

MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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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
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- _____
- _____
- _____



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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.fcsso.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

Revenue codes 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 hospitals, including critical access hospitals (CAHs), submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

What you need to know

As of January 19, 2011, Medicare's claims processing systems will accept revenue codes 0860 (Magnetoencephalography (MEG) – General classification) and 0861 (MEG) created by the National Uniform Billing Committee. The revenue code field is required on all institutional claims and Medicare will accept these codes from hospitals (for inpatient and outpatient services) on types of bill 11x and 13x and from CAHs on type of bill 85x for dates of service on or after April 1, 2010.

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Additional information

The official instruction, CR 7100, issued to your FI or A/B MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/Transmittals/downloads/R783OTN.pdf>.

If you have any questions, please contact your 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: MM7100

Related Change Request (CR) Number: 7100

Related CR Release Date: October 15, 2010

Related CR Transmittal Number: R783OTN

Effective Date: April 1, 2010

Implementation Date: January 19, 2011

Source: CMS Pub. 100-20, Transmittal 783, CR 7100

Reminder regarding the timely filing limit changes

Background

Section 6404 of Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements to reduce the maximum time period for submission of all Medicare fee-for-service claims to one calendar year after the date of service. These amendments apply to services furnished on or after January 1, 2010. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010, must be filed with the appropriate Medicare claim processing contractor no later than December 31, 2010.

Key points to remember

- Providers must allow time for mailing as the timeliness is calculated on the contractor receipt date not the postmark date of when the claim is mailed.
- The electronic data interchange (EDI) system accepts claims 24/7; however, the cutoff for the date received is 6:00 p.m. Any claim received after 6:00 p.m. or on weekends/holidays would be considered received the next business day.
- The direct data entry (DDE) system hours of receipt are from 7:00 a.m. to 7:00 p.m., Monday-Friday and 7:00 a.m. to 4:00 p.m. on Saturday. Since the customer is entering into the processing system, the receipt date is the actual date received.
- Adjustment to previously processed claims and claims returned to providers (RTP) are subject to the same timely filing guidelines.
- For institutional claims that include span dates of service (i.e., a “from” and “through” date span on the claim), the “through” date on the claim will be used to determine the date of service for claim filing timeliness.
- Claims having a date of service of February 29 must be filed by February 28 of the following year to be considered as timely filed. If the date of service is February 29 of any year and is received on or after March 1 of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional information

For additional information, please see the related change request 6960 at <http://www.cms.gov/Transmittals/downloads/R697OTN.pdf>.

The MLN Matters article MM6960 is available at <http://www.cms.gov/MLNMattersArticles/downloads/mm6960.pdf>. ❖

Source: CMS Pub. 100-20, Transmittal 697, CR 6960

Suspension of automatic denial of institutional claims reporting modifier GA

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

Provider types affected

Providers and suppliers who submit institutional claims to Medicare contractors (fiscal intermediaries, [FIs], regional home health intermediaries [RHHIs], and Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7106, which directs Medicare contractors to notify you that services submitted with the modifier GA on institutional claims will not be subject to automatic denial until further notice.

Caution – what you need to know

In October 2009, the Centers for Medicare & Medicaid Services (CMS) issued CR 6563, entitled “Billing for Services Related to Voluntary Uses of Advance Beneficiary Notices of Noncoverage (ABNs)”, effective April 1, 2010. CR 6563 changed processing of institutional claims with the **modifier GA** and directed Medicare contractors processing institutional claims to automatically deny line items submitted with the **modifier GA**. Until further notice, such denials have since been subsequently suspended at the direction of CMS.

Go – what you need to do

You do not need to do anything now. You may wish to review the *MLN Matters*[®] article related to CR 6563, which is available on the CMS website at <http://www.cms.gov/MLN MattersArticles/downloads/MM6563.pdf>.

Additional information

The official instruction, CR 7106 issued to your FI, RHHI, and A/B MAC, regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R7700TN.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: MM7106

Related Change Request (CR) Number: 7106

Related CR Release Date: September 17, 2010

Related CR Transmittal Number: R7700TN

Effective Date: April 1, 2010

Implementation Date: October 17, 2010

Source: CMS Pub. 100-20, Transmittal 770, CR 7106

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Partial code freeze prior to ICD-10 implementation

At the ICD-9-CM Coordination & Maintenance Committee meeting on September 15, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM/PCS codes prior to implementation on October 1, 2013. There was considerable support for this partial freeze.

The partial freeze will be implemented as follows:

- The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012, there will be only limited code updates to both ICD-9-CM and ICD-10 code sets to capture new technology and new diseases.
- There will be no updates to ICD-9-CM on October 1, 2013, as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

You may view the transcript of the meeting at http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp. From there, select the September 15-16, 2010 meeting transcript in the *Download* section, and then from the ZIP files, select the 091510_Morning_Transcript file. This section appears on page 4 of the 78-page proceeding.

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

Source: CMS PERL 201010-35

Influenza vaccine payment allowances – annual update for 2010-2011 season

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 (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for influenza vaccines provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7120 in order to update payment allowances, effective September 1, 2010, for influenza vaccines when payment is based on 95 percent of the average wholesale price (AWP). CR 7120 refers only to the seasonal influenza vaccines. According to CR 6617, only the Level II Healthcare Common Procedure Coding System code G9142 is used to identify the H1N1 vaccine on Medicare claims. Therefore, *Common Procedure Terminology (CPT)* codes 90663, 90664, 90666, 90666, 90667, and 90668 will not be recognized on Medicare claims for the H1N1 vaccine.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

CR 7120 provides the payment allowances for the following seasonal influenza virus vaccines: CPT codes 90655, 90656, 90657, 90658, 90660, and 90662 when payment is based on 95 percent of the AWP. The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year.

The Medicare Part B payment allowance in these situations for:

- CPT 90655 is \$12.398
- CPT 90656 is \$12.375
- CPT 90657 is \$6.297

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- CPT 90658 (for dates of service September 1, 2010 through December 31, 2010,) is \$11.368

CPT 90660 (FluMist, a nasal influenza vaccine) or CPT 90662 (Fluzone High-Dose) may be covered if your Medicare claims processing contractor determines the use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance effective September 1, 2010, for CPT 90660 is \$22.316, and for CPT 90662 is \$29.213.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine. The current payment allowances for pneumococcal vaccines may be found on the quarterly drug pricing files.

Additional information

Note that Medicare contractors will not search their files to adjust claims already processed prior to implementation of CR 7120. However they will adjust those claims that you bring to their attention.

The official instruction, CR 7120 issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2071CP.pdf>.

If you have any questions, please contact your carrier, 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: MM7120

Related Change Request (CR) Number: 7120

Related CR Release Date: October 22, 2010

Related CR Transmittal Number: R2071CP

Effective Date: September 1, 2010

Implementation Date: November 24, 2010

Source: CMS Pub. 100-04, Transmittal 2071, CR 7120

Welcome to Medicare

If you're new to the Medicare community or if you just need a review of the basics, please visit our Welcome to Medicare page at http://medicare.fcso.com/Welcome_to_Medicare/. You'll find everything you need to build your foundation of Medicare knowledge, from a recommended training curriculum to links to key resources to help you on your way to success as a Medicare provider or biller.

Fee schedule for administration of influenza and pneumococcal virus vaccines

The allowances for the administration of influenza and pneumococcal virus vaccines, Healthcare Common Procedure Coding System (HCPCS) codes G0008 and G0009 respectively, are not included in the Medicare physician fee schedule (MPFS). However, according to the *Medicare Claims Processing Manual*, Chapter 18 (Preventing and Screening Services), Section 10.2.2.1, reimbursement for HCPCS code G0008 and G0009 on and after March 1, 2003, should be made based upon the rate in the MPFS associated with CPT code 90471.

Therefore, to determine the allowance for administration of influenza and pneumococcal virus vaccines, you may access the fee schedule lookup page at http://medicare.fcso.com/Fee_lookup/fee_schedule.asp, select MPFS from the drop-down menu, enter the date of service, locality, procedure code 90471, and submit.

Source: CMS Pub. 100-20, Transmittal 774, CR 7124

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2010 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations

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

Provider types affected

This article physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for influenza and pneumococcal immunization services provided to Medicare beneficiaries.

Provider action needed

This article is for informational purposes and is based on change request (CR) 7124 which serves to remind the Medicare provider community of the requirements to correctly complete roster billing and centralized billing for influenza and pneumococcal immunizations. Be sure billing staffs know of these requirements.

Background

According to the Centers for Disease Control and Prevention, the seasonal vaccine for the 2010-2011 influenza season will protect against the 2009 H1N1 and two other influenza viruses (See <http://www.cdc.gov/flu/protect/keyfacts.htm> on the Internet) Medicare allows one flu shot per year, and Part B of Medicare pays 100 percent for pneumococcal vaccines and influenza virus vaccines and their administration.

Note: The Part B deductible and coinsurance do not apply for pneumococcal and influenza virus vaccine.

Medicare does not require, for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision. Typically, the pneumococcal vaccine is administered once in a lifetime. Claims are paid for beneficiaries who are at high risk of pneumococcal disease and have not received a pneumococcal vaccine within the last five years or are revaccinated because they are unsure of their vaccination status.

When completing a claim for reimbursement, providers are reminded to use the appropriate influenza and pneumococcal (PPV) *Current Procedural Terminology* (CPT) codes for the vaccine and the appropriate Healthcare Common Procedure Coding System (HCPCS) codes for the administration as follows:

G0008 Administration of influenza virus vaccine

G0009 Administration of pneumococcal vaccine

Please see *Medicare Claims Processing Manual* (Chapter 18, Section 10) on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/manuals/downloads/chn104c18.pdf> for any additional information regarding reimbursement of influenza and PPV claims.

Providers who only render influenza services may enroll as one of two types of providers:

- A mass immunization roster biller (specialty provider type 73), or
- A centralized biller.

Other facilities that bill Part B of Medicare, including outpatient or inpatient, but do not qualify as type 73, may continue to roster bill.

Providers are responsible for meeting the guidelines for being either a mass immunizer or centralized biller. Additionally, providers (except suppliers) already enrolled in the Medicare program may use their national provider identifier (NPI) to provide influenza vaccinations. Mass immunization roster billers and centralized billers must enroll in the Medicare program even if mass influenza and/or pneumococcal immunizations are the only service being provided. They must accept assignment on both the vaccine and its administration, bill only for influenza and/or PPV vaccinations, and submit claims using the roster billing process.

Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals. They must be properly licensed in the States in which they plan to operate flu clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors processing claims. Individuals and entities must be properly licensed in the states in which they plan to operate flu and/or pneumococcal clinics. Participation as a centralized biller is limited to one

2010 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations (continued)

year and must be renewed annually by contacting the CMS central office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier to render influenza vaccination services to Medicare beneficiaries.

Providers and suppliers must enroll using the appropriate CMS-855 Medicare enrollment application. Information on provider enrollment forms may be found on the CMS website at http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp.

Refer to the *Medicare Claims Processing Manual*, Chapter 18, Sections 10-10.5 at <http://www.cms.gov/manuals/downloads/clm104c18.pdf> for more information on billing requirements.

Additional Information

The official instruction, CR 7124, issued to your carriers, FIs, and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R774OTN.pdf>.

If you have any questions, please contact your carriers, FIs, or A/B MACs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7124

Related Change Request (CR) Number: 7124

Related CR Release Date: September 24, 2010

Related CR Transmittal Number: R774OTN

Effective Date: October 25, 2010

Implementation Date: October 25, 2010

Source: CMS Pub. 100-20, Transmittal 774, CR 7124

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2011 annual update for the health professional shortage area bonus payments

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

Provider types affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries in health professional shortage areas (HPSAs).

What you need to know

Change request (CR) 7139, from which this article is taken, alerts providers that the annual health professional shortage area (HPSA) bonus payment file 2011 file will be made available by the Centers for Medicare & Medicaid Services (CMS) to your Medicare contractor on November 15, 2010. This file will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2011, through December 31, 2011.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors by early December of each year.

Additional information

The official instruction, CR 7139 issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2054CP.pdf>.

You will find annual HPSA files (as they become available) and other important HPSA information on the CMS website at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>.

If you have any questions, please contact your carrier, 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: MM7139

Related Change Request (CR) Number: 7139

Related CR Release Date: September 17, 2010

Related CR Transmittal Number: R2054CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2054, CR 7139

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January 2011 quarterly average sales price update and revision to prior files

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

Provider types affected

This article is for all physicians, providers and suppliers who submit claims to Medicare contractors (Medicare administrative contractors (MACs), fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7188 and instructs Medicare contractors to download and implement the January 2011 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2010, July 2010, April 2010, and January 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2011, with dates of service January 1, 2011, through March 31, 2011. See the *Background and Additional information* sections of this article for further details regarding these changes.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
January 2011 ASP and ASP NOC files	January 1, 2011 through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and ASP NOC files	January 1, 2010, through March 31, 2010

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

Additional information

The official instruction (CR 7188) issued to your Medicare MAC, carrier, and/or FI may be found at <http://www.cms.gov/Transmittals/downloads/R2067CP.pdf>.

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

MLN Matters® Number: MM7188

Related Change Request (CR) Number: 7188

Related CR Release Date: October 15, 2010

Related CR Transmittal Number: R2067CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2067, CR 7188

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Written transcript of the September 13 ICD-10 follow-up conference call

The written transcript is now available for the September 13 Centers for Medicare & Medicaid Services' (CMS) national provider conference call, "ICD-10 Implementation in a 5010 Environment." The written transcript may be accessed at http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp. Scroll to the bottom of the Web page to the *Downloads* section to locate the written transcript PDF file.

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

Source: CMS PERL 201010-19

October 2010 Medicare physician fee schedule database update

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

Provider types affected

Physicians and nonphysician practitioners submitting claims to fiscal intermediaries (FI), carriers or A/B Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries are affected.

What you need to know

Payment files were issued to Medicare contractors based upon the 2010 Medicare physician fee schedule final rule. This article is based on change request (CR) 7112, which amends those payment files. Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that were processed prior to implementation of CR 7112. However, contractors will adjust claims brought to their attention.

Background

Changes included in the October update to the 2010 Medicare physician fee schedule database (MPFSDB) are as follows:

The following changes are effective for dates of service on and after January 1, 2010:

CPT/HCPCS/modifier	Action
51725 TC	Multiple procedure indicator: 2
51726 TC	Multiple procedure indicator: 2
51727 TC	Multiple procedure indicator: 2
51728 TC	Multiple procedure indicator: 2
51729 TC	Multiple procedure indicator: 2
51736 TC	Multiple procedure indicator: 2
51741 TC	Multiple procedure indicator: 2
51784 TC	Multiple procedure indicator: 2
51785 TC	Multiple procedure indicator: 2
51792 TC	Multiple procedure indicator: 2
54240	Multiple procedure indicator: 0
54240 26	Multiple procedure indicator: 0
54250	Multiple procedure indicator: 0
54250 26	Multiple procedure indicator: 0
59020	Multiple procedure indicator: 0
59020 26	Multiple procedure indicator: 0
59025	Multiple procedure indicator: 0
59025 26	Multiple procedure indicator: 0
76813 TC	Physician supervision diagnostic indicator: 01
76814 TC	Physician supervision diagnostic indicator: 01
G8443	Procedure status: I
G8445	Procedure status: I
G8446	Procedure status: I

Magnetic resonance angiography

On June 3, 2010, the Centers for Medicare & Medicaid Services (CMS) discontinued separate national coverage determinations (NCD) for magnetic resonance angiography (MRA) and magnetic resonance imaging (MRI) and eliminated the noncoverage language that currently exists for MRA in the *NCD Manual*, Section 220.3, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally noncovered. As a result of this change, the procedure status for CPT codes 72159 and 73225 has changed from noncovered to restricted. This change is effective for **dates of service on or after June 3, 2010**.

October 2010 Medicare physician fee schedule database update (continued)

The following changes are effective for **dates of service on and after July 1, 2010**:

CPT/HCPCS	Action
0223T	Assistant at surgery indicator: 9
0224T	Assistant at surgery indicator: 9
0225T	Assistant at surgery indicator: 9
0226T	Assistant at surgery indicator: 9
0227T	Assistant at surgery indicator: 9
0228T	Assistant at surgery indicator: 9
0229T	Assistant at surgery indicator: 9
0230T	Assistant at surgery indicator: 9
0231T	Assistant at surgery indicator: 9
0232T	Assistant at surgery indicator: 9
0233T	Assistant at surgery indicator: 9

Descriptor changes

The long and/or short descriptor has been revised for the following codes:

HCPCS code	Revised long descriptor	Revised short descriptor
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening	N/A
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening	N/A
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening	Rapid immunoassay HIV-1,2

Additional information

The official instruction, CR 7112 issued to your carrier, FI, or A/B MAC, regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2051CP.pdf>.

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

MLN Matters® Number: MM7112

Related Change Request (CR) Number: 7112

Related CR Release Date: September 17, 2010

Related CR Transmittal Number: R2051CP

Effective Date: January 1, 2010, unless otherwise noted

Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2051, CR 7112

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Unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims. ❖

Source: CMS Pub. 100-06, Chapter 5, Section 410.10

Use Internet-based PECOS for your Medicare enrollment actions

It's easy to use and offers a host of advantages over the paper-based enrollment process.

Do you want to save money and time? The Internet-based provider enrollment, chain and ownership system (PECOS) can help. Internet-based PECOS can be used in lieu of the paper Medicare enrollment application to:

- Submit an initial Medicare enrollment application
- Verify or change your enrollment information
- Track your enrollment application through the Web submission process
- Add or change a reassignment of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate your Medicare enrollment
- Voluntarily withdraw from the Medicare program

Use of this automated, online process results in less staff time and administrative costs to complete and submit enrollment information to Medicare.

Learn how to use the system by selecting the appropriate instructions below based on the type of provider:

Physicians and nonphysician practitioners

Learn how to use the system by reading *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners Fact Sheet*, available at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

And if you encounter problems or have questions as you navigate the system, help is available at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf.

Don't wait, set your practice free from paper -- start using Internet-based PECOS today at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage.

Using Internet-based PECOS is easy

Provider and supplier organizations

It's easy to use and offers a host of advantages over the paper-based enrollment process. Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) can now use Internet-based PECOS for Medicare enrollment actions.

Learn how to use the system by reading *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations Fact Sheet*, available at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf.

Using Internet-based PECOS is easy

Reminder: The process for access to Internet-based PECOS by an organization provider may take several weeks to complete. It is recommended that you begin this process (if you have not already) well in advance of any upcoming enrollment actions. DMEPOS suppliers should visit *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers Fact Sheet* at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf for more information on how to use the system.

Don't wait, set your organization free from paper – start using Internet-based PECOS (http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage) today

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

Source: CMS PERL 201010-18

Effective date on the procedure status indicator for CPT code 80101

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

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs].

Provider action needed

This article is based on CR 7140, which clarifies that the effective date for the change of the procedure status indicator to “I” for *Current Procedure Terminology (CPT)* code 80101 has been set to January 1, 2010 for all claims and CR 7140 supersedes all other CRs in relation to this issue. Thus;

- For claims with date of service (DOS) on or after January 1, 2010, the new test code G0431 (Drug screen, qualitative; single drug class method) must be utilized by those clinical laboratories that do not require a Clinical Laboratory Improvement Act (CLIA) certificate of waiver as CPT codes 80101 and 80101 QW are not valid on the clinical laboratory fee schedule (CLFS) as of January 1, 2010.
- Clinical laboratories should identify claims that were filed and denied during the period of January 1, 2010 through June 30, 2010, as a result of CPT 80101, and resubmit these claims with HCPCS code G0431. However, do not resubmit such claims if they were paid by Medicare.
- For claims with DOS on or after January 1, 2010, clinical laboratories that do require a CLIA certificate of waiver must utilize the new test code G0431 QW.

Background

The Center for Medicare & Medicaid Services (CMS) has been receiving inquiries on when the Medicare procedure status indicator should be changed to “I” (Not valid for Medicare purposes, Medicare recognizes another code) for CPT 80101 (*Drug Screen, Qualitative; Single Drug Class Method*). There has been some confusion regarding the compliance between CR 6852 (Transmittal 653) issued on March 19, 2010, which changed the indicator

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effective April 1, 2010 and CR 6909 (Transmittal 1957) issued on April 28, 2010 which changed the indicator effective date to July 1, 2010, as well as a third source, the CLFS file that is utilized by the Medicare contractors, which changed the indicator effective date to January 1, 2010. CR 7140 clarifies that the effective date for the change of the procedure status indicator to “I” for CPT code 80101 has been set to January 1, 2010. This CR supersedes all previous CMS transmittals concerning the indicator change for CPT code 80101.

Beginning January 1, 2010, the new test code G0431 (Drug screen, qualitative; single drug class method) must be used by those clinical laboratories that do not require a CLIA certificate of waiver.

For claims with DOS on or after January 1, 2010, those clinical laboratories that do require a CLIA certificate or waiver must utilize the new test code G0431 QW.

Claims that were filed and denied for the period January 1, 2010, through June 30, 2010, with CPT code 80101 should be resubmitted with the Healthcare Common Procedure Coding System (HCPCS) code G0431.

Additional Information

The official instruction (CR 7140) issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R776OTN.pdf>.

If you have any questions, please contact your carrier, FI, and 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: MM7140

Related Change Request (CR) Number: 7140

Related CR Release Date: September 24, 2010

Related CR Transmittal Number: R776OTN

Effective Date: October 26, 2010

Implementation Date: October 26, 2010

Source: CMS Pub. 100-04, Transmittal 776, CR 7140

Take advantage of FCSO's exclusive PDS report

Did you know that FCSO's exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through FCSO's PDS's portal at <https://medicare.fcso.com/reporting/index.asp>, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business bottom line.

UB-04 Overview fact sheet now available from the Medicare Learning Network

The new *Medicare Learning Network*® (MLN) UB-04 Overview fact sheet (revised July, 2010) is now available in both downloadable and hardcopy formats. This fact sheet details the UB-04 paper claim form, also known as the Form CMS-1450, which is only accepted from institutional providers who are excluded from the mandatory electronic claims submission. A downloadable version is available at http://www.cms.gov/MLNProducts/downloads/ub04_fact_sheet.pdf.

