DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Medicare Learning Network

MLN Matters®

CMS

Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The transcript of the Centers for Medicare & Medicaid Services (CMS) ICD-10-CM/PCS National Provider Conference Call for Physicians that was held on November 17, 2008 is now available at http://www.cms.gov/Medicare/Coding/ICD10/CMS-Sponsored-ICD-10-Teleconferences-Items/CMS1240860.html on the Centers for Medicare & Medicaid Services website.

MLN Matters Number: MM6349

Related Change Request (CR) #: 6349

Related CR Release Date: December 19, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R419OTN

Implementation Date: January 5, 2009

Summary of Policies in the 2009 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount

Note: This article was updated on August 16, 2012, to reflect current Web addresses. All other information remains the same.

Provider Types Affected

Physicians, other practitioners, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries and paid under the MPFS.

Provider Action Needed

This article is based on Change Request (CR) 6349 which provides a summary of the policies in the 2009 MPFS and announces the telehealth originating site facility fee payment amount. Be sure billing staff are aware of these Medicare changes.

Background

The Social Security Act (Section 1848(b)(1) at *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* requires the Centers for Medicare & Medicaid Services (CMS) to provide (by regulation before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year. CMS published a document that will affect payments to physicians effective January 1, 2009.

The Social Security Act (Section 1834(m) at *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm* established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002 at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI) as defined in §1842(i)(3) of the Act. The MEI increase for CY 2009 is 1.6 percent. The telehealth originating site facility fee for 2009 is 80 percent of the lesser of the actual charge or $23.72.

Summary of Key Changes Discussed by CR 6349

A complete summary of significant issues discussed in CMS-1403-FC, Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is attached to CR6349, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R419OTN.pdf on the CMS website. The following further summarizes the key points of that attachment to CR6349.

MPFS Issues

Payment for Preadministration-Related Services for Intravenous Infusion of Immune Globulin (IVIG)

Payment is no longer made under the physician fee schedule for G0332, for preadministration related services for IVIG infusion, effective January 1, 2009. This code has been deleted from the MPFS database and is no longer recognized for services furnished after December 31, 2008.

Multiple Procedure Payment Reduction (MPPR) for Diagnostic Imaging

CMS added several additional procedures to the MPPR list. Six procedures represent codes newly created since the MPPR list was established. Four additional procedures were identified as similar to procedures currently subject to the MPPR. CMS also removed CPT code 76778, a deleted code, from the list.

Proposed HCPCS code for Prostate Saturation Biopsies

Prostate Saturation Biopsy is a technique that was previously described by Category III CPT code 0137T, Biopsy, prostate, needle, saturation sampling for prostate mapping. Typically, this service entails 40-80 core samples taken from the prostate under general anesthesia. Currently, the biopsies are reviewed by a pathologist and this service is captured under CPT code 88305, Surgical pathology, gross and microscopic examination, which is separately billed by the physician for each core sample taken. CPT Code 88305 has a physician work value of 0.75 and a total nonfacility payment rate of $102.83. CMS added four G codes to more accurately represent the pathologic evaluation, interpretation, and report for this service. In the final rule with comment period, CMS finalized its proposal, but provided assigned values to the four new G codes based upon assumption of the number of cancerous cells.

New and Revised Codes

CMS received work relative value unit (RVU) recommendations for 128 new and revised CPT codes from the American Medical Association (AMA) Relative Update Committee (RUC) this year. Of the recommendations received, CMS accepted 114 and disagreed with 14.

The CPT Editorial Panel created 20 CPT codes to replace the G codes for monthly and per diem end-stage renal disease (ESRD) services. CMS accepted the AMA RUC recommendations for these services. The new CPT codes are listed in the following table:

Deleted G Code	New CPT Code	Short Descriptor
G0308	90951	Esrd serv, 4 visits p mo, <2
G0309	90952	Esrd serv, 2-3 vsts p mo, <2
G0310	90953	Esrd serv, 1 visit p mo, <2
G0311	90954	Esrd serv, 4 vsts p mo, 2-11
G0312	90955	Esrd srv 2-3 vsts p mo, 2-11
G0313	90956	Esrd srv, 1 visit p mo, 2-11

Deleted G Code	New CPT Code	Short Descriptor
G0314	90957	Esrd srv, 4 vsts p mo, 12-19
G0315	90958	Esrd srv 2-3 vsts p mo 12-19
G0316	90959	Esrd serv, 1 vst p mo, 12-19
G0317	90960	Esrd srv, 4 visits p mo, 20+
G0318	90961	Esrd srv, 2-3 vsts p mo, 20+
G0319	90962	Esrd serv, 1 visit p mo, 20+
G0320	90963	Esrd home pt, serv p mo, <2
G0321	90964	Esrd home pt serv p mo, 2-11
G0322	90965	Esrd home pt serv p mo 12-19
G0323	90966	Esrd home pt, serv p mo, 20+
G0324	90967	Esrd home pt serv p day, <2
G0325	90968	Esrd home pt srv p day, 2-11
G0326	90969	Esrd home pt srv p day 12-19
G0327	90970	Esrd home pt serv p day, 20+

