MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued after October 1, 1997, are available at no-cost from our provider Web site at *http://medicare.fcso.com/*.

Routing Suggestions:

[ ] Medicare Manager
[ ] Reimbursement Director
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The *Medicare A Bulletin* is published monthly by First Coast Service Options Inc. Provider Outreach and Education division, to provide timely and useful information to Medicare Part A providers.

Questions concerning this publication or its contents may be faxed to:

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THE FCSO MEDICARE A BULLETIN

About the *Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Medicare Part A providers in Florida, Puerto Rico and U.S. Virgin Islands in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important notifications requiring communication in between publications are posted to the FCSO Medicare provider education website *http://medicare.fcso.com.*

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education website. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy. Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

Distribution of the *Medicare Part A Bulletin* in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us*.

For additional copies, providers may purchase a separate annual subscription. A subscription order form may be found at the end of the *Educational Resources* section in each issue. Issues published since January 1997 may be downloaded from the Internet free of charge.

We use the same mailing address for *all* correspondence, and we cannot designate that the *Bulletin* be sent to a specific person/department within a medical facility. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare Provider Enrollment department. **Please remember that address changes must be done using CMS-855A.**

What is in the *Bulletin*?

The bulletin is divided into sections addressing general and coverage guidelines, and facility-specific information:

- Sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities are included in the first part of the publication.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- The *Local Coverage Determination* (LCD) section contains notification of new finalized medical LCDs and additions, revisions, and corrections to previously published LCDs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary.
- As needed, the *Bulletin* contains *Electronic Data Interchange* and *Fraud and Abuse* sections.
- The *Educational Resources* section includes educational events and materials, such as seminar schedules, Medicare provider education website information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

The *Medicare A Bulletin* represents formal notice of coverage policies

Articles included in each *Medicare A Bulletin* represent formal notice that specific coverage policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries.

Providers may access the QPU by going to the CMS website at *http://www.cms.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU. ❖

GENERAL INFORMATION

Completing and processing Form CMS-1450 data set

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Hospitals, home health agencies (HHA), hospices, skilled nursing facilities (SNF), and other providers submitting UB-04 claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

What you need to know

The *Medicare Claims Processing Manual*, Chapter 25 – Completing and Processing the Form CMS-1450 Data Set, is being revised to reference external code sources as is currently done in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Health Care Claim: Institutional (837) Implementation Guide. Providers submitting UB-04s to Medicare may obtain billing codes from the external code sources, the National Uniform Billing Committee (NUBC), or from their Medicare contractor. The Centers for Medicare & Medicaid Services (CMS) will continue to communicate specific code implementation direction via change requests (CRs) as it does today. Specifically, the manual changes are made to include the following language:

- Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC in their official UB-04 Data Specifications Manual available at http://www.nubc.org on the Internet.
- Health insurance prospective payment system (HIPPS) rate codes/ modifiers/assessment type indicators and Healthcare Common Procedure Coding System (HCPCS) modifiers used for Medicare claims are available from Medicare contractors.

Additional information

The official instruction issued to your Medicare contractor regarding this change may be viewed on the CMS website at http://www.cms.gov/Transmittals/downloads/R1973CP.pdf.

If you have questions, please contact your Medicare contractor (FI, RHHI or A/B MAC at their toll-free number which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6907
Related Change Request (CR) Number: 6907
Related CR Release Date: May 21, 2010
Related CR Transmittal Number: R1973CP
Effective Date: September 1, 2010
Implementation Date: September 1, 2010

Source: CMS Pub. 100-04, Transmittal 1973, CR 6907

Claims receiving reason codes 31259, 37540, or 37541

First Coast Service Options Inc. has completed researching the issue that occurs when customers are attempting to correct/ adjust non-Medicare secondary payer claims via direct data entry (DDE) and are receiving reason code 31259, 37540, and/or 37541.

A change to the Part A system is required in order to correct this issue. Until this change is implemented, corrections or adjustments may continue to be submitted via electronic media claims (EMC). At this time, we do not have an estimated completion date.

We continue to ask that you refrain from contacting the provider contact center or DDE support. Additional information will be provided on the provider education website as it becomes available.

We apologize for any inconvenience this has caused. ❖

Guidelines for processing appeals via facsimile or via secure Internet portal/application

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, providers, and suppliers submitting Medicare fee-for-service (FFS) claim appeal requests to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]).

Provider action needed

Stop – impact to you

This article is based on change request (CR) 6958, which updates the current instructions in the *Medicare Claims Processing Manual*, Chapter 29, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application.

Caution – what you need to know

CR 6958 provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via facsimile and/or via a secure Internet portal/application. At this time, Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must seek approval from the Centers for Medicare & Medicaid Services (CMS) prior to implementation of that portal/application.

Go – what you need to do

Note that, even if your contractor allows submission of appeal requests via facsimile and/or via a secure Internet portal/application, the decision to use those venues is yours. Your contractor may not require you to use those venues. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Several Medicare contractors have requested authority from CMS to utilize a secure Internet portal/application to receive and process Medicare FFS claim appeal requests. In addition, several Medicare contractors have begun to accept claim appeal requests received in writing via facsimile.

CR 6958 provides guidance regarding appeal requests received in writing via facsimile or via a secure Internet portal/application, and it provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via these mechanisms.

The purpose of CR 6958 is to update the current instructions in the *Medicare Claims Processing Manual*, Chapter 29 (Appeals of Claims Decisions), to allow Medicare contractors to accept appeal requests via facsimile and/or via a secure Internet portal/application.

CMS does not require its contractors to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application is at the discretion of the appellant. Contractors will continue to accept appeal requests in hard copy via mail. Key portions of CR 6958 for providers are as follows:

What constitutes a request for redetermination

Written requests for redetermination submitted by a state, provider, physician or other supplier

States, providers, physicians, or other suppliers with appeal rights must submit written requests via mail, facsimile (if the contractor chooses to receive requests via facsimile), or, where available, secure Internet portal/application indicating what they are appealing and why. The acceptable written ways of doing this are as follows:

- **A completed Form CMS-20027 (constitutes a request for redetermination)**. The contractor supplies these forms upon request by an appellant. "Completed" means that all applicable spaces are filled out and all necessary attachments are included with the request.
- **A written request not on Form CMS-20027**.

At a minimum, the request shall contain the following information:

- Beneficiary name
- Medicare health insurance claim (HIC) number
- The specific service(s) and/or item(s) for which the redetermination is being requested
- The specific date(s) of the service
- The name and signature of the party or the representative of the party

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either: (1) explicitly asks the contractor to take further action, or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination.

- **A secure Internet portal/application.** If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall include the required elements for a valid appeal request as outlined under Chapter 29, Section 310.1.B.2.b which is attached to CR 6958.

Note: Some redetermination requests may contain attachments. For example, if the remittance advice (RA) is attached to the redetermination request that does not contain the dates of service on the cover and

Guidelines for processing appeals via facsimile or via secure Internet portal/application (continued)

the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Requirements for a valid signature on an appeal request

For appeal purposes, the only acceptable method of documenting the appellant's signature on the appeal request is by written, digital, digitized, or electronic signature as discussed below:

- **A written signature** may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- **An electronic, digital, and/or digitized signature** is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application. The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, "electronically signed by" or "verified/approved by" etc.
- **A stamp signature or other indication that a "signature is on file"** on the Form CMS 20027 or other documentation (such as a blank claim form) submitted to support the appeal request shall not be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

How contractors will handle multiple requests for redetermination for the same item/service

If a contractor receives multiple timely requests for redetermination for the same item or service from either multiple parties or via multiple venues (i.e., hard copy mail, facsimile, or via a secure Internet portal/application) the contractor acts as follows:

- If a decision or dismissal notice has already been issued or the claim for the item/service at issue has been adjusted/paid in accordance with the redetermination decision and the contractor receives additional redetermination request(s) for the same items/services, the contractors will treat the additional request as an inquiry. Contractors shall not issue a dismissal notice.

  Note: In accordance with the *Medicare Claims Processing Manual* (Chapter 29, Section 310.6.3, which is attached to CR 6958), if an appellant requests that the contractor vacates its dismissal action and the contractor determines that it cannot vacate the dismissal; it sends a letter notifying the appellant accordingly. The contractor shall not issue a second dismissal notice to the appellant since a dismissal should only be issued in response to an appeal request.

- If a decision or dismissal notice has not been issued (i.e., the appeal is pending), and the claim for the items/services at issue has not been otherwise adjusted/paid following the redetermination decision, then upon receipt of additional redetermination request(s) for the same items/services, the contractor shall:

  1. Combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with the requirements as outlined in 42 CFR 405.944(c). See *http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr405.944.pdf*.
  2. When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that multiple requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized) so that it is clear to the appellant that the decision or dismissal was issued timely in accordance with 42 CFR 405.944(c).

- If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting multiple requests for redetermination via multiple venues, the contractor shall take additional steps to educate the appellant regarding the appeals process.

Timely processing requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of the *Medicare Claims Processing Manual*, Chapter 29, Section 310.4(D)(4), which is attached to CR 6958). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties. Affirmations processed via a CMS-approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application.
2. For partial reversals and full reversals, when all of the following actions have been completed:
   - The decision letter, if applicable, is mailed to the parties (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application), and
   - The actions to initiate the adjustment action in the claims processing system are taken.
3. For withdrawals and dismissals, the date that the dismissal notice is mailed (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application) to the parties.

Guidelines for processing appeals via facsimile or via secure Internet portal/application (continued)

The redetermination decision

The law requires contractors to conclude and mail and/or otherwise transmit, as noted below, the redetermination within 60 days of receipt of the appellant's request, as indicated in the *Medicare Claims Processing Manual*, Chapter 29, Section 310.4, which is attached to CR 6958. For unfavorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and appointed representative, if applicable).

Contractors shall provide the decision, as required below; in writing via hard copy mail (unless the contractor has submitted a request and received approval for use of secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically). Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism.

Requirements for use of secure Internet portal/application to support appeals activities

Contractors who develop and utilize a secure Internet portal/application for appeals purposes will ensure, at a minimum:

- CMS approves the proposed portal/application and usage prior to development and implementation.
- Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request (the system must include verbiage instructing the appellant not to submit additional redetermination requests for the same item/service via a different venue).
- The secure Internet portal/application includes a formal registration process that validates the signature and requires, at a minimum, use of restricted user IDs and passwords.
- Templates for submission of electronic appeal requests must include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- Contractors utilizing an approved portal/application must provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.
- Contractors must also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.
- Contractors utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.
- Redetermination decision and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements. In addition, contractors shall provide hard copy decision and/or dismissal notices to parties to the appeal and who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).
- Contractors will also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.

Additional information

The official instruction, CR 6958, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R1986CP.pdf*.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6958
Related Change Request (CR) Number: 6958
Related CR Release Date: June 11, 2010
Related CR Transmittal Number: R1986CP
Effective Date: October 1, 2010
Implementation Date: October 1, 2010

Source: CMS Pub. 100-04, Transmittal 1986, CR 6958

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010

The President signs the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 – 2.2 percent Medicare physician fee schedule update for June 1, 2010, through November 30, 2010

On June 25, 2010, President Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010." This law establishes a 2.2 percent update to the Medicare physician fee schedule (MPFS) payment rates retroactive from June 1 through November 30, 2010.

The Centers for Medicare & Medicaid Services (CMS) has directed Medicare claims administration contractors to discontinue processing claims at the negative update rates and to temporarily hold all claims for services rendered June 1, 2010, and later, until the new 2.2 percent update rates are tested and loaded into the Medicare contractors' claims processing systems. Effective testing of the new 2.2 percent update will ensure that claims are correctly paid at the new rates. CMS expects contractors to begin processing claims at the new rates no later than July 1, 2010. Claims for services rendered prior to June 1, 2010, will continue to be processed and paid as usual.

Claims containing June 2010 dates of service that have been paid at the negative update rates will be reprocessed as soon as possible. Under current law, Medicare payments to physicians and other providers paid under the MPFS are based upon the lesser of the submitted charge on the claim or the MPFS amount. Claims containing June dates of service that were submitted with charges greater than or equal to the new 2.2 percent update rates will be automatically reprocessed. Affected physicians/providers who submitted claims containing June dates of service with charges less than the 2.2 percent update amount will need to contact their Medicare contractor to request an adjustment. Submitted charges on claims cannot be altered without a request from the physician/provider. Physicians/providers should not resubmit claims already submitted to their Medicare contractor. ❖

Source: CMS PERL 201006-42

July 2010 average sales price files available

The Centers for Medicare & Medicaid Services has posted a **revised** July 2010 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. The ASP pricing files for April 2010, January 2010, October 2009, and July 2009 have also been updated. All are available for download at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-41 and PERL 201006-28

July 2010 Healthcare Common Procedure Coding System update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6809 which provides the July 2010 Quarterly Healthcare Common Procedure Coding System (HCPCS) changes. Be sure your billing staff know of these HCPCS code changes as noted below.

Background

The HCPCS code set is updated on a quarterly basis. CR 6809 describes the process for updating these specific HCPCS codes.

Effective for claims with dates of service on or after July 1, 2010, the following HCPCS code will be payable for Medicare:

HCPCS code	Short description	Long description	MPFSDB status indicator
Q2025	Oral fludarabine phosphate	Fludarabine phosphate, oral, 1mg	E

Note that suppliers are currently instructed to bill oral anti-cancer drugs to the DME MACs using the appropriate national drug code (NDC).

In addition, the Centers for Medicare & Medicaid Services (CMS) recently concluded that dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration for this purpose, and then only in HIV infected beneficiaries when facial LDS caused by antiretroviral HIV

July 2010 Healthcare Common Procedure Coding System update (continued)

treatment is a significant contributor to their depression. Consequently, effective for claims with dates of service on or after March 23, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short description	Long description	MPFSDB status indicator
Q2026	Radiesse injection	Injection, Radiesse, 0.1ml	E
Q2027	Sculptra Injection	Injection, Sculptra, 0.1ml	E

Additional information

Medicare contractors will not search their files to reprocess claims already processed, but will adjust such claims that you bring to their attention. The official instruction, CR 6809, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1972CP.pdf*.

If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6809
Related Change Request (CR) Number: 6809
Related CR Release Date: May 21, 2010
Related CR Transmittal Number: R1972CP
Effective Date: July 1, 2010 unless otherwise specified
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1972, CR 6809

New additions to the CMS ICD-10 website section

There are two new additions to the "Latest News" page of the Centers for Medicare & Medicaid Services (CMS) ICD-10 website section. The address for the "Latest News" page is *http://www.cms.gov/ICD10/02b_Latest_News.asp*.

Details of these additions are outlined below.

Latest News page watch

This free service enables you to receive e-mail notifications when the information on "CMS' ICD-10 Latest News" page changes or is updated. If you are interested in receiving this information, please go to the link in the "Related Links Inside CMS" section to subscribe.

Executive summary of CMS' ICD-10 vendor conference now available

On April 27 at the Capitol Hilton Hotel in Washington D.C., CMS held a free, one-day ICD-10 conference for software vendors, billing services and clearinghouses that support the health care industry. Attendees had the opportunity to openly discuss the ICD-10 and version 5010 transitions, including key implementation issues such as testing, and resources that can help make the transition easier.

Vendor conference highlights

- A presentation by Dr. Douglas Fridsma, Acting Director, Officer of Interoperability and Standards, Office of the National Coordinator, on ICD-10 within the broad scope of health reform initiatives.
- Software vendor, billing services, and clearinghouse panels to discuss their high-level view of industry readiness for version 5010 and ICD-10.
- Breakout sessions to explore readiness, barriers, testing, and other issues specific to these three industry segments.

The executive summary of the ICD-10 vendor conference proceedings is now available in the "Downloads" section at the bottom of the page. A link to a video download of a condensed version of the conference's plenary session will be made available within the next few weeks.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-34

Messages regarding prescription drug coverage for Medicare beneficiaries

Medicare helps low-income beneficiaries get big savings on prescription drug costs

Thanks to changes to Medicare's low-income subsidy program (also known as LIS or "extra help") that take effect this year, more Medicare beneficiaries will qualify for "extra help" with their prescription drug costs and will be eligible to pay no more than $2.50 for generic drugs and $6.30 for each brand name drug. These changes make it easier than ever for people with Medicare who have limited income to save on their drug costs.

The Centers for Medicare & Medicaid Services (CMS) estimates that "extra help" can save eligible Medicare beneficiaries as much as $3,900 per year. It is estimated that more than 1.8 million people with Medicare may be eligible for "extra help" but are not currently enrolled to take advantage of these savings.

Changes enacted in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 make it easier for Medicare beneficiaries to qualify for "extra help" by changing the way income and assets are counted in 2010. When determining eligibility for "extra help," the Social Security Administration, who handles enrollment in the program, will no longer count life insurance policies as a resource. In addition, help received from family and friends to pay for household expenses like food, mortgage, rent, and utilities will no longer count as income.

"These changes to the 'extra help' program make it easier for more people to get help paying for their prescription drugs," said Marilyn Tavenner, CMS Principal Deputy Administrator. "Even if you were turned down for 'extra help' before, you should reapply. If you qualify, you will receive help paying for Medicare prescription drug coverage premiums, copayments and deductibles."

To qualify, a Medicare beneficiary's income must be less than $16,245 a year (or $21,855 for married couples) and have resources limited to $12,510 (or $25,010 for married couples). Resources include bank accounts, stocks, and bonds but do not include houses, cars, or life insurance policies.

There is no cost to apply for "extra help." Medicare beneficiaries, family members, trusted counselors or caregivers may apply online at *http://www.socialsecurity.gov/prescriptionhelp* or call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) and ask for the "Application for Help with Medicare Prescription Drug Plan Costs."

Medicare beneficiaries can also receive assistance in their local communities from their State Health Insurance Assistance Program (SHIP). Local SHIP contact information may be found on the back of the Medicare & You 2010 handbook or online at *http://www.medicare.gov/contacts/staticpages/ships.aspx*. Information given will remain confidential.

Most beneficiaries enrolled in a Part D plan whose income is too high to qualify for the "extra help," but who enter the donut hole in 2010, will receive a one-time, tax-free rebate check of $250 to help with high prescription drug costs thanks to the Affordable Care Act. The new law contains some important new benefits to help seniors and others who are caught in the coverage gap. To learn more about the Affordable Care Act and these new benefits through Medicare, visit *http://www.medicare.gov/Publications/Pubs/pdf/11467.pdf*.

These $250 checks will begin to be mailed out to eligible beneficiaries on June 10 and will be sent to beneficiaries soon after they enter the coverage gap. For more information on how to get your rebate check, log on to *http://www.medicare.gov/Publications/Pubs/pdf/11464.pdf*.

The donut hole is the period in the prescription drug benefit in which beneficiaries generally pay 100 percent of the cost of their drugs until they hit the catastrophic coverage. Beneficiaries who qualify for Medicare "extra help" do not have a donut hole.

To learn more about Medicare prescription drug coverage, visit *http://www.medicare.gov*, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Beneficiary information about the $250 Part D rebate

CMS posted the brochure titled "Closing the Prescription Drug Coverage Gap" at *http://www.medicare.gov* (under "What's New"). This brochure describes details about the tax-free, one-time check for $250 for people who enter the Part D donut hole and are not eligible for Medicare extra help. The first checks are being mailed June 10 and checks will be mailed monthly after people have entered the coverage gap.

To help fight fraud and protect beneficiaries from potential scams, Medicare is reminding seniors there are no forms to fill out to receive this benefit. Medicare will automatically send a check.

The envelope will have the U.S. Department of Health and Human Services symbol on it and will say "Medicare Part D." Beneficiaries don't need to provide any personal information. They do not need to provide any personal information like Medicare, social security number, or bank account numbers to get the rebate check. They are reminded not to give any personal information to anyone who calls about the $250 rebate check. People with Medicare should call 1-800-MEDICARE (1-800-633-4227) to report any suspected fraud or scams or with any questions.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-10

Third-party websites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Fraud prevention education campaign launch

The U.S. Department of Health & Human Services, the Centers for Medicare & Medicaid Services (CMS) and the Administration on Aging launch the Fraud Prevention Education Campaign to ensure Medicare beneficiaries are protected from scams.