To order a print version free of charge, please visit the MLN homepage at <http://www.cms.gov/mlnngeninfo>. Click on “MLN Product Ordering Page” in the “Related Links Inside CMS” section.

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

Source: CMS PERL 201009-39

Medicare Advantage news – wide range of Medicare health and drug plan options continues in 2011

Medicare Advantage premiums fall, enrollment rises, and benefits similar compared to 2010.

The Centers for Medicare & Medicaid Services (CMS) has announced that, on average, Medicare Advantage premiums will be one percent lower in 2011 than in 2010. The majority of Medicare beneficiaries, on average, enrolled in Medicare health and prescription drug plans this year should find little or no change in their benefits in 2011, in addition to seeing more drug plans offering coverage in the prescription drug coverage gap or “donut hole.” Medicare Advantage plans project that enrollment will increase by five percent in 2011. And, consistent with the Affordable Care Act, beneficiaries, in most Medicare Advantage plans and original Medicare will gain access to preventive benefits with no out of pocket costs.

Through the new tools provided to Medicare under the Affordable Care Act, and working closely with Medicare Advantage organizations and Prescription Drug Plan, CMS took steps to:

- Protect beneficiaries from excessive increases in premiums and cost sharing through aggressive bid reviews
- Consolidate low enrollment and duplicative plans so beneficiaries have meaningful differences between plans offered by the same organization
- Set limits on out-of-pocket expenses
- Cover preventive services with no cost sharing
- Limit plan cost sharing for skilled nursing care, chemotherapy and renal dialysis to the amounts paid by beneficiaries in original Medicare.

The Affordable Care Act also provides some new benefits to Medicare beneficiaries in 2011 like free wellness visits, some new free health screenings, and a 50 percent discount on brand-name drugs for seniors who fall into the coverage gap.

CMS is encouraging beneficiaries enrolled in Medicare Advantage and Medicare prescription drug plans to review their current health and drug plan coverage for any changes their plans may be making for 2010 before the annual enrollment period begins November 15. In addition to the five-star ratings on the Medicare plan finder at <https://www.medicare.gov/find-a-plan/questions/home.aspx>, users will find an icon that shows those plans that had a low overall quality rating the past three years.

Additional resources

- National press release issued 9/21: http://www.cms.gov/apps/media/press_releases.asp
- Medicare health and drug plan state-by-state fact sheets: <http://www.cms.gov/center/openenrollment.asp>
- 2011 plan landscape files: <http://www.cms.gov/PrescriptionDrugCovGenIn/>

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

Source: CMS PERL 201009-39

Results of the 2010 Medicare contractor provider satisfaction survey

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

Provider types affected

This article is informational only for all physicians, providers, and suppliers billing the Medicare program.

Provider action needed

No action is needed. This article is informational only and provides a summary of the findings from the annual Medicare contractor provider satisfaction survey (MCPSS) by the Centers for Medicare & Medicaid Services (CMS) to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]).

Background

The MCPSS offers Medicare fee-for-service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. The MCPSS elicits information from a sample of hospitals, physicians, skilled nursing facilities (SNFs), home health agencies, clinical laboratories, and other providers and suppliers.

Survey questions focus on seven key business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit & reimbursement. The 2010 MCPSS survey questions used a new fully labeled rating scale of 1 to 5, "1" representing "very dissatisfied" and "5" representing "very satisfied".

CMS distributed the 2010 survey to approximately 33,000 randomly selected providers, including physicians and other health care practitioners, suppliers, and institutional facilities that serve Medicare beneficiaries across the country. Those health care providers selected to participate in this year's survey were notified in January.

In January 2011, the next MCPSS will be distributed to a new sample of approximately 33,000 Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2011 MCPSS implementation, you have an opportunity to help

CMS improve service to all providers.

Key points/2010 results

- Of all providers who responded, more than 69 percent stated they were satisfied or very satisfied with their contractor's overall performance and 13 percent were dissatisfied or very dissatisfied with their contractor's overall performance.
- Audit and reimbursement and claim processing business functions were rated with the highest level of provider satisfaction.
- High satisfaction was also expressed by hospices, end-stage renal disease (ESRD) providers, and rural health clinics; while low satisfaction was expressed by licensed practitioners and laboratories.
- Individual results were provided to Medicare contractors for their use in process improvement activities.
- CMS is gradually migrating to a fully Web-based survey. The migration to the Web mode of response this year reached an overall total of 65 percent.
- The public report may be found at <http://www.cms.gov/MCPSS/>.

Additional information

For more information about the MCPSS, please visit <http://www.cms.gov/MCPSS/>.

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: SE1030

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 SE1030

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Feedback page

One of the trends identified in the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) was our providers' preference to have more ways to communicate with us. Our feedback page offers our customers the convenience of a central "hub" for communication and includes three interactive feedback, available at <http://medicare.fcso.com/feedback/>.

2010 Medicare contractor provider satisfaction survey – results are now available

The Centers for Medicare & Medicaid Services (CMS) has completed the administration of the 2010 Medicare contractor provider satisfaction survey (MCPSS). The 2010 results reflect the percentage of provider satisfaction as distributed on the new, fully labeled, five-point scale:

1. Very dissatisfied
2. Dissatisfied
3. Neither satisfied nor dissatisfied
4. Satisfied
5. Very satisfied

A random sample of over 33,000 providers was selected to participate in this year's survey. Providers were asked to rate their satisfaction with services provided by their Medicare fee-for-service (FFS) contractors. Of all providers who responded, more than 69 percent stated they were

satisfied or very satisfied with their contractor's overall performance. Approximately 13 percent stated they were dissatisfied or very dissatisfied.

From the results, CMS is able to identify the contractor services that providers value the most as well as areas that need improvement. CMS will use this information to encourage process improvements with the Medicare FFS contractors.

The 2010 MCPSS public report details findings from the survey and may be accessed at <http://www.cms.hhs.gov/MCPSS>.

Thank you for your interest in the MCPSS.

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

Source: CMS PERL 201009-37

Medicare self-referral disclosure protocol

Section 6409(a) of the Affordable Care Act (ACA) requires the Secretary of the Department of Health & Human Services, in cooperation with the Inspector General of the Department of Health and Human Services (HHS), to establish a Medicare self-referral disclosure protocol (SRDP) that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of Section 1877 of the Social Security Act (the Act).

The SRDP requires health care providers of services or suppliers to submit all information necessary for the Centers for Medicare & Medicaid Services (CMS), on behalf of the Secretary, to analyze the actual or potential violation of Section 1877 of the Act. Section 6409(b) of the ACA, gives the Secretary of HHS the authority to reduce the amount due and owing for violations of Section 1877. The SRDP is located on the CMS website at <http://www.cms.gov/PhysicianSelfReferral/>.

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

Source: CMS PERL 201009-40

Billing and processing for healthy control group volunteers in a qualified clinical trial

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 MM6776 to reflect a revised change request (CR) 6776, which was issued on September 17, 2010. In this article, the CR release date, and the Web address for accessing CR 6776 were revised. All other information remains the same. The article was published in the February 2010 *Medicare A Bulletin* (page 9).

Provider types affected

All providers submitting inpatient and outpatient claims for qualified clinical trials to fiscal intermediaries (FI) and Part A/B Medicare administrative contractors (A/B MAC) for healthy control group volunteers are affected.

Provider action needed

This article is based on CR 6776, which corrects institutional billing requirements for clinical trial claims. Institutional providers billing inpatient and outpatient clinical trial services must report International Classification of Diseases, Ninth Edition Clinical Modification (ICD-9-CM) diagnosis code of V70.7 (Examination of participant in clinical trial) in the secondary position (or in the primary position if the patient is a healthy, control group volunteer) and condition code 30 regardless of whether all services are related to the clinical trial or not.

Note: For claims with dates of service on or after September 19, 2000 through December 31, 2001, V70.5 should be used for the primary diagnosis. Please be sure that your billing staffs are aware of these changes.

Background

Healthy control group volunteers, by definition, do not have any underlying conditions. Therefore, providers need to report ICD-9-CM diagnosis code, V70.7 (V70.5 for dates of service on or after September 19, 2000 through December 31, 2001), as the primary diagnosis instead of the secondary diagnosis, as no primary diagnosis exists.

Billing and processing for healthy control group volunteers in a qualified clinical trial (continued)

Note: For clinical trial billing requirements for patients enrolled in a managed care plan, please refer to the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Chapter 32, Section 69.9, available at <http://www.cms.hhs.gov/manuals/downloads/clm104c32.pdf>.

Additional information

The official instruction, CR 6776, issued to your FI or A/B MAC regarding this change, may be viewed on the CMS Web site at <http://www.cms.hhs.gov/Transmittals/downloads/R2052CP.pdf>.

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

MLN Matters® Number: MM6776 – Revised

Related Change Request (CR) Number: 6776

Related CR Release Date: September 17, 2010

Related CR Transmittal Number: R2052CP

Effective Date: September 19, 2000

Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 2052, CR 6776

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ELECTRONIC HEALTH RECORDS

Additional electronic health record certification bodies named

The Office of the National Coordinator for Health Information Technology (ONC) named InfoGard Laboratories, Inc., San Luis Obispo, California, as an ONC-authorized testing and certification body (ONCATCB).

The addition of InfoGard Laboratories, Inc. as an ONC-ATCB provides more options for EHR vendors to have their products tested and certified for compliance with the standards and certification criteria that were issued by the U. S. Department of Health & Human Services earlier this year.

Certification of EHRs is part of a broad initiative undertaken by Congress and President Obama under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act (ARRA) of 2009. HITECH created new incentive payment programs to help health providers as they transition from paper-based medical records to EHRs. Incentive payments totaling as much as \$27 billion may be made under the program. Individual physicians and other eligible professionals can receive up to \$44,000 through Medicare and almost \$64,000 through Medicaid. Hospitals can receive millions.

To qualify for the incentive payments offered by the Centers for Medicare & Medicaid Services (CMS) providers must not only adopt, but also demonstrate the meaningful use of, certified EHR systems.

ONC authorized the first two ONC-ATCBs in late August. Additional applications are under review.

For more information about the ONC certification programs visit <http://healthit.hhs.gov/certification>.

To learn more about InfoGard Laboratories, Inc. visit <http://www.infogard.com/>.

Information about the Medicare & Medicaid EHR incentive programs may be found at <http://www.cms.gov/EHRIncentivePrograms>.

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

Source: CMS PERL 201009-32

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Electronic health record incentive programs beginning in 2011

Incentive payments totaling as much as \$27 billion may be made under the Medicare and Medicaid electronic health record (EHR) incentive programs beginning in 2011. Are you eligible for an incentive? How much can an eligible professional earn? What are the key dates for these programs? Learn more on the Centers for Medicare & Medicaid Services (CMS) EHR incentive programs website.

Tip sheets for eligible professionals

- **Updated: Medicare EHR incentive programs, Physician Quality Reporting Incentive (PQRI), and e-Prescribing comparison**
Learn what opportunities are available to Medicare eligible professionals to receive incentive payments for participating in important Medicare initiatives. This fact sheet provides information on eligibility, timeframes, and maximum payments for each program.
- **Updated flow chart: Determine eligibility for Medicare and Medicaid EHR incentive programs**
Unsure if you are eligible to participate in the Medicare or Medicaid EHR incentive programs? Use this handy flow chart to find out.
- **Medicare EHR incentive payments for eligible professionals**
Which types of individual practitioners can participate in the Medicare EHR incentive program? This easy tip sheet provides information about incentive payment amounts and describes how payments are calculated for fee for service (FFS) and Medicare Advantage

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providers. It also describes payment adjustments beginning in 2015 for eligible professionals who are not meaningful users of certified EHR technology.

For the three tip sheets above, go to <http://www.cms.gov/EHRIncentivePrograms>. Select the “Medicare Eligible Professional” tab on the left, and then scroll to “Downloads.”

- **NEW: Medicaid EHR incentive payments for eligible professionals**

Which types of individual practitioners can participate in the Medicaid EHR incentive program? Learn about Medicaid patient volume requirements, payment amounts, and the timeframes for the Medicaid EHR incentive program.

Go to <http://www.cms.gov/EHRIncentivePrograms>. Select the “Medicaid Eligible Professional” tab on the left, and then scroll to “Downloads.”

Important dates

- **NEW: EHR incentive program timeline**
Find it at <http://www.cms.gov/EHRIncentivePrograms> in the “Downloads” section of the “Overview” tab.

Electronic health record incentives – get the facts from CMS.

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

Source: CMS PERL 201009-42

News on electronic health records – 33 products certified

The Certification Commission for Health Information Technology (CCHIT®) has announced that it has tested and certified 33 electronic health record (EHR) products under the commission of the Office of the National Coordinator for Health Information Technology as an Authorized Testing and Certification Body (ONC-ATCB) ONC-ATCB program, which certifies that the EHRs are capable of meeting the 2011/2012 criteria supporting Stage 1 meaningful use as approved by the Secretary of Health & Human Services (HHS). Certification is required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act (ARRA). The certifications include 19 complete EHRs, which meet all of the 2011/2012 criteria for either eligible provider or hospital technology, and 14 EHR modules, which meet one or more – but not all – of the criteria.

More news

<http://www.cchit.org/media/news/2010/10/commission-announces-first-onc-atcb-20112012-certifications>.

Personal health record – Understanding the evolving landscape

On Friday, December 3, the Office of National Coordinator for Health Information Technology (ONC) will host a free day-long public roundtable on:

Personal Health Records – Understanding the Evolving Landscape

Friday, December 3, 2010

FTC Conference Center, 601 New Jersey Avenue, NW, Washington, DC 20001

The roundtable is designed to inform ONC’s congressionally mandated report on privacy and security requirements for noncovered entities (non-CEs), with a focus on personal health records (PHRs) and related service providers (Section 13424 of the HITECH Act).

The roundtable will include four panels of prominent researchers, legal scholars, and representatives of consumer, patient, and industry organizations. It will address the current state and evolving nature of PHRs and related technologies (including mobile technologies and social networking), consumer and industry expectations and attitudes toward privacy and security practices, and the pros and cons of different approaches to the requirements that should apply to non-CE PHRs and related technologies.

Mark your calendars now

Registration and additional conference information will be available in October at <http://healthit.hhs.gov/PHRroundtable>.

News on electronic health records – 33 products certified (continued)

Two final awardees for the regional extension center (REC) program

The ONC has announced the selection of two final awardees for the regional extension center (REC) program:

- CalOptima Foundation, covering Orange County, California (\$4,662,426)
- Massachusetts eHealth Collaborative, covering New Hampshire (\$5,105,495) ONC also announced expanded coverage areas for two existing RECs in Florida:
 - Community Health Center Alliances will cover additional areas in Glades and Hendry counties
 - Health Choice Network of Florida will cover additional areas in Indian River, Palm Beach, St. Lucie, Martin and Okeechobee counties

These additional awards complete a nationwide system of RECs that will help providers move from paper-based medical records to electronic health records (EHRs).

For more information about the awards and a complete listing of RECs, visit

<http://www.HealthIT.hhs.gov/programs/REC/>.

Learn more about the Medicare and Medicaid EHR incentive programs at <http://www.cms.gov/EHRIncentivePrograms/>.

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

Source: CMS PERL 201010-04

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RECOVERY AUDIT CONTRACTOR

Recovery audit contractor demonstration high-risk medical necessity vulnerabilities for inpatient hospitals

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

This is the second in a series of articles that will disseminate information on recovery audit contractor (RAC) demonstration high dollar improper payment vulnerabilities. The purpose of this article is to provide inpatient hospital education regarding 17 RAC demonstration-identified medical necessity vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC program and the initiation of complex medical necessity review in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Provider types affected

This article is for all inpatient hospital providers that submit fee-for-service claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (MACs).

Provider action needed

Review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

Background

The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. The Centers for Medicare & Medicaid Services (CMS) directed the RAC staff to organize their efforts primarily to attain that goal. Supplemental goals, such as correcting identified vulnerabilities, were identified after the fact and were not required tasks. CMS did collect improper payment information from the RACs. However, it was on a voluntary basis, and was done at the claim level and focused on the collection. Some of these high risk medical necessity inpatient hospital vulnerabilities are listed in Table 1. These claims were denied because the demonstration RACs determined that the documentation submitted did not support that the services provided required an inpatient level of care and could have been performed in a less intensive setting.

RAC demonstration high-risk medical necessity vulnerabilities for inpatient hospitals (continued)

Table 1

	Provider type	Improper payment amount (pre-appeal)	RAC demonstration findings
1	Inpatient hospital	\$64,739,662	Cardiac defibrillator implant (DRG 514/515)
2	Inpatient hospital	\$34,155,158	Heart failure and shock (DRG 127)
3	Inpatient hospital	\$21,956,139	Other cardiac pacemaker implantation (DRG 116)
4	Inpatient hospital	\$19,169,815	Chest pain (DRG 143)
5	Inpatient hospital	\$14,374,696	Misc. digestive disorders (DRG 182)
6	Inpatient hospital	\$13,881,479	Other vascular procedure (DRG 478)
7	inpatient hospital	\$10,359,085	COPD (DRG 88)
8	Inpatient hospital	\$9,978,346	Medical back problems (DRG 243)
9	Inpatient hospital	\$7,355,002	Nutritional & misc. metabolic disorders (DRG 296)
10	Inpatient hospital	\$6,979,129	Transient ischemia (DRG 524)
11	Inpatient hospital	\$6,228,919	Other circulatory system diagnoses (DRG 144)
12	Inpatient hospital	\$4,758,678	Kidney & UTI (DRG 320)
13	Inpatient hospital	\$3,239,751	Cardiac arrhythmia (with CC DRG-138)
14	Inpatient hospital	\$2,912,155	Degenerative nervous system disorders (DRG 012)
15	Inpatient hospital	\$2,889,840	Atherosclerosis (with CC DRG-132)
16	Inpatient hospital	\$2,545,289	Other digestive system diagnosis (DRG 188)
17	Inpatient hospital	\$2,314,001	Percutaneous cardiac procedure (DRG 517)

Note: This listing describes what the RACs found the majority of the time when an improper payment was identified. Since each admission is unique, the root causes of each improper payment determination are also unique. *The collection figures identified do not take into account the results of appeals.* In addition to the list above, there are three other general categories of denials which included:

- Medical necessity denials for multiple codes (not mentioned above).
- ASC list violations for codes paid at the inpatient rate that should have been paid as outpatient (no complications identified to justify inpatient stay).
- Other outpatient charges that should have been billed since services were not medically necessary in the inpatient setting.

These three catch-all categories of medical necessity denials impacted multiple codes and no specific coding trends were self-reported by the RACs for these categories.

Summary of RAC demonstration findings

The inpatient hospital vulnerabilities listed in Table 1 were denied because the services were not medically necessary for the setting billed. In many instances, the service/procedure was medically necessary but the services could have been performed in a less-intensive setting. Often, these denials occurred because the submitted medical documentation did not contain sufficient, accurate information to: 1) support the diagnosis, 2) justify the treatment/procedures, 3) document the course of care, 4) identify treatment/diagnostic test results, and 5) promote continuity of care among health care providers.

Inpatient hospital medical documentation reminders

CMS reminds providers that the medical record must contain sufficient documentation to demonstrate that the beneficiary's signs and/or symptoms were severe enough to warrant the need for inpatient medical care. See *Medicare Program Integrity Manual*, Chapter 6, Section 6.5.2 at <http://www.cms.gov/manuals/downloads/pim83c06.pdf> for more detailed information.

CMS recommends that providers document any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. (For more details see the manual chapter cited in the preceding paragraph.) Some factors that providers should consider when making the decision to admit may include:

RAC demonstration high-risk medical necessity vulnerabilities for inpatient hospitals (continued)

- The severity of the signs and symptoms exhibited by the patient.
- The medical predictability of something adverse happening to the patient.
- The need for diagnostic studies.
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital (see Chapter 1, Section 10 of the *Medicare Benefit Policy Manual* on the CMS website at <http://www.cms.gov/manuals/downloads/bp102c01.pdf>).

Documentation that is not legible has a direct affect on the RAC reviewer's ability to support that the services billed were medical necessary and were provided in an appropriate setting. CMS encourages providers to ensure that all fields on documentation tools (such as assessments, flow sheets, checklists, etc.) are completed, as appropriate. If a field is not applicable, CMS recommends that providers use an entry like "N/A" to show that the questions were reviewed and answered. Fields that are left blank often lead the reviewer to make an inaccurate determination.

CMS encourages providers to comply with CMS inpatient hospital policy and Coding Clinic guidance. In the absence of a specific Medicare policy, Medicare contractors may use clinical review judgment to assist in making a payment determination (See the *Program Integrity Manual* Chapter 3, Section 3.14 on the CMS website at <http://www.cms.gov/manuals/downloads/pim83c03.pdf>).

During the RAC demonstration, reviewers noted that entries in the medical records were not consistent. CMS encourages providers to ensure all entries are consistent with other parts of the medical record (assessments, treatment plans, and physician orders, nursing notes, medication and treatment records, etc. and other facility documents such as admission and discharge data, pharmacy records, etc.). If an entry is made that contradicts previous documentation, CMS recommends providers include documentation that explains why there is a contradiction.

Demonstration review staff often noted that providers failed to adequately document significant changes in the patient's condition or care issues that in some instances impacted the review determination. CMS recommends that providers document any changes in the patient's condition or care.

Lastly, CMS reminds providers to ensure that any information that affects the billed services and is acquired after physician documentation is complete must be added to the existing documentation in accordance with accepted standards for amending medical record documentation.

Additional information

Providers are also encouraged to visit the CMS RAC website for updates on the national RAC program at <http://www.cms.gov/RAC>.

On that website, you can register to receive e-mail updates and view current RAC activities nationwide.

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Recovery audit contractor demonstration – high-risk, diagnosis-related group coding vulnerabilities for inpatient hospitals

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

This is the third in a series of articles that will disseminate information on recovery audit contractor (RAC) demonstration high dollar improper payment vulnerabilities. The purpose of this article is to provide inpatient hospital education regarding four RAC demonstration-identified inpatient hospital coding vulnerabilities, in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC program and the initiation of complex coding review in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Provider types affected

This article is for all inpatient hospital providers that submit fee-for-service claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (MACs).

