



FLORIDA SOCIETY OF CLINICAL ONCOLOGY
FLASCO BLAST –December 14, 2009
FLASCO WEBSITE: www.flasco.org
FLASCO CLINICAL TRIALS NETWORK WEBSITE: www.fctn.org

MESSAGE FROM THE PRESIDENT: Gerald Robbins, MD

Comments from Thomas Marsland, MD, FLASCO Liaison to ASCO:

Recently I had a conference with Dr. Joe Bailes. . Lots of hot air in DC but not much of substance at this point..... Joe says Dems 6 votes short in Senate of getting anything done.... Lots of jockeying next couple of weeks.... If nothing chances are less in '10 fall back position maybe just “insurance” reform.... SGR still up in the air.... If no health care bill look for probably attempt at short term fix as amendment to budget reconciliation bill in two weeks.... CMS instructed carriers **NOT** to hold any payments in Jan '10 like they did a couple of years ago while waiting for fix... Joe claims some movement to revisit the consult issue..... AMA did good job on that.... Any healthcare reform like to be detrimental to specialties.... Message to congressional folks need to maintain access to specialty care...

On side note large Georgia practice under OIG investigation for modifier 25... usage of office visit code and chemo on same day.... Going back 8 years and looking at over 200 charts..... ASCO position that it is OK for office visit and chemo same day and supposedly had clarified that with CMS a couple of years ago but..... OIG looking into it..... **be sure you have good documentation and if anyone gets requests from OIG, get lawyer in and let organized medicine folks know.**

CLINICAL PRACTICE COMMITTEE: Thomas Gaddis, MD, Chairman

Please see Issue #22, December 2009 – Reimbursement News from Bobbi Buell- (at end of this Blast Fax)

DRUG AND INDUSTRY UPDATES:

Nplate® (romiplostim).

The following information was taken from a fax blast to all providers currently enrolled in the Nplate® NEXUS program”. Keep in mind that their fax blast was written as general information. For example, providers in Florida may have been using the miscellaneous code J3490 for claims vs. the J3590.

Amgen is pleased to announce that the Centers for Medicare and Medicaid Services (CMS) have established a product-specific Healthcare Common Procedures Coding System (HCPCS) J-code, or permanent code, for Nplate® (romiplostim). Effective for dates of service on or after January 1, 2010, the new J-code for Nplate® is **J2796**.

The new J-code, **J2796** for 10 mcg units of Nplate®, should be used instead of the current miscellaneous J-code (J3590) as well as the current C-code (C9245) when used on a claims form starting on January 1, 2010. If you or your Medicare contractor wishes to see a copy of the HCPCS table to verify the availability of this code, go to: <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage> for more information.

The new **J2796** code is included in the 2010 version of coding manuals that providers rely on for coding information and we expect that this new code should be implemented by payors within the first 90 days of the calendar year. Furthermore, since many private payors recognize HCPCS codes, plans should process Nplate® claims containing the **J2796** code for dates of service on or after January 1,2010. Of course, it is important that you always confirm with each payor that they have implemented and are using the new Nplate® J-code starting January 1, 2010, to avoid unnecessary delays in processing your claims.

If you have any questions about coding or billing for Nplate®, please call 1-877-Nplate1 (1-877-675-2831) for reimbursement assistance.

FCSO UPDATES:

Medicare Part B remittance files experiencing a delay in processing

On November 24, 2009, a national issue was identified that caused Medicare Part B electronic remittance advice (ERA) files -- for checks dated November 23 forward -- to be unavailable for download. Providers are requested to take no action until the issue has been resolved.

Please be assured that First Coast Service Options Inc. (FCSO) is working diligently with the system maintainer to correct this issue as quickly as possible. FCSO will provide future updates regarding this issue as more information becomes available. Thank you for your patience.

FCSO apologizes for any inconvenience you may have experienced related to this issue.