Renumbered CPT Codes

Effective for CY 2009, the following CPT codes have been renumbered:

Deleted CPT Code	New CPT Code	Short Descriptor
90760	96360	Hydration iv infusion, init
90761	96361	Hydrate iv infusion, add-on
90765	96365	Ther/proph/diag iv inf, init
90766	96366	Ther/proph/diag iv inf addon
90767	96367	Tx/proph/dg addl seq iv inf
90768	96368	Ther/diag concurrent inf
90769	96369	Sc ther infusion, up to 1 hr

Deleted CPT Code	New CPT Code	Short Descriptor
90770	96370	Sc ther infusion, addl hr
90771	96371	Sc ther infusion, reset pump
90772	96372	Ther/proph/diag inj, sc/im
90773	96373	Ther/proph/diag inj, ia
90774	96374	Ther/proph/diag inj, iv push
90775	96375	Tx/pro/dx inj new drug addon
90776	96376	Tx/pro/dx inj new drug adon
90779	96379	Ther/prop/diag inj/inf proc
99289	99466	Ped crit care transport
99290	99467	Ped crit care transport addl
99293	99471	Ped critical care, initial
99294	99472	Ped critical care, subsq
99295	99468	Neonate crit care, initial
99296	99469	Neonate crit care, subsq
99298	99478	Ic, lbw inf < 1500 gm subsq
99299	99479	Ic lbw inf 1500-2500 g subsq
99300	99480	Ic inf pbw 2501-5000 g subsq
99431	99460	Init nb em per day, hosp
99432	99461	Init nb em per day, non-fac
99433	99462	Sbsq nb em per day, hosp
99435	99463	Same day nb discharge
99436	99464	Attendance at delivery
99440	99465	Nb resuscitation

Medicare Telehealth Services

CMS has added HCPCS codes specific to follow-up inpatient consultation delivered via telehealth and clarified that the criteria for these services will be consistent with Medicare policy for consultation services.

For 2009, Medicare contractors will pay for the Medicare telehealth originating site facility fee as described by Healthcare Common Procedure Coding System (HCPCS) code Q3014 at 80 percent of the lesser of the actual charge or $23.72. The beneficiary is responsible for any unmet deductible amount or coinsurance.

Part B Drug Issues

In the 2009 MPFS final rule, CMS announces it will adopt three regulatory changes affecting payment of Part B Drugs under the Average Sales Price (ASP) methodology, i.e.:

- CMS will update its regulations to comport with the new volume-weighting ASP calculation methodology established in section 112(a) of the Medicare and Medicaid SCHIP Extension Act (MMSEA) of 2008.
- CMS will make conforming changes to its regulations to address the special payment rule for certain single source drugs or biologicals that are treated as multiple source drugs because of the application of the grandfathering provisions of section 1847A of the Act.
- Section 1847A(d)(1) of the Act allows the Secretary to disregard the ASP for a Part B drug or biological that exceeds the WAMP or the AMP for such drug by an applicable threshold percentage. For CY 2009, CMS will maintain the threshold at 5 percent, absent of data that suggests a change is appropriate.

Application of Health Professional Shortage Area (HPSA) Bonus Payment

CMS makes minor policy revisions to clarify that physicians who furnish services in areas that are designated as geographic HPSAs as of December 31 of the prior year but not included on the list of zip codes for automated HPSA bonus payments should use the AQ modifier to receive the HPSA bonus payment.

Independent Diagnostic Testing Facilities (IDTF)

CMS is requiring all mobile units providing diagnostic testing services to Medicare beneficiaries to enroll in the Medicare program. In addition, all mobile units furnishing diagnostic testing services will be required to bill for services unless the service is furnished under arrangement with a hospital. When services are furnished under arrangement, the hospital will continue to bill for the diagnostic testing services.

Physician and Nonphysician Enrollment Safeguards

The following is a summary of the enrollment provisions in the MPFS final rule for 2009:

1. Limit retrospective payments to physicians and nonphysician practitioners and physician and nonphysician practitioner organizations.

CMS has established that the effective date of billing for physicians and nonphysician practitioners and physician or nonphysician practitioner organizations as the later of: (1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date an enrolled physician or nonphysician practitioner first started rendering services at a new practice location. This provision permits physicians and nonphysician practitioners to retrospectively bill for services furnished up to 30 days prior to the effective date of enrollment if the physician or nonphysician practitioner meets all program requirements, even if the initial enrollment application is rejected or denied as long as the application is ultimately approved. In addition, physicians and non-physician practitioners will be permitted to retrospectively bill for services furnished up to 90 days prior to the effective date if the physician or non-physician practitioner meets all program requirements and there is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act).