The campaign kicks off with a $1 million national and ethnic radio advertising campaign targeted around the $250 one time tax-free donut hole rebate check included in the Affordable Care Act.

As eligible seniors who have entered the Medicare Part D donut hole this year begin to receive their tax-free, one time rebate check for $250, the HHS Secretary Kathleen Sebelius and senior officials from the Administration on Aging and CMS launched a national education effort to ensure that seniors have the information they need to protect themselves from potential scams or fraud when it comes to their Medicare benefits.

The national fraud prevention campaign will include radio, television, and print advertising and outreach efforts.

The campaign will begin with a $1 million national radio advertising campaign that will run in June through August as $250 tax-free rebate checks get mailed out to eligible seniors each month. CMS will purchase time in markets with high percentages of Medicare recipients who fall into the donut hole and time on ethnic radio to communicate with groups of seniors who have been particularly targeted by scam artists.

Thirty-second and sixty-second radio spots will be produced in English, Spanish, Korean, and Armenian for the initial radio advertising campaign. English-language spots will begin running in a small number of markets by the end of this week. The number of markets will steadily increase and the national advertising campaign will be completely in place by the end of June.

CMS posted audio files of the English language and Spanish language 60-second spots on the Medicare.gov Web site at *http://www.medicare.gov/*. Scripts for the spots may be found on *http://www.medicare.gov/Default.aspx*.

The press release was posted on June 8, 2010, at *http://www.cms.gov/apps/media/press_releases.asp*.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-11

Third-party websites. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

Banking transition update

The Centers for Medicare & Medicaid Services recently awarded new banking contracts to U.S. Bank and JPMorgan Chase. Medicare providers do not have to take any action. However, providers should be aware that as a result of these new banking contracts, Medicare payments may be made by a different bank than in the past.

The following Medicare claim processing contractors will remain with JPMorgan Chase:

- Cahaba Government Benefit Administrators
- Pinnacle Business Solutions
- First Coast Service Options Inc.
- Palmetto GBA (except for A/B Medicare administrative contractor (MAC) for jurisdiction 1)
- Wisconsin Physician Service

Providers that bill to these contractors will not experience any change.

The following Medicare claim processing contractors will transition to JPMorgan Chase on August 2:

- Palmetto A/B MAC for jurisdiction 1
- Trailblazer

The following contractors will transition to U.S. Bank on August 2:

- Noridian Administrative Services
- CIGNA Government Services
- Highmark Medicare Services
- National Government Services
- NHIC, Corp. ❖

Source: CMS PERL 201005-31

Clinical review judgment

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® article MM6954 to include an additional reference to Chapter 3 of the *Medicare Program Integrity Manual* in the *Additional information* section. All other information remains the same. The article was published in the May 2010 *Medicare A Bulletin* (page 5)**.**

Provider types affected

This impacts all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

What you need to know

CR 6954, from which this article is taken:

- Adds Section 3.14 (Clinical Review Judgment) to the *Medicare Program Integrity Manual*, clarifying existing language regarding clinical review judgments, and
- Requires that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Background

Medicare claim review contractors (carriers, FIs [called affiliated contractors, or ACs], MACs, the comprehensive error rate testing (CERT) contractor, and recovery audit contractors [RACs]), along with program safeguard contractors (PSC) and zone program integrity contractors (ZPIC) are tasked with measuring, detecting and correcting improper payments in the Medicare fee-for-service (FFS) program.

Change request (CR) 6954, from which this article is taken, updates the *Medicare Program Integrity Manual* by adding a new section (3.14 – Clinical Review Judgment) which clarifies existing language regarding clinical review judgments; and also requires that Medicare claim review contractors instruct their clinical review staffs to use the clinical review judgment process when making complex review determinations about a claim.

This clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.,) to create a longitudinal clinical picture of the patient.
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

Note: Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).

Additional information

You may find more information about clinical review judgment by going to CR 6954, located on the CMS website at *http://www.cms.gov/Transmittals/downloads/R338PI.pdf*.

You will find the updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section14 (Clinical Review Judgment) as an attachment to that CR. The original Chapter 3, which contains more information on CMS' medical review processes, is available on the CMS website at *http://www.cms.gov/manuals/downloads/pim83c03.pdf*.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6954 – Revised
Related Change Request (CR) Number: 6954
Related CR Release Date: May 14, 2010
Related CR Transmittal Number: R338PI
Effective Date: April 23, 2010
Implementation Date: June 15, 2010

Source: CMS Pub. 100-08, Transmittal 338, CR 6954

Enhancements to home health consolidated billing enforcement

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® article MM6911 to reflect the revised change request (CR) 6911. In this article, the CR release date and transmittal number were revised. Also, the Web address for accessing CR 6911 was revised. All other information remains the same. The article was published in the May 2010 *Medicare A Bulletin* (pages 17-18).

Provider types affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries during an episode of home health care.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the home health prospective payment system (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

What you need to know

Consolidated billing edit modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, Chapter 10, Section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both "from" and "to" dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item "from" or "to"" date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the "from" and "to." Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the "from" date and the date by which the supplies will be used in the "to" date. When this causes the "to" date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the "from" date on the supply line item falls within a HH episode.

A new file of HH certification information

Chapter 10, Section 20.1 of the *Medicare Claims Processing Manual* describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

G0179 Physician re-certification for Medicare-covered home health services under a plan of care

G0180 Physician certification for Medicare-covered home health services under a plan of care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their request for anticipated payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60 percent or 50 percent payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's common working file (CWF) query screens, Medicare systems will display all certification code dates within nine months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within nine months before the current date as the default response.

Note: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing

Enhancements to home health consolidated billing enforcement continued)

HH episode information, this new information is only as complete and timely as billing by provid**ers** allows it to be. This is particular true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40 percent of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Additional information

The official instruction (CR 6911) issued to your Medicare RHHI/MAC is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1988CP.pdf*.

If you have questions, please contact your Medicare RHHI/MAC at their toll-free number which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6911 – Revised
Related Change Request (CR) Number: 6911
Related CR Release Date: June 14, 2010
Related CR Transmittal Number: R1988CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1988, CR 6911

Preparing for transition to a Medicare administrative contractor

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) has updated the information published under the *MLN Matters* special edition article SE0837 and re-issued as SE1017. The *MLN Matters* special edition article SE1017 is being published in this publication on pages 14-19. The *MLN Matters* special edition article SE0837 was published in the March 2009 *Medicare A Bulletin* (pages 13-17).

MLN Matters® Number: SE0837 – Replaced with SE1017
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters* Article SE0837

Preparing for transition to a Medicare administrative contractor

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) initially issued this information under the *MLN Matters* special edition article SE0837. The *MLN Matters* special edition article SE0837 is being replaced with *MLN Matters* special edition article SE1017 in order to update the content to reflect current experiences with transitions to a MAC.

Provider types affected

All fee-for-service physicians, providers, and suppliers who submit claims to fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), or durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries. However, suppliers billing DME MACs may find the article of value as the Centers for Medicare & Medicaid Services (CMS) re-competes the DME MAC contracts, which could cause a transition from an incumbent DME MAC to a new DME MAC.

Impact on providers

This article is intended to assist all providers that will be affected by MAC implementations (or DME MAC transitions due to re-competing the DME MAC contracts). CMS is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC (or your DME MAC to another DME MAC). Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business. Please note that other Medicare contractors servicing your region will be unaffected by this change, such as the qualified independent contractor (QIC) for

Preparing for transition to a Medicare administrative contractor (continued)

reconsiderations, recovery audit contractor (RAC), the program safeguard contractor (PSC), and the zone program integrity contractor (ZPIC).

Note to DME suppliers:

The remainder of this article focuses on transitions from carriers or FIs to MACs, but suppliers note the information may also pertain to your business if there is a transition from your DME MAC to another DME MAC as those contracts are re-competed.

Background

Medicare contracting reform (or Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B fee-for-service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new MAC authority. Medicare contracting reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare FFS program.

When completed, there will be 15 new MACs processing Part A and Part B claims. Each MAC services a distinct set of contiguous states, also known as a "jurisdiction". Each MAC will handle different volumes of work based upon the geographic breakout of the 15 MACs. Because of this, the MACs will vary in geographic size and the amount of work they handle. Having 15 MACs should result in greater consistency in the interpretation of Medicare policies, which is a key goal of Medicare contracting reform.

MAC implementation milestones/definitions

There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action relative to the milestones defined below:

Award – this is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

Cutover – this is the date on which the carrier or FI work ceases and MAC work begins. Cutover is often done in phases by state-level jurisdictions. Because of the amount of activity involved in a cutover, there may be interrupted services for a day or two.

Outgoing contractor – a Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare contracting reform and whose work will transition to a MAC.

Incoming MAC – the entity that has won a contract under Medicare contracting reform and which will assume the workload that was performed by a carrier or FI.

Pre-award

If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare contracting reform by visiting the CMS website *http://www.cms.gov/medicarecontractingreform/*.

Post-award

Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

Pay attention to the mail you receive from your outgoing Medicare contractor and your new MAC –-you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic funds transfers, appeals, customer service, etc. Focus on necessary actions you must take and the critical due dates assigned, to avoid any disruptions in claims payment.

Sign up for your new MAC's listserv or if you aren't signed up for your current FI or carrier's listserv, please do so immediately. While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Subscribing to the MAC listserv distribution will ensure that you receive news and resource tools as they become available concerning the implementation.

Access and bookmark the MAC's website, particularly any part of the site devoted to information about the MAC transition/ implementation) and visit it regularly. The MAC may have a new website that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.

Review the frequently asked questions (FAQs) on the MAC's website.

Participate in the MAC's advisory groups and "Ask the Contractor" teleconferences. (Note that these advisory groups are usually limited in size.) Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC.

Review the MAC's local coverage determinations (LCDs) as they may be different from the outgoing contractor's LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and website for information regarding potential changes to the LCDs.

Two-three months prior to cutover

- **Complete and return your electronic funds transfer (EFT) agreements**. CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC **and, if you are not on EFT, this may be a good opportunity to consider enrollment in EFT**. (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into

Preparing for transition to a Medicare administrative contractor (continued)

your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and submit it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. If you fail to submit the CMS-588 form as required, the new MAC will place you in a "Do Not Forward" (DNF) status as required by Chapter 1, Section 80.5 of the *Medicare Claims Processing Manual*. Contact your MAC with any questions concerning the agreement.

The CMS-588 form may be found on the CMS Website at *http://www.cms.gov/cmsforms/downloads/CMS588.pdf*.

You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's website. Your current contractor may also provide instructions on its website on accurately completing the form.

- Your new MAC may also request you to execute a new electronic data interchange (EDI) trading partner agreement as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available on the CMS website at *http://www.cms.gov/EducationMaterials/downloads/TradingPartner-8.pdf*.
- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their website for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these submitter IDs and passwords to you in hardcopy or electronically. **You don't need to do anything to get the new IDs**; however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.
- **Contact your claim processing vendor, billing department, and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"
- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.
- Be aware of the last date you can receive and download electronic remittance advices (ERAs) from your outgoing contractor.
- Be aware that some MACs may offer participation in an "early boarding" process for electronic claim submission and/or electronic remittance advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password —watch for and document them for use after cutover to the MAC.

Cutover weekend

Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend (weekend prior to cutover). Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.

Be aware that providers may also experience system **"dark days"** around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to fiscal intermediary standard system (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

Be aware that some interactive voice response (IVR) functionality may also be unavailable during a dark day.

Post-cutover

- The first week or two may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll-free number for use.
- Be prepared that you may experience longer than normal wait times for customer service representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Learn how to use the MAC's IVR**. The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the CSR line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.
- Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's websites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.

Preparing for transition to a Medicare administrative contractor (continued)

- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that there will be changes to PO Boxes and addresses for the submission of requests for redeterminations (appeals), inquiries, and written reopening requests.
- Be aware that the MAC may edit claims differently from your outgoing contractor, so it is important to review your remittance advices (RAs) carefully to identify when this occurs.
- Be aware that you may experience changes in RA coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS post-cutover monitoring

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

Additional assistance

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A is a summary of what you need to do and information you will need;
- Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation, and
- Attachment C may be used to assist you in tracking major MAC milestones.

Additional information

The following *MLN Matters* article provides additional information about the MAC implementation process:

- MM5979: "Assignment of Providers to Medicare Administrative Contractors" located on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/mm5979.pdf*.
- MM6207: "Initial Enrollment Assignment for Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs)", located on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6207.pdf*.

If you have questions, please contact your Medicare carrier, FI, A/B MAC, and/or RHHI, at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

Attachment A

Timeline and checklist for preparing for MAC implementation

Checklist item	Input
Scheduled award date:	
Actual award date:	
MAC contractor:	
MAC contractor number:	
MAC mailing address:	
MAC scheduled dark days:	
MAC website:	
MAC contact center number:	1-800-
MAC EDI mailing address:	

90 days before cutover

1. **Visit** MAC website and bookmark for future use
2. **Join** the MAC listserv
3. **Monitor**: LCDs published by the new MAC; compare current LCD's that affect your practice's services.

Preparing for transition to a Medicare administrative contractor (continued)

4. **Review:**
   - Provider enrollment status for all providers, update as needed.
   - Pay-to address information for practice/providers, update as needed.
5. **Contact:**
   - Your practice management/billing software vendor to determine if your system will be able to send and receive data to/from the new MAC.
   - Claims clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.
   - Your billing department, vendor, or clearinghouse to be sure they are aware of the changes communicated from the incoming and outgoing contractors. To avoid delays in claims submission and processing and appeals requests submission, effective dates must be communicated to your appropriate provider staff and resources.

75 days before cutover

1. Check the MAC's website and/or listserv for outreach programs, educational and informational events, FAQs, and conference calls.
2. Check your state's medical society or local provider organization website for MAC transition information, MAC coordinators.

60 days before cutover

1. Submit CMS-588 – EFT form(s) to the new MAC, if needed.
2. Register for electronic remittance advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample remittance advice (RA). RA codes are standard but use of codes may vary across contractors.

45 days before cutover

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

30 days before cutover

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims if you have not done so by now.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of the MAC website and e-mail from the MAC listserv.

15 days before cutover

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational in the new environment.
3. Collect and record all MAC telephone and fax numbers for: general inquiry customer service, provider enrollment, provider relations, EDI and ERA.
4. Become familiar with the MAC IVR query system by taking advantage of educational opportunities as most IVRs are not available until cutover because new outgoing claims/national provider identification (NPI) information has not been loaded for accessibility.
5. Continue daily monitoring of e-mail from the MAC listserv and the MAC website.

10 days before cutover

1. Address any existing open items.
2. Continue daily monitoring of e-mail from the MAC listserv and the MAC website.

5-10 days after cutover

1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of the MAC listserv.
3. Monitor and follow up on the MAC open item list.

30 days after cutover

1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

Attachment B

Schedule of MAC contractor training classes

Scheduled Date	Title of Class	Attendee

Preparing for transition to a Medicare administrative contractor (continued)

Schedule of MAC conferences

Scheduled Date	Conference Subject	Attendee

Attachment C

Important MAC implementation dates

MAC dark days	
Cutoff date for claims submission to the outgoing contractor	
Last date outgoing contractor will make payment	
Last date outgoing contractor will have telephone/ customer service	
Last date outgoing contractor will send file to bank	
Last date to retrieve ERAs from outgoing contractor	
Date MAC will accept electronic claims	
Date MAC will accept paper claims	
Date MAC will/claim cycle begins	
Date MAC will accept written appeals requests (redeterminations)	
First anticipated MAC payment date	
Date MAC begins customer service	

MLN Matters® Number: SE1017
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source:CMS Special Edition *MLN Matters*® Article SE1017

AMBULANCE SERVICES

Extension of add-ons for ambulance services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Ambulance providers submitting claims to Medicare contractors (fiscal intermediaries [FI], carriers and Medicare administrative contractors [MAC]) for ambulance services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6972, which instructs Medicare contractors to adjust the ambulance fee schedule amounts for ground and air ambulance services for claims with dates of service on or after January 1, 2010, through December 31, 2010.

Any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, should be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period beginning January 1, 2010, and ending on December 31, 2010. Please ensure that your staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 amended the Social Security Act with section 1834(l) (13) (A). This section provided increases in payment rates for covered ground ambulance transports which originated in a rural area in the amount of two percent, and for covered ground ambulance transports which originated in a non-rural area by one percent. This provision was effective for the period July 1, 2004 to January 1, 2007.

Section 146(a) of Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) provided for an increase in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by three percent and for covered ground ambulance transports which originated in urban areas by two percent. These increases were only applicable for claims with dates of service July 1, 2008, through December 31, 2009; however, sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act of 2010 (PPACA) reinstate these provisions on or after January 1, 2010, and before January 1, 2011.

Further, section 146(b) (1) of MIPPA amended the designation of rural areas for air ambulance services. The statute specified that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services should continue to be treated as a rural area for purposes of making air ambulance service payments under the ambulance fee schedule. This statute was also applicable for claims with dates of service July 1, 2008 through December 31, 2009; however, Sections 3105(b) and 10311(b) of the PPACA further amends Section 146(b) (1) of MIPPA to reinstate these provisions for claims with dates of service on or after January 1, 2010, and ending December 31, 2010. Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently re-designated as urban, the Centers for Medicare & Medicaid Services (CMS) has re-established the "rural" indicator on the ZIP code file for air ambulance services, effective January 1, 2010.

In addition, section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) specified that, for services furnished during the period July 1, 2004, through December 31, 2009, the payment amount for the ground ambulance base rate was increased where the ambulance transport originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). Approximately half of all rural areas (rural counties plus Goldsmith areas) were required to include 25 percent of the rural population arrayed in order of population density. The amount of this increase was based on the Department of Health and Human Services Secretary's estimate of the ratio of the average cost per trip for the rural areas comprised of the lowest quartile of population arrayed by density compared to the average cost per trip for the rural areas comprised of the highest quartile of population arrayed by density. CMS determined that the amount of this increase was equal to 22.6 percent. Sections 3105(c) and 10311(c) of ACA further amend Section 1834(l) (12) (A) of the Social Security Act to reinstate this provision for claims with dates of service on or after January 1, 2010, and before January 1, 2011, using the percentage increase that was applicable under this provision to ambulance services during 2009.

Additional information

The official instruction issued to your Medicare contractor regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R706OTN.pdf*.

If you have questions, please contact your Medicare contractor at their toll-free number which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6972
Related Change Request (CR) Number: 6972
Related CR Release Date: May 21, 2010
Related CR Transmittal Number: R706OTN
Effective Date: January 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-20, Transmittal 706, CR 6972

Extension of add-ons for ambulance services (continued)

Ambulance Florida fees

Code	Loc 99	Loc 03	Loc 04	
A0425	$6.87	$6.87	$6.87	
A0425	$6.94	$6.94	$6.94	*
A0426	$251.22	$259.84	$269.01	
A0426	$253.69	$262.39	$271.64	*
A0427	$397.77	$411.42	$425.93	
A0427	$401.67	$415.45	$430.10	*
A0428	$209.35	$216.54	$224.17	
A0428	$211.40	$218.66	$226.37	*
A0429	$334.96	$346.46	$358.67	
A0429	$338.25	$349.86	$362.19	*
A0430	$2.802.46	$2.870.75	$2.943.30	
A0430	$4.203.69	$4.306.12	$4.414.95	*
A0431	$3.258.27	$3.337.66	$3.422.01	
A0431	$4.887.41	$5.006.49	$5.133.02	*
A0432	$366.37	$378.94	$392.30	
A0432	$369.96	$382.66	$396.15	*
A0433	$575.72	$595.48	$616.47	
A0433	$581.36	$601.32	$622.52	*
A0434	$680.39	$703.75	$728.56	
A0434	$687.07	$710.65	$735.70	*
A0435	$8.07	$8.07	$8.07	
A0435	$12.11	$12.11	$12.11	*
A0436	$21.53	$21.53	$21.53	
A0436	$32.30	$32.30	$32.30	*

* Rural rate

Ambulance U.S. Virgin Islands fees

Code	Allowance	
A0425	$6.87	
A0425	$6.94	*
A0426	$229.13	
A0426	$231.37	*
A0427	$362.79	
A0427	$366.34	*
A0428	$190.94	
A0428	$192.81	*
A0429	$305.50	
A0429	$308.50	*
A0430	$2.627.49	
A0430	$3.941.23	*
A0431	$3.054.84	
A0431	$4.582.25	*
A0432	$334.15	
A0432	$337.42	*
A0433	$525.09	
A0433	$530.23	*
A0434	$620.56	
A0434	$626.64	*
A0435	$8.07	
A0435	$12.11	*
A0436	$21.53	
A0436	$32.30	*

* Rural rate

ELECTRONIC HEALTH RECORDS

Web page for electronic health record incentive programs now available

The Centers for Medicare & Medicare Services (CMS) has launched the official Web page for the Medicare & Medicaid electronic health record (EHR) incentive programs, available at *http://www.cms.gov/EHRIncentivePrograms/*. This page provides the most up-to-date, detailed information about the EHR incentive programs.