January quarterly update to Correct Coding Initiative edits

Effective date: January 1, 2010

Implementation date: January 4, 2010

Summary

This article provides a reminder for physicians of the quarterly updates to the Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in October 2009. The latest package of CCI edits, version 16.0, is effective January 1, 2010, and includes all previous versions and updates from January 1, 1996, to the present. Additional information about CCI, including the current CCI and mutually exclusive edits, is available at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

CMS UPDATES:

MS Updates to Coverage Pages

Mon, 30 Nov 2009

Date: 11/30/2009

Subject: CMS Updates to Coverage Pages

Content: Posted proposed decision memo for Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer. For complete information go to:

<http://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?from2=viewdraftdecisionmemo.asp&id=233&>

Additional Documentation Limits for FY 2010 for DRG Validation as of December 1, 2009

In response to feedback from the RACs, providers/suppliers and their associations, CMS has modified the additional documentation request limits for the RAC program in FY 2010. These limits will be set by each RAC (CMS) on an annual basis to establish a cap per campus on the maximum number of medical records that may be requested per 45-day period. A campus unit (defined below) may consist of one or more separate facilities/practices under a single organizational umbrella; each limit will be based on that unit's prior fiscal year Medicare claims volume.

1. Limits will be based on the servicing provider/supplier's Tax Identification Number (TIN) and the first three positions of the ZIP code where they are physically located. Using TINs will reduce the total number of limits that would have been imposed per organization under the previous draft policy, which was based on National Provider Identifiers, while factoring in ZIP codes will promote equitability for regional or national organizations. For example:

Provider A has TIN 123456789 and two physical locations in ZIP codes 12345 and 12356; the two locations would qualify as a single campus unit for additional documentation limit purposes.

Provider B has TIN 123456780 and is physically located in 12345 as well as 21345. This provider would be considered as two distinct entities for additional documentation purposes, and each location would have its own additional documentation limit.

Please note that the definition of a campus for RAC documentation request limits differs significantly from the definition in 42 CFR 413.65(a)(2) used to determine eligibility for provider-based billing.

2. Limits will be set at 1% of all claims submitted for the previous calendar year (2008), divided into eight periods (45 days). Although the RACs may go more than 45 days between record requests, in no case shall they make requests more frequently than every 45 days. A provider's limit will be applied across all claim types, including professional services. Note: FY 2010 limits are based on submitted claims, irrespective of paid/denied status and/or individual lines, although interim/final bills and RAPs/final claims shall be considered as a unit. For example:

Provider C billed 156,253 claims last year. The provider's additional documentation limit would be $(156253 * .01)/8 = 195.31$, or 195 additional documentation requests per 45 days. Provider D billed 50,000 inpatient claims, 75,000 outpatient claims, 20,000 SNF covered stays, 20,000 home health episodes of care, 250,000 physician claims, 10,000 inpatient rehab claims and 1,000 hospice claims. The total number of claims for this provider would equal 426,000. The provider's additional documentation limit would be $(426000 * .01)/8 = 532.5$. The provider's additional documentation limit would be 532 additional documentation requests every 45 days, if there were no cap in place (see below).

While respecting a provider's overall limit, the RAC may exercise discretion in the exact composition of an additional documentation request. For example, the RAC may request inpatient records up to the full limit even though the provider's inpatient business may only be a small portion of their total claim volume.

3. Two caps will exist in FY 2010: Through March 2010, the cap will remain at 200 additional documentation requests per 45 days for all providers/suppliers. However, from April through September 2010, providers/suppliers who bill in excess of 100,000 claims to Medicare (per TIN, across all claims processing contractors) will have a cap of 300 additional documentation requests per campus unit, per 45 days.
4. In addition, in FY 2010 CMS will allow the RACs to request permission to exceed the cap. Permission to exceed the cap cannot be requested in the first six (6) months of the fiscal year. The expanded cap will not be automatic; the RACs must request approval from CMS on a case-by-case basis and affected providers will be notified prior to receiving additional requests.

Questions concerning this update can be directed to RAC@cms.hhs.gov.