2. Prohibit physicians and nonphysician practitioners, as well as owners, authorized officials, and delegated officials of a physician or nonphysician practitioner organization from obtaining additional billing privileges if their current billing privileges are suspended or an overpayment is pending.

3. Require all providers and suppliers, including individual practitioners, to maintain ordering and referring documentation for 7 years from the date of service.

4. Require physician and nonphysician organizations, physicians and nonphysician practitioners, and IDTFs to submit all outstanding claims within 60 days of the revocation date.

5. Require physicians and nonphysician practitioners and physician and nonphysician practitioner organizations to notify their Medicare contractor of a change of ownership, final adverse action, or change of location that impacts a payment amount within 30 days. Failure to notify the designated contractor of these changes may result in an overpayment from the date of the reportable change.

Educational Requirements for Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)

In the 2009 MPFS final rule, CMS finalizes its proposal to recognize the doctor of nursing practice (DNP) degree and also states that it will continue to study the evolution of the DNP degree to ensure that it continues to be consistent with our program requirements. In addition, CMS finalized a proposed technical correction to the NP regulatory qualifications that will clarify that the requirement for a master's degree in nursing is the minimum educational level for newly enrolled NPs and CNSs independently treating Medicare beneficiaries.

PROVISIONS FROM THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

Section 101: Improvements to Coverage of Preventive Services

Payment for the IPPE

The MMA provided for one IPPE per beneficiary per lifetime. A beneficiary is eligible when first enrolling in Medicare Part B on or after January 1, 2005, and receives the IPPE benefit within the first 6 months of the effective date of the initial Part B coverage period. If the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate existing HCPCS G code(s). MIPPA made several changes to the IPPE including expanding the IPPE benefit period to not later than 12 months after an individual's first coverage period begins under Medicare Part B. (Other changes to this benefit were included in segment 1 of the rule.) The following is a summary of the payment changes resulting from section 101 of the MIPPA:

The Deductible Change with MIPPA

The Medicare deductible does not apply to the IPPE if performed on or after January 1, 2009 within the beneficiary's 12-month initial enrollment period of Medicare Part B. The waived deductible is applicable to the IPPE service only. Medicare will pay for one IPPE per beneficiary per lifetime. The Medicare deductible for the IPPE performed before January 1, 2009 (G0344) applies. Co-insurance applies irrespective of codes or date of the IPPE. The waived deductible for the IPPE, effective January 1, 2009, does not apply to the screening EKG.

New G Codes Needed with MIPPA Implementation

CMS revised the G codes for the IPPE and EKG to reflect the changes in the legislation. The EKG codes will reflect a once-in-a lifetime screening with a referral from an IPPE.

Section 132: Incentives for Electronic Prescribing

Eligible professionals who are successful electronic prescribers shall be paid 2 percent incentive of estimated allowable charges submitted not later than 2 months after the end of the reporting period for 2009 successful electronic prescribing.

A "successful electronic prescriber" is defined under section 1848(m)(3)(B)(ii) of the Social Security Act as an eligible professional who reports the e-prescribing measure in at least 50 percent of the cases in which the measure is reportable by the professional. Although the Secretary is given authority to assess successful

electronic prescribing using either data reported by eligible professionals using electronic prescribing quality measures or using Part D prescription data, CMS will use the former for 2009. CMS will set forth the statutory criteria for successful electronic prescriber as reporting the measure in 50 percent of applicable cases.

There is also a limitation of the applicability of the e-prescribing incentive. For CY 2009, in order to be considered an eligible professional for purposes of the e-prescribing incentive, the e-prescribing measure denominator codes must apply to at least 10 percent of the total of allowed charges for all such covered services furnished by the eligible professional.

Section 149: Adding Certain Entities as Originating Sites for Payment of Telehealth

Currently, telehealth may substitute for a face-to-face, "hands on" encounter for professional consultations, office visits, office psychiatry services, and a limited number of other PFS services that CMS has determined to be appropriate for telehealth. Medicare will make a fixed payment to the originating site as well as a PFS payment to the physician. The originating site must be located in a non-metropolitan statistical area (non-MSA) county or rural HPSA. To date, originating sites have been limited to: the office of a physician or practitioner; a hospital; a critical access hospital (CAH); a rural health clinic (RHC); and a federally qualified health center (FQHC).

The MIPPA recognizes the following additional originating sites, effective for services furnished on or after January 1, 2009: a hospital-based or CAH-based renal dialysis center (including satellites); a skilled nursing facility (SNF); and a community mental health center (CMHC).

Additional Information

If you have questions, please contact your Medicare MAC, carrier or FI 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. The official instruction, CR6349, issued to your Medicare A/B MAC, carrier or FI regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R419OTN.pdf on the CMS website.