Provider action needed

Review the article and take steps, if necessary, to meet Medicare’s documentation requirements to avoid unnecessary denial of your claims.

Background

Effective March 2005, the RAC demonstration began in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008. The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. The Centers for Medicare & Medicaid Services (CMS) directed the RAC staff to organize their efforts primarily to attain that goal. Supplemental goals, such as correcting identified vulnerabilities, were identified after the fact and were not required tasks. CMS did collect improper hospital payment information from the RACs. However, it was on a voluntary basis, at the claim level and focused on the collection and not the principal and secondary diagnoses on a claim. Four of the high risk inpatient hospital coding vulnerabilities identified are listed in Table 1 below. These claims were denied because the demonstration RACs determined that the medical record documentation submitted did not support the codes billed.

Table 1

	Provider type	Improper payment amount (pre-appeal)	RAC demonstration findings
1	Inpatient hospital	\$15,999,757	Respiratory system diagnosis with vent support – (CMS DRG 475) – principal diagnosis on the claim did not match the principal diagnosis in the medical record.
2	Inpatient hospital	\$11,769,645	Closed biopsy of lung (CMS DRG 076, 077,120) – A transbronchial lung biopsy was billed but the medical record showed a transbronchial biopsy was performed.
3	Inpatient hospital	\$10,014,530	OR Procedure for infections, parasitic diseases (CMS DRG 415) – The codes on the claim did not match information in the medical record.
4	Inpatient hospital	\$2,127,568	Coagulopathy (CMS DRG 397/143) – principal diagnosis on the claim did not match the principal diagnosis in the medical record.

Note: The collection figures identified do not take into account the results of appeals.

For example, one of the coding vulnerabilities the RACs identified was that hospitals were inappropriately reporting a surgical code 33.27, closed endoscopic biopsy of the lung. The medical record documentation indicated that the site of the biopsy was the bronchus, not the lung, and therefore the correct code to bill is the non-surgical code 33.24, closed endoscopic biopsy of the bronchus.

Inpatient hospital medical documentation reminders

ICD-9-CM official guidelines for coding and reporting can be found on the Internet at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm.

The general rules for reporting secondary diagnoses (Section III, “Reporting Additional Diagnoses” of the official coding guidelines) are that they affect patient care in terms of requiring:

1. Clinical evaluation, or
2. Diagnostic treatment, or
3. Therapeutic treatment, or

RAC demonstration high-risk diagnosis related group coding vulnerabilities for inpatient hospitals (continued)

4. Causes an increase in the length of stay (LOS) or
5. Increased nursing care and/or monitoring.

CMS encourages providers to ensure that all fields on documentation tools (such as assessments, flow sheets, checklists, etc.) are completed. If a field is not applicable, CMS recommends that providers use an entry such as “N/A” to show that the questions were reviewed and answered. Fields that are left blank often lead the reviewer to make an inaccurate determination.

CMS encourages providers to comply with CMS’ inpatient hospital policy, the ICD-9-CM official guidelines for coding and reporting and coding clinic for ICD-9-CM guidance. In the absence of a specific Medicare policy, Medicare contractors may use clinical review judgment to assist in making a payment determination (See the *Program Integrity Manual* Chapter 3, Section 3.14 on the CMS website at <http://www.cms.gov/manuals/downloads/pim83c03.pdf>).

Documentation that is not legible has a direct effect on the RAC reviewer’s ability to support that the services billed were coded correctly, medically necessary and were provided in an appropriate setting.

During the RAC demonstration reviewers noted that entries in the medical records were not consistent. CMS encourages providers to ensure all entries are consistent with

other parts of the medical record (assessments, treatment plans, and physician orders, nursing notes, medication and treatment records, etc. and other facility documents such as admission and discharge data, pharmacy records, etc.). If an entry is made that contradicts documentation found elsewhere in the record, clarification should be obtained and documented by the attending physician.

Lastly, CMS reminds providers to ensure that any information that affects the billed services and is acquired after physician documentation is complete, must be added to the existing documentation in accordance with accepted standards for amending medical record documentation.

Additional information

Providers are also encouraged to visit the CMS RAC website for updates on the national RAC program at <http://www.cms.gov/RAC>.

On that website, you can register to receive e-mail updates and view current RAC activities nationwide.

MLN Matters® Number: SE1028

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Recovery audit contractor demonstration high-risk vulnerabilities – no documentation or insufficient documentation submitted

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 the first in a series of *MLN Matters*® special edition article SE1024 to correct the Web address for Diversified Collection Services. All other information is the same. The article was published in the July 2010 *Medicare A Bulletin* (pages 18-20).

This is the **first** in a series of articles that will disseminate information on recovery audit contractor (RAC) high dollar improper payment vulnerabilities. This article provides education regarding RAC demonstration-identified vulnerabilities in an effort to prevent the same problems from occurring in the future. With the expansion of the RAC program and the initiation of complex medical review (coding and medical necessity) in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Provider types affected

This article is for all inpatient hospital and skilled nursing facility providers that submit fee-for-service claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (MACs).

Provider action needed

Review the article and take steps, if necessary, to meet Medicare’s documentation requirements to avoid unnecessary denial of your claims.

Background

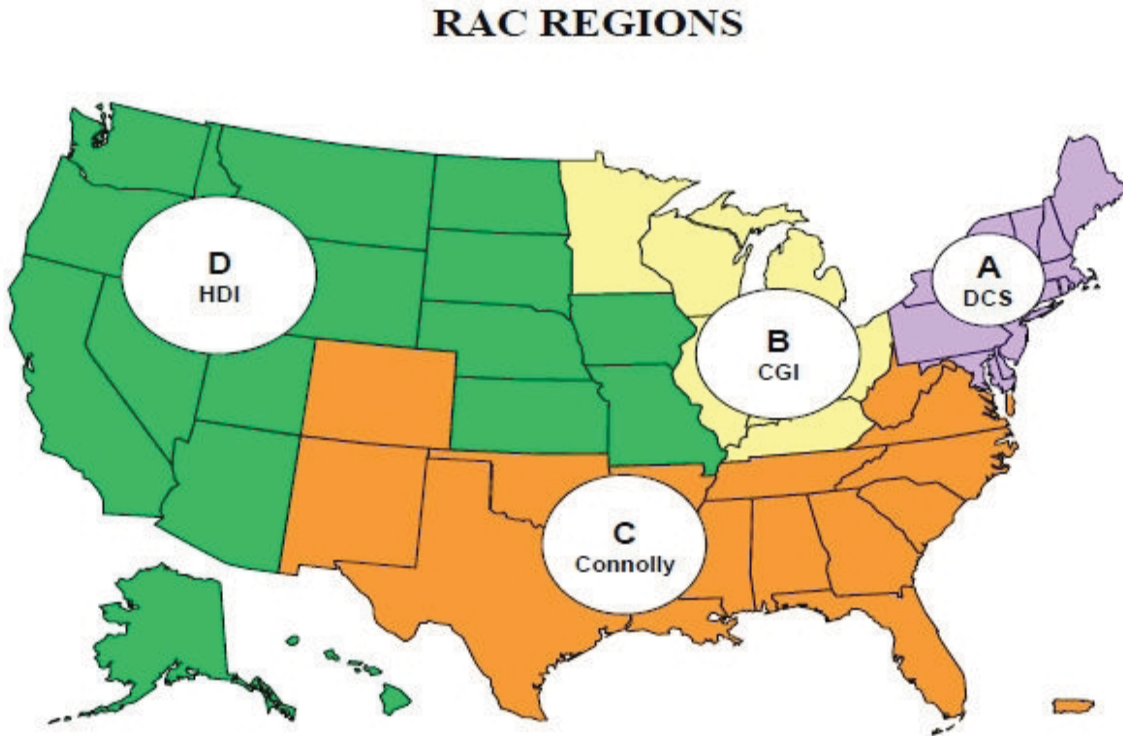
The Medicare Modernization Act of 2003 (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) establish the recovery audit contractor (RAC) program as a three-year demonstration. The demonstration began March 2005 in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008.

The success of the demonstration resulted in the passage of legislation in the Tax Relief and Healthcare Act of 2006, Section 302, which required CMS to establish a national RAC program by January 1, 2010.

CMS uses four RACs to implement the national RAC program. Each RAC is responsible for identifying overpayments and underpayments in approximately one quarter of the country. Figure 1 displays each of the four RAC regions and identifies the RAC responsible for recovery activities in that region.

RAC demonstration high-risk vulnerabilities – no documentation or insufficient documentation submitted (continued)

Figure 1:



The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. While the demonstration proved recovery auditing was successful identifying and correcting improper payments in Medicare, it also provided best practices for developing a national program and allowed CMS to identify high risk vulnerabilities. Two of the high risk vulnerabilities identified during the RAC demonstration include:

- Provider non-compliance with timely submission of requested medical documentation
- Insufficient documentation that did not justify that the services billed were covered, medically necessary, or correctly coded.

Medical documentation reminders

CMS reminds providers that **medical documentation must be submitted within 45 days** of the date of the additional documentation request (ADR) letter. Medicare contractors, including RACs, have the legal authority to review any information, including medical records, pertaining to a Medicare claim. If a provider fails to submit documentation, there is no justification for the services or the level of care billed. Failure to submit medical records (unless an extension has been granted) results in denial of the claim.

Submission of incomplete or illegible medical records can also result in denial of payment for services billed. Claim payment decisions that result from a medical review of records are based on the documentation that Medicare contractors received. For a Medicare claim to be paid, there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing

requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment and the provider may be requested to repay the claim paid amount to Medicare.

Actions to assist providers

The following requirements have been developed to assist providers in ensuring the timely submission of sufficient documentation to justify the services billed:

- RACs must clearly indicate deadlines for submission of medical records in ADR letters
- RACs must initiate one additional contact with the provider before issuing a denial for a failure to submit documentation
- RACs must accept and review extensions requests if providers are unable to submit documentation timely
- RACs must clearly indicate in ADR letters suggested documentation that will assist them in adjudicating the claim
- RACs must allow providers to submit medical records on CD/DVD or to fax the needed medical records
- RACs must implement the RAC look back date of three years with a maximum look back date of October 1, 2007
- RACs must limit the number of medical records requests every 45 days
- RACs must indicate the status of a provider's additional documentation requests on their claim status websites

RAC demonstration high-risk vulnerabilities – no documentation or insufficient documentation submitted (continued)

- RACs must establish a provider web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters
- RACs must post all approved issues under review on their websites.

Preparing for RAC audits

CMS recommends providers implement a plan of action for responding to RAC ADR letters. This could involve developing a RAC team to coordinate all RAC activities that may include tracking audit and appeal findings, identifying patterns of error, implementing corrective actions, etc. Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters. Providers should tell the RAC the precise address and contact person to use when sending ADR letters. Providers may submit this information to the RAC. Additional information on how to identify a point of contact may be found on the individual RAC Web pages listed at the end of this article. Providers may also check the status of the submitted documentation by accessing the applicable RAC website. This allows providers to track whether the RAC received the documentation. Providers should consult the individual RAC Web pages to determine the proper method for accessing this information. Providers should also consider monitoring their RAC websites for updates on approved new issues. This will assist providers in better understanding what audits are taking place so they can prepare to respond to ADR letters.

CMS RAC website information

The following list identifies information unique to each of the four RACs, the states they cover, their subcontractor(s), and includes website information to assist providers in preparing for RAC audits:

RAC region A – Diversified Collection Services (DCS), Inc. of Livermore, California

- **States in region:** Maryland (MD), Washington, D.C., Delaware (DE), New Jersey (NJ), Pennsylvania (PA), New York (NY), Maine (ME), Vermont (VT), New Hampshire (NH), Massachusetts (MA), Connecticut (CT), and Rhode Island (RI).
- **Subcontractors:** PRGX (formerly PRG Schultz), Federal Review Services, and iHealth Technologies
- **E-mail:** Info@dcsrac.com
- **Website:** <http://www.dcsrac.com/PROVIDERPORTAL.aspx>

RAC region B – CGI Technologies and Solutions, Inc. of Fairfax, Virginia

- **States in region:** Michigan (MI), Minnesota (MN), Wisconsin (WI), Illinois (IL), Indiana (IN), Kentucky (KY), and Ohio (OH).
- **Subcontractor:** PRGX
- **E-mail:** racb@cgi.com
- **Website:** <http://racb.cgi.com/>

RAC region C – Connolly, Inc. of Philadelphia, Pennsylvania

- **States in region:** Colorado (CO), New Mexico (NM), Texas (TX), Oklahoma (OK), Arkansas (AR), Louisiana (LA), Mississippi (MS), Tennessee (TN), Alabama (AL), Georgia (GA), North Carolina (NC), South Carolina (SC), West Virginia (WV), Virginia (VA), Florida (FL), US Virgin Islands (VI) and Puerto Rico (PR).
- **Subcontractor:** Viant
- **E-mail:** racinfo@connollyhealthcare.com
- **Website:** <http://www.connollyhealthcare.com/RAC/>

RAC Region D – HealthDataInsights (HDI), Inc. of Las Vegas, Nevada

- **States in region:** Washington (WA), Oregon (OR), California (CA), Alaska (AK), Hawaii (HI), Nevada (NV), Idaho (ID), Montana (MT), Utah (UT), Arizona (AZ), Wyoming (WY), North Dakota (ND), South Dakota (SD), Nebraska (NE), Kansas (KS), Iowa (IA), and Missouri (MO).
- **Subcontractor:** PRGX
- **Email:** racinfo@emailhdi.com
- **Website:** <https://racinfo.healthdatainsights.com/>

Additional information

Providers are also encouraged to visit the CMS RAC website for updates on the national RAC program at <http://www.cms.gov/RAC>.

On that website, you can register to receive e-mail updates and view current RAC activities nationwide.

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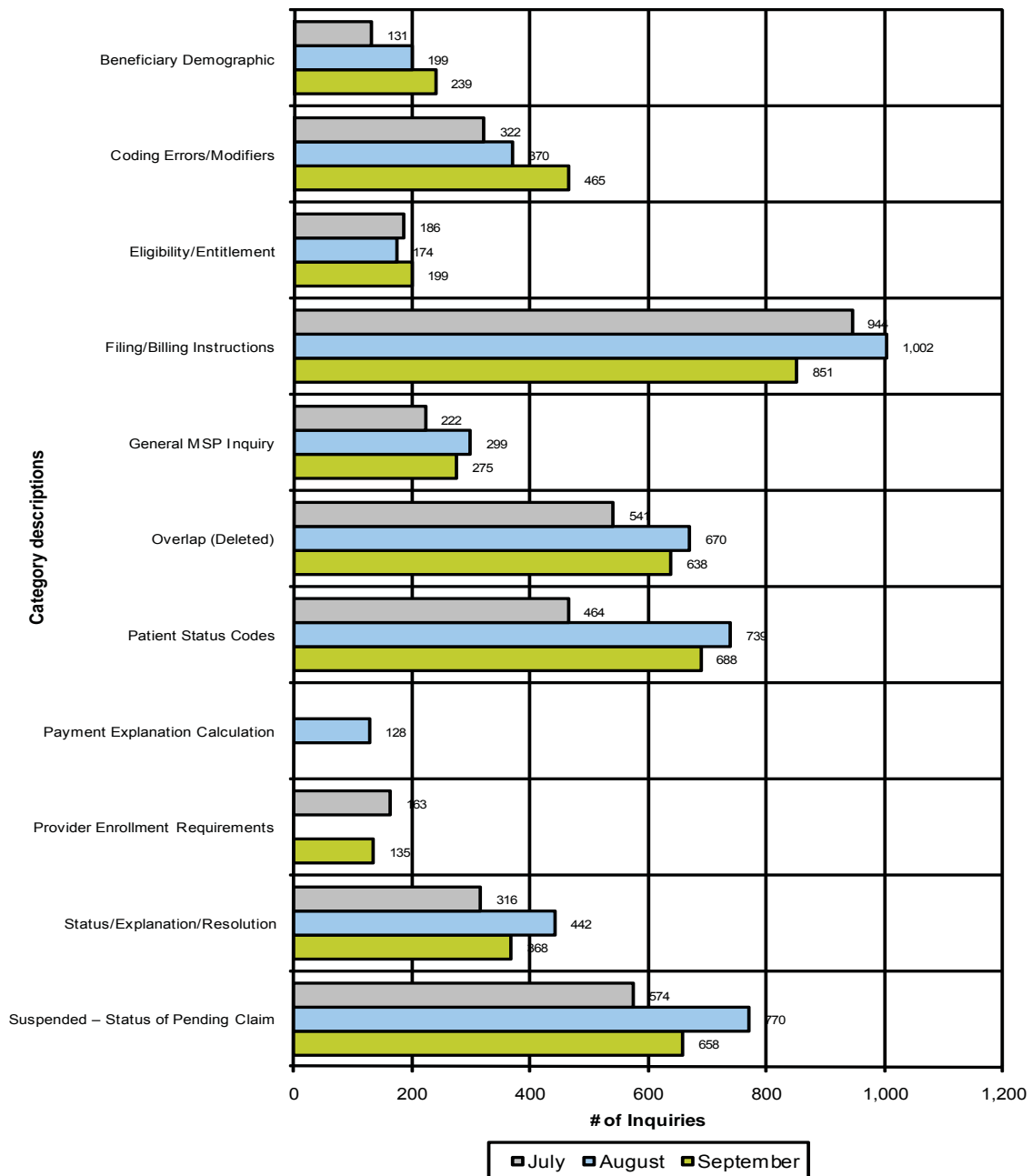
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for July-September 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 July-September 2010.

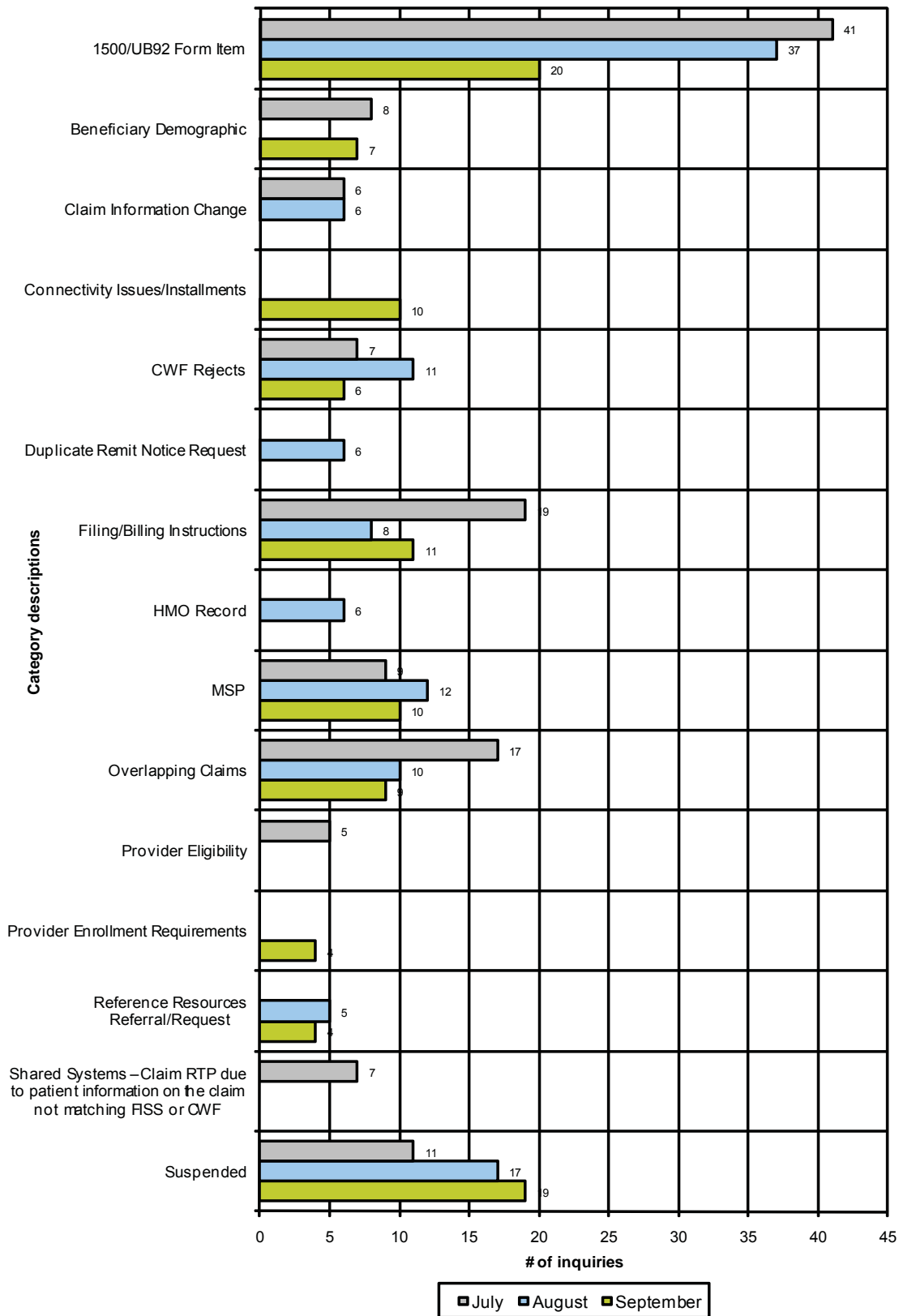
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Florida Part A top inquiries for July-September 2010