The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.
Bookmark this page and visit often. On this page, you will learn about who is eligible for the programs, how to register, the definition of meaningful use, upcoming EHR training and events, and much more.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-21

There is no 'one-size-fits-all' in building a nationwide health information network

A message from Dr. David Blumenthal, national coordinator for Health Information Technology.

Private and secure health information exchange enables information to follow the patient when and where it is needed for better care. The federal government is working to enable a wide range of innovative and complementary approaches that will allow secure and meaningful exchange within and across states, but all of our efforts must be grounded in a common foundation of standards, technical specifications, and policies. Our efforts must also encourage trust among participants and provide assurance to consumers about the security and privacy of their information. This foundation is the essence of the Nationwide Health Information Network (NHIN).

The NHIN is not a network per se, but rather a set of standards, services, and policies that enable the Internet to be used for the secure exchange of health information to improve health and health care. Different providers and consumers may use the Internet in different ways and at different levels of sophistication. To make meaningful use possible, including the necessary exchange of information, we need to meet providers where they are, and offer approaches that are both feasible for them and support the meaningful use requirements of the Centers for Medicare & Medicaid Services (CMS) electronic health record incentive programs. As with the Internet, it is likely that what is today considered "highly sophisticated" will become common usage. Moreover, users may engage in simpler exchange for some purposes and more complex exchange for others.

Current NHIN exchange capabilities are the result of a broad and sustained collaboration among federal agencies, large provider organizations, and a variety of state and regional health information organizations that all recognized a need for a high level of interoperable health information exchange that avoided "one-off" approaches. Based on this pioneering work, a subset of these organizations is now actively exchanging information. This smaller group currently includes the Department of Defense, Social Security Administration, Veterans Health Administration, Kaiser Permanente, and MedVirginia. They initially came together to show, on a pilot scale, that this type of highly evolved exchange was possible. Having succeeded, they continue to expand the level of exchange among their group and with their own respective partners in a carefully phased way to demonstrate and learn from these widening patterns of exchange. The robust exchange occurring at this level has several key attributes, including the:

1. Ability to find and access patient information among multiple providers.
2. Support for the exchange of information using common standards.
3. Documented understanding of participants, enabling trust, such as the data use and reciprocal support agreement (DURSA).

Not every organization and provider, however, needs or is ready for this kind of health information exchange today. Nor do the 2011 meaningful use requirements set forth by CMS in the recent proposed rule require it. Direct, securely routed information exchange may meet the current needs of some providers for their patients and their practices, such as receiving lab results or sending an electronic prescription.

To enable a wide variety of providers—from small practices to large hospitals—to become meaningful users of electronic health records in 2011, we need to ensure the availability of a reliable and secure "entry level" exchange option that aligns with the long-range information exchange vision we have for our nation. Such an option should balance the need for a consistent level of interoperability and security across the exchange spectrum with the reality that not all users are at the same point on the path to comprehensive interoperability. In an effort to provide the best customer service possible, the Office of the National Coordinator for Health IT (ONC) will consider what a complete toolkit would be for all providers who want to accomplish meaningful health information exchange.

Broadening the use of the NHIN to include a wider variety of providers and consumers who may have simpler needs for information exchange, or perhaps less technically sophisticated capabilities, is critical to bolstering health information exchange and meeting our initial meaningful use requirements. Building on the solid foundation established through the current exchange group mentioned above and the recommendations of the HIT policy committee (which originated with the committee's NHIN workgroup), ONC is exploring this expansion of NHIN capabilities to find solutions that will work across different technologies and exchange models.

The newly launched NHIN Direct project is designed to identify the standards and services needed to create a means for direct electronic communication between providers, in support of the 2011 meaningful use requirements. It is meant to enhance, not replace, the capabilities offered by other means of exchange. An example of this type of exchange would be a primary care physician sending a referral and patient care summary to a specialist electronically.

We are on an aggressive timeline to define these specifications and standards and to test them within real-world settings by the end of 2010. Timing is critical so that we may provide this resource to a broader array of participants in health information exchange as a wave of new, meaningful users prepare to qualify for incentives provided for in the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and ultimately defined by CMS. This model for exchange will meet current provider needs within the broader health care community, complement existing NHIN exchange capabilities, and strengthen our efforts toward comprehensive interoperability across the nation.

A natural evolution in NHIN capabilities to support a variety of health information exchange needs is being reinforced by trends that are leading us toward widespread multi-point interoperability. The current movement toward

There is no 'one-size-fits-all' in building a nationwide health information network (continued)

consolidation in health care, coupled with health reform's encouragement of bundled payments for coordinated care, will mean more providers need it. Quality improvement, public health, research, and a learning health care system all require it. Ultimately, simple exchange will be part of a package of broader functions that allows any provider, and ultimately consumers, to exchange information over the Internet, enabled by NHIN standards, services, and policies.

Your continued input will help guide us toward and maintain a direction that is in harmony with the rapid innovations in health IT today. The NHIN Direct project will conduct an open, transparent, and collaborative process throughout its development by using a community wiki, blogs, and open source implementation already available on the project's website (*http://nhindirect.org*). I encourage you to participate through the website, via public participation at the implementation group meetings, and by deploying and testing the resulting standards and specifications. For those of you who are participants in the current exchange group, I urge you to take every opportunity to share your experiences. Lessons learned from the NHIN direct project and the exchange group will inform the evolution of the NHIN as new uses and users come forward, and as continued innovation occurs to meet the growing needs of our community.

As we head into the next stage in the development of nationwide health information exchange, we should all take a moment to reflect on how far we have come and evaluate our plans for the future. ONC is committed to providing resources and guidance to stakeholders at all levels of exchange through HITECH programs, such as the Health IT regional extension centers, the national Health IT Research Center, and the State Health Information Exchange Program. As you assess your own needs for exchange, please take advantage of the many federal resources available to you on the ONC website and the online resources of the programs mentioned above, as well as through the "NHIN University " education program hosted by our public-private partner, the National *e*Health Collaborative.

We have done a great deal of work in the short period of time since the passage of the HITECH Act. We at ONC appreciate your willingness to stay engaged and involved in every step of our journey, and we look forward to our continuing collaboration to improve the health and well-being of our nation.

Sincerely,

David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health & Human Services

The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology.

Source: CMS PERL 201005-35

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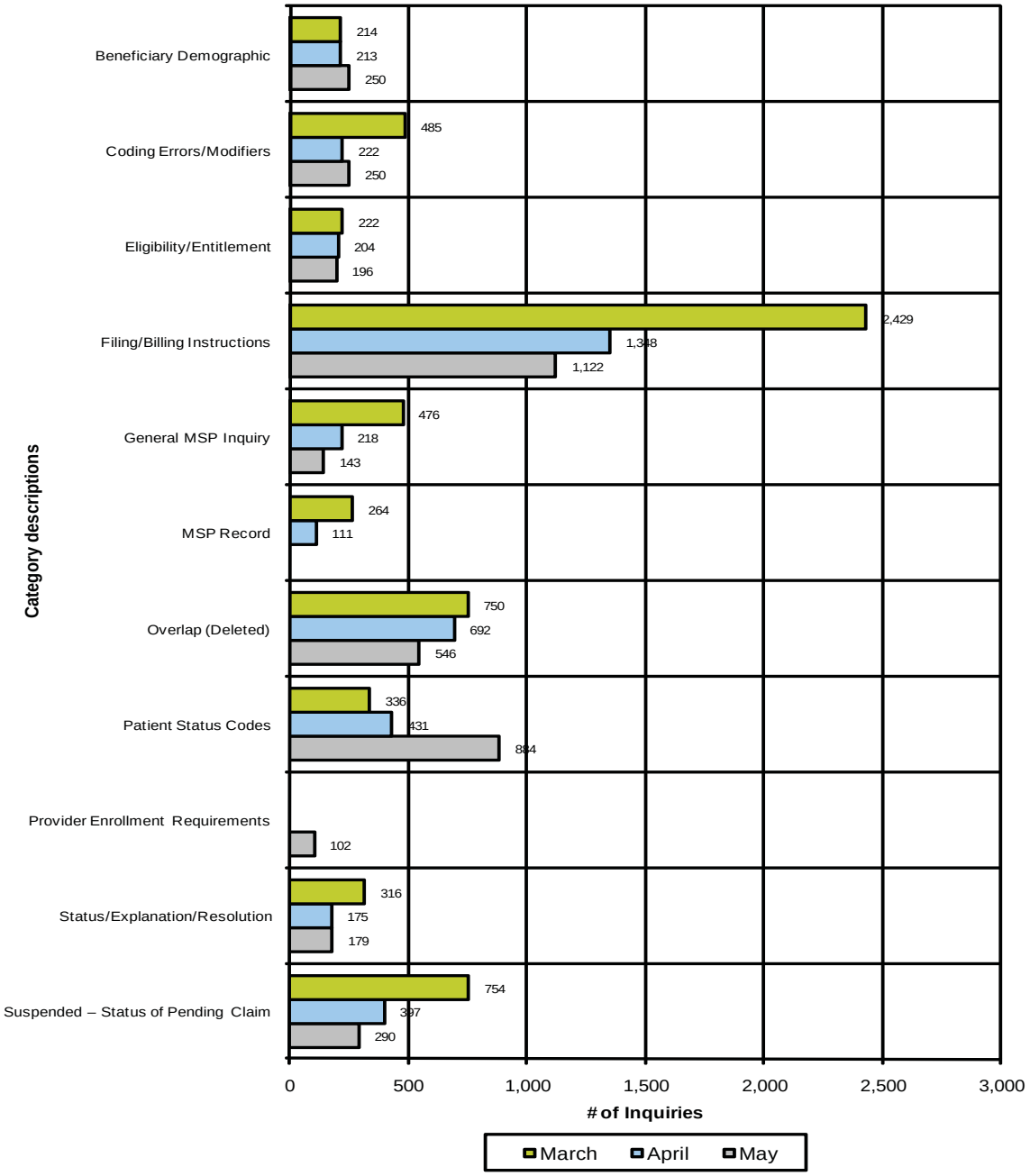
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for March-May 2010

The following charts demonstrate the available top number of inquiries, the top reason codes for return to providers (RTPs), and reject claims submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during March-May 2010.

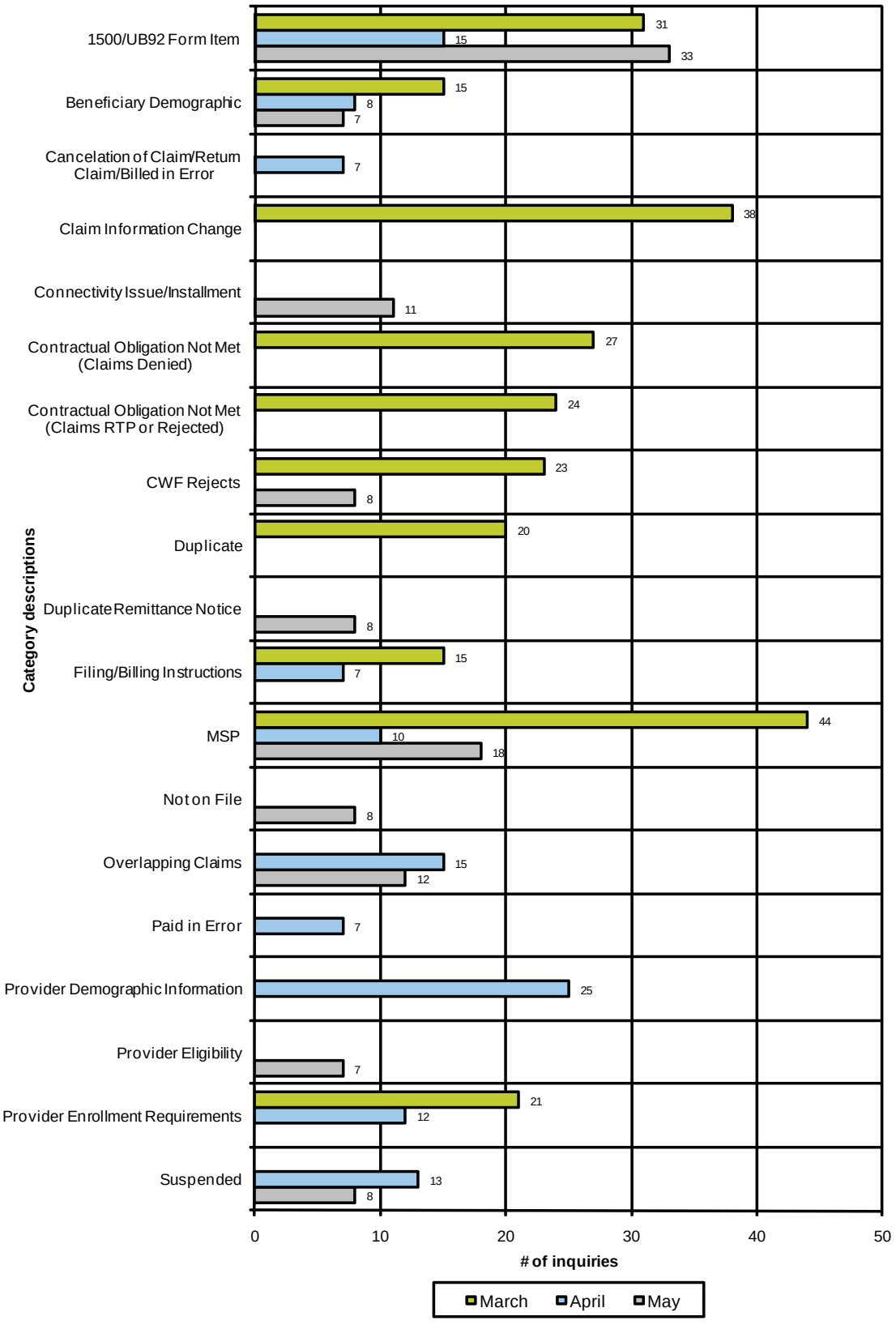
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for March-May 2010



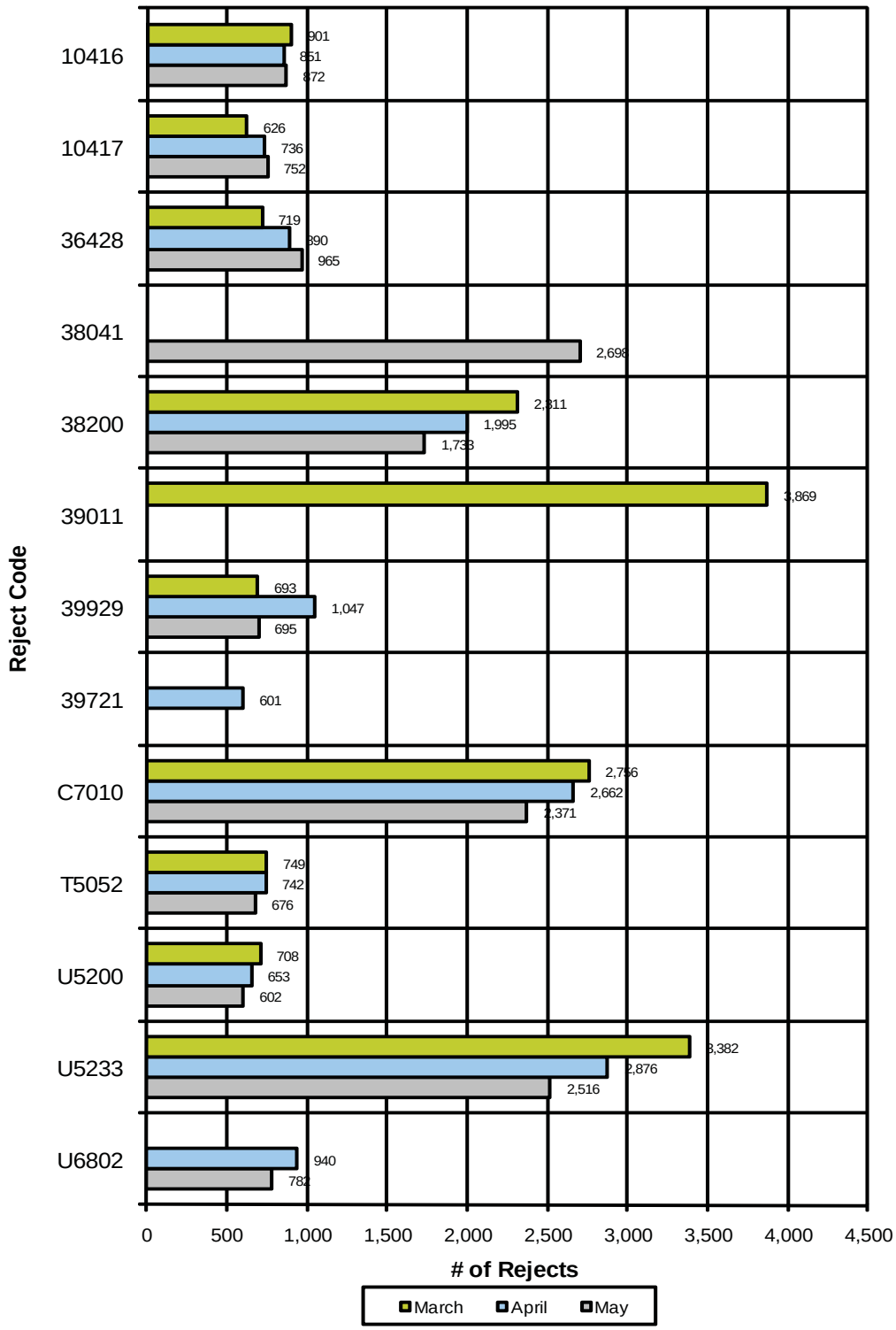
Top inquiries, return to provider, and reject claims for March-May 2010 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for March-May 2010