Providers Must Wait for Medicare Claim Crossover Process to Work

The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work—approximately 15 work days after Medicare's reimbursement is made, as stated in MLN Matters Article SE0909 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0909.pdf>) — **before** attempting to balance bill their patients' supplemental insurers. That is, **do not balance bill** until you have received written confirmation from Medicare that your patients' claims **will not** be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare's intention to cross your patients' claims over. Medicare will continue to issue supplemental notifications to all participating providers, physicians, and suppliers informing them if claims targeted for crossover, as evidenced by MA18 or N89 on the MRA, do not actually result in successful crossover transmissions.

New Medicare Learning Network (MLN) Booklet: How to Use the Medicare Coverage Database Search Tool

Do you ever wonder about how to utilize search tools in selected areas of the CMS website? The searchable Medicare Coverage Database (MCD) contains all Medicare National Coverage Determinations (NCDs), National Coverage Analyses (NCAs), Local Coverage Determinations (LCDs), and local policy articles. The Medicare Learning Network (MLN) has produced a "How To" booklet (2.5 MB), that provides an explanation of the MCD, as well as how to use the Search, Indexes, Reports and Downloads features. The **How to Use the Medicare Coverage Database** booklet (November 2009) can be located at <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp> on the MLN Publications page. Use search key words "*how to*" to locate this publication quickly. Understanding the search tool is the best way to find the information for which you are looking!

Are you wondering how to find the latest and greatest Medicare resources by subject?

The REVISED Guided Pathways (November 2009) booklets incorporate existing Medicare Learning Network (MLN) products and other resources into well organized sections that can help Medicare Fee-for-Service (FFS) providers and suppliers find information to understand and navigate the Medicare Program. These booklets guide learners to Medicare program resources, FFS policies and requirements. You can access the **REVISED Guided Pathways** (November 2009) booklets at http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp on the Medicare Learning Network.

MLM UPDATES:

New:

MM6662 – **Annual Update of HCPCS Codes Used for Home Health (HH) Consolidated Billing Enforcement**

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6662.pdf>

MM6728 – **Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 16.0, Effective January 1, 2010**

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6728.pdf>

MM6631 – **Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2010**

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6631.pdf>

MM6753 – **Positron Emission Tomography (PET) (FDG) for Cervical Cancer**

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6753.pdf>

FDA UPDATES:

CT Brain Perfusion Scans Safety Investigation - Additional cases of excess radiation exposure, recommendations provided

UPDATED 12/07/2009] The FDA, working with state and local health authorities, has identified at least 50 additional patients who were exposed to excess radiation of up to eight times the expected level during their CT perfusion scans.

On the basis of its investigation to date, the FDA is providing interim recommendations for imaging facilities, radiologists, and radiologic technologists to help prevent additional cases of excess exposure.

These recommendations include:

- Facilities assess whether patients who underwent CT perfusion scans received excess radiation.
- Facilities review their radiation dosing protocols for all CT perfusion studies to ensure that the correct dosing is planned for each study.
- Facilities implement quality control procedures to ensure that dosing protocols are followed every time and the planned amount of radiation is administered.
- Radiologic technologists check the CT scanner display panel before performing a study to make sure the amount of radiation to be delivered is at the appropriate level for the individual patient.
- If more than one study is performed on a patient during one imaging session, practitioners should adjust the dose of radiation so it is appropriate for each study.

Read the MedWatch safety summary, including a link to the FDA News Release, at:

<http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm186105.htm>

PROGRAM COMMITTEE UPDATES: Jose Lutzy, MD, Chairman

Clinical Breakthroughs & Challenges in Hematologic Malignancies

We are pleased to announce that FLASCO is co-sponsoring with Moffitt Cancer Center a conference on Clinical Breakthroughs & Challenges in Hematologic Malignancies, which will be held on **January 16, 2010** at the Grand Floridian Resort, Lake Buena Vista - For more information, call (813) 745-1247 or e-mail:

Melissa.Pearson@MOFFITT.org

2010 PA/NP Conference:

We are pleased to announce that FLASCO will sponsor its Second Annual Conference for PAs/NPs on March 26, 2010, in Miami. Special thanks are extended to Dayne Alonso, PA-C and Michele Taffaro Neskey, RN for agreeing to serve as Co-Chairmen of the Workgroup to plan this Conference.