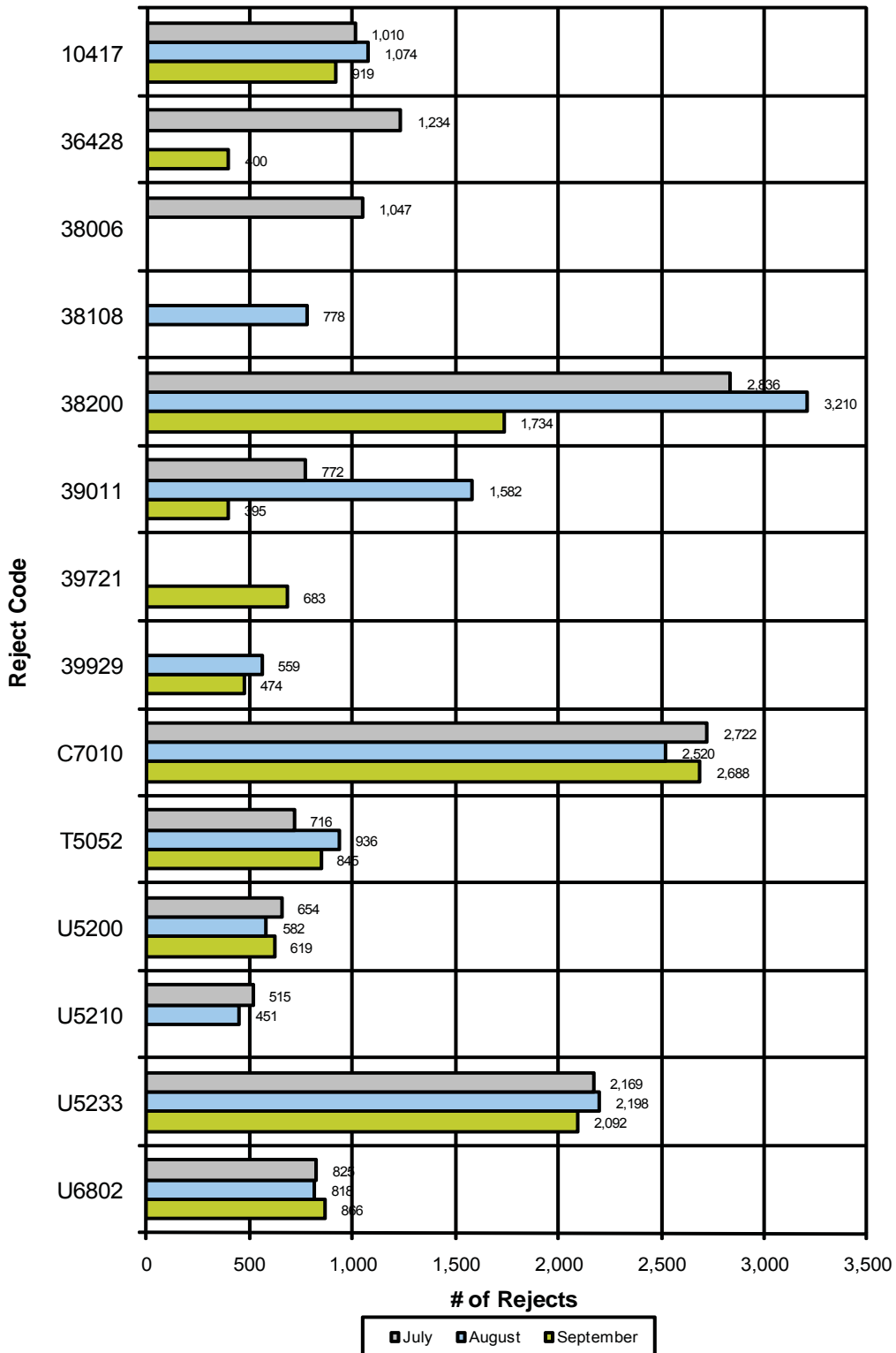
Top inquiries, return to provider, and reject claims for July-September 2010 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for July-September 2010



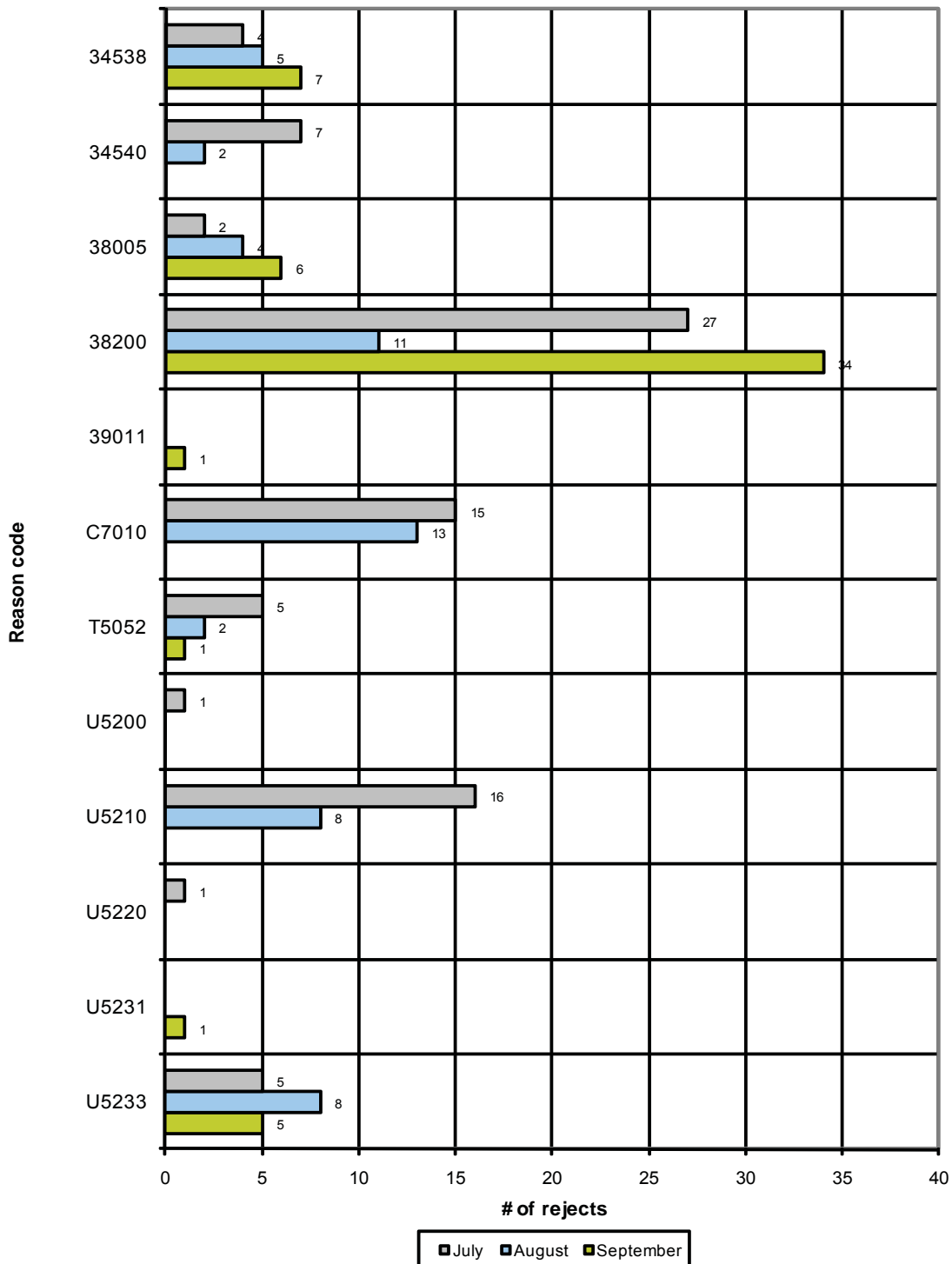
Top inquiries, return to provider, and reject claims for July-September 2010 (continued)

Florida Part A top rejects for July-September 2010



Top inquiries, return to provider, and reject claims for July-September 2010 (continued)

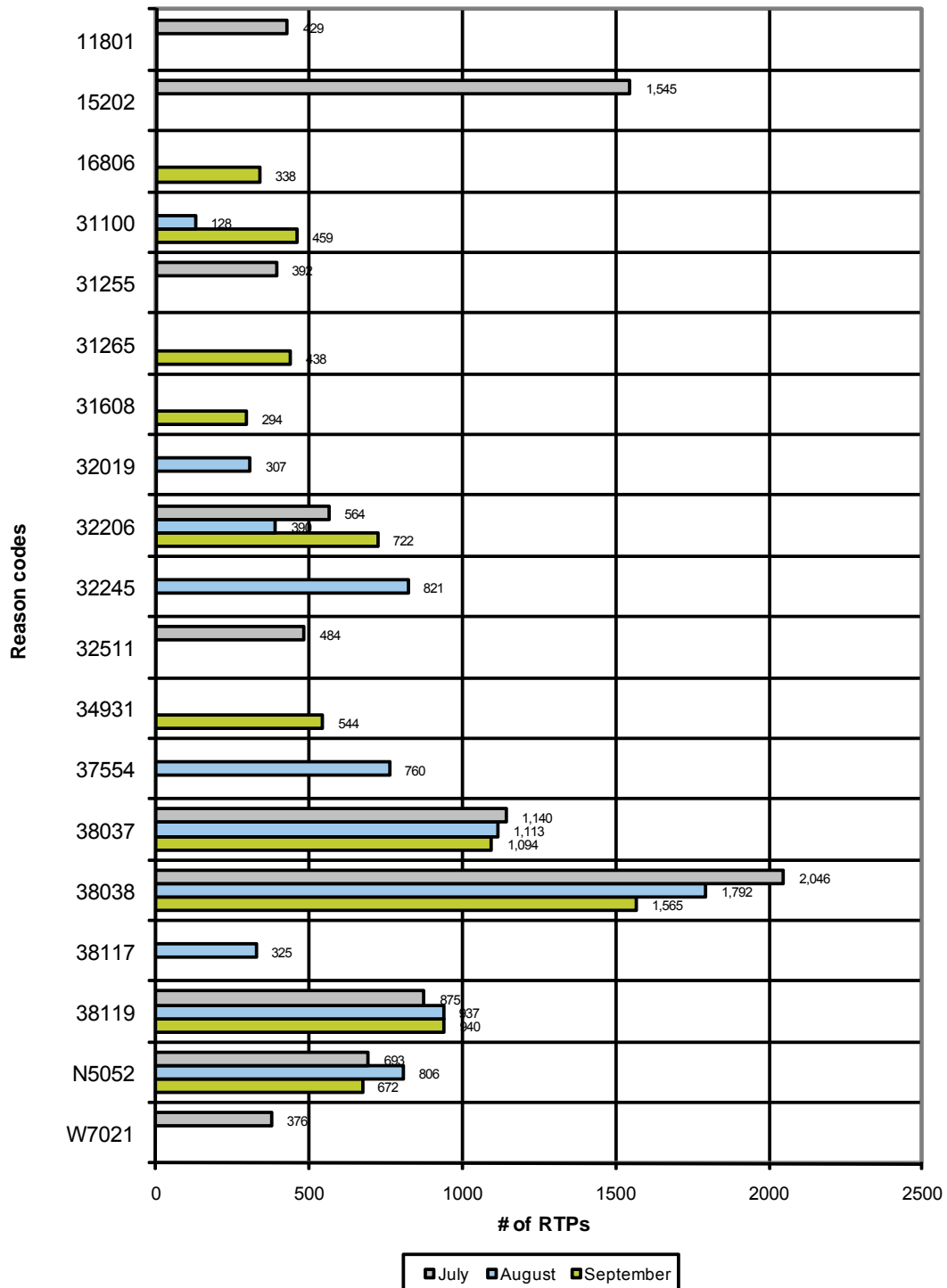
U.S. Virgin Islands Part A top rejects for July-September 2010



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 July-September 2010 (continued)

Florida Part A top return to providers (RTPs) for July-September 2010

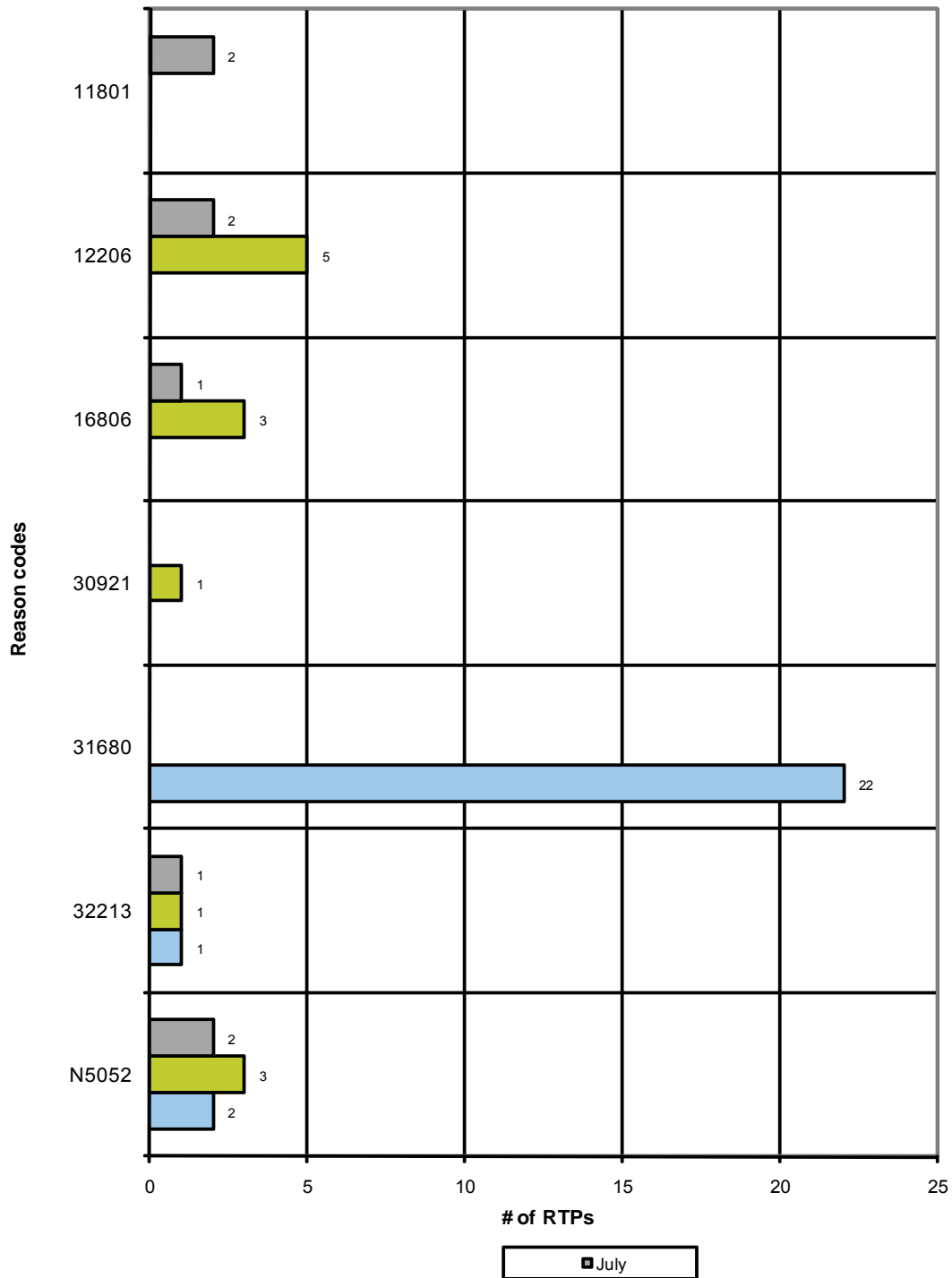


Educational Resources

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.

Top inquiries, return to provider, and reject claims for July-September 2010 (continued)

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



GENERAL COVERAGE

FDG-PET for initial treatment strategy in solid tumors and myeloma

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

Provider types affected

This article is for physician, hospitals, and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], or Medicare administrative contractors [A/B MAC]) for providing fluorodeoxyglucose positron emission tomography (FDG PET) services to Medicare beneficiaries.

What you need to know

Change request (CR) 7148, from which this article is taken, announces that on August 4, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum determining that currently restricting the use of only one positron emission tomography (PET) scan for therapeutic purposes in the initial treatment strategy for suspected solid tumors and myeloma is not supported by available evidence.

Therefore, effective August 4, 2010, Medicare will continue to nationally cover one FDG PET scan for these indications; and local Medicare contractors will have discretion to cover (or not cover), within their jurisdictions, any additional FDG PET scans for therapeutic purposes related to the initial treatment strategy. You should make sure that your billing staffs are aware of this national coverage determination (NCD).

Background

Currently, CMS covers only one FDG PET study for beneficiaries who have biopsy-proven solid tumors, or those in whom such tumors are strongly suspected based on other diagnostic testing; when the beneficiary's treating physician determines that the study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to the initial treatment strategy in order to:

- Determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure
- Determine the optimal anatomic location for an invasive procedure, or
- Determine the anatomic extent of the tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

CMS believes that the usefulness of an additional FDG PET scan in the initial treatment plan for any individual beneficiary might be affected by their specific medical problem, the availability of results of other diagnostic tests, and the expertise of the interpreting physician. CMS does not believe an NCD is the most appropriate way to address

coverage for additional FDG PET scans in these situations, but rather believes that the local Medicare contractor should determine the efficacy for these tests for therapeutic purposes related to initial treatment strategy.

Effective for claims with dates of service on or after August 4, 2010, CMS issued a final decision memorandum which:

- Removes the current absolute restriction of coverage of only one FDG PET scan to determine the location and/or extent of the tumor for therapeutic purposes related to initial treatment strategy (Medicare will continue to nationally cover one FDG PET scan for these indications), and
- Provides that your local Medicare contractors will have the discretion to cover (or not cover), within their jurisdictions, any additional FDG PET scans for therapeutic purposes related to the initial treatment strategy.

Additional information

You may find more information about the policy that changes the limitation of FDG PET scans for initial treatment strategy in solid tumors and myeloma by going to CR 7148, located at <http://www.cms.gov/Transmittals/downloads/R124NCD.pdf>.

You will find the updated *Medicare National Coverage Determinations Manual* Chapter 1 (Chapter 1, Part 4 (Sections 200-310.1) Coverage Determinations, Section 220.6.17 (Positron Emission Tomography [PET] [FDG] for Oncologic Conditions – [Various Effective Dates]) as an attachment to that CR.

You might also want to review the *MLN Matters*[®] article related to CR 6632 (FDG PET for Solid Tumors and Myeloma), released May 6, 2010 (at <http://www.cms.gov/MLNArticles/downloads/MM6632.pdf>) for existing coding and claims processing requirements.

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

MLN Matters[®] Number: MM7148

Related Change Request (CR) Number: 7148

Related CR Release Date: September 24, 2010

Related CR Transmittal Number: R124NCD

Effective Date: August 4, 2010

Implementation Date: October 25, 2010

Source: CMS Pub. 100-03, Transmittal 124, CR 7148

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Intensive cardiac rehabilitation programs – Dr. Ornish’s program for reversing heart disease and the Pritikin program

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 intensive cardiac rehabilitation (ICR) program services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 7113, from which this article is taken, announces that (through a national coverage determination [NCD]) the Centers for Medicare & Medicaid Services (CMS) has determined that, effective for claims with dates of service on and after August 12, 2010, the Ornish program for reversing heart disease and the Pritikin program each meet the ICR program requirements. As such, both programs have been included on the list of approved ICR programs available at <http://www.cms.gov/MedicareApprovedFacilitie/>.

You should make sure that your billing staffs are aware of this new NCD.

Background

ICR refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner than other such programs. As required by Section 1861(eee)(4)(A) of the Social Security Act (the Act), an ICR program must show (in peer-reviewed published research) that it accomplished one or more of the following for its patients: 1) positively affected the progression of coronary heart disease; 2) reduced the need for coronary bypass surgery; and, 3) reduced the need for percutaneous coronary interventions.

In addition, the program must show (also in peer-reviewed literature) that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

- low density lipoprotein
- triglycerides
- body mass index
- systolic blood pressure
- diastolic blood pressure
- the need for cholesterol, blood pressure, and diabetes medications

Individual ICR programs must be approved through the NCD process to ensure they demonstrate the above accomplishments. In order to implement these coverage

provisions effective January 1, 2010, CMS added 42 CFR, Part 410.49 through rulemaking in the 2010 Medicare Physician Fee Schedule Final Rule, *Federal Register*, Volume 74, Number 226, pages 61,738 & 61,872, on November 25, 2009. (You may find this information at <http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>).

The Ornish program for reversing heart disease (also known as the multisite cardiac lifestyle intervention program, the multicenter cardiac lifestyle intervention program, and the lifestyle heart trial program) was initially described in the 1970s and incorporates comprehensive lifestyle modifications including exercise, a low-fat diet, smoking cessation, stress management training, and group support sessions. Over the years, the Ornish program has been refined, but continues to focus on these specific risk factors.

The Pritikin diet was designed and adopted by Nathan Pritikin in 1955. The diet was modeled after the diet of the Tarahumara Indians in Mexico, which consisted of 10 percent fat, 13 percent protein, 75-80 percent carbohydrates, and provided 15-20 grams per day of crude fiber with only 75 mg/day of cholesterol. Over the years, the Pritikin program (also known as the Pritikin longevity program) evolved into a comprehensive program that is provided in a physician’s office and incorporates a specific diet (10-15 percent of calories from fat, 15-20 percent from protein, 65-75 percent from complex carbohydrates), exercise, and counseling lasting 21-26 days. An optional residential component is also available for participants.

Please refer to *MLN Matters* article MM6850 (Cardiac Rehabilitation and Intensive Cardiac Rehabilitation), released on May 21, 2010, to learn more about detailed claims processing, coverage, coding, and payment regarding ICR. You may find this article at <http://www.cms.gov/MLNMattersArticles/downloads/MM6850.pdf>.

Additional information

You may find the official instruction, CR 7113, issued to your carrier, FI, or A/B MAC on the CMS website at <http://www.cms.gov/Transmittals/downloads/R125NCD.pdf>.

If you have any questions, please contact your carrier, 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: MM7113

Related Change Request (CR) Number: 7113

Related CR Release Date: September 24, 2010

Related CR Transmittal Number: R125NCD

Effective Date: August 12, 2010

Implementation Date: October 25, 2010

Source: CMS Pub. 100-03, Transmittal 125, CR 7113

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Counseling to prevent tobacco use

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

Provider types affected

Physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for tobacco cessation counseling services provided to Medicare beneficiaries who are outpatients or are hospitalized are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7133 which announces that the Centers for Medicare & Medicaid Services (CMS) will cover counseling to prevent tobacco use for outpatient and hospitalized beneficiaries.