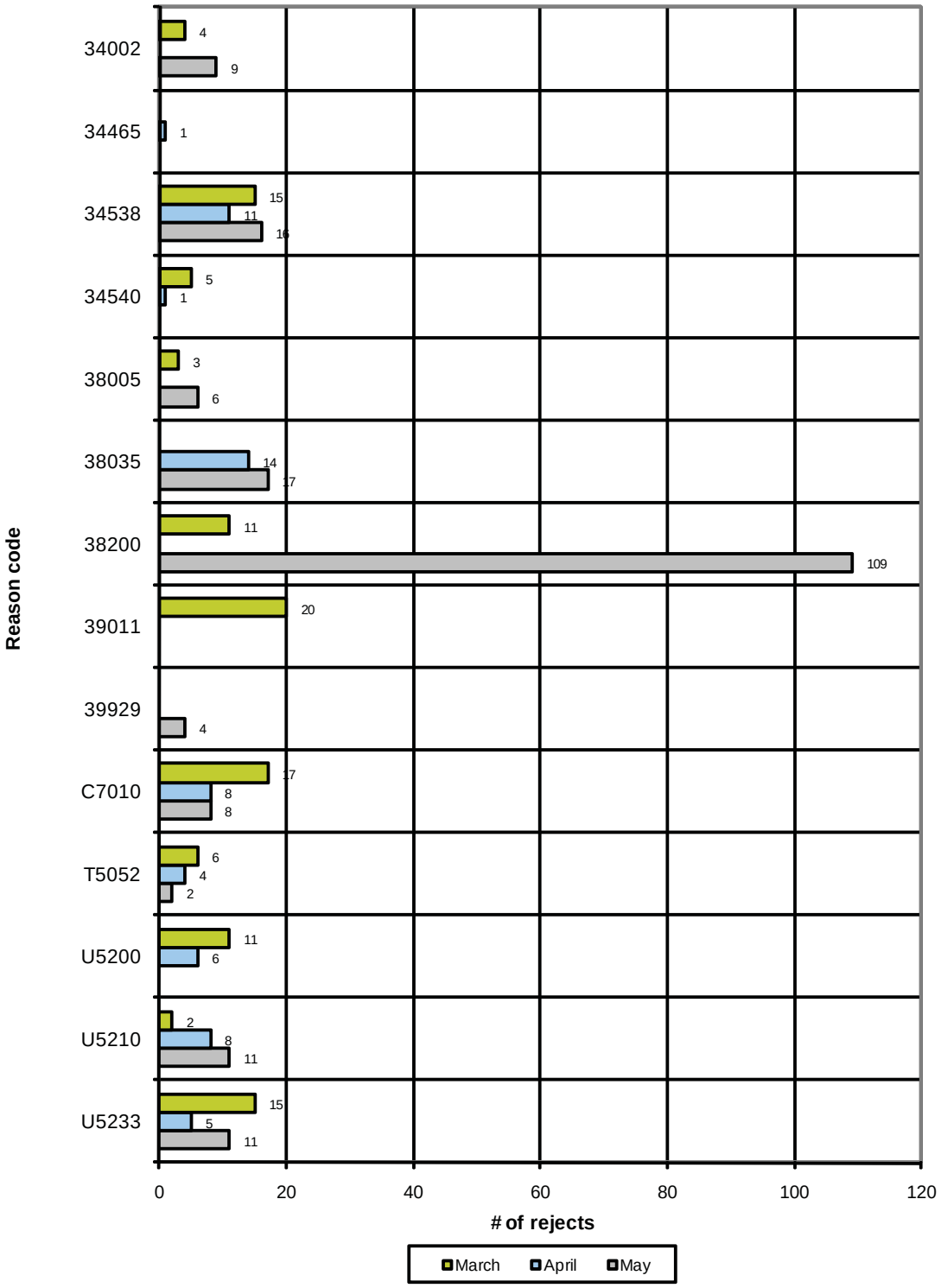
Top inquiries, return to provider, and reject claims for March-May 2010 (continued)

Florida Part A top rejects for March-May 2010



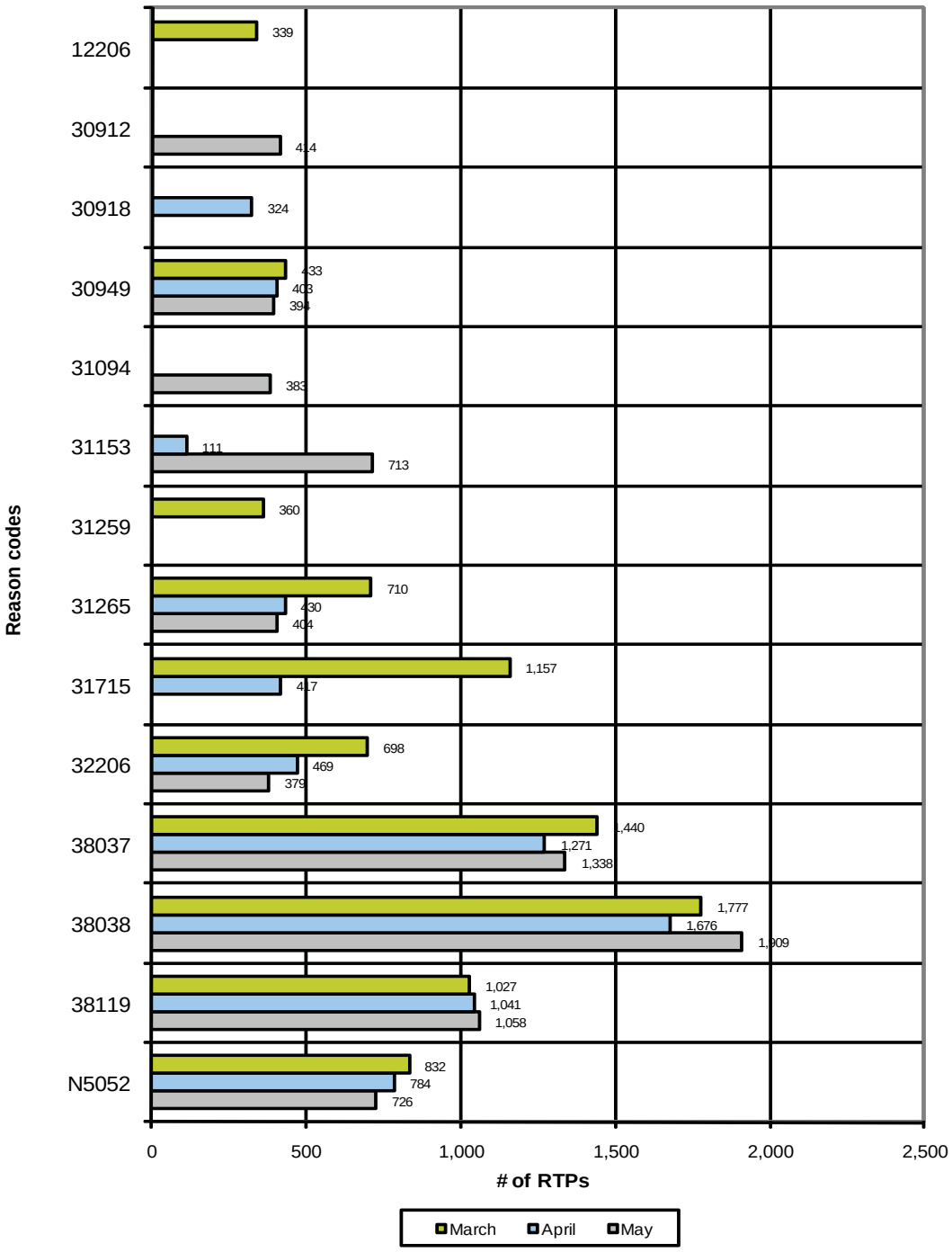
Top inquiries, return to provider, and reject claims for March-May 2010 (continued)

U.S. Virgin Islands Part A top rejects for March-May 2010



Top inquiries, return to provider, and reject claims for March-May 2010 (continued)

Florida Part A top return to providers (RTPs) for March-May 2010

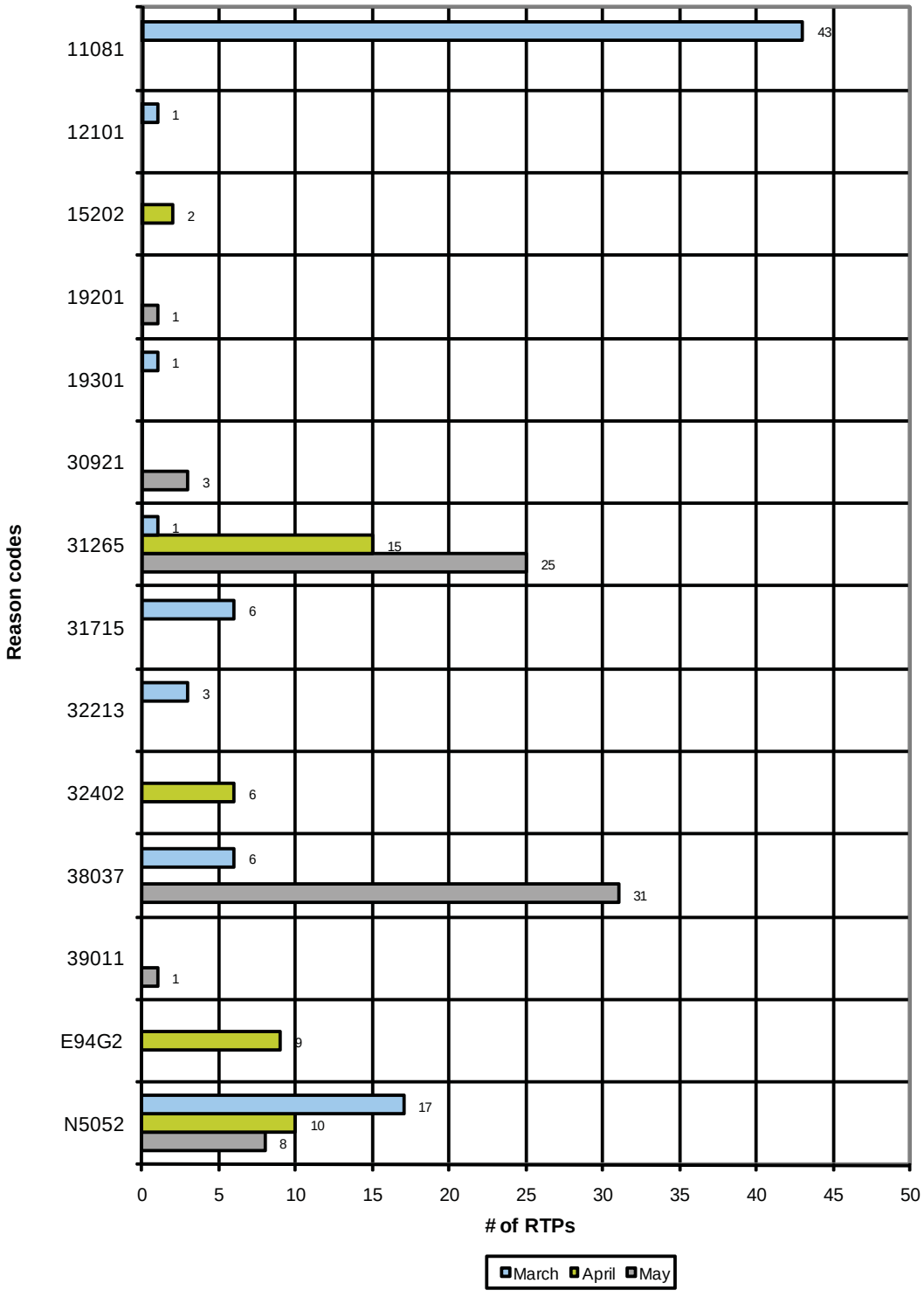


Keep Informed

Join *e-News*, FCSO e-mailing list to receive the most current revisions and updates. Check our upcoming provider events calendar and learn how to register for free teleconferences and webcasts that will help you increase your knowledge of the Medicare program and find ways to improve Medicare billing and payment efficiency.

Top inquiries, return to provider, and reject claims for March-May 2010 (continued)

U.S. Virgin Islands Part A top return to providers (RTPs) for March-May 2010



GENERAL COVERAGE

Collagen meniscus implant

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, nonphysician practitioners (NPPs) and facilities that bill Medicare carriers, fiscal intermediaries (FIs), and/or Medicare administrative contractors (MACs) for services related to the collagen meniscus implant procedure for Medicare beneficiaries.

What you need to know

This article pertains to change request (CR) 6903 and announces that claims submitted for a collagen meniscus implant procedure will be denied. Also, effective with the July updates of the Medicare physician fee schedule database (MPFSDB) and the integrated outpatient code editor (I/OCE), a new HCPCS code, G0428 (Collagen or other tissue engineered meniscus knee implant procedure for filling meniscal defects [e.g. collagen scaffold, Menaflex]), will be available for use in noncovering collagen meniscus implant procedure claims with dates of service on and after May 25, 2010.

Background

The Centers for Medicare & Medicaid Services (CMS) concluded that the evidence demonstrates that the collagen meniscus implant does not improve health outcomes. Thus, CMS determined that the collagen meniscus implant is not reasonable and necessary for the treatment of meniscal injury/tear and is noncovered by Medicare, as identified in section 150.12 of the *National Coverage Determination* (*NCD*) *Manual*. That section of the NCD manual is available as an attachment to CR 6903.

This is a new NCD as there was no existing NCD on collagen meniscus implants. On August 27, 2009, CMS initiated a national coverage analysis (NCA) on the collagen meniscus implant. The collagen meniscus implant is manufactured from bovine collagen and is used to fill a meniscal defect that results from a partial meniscectomy. CR 6903 communicates the findings of that analysis. Upon completion of a NCA for the collagen meniscus implant, the decision was made that the collagen meniscus implant is noncovered for Medicare beneficiaries.

Key points of change request 6903

- Effective for dates of service on and after May 25, 2010, claims submitted for a collagen meniscus implant procedure will be denied.
- In denying such claims, Medicare will use claim adjustment reason code 96 (Non-covered charge(s)" and remittance advice remark code N386 (This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/mcd/search.asp*. If you do not have access, you may contact the local contractor to request a copy of the NCD.) In addition, Medicare contractors will use group code PR (patient responsibility) assigning financial liability to the beneficiary if a signed advance beneficiary notice (ABN) is on file; otherwise, group code CO (contractual obligation) will be used assigning financial liability to the provider if no signed ABN is on file.
- Your contractor will not search their files to recover payment for claims paid prior to implementing CR 6903.

However, they will adjust such claims that are brought to their attention.

Additional information

The official instruction, CR 6903, issued to your Medicare FI, carrier and/or MAC regarding this change may be viewed on CMS website at *http://www.cms.gov/Transmittals/downloads/R121NCD.pdf* (for the *NCD Manual* revision) and *http://www.cms.gov/Transmittals/downloads/R1977CP.pdf* (for claims processing instructions).

If you have questions, please contact your Medicare FI, carrier and/or MAC at their toll-free number which may be found on CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6903
Related Change Request (CR) Number: 6903
Related CR Release Date: May 28, 2010
Related CR Transmittal Number: R121NCD and R1977CP
Effective Date: May 25, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1977, CR 6903

Cardiac rehabilitation and intensive cardiac rehabilitation

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, hospitals, and other providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, and Part A/B Medicare administrative contractors [A/B MAC]) for cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) program services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 6850, from which this article is taken, announces that, effective January 1, 2010, Medicare Part B pays for CR and ICR programs, and related items and services if specific criteria are met by the Medicare beneficiary, the CR/ICR program itself, the setting in which is it administered, and the physician administering the program. Please see the *Background* section for details.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 established coverage provisions for CR and ICR programs. The Centers for Medicare & Medicaid Services (CMS) implemented the MIPPA CR and ICR statutory coverage provisions through rule making, in the calendar year (CY) 2010 physician fee schedule (PFS), by adding Section 410.49 (Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage) to the *Public Health Code of Federal Regulations* (42 CFR).

The regulation at 42 CFR 410.49 includes all coverage provisions for CR and ICR items and services, identifies definitions, covered indications, settings, physician supervision requirements, and physician standards, required CR and ICR components, limitations to the number of sessions covered, and the period of time over which the sessions may be covered.

On October 30, 2009, the CY 2010 PFS final rule with comment was finalized and put on display and is available at *http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf*.

The final rule was published in the *Federal Register* on November 25, 2009, and is available on pages 62004-62005.

ICR services means a physician-supervised program that furnishes the same items/services under the same conditions as a CR program but must also demonstrate through peer-reviewed published research that it improves patients' cardiovascular disease through specific outcome measurements that are described in 42 CFR 410.49(c).

CR 6850 provides specific criteria for CR/ICR programs, outlined as follows:

CR/ICR program beneficiary coverage requirements (effective January 1, 2010)

Medicare Part B covers CR and ICR program services for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months
- A coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- A heart or heart-lung transplant, or
- Other cardiac conditions as specified through a national coverage determination (NCD) (CR only).

CR/ICR program component requirements

Covered CR and ICR programs must include the following components:

- **Physician-prescribed exercise** – this physical activity includes aerobic exercise combined with other types of exercise (i.e., strengthening, stretching) as determined to be appropriate for individual patients by a physician each day CR/ICR items/services are furnished.
- **Cardiac risk factor modification** – this includes education, counseling, and behavioral intervention, tailored to the patients' individual needs.
- **Psychosocial assessment** – this assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation. It should include: (1) an assessment of those aspects of the individual's family and home situation that affects the individual's rehabilitation treatment, and, (2) a psychosocial evaluation of the individual's response to, and rate of progress under, the treatment plan.
- **Outcomes assessment** – these should include: (i) minimally, assessments from the commencement and conclusion of CR/ICR, based on patient-centered outcomes which must be measured by the physician immediately at the beginning and end of the program, and, (ii) objective clinical measures of the effectiveness of the CR/ICR program for the individual patient, including exercise performance and self-reported measures of exertion and behavior.
- **An individualized treatment plan** – this plan should be written and tailored to each individual patient and include (i) a description of the individual's diagnosis; (ii) the type, amount, frequency, and duration of the CR/ICR items/services furnished; and (iii) the goals set for the individual under the plan. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

Frequency limitations

CR sessions are limited to a maximum of two one-hour sessions per day (up to 36 sessions, over a period of up to 36 weeks), with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor under section 1862(a)(1)(A) of the Social Security Act.

ICR sessions are limited to 72 one-hour sessions, up to six sessions per day, over a period of up to 18 weeks.

CR/ICR program setting requirements

CR/ICR services must be furnished in a physician's office or a hospital outpatient setting (for ICR, the hospital outpatient setting must provide ICR using

Cardiac rehabilitation and intensive cardiac rehabilitation (continued)

an approved ICR program). All settings must have a physician immediately available and accessible for medical consultations and emergencies at all times when items/services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26, and for hospital outpatient services as specified at 42 CFR 410.27.

CR/ICR program physician requirements

Physicians responsible for CR/ICR programs are identified as medical directors who oversee or supervise the CR/ICR program at a particular site. The medical director, in consultation with staff, is involved in directing the progress of individuals in the program. The medical director, as well as physicians acting as the supervising physician, must possess all of the following: (1) expertise in the management of individuals with cardiac pathophysiology, (2) cardiopulmonary training in basic life support or advanced cardiac life support, and (3) license to practice medicine in the state in which the CR/ICR program is offered. Direct physician supervision may be provided by a supervising physician or the medical director.

ICR program approval requirements

All prospective ICR programs must be approved by CMS through the NCD process. To be approved, an ICR program must demonstrate through peer-reviewed, published research that it:

- Accomplished one or more of the following for its patients: (i) positively affected the progression of coronary heart disease, (ii) reduced the need for coronary bypass surgery, or, (iii) reduced the need for percutaneous coronary interventions, and
- Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services: (i) low density lipoprotein, (ii) triglycerides, (iii) body mass index, (iv) systolic blood pressure, (v) diastolic blood pressure, and, (vi) the need for cholesterol, blood pressure, and diabetes medications.

Once an ICR program is approved through the NCD process, all prospective ICR sites that want to furnish ICR items/services via the approved program must enroll with their local Medicare contractor to become an ICR program supplier using the designated forms at 42 CFR 424.510, and report specialty code 31 (single or multi-specialty group practice) in order to be identified as an enrolled ICR supplier.

Note: For purposes of appealing an adverse determination concerning site approval, an ICR site is considered a supplier (or prospective supplier) as defined in 42 CFR 498.2**.**

A list of approved ICR programs, identified through the NCD process, will be posted to the CMS website and listed in the *Federal Register*.

Claim processing requirements

The following requirements all pertain to claims for CR and /or ICR services with dates of service on and after January 1, 2010.

Your carrier or MAC will pay claims containing the following professional claims containing Healthcare Common Procedure Coding System (HCPCS) codes:

93797 *Physician services for outpatient cardiac rehabilitation; without continuous electrocardiographic (ECG) monitoring (per session)*

93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring [per session]*

G0422 Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per session

G0423 Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per session (only when billed with place of service codes 11 [services provided in a physician's office] or 22 [services provided in a hospital outpatient setting].

All professional claims for CR/ICR services containing any other POS codes will be denied using the following:

Remittance advice remark code (RARC) N428 – "Service/procedure not covered when performed in this place of service"

Claim adjustment reason code (CARC) 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present"

If the claim is received with a modifier GA indicating a signed advance beneficiary notice (ABN) is on file, group code PR (patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN is on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Your FI or MAC will pay institutional claims containing HCPCS *93797*, *93798*, G0422, and G0423 on types of bill (TOB) 13x under the hospital outpatient prospective payment system (OPPS) and 85x on reasonable cost. They will pay for CR/ICR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (HSCRC) on an outpatient basis (TOBs 13x) in accordance with the terms of the Maryland waiver. Claims for G0422 and G0423 from method II critical access hospitals should be billed on TOB 85x with revenue codes 96x, 97x, or 98x.

