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CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The reporting period for the 2009 Physician Quality Reporting Initiative (PQRI) has begun. Eligible professionals choosing to participate in the 2009 PQRI through claims-based submission of individual quality measures should have started submitting appropriate 2009 Quality Data Codes on qualifying Part B claims with a date of service of January 1, 2009 or later. Information on the 153 2009 PQRI measures, release notes, detailed specifications, and a guide to assist implementing PQRI measure reporting are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website. Information on alternative reporting periods and reporting criteria for satisfactory reporting of measures groups can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website.

MLN Matters Number: MM6397
Related Change Request (CR) #: 6397
Related CR Release Date: March 4, 2009
Effective Date: January 1, 2009
Related CR Transmittal #: R1691CP
Implementation Date: April 6, 2009

Note: This article was updated on December 20, 2012, to reflect current Web addresses. All other information remains unchanged.

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

Provider Types Affected

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) 6397 which amends payment files that were issued to contractors based upon the 2009 Medicare Physician Fee Schedule (MPFS) Final Rule. Physical therapists should pay particular attention to

the "Background Section" regarding the billing of Canalith repositioning procedures.

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.

Canalith Repositioning

In the 2009 MPFS Final Rule, the Centers for Medicare & Medicaid Services (CMS) discussed a newly created CPT code, 95992, describing canalith repositioning procedures. CMS indicated that, prior to the new CPT code, this service was billed by physicians as part of an Evaluation and Management service, and by other practitioners, primarily therapists, using existing codes. CMS assigned the code a status indicator of B (bundled), and stated that bundling this code is most appropriate because this service is currently being paid for as part of an Evaluation and Management (E and M) service. However, since therapists also provide this service and they cannot bill for E and M services, they should continue to bill CPT code 97112 for this service.

2009 Physician Quality Reporting Initiative (PQRI) Program

CMS identified a technical problem affecting twenty quality-data codes (QDCs) used for reporting thirteen quality measures through the claims-based method for the 2009 Physician Quality Reporting Initiative (PQRI). These twenty QDCs are new codes for the 2009 PQRI. The CPT II codes and the 2009 PQRI measures affected are listed below.

CPT II Code	Measure #	Measure
3250F	99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3250F	100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
3570F	147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
3016F	173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening
3455F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
4195F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening

CPT II Code	Measure #	Measure
4196F	176	Rheumatoid Arthritis (RA): Tuberculosis Screening
3470F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3471F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
3472F	177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
1170F	178	Rheumatoid Arthritis (RA): Functional Status Assessment
3475F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
3476F	179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
0540F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4192F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4193F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4194F	180	Rheumatoid Arthritis (RA): Glucocorticoid Management
4148F	183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV
4149F	184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV
0529F	185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
4267F	186	Wound Care: Use of Compression System in Patients with Venous Ulcers

In most instances, the technical problem has caused line items containing any of the QDCs listed above to reject/return as unprocessable. In those circumstances, the eligible professional (EP) received a message other than N365 indicating that the procedure code was not accepted for reporting proposes. Since this is an issue that affects claims-based PQRI reporting only, the reporting of quality measures through registries is not affected.

CMS is actively working with the carriers and A/B MACs to address this issue. All carriers and A/B MACs will be able to accept the affected codes within the next 3 weeks. Once this has been accomplished, submission of the affected CPT II

codes will result in the normal N365 message on the remittance advice indicating that the code has been accepted for reporting purposes.

In order to minimize any adverse impact on EPs for determination of satisfactory reporting for affected measures, CMS will exclude from the reporting denominator all cases for dates before which the carriers and A/B MACs could accept the affected CPT II codes, unless inclusion of cases for such dates is more favorable to the EP. In view of this, EPs have the option to seek correction of 1st Quarter (i.e., January 1, 2009 – March 31, 2009) QDC submissions which were returned as unprocessed if desired, but EPs would not be required to seek correction for the affected codes. The two basic options for EPs are:

A. Do not seek correction of the submitted codes which were returned unprocessed.

As indicated above, CMS will exclude from the determination of satisfactory reporting cases for dates prior to the date the carriers and A/B MACs can process the relevant codes. Thus, EPs are not required to seek correction of claims. On the other hand, EPs who have begun to submit codes for the affected measures should continue to submit such codes. The beginning of acceptance of the codes will be apparent when the N365 message is noted on the remittance advice. The 2009 reporting period will not be changed and the EP who qualifies for the incentive based on the listed or affected measures will receive the 2% incentive payment with respect to the entire reporting period.

B. Seek correction of the submitted codes that were returned unprocessed.

In certain circumstances, EPs may desire to seek correction of the unprocessed claims. To accomplish this, EPs who have already billed and included any of the listed QDCs for dates of service January 1, 2009 and after and received a message other than N365 on their remittance advice, can call their carrier or A/B MAC and request a correction beginning April 1, 2009. In this case the EP should be prepared to give specific claim information to the carrier or A/B MAC, such as, the internal control number (ICN), the beneficiary's health insurance claim number (HIC), dates of service and the QDCs. EPs who began reporting the affected measures using the Measures Group Consecutive Method during the first three months of 2009 may find that it is worthwhile to pursue correction.

Note: PQRI reporting and performance rate analysis for ONLY the affected measures will initially be performed after excluding cases for the first three months of 2009. If an EP does not qualify based on this calculation, then the EP's claims without excluding claims for the first 3 months of 2009 will be evaluated. Thus, the

determination of satisfactory reporting will be evaluated both ways for all EPs who report on the relevant measures.

Other specific changes included in the April Update to the 2009 MPFSDB are detailed in Attachment 1 of CR 6397. That CR is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1691CP.pdf on the CMS website. Key changes, however, are summarized as follows:

These Current Procedural Terminology /Healthcare Common Procedure Coding System (CPT/HCPCS) codes are assigned a Procedure Status = M as follows:

0529F, 0540F, 1170F, 3016F, 3250F, 3455F, 3470F, 3471F, 3472F, 3475F, 3476F, 3570F, 4148F, 4149F, 4192F, 4193F, 4194F, 4195F, 4196F, 4267F, G8489, G8490, G8491, G8492, G8493, G8494.

These CPT/HCPCS codes are assigned a Procedure Status = I as follows:

0575F, 4270F, 4271F, 4279F, 4280F.

Physicians/providers should also note the following:

CPT/HCPCS	ACTION
93351 Global	Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision Short Descriptor: Stress tte complete
93351 TC	Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision Short Descriptor: Stress tte complete
93351 26	Long Descriptor: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of

continuous electrocardiographic monitoring, with physician supervision

Short Descriptor: Stress tte complete

Descriptor Changes

The long descriptor has been revised for the following codes:

CPT Code	Revised Long Descriptor	Revised Short Descriptor
G0248	Demonstration, prior to initiation of home INR monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient's ability to perform testing and report results	N/A
G0249	Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests	N/A
G0250	Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests	N/A

Change in Procedure Status for CPT code 0085T

Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath Test used to predict heart transplant rejection is nationally non-covered. CPT code 0085T, breath test for heart transplant rejection, is assigned procedure status of N and is no longer payable by Medicare.

Additional Information

The official instruction, CR 6397, 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/R1691CP.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.