ASH UPDATES:

Alert: Reporting Request of New Cancer Cases and Stelara

The American Society of Hematology (ASH) is providing this information at the request of the Food and Drug Administration (FDA) and Centocor Ortho Biotech Inc. in conjunction with a Risk Evaluation and Mitigation Strategy (REMS) for Stelara™ (ustekinumab). All questions should be directed to Centocor Ortho Biotech Inc. at 1-800-457-6399.

FDA and Centocor Ortho Biotech Inc. are asking for your assistance in reporting new cancer cases in patients who have taken Stelara™ (ustekinumab), a new human monoclonal antibody indicated for the treatment of adults with moderate to severe plaque psoriasis. Because Stelara targets interleukin-12 (IL-12) and interleukin-23 (IL-23) and based on data from rodent models, there is a theoretical concern that blockade of IL-12 and IL-23 may increase the risk for malignancies.

FDA and Centocor Ortho Biotech Inc. ask that if you are consulted to see a patient with cancer at any time after he or she has received Stelara therapy, it is important that you report the case even if you do not think there is a causal relationship.

You can report the case to either FDA or Centocor Ortho Biotech Inc.:

- MedWatch (FDA safety information and adverse event reporting program) at 1-800-332-1088 or online at www.fda.gov/medwatch/report.htm
- Centocor Ortho Biotech Inc. at 1-800-457-6399

Reporting is designed to be easy and maintain patient confidentiality. Your patient’s name or contact information is not needed. HIPAA does not apply to this adverse event reporting. For further information, please see the manufacturer’s [notice to oncologists](#), [letter to health-care professionals](#) (http://www.medversation.com/medversation/assets/rems/stelara/pdfs/STELARA_OIP.pdf), and [prescribing information](#). (http://www.medversation.com/medversation/assets/rems/stelara/pdfs/STELARA_PI.pdf)

EDUCATIONAL OPPORTUNITIES:

Teleconference: Medicare Physician Payment Update

Centocor Ortho Biotech Inc. is pleased to invite you and your colleagues to participate in an informational teleconference entitled “Medicare Physician Payment Update.” The goal of this session will be to provide physicians and their staff with a concise overview of key issues contained within the 2010 final rule on Medicare physician office payment. These issues include:

- Overview of the 2010 final physician payment rule;
- Update on the sustainable growth rate formula and changes; and
- Update on regulatory changes to reimbursement for physician services.

This session, approximately 30 minutes in length, will be hosted by Akin Gump Strauss Hauer & Feld LLP, and The Resource Group, and will be offered at a variety of times for your scheduling convenience.

Teleconference Schedule

| Date | Time (Eastern time) |
|-------------|------------------------|
| December 7 | 5:00 pm |
| December 8 | 8:00 am |
| December 9 | 11:00 am |
| December 10 | 12:00 pm |
| December 11 | 3:00 pm |
| December 14 | 8:00 pm |
| December 15 | 10:00 am |
| December 16 | 9:00 am |
| December 17 | 10:00 am |

| Date | Time (Eastern time) |
|-------------|------------------------|
| December 21 | 5:00 pm |
| December 22 | 8:00 am |
| December 23 | 3:00 pm |
| December 28 | 3:00 pm |
| December 29 | 2:00 pm |
| January 5 | 8:00 pm |
| January 6 | 12:00 pm |
| January 7 | 3:00 pm |
| January 8 | 4:00 pm |

To sign up to participate in a teleconference, please call Colleen Flanders at Akin Gump at 202-416-5064. Colleen will provide you with a toll-free call-in number and pass code, and will send you by email or fax the slide deck that will be presented during the teleconference.