They will deny claims for CR/ICR services (HCPCS codes *93797, 93798*, G0422, and G0423) for services that are provided in other than TOBs 13x and 85x using:

RARC N428 – "Service/procedure not covered when performed in this place of service"

CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 832 healthcare policy identification segment (loop 2110 service payment information REF), if present"

If the claim is received with a modifier GA indicating a signed ABN is on file, group code PR

Cardiac rehabilitation and intensive cardiac rehabilitation (continued)

(patient responsibility) is used or if the claim contains the modifier GZ indicating no ABN is on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Your contractors will deny both professional and institutional claims for CR services that exceed two units per date of service, or six units per date of service for ICR, using:

CARC 119 – "Benefit maximum for this time period or occurrence has been reached"

RARC N362 – "The number of days or units exceeds our acceptable maximum"

If the claim is received with **modifier GA** indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the **modifier GZ** indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Medicare will pay for HCPCS codes *93797* and *93798* for CR services that exceed 36 sessions when the **modifier KX** is on the claim. However, Medicare contractors will deny claims for over 36 sessions of CR services without **modifier KX** and, in doing so, will use the following:

CARC 151 – "Payment adjusted because the payer deems the information submitted does not support this many/ frequency of services"

RARC N435 – "Exceeds number/frequency approved / allowed within time period without support documentation"

If the claim is received with **modifier GA** indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the **modifier GZ** indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Your contractors will deny ICR claims (G0422 and G0423) that exceed 72 sessions within 126 days from the date of the first session unless the **modifier KX** is on the claim. In denying such claims, they will use:

CARC 119 – "Benefit maximum for this time period or occurrence has been reached"

RARC N435 – "Exceeds number/frequency approved / allowed within time period without support documentation"

If the claim is received with **modifier GA** indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the **modifier GZ** indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Contractors will only pay for ICR services when submitted by providers enrolled as supplier specialty code 31 (intensive cardiac rehabilitation). ICR services submitted by providers enrolled as other than specialty code 31 will be denied using:

CARC 8 – "The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present"

RARC N95 – "This provider type may not bill this service"

If the claim is received with **modifier GA** indicating a signed ABN is on file, group code PR (patient responsibility) is used or if the claim contains the **modifier GZ** indicating no ABN on file, group code CO (contractual obligation) is used to assign financial liability to the provider.

Finally, your contractors will not research and adjust any CR or ICR claims (HCPCS *93797*, *93798*, G0422, and G0423), processed prior to the implementation of CR 6850; however, they will adjust claims that you bring to their attention.

Additional information

You may find more information about CR and ICR services by going to CR 6850, which was issued in four transmittals as follows:

- Transmittal R1974CP modified the *Medicare Claims Processing Manual* and is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1974CP.pdf*.
- Transmittal R126BP modified the *Medicare Benefit Policy Manual* at *http://www.cms.gov/Transmittals/downloads/R126BP.pdf*.
- Transmittal R339PI modifies the *Medicare Program Integrity Manual* at *http://www.cms.gov/Transmittals/downloads/R339PI.pdf*.
- Transmittal R170FM modifies the *Medicare Financial Management Manual* at *http://www.cms.gov/Transmittals/downloads/R170FM.pdf*.

If you have any questions, please contact your FI, carrier, or MAC at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6850
Related Change Request (CR) Number: 6850
Related CR Release Date: May 21, 2010
Related CR Transmittal Number: R1974CP, R126BP, R339PI, and R170FM
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1974, CR 6850

Pulmonary rehabilitation services

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (Medicare administrative contractors [A/B MACs], fiscal intermediaries [FIs] and/or carriers) for pulmonary rehabilitation (PR) services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6823 which alerts providers that the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added payment and coverage improvements for patients with chronic obstructive pulmonary disease (COPD) and other conditions effective January 1, 2010. As a result, Medicare provides a covered benefit for a comprehensive PR program under Medicare Part B effective for services on or after January 1, 2010. Be certain your billing staffs are aware of these Medicare changes and of the claims processing system changes to handle claims for PR services that must be implemented no later than October 4, 2010.

Background

Pulmonary rehabilitation (PR) is a multi-disciplinary program of care for patients with chronic respiratory impairment who are symptomatic and often have decreased daily life activities.

A PR program is individually tailored and designed to optimize physical and social performance and autonomy. The program must provide an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory impairment. In September 2007, the Centers for Medicare & Medicaid Services (CMS), in its final decision memorandum for PR Services, announced there was no basis for a national coverage determination at that time. Specifically, this decision was based on a determination by CMS that the Social Security Act did not expressly define a comprehensive PR program as a Part B benefit, and the evidence was not adequate to draw conclusions on the benefit of the individual components of PR. CMS did (and still does) cover medically reasonable and necessary respiratory treatment services in comprehensive outpatient rehabilitation facilities (CORFs), as well services to patients with respiratory impairments who are not eligible for PR but for whom local contractors determine respiratory treatment services are covered. MIPPA added payment and coverage improvements for patients with COPD and other conditions, and now provides a covered benefit for a comprehensive PR program under Medicare Part B effective January 1, 2010. This law authorizes a PR program, which was codified in the physician fee schedule calendar year 2010 final rule at 42 CFR 410.47.

Key points of change request 6823

Effective January 1, 2010, MIPPA provisions added a physician-supervised, comprehensive PR program. Medicare will pay for up to two one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of PR. The PR program must include the following mandatory components:

1. Physician-prescribed exercise
2. Education or training
3. Psychosocial assessment
4. Outcomes assessment
5. An individualized treatment plan.

The following bullet points detail Medicare claim processing requirements for PR services furnished on or after January 1, 2010:

- Effective January 1, 2010, Medicare contractors will pay claims containing Healthcare Common procedure Coding System (HCPCS) code G0424 when billing for PR services, including exercise and monitoring, as described in the *Medicare Benefit Policy Manual*, Chapter 15, Section 231, as revised by CR 6823, and the *Medicare Claims Processing Manual*, Chapter 32, Section 140, as revised by CR 6823. These revised documents are attached to CR 6823, which are available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R124BP.pdf* (*Medicare Benefit Policy Manual*) and *http://www.cms.gov/Transmittals/downloads/R1966CP.pdf* (*Medicare Claims Processing Manual*).
- Medicare contractors will pay claims for HCPCS code G0424 (PR) only when services are provided in the following places of service (POS): 11 (physician's office) or 22 (hospital outpatient). Medicare will deny claims for HCPCS code G0424 performed in other than, and billed without, POS 11 or 22, using the following:
  - Claim adjustment reason code (CARC) 58 – "treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 healthcare policy identification segment (loop 2110 Service Payment Information REF), if present."
  - Remittance advice remark code (RARC) N428 – "Service/procedure not covered when performed in this place of service."
  - Group code PR (patient responsibility) assigning financial liability to the patient if the claim was received with **modifier GA** indicating a signed advance beneficiary notice (ABN) is on file or group code CO (contractual obligation) assigning financial liability to the provider if the claim is received with **modifier GZ** indicating no signed ABN on file.
- Medicare contractors will pay claims for PR services containing HCPCS code G0424 and revenue code 0948 on types of bill (TOB) 13x and 85x under reasonable cost.
- Contractors will pay for PR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission on an outpatient basis, TOB 13x, in accordance with the terms of the Maryland waiver.

Pulmonary rehabilitation services (continued)

- Contractors will deny claims for PR services provided in other than TOB 13x and 85x using the following:
  - CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present."
  - RARC N428 – "Service/procedure not covered when performed in this place of service."
  - Group code PR assigning financial liability to the patient if the claim was received with **modifier GA** indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with **modifier GZ** indicating no signed ABN on file.
- Using the Medicare physician fee schedule, Medicare contractors will also pay for PR services billed with HCPCS code G0424 and revenue code 096x, 097x, or 098x on TOB 85x from method II critical access hospitals (CAHs).
- Medicare will deny PR services that exceed two units on the same date of service and, in doing so, will use the following:
  - CARC 119 – "Benefit maximum for this time period or occurrence has been reached."
  - RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
  - Group code PR assigning financial liability to the patient if the claim was received with **modifier GA** indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with **modifier GZ** indicating no signed ABN on file.
- Medicare will normally pay for 36 sessions of PR, but may pay up to 72 sessions when the claim(s) for sessions 37-72 includes **modifier KX**. Claims for HCPCS code G0424 which exceed 36 sessions without the **modifier KX** will be denied using the following:
  - CARC 151 – "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."
  - Group code PR assigning financial liability to the patient if the claim was received with **modifier GA** indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with **modifier GZ** indicating no signed ABN on file.
- Medicare contractors will deny claims for HCPCS code G0424 when submitted for more than 72 sessions even where the **modifier KX** is present. In the denials, contractors will use the following:
  - CARC B5 – "Coverage/program guidelines were not met or were exceeded."
  - Group code PR assigning financial liability to the patient if the claim was received with **modifier GA** indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the **modifier GZ** indicating no signed ABN on file.

Additional Information

CR 6823 was issued to your Medicare MAC, FI, or carrier in two transmittals. One transmittal modifies the *Medicare Benefit Policy Manual* and that transmittal is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R124BP.pdf*.

The second transmittal modifies the *Medicare Claims Processing Manual* and that transmittal is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1966CP.pdf*.

For related detailed policy and claims processing instructions issued December 11, 2009, you may review MM6715 on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6751.pdf*.

If you have questions, please contact your Medicare MAC, FI, or carrier at their toll-free number which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6823
Related Change Request (CR) Number: 6823
Related CR Release Date: May 7, 2010
Related CR Transmittal Number: R124BP and R1966CP
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1966, CR 6823

Revisions and re-issuance of audiology policies

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, nonphysician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare administrative contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6447. The Centers for Medicare & Medicaid Services (CMS) issued CR 6447 to respond to provider requests for clarification of some of the language in CR 5717 and CR 6061. Special attention is given to clarifying policy concerning services incident to physician services that are paid under the Medicare physician fee schedule (MPFS). See the *Key points* section of this article for the clarifications provided by CR 6447.

Background

Key parts of the clarified policy are in the revised Chapter 12, Section 30.3 of the *Medicare Claims Processing Manual* and in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual*. These revised manual sections are attached to CR 6447. As mentioned in these revised sections of the manuals and per Section 1861 (II) (3) of the Social Security Act, "audiology services" are defined as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under state law (or the state regulatory mechanism provided by state law), as would otherwise by covered if furnished by a physician. These hearing and balance assessment services are termed "audiology services," regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable state laws.

Note: References to technicians in CR 6447 and this article apply also to other qualified clinical staff. The qualifications for technicians vary locally and may also depend on the type of test, the patient, and the level of participation of the physician who is directly supervising the test. Therefore, an individual must meet qualifications appropriate to the service furnished as determined by the Medicare contractor to whom the claim is billed. If it is necessary to determine whether the individual who furnished the labor for appropriate audiology services is qualified, contractors may request verification of any relevant education and training that has been completed by the technician, which shall be available in the records of the clinic or facility.

Audiology services, like all other services, should be reported under the most specific HCPCS code that describes the service that was furnished and in accordance with all *CPT* guidance and Medicare national and local contractor instructions.

See the CMS website at *http://www.cms.gov/therapyservices* for a listing of all *CPT* codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The MPFS at *http://www.cms.gov/PFSlookup/* allows you to search pricing amounts, various payment policy indicators, and other MPFS data.

Qualifications discussion

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable, are appropriate to the test.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to the following:

- Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test.
- Development and modification of the test battery and test protocols.
- Clinical judgment, assessment, evaluation, and decision-making.

Revisions and re-issuance of audiology policies (continued)

- Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes.
- Tests related to implantation of auditory prosthetic devices, central auditory processing, contra-lateral masking.
- Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss.

Key points of change request 6447

- For claims with dates of service on or after October 1, 2008, audiologists are required to be enrolled in the Medicare program and use their national provider identifier (NPI) on all claims for services they render in office settings.
- For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital outpatient prospective payment system (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.
- Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.
- When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of Section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the audiologist must submit a claim to Medicare.
- Medicare pays for diagnostic audiological tests under the MPFS when they meet the requirements of audiology services as shown in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual* as attached to CR 6447.
- For claims with dates of service on or after October 1, 2008, the NPI of the enrolled audiologist is required on claims in the appropriate rendering and billing fields.
- Medicare will not pay for services performed by audiologists and billed under the NPI of a physician.
- Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills.
- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician.
- Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified to perform the service. (Once again, the list of audiology services is posted on the CMS website on the CMS website at *http://www.cms.gov/therapyservices*.)
- Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services at *http://www.cms.gov/therapyservice*s and are not "always" therapy services and the audiologist is qualified to perform the service.
- All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
- The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.
- When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
- The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.
- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.

Revisions and re-issuance of audiology policies (continued)

- The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
- Tests that have no appropriate *CPT* code may be reported under *CPT* code *92700* (Unlisted otorhinolaryngological service or procedure).
- Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
- The opt-out law does not define "physician" or "practitioner" to include audiologists; therefore, they may not opt out of Medicare and provide services under private contracts.

Additional information

There are two transmittals related to CR 6447, the official instruction issued to your Medicare A/B MAC, FI and/or carrier. The first modifies the *Medicare Benefit Policy Manual* and that transmittal is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R127BP.pdf*.

The other transmittal modifies the *Medicare Claims Processing Manual* and it is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1975CP.pdf*.

If you have questions, please contact your Medicare A/B MAC, FI or carrier at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6447
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Implementation Date: July 28, 2010

Source: CMS Pub. 100-04, Transmittal 1975, CR 6447

Signature guidelines for medical review purposes

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® article MM6698 to include a table from excerpted from change request (CR) 6698 that summarizes signature requirements. All other information remains the same. The article was published in the April 2010 *Medicare A Bulletin* (pages 29-31).

Provider types affected

This article is for physicians, nonphysician practitioners, and suppliers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), carriers, regional home health intermediaries (RHHIs) and/or durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for e-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for reviews conducted on or after the implementation date of April 16, 2010. **Please note that all signature requirements in CR 6698 are effective retroactively for comprehensive error rate testing (CERT) for the November 2010 report period.**

Background

Those contractors who review Medicare claims include MACs, affiliated contractors (ACs), the CERT contractors, recovery audit contractors (RACs), program safeguard contractors (PSCs), and zone program integrity contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Medicare fee-for-service (FFS) program.

Signature guidelines for medical review purposes (continued)

The previous language in the *Program Integrity Manual (PIM)* required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds e-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

Exception 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

Exception 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the *Medicare Benefit Policy Manual*, Chapter 15, Section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

Exception 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, national coverage determination (NCD), local coverage determination (LCD) and CMS manuals are silent on whether the signature is legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g., MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.

  Example:

  The claim selected for review is for a hospital visit on October 4. The additional documentation request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.
- **Definition of a signature log**: Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- **Definition of an attestation statement**: In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

Signature guidelines for medical review purposes (continued)

"I, _____[print full name of the physician/ practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.
- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
  - In the situations where the guidelines indicate "**signature requirements met**," the reviewer will consider the entry.
  - In situations where the guidelines indicate "**contact provider and ask a non-standard follow-up question**," the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
  - In the situations where the guidelines indicate "**signature requirements not met**," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic prescribing

Electronic prescribing (e-Prescribing) is the transmission of prescription or prescription-related information through electronic media. e-Prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-Prescribing network. With e-Prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. e-Prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified r-Prescribing system. For Medicare Part B medical review purposes, a qualified e-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, 42 CFR 423.160 Standards for Electronic Prescribing, you may go to *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf*.
- When Part B drugs, other than controlled substances, have been ordered through a qualified e-Prescribing system, the reviewer will **not** require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall **not** accept as a valid order any controlled substance drugs that are ordered through any e-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.
- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified e-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified e-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified e-Prescribing system, the reviewer shall **not** require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional information

CR 6698 includes a helpful table that summarizes the situations where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit an attestation statement or signature log. Key portions of that table are as follows:

Signature guidelines for medical review purposes (continued)

		Signature requirement met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator. **Example:** An illegible signature appears on a prescription. The letterhead of the prescription lists three physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and **not** on letterhead, but the submitted documentation **is accompanied** by: 1) a signature log, or 2) an attestation statement	X	
6	Illegible signature **not** over a typed/printed name, **not** on letterhead and the documentation **is UNaccompanied** by: a) a signature log, or b) an attestation statement		X
7	Initials over a typed or printed name	X	
8	Initials **not** over a typed/printed name but **accompanied** by: a) a signature log, or b) an attestation statement	X	
9	Initials **not** over a typed/printed name **UNaccompanied** by: a) a signature log, or b) an attestation statement		X
10	Unsigned typed note with provider's typed name **Example**: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

The official instruction, CR 6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R327PI.pdf*.

Signature guidelines for medical review purposes (continued)

If you have questions, please contact your Medicare FI, carrier, A/B MAC, RHHI or DME MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6698 – Revised
Related Change Request (CR) Number 6698
Related CR Release Date: March 16, 2010
Related CR Transmittal Number: R327PI
Effective Date: March 1, 2010
Implementation Date: April 16, 2010

Source: CMS Pub. 100-08, Transmittal 327, CR 6698

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education website *http://medicare.fcso.com* through the CMS Medicare Coverage Database.

Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part A section under the Part A Medical Coverage section.

This section of the *Medicare A Bulletin* features summaries of new and revised LCDs developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the fiscal intermediary's LCDs and review guidelines are consistent with accepted standards of medical practice.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the provider education website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the FCSO *eNews* mailing list. It is very easy to do. Simply go to our educational website *http://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

More information

If you do not have Internet access, contact the Medical Policy and Procedures department at:

Medical Policy and Procedures – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

Table of contents

Additions/revisions to existing LCDs

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our provider education website at *http://medicare.fcso.com*.

ADDITIONS/REVISIONS TO EXISTING LCDS

AJ7186: Hemophilia clotting factors – revision to the LCD

LCD ID Number: L28851 (Florida)
LCD ID Number: L28884 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hemophilia clotting factors was most recently revised on January 1, 2010. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) Transmittal 1980, Change Request 6996, dated June 4, 2010, to add HCPCS code C9267 (Injection, von Willebrand factor complex [human], Wilate, per 100 IU VWF:RCO) to the "*CPT*/HCPCS Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after July 6, 2010,** for services provided **on or after July 1, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

ANCSVCS: The list of Medicare noncovered services – revision to the LCD

LCD ID Number: L28991 (Florida)
LCD ID Number: L29023 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on June 7, 2010. Since that time, a revision was made to the LCD to remove *CPT* code *50593 (Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy*) based on review of peer-reviewed literature that was submitted with a reconsideration request along with additional researched literature that supports coverage for this service.

Currently, First Coast Service Options Inc. (FCSO) does not have a local coverage determination outlining coverage criteria for this service. Therefore, it is expected that claims for this service would be medically reasonable and necessary for the patient and performed according to standards of care. In order for a service to be considered medically reasonable and necessary, all of the following criteria must be met (CMS Internet-only Manuals, Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.1):

- Not experimental or investigational
- The duration and frequency considered appropriate for the service
- Furnished in accordance with accepted standards of medical practice for the treatment of the patient's condition
- Furnished in a setting appropriate to the patient's medical needs and condition
- Ordered and furnished by qualified personnel; and
- Meets but does not exceed the patient's medical need.

Records must be made available to FCSO Medicare upon request.

Effective date

This LCD revision is effective for services provided **on or after June 7, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

Find LCDs faster on our new medical coverage page

Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news and resources you need more quickly and easily than ever before – try it today. *http://medicare.fcso.com/Landing/139800.asp*.

HOSPITAL SERVICES

PECOS enrollment required for Medicare electronic health record incentive

One more reason to establish your enrollment record in the provider enrollment, chain and ownership system (PECOS)

The Recovery Act of 2009 established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified electronic health records (EHR) technology. These EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading or meaningful use of certified EHR technology.

