

The article, titled "Magnetic Resonance Angiography (MRA)," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM7040.pdf>

Providers may reference [Change Request \(CR\) 7040](#), Transmittal 1998, dated July 9, 2010.

Electronic Prescribing Incentive Program 2010 Updates – CMS SE 1021

CMS is issuing Special Edition (SE) 1021 to alert providers that it is not too late to start participating in the Electronic Prescribing (eRx) Incentive Program to potentially qualify to receive a full-year incentive payment. Eligible professionals may begin reporting eRx at any time throughout the 2010 program year of January 1, 2010, through December 31, 2010, to be eligible for the incentive.

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

For 2010, eligible professionals who successfully report the eRx measure will be eligible to receive an eRx incentive equal to 2 percent of their total Medicare Part B Physician Fee Schedule (PFS) allowed charges for services performed during the reporting period. Beginning in 2012, eligible professionals who are not successful electronic prescribers will be subject to a PFS payment adjustment or penalty.

The article, titled “Electronic Prescribing (eRx) Incentive Program 2010 Updates,” is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLNMattersArticles/downloads/SE1021.pdf>

Coding Updates

ICD-9-CM Annual Update – CMS CR 7006

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

The new, revised and discontinued ICD-9-CM diagnosis codes are available on the following Web sites:

- CMS New, Deleted, and Revised ICD-9-CM Codes - Summary Tables Web page.
http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp
- National Center for Health Statistics (NCHS) Web site in June of each year.
<http://www.cdc.gov/nchs/icd9.htm>

Providers are encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Effective: October 1, 2010

Implementation: October 4, 2010

The article, titled “Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM),” is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLNMattersArticles/downloads/MM7006.pdf>

Providers may reference [CR 7006](#), Transmittal 1996, dated July 2, 2010.

October 2010 Claim Status Category and Claim Status Code Update – CMS CR 7052

The claim status codes and claim status category codes used by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277, along with the 277 Health Care Claim Acknowledgement, were updated during the June 2010 meeting of the national Code Maintenance Committee. Code changes are posted on the Washington Publishing Company (WPC) Web site at:

<http://www.wpc-edi.com/content/view/180/223/>

These codes explain the status of a submitted claim. Included in the code lists are specific details, including the date when a code was added, changed or deleted.

Effective: October 1, 2010

Implementation: October 4, 2010

The article, titled “Claim Status Category and Claim Status Code Update,” is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM7052.pdf>

Providers may reference [Change Request \(CR\) 7052](#), Transmittal 2002, dated July 16, 2010.

Consolidated Billing

October 2010 Annual Update of HCPCS Codes Used for SNF Consolidated Billing – CMS CR 7002

Change Request (CR) 7002 provides the October quarterly update to the 2010 HCPCS codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB). The SNF CB file reflects new codes that have been developed and those that have been discontinued for 2010, and any additions and deletions to categories of services excluded from CB.

Effective: October 1, 2010

Implementation: October 4, 2010

The article, titled “October Quarterly Update to 2010 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement,” is available on the CMS MLN Matters® Web page. The “Background” section includes detailed information regarding this update.

<http://www.cms.gov/MLN MattersArticles/downloads/MM7002.pdf>

Providers may reference [CR 7002](#), Transmittal 1989, dated June 18, 2010.

Home Health/Hospice Updates

New Hospice Site of Service Code – CMS CR 6905

Effective for claims with dates of service on or after October 1, 2010, hospices will report **HCPCS code Q5010** when Routine Home Care (RHC) or Continuous Home Care (CHC) is provided at a hospice residential facility or a hospice facility that is also certified to provide inpatient care.

Medicare regulations limit provision of General Inpatient (GIP) or respite care to a Medicare or Medicaid certified facility; therefore, Medicare contractors will Return to Providers (RTP) any claims submitted for GIP or respite care where the site of service is coded as HCPCS code Q5010.

In addition, the Internet-Only Manual (IOM) is being updated to include long-standing policy regarding hospice billing on the day a hospice patient transfers from one facility to another.

Effective: October 1, 2010

Implementation: October 4, 2010

The article, titled "New Hospice Site of Service Code," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM6905.pdf>

Providers may reference [Change Request \(CR\) 6905](#), Transmittal 1955, dated April 28, 2010.

