



Indianapolis Medical Management
7330 Shadeland Station, Ste 200
Indianapolis, IN 46256

IN OCTOBER'S ISSUE:

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MEDICARE - H1N1 CODING INFORMATION

MLN Matters® Number: SE0920

Medicare Part B provides coverage for the seasonal influenza virus vaccine and its administration as part of its preventive immunization services. The Part B deductible and coinsurance do not apply for the seasonal influenza virus vaccine and its administration. Typically, the seasonal influenza vaccine is administered once a year in the fall or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when deemed to be a medical necessity. The Influenza A (H1N1) virus has been identified as an additional type of influenza. The H1N1 virus vaccine will be provided to Medicare Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the **administration** of the H1N1 vaccine.

The Centers for Medicare & Medicaid Services (CMS) has created two new HCPCS codes for H1N1, effective for dates of service on and after September 1, 2009:

G9141—Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)

G9142---Influenza A (H1N1) vaccine, any route of administration

Payment for G9141 (Influenza A (H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis V04.81 (influenza), and, depending on the provider type, using revenue code 771. The same billing rules apply to the H1N1 virus vaccine as the seasonal influenza virus vaccine with one exception. Since the H1N1 vaccine will be made available **at no cost to providers**, Medicare will not pay providers for the vaccine. Providers do not need to place the G9142 (H1N1 vaccine code) on the claim. However, if the G9142 appears on the claim, only the claim line will be denied.

Payment will not be made to providers for office visits when the only purpose of the visit is to administer either the seasonal and/or the H1N1 vaccine(s).

Providers who normally participate in the Medicare Part B program as mass immunizer roster billers and mass immunizer centralized billers may submit H1N1 administration claims using the roster billing format. The same information must be captured for the H1N1 roster claims as it is for the seasonal influenza roster claims. The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;
- Control number for Medicare contractor;
- Patient's health insurance claim number;
- Patient's name;
- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary's signature or stamped "signature on file".

For this upcoming flu season, Medicare will reimburse Medicare beneficiaries, up to the fee schedule amount, for the administration of H1N1 influenza vaccine when furnished by a provider not enrolled in Medicare. Beneficiaries must submit a Form

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MEDICARE - H1N1 CODING INFORMATION (CONTINUED)...

CMS-1490S to their local Medicare contractor. Medicare will reimburse beneficiaries for the administration of the H1N1 vaccine, but not the H1N1 vaccine itself because the H1N1 vaccine will be furnished at no cost to all providers. Medicare beneficiaries may not be charged any amount for the H1N1 vaccine itself.

Finally, Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. We understand that such preparations are critical for the upcoming flu season, especially in planning for the influenza A [H1N1] vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e. the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A [H1N1] vaccination, then Medicare will pay for both. However, as noted earlier, please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

Additional Information: If you have any questions, please contact your FI, Medicare carrier, or A/B MAC at their toll-free number, which may be found at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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CMS REVISION TO EDIT FOR ORDERING/REFERRING PROVIDERS

MLN Matters® Number: MM6417 Revised

Effective Dates: Phase 1: October 1, 2009, Phase 2: January 1, 2010

Implementation Dates: Phase 1: October 5, 2009, Phase 2: January 4, 2010

Note: This article was revised on September 14, 2009 to provide further clarification of what will happen during the two phases of implementing this change.

Provider Types Affected: Physicians, non-physician practitioners, and other Part B providers and suppliers submitting claims to carriers or Part B Medicare Administrative Contractors (MACs) for items or services that were ordered or referred. (A separate Article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421. That article is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6421.pdf> on the CMS website.)

Provider Action Needed: This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services **only** when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners who

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CMS REVISION TO EDIT FOR ORDERING/REFERRING PROVIDERS (CONTINUED)...

order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty who are eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

The providers who can order/refer are:

- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Chiropractic Medicine;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

Key Points:

- **During Phase 1 (October 5, 2009-January 3, 2010):** If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. **If the ordering/referring provider is not in PECOS the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice.**
- **During Phase 2, (January 4, 2010 and thereafter):** If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.**

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CMS REVISION TO EDIT FOR ORDERING/REFERRING PROVIDERS (CONTINUED)...

In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.

- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at <https://pecos.cms.hhs.gov/pecos/login.do> on the CMS website. Before using Internet-based PECOS, providers should read the educational material at http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website. Once at that site, scroll to the downloads section of that page and click on the materials that apply to you and your practice.

Additional Information:

You can find the official instruction, CR6417, issued to your carrier by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R510OTN.pdf> on the CMS website. If you have any questions, please contact your carrier at their toll-free number, which may be found on the CMS website:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

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“WHAT’S NEW WITH THE PQRI INCENTIVE PROGRAM?”

The eligible providers who qualified following the back-end analysis and re-run of 2007 PQRI data will receive a 2007 re-run feedback report in October. You may access your 2007 PQRI Feedback Report through the PQRI Portal on the Quality Net website. To access your report, you must first register for access through a CMS security system know as the Individual Authorized Access to CMS Computer Services (IACS) to receive a user ID and Password. Physicians and non-physician practitioners must have an approved Medicare enrollment in the PECOS system, CMS’ national enrollment database, in order to successfully receive an IACS account. The incentive payment based on the re-run of the 2007 data will be issued in November 2009.

Further information can be found at: www.cms.hhs.gov/PQRI and click on "2007 PQRI Program" in the left hand column.

Medicare Learning Network now has a 2009 PQRI and E-Prescribing Program Web-based training course. The course provides information regarding the completion, submission and maintenance of the documentation required to successfully participate in the PQRI and E-Prescribing incentive programs. Continuing Education credits are offered. The course can be accessed by going to:

<http://www.cms.hhs.gov/MLNGenInfo> and select Web Based Training (WBT) Modules.

Additional helpful resources:

[User Guide: 2007 Re-Run and 2008 PQRI Feedback Reports \[PDF 1MB\]](#)

[A Guide for Understanding the 2007 Re-Run PQRI Incentive Payment \[PDF 47KB\]](#)

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NEW REQUIREMENTS TO TELL PATIENTS ABOUT HIPAA BREACHES INVOLVING THEIR PHI

The government has published new rules strengthening the HIPAA Privacy and Security Rules. Those rules now require health care providers to notify patients any time their protected health information (PHI) has been accessed, used, or disclosed by an unauthorized person. Unauthorized access, use or disclosure of PHI is called a "breach." The notification requirement applies to all breaches, including misdirected faxes and unauthorized viewing of records by employees, physicians, volunteers and others who do not have a "need to know."

Other requirements:

- Providers must submit a log of a privacy and security breaches to the government;
- Providers must train all workforce members on the new requirements.

IMM is developing policies and processes for notifying patients about privacy and security breaches. Expect to see more information and required education in the coming months.

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SOME HEALTHCARE RECOGNITION DATES FOR OCTOBER

Adult Immunization Week, National (4th Tues. + week)
Alzheimer's Memory Walk
American Heart Walk, Healthy Choice
Brain Injury Awareness Month
Breast Cancer Awareness Month, National
Campaign for Healthier Babies Month, National
Cold and Flu Campaign
Depression Screening Day, National (1st Thursday)
Depression & Mental Health Month
Domestic Violence Awareness Month
Down Syndrome Awareness Month, National
Healthcare Quality Week, National (2nd full week)
Health Education Week, National (3rd Mon. for 7 days)
Mammography Day, National (3rd Friday)
Respiratory Care Week (last week)
Rett Syndrome Awareness Month
World Blindness Awareness Month

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