While more detail on the EHR incentive program is forthcoming in the impending final rule, the Centers for Medicare & Medicaid Services (CMS) is announcing that PECOS records will be used to verify Medicare enrollment prior to making Medicare EHR incentive payments. **Your hospital's enrollment information must be in PECOS, so act now if your hospital does not have an enrollment record in this system.**

Enrolled in Medicare before November 2003?

Medicare hospitals and critical access hospitals that enrolled in Medicare before November 2003 **and have not updated Medicare enrollment information since then**, do **not** have an enrollment record in PECOS. **Act now to establish an enrollment record in PECOS**.

For instructions, go to *http://www.cms.gov/MedicareProviderSupEnroll/*, click on "Tips to Facilitate the Medicare Enrollment Process" under "Downloads."

If your hospital enrolled in Medicare after November 2003, or enrolled before November 2003 and has updated its Medicare enrollment information since November 2003, no further action is required.

If you are unsure, here are ways to verify that your hospital has an enrollment record in PECOS:

1. Use Internet-based PECOS to look for your hospital's PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) If no record is displayed, your hospital does not have an enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll , click on "Internet-based PECOS" on the left, for information on using Internet-based PECOS.
2. Contact your Medicare enrollment contractor and ask if your hospital has an enrollment record in PECOS. Access *http://www.cms.gov/MedicareProviderSupEnroll*, click on "Medicare Fee-for-Service Contact Information" under "Downloads."

Note: If you have submitted an enrollment application within the last 90 days, and your enrollment application has been accepted for processing by the fiscal intermediary or A/B MAC, you need not take any additional actions based on this listserv message. Information on how to establish an enrollment record in PECOS may be found on the CMS website at *http://questions.cms.hhs.gov/app/answers/detail/a_id/9909*.

The Medicare and Medicaid EHR incentive programs are designed to support providers in this period of health-information technology transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

More information on Medicare and Medicaid EHR incentive programs may be found on the Web at *http://www.cms.gov/Recovery/11_HealthIT.asp*.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-16

Update to the fiscal year 2010 inpatient prospective payment system PC PRICER

The fiscal year (FY) 2010 inpatient prospective payment system (PPS) personal computer (PC) PRICER has been updated to correct a typographical error in the program. If you use the FY 2010 inpatient PPS PC PRICER, please go to the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPricer/03_inpatient.asp#TopOfPage*, and download the latest version of the PC PRICER.

Note there are now two PRICER versions for FY 2010. One is for claims dated from October 1, 2009, to March 31, 2010, and the other is for claims dated from April 1, 2010, to September 30, 2010. The download for the April 1, 2010, to September 30, 2010, is the module that changed. The update is dated June 15, 2010.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-23

Affordable Care Act provisions and proposed changes for fiscal year 2011 rates

Proposed rule CMS-1498-P2, which is titled "Medicare Program; Provisions of the Affordable Care Act and Supplemental Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Supplemental Proposed Fiscal Year 2011 Rates" went on display at the Office of the Federal Register on May 21, 2010.

This proposed rule is a supplement to the fiscal year (FY) 2011 hospital inpatient prospective payment systems (IPPS) and long-term care prospective payment system (LTCH PPS) proposed rule published in the May 4, 2010, *Federal Register*. This supplemental proposed rule would implement certain statutory provisions relating to Medicare payments to hospitals for inpatient services that are contained in the Patient Protection and Affordable Care Act (the Affordable Care Act) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively known as the Affordable Care Act). It would also specify statutorily required changes to the amounts and factors used to determine the rates for Medicare acute-care hospital inpatient services for operating costs and capital related costs, and for long-term care hospital costs.

To view the display copy of the regulation, impact files, data files and tables, go to *http://www.cms.gov/AcuteInpatientPPS/IPPS2010/list.asp*.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-30

INPATIENT PSYCHIATRIC FACILITY SERVICES

Inpatient psychiatric facility prospective payment system rate year 2011 update

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the inpatient psychiatric facilities prospective payment system (IPF PPS) are affected.

Provider action needed

This article is based on change request (CR) 6986 which identifies changes that are required as part of the annual IPF PPS update from the rate year (RY) 2011 IPF PPS update notice, published on April 30, 2010. These changes are applicable to IPF discharges occurring during the rate year July 1, 2010 through June 30, 2011, and this is the fifth RY update to the IPF PPS. The applicable previous year update is detailed in *MLN Matters*® article MM6461 and may be reviewed on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6461.pdf*.

Make sure that your billing staff are aware of these IPF PPS changes.

Background

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually. The RY update is effective July 1 through June 30, and the Medicare severity diagnosis related groups (MS-DRGs) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

CR 6986 identifies changes that are required as part of the annual IPF PPS update from the RY 2011 IPF PPS update notice, published on April 30, 2010. These changes are applicable to IPF discharges occurring during the rate year July 1, 2010 through June 30, 2011.

Market basket update

CMS is required to apply an "other adjustment" that reduces any update to the IPF PPS base rate by 0.25 percentage point for the rate year beginning in 2010, and CR 6986 implements this requirement for RY 2011. See the Social Security Act (Section 1886(s)(3)(A); *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm* on the Internet), which was added by:

- The Affordable Care Act (Pub. L. 111-148; Sections 3401(f) amended by Section 10319(e); *http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf*.)
- The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152; Section 1105; *http://www.gpo.gov/fdsys/pkg/BILLS-111hr4872EH/pdf/BILLS-111hr4872EH.pdf*.)

Note: CR 6986 reduces the update to the IPF PPS base rate by 0.25 percent (0.25%) for rate year 2011.

Inpatient psychiatric facility prospective payment system rate year 2011 update (continued)

Starting with the RY 2010 federal per diem base rate of $651.76 and applying the market basket increase of 2.4 percent, with the "Other Adjustment" of -0.25%, and the wage index budget neutrality factor of 0.9999 yields **a federal per diem base rate of $665.71 for RY 2011**.

Similarly, applying the market basket increase with the "Other Adjustment," and the wage index budget neutrality factor to the RY 2010 electroconvulsive therapy (ECT) rate yields an **ECT rate of $286.60 for RY 2011**.

PRICER updates

For IPF PPS RY 2011, the following are effective for discharges on July 1, 2010 through June 30, 2011:

- The federal per diem base rate is $665.71.
- The fixed dollar loss threshold amount is $6,372.00.
- The IPF PPS will use the FY 2010 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is 75.400 percent.
- The non-labor related share is 24.600 percent.
- The ECT rate is $286.60.

Cost to charge ratios

The national urban and rural cost-to-charge ratios (CCR) for the IPF PPS RY 2011 are displayed in the following table:

Cost to charge ratio	Median	Ceiling
Urban	0.5170	1.7377
Rural	0.6480	1.7383

CMS is applying the national median CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the Medicare FI or A/B MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

MS-DRG Update

The code set and adjustment factors are unchanged for RY 2011.

Additional Information

Note: For the FY 2010 pre-floor, pre-reclassified hospital wage index, CMS is using the updated wage index and the wage index budget neutrality factor of 0.9999.

The official instruction, CR 6986, issued to your Medicare FI and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1981CP.pdf*.

If you have any questions, please contact your Medicare FI or A/B MAC at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6986
Related Change Request (CR) Number: 6986
Related CR Release Date: June 4, 2010
Related CR Transmittal Number: R1981CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1981, CR 6986

Reminder to inpatient psychiatric facilities to use source of admission code D for patient transfers within the same facility

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Inpatient psychiatric facilities (IPFs) submitting claims involving inpatient transfers within the same facility to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) are affected.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is issuing special edition *MLN Matters*® SE1020 to emphasize the importance **of using source-of-admission code D to identify beneficiaries who were discharged from the acute-care section of the same hospital. When there is a transfer within the same inpatient facility, this code D** ensures that the hospital-based IPF does not receive an additional payment for the costs of emergency department services that Medicare covers in its payment to the acute-care hospital. Be certain your billing staffs are aware of this policy.

Background

In May of 2010 the Office of the Inspector General (OIG) issued the *Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities During Calendar Years 2006 and 2007* and the report notes that many IPFs were not aware that source-of-admission code D existed.

Under the Medicare prospective payment system for IPF, CMS makes an additional payment to an IPF for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. CMS makes this payment to every IPF that has a qualifying emergency department, regardless of whether the beneficiary was admitted through the emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute-care section of a hospital to its own hospital-based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the hospital receives for the beneficiary's immediately preceding inpatient stay.

Key Points

- CMS designated source-of-admission code D for a hospital-based IPF to enter on its Medicare claim form to indicate that the beneficiary was admitted from the acute-care section of the same hospital.
- This code is designed to ensure that the hospital-based IPF does not receive an additional payment for the costs of emergency department services that Medicare covers in its payment to the acute-care hospital.
- In April of 2006 CMS issued change request (CR) 3881 and the accompanying MLN Matters® article MM3881 for claims involving transfer within the same facility. That article may be reviewed on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM3881.pdf*.

Be aware that the OIG points out that Medicare contractors should try to determine the extent to which FIs, MACs and the Medicare claims processing systems properly adjudicated claims that should have used source-of-admission code D and recover overpayments.

Additional information

To read the entire *Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities During Calendar Years 2006 and 2007 (A-01-09-00504)*, you may go on the Internet to *http://oig.hhs.gov/oas/reports/region1/10900504.pdf*.

If you have questions, please contact your Medicare contractor at their toll-free number which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE1020
Related Change Request (CR) Number: 3881
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE1020

ESRD Services

Dialysis adequacy, infection and vascular access reporting

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article 6782 to add a note regarding the use of *CPT* code *90999* in dialysis revenue code lines in order to report the required infection modifiers. All other information remains the same. The article was published in the April 2010 *Medicare A Bulletin* (pages 48-50).

Provider types affected

Renal dialysis facilities (RDFs) submitting claims to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries are impacted by this issue.

Provider action needed

STOP – impact to you

RDFs need to know that CR 6782 requires new quality data reporting for dialysis adequacy, infection and vascular access on all end-stage renal disease (ESRD) claims and **all ESRD hemodialysis claims with dates of service on or after July 1, 2010**.

CAUTION – what you need to know

The new data reporting will allow the Centers for Medicare & Medicaid Services (CMS) to implement an accurate **quality incentive payment for dialysis providers** by January 1, 2012, as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153c.

GO – what you need to do

Make sure that your billing staffs are aware of these new reporting and claim requirements described below.

Background

This article is based on CR 6782, which explains that section 153c of the MIPPA requires CMS to implement a quality based payment program for dialysis services effective January 1, 2012. CMS currently collects two monthly measurements of quality of care via the ESRD claims submitted by dialysis providers: hemoglobin or hematocrit as a measure of anemia management and urea reduction ratio (URR) as a measure of hemodialysis adequacy.

The source data for the two current quality measures are collected on dialysis provider claims. The anemia management quality measure uses the most recent hemoglobin or hematocrit lab value, collected using value codes 48 or 49 on type of bill 72x. The hemodialysis adequacy measure uses the current month's urea reduction ratio (URR) lab value, collected using Healthcare Common Procedure Coding Systems (HCPCS) modifiers G1 through G6 on hemodialysis line items (revenue center 082x and *CPT* code *90999*).

These two quality measures meet the minimum requirements as mandated in MIPPA section 153c. However, the URR measure of dialysis adequacy does not provide data for the entire ESRD dialysis population. Not having dialysis adequacy data for a segment of the dialysis population (peritoneal dialysis patients) is problematic in the development of a quality based payment program that will decrease provider payment by up to two percent based on quality outcome data because, with the missing data, CMS will not be able to assess all ESRD dialysis providers based on the same criteria.

MIPPA section 153c also requires the use of quality measures endorsed by a consensus organization. CMS recently reexamined and received National Quality Forum (NQF) endorsement for the ESRD quality measures. Both CMS and NQF found that dialysis adequacy is best measured by Kt/V (K-dialyzer clearance of urea; t-dialysis time; V-patient's total body water) for both hemodialysis and peritoneal dialysis patients. The NQF granted time-limited endorsement of URR for hemodialysis patients and recommended that CMS drop it in favor of Kt/V as soon as possible. While dialysis adequacy is measured monthly for in-center hemodialysis patients, dialysis adequacy is measured less frequently for peritoneal dialysis patients (at least every four months). Therefore, it is necessary to track both the date of the most recent measurement and the result of the most recent measurement.

Finally, MIPPA section 153c provides for the use of additional quality measures for the quality based payment program as determined by the Secretary of Health & Human Services. Two additional quality measures could easily be collected using HCPCS modifiers for hemodialysis patients to record vascular access. The first measure is use of an arteriovenous fistula with two needles, which is recognized as the best vascular access because it is associated with the least infections. The second measure is the use of any vascular catheter, which is recognized as the worst vascular access because it is associated with the most infections. Collecting vascular access data will allow CMS to develop a more robust quality based payment program in order to implement national policy without additional data collection burden on dialysis providers, who are already required to collect these data under the fistula first initiative.

Consequently, **CMS will require the reporting of the Kt/V reading and date of the reading, vascular access and infection data on ESRD claims with dates of service on or after July 1, 2010.** This new data reporting requirement will allow CMS to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by MIPPA, section 153c. The July 2010 implementation date is needed because the quality incentive payment must be in part based on provider improvement over time; thus, CMS requires an accurate measurement of baseline provider performance. CMS will require that providers continue to report the existing modifiers G1 through G6 for URR at this time.

Dialysis adequacy, infection and vascular access reporting (continued)

New quality data required on all ESRD claims with dates of service on or after July 1, 2010:

Claim level codes

- **Value code D5:** Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within four months of the claim date of service.
- **Occurrence code 51:** Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the claim date of service.

In the event that the provider has not performed the Kt/V test for the patient, the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value. The occurrence code date should not be reported on the claim in the case of no Kt/V reading being reported. For dates of service on or after July 1, 2010, failure to report the D5 value code on the type of bill 72x will result in the claim being returned to the provider. Also, Medicare will return type of bill 72x with dates of service on or after July 1, 2010 to the provider if the claim does not contain occurrence code 51, except where there is a D5 value code with 9.99.

Line level codes to report on dialysis revenue code lines

- **Modifier V8:** Dialysis access-related infection present (documented and treated) during the billing month. Reportable dialysis access-related infection is limited to peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients. Facilities must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) if identified during the billing month. For individuals that receive different modalities of dialysis during the billing month and an infection is identified, the V8 code should only be indicated on the claim for the patient's primary dialysis modality at the time the infection was first suspected. Non-access related infections should not be coded as V8. If no dialysis-access related infection is present by this definition, providers should instead report modifier V9.
- **Modifier V9:** No dialysis-access related infection, as defined for modifier V8, present during the billing month. Dialysis access-related infection, defined as peritonitis for peritoneal dialysis patients or bacteremia for hemodialysis patients must be reported using modifier V8. Providers must report any peritonitis related to a peritoneal dialysis catheter, and any bacteremia related to hemodialysis access (including arteriovenous fistula, arteriovenous graft, or vascular catheter) using modifier V8.

Note: Medicare systems will return to the provider 72x bill types with dates of service on or after July 1, 2010, when either the modifier V8 or V9 is not present on each dialysis revenue code line (0821, 0831, 0841, or 0851). Providers may report *CPT* code *90999* in all dialysis revenue code lines in order to report the required infection modifiers.

New quality data required on All ESRD Hemodialysis claims with dates of service on or after July 1, 2010

Line level codes to report on hemodialysis revenue code lines:

Vascular access for ESRD hemodialysis patients – an indicator of the type of vascular access used for the delivery of hemodialysis at the last hemodialysis session of the month. The code is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider.

- **Modifier V5:** Any vascular catheter (alone or with any other vascular access)
- **Modifier V6:** Arteriovenous graft (or other vascular access not including a vascular catheter)
- **Modifier V7:** Arteriovenous fistula only (in use with two needles)

Note: Medicare systems will return to the provider type of bill 72x with dates of service on or after July 1, 2010 billing for hemodialysis when the latest line item date of service billing for revenue code 0821 does not contain one of the following modifiers: V5, V6, or V7.

The modifiers V5-V9 are effective January 1, 2010, and the Medicare integrated code editor has been updated to allow the reporting of these codes for claims with dates of service on or after January 1, 2010. Therefore, providers may voluntarily report these modifiers for claims with dates of service January 1, 2010 through July 1, 2010.

Additional information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI or A/B MAC, which is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1932CP.pdf*.

The *Medicare Learning Network* catalog of products contains a fact sheet Outpatient Maintenance Dialysis – End-Stage Renal Disease fact sheet, which provides general information about Outpatient Maintenance Dialysis for ESRD, the composite payment rate system, and separately billable items and services. The fact sheet is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/ESRDpaymtfctsht08-508.pdf*.

If you have questions, please contact your Medicare FI or A/B MAC at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6782 – Revised
Related Change Request (CR) Number: 6782
Related CR Release Date: March 17, 2010
Related CR Transmittal Number: R1932CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1932, CR 6782

SKILLED NURSING FACILITY SERVICES

Clarification on use of the skilled nursing facility advance beneficiary notice and denial letters

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for skilled nursing facilities (SNFs) billing Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6987 which clarifies that SNFs may use either the skilled nursing facility advance beneficiary notice (SNFABN) or notices of noncoverage (denial letters) for items and services expected to be denied under Medicare Part A. Be sure your billing staff is aware of these changes.

Background

Historically, Centers for Medicare & Medicaid Services (CMS) instructed SNF providers to use either the SNFABN (CMS Form-10055) or one of the five uniform denial letters for items and services expected to be denied under Medicare Part A to fulfill the notification requirements under Section 1879 of the Social Security Act and 42 CFR 411.404. However, the corresponding manual instructions stated that only the SNFABN could be used for this purpose. CR 6987 modifies the *Medicare Claims Processing Manual* to show that SNFs may use **either the SNFABN (CMS Form-10055)**, which is available at *http://www.cms.gov/BNI/downloads/CMS10055.pdf* **or the denial letters** for items and services expected to be denied under Medicare Part A. The Denial Letters are available on the CMS website at *http://www.cms.gov/BNI/Downloads/SNF%20DENIAL%20LETTERS.pdf*.

Note: Medicare contractors will accept either the SNFABN (CMS-Form 20005) or the SNF notices of noncoverage (denial letters) as valid notification for items and services expected to be denied under Medicare Part A.

Additional information

The official instruction (CR6987) issued to your Medicare A/B MAC and/or FI is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1983CP.pdf*.

If you have questions, please contact your Medicare contractor (FI, RHHI or A/B MAC at their toll-free number which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6987
Related Change Request (CR) Number: 6987
Related CR Release Date: June 11, 2010
Related CR Transmittal Number: R1983CP
Effective Date: July 12, 2010
Implementation Date: July 12, 2010

Source: CMS Pub. 100-04, Transmittal 1983, CR 6987

Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

Updated information on payments under the SNF prospective payment system for fiscal year 2011

Affected providers: Freestanding and hospital-based skilled nursing facilities (SNFs) and rural hospital swing beds

Section 10325 of the Patient Protection and Affordable Care Act (ACA) includes a provision addressing Medicare payments for SNFs in fiscal year (FY) 2011. This section mandates a delay in the introduction of the resource utilization groups, version 4 (RUG-IV) case-mix classification system until FY 2012. In addition, it requires that version 3.0 of the minimum data set (MDS 3.0) resident assessment instrument will be implemented as planned in FY 2011. Finally, the section requires that certain specific components of RUG-IV, specifically, the concurrent therapy and look-back revisions, be applied in FY 2011.

While there is currently an existing GROUPER that utilizes the 53-group RUG-III system and the MDS 2.0, and a revised GROUPER that utilizes RUG-IV and the MDS 3.0, a GROUPER that incorporates the particular combination of features mandated by the statute does not currently exist.

GROUPER is the software program that uses assessment data to assign each SNF resident to the appropriate RUG.

Accordingly, as the Centers for Medicare & Medicaid Services (CMS) continues to build the payment infrastructure needed to incorporate the combination of features mandated by ACA, CMS will apply interim payment rates, effective October 1, 2010. These payment rates reflect not only the use of MDS 3.0 but also the new RUG-IV system in its entirety as finalized in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009). Once the necessary infrastructure is in place, CMS will then retroactively adjust the rates to reflect a hybrid RUG-III (HR-III) system, which incorporates RUG-IV's specific revisions on concurrent therapy and the look-back period within the framework of the existing 53-group RUG-III system, along with the use of MDS 3.0.