Caution – what you need to know

Effective for claims with dates of service on and after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries 1) who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations. The ICD-9 diagnosis codes that should be reported for these individuals are 305.1 (non-dependent tobacco use disorder) or V15.82 (history of tobacco use).

Go – what you need to do

New HCPCS G codes and C codes are also created for these services. See the *Background* and *Additional information* sections of this article for further details regarding these changes and the use of the new G and C codes.

Background

Medicare Part B (Section 210.4 of the *National Coverage Determination [NCD] Manual*) already covers cessation counseling for individuals who:

1. Use tobacco and have been diagnosed with a recognized tobacco-related disease, or
2. Use tobacco and exhibit symptoms consistent with a tobacco-related disease.

In November 2009, based upon authority to cover “additional preventive services” for Medicare beneficiaries if certain statutory requirements are met, the CMS initiated a new national coverage analysis. This analysis was to evaluate whether the existing evidence on counseling to prevent tobacco use is sufficient to extend national coverage for cessation counseling to those individuals who use tobacco (but do not have signs or symptoms of tobacco-related disease).

One of these statutory requirements is that the service be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the US Preventive Services Task Force (USPSTF).

CR 7133 instructs that, effective for claims with dates of service on and after August 25, 2010, CMS will cover counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries:

1. Who use tobacco (regardless of whether they have signs or symptoms of tobacco-related disease)
2. Who are competent and alert at the time that counseling is provided
3. Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner.

These individuals who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the above conditions of coverage are met, subject to certain frequency and other limitations.

The diagnosis codes that should be reported for these individuals are:

- ICD-9 code 305.1 (non-dependent tobacco use disorder), or
- ICD-9 code V15.82 (history of tobacco use).

The CMS has created two new HCPCS G codes for billing for tobacco cessation counseling services to prevent tobacco use for dates of service on or after January 1, 2011. These are in addition to the two CPT codes 99406 and 99407 that currently are used for tobacco cessation counseling for symptomatic individuals. Medicare will waive the deductible and coinsurance/copayment for counseling and billing with these two new G codes on or after January 1, 2011. The new G codes for use on claims with dates of service on or after January 1, 2011 are:

- **G0436: Long descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes. **Short descriptor:** Tobacco-use counsel 3-10 min.
- **G0437: Long descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes. **Short descriptor:** Tobacco-use counsel >10 min.

Medicare will pay claims not paid under the outpatient prospective payment system (OPPS) with dates of service on or after August 25, 2010, through December 31, 2010, but received prior to January 1, 2011, when billed with diagnosis code 305.1 (non-dependent tobacco-use disorder) or V15.82 (history of tobacco use) and unlisted CPT code 99199 for counseling to prevent tobacco use services. CPT code 99199 is Medicare contractor-priced.

However, two new, temporary HCPCS C codes have been created for facilities paid under the OPPS when billing for counseling to prevent tobacco use and tobacco-related disease services during the interim period of August 25, 2010, through December 31, 2010. (Facilities paid under the OPPS may not bill the unlisted CPT code 99199.) The two new C codes are:

- **C9801: Long descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.

Counseling to prevent tobacco use (continued)

Short descriptor: Tobacco-use counsel 3-10 min.

- **C9802: Long descriptor:** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.

Short descriptor: Tobacco-use counsel >10 min.

CMS will allow two individual tobacco cessation counseling attempts per year. Each attempt may include a maximum of four intermediate **or** intensive sessions, with a total benefit covering up to eight sessions per year per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than three minutes up to 10 minutes) or intensive (more than 10 minutes) cessation counseling sessions for each attempt.

Note: Section 4104 of the Affordable Care Act provided for a waiver of the Medicare coinsurance and Part B deductible requirements for counseling to prevent tobacco use services, codes G0436 and G0437, effective on or after January 1, 2011. No other tobacco cessation codes are eligible for waiver of coinsurance/deductible at this time. Prior to January 1, 2011, this service will be subject to the standard Medicare coinsurance and Part B deductible requirements.

The method of payment to institutional providers for outpatient services is as shown in the following table:

Type of facility	Method of payment
Rural health centers (RHCs) (type of bill [TOB]) 71x Federally qualified health centers (FQHCs) (TOB 77x)	All-inclusive rate (AIR) for the encounter
Hospitals (TOBs 12x and 13x)	OPPS for hospitals subject to OPPS Medicare physician fee schedules (MPFS) for hospitals not subject to OPPS
Indian health services (IHS) (TOB 13x)	AIR for the encounter
Skilled nursing facilities (SNFs) (TOBs 22x and 23x)	Medicare physician fee schedules
Home health agencies (HHAs) (TOB 34x)	Medicare physician fee schedules
Critical access hospitals (CAHs) (TOB 85x), IHS CAHs (TOB 85x)	Method I: Technical services are paid at 101 percent of reasonable cost. Method II: Technical services are paid at 101 percent of reasonable cost, and professional services are paid at 115 percent of the MPFS based on specific rate
Maryland hospitals	Payment is based according to the Health Services Cost Review Commission (HSCRC) that is 94 percent of submitted charges subject to any unmet deductible, coinsurance, and noncovered charges policies.

Note also the following claims processing information from CR 7133:

- Claims submitted with the tobacco cessation counseling HCPCS codes of G0436 and G0437, but which lack a required diagnosis code (305.1 or V15.82) will be denied with claim adjustment reason code (CARC) 167 (This (these) diagnosis (es) is (are) not covered).

Note: Refer to the 835 Health Care Policy Identification Segment (loop 2110 Service payment information REF), if present.), remittance advice remarks code (RARC) M64 (Missing/incomplete/invalid other diagnosis), and group code PR assigning financial liability to the beneficiary if a claim is received with a signed advance beneficiary notice (ABN). If no ABN is on file, group code CO is used to assign financial liability to the provider.

- Claims are accepted for HCPCS G0436 and G0437 with revenue code 0942 on TOB 12x, 13x, 22x, 23x, 34x, and 85x.
- Claims are accepted for HCPCS G0436 and G0437 with revenue codes 096x, 097x, or 098x when billed on TOB 85x Method II under the MPFS.
- Claims are accepted for HCPCS G0436 and G0437 with revenue code 052x when billed on TOBs 71x or 77x.
- Claims are accepted for HCPCS G0436 and G0437 with revenue code 0510 when billed by IHS facilities.
- Institutional claims billed on TOBs other than 12x, 13x, 22x, 23x, 34x, 71x, 77x, or 85x will be returned to the provider.
- When claims are denied for exceeding a combined total of eight sessions within a 12-month period, the claims will be denied using CARC 119 (Benefit maximum for this time period or occurrence has been reached.), RARC N362 (The

Counseling to prevent tobacco use (continued)

number of days or units of service exceeds our acceptable maximum.), and group code PR if a signed ABN is on file. A group code of CO is assigned if no ABN is on file.

Note: In calculating a 12-month period, 11 months must pass following the month in which the 1st Medicare covered cessation counseling session was performed.

- Medicare will allow payment for a medically necessary evaluation and management (E/M) service on the same date as tobacco cessation counseling, provided it is clinically appropriate. Such E/M service should be reported with modifier 25 to indicate it is separately identifiable from the tobacco use service.

Additional information

The official instruction, CR 7133, was issued to your carrier, FI, or A/B MACs via two transmittals.

The first transmittal modified the *NCD Manual* and it may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R125NCD.pdf>.

The second transmittal modifies the *Medicare Claims Processing Manual* and it is available on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2058CP.pdf>.

If you have questions, please contact your carrier, 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: MM7133

Related Change Request (CR) Number: 7133

Related CR Release Date: September 30, 2010

Related CR Transmittal Number: R125NCD and R2058CP

Effective Date: August 25, 2010

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2058, CR 7133

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Allogeneic hematopoietic stem cell transplantation for myelodysplastic syndrome

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 hospitals billing Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors [A/B MACs]) for providing allogeneic hematopoietic stem cell transplantation (HSCT) services to Medicare beneficiaries with myelodysplastic syndrome (MDS).

What you need to know

Change request (CR) 7137, from which this article is taken, announces (through a national coverage determination [NCD]) that, effective for claims with dates of service on and after August 4, 2010, Medicare will cover the use of allogeneic HSCT for treatment of MDS under Section 1862(a)(1)(E) of The Social Security Act (the Act) **only** if provided in the context of a Medicare-approved clinical study meeting specific criteria under coverage with evidence development (CED). The Centers for Medicare & Medicaid Services (CMS), pursuant to the NCD process, has determined that the evidence does not demonstrate the use of allogeneic HSCT improves health outcomes in Medicare beneficiaries with MDS, is not reasonable and necessary under Section 1862(a)(1)(A) of the Act, and is therefore not covered by Medicare **except** when provided in a Medicare-approved clinical study.

Background

MDS refers to a group of diverse blood disorders in which the bone marrow does not produce enough healthy, functioning blood cells. These blood disorders are varied with regard to clinical characteristics, cytologic and pathologic features, and cytogenetics. The abnormal production of blood cells in the bone marrow leads to low blood cell counts, referred to as cytopenias, which are a hallmark feature of MDS along with a dysplastic and hypercellular-appearing bone marrow.

On November 10, 2009, CMS accepted a formal request from several bone marrow and cancer organizations and societies, asking for national coverage of allogeneic HSCT for Medicare beneficiaries “who would either be at high risk for progression to leukemia or be at risk for MDS complications that place them at high risk for death or prevent the future possibility of a transplant.”

Coding information

CR 7137 describes, effective for claims with dates of service on and after August 4, 2010, the codes that you will need to supply on your claims for the use of HCST for MDS to help your FI, carrier, or A/B MAC, determine if the treatment was provided pursuant to a Medicare-approved clinical study under CED using existing clinical trial coding

Allogeneic hematopoietic stem cell transplantation for myelodysplastic syndrome (continued)

conventions described in *MLN Matters*® article MM5790, *Use of an 8-Digit Registry Number on Clinical Trial Claims*, released on January 18, 2008, (found on the CMS website at <http://www.cms.gov/MLN MattersArticles/downloads/MM5790.pdf>).

Effective for claims with discharge dates on or after August 4, 2010, inpatient claims (type of bill [TOB] 11x) for HSCT for the treatment of MDS in a clinical study must contain:

- ICD-9 diagnosis code V70.7
- Condition code 30
- HSCT-ICD-9-CM procedure codes 41.02, 41.03, 41.05, or 41.08
- MDSICD-9-CM diagnosis code 238.75.

Outpatient hospital claims (TOB 13x) for dates of service on or after August 4, 2010, for HSCT for the treatment of MDS in a clinical study must contain:

- HSCT CPT code 38240
- MDS ICD-9-CM diagnosis code 238.75
- Clinical trial ICD-9-CM diagnosis code V70.7
- Clinical trial procedure code modifier Q0.

Practitioner claims for dates of service on or after August 4, 2010, billed by a method II critical access hospital on TOB 85x with revenue code 96x, 97x, or 98x, for HSCT for the treatment of MDS must contain:

- HSCT CPT code 38240
- MDS ICD-9-CM diagnosis code 238.75
- Clinical trial ICD-9-CM diagnosis code V70.7
- Clinical trial procedure code modifier Q0.

Professional claims for HSCT for the treatment of MDS for dates of service on or after August 4, 2010, for HSCT for the treatment of MDS must contain:

- HSCT CPT code 38240
- MDS ICD-9-CM diagnosis code 238.75
- Clinical trial ICD-9-CM diagnosis code V70.7
- Clinical trial procedure code modifier Q0
- Place of service code 21 or 22.

Note: The eight-digit clinical trial number may also appear on the claim, at the discretion of the provider (along with value code D4 for inpatient claims).

Medicare contractors will use the following messages if they deny claims for HSCT for the treatment of MDS that do not contain all of the required coding requirements mentioned above:

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- **Claim adjustment reason code (CARC) 50** – These are noncovered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- **Remittance advice remark code (RARC) 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 Web access, you may contact the contractor to request a copy of the NCD.
- **Group code** – patient responsibility (PR) if an advance beneficiary notice (ABN) or hospital issued notice of noncoverage (HINN) given to the beneficiary, otherwise contractual obligation (CO).

Finally, you should be aware that for claims with dates of service between August 4, 2010, and the implementation date of CR 7137; your contractor will perform necessary adjustments only when you bring affected claims to their attention.

Additional information

More details are available in the official notice to your Medicare contractor, CR 7137, which was issued in two transmittals. The first transmittal updated the *Medicare NCD Manual*, and it is available on the CMS website at <http://www.cms.gov/Transmittals/downloads/R127NCD.pdf>.

The second transmittal updated the *Medicare Claims Processing Manual* and it is available on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2062CP.pdf>.

You may also review the entire decision memorandum regarding this NCD on the CMS website at <http://www.cms.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=238&>.

Appendix D of that memorandum contains instructions for submission of applications for protocols to address CED as required by an NCD.

If you have questions, please contact your carrier, 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: MM7137

Related Change Request (CR) Number: 7137

Related CR Release Date: October 8, 2010

Related CR Transmittal Number: R127NCD and R2062CP

Effective Date: August 4, 2010

Implementation Date: November 10, 2010

Source: CMS Pub. 100-04, Transmittal 2062, CR 7137

Medicare fee-for-service emergency policies and procedures

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 informational only and advises providers on where to find information regarding Medicare policies related to emergency guidance for the duration of the emergency, such as the H1N1 pandemic.

Background

As part of its preparedness efforts for an influenza pandemic, the Centers for Medicare & Medicaid Services (CMS) developed certain emergency guidance and procedures that may be implemented for the Medicare fee-for-service (FFS) program in the event of a pandemic or disaster.

Additional pandemic-specific preparedness guidance and procedures were issued in prior change requests (CRs). CR 6837 rescinds the CRs implementing selected influenza pandemic-specific guidance and procedures. Specifically, CR 6837 rescinds CRs 5099, 6146, 6164, 6174, 6209, 6256, 6280, 6284, and 6378.

Disclaimer – This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

The guidance and procedures (in the form of questions and answers [Qs & As]) previously implemented by the aforementioned CRs will, instead, be made available on the CMS “Emergency” website at <http://www.cms.gov/Emergency/>, and titled:

- “Emergency Qs & As – no 1135 waivers required”
- “Emergency Qs & As – applicable only when an applicable 1135 waiver has been granted.”

Additional information

The official instruction, CR 6837, 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/R772OTN.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: MM6837

Related Change Request (CR) Number: 6837

Related CR Release Date: September 21, 2010

Related CR Transmittal Number: R772OTN

Effective Date: November 22, 2010

Implementation Date: November 22, 2010

Source: CMS Pub. 100-20, Transmittal 772, CR 6837

Dermal injections for treatment of facial lipodystrophy syndrome

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 MM6953 to correct typographical errors in the original article. Previously, the article referenced HCPCS code G0249 in several places in the billing instructions sections. Instead, the article should have referenced HCPCS code G0429. The article was published in the July 2010 *Medicare A Bulletin* (pages 28-30).

Provider types affected

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

What you need to know

This article is based on change request (CR) 6953, which informs Medicare contractors that effective for claims with dates of service on and after March 23, 2010, dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in human immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Background

The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial LDS for human immunodeficiency virus (HIV)-infected Medicare beneficiaries. LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or highly active antiretroviral therapy (HAART). Due to their appearance, patients with LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

*Dermal injections for treatment of facial lipodystrophy syndrome (continued)***Nationally covered indications**

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

Nationally noncovered indications

- Dermal fillers that are not approved by the FDA for the treatment of LDS
- Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

Claims coding/pricing information

Effective with the July 2010 Healthcare Common Procedure Coding System (HCPCS) update, the July Medicare physician fee schedule (MPFS), and the July integrated outpatient code editor (IOCE):

- HCPCS codes Q2026, Q2027, and G0429 will be designated for dermal fillers Sculptra® and Radiesse®
- HCPCS codes Q2026, Q2027, and G0429 are effective for dates of service on or after March 23, 2010
- HCPCS codes Q2026 and Q2027 are contractor-priced under the July MPFS
- HCPCS code G0429 is payable under the July MPFS.

However, because HCPCS Q2026, Q2027 and G0429 are not considered valid HCPCS until implementation of the July 2010 HCPCS update, providers will not be able to bill and receive payment for these HCPCS codes prior to July 6, 2010.

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the dermal filler product. This code provides a payment mechanism to hospital outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) providers until average sales price (ASP) or wholesale acquisition cost (WAC) pricing information becomes available. When ASP or WAC pricing information becomes available, the temporary HCPCS code will be deleted and separate payment will be made under the OPPS and ASC payment systems for HCPCS Q2026, Q2027, and G0429.

For hospital institutional non-OPPS claims, Medicare contractors will use current payment methodologies for claims for dermal injections for treatment of LDS.

Hospital and ASC billing instructions

For hospital outpatient claims, hospital institutional non-OPPS claims, and ASCs, covered dermal injections for treatment of LDS must be billed by having all the required elements on the claim:

- A line with HCPCS codes Q2026 or Q2027 with a line item date of service (LIDOS) on or after March 23, 2010
- A line with HCPCS code G0429 with a LIDOS on or after March 23, 2010

- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (lipodystrophy)

Medicare will line item deny institutional claims where the LIDOS is prior to March 23, 2010.

Note to OPSS hospitals or ASCs: For line item dates of service on or after March 23, 2010, and until pricing information is made available to price OPSS claims, LDS claims will contain the temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

Note on all hospital claims: An ICD-9-CM diagnosis code for a depression-comorbidity may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

Practitioner billing instructions

Practitioners must bill covered claims for dermal injections for treatment of LDS by having all the required elements on the claim:

- A date of service (LIDOS) on or after March 23, 2010
- HCPCS codes Q2026 or Q2027
- A line with HCPCS code G0429
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

Note: An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage based on the individual Medicare contractor's policy.

Billing for services prior to Medicare coverage

ASCs and practitioners billing for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following messages upon their Medicare denial:

- **Remittance advice remark code (RARC) 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 web access, you may contact your local contractor to request a copy of the NCD.

- **Group code:** contractual obligation (CO)

Medicare beneficiaries whose provider bills Medicare for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following Medicare summary notice (MSN) message upon the Medicare denial:

- **21.11:** This service was not covered by Medicare at the time you received it.

Billing for services not meeting comorbidity coverage requirements

Hospitals and practitioners billing for dermal injections for treatment of LDS on patients that do not have on the claim both ICD-9-CM diagnosis codes of 042 and 272.6, indicating HIV and lipodystrophy will receive the following messages upon their Medicare claims denial:

Dermal injections for treatment of facial lipodystrophy syndrome (continued)

- **CARC 50:** These are noncovered services because this is not deemed a “medical necessity” by the payer. **Note:** Refer to the 835 health care policy identification segment (loop 2110 Service Payment Information REF), if present.
- **RARC M386:** 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.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- **Group code:** contractual obligation (CO)

Medicare beneficiaries who do not meet Medicare comorbidity requirements of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) and whose provider bills Medicare for dermal injections for treatment of LDS will receive the following MSN message upon the Medicare denial:

- **15.4:** The information provided does not support the need for this service or item.

Additional information

The official instruction, CR 6953, issued to your carrier, FI, and A/B MAC regarding this change via two transmittals. The first transmittal revised the *Medicare NCD Manual* and it may be viewed on the CMS website at <http://www.cms.gov/transmittals/downloads/R122NCD.pdf>.

The second transmittal revises the *Medicare Claims Processing Manual* and it is on the CMS website at <http://www.cms.gov/Transmittals/downloads/R1978CP.pdf>.

If you have any questions, please contact your carrier, 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: MM6953 – Revised

Related Change Request (CR) Number: 6953

Related CR Release Date: June 4, 2010

Related CR Transmittal Number: R122NCD and R1978CP

Effective Date: March 23, 2010

Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1978, CR 6953

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Website Welcome screen – new bookmark feature

Upon entry to either provider website, visitors are asked to indicate their line of business and geographic location before proceeding to the homepage. The purpose of this feature is to allow providers to find the information they need more quickly by focusing content based upon their selections. Since frequent site visitors may prefer not to have to indicate their references at the beginning of every visit, a Bookmark this page link is not only featured on every page of the provider website but also has been added to the site’s Welcome pop-up screen. This new feature will allow visitors to save their preferences by bookmarking the homepage. More information is available at <http://medicare.fcso.com/Help/171993.asp>.

LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by LCMS, 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

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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>.

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ADDITIONS/REVISIONS TO EXISTING LCDs

AJ1459: Intravenous immune globulin – revision to the LCD

LCD ID Number: L28895 (Florida)

LCD ID Number: L28917 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intravenous immune globulin was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) Transmittal 2050, Change Request (CR) 7117, dated September 17, 2010, to add new HCPCS code C9270 (Injection, immune globulin [Gammaplex], intravenous, non-lyophilized [e.g. liquid], 500 mg) under the “CPT/HCPCS Codes” section of the LCD. Gammaplex is an immune globulin intravenous (human) drug approved by the U.S. Food and Drug Administration (FDA) in September 2009 for the replacement therapy of primary immunodeficiency (PI).

Effective date

This LCD revision is effective for claims processed **on or after October 4, 2010**, for services provided **on or after October 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. ❖

ADDITIONAL MEDICAL INFORMATION

Clarification of modifier use when billing more than one diagnostic test for same procedure on same date of service

When a diagnostic procedure such as CPT code 73221 [*Magnetic resonance (eg. proton) imaging, any joint of upper extremity; without contrast material(s)*] is billed for two joints, such as the shoulder and elbow, at the same encounter on the same date of service, CPT code 73221 should be billed on two separate detail lines on the claim form. The second procedure should have modifier 76 [*Repeat procedure or service by same physician*] appended to allow the technical component (TC) multiple procedures reduction for this service.

The above example represents indications that warrant more than one site for the procedure, such as cases involving trauma affecting more than one area. Multiple procedures would not be expected as routine or when there is insufficient medical necessity to support the additional testing. If three or more repeat services are performed on the same day, they may be subject to medical review at the appeals level.