This document is presented for informational purposes only and is not intended to provide reimbursement or legal advice. Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. While we have made an effort to be current as of the issue date of this document, the information may not be as current or comprehensive when you view it. In addition, this information does not represent any statement, promise or guarantee by Centocor Ortho Biotech Inc. about coverage, levels of reimbursement, payment or charge. Please consult with your payer organization(s) for local or actual coverage and reimbursement policies and determination processes. Please consult with your counsel or reimbursement specialist for any reimbursement or billing questions specific to your institution.

BUSINESS Q & A: (Source: The Phipps Wealth Management Group)

Q. A Boca Raton FLASCO member asked us -“With interest rates at all time lows can I expect this to be reflected in any borrowing I choose to do through you?

A. Assuming you have a good credit rating, ABSOLUTELY.

For more information you may contact: 561-276-1635 Direct - 877-276-1635 Toll Free – fax: 561-922-3275 - E-mail: jeffrey_phippsr@ml.com - <http://fa.ml.com/PhippsGroup/>

CORPORATE MEMBERSHIP/SPONSORSHIP: (January 1 – December 31, 2009)

FLASCO Members extend a big thanks to all of our 2009 Corporate Members/Sponsors (Companies listed below have either paid 2009 dues or have submitted letters of intent)

PLATINUM

AMGEN
Bayer/Onyx
Cephalon Oncology
Eli Lilly
Oncology Supply/ION
Sanofi-Aventis
Celgene
Eisai, Inc.
Ortho Biotech
Genentech
GlaxoSmithKline
The Phipps Wealth
Management Group
Novartis
Astra Zeneca
Pfizer

GOLD

Abraxis Oncology
Bristol Myers Squibb
Genomic Health
Wyeth
Roche
Millennium
Allos Therapeutics, Inc.
ImClone

SILVER

OSI Pharmaceuticals
US Oncology

BRONZE

Genzyme

FLASCO MEETINGS:

March 5-6, 2010 – FLASCO Spring Meeting and Annual Session – Tampa Airport Marriott Hotel

March 26, 2010 – PA/NP Conference – Miami

November 5-6, 2010 – FLASCO Fall Meeting – Miami

FLASCO CO-SPONSORED MEETINGS:

January 16, 2010 - Clinical Breakthroughs & Challenges in Hematologic Malignancies – Grand Floridian Resort – Lake Buena Vista - For more information, call (813) 745-1247 or e-mail: Melissa.Pearson@MOFFITT.org

OTHER MEETINGS/WEBCASTS

December 10 - 13, 2009 - San Antonio Breast Cancer Symposium (SABCS) San Antonio, TX
Feb 25-27, 2010 - American College of Radiation Oncology Annual Meeting – Lake Buena Vista, FL
March 17-20, 2010 - ACCC's 36th Annual National Meeting - Baltimore Marriott Waterfront

FLASCO Contact Info:

Dorothy Green Phillips, Executive Director - Phone: 1.813.349.4410 – Dorothy.Green@cancer.org

REIMBURSEMENT NEWS: Bobbi Buell

Issue 22 – December 2009

Well, it happens every year. The Final Rule says one thing. CMS does another thing. **This year, the Final Rule said they would modify the code for e-prescribing (G8443) for the 2010 E-Prescribing Initiative. Instead, they replaced and re-defined it...**Read on!! Sorry to those of you that I told to use G8443...this is the very latest coding. It was in the Final Rule, so I thought it was right...who's to know???

We also have a non-update on consult coding. This is just to say that CMS has been deafening in their silence. **THIS JUST IN (12-11-09 at 11 AM EST) !!! Senator Arlen Specter (D-PA) has just introduced an amendment to put off discontinuation of consults until "further investigation and re-evaluation" can take place, January 1, 2011! Get involved in getting this passed right now...YAY!** We'll see what happens to this important amendment. Remember this is a proposed amendment, not a reprieve (yet).

The conversion factor under 21.2% reduction has been lowered because of 'typos'. The typos never seem to favor the provider.