This approach will allow CMS to make payments with the least disruption for providers and beneficiaries. CMS will publish every year the specific payment rates for the upcoming fiscal year in the Federal Register, and provide additional guidance concerning implementation of the FY 2011 payments in the near future. Finally, CMS notes that there is legislation pending in Congress that would repeal section 10325 of the ACA and thus eliminate the need to adjust payments retroactively.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-32

Nursing homes and swing bed providers – minimum data set 3.0 updates

Under the Downloads section on the MDS 3.0 Training Materials page, the following revised training materials are now available (*http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*):

- **MDS 3.0 RAI Manual V1.02 June 9, 2010** – this update includes the following revised Chapter 3 sections of the *Resident Assessment Instrument* (RAI) manual: Z along with an updated version of E (a minor edit to correct the inadvertent mis-numbering of the examples on page E-3). This file now contains revised versions of the following sections of the RAI manual: Chapter 3, Sections: B, D, E, F, H, I, K, L, N, P, X and Z.
- **MDS 3.0 Training Slides V1.00 June 9, 2010** – with this update we have replaced the "pdf" files with "Microsoft PowerPoint®" files to improve ease of use. Content in the sections previously published has not changed. This update includes the following revised Chapter 3 sections of the MDS 3.0 Training Slides: Z. This file now contains revised versions of the following sections of the MDS 3.0 training slides: Chapter 3, Sections: B, D, E, F, H, I, K, L, N, P, X and Z.
- **MDS 3.0 Instructor Guides V1.00 June 9, 2010** – this update includes the following revised Chapter 3 sections of the MDS 3.0 instructor guides: Z. This file now contains revised versions of the following sections of the MDS 3.0 instructor guides: Chapter 3, Sections: B, D, E, F, H, I, K, L, N, P, X and Z.

The Centers for Medicare & Medicaid Services (CMS) staff are working hard to complete the posting of the MDS 3.0 RAI manual, training slides, and instructor guides by Friday, June 11. CMS has targeted the week of June 14th for the publishing of the remaining sections of Chapter 3 as well as Chapters 1, 2, 4, 5, and 6.

Technical information update: A special e-mail address for MDS 3.0 "technical" questions or issues has been established. Any inquiries should now be sent to mailto:mdstechissues@cms.hhs.gov.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-13

Five-star quality rating system – June news

The five-star provider preview reports are available from Tuesday, June 15, 2010. Providers, in order to access your five star preview report, go to the minimum data set (MDS) state welcome page available on the state servers where you submit the MDS information and select the CASPER (certification and survey provider enhanced reporting) link located at the bottom of the page. Once in the CASPER system,

- Click on the 'Folders' button.
- Then click on 'My Inbox' on the left hand side of the screen and access the five star report in your 'st LTC facid' folder, where 'st' is the two-digit postal code of the state in which your facility is located and 'facid' is the state assigned facid of your facility.

The five-star helpline will be available the week of June 21-25, 2010 for questions and concerns about the June data. The Nursing Home Compare website will update with June's five-star data on Thursday, June 24, 2010.

Please visit *http://www.cms.gov/CertificationandComplianc/13_FSQRS.asp* for the latest five-star quality-rating system information.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-19

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

July 2010 integrated outpatient code editor specifications – version 11.2

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency (HHA) not under the home health prospective payment system (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider action needed

This article is based on change request (CR) 6967, which describes changes to the integrated outpatient code editor (I/OCE) and OPPS to be implemented in the July 2010 OPPS and I/OCE updates. Be sure billing staffs are aware of these changes.

Background

CR 6967 describes changes to billing instructions for various payment policies implemented in the July 2010 OPPS update. The July 2010 I/OCE changes are also discussed in CR 6967.

Note: The full list of I/OCE specifications can now be found on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/OutpatientCodeEdit/*.

A summary of the changes for July 2010 is within Appendix M of Attachment A of CR 6967 and that summary is captured in the following key points.

Key Points of CR 6967 Based on Appendix M of the I/OCE Specifications

- Effective October 1, 2003, Medicare will delete edit 59.
- Effective January 1, 2008, Medicare will apply modified edit 74 to type of bill (TOB) 85x with revenue codes 96x, 97x, or 98x.
- Effective March 23, 2010, Medicare will apply a mid-quarter date and associated edit to codes as necessary.
- Effective July 1, 2010, Medicare will:
  - Modify the I/OCE interface for Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 to: a) increase the number of diagnosis codes up to 28, and the field size to 8 bytes, input & output; b) increase the number of condition codes up to 11; and c) add a new one-byte field for code type indicator.
  - Make Healthcare Common Procedure Coding System/ambulatory payment class/status indicator (HCPCS/APC/SI) changes (data change files).
  - Implement version 16.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers) (edits 19, 20, 39 and 40 are affected).
  - Create 508-compliant versions of the specifications and summary of data changes documents for publication on the CMS website.

Additional Changes

The following ambulatory payment classification (APC) was added to the I/OCE, effective April 1, 2010

APC	APC description	Status indicator
01310	Pneumococcal vacc, 13 val im	K

The following APC(s) were added to the I/OCE, effective July 1, 2010

APC	APC description	Status indicator
09264	Tocilizumab injection	G
09265	Romidepsin injection	G
09266	Collagenase clostridum histo	G
09267	Injection, Wilate	G

July 2010 integrated outpatient code editor specifications – version 11.2 (continued)

APC	APC description	Status indicator
09268	Capsaicin patch	G
09367	Endoform Dermal Template	G

The following APC had description changes, effective July 1, 2010

APC	Old description	New description
09262	Fludarabine phosphate, oral	Oral Fludarabine phosphate

The following new HCPCS code(s) were added to the I/OCE, effective January 1, 2010

HCPCS	Code description	SI	APC	Edit	Active date
C9800	Dermal filler inj px/ suppl	T	00135	55	20100323
G0429	Dermal filler injection(s)	B	00000	62	20100323
Q2026	Radiesse injection	B	00000	62	20100323
Q2027	Sculptra injection	B	00000	62	20100323

The following new HCPCS code was added to the I/OCE, effective April 1, 2010

HCPCS	Code description	SI	APC	Edit
G0428	Collagen meniscus implant	E	00000	9

The following new HCPCS/*CPT* code(s) were added to the I/OCE, effective July 1, 2010

HCPCS/*CPT*	Code description	SI	APC	Edit
0223T	*Acoustic/electr cardgrphy*	S	00099	
0224T	*Acstic/elec cardgrphy av/vv*	S	00690	
0225T	*Acstic/elec cardgrphy av+vv*	S	00690	
0226T	*Anosc high resol dx +-coll*	X	00340	
0227T	*Anosc high resol dx w/bx*	T	00146	
0228T	*US tfrml edrl inj crv/t 1lvl*	T	00207	
0229T	*US tfrml edrl inj crv/t +lvl*	T	00206	
0230T	*US tfrml edrl inj l/s 1lvl*	T	00207	
0231T	*US tfrml edrl inj l/s +lvl*	T	00206	
0232T	*Inj plsm img guid hrvrst&prep*	X	00340	
0233T	*Skn age meas spctrscpy*	A	00000	
90664	*Flu vacc pandemic live nasal*	E	00000	28
90666	*Flu vacc pandemic no prsv im*	E	00000	28
90667	*Flu vacc pandemic adj im*	E	00000	28
90668	*Flu vacc pandemic split v im*	E	00000	28
C9264	Tocilizumab injection	G	09264	55
C9265	Romidepsin injection	G	09265	55
C9266	Collagenase clostridum histo	G	09266	55
C9267	Injection, Wilate	G	09267	55
C9268	Capsaicin patch	G	09268	55

July 2010 integrated outpatient code editor specifications – version 11.2 (continued)

HCPCS/*CPT*	Code description	SI	APC	Edit
C9367	Endoform Dermal Template	G	09367	55
Q2025	Oral Fludarabine phosphate	G	09262	

The following HCPCS/CPT code was deleted from the I/OCE, effective July 1, 2010

HCPCS	Code description
C9262	Fludarabine phosphate, oral

The following code descriptions were changed, effective July 1, 2010

HCPCS	Old description	New description
K0669	Seat/back cus no sadmerc ver	Seat/back cus no dmepdac ver
K0899	Pow mobil dev no SADMERC	Pow mobil dev no dme pdac

The following code had an APC and/or SI and/or edit change, effective April 1, 2010

CPT	Code description	Old APC	New APC	Old SI	New SI	Old edit	New edit
90670	*Pneumococcal vacc, 13 val im*	00000	01310	E	K	9	N/A

The following HCPCS codes were added to edit 68 effective January 1, 2010

HCPCS	Edit number	Active date	Term date
C9800	68	20100323	0
G0429	68	20100323	0
Q2026	68	20100323	0
Q2027	68	20100323	0

Additional information

The official instruction (CR 6967) issued to your Medicare MAC and/or FI is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1982CP.pdf*.

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found on the CMS website d at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6967
Related Change Request (CR) Number: 6967
Related CR Release Date: June 4, 2010
Related CR Transmittal Num: R1982CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1982, CR 6967

July 2010 update of the hospital outpatient prospective payment system

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) are affected.

What you need to know

This article is based on change request (CR) 6996 which describes changes to and billing instructions for various payment policies implemented in the July 2010 OPPS update. The July 2010 integrated outpatient code editor (I/OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 6996.

July 2010 revisions to the integrated/outpatient code editor (I/OCE) data files, instructions, and specifications are provided in CR 6967, July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.2." The *MLN Matters*® article related to CR 6967 is available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6967.pdf*.

Background

Change request (CR) 6996 updates Sections 20.4 and 20.5 of Chapter 6 of the *Medicare Benefits Policy Manual* to further clarify CMS policies requiring physician supervision of diagnostic and therapeutic services provided to hospital outpatients.

CMS updated Sections 20.4 and 20.5 to reflect changes in these policies that were implemented in the calendar year (CY) 2010 outpatient prospective payment system/ambulatory surgical center payment system (OPPS/ASC) final rule with comment period [(74 FR 60588 through 60591; hospital outpatient diagnostic services); (74 FR 60578 through 60588); hospital outpatient therapeutic services)]. CR 6996 further clarifies CY 2010 CMS policies in response to additional questions and comments received since publication of that rule. Specifically, CR 6996 discusses:

- Discusses supervision of diagnostic tests by non-physician practitioners
- Defines the term "immediately available"
- Clarifies the credentials, knowledge, skills, ability, and privileges that the supervisory practitioner must possess in order to be qualified to perform a given service or procedure
- Clarifies what constitutes a therapeutic service in the hospital outpatient department, including observation.

These updates to Sections 20.4 and 20.5 of the *Medicare Benefits Policy Manual* are included as an attachment to CR 6996. The updates are summarized as follows:

- Physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives who operate within the scope of practice under state law may order and perform diagnostic tests, as discussed in 42 CFR 410.32(a)(2) and corresponding guidance in chapter 15, section 80 of this manual. However, this manual guidance and the long established regulation at 42 CFR 410.32(b)(1) also state that diagnostic X-ray and other diagnostic tests must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act. Some of these nonphysician practitioners may perform diagnostic tests without supervision, see the regulation at 410.32(b)(2) and 42 CFR 410.32(b)(3). Thus, while physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives only require physician supervision included in any collaboration or supervision requirements particular to that type of practitioner when they personally perform a diagnostic test, these practitioners are not permitted to function as supervisory "physicians" for the purposes of other hospital staff performing diagnostic tests.
- Immediate availability requires the immediate physical presence of the physician. CMS has not specifically defined the word "immediate" in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away.
- The supervisory physician must have, within his or her state scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic testing equipment, and while in such cases CMS does not expect the supervisory physician to operate this equipment instead of a technician, the physician that supervises the provision of the diagnostic service must be knowledgeable about the test and clinically appropriate to furnish the test.
- The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure and, as appropriate to the supervisory physician and the patient, to change a procedure or the course of care for a particular patient. CMS would not expect that the supervisory physician would make all decisions unilaterally without informing or consulting the patient's treating physician or nonphysician practitioner. In summary, the supervisory physician must be clinically appropriate to supervise the service or procedure.

July 2010 update of the hospital outpatient prospective payment system (continued)

- Direct supervision is the minimum standard for supervision of all Medicare hospital outpatient therapeutic services. Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws, and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations. For services not furnished directly by a physician or nonphysician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate.

  Note: CMS decided not to enforce the requirements for direct supervision of therapeutic services that are furnished to outpatients in critical access hospitals (CAHs) during calendar year 2010. For more information on this issue, see on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/Downloads/WebNotice.pdf*.

In addition, CR 6996 makes the following OPPS changes:

1. Procedure to device edits for July 2010

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Procedures for which both a device A and a device B are specified require that at least one each of device A and device B be present on the claim (i.e., there must be some combination of a device A with a device B in order to pass the edit). device B can be reported with any device A for the same procedural HCPCS code.

Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits may be found under "Device, Radiolabeled Product, and Procedure Edits" on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/*.

2. Category III *CPT* codes

The American Medical Association (AMA) releases category III *CPT* codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, CMS implemented new category III *CPT* codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567; see *http://www.access.gpo.gov/su_docs/fedreg/a051110c.html* on the Internet), CMS modified the process for implementing the category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between category III CPT codes and some of the C-codes that are payable under the OPPS and were created in response to applications for new technology services. Therefore, on July 1, 2010, CMS is implementing the OPPS 11 category III CPT codes that the AMA released in January 2010 for implementation in July 2010. Of the 11 category III CPT codes, 10 are separately payable under the hospital OPPS. The category III *CPT* codes, status indicators (SI), and ambulatory payment classifications (APC) are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2010 OPPS update that is posted at http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp on the CMS website. *CPT* code *0233T (skin advanced glycation end products (AGE) measurement by multi-wavelength fluorescent spectroscopy*) will be paid under the Medicare physician fee schedule, beginning July 1, 2010, when billed by OPPS providers.

Table 1 – category III *CPT* codes implemented as of July 1, 2010

CPT codes	Long descriptor	SI	APC
0223T	*Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report*	S	0099
0224T	*Multiple, including serial trended analysis and limited reprogramming of device parameter - AV or VV delays only, with interpretation and report*	S	0690
0225T	*Multiple, including serial trended analysis and limited reprogramming of device parameter - AV and VV delays, with interpretation and report*	S	0690
0226T	*Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed*	X	0340
0227T	*Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)*	T	0146
0228T	*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level*	T	0207

July 2010 update of the hospital outpatient prospective payment system (continued)

CPT codes	Long descriptor	SI	APC
0229T	*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)*	T	0206
0230T	*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level*	T	0207
0231T	*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)*	T	0206
0232T	*Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed*	X	0340
0233T	*Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy*	A	NA

3. Dermal injections for treatment of facial lipodystrophy syndrome (LDS)

Effective for claims with dates of service on and after March 23, 2010, coverage for dermal injections for the treatment of facial lipodystrophy syndrome (LDS) is considered reasonable and necessary only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment. CMS will cover and pay separately for the dermal filler injection procedure and the dermal filler products that are approved by the Food and Drug Administration (FDA).

CMS has created four *Level II HCPCS* codes to describe the dermal filler injection procedure and the dermal filler products. Those codes are shown in Table 2 below. Under the hospital OPPS, CMS has assigned HCPCS code C9800 to APC 0135 with an SI of "T." Since HCPCS code C9800 describes both the injection procedure and the dermal filler items and supplies, CMS has assigned HCPCS codes G0429, Q2026, and Q2027 to SI "B" to indicate that these codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x or 13x.

Table 2 – HCPCS codes for dermal filler injection implemented as of July 1, 2010

HCPCS code	Long descriptor	SI	APC
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	T	0135
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	B	NA
Q2026	Injection, Radiesse, 0.1 ml	B	NA
Q2027	Injection, Sculptra, 0.1 ml	B	NA

4. Billing for allogeneic stem cell transplant procedures

CR 6996 revises Section 231.11 of the *Medicare Claims Processing Manual* (Chapter 4) to clarify that charges for allogeneic stem cell acquisition services billed with revenue code 0819 (other organ acquisition) should be reported on the same date of service as the allogeneic transplant procedure in order to be appropriately packaged for payment purposes. The revision to Section 231.11 of the *Medicare Claims Processing Manual* is included as an attachment to CR 6996.

5. Billing for drugs, biologicals, and radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the FDA under the new drug application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

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a. Drugs and biologicals with payments based on average sales price (ASP) effective July 1, 2010
For CY 2010, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP plus four percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2010, a single payment of ASP plus six percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the third quarter of CY 2010, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B drug CAP program be reinstituted sometime during CY 2010, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute. In the CY 2010 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2010 release of the OPPS PRICER. The updated payment rates, effective July 1, 2010 will be included in the July 2010 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp*.

b. Drugs and biologicals with OPPS pass-through status effective July 1, 2010
Six drugs and biologicals have been granted OPPS pass-through status effective July 1, 2010. These items, along with their descriptors and APC assignments, are identified in Table 3 below.

Table 3 – drugs and biologicals with OPPS pass-through status effective July 1, 2010

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/10
C9264*	Injection, tocilizumab, 1mg	9264	G
C9265*	Injection, romidepsin, 1 mg	9265	G
C9266*	Injection, collagenase clostridium histolyticum, 0.1 mg	9266	G
C9267*	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	9267	G
C9268*	Capsaicin, patch, 10cm2	9268	G
C9367*	Skin substitute, endoform dermal template, per square centimeter	9367	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2010.

c. New HCPCS codes effective for certain drugs and biologicals
One new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for July 2010. This code is listed in Table 4 below and replaces C9262. This code is effective for services furnished on or after July 1, 2010.

Table 4 – new HCPCS codes effective for certain drugs and biologicals effective July 1, 2010

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/10
Q2025	Fludarabine phosphate, oral, 1 mg	9262	G

d. Updated payment rates for certain HCPCS codes effective April 1, 2010 through June 30, 2010
The payment rates for three HCPCS codes were incorrect in the April 2010 OPPS PRICER. The corrected payment rates are listed in Table 5 below and have been incorporated into the reissued PRICER, effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Affected claims that were already processed/paid prior to the reissued PRICER, have been reprocessed (or are in the process of being reprocessed).

Table 5 – updated payment rates for certain HCPCS codes effective April 1, 2010 through June 30, 2010

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
C9258	G	9258	Telavancin injection	$2.12	$0.42
C9262	G	9262	Fludarabine phosphate, oral	$8.18	$1.61
J1540	K	0923	Gamma globulin 9 CC inj	$141.64	$28.33

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e. Adjustment to status indicator for HCPCS code 90670 effective April 1, 2010

Effective April 1, 2010, the status indicator for *CPT* code *90670* (*Pneumococcal conjugate vaccine, 13 valent, for intramuscular use*) will change from SI=E (not paid by Medicare when submitted on outpatient claims [any outpatient bill type]) to SI=K (paid under OPPS; separate APC payment). For the remainder of CY 2010, *CPT* code *90670* will be separately paid and the price will be updated on a quarterly basis.

f. Category I H1N1 vaccine *CPT* codes

As stated in the October 2009 update of the hospital OPPS that was published in CR 6626 (Transmittal 1803, August 28, 2009; see *http://www.cms.gov/MLNMattersArticles/downloads/MM6626.pdf* on the CMS website), CMS created two level II HCPCS codes to describe the H1N1 vaccine itself and the H1N1 vaccine administration. Specifically, G9141 (Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)) and G9142 (Influenza A (H1N1) vaccine, any route of administration) were made effective September 1, 2009. Under the OPPS, HCPCS code G9142 is assigned to status indicator "E" indicating that payment is not made by Medicare when this code is submitted on an outpatient bill type because the H1N1 vaccine is supplied at no cost to providers. However, payment will be made to a provider for the administration of the H1N1 vaccine when reported under HCPCS code G9141, even if the vaccine is supplied at no cost to the provider. HCPCS code G9141 is assigned to APC 0350 (Administration of flu and PPV vaccine) with a status indicator of "S" and a payment rate of $25.61 for CY 2010. Beneficiary copayment and deductible do not apply to HCPCS code G9141 (for both OPPS and non-OPPS providers). Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

In January 2010, the CPT Editorial Panel, through the AMA website, released four new H1N1 vaccine CPT codes for implementation on July 1, 2010. The four new *CPT* codes H1N1 vaccine codes are: *90664*, *90666*, *90667*, and *90668* (see Table 6 for the code descriptors). CMS notes that *CPT* code *90663* was made effective September 28, 2009, and was assigned to status indicator "E" under the OPPS since its effective date. Because two existing H1N1 G-codes appropriately describe the vaccine itself and the administration, Medicare will only recognize the G-codes. Under the hospital OPPS, providers must report the H1N1 vaccine itself by reporting G9142 and G9141 for the H1N1 vaccine administration. Table 6 provides a list of H1N1 vaccine and H1N1 vaccine administration HCPCS codes, status indicators, APCs, and payment rates as of July 1, 2010 under the hospital OPPS.