This information applies to diagnostic procedures that are subject to the TC multiple procedures reduction. ❖

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Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO’s LCD lookup, available at http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp, helps you find the coverage information you need quickly and easily. Just enter a procedure code or the LCD’s “L number,” click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

HOSPITAL SERVICES

Fiscal year 2011 inpatient prospective payment system, long term care hospital PPS, and inpatient psychiatric facility PPS changes

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

Provider types affected

This article is for hospitals and facilities submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs)) for inpatient hospital and long term care hospital services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7134 which provides the fiscal year (FY) 2011 update to the inpatient prospective payment system (IPPS), long term care hospital (LTCH) PPS, and inpatient psychiatric facility (IPF) PPS. Medicare Claims Processing Manual updates are also made by CR 7134. In addition, CR 7134 addresses the FY 2011 update to the Medicare severity-diagnosis related groups (MS-DRGs) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding.

Background

CR 7134 outlines changes to the IPPS for acute care hospitals and the LTCH PPS for long term care hospitals (LTCHs) for fiscal year (FY) 2011. The policy changes for fiscal year (FY) 2011 appeared in the *Federal Register* on August 16, 2010.

Note: All items covered in CR 7134 are effective for hospital discharges occurring on or after October 1, 2010, unless otherwise noted.

CR 7134 also addresses the FY 2011 update to the MS-DRGs and the ICD-9-CM coding. The coding changes require an update to the IPF PPS comorbidity adjustment, effective October 1, 2010.

Note: The IPF PPS rate changes occurred on July 1, 2010. Refer to CR 6986 (Transmittal 1981, June 4, 2010) for IPF PPS policy changes on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/Transmittals/downloads/R1981CP.pdf>.

ICD-9-CM changes

ICD-9-CM coding changes are effective October 1, 2010. New ICD-9-CM codes are listed, along with their MS-DRG classifications, in Tables 6a and 6b of the August 16, 2010, *Federal Register*. (See http://www.access.gpo.gov/su_docs/fedreg/frcont10.html on the Internet.)

The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f.

The IPPS FY 2011 update

The FY 2011 IPPS PRICER will be provided to Medicare's Fiscal Intermediary Shared System (FISS) for discharges occurring on or after October 1, 2010. It includes all pricing files for FY 2006 through FY 2011 to process bills with discharge dates on or after October 1, 2005.

FY 2011 IPPS rates

Standardized amount update factor	1.0235 1.0035 (for hospitals that do not submit quality data)
Hospital specific update factor	1.0235 1.0035 (for hospitals that do not submit quality data)
Common fixed loss cost outlier threshold	\$23,075.00
Federal capital rate	\$420.01
Puerto Rico capital rate	\$197.66
Outlier offset-operating national	0.948999
Outlier offset-operating Puerto Rico	0.948079
Indirect medical education (IME) formula (no change for FY10)	$1.35 \times [(1 + \text{resident to bed ratio}) \cdot 405 - 1]$

Fiscal year 2011 inpatient PPS, LTCH PPS, and inpatient psychiatric facility PPS changes (continued)

FY 2011 IPPS rates

Medicare dependent hospital (MDH)/sole community hospital (SCH) budget neutrality factor	0.996731
MDH/SCH documentation and coding adjustment factor	0.9718

Operating rates with FULL market basket

	Wage index > 1 labor share	Wage index ≤ 1 labor share
National	\$3,552.91	\$3,201.75
PR national	\$3,552.91	\$3,201.75
PR specific	\$1,518.14	\$1,515.70

	Wage index > 1 non-labor share	Wage index ≤ 1 non-labor share
National	\$1,611.20	\$1,962.36
PR national	\$1,611.20	\$1,926.36
PR specific	\$926.53	\$928.97

Operating rates with REDUCED market basket

	Wage index > 1 labor share	Wage index ≤ labor share
National	\$3,483.49	\$3,139.19
PR national	\$3,552.91	\$3,201.75
PR specific	\$1,518.14	\$1,515.70

	Wage index > 1 labor share	Wage index ≤ labor share
National	\$1,579.72	\$1,924.02
PR national	\$1,611.20	\$1,962.36
PR specific	\$926.53	\$928.97

Postacute transfer policy

A listing of all postacute and special postacute MS-DRGs (Table 5 of the IPPS Final Rule) is available on the CMS website at <http://www.cms.gov/AcuteInpatientPPS/IPPS2011/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237948&intNumPerPage=10>.

Acute care transfer policy changes

The current acute care transfer policy only applies to transfers between acute care hospitals that participate in the Medicare program (“participating acute care hospitals”); it does not currently apply to acute care hospitals that would otherwise be eligible to be paid under the IPPS, but do not have an agreement to participate in the Medicare program (“nonparticipating acute care hospitals”). It also does not currently apply to transfers from IPPS acute care hospitals to critical access hospitals (CAHs).

Effective for discharges on or after October 1, 2010, IPPS hospitals that transfer patients to a non-participating acute-care hospital or a CAH would be subject to the transfer policy. Note that the system changes needed to accommodate this change (transfers to CAHs) will occur in April 2011.

New technology add-on payments

The following items are eligible for new-technology add-on payments in FY 2011:

- **Total artificial heart (TAH-t)** – effective for FY 2009 through FY 2011, the new technology add-on payment for the TAH-t is triggered by the presence of ICD-9-CM procedure code 37.52 (Implantation of total heart replacement system), condition code 30, and the diagnosis code V70.7 (Examination of participant in clinical trial). The maximum add-on payment is \$53,000 per case.
- **Spiration IBV** – effective for FY 2010 and FY 2011, revised for FY 2011. Cases involving the Spiration® IBV® that are eligible for the new technology add-on payment (the maximum add on payment for the Spiration IBV is \$3,437.50 per case) will be identified by:
 - ♦ Assignment to MS-DRGs 163, 164, and 165 with procedure code 33.71 or 33.73 in combination with one of the following procedure codes: 32.22, 32.30, 32.39, 32.41, or 32.49; or

Fiscal year 2011 inpatient PPS, LTCH PPS, and inpatient psychiatric facility PPS changes (continued)

- ♦ Assignment to MS-DRGs 199, 200, and 201 with procedure code 33.71 or 33.73 in combination with diagnosis code 512.1.
- **AutoLITT** – effective for FY 2011. Cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26, and 27 with a procedure code of 17.61 in combination with one of the following primary diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, or 191.9. The maximum add-on payment for a case involving the AutoLITT™ is \$5,300.

If the costs of the discharge (determined by applying cost-to-charge ratios as described in 42 CFR 412.84(h)) exceed the full DRG payment, an additional amount will be paid that is equal to the lesser of 50 percent of the costs of the new medical service/technology or 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

National rural floor budget neutrality (RFBN) adjustment factors

The wage index table loaded for the FY 2011 PRICER contains wage index values **already adjusted by** the national rural floor budget neutrality factor of 0.996641. The statewide rural floor budget neutrality factors in place in FY 2009 and FY 2010 are not effective for FY 2011 per the Affordable Care Act which established the rural floor budget neutrality adjustment as a national factor. To confirm the wage index PRICER uses in calculating payments with the wage index printed in the *Federal Register*, take the wage index from PRICER and compare it to the wage index value shown in Table 4A, 4B or 4C as appropriate.

Cost of living adjustment (COLA) update for IPPS PPS

IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2011. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2010, can be found in the FY 2011 IPPS/LTCH PPS final rule.

Expiration of Section 508 reclassifications

The Medicare Modernization Act of 2003 (Section 508) as extended by the Affordable Care Act will expire on September 30, 2010; (visit <http://www.govtrack.us/congress/bill.xpd?bill=h111-3590> on the Internet).

Section 505 hospital (out-commuting adjustment)

Attachment A of CR 7134 shows the IPPS providers that will be receiving a “special” wage index for FY 2011 (i.e., receive an out-commuting adjustment under section 505 of the MMA).

Hospital-specific (HSP) rate update for sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs)

For FY 2011, the hospital-specific (HSP) rates for SCHs and MDHs in the PSF will continue to be entered in FY 2007 dollars. As noted above, the HSP rate market basket update for FY 2011 is 1.0235 (or 1.0035 for hospitals that do not submit quality data) and the budget neutrality factor is 0.996731. Beginning in FY 2011, a documentation and coding adjustment factor of 0.9718 will also be applied to the HSP rates.

Low volume hospitals

The Affordable Care Act (Sections 3125 and 10314) provides for a temporary increase in the low volume adjustment for FYs 2011 and 2012. Specifically, for FY 2011 and FY 2012 a hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has fewer than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year. The Affordable Care Act (Sections 3125 and 10314) also revised the payment adjustment (the applicable percentage increase) for FYs 2011 and 2012. In the FY 2011 IPPS/LTCH PPS final rule, CMS established at 412.101(c)(2) that the low-volume adjustment for FYs 2011 & 2012 will be determined as follows:

- Low-volume hospitals with 200 or fewer Medicare discharges will receive a low-volume adjustment of an additional 25 percent for each discharge.
- Low-volume hospitals with Medicare discharges of more than 200 and fewer than 1,600 will receive for each discharge a low-volume adjustment of an additional percent calculated using the formula: $[(4/14) - (\text{Medicare discharges}/5600)]$.

As established in that same final rule, for FY 2011, the low-volume payment adjustment will be determined using Medicare discharge data for FY 2009 from the March 2010 update of the MedPAR files. CMS provided a chart listing the hospitals with fewer than 1,600 Medicare discharges based on the March 2010 update of the FY 2009 MedPAR files. However, this list of hospitals with fewer than 1,600 Medicare discharges does not reflect whether or not the hospital meets the mileage criterion, that is, the hospital also must be located more than 15 road miles from any other IPPS hospital. In order to receive the applicable low-volume percentage add-on payment for FY 2011, a hospital must meet both the discharge and mileage criteria.

For FY 2011, the hospital should have made its request for low-volume hospital status in writing to its FI or MAC by September 1, 2010, so that the applicable low-volume percentage add-on will be applied to payments for its discharges beginning on or after October 1, 2010, and should have provided documentation that it meets the mileage criterion. FIs/MACs will verify that the hospital meets the discharge criteria by using the table of Medicare discharges based on the March 2010 update of the FY 2009 MedPAR files from the FY 2011 IPPS/LTCH PPS final rule or the table posted on the CMS website on the CMS website at

Fiscal year 2011 inpatient PPS, LTCH PPS, and inpatient psychiatric facility PPS changes (continued)

<http://www.cms.gov/AcuteInpatientPPS/IPPS2011/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237932&intNumPerPage=10>.

For requests for low-volume hospital status received after September 1, 2010, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the applicable low-volume adjustment prospectively within 30 days of the date of the FI/MAC’s determination that the applicable low-volume payment adjustment will apply to discharges occurring on or after the effective date of the hospital’s low-volume status, within federal FY 2011.

In order to implement this policy for FY 2011, the PRICER will include a new table containing the provider number and discharge count determined from the March 2010 update of the FY 2009 MedPAR file. The discharge count includes any health maintenance organization (HMO)/Medicare Advantage claims, but will exclude any claims serviced in non-IPPS units. The table in PRICER will only hold providers with less than 1600 Medicare discharges and does not consider whether the provider meets the mileage criterion (that is, located more than 15 road miles from any other IPPS hospital).

The applicable low-volume percentage add-on payment is based on and in addition to any other IPPS payments, including capital, disproportionate share hospital (DSH), indirect medical education (IME), and outliers. For SCHs and MDHs, the applicable low-volume percentage add-on payment is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater payment.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed on the Internet at <http://www.qualitynet.org>.

This website is expected to be updated in September 2010. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website. Hospitals not receiving the 2 percent reporting hospital quality data annual payment update for FY 2011 are listed in Attachment B of CR 7134. The Web address for accessing CR 7134 is in the “Additional Information” section at the end of this article.

Capital PPS payment for providers redesignated under Section 1886(d)(8)(B) of the Social Security Act

42 CFR 412.64(b)(II)(D)(3) (see http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr412.64.pdf on the Internet) implements the Social Security Act (section 1886(d)(8)(B); visit http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet), which redesignates certain rural counties (commonly referred to as “counties”), adjacent to one or more urban areas, as urban for the purposes of payment under the IPPS. Accordingly, hospitals located in these “Lugar counties” (commonly referred to as “Lugar hospitals”) are deemed to be located in an urban area and receive the federal payment amount for the urban area to which they are redesignated. To ensure these “Lugar hospitals” are paid correctly under the capital PPS, FIs and A/B MACs will enter the urban core based statistical area (CBSA) (for the urban area shown in chart 6 of the FY 2005 IPPS final rule (August 11, 2004; 69 FR 49057 – 49059)) in the standardized amount CBSA field on the PSF. (Note: this may be different from the urban CBSA in the wage index CBSA field on the PSF for “Lugar hospitals” that are reclassified for wage-index purposes.)

Treatment of certain urban hospitals reclassified as rural hospitals under Section 412.103 for purposes of capital PPS payments

Hospitals reclassified as rural under section 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see section 412.320(a)(1)). Similarly, the geographic adjustment factor (GAF) for hospitals reclassified as rural under section 412.103 is determined from the applicable statewide rural wage index.

Frontier wage index RFBN

The Affordable Care Act(Section 10324(a)(1); visit <http://www.govtrack.us/congress/bill.xpd?bill=h111-3590> on the Internet) amended the Social Security Act (Section 1886(d)(3)(E); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet) by adding a provision under new subsection (iii) to establish an adjustment to create a wage index floor of 1.00 for all hospitals located in states determined to be “frontier states,” beginning in FY 2011.

For the final FY 2011 IPPS wage indices, CMS identified the following frontier states that will receive the floor adjustment for FY 2011. These frontier states also are identified by a footnote in Table 4D-2 of the Addendum to the final rule. PRICER will calculate all applicable frontier wage indexes.

Frontier states identified for the FY 2011 wage index floor adjustment under Section 10324(a) of the Affordable Care Act

State	Total counties	Frontier counties	Percent of counties identified as frontier
Montana	56	45	80 percent
Wyoming	23	17	74 percent
North Dakota	53	36	68 percent
Nevada	17	11	65 percent
South Dakota	66	34	52 percent

*Fiscal year 2011 inpatient PPS, LTCH PPS, and inpatient psychiatric facility PPS changes (continued)***Section 1109**

Section 1109 of Pub. L. 111-152 provides for additional payments for FY 2011 and 2012 to “qualifying hospitals.” Section 1109(d) defines a “qualifying hospital” as a “subsection (d) hospital [...] that is located in a county that ranks, based upon its ranking in age, sex and race adjusted spending for benefits under parts A and B [...] per enrollee within the lowest quartile of such counties in the United States.” In the FY 2011 final rule, CMS provided tables with a list of qualifying hospitals, their payment weighting factors and eligible counties. As finalized in the FY 2011 final rule, CMS expects to distribute \$150 million for FY 2011 and \$250 million for FY 2012 to qualifying hospitals. CMS plans on distributing these payments through the individual hospital’s Medicare contractor through an annual one-time payment during each of FY 2011 and FY 2012. CMS plans on issuing instructions to Medicare contractors subsequent to this notification on the distribution of these payments. Qualifying hospitals will report these additional payments on their Medicare hospital cost report corresponding to the appropriate cost reporting period that the hospitals receive the payments. CMS plans to issue additional cost reporting instructions for qualifying hospitals and Medicare contractors on how to report these additional payments. CMS notes that it is requiring these payments be reported on the cost report for tracking purposes only. These additional payments will not be adjusted or settled by the FI or MAC on the cost report.

The long-term care hospital (LTCH) PPS FY 2011 update**FY 2011 LTCH PPS rates**

Federal rate	\$39,599.95
High cost outlier fixed-loss amount	\$18,785.00
Labor share	75.271 percent
Non-labor share	24.729 percent

MS-LTC-DRG update

The LTCH PPS PRICER has been updated with the version 28.0 MS-LTC-DRG table and weights, effective for discharges occurring on or after October 1, 2010, and on or before September 30, 2011.

Cost of living adjustment (COLA) update for LTCH PPS

LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2011. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2010, can be found in the FY 2011 IPPS/LTCH PPS final rule.

Changes to certain LTCH PPS payment policies made by the Affordable Care Act of 2010

The Affordable Care Act (Section 3106 and 10312; visit <http://www.govtrack.us/congress/bill.xpd?bill=h111-3590> on the Internet) provided for an extension of certain payment rules under the LTCH PPS and the moratorium on the establishment of certain LTCHs and LTCH satellites and the increase in number of beds in existing LTCHs and LTCH satellites. The changes required by sections 3106 and 10312 of the Affordable Care Act are self-implementing and were announced in the FY 2011 IPPS/LTCH PPS final rule, and CMS is revising sections 150.9.1.1 and 150.9.1.4 of the *Medicare Claims Processing Manual* (Chapter 3), which is included as an attachment to CR 7134 to reflect these changes as applicable.

The inpatient psychiatric facility (IPF) PPS update**DRG Adjustment Update**

The IPF PPS has DRG specific adjustments for MS-DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric MS-DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the identified psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments.

The IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and MS-DRG classification system, in order to maintain consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the ICD-9-CM coding system used under the IPPS, the following changes are being made to the principal diagnoses that are used to assign MS-DRGs under the IPF PPS. The following table lists the FY 2011 new ICD-9-CM diagnosis codes that group to one of the MS-DRGs, for which the IPF PPS provides an adjustment. This table is only a listing of FY 2011 new codes, and does not reflect all of the currently valid and applicable ICD-9-CM codes classified in the MS-DRGs. When coded as a principal diagnosis, these codes receive the correlating MS-DRG adjustment. Please note that there are no invalid ICD-9-CM diagnosis codes that impact the MS-DRG adjustment under the IPF PPS for FY 2011.

Fiscal year 2011 inpatient PPS, LTCH PPS, and inpatient psychiatric facility PPS changes (continued)

Diagnosis code	Description	DRG adjustment
799.51	Attention or concentration deficit	886
799.52	Cognitive communication deficit	884
799.54	Psychomotor deficit	884
799.55	Frontal lobe and executive function deficit	884
799.59	Other signs and symptoms involving cognition	884

The table below lists the FY 2011 revised ICD-9-CM diagnosis code that impacts the MS-DRG adjustment under the IPF PPS. The table only lists the FY 2011 revised code and does not reflect all of the currently valid ICD codes applicable for the IPF PPS MS-DRG adjustment.

Diagnosis code	Description	MS-DRG
307.0	Adult onset fluency disorder	887

The table below lists the seventeen MS-DRG adjustment categories for which CMS is providing an adjustment, their respective codes and their respective adjustment factors. Please note that CMS does not plan to update the regression analysis until the IPF PPS data is analyzed. The MS-DRG adjustment factors, shown below, are effective October 1, 2010, and will continue to be paid for rate year (RY) 2011.

MS-DRG	MS-DRG description	Adjustment factor
056	Degenerative nervous system disorders w MCC	1.05
057	Degenerative nervous system disorders w/o MCC	1.05
080	Nontraumatic stupor & coma w MCC	1.07
081	Nontraumatic stupor & coma w/o MCC	1.07
876	O.R. procedure w principal diagnosis of mental illness	1.22
880	Acute adjustment reaction & psychosocial dysfunction	1.05
881	Depressive neurosis	0.99
882	Neurosis except depressive	1.02
883	Disorders of personality & impulse control	1.02
884	Organic disturbances & mental retardation	1.03
885	Psychoses	1.00
886	Behavioral & developmental disorders	0.99
887	Other mental disorder diagnoses	0.92
894	Alcohol/drug abuse or dependence, left AMA	0.97
895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
896	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC	0.88
897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity adjustment update

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes for certain comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to eight additional diagnoses if they co-exist at the time of admission or develop subsequently.

Comorbidities and complications (CCs) are specific patient conditions that are secondary to the patient’s primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and shall not be reported on IPF claims. Comorbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

The IPF PPS uses the Medicare-severity DRG coding system in order to maintain consistency with the IPPS, which is effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. CMS is currently using the FY 2011 GROUPER, version 28.0 which is effective for discharges occurring on or after October 1, 2010.

Fiscal year 2011 inpatient PPS, LTCH PPS, and inpatient psychiatric facility PPS changes (continued)

The following table lists the FY 2011 new ICD-9-CM diagnosis codes which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. The table lists only the FY 2011 new codes, and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. The RY 2011 IPF PRICER will be updated to include these codes in the comorbidity tables, effective for discharges on or after October 1, 2010. There are no invalid or revised ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS for FY 2011.

Diagnosis code	Description	Comorbidity category
237.73	Schwannomatosis	Oncology
237.79	Other neurofibromatosis	Oncology

The table below lists the seventeen comorbidity categories for which CMS is providing an adjustment, their respective codes, including the new FY 2011 ICD codes, and their respective adjustment factors.

Description of comorbidity	ICD-9CM code	Adjustment factor
Developmental disabilities	317, 3180, 3181, 3182, and 319	1.04
Coagulation factor deficits	2860 through 2864	1.13
Tracheostomy	51900 through 51909 and V440	1.06
Renal failure, acute	5845 through 5849, 63630, 63631, 63632, 63730, 63731, 63732, 6383, 6393, 66932, 66934, 9585	1.11
Renal failure, chronic	40301, 40311, 40391, 40402, 40412, 40413, 40492, 40493, 5853, 5854, 5855, 5856, 5859, 586, V4511, V4512, V560, V561, and V562	1.11
Oncology treatment	1400 through 2399 with a radiation therapy code 92.21-92.29 or chemotherapy code 99.25	1.07
Uncontrolled diabetes-mellitus with or without complications	25002, 25003, 25012, 25013, 25022, 25023, 25032, 25033, 25042, 25043, 25052, 25053, 25062, 25063, 25072, 25073, 25082, 25083, 25092, and 25093	1.05
Severe protein calorie malnutrition	260 through 262	1.13
Eating and conduct disorders	3071, 30750, 31203, 31233, and 31234	1.12
Infectious disease	01000 through 04110, 042, 04500 through 05319, 05440 through 05449, 0550 through 0770, 0782 through 07889, and 07950 through 07959	1.07
Drug and/or alcohol induced mental disorders	2910, 2920, 29212, 2922, 30300, and 30400	1.03
Cardiac conditions	3910, 3911, 3912, 40201, 40403, 4160, 4210, 4211, and 4219	1.11
Gangrene	44024 and 7854	1.10
Chronic obstructive pulmonary disease	49121, 4941, 5100, 51883, 51884, V4611 and V4612, V4613 and V4614	1.12
Artificial openings – digestive and urinary	56960 through 56969, 9975, and V441 through V446	1.08
Severe musculoskeletal and connective tissue diseases	6960, 7100, 73000 through 73009, 73010 through 73019, and 73020 through 73029	1.09
Poisoning	96500 through 96509, 9654, 9670 through 9699, 9770, 9800 through 9809, 9830 through 9839, 986, 9890 through 9897	1.11

Fiscal year 2011 inpatient PPS, LTCH PPS, and inpatient psychiatric facility PPS changes (continued)

Additional information

The official instruction, CR 7134, issued to your FI or A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2060CP.pdf>.