Yikes...what's next???

E-Prescribing Coding Changes for 2010

Recently, CMS (Can More Suck?) released their "Measure Specifications for 2010 E-Prescribing Incentive". This measure specification outlines the actual requirements for the incentive in 2010. A little surprise came in this package---a new code for the measure in 2010 which appears to be **G8553, Prescription(s) Generated and Transmitted Via A Qualified E-Prescribing System: At least one prescription created during the encounter was generated and transmitted using a qualified e-prescribing system.**

The code choices that can be used with the e-prescribing G-code, (sometimes known as the denominator codes) include: **90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109.** .

Here's what you need to do to be a successful electronic prescriber. **According to CMS, "a successful individual prescriber, eligible to receive an incentive payment, must generate and report one or more e-prescriptions associated with a patient visit included in the denominator (seen above), a minimum of 25 unique visits per year".** Each visit must be accompanied by the funky new G- code attesting that during the patient visit at least one prescription was electronically prescribed. Electronically generated prescriptions not associated with a denominator eligible patient visit do not count towards the minimum of 25 different eRx events. **Additionally, 10% of an eligible professional's Medicare Part B charges (all allowed charges for fee schedule services, which exclude drugs and labs) must be comprised of the codes in the denominator of the measure to be incentive eligible.**

The G-code change has not been widely publicized and is on the [Part B News Blog!](#) But, it has been printed and released in the measure specification by Medicare, so we assume that it will be the e-prescribing incentive coding for 2010.

Consults: No News Is...Huh???

Well, we are waiting patiently (???) for a Medicare Transmittal regarding consults. Just in case you have been going to lots of holiday parties and thought you missed it--as of this minute, there is no transmittal, no Medlearn Matters, no nothing. There are many questions regarding the **elimination of Medicare consults for dates of service on or after January 1** such as:

- Are the documentation of reason for, referral, report, etc. still necessary without the consult codes?
- How do you go from 5 hospital consult codes to three admission codes in the hospital?
- Will concurrent edits prevail with the hospital consults, meaning if two different types of oncologists, e.g. Radiation and Medical, see the patient the same day using the same diagnosis, will one claim be denied?
- What is the modifier for the Admitting Physician (99221-99223) in the hospital as opposed to the consulting one(s)?

There are folks (like me and Part B News) who speculate (meaning wild guess) that modifier -AI (that is the letter "I") will be the one used on hospital admissions to distinguish them from consults. But, it is a wild guess until someone at some time confirms the use of this modifier and the guidelines for using it.

Practices have asked me whether they should use crosswalks to code physician consults for Medicare patients on or after January 1. To me, this means, if a physician uses 99244, you would cross walk it to 99204 *without the physician's knowledge*. Let me say that, based on experience with Medicare, federal, and state auditors, that **the physician should select the code based upon code criteria and their knowledge of the patient, the medical necessity of the encounter, and the documentation in the chart.** There is an official Medicare Crosswalk, but this was developed to tell the world that this change is budget neutral. Hmmmm...sure it is.

Keep your eyes and ears open...we are going to the eleventh (or maybe twelfth) hour on this...see note in my introduction for breaking news.

Medicare Lowers 2010 The Conversion Factor

If things were not bad enough already, recently, CMS published a notice "correcting technical and typographical errors" (don't they proof read this stuff?) in the Medicare CY 2010 physician fee schedule final rule with comment period, published November 25, 2009. Among other things, CMS is correcting the CY 2010 conversion factor because of a technical error in adjusting relative value units to reflect the agency's policy related to the consultation codes. **The change results in the conversion factor being reduced from \$28.4061 to \$28.3895.** You would know that this change is not favorable to us!

Remember this newsletter is a summary of regulations for Medical Oncology. It is a preliminary reading of complex coding and billing material. There may be typos and misinterpretations. You are responsible for the information on every claim. Reading this newsletter does not substitute for understanding regulations and verifying the validity of every claim.

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