Lab/Pathology

Additional HCPCS Codes Subject to CLIA Edits – CMS CR 6985

Change Request (CR) 6985 informs Medicare carriers and A/B Medicare Administrative Contractors (MACs) about additional new HCPCS codes for 2010 that are subject to Clinical Laboratory Improvement Amendments (CLIA) edits. The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

Effective: January 1, 2009

Implementation: July 19, 2010

The article, titled "Additional Healthcare Common Procedure Coding System (HCPCS) Codes Subject to Clinical Laboratory Improvement Amendments (CLIA) Edits," is available on the CMS MLN Matters® Web page. The "Background" section includes a list of the additional HCPCS codes.

<http://www.cms.gov/MLN MattersArticles/downloads/MM6985.pdf>

Providers may reference [CR 6985](#), Transmittal 720, dated June 18, 2010.

October 2010 Laboratory National Coverage Determination Edit Software Changes – CMS CR 7057

Change Request (CR) 7057 announces the changes that will be included in the October 2010 release of the Medicare edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in July 2010. The changes become effective for dates of service on or after October 1, 2010.

The MLN Matters® article includes specific coding changes for the following NCDs:

- Bacterial Urine Cultures.
- Human Immunodeficiency Virus (HIV) Testing (Diagnosis).
- Blood Counts.
- Partial Thromboplastin Time (PTT).
- Prothrombin Time.
- Serum Iron Studies.
- Blood Glucose Testing.
- Glycated Hemoglobin/Glycated Protein.
- Lipids Testing.
- Digoxin Therapeutic Drug Assay.
- Alpha-fetoprotein.
- Gamma Glutamyl Transferase.
- Hepatitis Panel/Acute Hepatitis Panel.
- Fecal Occult Blood Test.

Effective: October 1, 2010

Implementation: October 4, 2010

The article, titled "Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2010," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM7057.pdf>

Providers may reference [CR 7057](#), Transmittal 2001, dated July 16, 2010.

Payment/Fee Schedule Updates

October 2010 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – CMS CR 7007

Change Request (CR) 7007 instructs Medicare contractors to download and implement the October 2010 ASP drug pricing file for Medicare Part B drugs and, if released by CMS, also the revised July 2010, April 2010, January 2010 and October 2009 files.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010.

Effective: October 1, 2010

Implementation: October 4, 2010

The article, titled "October 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM7007.pdf>

Providers may reference [CR 7007](#), Transmittal 1990, dated June 18, 2010.

July 2010 Medicare Physician Fee Schedule Database Update – CMS CR 6974

Change Request (CR) 6974 amends payment files that were issued to Medicare contractors based on the 2010 Medicare Physician Fee Schedule (MPFS) Final Rule. Effective for dates of service on or after January 1, 2010, these changes to the MPFS Database (MPFSDB) include the following:

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

Outpatient Intravenous Insulin Treatment (OIVIT) – On December 23, 2009, CMS issued a non-coverage decision on the use of OIVIT. HCPCS code G9147 will be added to the procedure code file and MPFSDB effective for dates of service on or after December 23, 2009.

Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS) – The effective date for HCPCS codes G0429, Q2026 and Q2027 will be adjusted on the procedure code file and the MPFSDB to indicate they are effective for dates of service on or after March 23, 2010.

Collagen Meniscus Implant – The effective date for HCPCS code G0428 will be adjusted on the procedure code file and the MPFSDB to indicate it is effective for dates of service on or after May 25, 2010.

In addition, Attachment 1 of CR 6974 contains numerous adjustments of the MPFSDB for various CPT/HCPCS codes and associated indicators.

Effective: January 1, 2010

Implementation: July 6, 2010

The article, titled “July Update to the 2010 Medicare Physician Fee Schedule Database (MPFSDB),” is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM6974.pdf>

Providers may reference [CR 6974](#), Transmittal 1992, dated June 25, 2010.

July 2010 Ambulatory Surgical Center Payment System Update – CMS CR 7008

Change Request (CR) 7008 describes changes to and billing instructions for payment policies implemented in the July 2010 Ambulatory Surgical Center (ASC) payment system update. This instruction provides information on eight newly created HCPCS codes that will be added to the ASC list of covered surgical procedures and seven newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective July 1, 2010.