If you have any questions, please contact your 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: MM7134

Related Change Request (CR) Number: 7134

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Source: CMS Pub. 100-04, Transmittal 2060, CR 7134

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Inpatient rehabilitation facility prospective payment system fact sheet

The revised publication titled “*Inpatient Rehabilitation Facility Prospective Payment System*” (August 2010) is now available in downloadable format from the Medicare Learning Network® at <http://www.cms.gov/MLNProducts/downloads/InpatRehabPaymftcsht09-508.pdf>. This fact sheet provides information about inpatient rehabilitation facility prospective payment system rates, classification criterion, and reasonable and necessary criteria.

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Source: CMS PERL 201010-38

Hospital outpatient department payment information for value-driven health care

The Centers for Medicare & Medicaid Services (CMS) updates hospital outpatient department payment information for value-driven health care to support the delivery of high-quality, efficient health care and enable consumers to make more informed health care decisions. In addition, the U.S. Department of Health & Human Services is making cost and quality data available to all Americans. As part of this initiative, Medicare posted information in 2007, 2008, and 2009 about the payments it made during the previous year for common and elective procedures and services provided by hospitals, ambulatory surgery centers (ASCs), hospital outpatient departments, and physicians.

The hospital information is posted on the Hospital Compare website where it may be viewed along with hospital quality information. The Hospital Compare website may be found at <http://www.medicare.gov/>.

On August 20, 2010, Medicare posted an update to the ambulatory surgery center data. The hospital outpatient department payment data was posted on September 29, 2010. Physician data will be updated later this year. The information is being displayed in the same format as in previous years, updated with calendar year (CY) 2009 data. The posting updates may be found at <http://www.cms.gov/HealthCareConInnt/>.

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Source: CMS PERL 201010-02

Find fees faster: Try FCSO’s fee schedule lookup

Now you can find the fee schedule information you need faster than ever before with FCSO’s redesigned fee schedule lookup, located at http://medicare.fcso.com/Fee_lookup/fee_schedule.asp. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Fiscal year 2012 wage-index public use files

On Monday, October 4, 2010, the Centers for Medicare & Medicaid Services (CMS) released the preliminary fiscal year (FY) 2012 wage-index public use file (PUF). The PUF contains two spreadsheets of data: 1) the worksheet S-3 wage data, which includes worksheet S-3, Parts II and III wage data from cost-reporting periods beginning on or after October 1, 2007, through September 30, 2008; that is, the FY 2008 wage data; and 2) the occupational-mix data, which includes data from the 2007-2008 occupational-mix survey, Form CMS-10079.

The FY 2008 wage data and 2007-2008 occupational-mix data will be used in the development of the proposed FY 2012 wage index, to be published in the *Federal Register* in the Spring of 2011. Hospitals must review the PUF to confirm the inclusion and accuracy of their data for the FY 2012 wage index. Hospitals may also request revisions to their data.

All requests from hospitals for changes to their FY 2012 wage-index data must be submitted to and received by their fiscal intermediaries or Medicare administrative contractors on or before December 6, 2010.

The preliminary FY 2012 wage-index PUF and time table are available on CMS's website at <http://www.cms.gov/AcuteInpatientPPS/WIFN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1239640&intNumPerPage=10>.

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Source: CMS PERL 201010-10

Round one rebid of the durable medical equipment, prosthetics, orthotics, and supplies competitive bidding program – Phase 8A: Hospital exception

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 MM6677** to remove a reference to the national competitive billing indicator from the fourth bullet under the key point section. Providers are not responsible for coding that indicator. All other information remains the same. The article was published in the November 2009 *Medicare A Bulletin* (pages 29-30).

Provider types affected

This article is for hospitals that bill durable medical equipment Medicare administrative contractors (DME MACs) for specific allowed competitively bid items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) to their patients on the day of discharge.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6677 to announce that hospitals may furnish certain competitively bid durable medical equipment (DME) items to their patients on the date of discharge without submitting a bid and being awarded a contract under the competitive bidding program round one rebid. The DME competitive bid items that a hospital may furnish upon discharge as part of this exception for round one rebid are walkers and related accessories. Note that this applies to claims received upon implementation of the DMEPOS competitive bidding program round one. That date is January 1, 2011, but the date is subject to change.

Key points of change request 6677

- Hospitals may furnish walkers and related accessories to their patients on the date of discharge whether or not the hospital has a contract under the DMEPOS competitive bidding program.
- Separate payment is not made for walkers and related accessories furnished by a hospital **on the date of admission** as payment for these items is included in the Part A payment for inpatient facility services.
- Hospitals as defined below may furnish walkers and related accessories to their patients for use in the home on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier.
- To be paid for walkers and accessories as a non-contract supplier, hospitals should use the **modifier J4** and the on the claim line in combination with the following **HCPCS codes: A4636, A4637, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0154, E0155, E0156, E0157, E0158, and E0159.**
- Hospital claims submitted for these items, for which Medicare does not find a matching date of discharge will be denied with remittance advice messages B15 (Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying service/procedure had not been received/adjudicated.), M114 (This service was processed in accordance with rules and guidelines under the DMEPOS competitive bidding program or other demonstration project. For more information regarding these projects, contact your local contractor.), and MA13 (Alert: you may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.). Prior to denying these DME claims, Medicare will hold the claim for up to 15 business days to await the arrival of the hospital claim with the related discharge date. If such discharge is not processed by the end of the 15 business days, the DME claim will be denied.

*Round one rebid of the DMEPOS competitive bidding program – Phase 8A: Hospital exception (continued)***Background**

Section 302(b) (1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended Section 1847 of the Social Security Act (the Act) to require the Secretary to establish and implement programs under which competitive bidding areas (CBAs) are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Part B (the “Medicare DMEPOS competitive bidding program”).

On July, 15, 2008, Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the MMA and mandated certain changes to the competitive bidding program. One of these changes established an exception for hospitals from the competitive bidding program when they are furnishing certain items to their own patients during an admission or on the date of discharge.

A hospital under this exception **does not include a hospital-owned DME supplier**. Instead, a hospital is defined in accordance with Section 1861(e) of the Social Security Act. A DME supplier that furnishes the DME item to the hospital, which then furnishes the item to the patient on the date of discharge, must be a contract supplier in the competitive bidding program.

Additional information

The official instruction (CR 6677) issued to your Medicare FI, DME/MAC, or A/B MAC is available on the CMS website at <http://www.cms.hhs.gov/Transmittals/downloads/R5900TN.pdf>.

For discussion of the program instructions designating the competitive bidding areas and product categories included in the DMEPOS competitive bidding program round one rebid in CY 2009 you may review MM6571 on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6571.pdf>.

The metropolitan statistical areas (MSAs) and product categories that are included in the DMEPOS competitive bidding round one rebid in 2009 may also be found on the CMS website at http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp.

Further information on the boundaries and list of ZIP codes for each competitive bid area (CBA) and the *Healthcare Common Procedure Coding System* (HCPCS) codes for each product category are available by visiting http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website and following the link to the competitive bidding implementation contractor (CBIC).

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

MLN Matters® Number: MM6677 – Revised

Related Change Request (CR) Number: 6677

Related CR Release Date: November 6, 2009

Related CR Transmittal Number: R5900TN

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

Source: CMS Pub. 100-20, Transmittal 590, CR 6677

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ELECTRONIC HEALTH RECORDS

Electronic health record incentive program information for hospitals and critical access hospitals

Incentive payments totaling as much as \$27 billion may be made under the Medicare & Medicaid electronic health record (EHR) incentive programs beginning in 2011. Is your hospital eligible for an incentive? How are hospital incentive payments calculated? What are the key dates for these programs?

Learn more on the Centers for Medicare & Medicaid Services (CMS) EHR incentive programs website <http://www.cms.gov/EHRIncentivePrograms/>.

Tip sheets for eligible hospitals and critical access hospitals

- New: Medicaid hospital incentive payment calculations
Which hospitals can participate in the Medicaid EHR incentive program? Learn about Medicaid patient volume requirements, payment amounts, and the timeframes for the Medicaid EHR incentive program.
- EHR incentive program for Medicare hospitals
Learn which hospitals are eligible for Medicare incentive payments. (See the separate tip sheet for critical access hospitals [CAHs] below.) This sheet discusses the factors which impact incentive payment amounts and provides sample payment calculations.

- EHR incentive program for critical access hospitals
How are Medicare incentive payments calculated for CAHs? When can they be earned? Learn more in this informative discussion of the calculation of Medicare incentive payments. Sample calculations are provided. This sheet also provides information on how Medicare reimbursement will be reduced for CAHs which have not demonstrated meaningful use of certified EHR technology by 2015.

For the three tip sheets above, go to <http://www.cms.gov/EHRIncentivePrograms/>. Select the “Hospitals” tab on the left, and then scroll to “Downloads.”

Important dates

- New: EHR incentive program timeline
Find it at <http://www.cms.gov/EHRIncentivePrograms/> in the “Downloads” section of the “Overview” tab.

Electronic health record incentives – get the facts from CMS.

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Source: CMS PERL 201010-16

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Hospitals and CAHs can earn Medicare electronic health record incentive payments

Take the first step

Hospitals and critical access hospitals (CAHs) must have an enrollment record in the provider enrollment, chain and ownership system (PECOS) in order to be eligible to receive a Medicare electronic health record (EHR) incentive payment.

How can I find out if my facility has an enrollment record in PECOS?

Billing and receiving payments from Medicare does not necessarily mean that a hospital or a CAH has an enrollment record in PECOS.

Don't wait.

- Act now to verify that your facility has an enrollment record in PECOS.
- If your facility does not have a record in PECOS, establish an enrollment record now.

If you have submitted a Medicare enrollment application within the last 90 days, and your enrollment application has been accepted for processing by the fiscal intermediary or A/B Medicare administrative contractor (MAC), you need not take any additional actions based on this message. (You will be contacted by your fiscal intermediary or A/B MAC if additional information is needed.)

To find out if your facility has an enrollment record in PECOS, choose one of the following:

- Use Internet-based PECOS to look for your PECOS enrollment record. If no record is displayed, you do not have an enrollment record in PECOS. (If you do not currently have access to Internet-based PECOS, see Basics of Internet-based PECOS for Provider and Supplier Organizations at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf for instructions.)

Hospitals and CAHs can earn Medicare electronic health record incentive payments (continued)

- Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Go to Contractor List at http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf for contact information.

My facility doesn't have an enrollment record. What should I do?

Internet-based PECOS is the fastest and most efficient way to submit your enrollment application.

For instructions, see Basics of Internet-based PECOS for Provider and Supplier Organizations at

http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf.

If you encounter problems or have questions as you navigate the system, there is help available on the Centers for Medicare & Medicaid Services (CMS) website at

http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf.

Electronic health record incentives – get the facts from CMS at <http://www.cms.gov/EHRIncentivePrograms/>.

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Source: CMS PERL 201010-29

CRITICAL ACCESS HOSPITAL SERVICES

Submission of informational only claims by Maryland waiver hospitals and critical access hospitals for electronic health records purposes

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

Provider types affected

This article is for Maryland waiver hospitals and critical access hospitals (CAHs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7172 which instructs Maryland waiver hospitals and CAHs to submit informational only claims to their Medicare contractor for the Medicare Advantage (MA) plan beneficiaries they treat effective for discharges on or after October 1, 2010.

Caution – what you need to know

Informational only claims are claims billed for patients enrolled in an MA plan and contain the following elements: covered type of bill (TOB) 11x (not 110); condition code 04; Medicare listed as the primary payer; Medicare secondary payers not listed; the MA beneficiary's Medicare health insurance claim number (HICN); and all other required claim elements.

Go – what you need to do

See the *Background and Additional Information* sections of this article for further details regarding these changes.

Background

The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5) provides incentive payments for acute care hospitals (subsection (d) hospitals) and critical access hospitals who are meaningful users of certified electronic health records (EHR) technology. You may review the ARRA on the Internet at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.txt.pdf.

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Acute care hospitals already submit informational only bills for purposes of including Part C or MA days in disproportionate share (DSH) calculations. However, Maryland waiver hospitals and CAHs do not currently submit informational only bills.

Therefore, in order for The Centers for Medicare & Medicaid Services (CMS) to capture Part C days for purposes of calculating EHR payments, CR 7172 instructs Maryland waiver hospitals and CAHs to submit informational only claims to their Medicare contractor for the MA beneficiaries they treat effective for discharges October 1, 2010.

Note: In April 2011, informational only claims will begin to accumulate on the Provider Statistics & Reimbursement (PS&R) report type 118 retroactive to October 1, 2010, in order for these hospitals to view their claim submissions.

Additional information

The official instruction, CR 7172, issued to your FI or A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2066CP.pdf>.

For more information on the EHR incentive programs under ARRA, visit the CMS website at <http://www.cms.gov/EHRIncentivePrograms/>.

If you have any questions, please contact your 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: MM7172

Related Change Request (CR) Number: 7172

Related CR Release Date: October 15, 2010

Related CR Transmittal Number: R2066CP

Effective Date: October 1, 2010

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2066, CR 7172

Expansion of the current scope of editing for critical access hospital claims

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

Provider types affected

Critical access hospitals (CAH) submitting claims that include attending, operating, other physician or nonphysician practitioner provider that order and refer to Medicare contractors (fiscal intermediary [FIs] and A/B Medicare administrative contractor [MACs]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7046. You should know that Medicare contractors will expand claims editing to verify that the attending, operating, or other physician or nonphysician practitioner provider on a CAH claim is eligible and active in the Medicare program's provider enrollment, chain and ownership system (PECOS). This means providers who are enrolled in the Medicare program must be in the PECOS in an approved or opt-out status.

The editing expansion will be done in two phases:

- Phase 1 will allow a claim to be paid, if the billed service requires an attending, operating, or other physician or nonphysician practitioner and the information is not on the claim. However, remittance advice (RA) messages will notify the billing provider that claims of this nature may not be paid in the future if the required data is not provided accurately on the claim. Phase 1 covers dates of service on or after January 1 through March 31, 2011.
- In phase 2, the claims will not be paid if the required information is missing or not accurate on the claim. Phase 2 will be effective for claims with dates of service on or after April 1, 2011.

Please ensure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is expanding the claim editing to meet the Social Security Act requirements for the attending, operating, or other physician or nonphysician practitioner when a plan of treatment is needed and submitted from a CAH. The expansion will verify that the attending, operating, or other physician or nonphysician practitioner provider on a CAH claim is eligible and enrolled in Medicare by allowing the Medicare's fiscal intermediary shared system (FISS) to match data (combination of the national provider identifier (NPI) and provider name will be matched) on a provider billed claim to that of a national PECOS file.

In this document, the word 'claim', means both electronic and paper claims, since the following are the only providers who can order/refer beneficiary services for CAHs:

- doctor of medicine or osteopathy
- dental medicine
- dental surgery
- podiatric medicine

- optometry
- chiropractic medicine
- physician assistant
- certified clinical nurse specialist
- nurse practitioner
- clinical psychologist
- certified nurse midwife
- licensed clinical social worker
- certified registered nurse anesthetist
- registered dietitian/nutritional professional.

The editing expansion will be done in two phases. Phase 1 will allow a claim to be paid, if the billed service requires an attending, operating, or other physician or nonphysician practitioner and the information is not on the claim. However, RA messages will notify the billing provider that claims of this nature may not be paid in the future if the required data is not provided accurately on the claim. Those RA messages may include the following, as appropriate:

- Remittance advice remark code (RARC) N272 (Missing/incomplete/invalid other payer attending provider.)
- RARC N273 (Missing/incomplete/invalid other payer operating provider identifier.)
- RARC N274 (Missing/incomplete/invalid other payer other provider identifier.)
- Claim adjustment reason code 16 (for adjusted claims).

In phase 2, the claims will not be paid if the required information is missing or not accurate on the claim. The same RA messages cited above will appear on rejected services in phase 2.

Additional information

The official instruction issued to your FI or MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R767OTN.pdf>.

If you have questions, please contact your FI 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: MM7046

Related Change Request (CR) Number: 7046

Related CR Release Date: September 10, 2010

Related CR Transmittal Number: R767OTN

Effective Date: Phase 1 - January 1, 2011; Phase 2 – April 1, 2011

Implementation Date: Phase 1 - January 3, 2011; Phase 2 – April 4, 2011

Source: CMS Pub. 100-20, Transmittal 767 CR 7046

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ESRD SERVICES

Issue affecting the crossing over of end-stage renal disease facility claims

The Centers for Medicare & Medicaid Services (CMS) has notified contractors that its coordination of benefits contractor (COBC) was unable to cross over several thousand end-stage renal disease (ESRD) facility claims (type of bill [TOB] 72x) successfully during the period from July 5 through August 16, 2010. Unfortunately, the COBC's translator and edit validation vendor had not made accommodations, prior to July 5, 2010, for the reporting of occurrence code 51, as prescribed by CMS change request 6782. The COBC thus rejected all types of bills 72x where occurrence code 51 qualifies the KT/V collection date with edit H51103, which means "51 is not a valid NUBC (National Uniform Billing Committee) code."

Consequently, your local Medicare contractor would have issued a special provider notification letter to your facility specifying that Medicare did not cross over the listed claims due to H51103—"51 is not a valid NUBC code." This would be true even though your Medicare remittance advice indicated that Medicare transferred your patient's claim to a given supplemental insurer.

Due to the current configuration of the COBC translator and edit validator, the COBC is unable to re-run the affected claims through its HIPAA edit validation routine to facilitate the crossing over of the affected TOB 72x claims to your patients' supplemental insurers. The COBC made changes on August 16, 2010, to accept the reporting of the KT/V collection date, as qualified by 51, on 837 institutional TOB 72x claims. Therefore, all claims that the Medicare contractors sent to the COBC as of August 16, 2010, will no longer be rejected with code H51103.

CMS has already notified all participating supplemental insurers and benefit programs of this issue. You are within your rights to now bill these insurers for any balances remaining following Medicare's payment determination on your TOB 72x claims. ❖

Source: CMS JSM 10416, September 23, 2010

End-stage renal disease publications from the Medicare Learning Network

Two publications that discuss Medicare end-stage renal disease (ESRD) payment systems are now available in downloadable format from the *Medicare Learning Network*[®]:

- The new publication titled *End-Stage Renal Disease Prospective Payment System* (September 2010) provides information about the Medicare ESRD prospective payment system that will be implemented on January 1, 2011, including the one-time election and transition period, payment rates for adult and pediatric patients, home dialysis, laboratory services and drugs, and beneficiary deductible and coinsurance. This publication may be accessed at http://www.cms.gov/mlnproducts/downloads/End-Stage_Renal_Disease_Prospective_Payment_System_ICN905143.pdf.
- The revised publication titled *End-Stage Renal Disease Composite Payment Rate System* (September 2010) (previously titled *Outpatient Maintenance Dialysis – End-Stage Renal Disease*) provides information about the Medicare ESRD composite payment rate system, the one-time election and transition period, and separately billable items and services. This publication may be accessed at <http://www.cms.gov/MLNProducts/downloads/ESRDpaymfctsh2010.pdf>.

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

Source: CMS PERL 201009-39

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.fcsso.com/Landing/139800.asp>.

SKILLED NURSING FACILITY SERVICES

Minimum data set 3.0 assessment submission and processing problem

The Centers for Medicare & Medicaid Services (CMS) recently identified a system problem that resulted in errors in the resource utilization group version III (RUG-III) and RUG-IV codes printed on facility final validation reports. Since accurate RUG data is required for billing and other facility operations, the following actions are being taken to correct the minimum data set (MDS 3.0) assessment submission and processing (ASAP) system:

- Providers that have submitted already MDS 3.0 data and received a final validation report, need to check the CASPER shared folder for the revised report for each MDS 3.0 file submitted. Providers need to disregard the old final validation reports and use the revised reports.
- Providers need to use the revised final validation reports to verify the RUG III and RUG IV values to ensure the submitted claim for payment is correct.

Submission and confirmation

- The transmission system remains in operation. All providers can continue to submit MDS 3.0 records.
- After each submission, providers will receive confirmation that the MDS 3.0 file has been received. The confirmation page includes submission identification and the date and time of the transmission. Providers may print the confirmation and retain it for their records.

File editing and final validation report generation stopped

- The editing of the submission files and generation of the final validation reports has been temporarily stopped pending final testing of the reprogrammed editing and validation system.

MDS 3.0 files submitted since October 1, 2010

- All MDS 3.0 files submitted since October 1, 2010, will be edited. Revised final validation reports will be available in the certification and survey provider enhanced reporting (CASPER) shared folder.

Note: The incorrect RUG information may have appeared on any previous final validation report.

Final validation reports release

- The release of all final validation reports, including the revised reports for earlier submissions, is expected to occur by 9:00 p.m. ET October 22, 2010.

Late submissions

- Providers receive only warning messages on validation reports for records submitted late. Since late submission is determined by the submission time stamp, delayed editing and validation processing does not affect whether the submission is late.
- The CMS survey and certification group has been notified that some MDS 3.0 assessments may be delayed due to this system problem. The survey and certification staff is expected to issue written policy instructions shortly.

jRAVEN (resident assessment validation and entry) software

Providers using jRAVEN software need to check the CMS website for an updated jRAVEN, which is available now at http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp.

Non-jRAVEN users need to check with their vendor for software updates that address the issues identified.

Note: It is recommended that all providers continue to check for software updates on a regular basis.