Table 6 – H1N1 vaccine and H1N1 vaccine administration HCPCS codes as of July 1, 2010

	CPT/ HCPCS	Long descriptor	SI	APC	Payment rate
H1N1 vaccine HCPCS codes	G9142	Influenza A (H1N1) vaccine, any route of administration	E	NA	NA
	90663	*Influenza virus vaccine, pandemic formulation, H1N1*	E	NA	NA
	90664	*Influenza virus vaccine, pandemic formulation, live, for intranasal use*	E	NA	NA
	90666	*Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use*	E	NA	NA
	90667	*Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use*	E	NA	NA
	90668	*Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use*	E	NA	NA
H1N1 vaccine administration HCPCS codes	G9141	Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)	S	0350	$25.61
	90470	*H1N1 immunization administration (intramuscular, intranasal), including counseling when performed*	E	NA	NA

g. Correct reporting of biologicals when used as implantable devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged

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into the payment for the associated procedure. When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

h. Correct reporting of units for drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

For example,

- If the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1.
- If the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4.

Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, the hospital should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

As discussed in the *Medicare Claims Processing Manual* (Chapter 17, Section 40; see on the CMS website at *http://www.cms.gov/manuals/downloads/clm104c17.pdf*) CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

i. Reporting of outpatient diagnostic nuclear medicine procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and CMS expects that the majority of hospitals will not encounter this situation.

6. Information regarding the core-based statistical area (CBSA) and wage indexes in effect for CY 2010

The Affordable Care Act (ACA); Sections 3137(a) and 10317 of Pub. L 111-148; (see *http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf* on the Internet) revised the wage indexes that are in effect for FY 2010. As a result of these changes, instructions were issued to contractors in a separate CR, regarding the revised wage indices in effect for FY 2010. The OPPS adopts the post reclassification fiscal year wage index in effect for the inpatient prospective payment system (IPPS) on a calendar year basis. Therefore, CMS adopted the reclassified wage indices that began for IPPS payment on April 1, 2010, for hospital outpatient payment under the OPPS beginning July 1, 2010, to align the mid-year change in post-reclassification wages for some CBSAs with the OPPS calendar year payment period. The OPPS also adopts section 508 geographic reclassifications on a fiscal year basis. The ACA extended section 508 reclassification wage indexes through September 30, 2010. Similar to CMS' treatment of section 508 reclassifications as previously extended under 124 of Pub. L. 110- 275 (MIPPA), hospitals with section 508 reclassifications will revert to their home

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area wage index, with out-migration adjustment if applicable, from October 1, 2010, to December 31, 2010. As CMS did for CY 2009, CMS is also beginning reclassification wage indexes for certain special exception hospitals on January 1, 2010, and extending them through December 31, 2010. Please note that the wage indices included in the July 1, 2010 OPPS PRICER reflect the revised post-reclassification wage index values implemented for the IPPS on April 1, 2010. Contractors shall maintain the current CBSA value assigned to all OPPS hospitals, including those with non section 508 wage index reclassifications that have been approved by the Medicare Geographic Classification Review Board (MGCRB).

7. Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. FIs)/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 6996, was issued to your FI, RHHI, and A/B MAC in two transmittals. One transmittal modifies the *Medicare Claims Processing Manual* and it is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1980CP.pdf*.

The other modifies the Medicare Benefit Policy Manual and it is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R128BP.pdf*.

If you have any questions, please contact your FI, RHHI, or A/B MAC at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6996
Related Change Request (CR) Number: 6996
Related CR Release Date: May 28, 2010
Related CR Transmittal Number: R128BP and R1980CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1980, CR 6996

Calendar year 2010 outpatient prospective payment system PRICER file updates

The calendar year 2010 outpatient prospective payment system (OPPS) PRICER Web page has been updated with new payment files for the Affordable Care Act (ACA). The files are ready for download from the "2nd Quarter 2010 Files" section of the OPPS PRICER Web page at *http://www.cms.gov/PCPricer/OutPPS/list.asp#TopOfPage*.

If you use OPPS PRICER files, please go to the page above and download the following affected files that were updated on June 16, 2010:

- BASEAPCS.txt
- BASEPTCO.txt
- BASEPTRO.txt
- DEVRED10.txt
- OPPSAPCS.txt
- OPPSCAL.txt
- OPPSPTCO.txt
- OPPSPTRO.txt

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-27

ELECTRONIC DATA INTERCHANGE

Additional instruction – HIPAA version 5010 for transaction 835

CMS has issued the following MLN Matters article. Information for Medicare Fee-for-Service Health Care Professionals.

Provider types affected

This article is for physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and regional home health intermediaries [RHHI]), for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6975 to alert providers that, according to the administrative simplification provisions of HIPAA regulations, the Secretary of the Department of Health & Human Services (DHHS) is required to adopt standard electronic transactions and code sets. CMS is currently in the process of implementing the next version of the HIPAA Transaction 835 standard – referred to as 835v5010 in this document. Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.

Key points of change request 6975

The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective date of the regulation: March 17, 2009
- Level I compliance by: December 31, 2010
- Level II Compliance by: December 31, 2011, and
- All covered entities have to be fully compliant on: January 1, 2012.

Background

Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

Level II compliance means that a "covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

CMS will be fully compliant on January 1, 2012, by completing Level I compliancy by December 31, 2010, and Level II compliancy by December 31, 2011. The transition period when both versions would be allowed in production mode for Medicare will be from January 1, 2011-December 31, 2011. The 835v4010A1 and the current standard paper remittance (SPR) should not be sent on or after January 1, 2012, irrespective of the date of receipt or date of service reported on the electronic or paper claim.

Additional information

The official instruction associated with CR 6975, issued to your Medicare carrier, A/B MAC, FI and/or RHHI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R709OTN.pdf*.

If you have questions, please contact your Medicare carrier, A/B MAC, FI and/or RHHI at their toll-free number, which may be found on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6975
Related Change Request (CR) Number: 6975
Related CR Release Date: May 21, 2010
Related CR Transmittal Number: R709OTN
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-20, Transmittal 709, CR 6975

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
July 2010 – August 2010

Topic – Hot Topics

When: Tuesday, July 13, 2010

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Puerto Rico, and U.S. Virgin Islands

Topic – Medicare's Medical Documentation

When: Tuesday, July 27, 2010

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Medicare's Claim Review Programs

When: Wednesday, August 4, 2010

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Puerto Rico, and U.S. Virgin Islands

Topic – Limitation on Recoupment (935)/Remittance Advice

When: Tuesday, August 10, 2010

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training Web site at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time User?** Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____
Registrant's Title: _____
Provider's Name: _____
Telephone Number: _____ Fax Number: _____
E-mail Address: _____
Provider Address: _____
City, State, ZIP Code: _____

Keep checking our Web site, *www.medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the FCSO Medicare training Web site, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses now offer CEUs. Learn more on the FCSO Medicare training Web site and explore our catalog of online courses. ❖

PREVENTIVE SERVICES

June 6 is National Cancer Survivors Day

In the spirit of National Cancer Survivors Day, the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage for a variety of preventive services, including certain cancer screenings. By encouraging your patients with Medicare to take advantage of covered screenings, you can help them lead healthier lives.

Medicare-covered cancer screenings

Medicare provides coverage for the following cancer screenings for eligible Medicare beneficiaries:

- Screening mammographies
- Screening Pap tests
- Screening pelvic exams
- Colorectal cancer screening
- Prostate screening

Additional information

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for the cancer screenings covered by Medicare.

- **The *Medicare Learning Network* (*MLN*) Preventive Services Educational Products Web page** – this page provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff.
  http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- **Cancer Screenings brochure** – this brochure provides coverage information on the Medicare-covered cancer screenings previously listed.
  http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare, including cancer screenings.
  http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- **Quick Reference Information: Medicare Preventive Services** – this chart contains coverage, coding, and payment information for the many preventive services covered by Medicare, including cancer screenings, in an easy-to-use quick-reference format.
  http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- **The Medicare Preventive Services Series: Part 3** – this Web-based training (WBT) includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, pap tests, and pelvic exams. To access the WBT, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules."
- **Preventive Services Educational Products** – this PDF document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more.
  http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf

To order hard copies of certain *MLN* products, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page."

For more information about National Cancer Survivors Day, please visit the official website at *http://www.ncsdf.org*.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate eligible beneficiaries about the importance of taking advantage of cancer screenings covered by Medicare.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-03

May 26 is National Senior Health and Fitness Day

In the spirit of National Senior Health and Fitness Day, the Centers for Medicare & Medicaid Services (CMS) reminds health-care professionals that Medicare provides coverage for a variety of preventive services. By encouraging your senior patients with Medicare to take advantage of covered preventive services, you can help them lead healthier lives.

Medicare-covered preventive services

Medicare provides coverage for the following preventive services for eligible Medicare beneficiaries:

- Abdominal aortic aneurysm screening
- Adult immunizations
- Bone mass measurements
- Cancer screenings
- Cardiovascular screenings
- Diabetes-related services and screenings
- Glaucoma screenings
- Smoking and tobacco-use cessation counseling
- Initial preventive physical examination

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their staff becomes familiar with coverage, coding, billing, and reimbursement for the many preventive services and screenings covered by Medicare.

The *Medicare Learning Network* (*MLN*) Preventive Services Educational Products Web Page: This page provides descriptions and ordering information for MLN preventive services educational products and resources for health care professionals and their staff.
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

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http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf

To order hard copies of certain MLN products, please visit the MLN homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page."

For more information about National Senior Health and Fitness Day, please visit the official website at *http://www.fitnessday.com/senior/index.htm*.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate eligible beneficiaries about the importance of taking advantage of the many preventive services covered by Medicare.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-36

***Third-party websites**. This document contains references to sites operated by third parties. Such references are provided for your convenience only. BCBSF and/or FCSO do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

June 14-20 is National Men's Health Week and June 20 is Father's Day

In the spirit of National Men's Health Week and Father's Day, the Centers for Medicare & Medicaid Services (CMS) asks providers to help keep men with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services.

What you can do

Medicare provides coverage for a variety of preventive services for eligible Medicare beneficiaries. As a trusted source of health care information, you are in a unique position to encourage your patients with Medicare to get covered screenings to detect certain conditions early, when treatment works best.

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for preventive services and screenings covered by Medicare.

- **The *Medicare Learning Network* (*MLN*) Preventive Services Educational Products Web page** – provides descriptions and ordering information for *Medicare Learning Network* (*MLN*) preventive services educational products and resources for health care professionals and their staff.
  http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals** – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare.
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  http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf

To order hard copies of certain *MLN* products, please visit the *MLN* homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page"

For more information about National Men's Health Week, please visit the official website at *http://www.menshealthmonth.org/week*.

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Source: CMS PERL 201006-18

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Web-based training for Medicare preventive services

The Centers for Medicare & Medicaid Services (CMS) would like to remind you that the Medicare Preventive Services Series Part 3 Web-based training course (WBT) is currently available for free. This course includes coverage, coding, and billing information for Medicare coverage of the following preventive services:

- Screening mammography
- Screening Pap tests and pelvic examinations
- Colorectal cancer screening
- Bone mass measurements
- Glaucoma screening

Taking this online course will help you and your staff understand Medicare rules surrounding these important benefits. Not only that, but if you pass this course, you can earn continuing education credit. You can access this course, free of charge, at any time, by visiting the "Preventive Services Educational Products" page at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*. Scroll down to the "Related Links Inside CMS" section and click on "Web Based Training Modules" to take the course.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-42

OTHER EDUCATIONAL RESOURCES

Medicare educating beneficiaries on the Affordable Care Act

Medicare beneficiaries will soon receive important information in the mail about the immediate benefits they may see from the enactment of the Affordable Care Act.

The mailing from the Centers for Medicare & Medicaid Services (CMS), which will be available in both English and Spanish, outlines key provisions of the Affordable Care Act that are important for people with Medicare as well as members of their families.

Medicare mails the Medicare & You handbook to all beneficiary households every fall to provide people with Medicare the most up to date information about changes in Medicare. These annual mailings have from time to time been supplemented with additional mailings that inform beneficiaries about major changes in the law that significantly affect Medicare.

"It's important that our Medicare beneficiaries get facts about this important new law timely so they can learn what stays the same and what will change and improve in terms of their benefits," said Marilyn Tavenner, acting CMS administrator. "As a trusted resource for beneficiaries and their families, we believe that this information will help to inform them about the Affordable Care Act and remind them to be on the alert for any scams asking for personal information. CMS has learned from implementing previous major pieces of health reform legislation like Medicare Part D that unfortunately new opportunities for Medicare beneficiaries also bring new opportunities for scam artists to try and defraud seniors."

"The new law not only strengthens Medicare, but also ensures the guaranteed benefits that beneficiaries have come to rely upon don't change," said Tavenner. "CMS is viewed by beneficiaries as the official and trusted source of information, so it is critical that we reach out quickly to ensure beneficiaries understand their Medicare coverage and how it will improve."

The first benefit that several million Medicare beneficiaries will receive as a result of the passage of the new law is a one-time check for $250, if they enter the Part D donut hole and are not eligible for Medicare extra help. The donut hole is the period in the prescription drug benefit in which the beneficiary pays 100 percent of the cost of their drugs until they hit the catastrophic coverage.

"The $250 check that some beneficiaries will soon see in the mail following the brochure for all Medicare beneficiaries is the first step towards the closing of the coverage gap," said Tavenner. "Next year, all beneficiaries who enter the gap will get a 50 percent discount for covered brand name Part D drugs, and by 2020 will no longer have a gap in coverage."

In addition to the rebate check, the new mailing to beneficiaries outlines other benefits available under the Affordable Care Act. Beginning next year, the Affordable Care Act ensures that Medicare beneficiaries will get preventive care services like colorectal cancer screening and mammograms without cost-sharing, in addition to an annual "wellness visit." The law also includes new tools to help fight fraud by helping Medicare crack down on criminals who are seeking to scam seniors and steal taxpayer dollars.

Because Medicare is a trusted resource for beneficiaries and their family members, the mailing encourages them to log on to *http://www.medicare.gov/* or call 1-800-MEDICARE to get their questions about Medicare or the Affordable Care Act answered.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-37

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Medicare Learning Network Guided Pathways to Medicare Resources – revised

Feeling lost in your search for Medicare knowledge? Let the *Medicare Learning Network* (*MLN*) Guided Pathways get you back on track. With the revised (April 2010) Guided Pathways to Medicare Resources, available at *http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp*, finding Medicare information has never been so easy.

Guided Pathways leads Medicare fee-for-service providers through a variety of resources that are organized by important topics such as billing, coverage, and reimbursement, and are offered in basic, intermediate, and advanced levels. Explore these easy-to-navigate online guides to quickly find the information you need on important Medicare policy and requirements.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-42

New from the Medicare Learning Network

The *Medicare Preventive Services Resources* CD (ICN #6640), which contains PDF (portable document file) format of the Centers for Medicare & Medicaid Services (CMS) Medicare preventive service educational products on a single convenient CD-ROM, is now available for order through the *Medicare Learning Network* – free of charge.

The CD includes the following products:

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*
- All three quick reference billing charts (*Medicare Preventive Services, The ABCs of Providing the Initial Preventive Physical Examination, and Medicare Immunization Billing*)

All seven brochures (*Adult Immunization, Bone Mass Measurements, Cancer Screenings, Diabetes-Related Services, Expanded Benefits, Glaucoma Screening, and Smoking and Tobacco-Use Cessation Counseling Services*).

To order a free copy of the CD, please visit the Preventive Services Educational Products page on the CMS website at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*. Scroll down to the "Related Links Inside CMS" section and click on "MLN Product Ordering."

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201006-04

New ICD-10 frequently asked questions from CMS

The Centers for Medicare & Medicaid Services (CMS) has posted 11 new frequently asked questions (FAQs) about the ICD-10 implementation. To access these FAQs, please visit the CMS ICD-10 Web page at *http://www.cms.gov/ICD10/*. Select the "Medicare Fee-for-Service Provider Resources" link on the left side of the page, scroll down the page to the "Related Links Inside CMS" section, and select "ICD-10 FAQs."

Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-40

New booklet for using the Medicare coverage database

Do you ever wonder about how to utilize search tools in selected areas of the Centers for Medicare & Medicaid Services website? The searchable Medicare coverage database (MCD) contains all Medicare national coverage determinations, national coverage analyses, local coverage determinations, and local policy articles. The *Medicare Learning Network* (*MLN*) has produced a "how to" booklet (2.5 MB) that provides an overview of the MCD and teaches users how to use the search, index, report and download features. The revised *How to Use The Medicare Coverage Database* booklet may be located at *http://www.cms.gov/MLNProducts/MPUB/itemdetail.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.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 201005-42

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

Order form for Medicare Part A materials

The following materials are available for purchase. To order these items, please complete and submit this form along with your check/money order payable to FCSO Account # (use appropriate account number)

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2009 through September 2010.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				

Please write legibly	Subtotal	**$**
	Tax (***add % for your area***)	**$**
	Total	**$**

Mail this form with payment to:

First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name:
_____

Provider/Office Name:
_____

Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
_____

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Addresses

CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

PART A REDETERMINATION
Medicare Part A Redetermination and Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

MEDICARE SECONDARY PAYER
Information on Hospital Protocols
Admission Questionnaires, Audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

General MSP Information
Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

MSPRC DPP Debt Recovery
Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

ELECTRONIC CLAIM FILING
Direct Data Entry (DDE) Startup
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

POST-PAY MEDICAL REVIEW
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and SNF Routine Cost Limit Exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

PROVIDER ENROLLMENT
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

PROVIDER ENROLLMENT
American Diabetes Association Certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

SPECIAL DELIVERY
Overnight Mail and/or other Special Courier Services
First Coast Service Options Inc.
532 Riverside Av.
Jacksonville, FL 32202-4914

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY
Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

RAILROAD MEDICARE
Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS
Customer Service Center Toll-Free
1-888-664-4112

Interactive voice response (IVR)
1-888-664-4112

Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY
Customer Service Center Toll-Free
1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
(check return assistance only)

Option 6
Automated Response Line

PROVIDER EDUCATION & OUTREACH
Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

CREDIT BALANCE REPORT
Debt Recovery
1-904-791-6281
Fax
1-904-361-0359

Medicare Websites

PROVIDERS
Florida Medicare Contractor
medicare.fcso.com
Centers for Medicare & Medicaid Services
www.cms.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
www.medicare.gov

Addresses

CLAIMS/CORRESPONDENCE
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First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

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Receipts and Acceptances
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Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and SNF Routine Cost Limit Exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
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PROVIDER ENROLLMENT
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Jacksonville, FL 32231-0048

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Jacksonville, FL 32202-4914

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Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
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RAILROAD MEDICARE
Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
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Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
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Orthotic and Prosthetic Device Claims
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1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

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Debt Recovery
1-904-791-6281
Fax
1-904-361-0359

Medicare Websites

PROVIDERS
U.S. V I Medicare Contractor
medicare.fcso.com
Centers for Medicare & Medicaid Services
www.cms.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
www.medicare.gov

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

First Coast Service Options, Inc ♦ P.O. Box 2078 ♦ Jacksonville, FL 32231-0048

♦ ATTENTION BILLING MANAGER ♦