Also, CR 7008 notes that the payment rates for three HCPCS codes (C9258, C9262 and J1540) were incorrect in the April 2010 ASC drug file. Medicare contractors will adjust, as appropriate, claims for these three HCPCS codes brought to their attention that have dates of service April 1, through July 1, 2010, and were originally processed prior to the installation of the revised April 2010 ASC drug file.

The following topics are discussed in detail:

- Billing for drugs and biologicals.
- New HCPCS codes for drugs and biologicals that are separately payable under the ASC payment system effective July 1, 2010.
- Updated payment rates for certain HCPCS codes effective April 1, 2010, through June 30, 2010.
- New category III CPT codes that are separately payable under the ASC payment system effective July 1, 2010.
- New HCPCS code that is separately payable under the ASC payment system effective March 23, 2010.

Effective: July 1, 2010

Implementation: July 6, 2010

The article, titled "July 2010 Update to the Ambulatory Surgical Center (ASC) Payment System," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM7008.pdf>

***Note:** This article was revised to reflect a new CR that was released June 25, 2010. The new CR added information on the payment indicator adjustment for HCPCS 90670 (page 3) and corrected the long descriptor for C9264 (page 4). The transmittal number, CR release date and Web address for accessing CR 7008 were also changed. All other information remains the same.*

Providers may reference [CR 7008](#), Transmittal 1991, dated June 25, 2010.

July 2010 Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule Update – CMS CR 6945

CMS has issued instructions updating the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule payment amounts.

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for DME, prosthetic devices, orthotics, prosthetics, surgical dressings and Parenteral and Enteral Nutrition (PEN).

Effective: **January 1, 2010, for implementation of fee schedule amounts for codes in effect January 1, 2010.**
 April 1, 2010, for revisions to the RA and RB modifier descriptors, effective April 1, 2010.
 July 1, 2010, for all other changes.

Implementation: July 6, 2010

Note: This article was revised July 1, 2010, to reflect changes to CR 6954. Language on page 2 **in bold** was corrected to state that claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 will be adjusted if brought to the contractor's attention. In addition, the transmittal number, CR release date and Web address for accessing the CR were changed. All other material remains the same.

The article, titled "July Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM6945.pdf>

Providers may reference [Change Request \(CR\) 6945](#), Transmittal 1993, dated July 1, 2010.

TrailBlazer Instructions:

CR 6945 instructs providers and suppliers to use modifier RA on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged.

HCPCS code Q0506, "Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only," was added to the HCPCS code list effective January 1, 2010. Based on information furnished by ventricular assist device manufacturers, CMS has determined that the reasonable useful lifetime of the lithium-ion battery described by HCPCS code Q0506 is 12 months.

Based on CR 6945, Medicare **will deny claims** that are submitted with HCPCS code Q0506 **prior** to the expiration of the battery's reasonable useful lifetime. Providers and suppliers should **add HCPCS modifier RA** to the claim for HCPCS code Q0506 in cases where the battery is being replaced because it was lost, stolen or irreparably damaged.

Hospital IPPS, LTCH, OPSS and IRF PPS Changes Due to the Affordable Care Act – CMS CR 7029

Change Request (CR) 7029 outlines changes for the following hospital payment systems as a result of the Affordable Care Act (ACA):

- Inpatient Prospective Payment System (IPPS) hospitals for Fiscal Year (FY) 2010.
- Long-Term Care Hospitals (LTCHs) for Rate Year (RY) 2010.
- Inpatient Rehabilitation Facilities (IRFs) for FY 2010.
- Outpatient Prospective Payment System (OPSS) for Calendar Year (CY) 2010.

The changes have various retroactive effective dates and Medicare contractors will be instructed via a CR on how to handle past claims paid under pre-ACA requirements. Providers will be notified of this information in a related MLN Matters® article.

Effective: Various Effective Dates Implementation: August 9, 2010

The article, titled "Updates to the Inpatient Prospective Payment System (IPPS), Long-Term Care Hospital (LTCH) PPS, Outpatient Prospective Payment System (OPSS), and Inpatient Rehabilitation Facility (IRF) PPS Changes Due to the Affordable Care Act (ACA)," is available on the CMS MLN Matters® Web page. Providers should review the "Background" and "Additional Information" sections for specific details regarding these changes.

