



News Flash – The revised publication titled, "The ICD-10 Transition: An Introduction" is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at <http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10Introduction.pdf> on the CMS website. This fact sheet provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations.

MLN Matters® Number: MM6617 **Revised**

Related Change Request (CR) #: 6617

Related CR Release Date: September 1, 2009

Effective Date: January 1, 2009

Related CR Transmittal #: R1810CP

Implementation Date: October 5, 2009

Note: This article was updated on January 3, 2013, to reflect current Web addresses. This article was previously revised on September 2, 2009, to reflect the revised CR 6617 that was issued by the Centers for Medicare & Medicaid Services on September 1, 2009. The article contains a revised CR release date, transmittal number, and Web address for accessing CR 6617. The article also now shows an effective date of September 1, 2009 for codes G9141 and G9142. All other information remains the same.

October Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6617 which amends payment files that were issued to contractors based upon the 2009 Medicare Physician Fee Schedule (MPFS) Final Rule. Billing staff should be aware of these updates.

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Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. The key change in CR6617 is the assignment of H1N1 Vaccine and Administration Level II Healthcare Common Procedure Coding System (HCPCS) Codes. In anticipation of the availability of a vaccine for the H1N1 virus in the fall of 2009, the Centers for Medicare & Medicaid Services (CMS) is creating two new Level II HCPCS codes that are effective September 1, 2009. Similar to the influenza vaccine and its administration, one HCPCS code has been created to describe the H1N1 vaccine itself (G9142, Influenza A (H1N1) vaccine, any route of administration), while another HCPCS code has been created to describe the administration of the H1N1 vaccine (G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)). More information on the H1N1 flu and the associated vaccine can be found at the Centers for Disease Control and Prevention website at <http://www.cdc.gov/h1n1flu/> on the Internet.

Under the MPFS, HCPCS codes G9141 and G9142 will be assigned status indicator "X," indicating these codes represent an item or service that is not within the statutory definition of "physicians' services" for MPFS payment purposes. CMS anticipates the H1N1 vaccine will be supplied at no cost to providers. Payment will be made to a provider for the administration of the H1N1 vaccine, even if the vaccine is supplied at no cost to the provider. Payment for the administration of the H1N1 vaccine is the same as the payment established for G0008 and G0009, codes used for reporting the administration of the influenza or pneumococcal vaccine. Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine. Beneficiary copayment and deductible do not apply to HCPCS code G9141.

CR6617 also clarifies Transmittal 1691, Change Request 6397, dated March 4, 2009 and Transmittal 1748, Change Request 6484, dated May 29, 2009, which included PE RVUs for CPT code 93351 (26). Transmittal 1748 noted that this service is typically not paid under the Medicare physician fee schedule when provided in a facility setting and the PE RVUs noted were informational only. CMS is clarifying that CPT code 93351 (26) is payable when performed by a physician in a facility setting.

Specific changes included in the October Update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6617. That CR is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1810CP.pdf> on the CMS website. Key changes, however, are summarized as follows:

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The following changes are effective for dates of service on and after January 1, 2009:

<i>CPT/HCPCS</i>	<i>ACTION</i>
38999	Assistant at Surgery Indicator: 0
55899	Assistant at Surgery Indicator: 0
69200	Bilateral Indicator: 1
93503	Transitional Facility PE RVU: 0.75 Fully Implemented Facility PE RVU: 0.77

The following change is effective for dates of service on and after October 1, 2009:

Q2024	Long Descriptor: Injection, Bevacizumab, 0.25 MG Short Descriptor: Bevacizumab injection Procedure Status: E
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Additional Information

The official instruction, CR 6617, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1810CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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