<http://www.cms.gov/MLN MattersArticles/downloads/MM7029.pdf>

Providers may reference [CR 7029](#), Transmittal 728, dated July 15, 2010.

Psychiatry

New Geriatric Psychiatry Physician Specialty Code – CMS CR 6533

Effective April 1, 2010, Medicare will recognize new physician specialty code “27” for geriatric psychiatry. The Medicare specialty code is self-designated or assigned during the Medicare enrollment process and describes the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice.

In addition, codes 32, 74 and 75 are being removed from the physician specialty section of the *Medicare Claims Processing Manual* because they are non-physician specialty codes.

Effective: April 1, 2010

Implementation: April 5, 2010

The article, titled “New Physician Specialty Code for Geriatric Psychiatry,” is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM6533.pdf>

Note: This article was revised July 20, 2010, to reflect revised Change Request (CR) 6533. The CR release date, transmittal number and Web address for accessing CR 6533 were revised. All other information remains the same.

Providers may reference [CR 6533](#), Transmittal 2003, dated July 19, 2010.

Radiology

Mailing to Practitioners, Medical Groups, Clinics and IDTFs Who Are Billing or Have Billed the Technical Component of Advanced Diagnostic Imaging Services – CMS CR 6912

Physicians and Non-Physician Practitioners (NPPs) who have billed the Medicare program for the technical component of advanced diagnostic testing services within the preceding six-month period and continue to have Medicare billing privileges will receive a letter from their Medicare contractor advising them of the need to **become accredited by January 1, 2012, to continue to provide these services and bill Medicare.**

Physicians and NPPs **must be accredited** by one of the three CMS-approved national accreditation organizations by January 1, 2012, to be eligible to continue to furnish the technical component of advanced diagnostic testing services to Medicare beneficiaries and submit claims for those services. The letter will be mailed quarterly beginning July 2010 through July 2011, and will include information about the three approved national accreditation organizations. If necessary, physicians and NPPs should follow the instructions in the letter to become accredited by January 1, 2012. Please note that when more than one physician or NPP is operating within a group, such as a single specialty or multispecialty clinic, only the group will receive the letter.

Advanced Diagnostic Imaging Procedures

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) specifically defines advanced diagnostic imaging procedures as including:

- Diagnostic Magnetic Resonance Imaging (MRI).
- Computed Tomography (CT).
- Nuclear medicine imaging, such as Positron Emission Tomography (PET).

List of Supplier-Billed Advanced Diagnostic Imaging CPT Codes							
70336	70543	71270	72146	73201	73721	76376	78007
70450	70544	71275	72147	73202	73722	76377	78010
70460	70545	71550	72148	73206	73723	76380	78011
70470	70546	71551	72149	73218	73725	76390	78015
70480	70547	71552	72156	73219	74150	76497	78016
70481	70548	71555	72157	73220	74160	76498	78018
70482	70549	72125	72158	73221	74170	77011	78020
70486	70551	72126	72159	73222	74175	77012	78070
70487	70552	72127	72191	73223	74181	77021	78075
70488	70553	72128	72192	73225	74182	77058	78099
70490	70554	72129	72193	73700	74183	77059	78811
70491	70555	72130	72194	73701	74185	77078	78812
70492	70557	72131	72195	73702	75557	77079	78813
70496	70558	72132	72196	73706	75559	78000	78814
70498	70559	72133	72197	73718	75561	78001	78815
70540	71250	72141	72198	73719	75563	78003	78816
70542	71260	72142	73200	73720	76360	78006	78891

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

The article, titled "Mailing to All Individual Practitioners, Medical Groups and Clinics and Independent Diagnostic Testing Facilities (IDTF) Who Are Billing or Have Billed for the Technical Component of Advanced Diagnostic Imaging Services," is available on the CMS MLN Matters® Web page at:

<http://www.cms.gov/MLNMArticles/downloads/MM6912.pdf>

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

Providers may reference [CR 6912](#), Transmittal 727, dated July 9, 2010.



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