If you have questions, please contact the QTSO help desk at (800) 339-9313 or help@qtso.com.

We appreciate your patience during this time.

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

Source: CMS PERL 201010-37

Revision to the skilled nursing facility prospective payment system fact sheet

The *Skilled Nursing Facility Prospective Payment System* fact sheet (revised July 2010), which provides the elements of the skilled nursing facility prospective payment system, is now available in print format from the *Medicare Learning Network*[®]. To place your order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

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

Source: CMS PERL 201010-30

September five-star preview reports

The five-star preview reports became available September 21. 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 MDS data and select the certification and survey provider enhanced reporting (CASPER) reporting link located at the bottom of the page.

Once in the CASPER reporting 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.

Nursing Home Compare website updated the five star report with the September data on September 23, 2010.

Note: The five star help line was available from September 20 through September 24, 2010. Provider preview reports will continue to be available on a monthly basis in advance of public posting and will include the dates and hours of helpline availability.

BetterCare@cms.hhs.gov is an alternative communication medium to direct inquiries.

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

Source: CMS PERL 201009-35

National provider call with question and answer session on SNF PPS RUG-IV

The Centers for Medicare & Medicaid Services’ (CMS) Provider Communications Group will host a national provider conference call on the skilled nursing facility (SNF) prospective payment system (PPS) resource utilization group-version 4 (RUG-IV).

This call is one in a series of calls designed to provide information on key aspects of the RUG-IV SNF PPS case-mix system, which was put into place on an interim basis effective October 1, 2010. CMS held three previous calls, which provided details of significant changes related to the RUG-IV payment system.

In June, CMS discussed coding procedures, with emphasis on the appropriate look-back period to be used when coding the minimum data set (MDS) 3.0 and how facility staff should separately report individual, concurrent and group therapy for accurate payment, along with changes to the activity of daily living (ADL) coding requirements and their impact on the assignment of MDS 3.0 records to a RUG-IV group. In August, CMS held a second call, where subject matter experts discussed the transition from RUG-III to RUG-IV. The third call, in September, discussed several SNF PPS policies, including start of therapy and end of therapy other Medicare required assessments and the SNF short stay policy.

For this call, CMS subject matter experts will review some of the significant changes associated with the RUGIV payment system.

Information on the previous calls and future information for this call will be available on the SNF PPS Web page at http://www.cms.gov/SNFPPS/03_RUGIVedu.asp#TopOfPage.

Following the formal presentation, callers will have an opportunity to ask questions of CMS subject matter experts.

Toll-free conference call details

Date: Tuesday, November 9, 2010

Time: 2:00-3:00 p.m. ET

Conference title:

Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Resource Utilization Group – Version 4 (RUG-IV) National Provider Call

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, not to allow participation.

Registration will close at 2:00 p.m. ET on November 8, 2010 or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call, participants need to go to <http://www.eventsvc.com/palmettogba/110910>.
2. Fill in all required data.
3. Verify that your time zone is displayed correctly in the drop down box.
4. Click “Register.”
5. You will be taken to the “Thank you for registering” page and will receive a confirmation e-mail shortly thereafter.

Note: Please print and save this page in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

6. If assistance for hearing impaired services is needed, the request must be sent to medicare.ttt@palmettogba.com no later than three business day before the event.

For those who will be unable to attend, a transcript and MP3 audio file of the call will be available at http://www.cms.gov/SNFPPS/03_RUGIVedu.asp#TopOfPage on the CMS website shortly after the call.

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

Source: CMS PERL 201010-31

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OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 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 submitting claims to Medicare contractors (fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services subject to the outpatient prospective payment system (OPPS) that are provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7117 which provides the October 2010 update for the OPPS and describes changes to and billing instructions for various payment policies implemented in the OPPS. The October 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 7117. October 2010 revisions to I/OCE data files, instructions, and specifications are provided in CR 7111 titled “October 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.3.” An *MLN Matters*® article related to CR 7111 is available on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/MLN MattersArticles/downloads/MM7111.pdf>.

Background

Key changes to and billing instructions for various payment policies implemented in the October 2010 OPPS update are as follows:

Procedure and device edits for October 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 may 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/>.

New device pass-through category

The Social Security Act (Section 1833(t)(6)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) also requires that the CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device category as of October 1, 2010, and the following table provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 1: New device pass-through codes

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Device offset from payment
C1749	10-01-10	H	1749	Endo, colon, retro imaging	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	\$0

The Social Security Act (Section 1833(t)(6)(D)(ii) requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8; see 2005 *Federal Register*, Vol. 70, page 68627 at <http://www.gpoaccess.gov/fr/retrieve.html> on the Internet). CMS has determined that they are not able to identify a portion of the APC payment amount associated with the cost of the device, that is, endoscope, retrograde imaging/illumination colonoscope device (implantable), in APC 143, lower GI endoscopy. The device offset from Payment represents this deduction from pass-through payments for category C1749, when it is billed with a service included in APC 143. Therefore, CMS is establishing an offset amount for C1749 of \$0 and will not make any deductions from pass-through payment for category C1749.

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

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.

Hospitals should note that under the OPSS, 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 Food and Drug Administration (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.

a. Drugs and biologicals with payments based on average sales price (ASP) effective October 1, 2010

For calendar year (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. We note 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 reinstated 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 OPSS/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 October 2010 release of the OPSS PRICER. The updated payment rates, effective October 1, 2010, will be included in the October 2010 update of the OPSS Addendum A and Addendum B, which will be posted on the CMS website.

b. Drugs and biologicals with OPSS pass-through status effective October 1, 2010

Five drugs and biologicals have been granted OPSS pass-through status effective October 1, 2010. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2: Drugs and biologicals with OPSS pass-through status effective October 1, 2010

HCPCS code	Long descriptor	APC	Status indicator effective 10/1/10
C9269*	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	9269	G
C9270*	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	9270	G
C9271*	Injection, velaglucerase alfa, 100 units	9271	G
C9272*	Injection, denosumab, 1 mg	9272	G
C9273*	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer’s, including leukapheresis and all other preparatory procedures, per infusion	9273	G

Note: The “*” indicate that these are new codes effective October 1, 2010.

c. Supplemental information on HCPCS code C9273

CMS has opened a national coverage determination analysis (NCD) for HCPCS code C9273, Provenge (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer’s, including leukapheresis and all other preparatory procedures, per infusion). A final decision on coverage is forthcoming in 2011. As with other drugs and biologicals, at this time, local contractors will retain the discretion to make individual claim determinations for Provenge® based on the medical necessity of the service(s) being provided. Additionally, the language given in the long descriptor of Provenge that states “all other preparatory procedures” refers to the transportation process of:

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

- Collecting immune cells from a patient during a non-therapeutic leukapheresis procedure
- Subsequently sending the immune cells to the manufacturing facility
- Then transporting the immune cells back to the site of service to be administered to the patient.

d. Updated payment rate for CPT code 90476 effective April 1, 2010, through June 30, 2010

The payment rate for CPT code 90476 was incorrect in the April 2010 OPSS PRICER. The corrected payment rate is listed in Table 3 below and has been installed in the October 2010 OPSS PRICER, effective for services furnished on April 1, 2010, through implementation of the July 2010 update.

Table 3: Updated payment rate for CPT code 90476 effective April 1, 2010, through June 30, 2010

CPT code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
90476	K	1254	Adenovirus vaccine, type 4	\$72.17	\$14.43

e. Updated payment rates for certain HCPCS codes effective July 1, 2010, through September 30, 2010

The payment rates for several HCPCS codes were incorrect in the July 2010 OPSS PRICER. The corrected payment rates are listed in Table 4 below and have been installed in the October 2010 OPSS PRICER, effective for services furnished on July 1, 2010, through implementation of the October 2010 update.

Table 4: Updated payment rates for certain HCPCS codes effective July 1, 2010, through September 30, 2010

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9264	K	1712	Paclitaxel protein bound	\$9.22	\$1.84
C9268	G	9268	Capsaicin patch	\$25.55	\$5.01

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

CPT code 90670 (*Pneumococcal vacc, 13 val im*) was erroneously assigned status indicator “K” effective April 1, 2010, in the July 2010 update issued in CR 6996 (see on the CMS website <http://www.cms.gov/Transmittals/downloads/R1980CP.pdf>). Therefore, retroactively effective April 1, 2010, the status indicator for CPT code 90670 will change from status indicator “K” (paid under OPSS; separate APC payment) to status indicator “L” (Not paid under OPSS. Paid at reasonable cost; not subject to deductible or coinsurance). Beginning April 1, 2010, CPT code 90670 will be paid at reasonable cost.

g. Payment for vaccine CPT code 90662

CPT code 90662 (*Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use*) has been assigned status indicator “E”. However, 90662 received approval from the FDA on December 23, 2009. Therefore, effective December 23, 2009, CPT code 90662 is assigned status indicator “L” (Not paid under OPSS. Paid at reasonable cost; not subject to deductible or coinsurance). CPT code 90662 will be paid at reasonable cost.

h. 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 OPSS payment for the biological is packaged 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 OPSS, 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.

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

i. 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. As another example, 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, hospitals 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, 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.

j. 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. CMS stated in the October 2009 OPSS update that 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 expects that the

majority of hospitals will not encounter this situation. When a radiolabeled product is administered in one hospital and the nuclear medicine scan is subsequently performed at another hospital, hospitals should comply with the OPSS policy that requires that radiolabeled products be reported and billed with nuclear medicine scans. In these specific cases, the hospital that bills for the nuclear medicine procedure would receive payment for both the nuclear medicine procedure and the radiolabeled product since a hospital cannot bill and be paid for a radiolabeled product solely submitted on a claim. In order for the hospital that administers the radiolabeled product to be paid, hospitals may enter into an arrangement (under Section 1861 (w)(1) of the Act and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3) where the hospital that administers the nuclear medicine scan pays the appropriate amount for the radiolabeled product to the hospital that administers the radiolabeled product. CMS considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and expects both services to be performed together.

Coding and payment for magnetic resonance angiography (MRA)

Effective for claims with dates of service on and after June 3, 2010, CMS permits local Medicare contractors to cover (or not cover) all indications of MRA that are not specifically nationally covered or nationally noncovered. CMS has created the six Level II HCPCS codes in Table 5 to allow OPSS providers to bill for certain MRA services that were previously noncovered but may now be covered at local Medicare contractor discretion. The six Level II HCPCS codes must be used in place of existing CPT codes for the previously noncovered MRA procedures due to a statutory requirement that the OPSS provide payment for imaging services provided with contrast and without contrast through separate payment groups. Specifically, HCPCS codes C8931, C8932, and C8933 replace CPT code 72159 (*Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)*), while HCPCS codes C8934, C8935, and C8936 replace CPT code 73225 (*Magnetic resonance angiography, upper extremity, with or without contrast material(s)*). CMS has changed the assignment of CPT codes 72159 and 73225 from status indicator “E” to status indicator “B” to indicate that these codes are not recognized by OPSS when submitted on an outpatient hospital Part B bill type 12x or 13x.

Under the hospital OPSS, these new HCPCS codes are assigned status indicator “Q3” to indicate that these services will be paid with one composite APC payment each time a hospital bills for 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.

CMS stated in the October 2009 OPSS update that 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,

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

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 expects that the majority of hospitals will not encounter this situation.

When a radiolabeled product is administered in one hospital and the nuclear medicine scan is subsequently performed at another hospital, hospitals should comply with the OPPTS policy that requires that radiolabeled products be reported and billed with nuclear medicine scans. In these specific cases, the hospital that bills for the nuclear medicine procedure would receive payment for both the nuclear medicine procedure and the radiolabeled product since a hospital cannot bill and be paid for a radiolabeled product solely submitted on a claim. In order for the hospital that administers the radiolabeled product to be paid, hospitals may enter into an arrangement (under Section 1861 (w)(1) of the Act and as discussed in 42 CFR 410.28(a) (1) and defined in 42 CFR 409.3) where the hospital that administers the nuclear medicine scan pays the appropriate amount for the radiolabeled product to the hospital that administers the radiolabeled product. CMS considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and expects both services to be performed together.

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Under the hospital OPPTS, these new HCPCS codes are assigned status indicator “Q3” to indicate that these services will be paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures in the same imaging family on a single date of service. The standard (non-composite) APC will be assigned when there are no other imaging procedures in the same imaging family present on the claim for the same date of service. The I/OCE logic will determine the assignment of the composite APCs for payment.

Table 5 – MRA codes

HCPCS code	Long descriptor	Composite APC	Standard (non-composite) APC
C8931	Magnetic resonance angiography with contrast, spinal canal and contents	8008	0284
C8932	Magnetic resonance angiography without contrast, spinal canal and contents	8007 or 8008	0336
C8933	Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents	8008	0337
C8934	Magnetic resonance angiography with contrast, upper extremity	8008	0284
C8935	Magnetic resonance angiography without contrast, upper extremity	8007 or 8008	0336
C8936	Magnetic resonance angiography without contrast followed by with contrast, upper extremity	8008	0337

Clarification on billing for observation services on condition code 44 claims

CR 7117 includes as an attachment, an update to the *Medicare Claims Processing Manual* (Chapter 1, Section 50.3) which clarifies billing for observation services on condition code 44 claims. The following is an extract from that attachment:

“When condition code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in condition code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician’s order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician’s order.”

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

“While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician’s order for observation services, in condition code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under condition code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see Chapter 4 Section 290 of this manual, and Chapter 6 Section 20.6 of the Medicare Benefit Policy Manual (IOM Pub. 100-02).”

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPSS 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 7117, issued to your FIs, A/B MACs, and/or RHHIs regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2061CP.pdf>.

If you have any questions, please contact your FIs, A/B MACs, and/or RHHIs 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: MM7117

Related Change Request (CR) Number: 7117

Related CR Release Date: October 1, 2010

Related CR Transmittal Number: R2061CP

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2061, CR 7117

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Calendar year 2010 outpatient prospective payment system PRICER file update

The outpatient prospective payment system (OPSS) PRICER Web page has been updated with new payment files for the 2010 update to the OPSS, as specified in change request (CR) 7117. The files are ready for download from the “4th Quarter 2010 Files” section of the OPSS PRICER Web page at <http://www.cms.gov/PCPricer/OutPPS/list.asp#TopOfPage>. If you use OPSS PRICER files, please go to this page and download the above files.

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

Source: CMS PERL 201010-01

ELECTRONIC DATA INTERCHANGE

Claim status category and claim status codes update

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

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHII], carriers, Part A/B Medicare administrative contractors [MAC] and durable medical equipment MACs or DME MACs) for Medicare beneficiaries are affected by this article.

Provider action needed

This article, based on change request (CR) 7158, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 along with the 277 health care claim acknowledgement updated during the October 2010 meeting of the National Code Maintenance Committee and code changes approved at that meeting are to be posted on the Internet at <http://www.wpc-edi.com/content/view/180/223/> on or about November 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on January 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only claim status codes and claim status category codes approved by the national Code Maintenance Committee

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in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (institutional or professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

The official instruction (CR 7158) issued to your Medicare contractor regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2049CP.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: MM7158

Related Change Request (CR) Number: 7158

Related CR Release Date: September 17, 2010

Related CR Transmittal Number: R2049CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2049, CR 7158

Take advantage of FCSO's exclusive PDS report

Did you know that FCSO's exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through FCSO's PDS's portal at <https://medicare.fcso.com/reporting/index.asp>, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business bottom line.

HIPAA VERSION 5010 IMPLEMENTATION

CMS helps in the transitions to HIPAA version 5010 and ICD-10

Have questions about HIPAA version 5010 and ICD-10 transition? The Centers for Medicare & Medicaid Services (CMS) is here to help.

CMS has resources for providers, vendors, and payers to prepare for the transition. Fact sheets available for educating staff and others about the transition include:

- The ICD-10 Transition: An Introduction <http://www.cms.gov/ICD10/Downloads/ICD10IntroFactSheet20100409.pdf>
- ICD-10 Basics for Medical Practices
<http://www.cms.gov/ICD10/Downloads/ICD10MedicalPracticesBasics20100409.pdf>
- Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices
<http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoVendorforMedicalPractices20100409.pdf>
- Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors
<http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoCustomersforVendors20100409.pdf>

Compliance timelines, materials from CMS-sponsored calls and conferences, and links to resources are available at <http://www.cms.gov/icd10/>. Check back often for the latest information and updates.

Keep up to date on version 5010 and ICD-10.

Please visit <http://www.cms.gov/icd10/> for the latest news and sign up for HIPAA version 5010 and ICD-10 e-mail updates.

HIPAA version 5010 and ICD-10 are coming. Will you be ready?

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Source: CMS PERL 201009-38

Medicare fee-for-service implementation of HIPAA 5010/D.0 – errata impacts

The purpose of this message is to clearly communicate the approach that Medicare fee-for-service (FFS) is taking to ensure compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) new versions of the Accredited Standards Committee (ASC) X12 and the National Council for Prescription Drug Programs (NCPDP) electronic data interchange (EDI) transactions.

The Standards Development Organizations have made corrections to the 5010 and D.0. versions of certain transactions. The errata versions replace the base versions for HIPAA compliance. Per the *Federal Register* (Vol. 75, No. 197, October 13, 2010, 62684–62686 [2010–25684] found at http://www.access.gpo.gov/su_docs/aces/fr-cont.html), HIPAA compliance will require the implementation of the errata versions and the base versions for those transactions not affected by the errata, as listed below. Compliance with the errata must be achieved by the original regulation compliance date of January 2012.

Transactions affected by the errata -- list of base and errata versions for 5010 and D.0.

Transactions affected by the errata version	Base version	Errata version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) Version D.0 of the Telecom Standard	D.0	D.0 April 2009

Medicare FFS will implement the errata versions to meet HIPAA compliance requirements. Also in compliance with the published regulation (RIN 0938-AM50 of 45 CFR Part 162), Medicare FFS testing with external trading partners must begin in January of 2011.

Medicare fee-for-service implementation of HIPAA 5010/D.0 – errata impacts (continued)**Testing**

Medicare FFS contractors will be ready to test the base versions of all transactions in January 2011, and the 5010/D.0 errata versions in April 2011. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. See <http://www.cms.gov/ElectronicBillingEDITrans/> under downloads, to find a Medicare FFS contractor in your state.

Production

The errata versions will be available for Medicare FFS production in April 2011. The errata transactions must be tested before using them for production. As a result, Medicare FFS HIPAA version 5010/D.0 test-to-production transition will begin in April 2011.

Medicare FFS timeline for HIPAA version 5010/D.0 implementation

1. Testing on base versions to begin in January 2011
2. Testing and transition to production on errata version to begin in April 2011
3. Implementation of HIPAA version 5010/D.0 on January 1, 2012

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Source: CMS PERL 201010-25

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Notification of X12 version 5010 and version D.0 errata published

On Wednesday, October 13, the Department of Health & Human Services (HHS) published in the *Federal Register* a notification announcing maintenance changes to the standards adopted in the regulation titled “Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards,” which was published in the *Federal Register* on January 16, 2009. These standards include the ASC X12 5010 (version 5010) HIPAA electronic health care transactions; and the National Council of Prescription Drug Programs (NCPDP) telecommunications version D.0 standard. This notice also instructs interested persons on how to obtain the corrections, and advises HIPAA-covered entities to be sure to use the HIPAA-compliant version of each respective standard that includes these error corrections.

For the complete *Federal Register* notice, please go to <http://edocket.access.gpo.gov/2010/pdf/2010-25684.pdf>.

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Source: CMS PERL 201010-26

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**Find out first: Subscribe to FCSO eNews**

One of the secrets to achieving success as a Medicare provider is access to the right information at the right time. Subscribe to First Coast Service Options eNews, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events November 2010-January 2011

Topic – SNF minimum data set-3.0 seminar

When: Tuesday, November 16, 2010, Shands Hospital, Jacksonville
 Time: 9:00 a.m. – noon ET **Delivery language:** English
 Type of Event: Face-to-face seminar **Focus:** Florida

Topic – SNF minimum data set-3.0 seminar

When: Thursday, November 18, 2010, Blue Cross and Blue Shield of Florida, Lake Mary
 Time: 9:00 a.m. – noon ET **Delivery language:** English
 Type of Event: Face-to-face seminar **Focus:** Florida

Topic – Open forum on medical documentation and physician signature

When: Tuesday, December 7, 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 – Hot topics – not yet open for registration

When: Tuesday, January 11, 2011
 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 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.fcsso.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

2010-2011 seasonal influenza resources for health care professionals

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

Provider types affected

All Medicare fee-for-service (FFS) physicians, nonphysician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

Provider action needed

- Keep this special edition *MLN Matters* article and refer to it throughout the 2010-2011 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the New Year.
- Don't forget to immunize yourself and your staff.

Introduction

Annual outbreaks of seasonal flu typically occur from the late fall through early spring. Typically, five to 20 percent of Americans catch the seasonal flu, with about 36,000 people dying from flu-related causes.¹ Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu vaccine. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Get the flu vaccine, not the flu.

Unlike last flu season patients needed to get both a seasonal vaccine and a separate vaccine for the H1N1 virus, this season, a single seasonal flu vaccine will protect your patients, your staff, and yourself.

The seasonal flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational products for health care professionals

CMS has developed a variety of educational resources to help Medicare FFS health care professionals understanding coverage, coding, billing, and reimbursement guidelines for seasonal flu vaccines and their administration.

MLN Matters seasonal influenza articles

- **MM7120:** Influenza Vaccine Payment Allowances – Annual Update for 2010-2011 Season at <http://www.cms.gov/MLNMattersArticles/downloads/MM7120.pdf>
- **SE1026:** Important News About Flu Shot Frequency for Medicare Beneficiaries at <http://www.cms.gov/MLNMattersArticles/downloads/SE1026.pdf>
- **MM7124:** 2010 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at <http://www.cms.gov/MLNMattersArticles/downloads/MM7124.pdf>
- **MM6608:** Influenza Vaccine Payment Allowances – Annual Update for 2009-2010 Season at <http://www.cms.gov/MLNMattersArticles/downloads/MM6608.pdf>
- **MM5511:** Update to *Medicare Claims Processing Manual*, Chapter 18, Section 10 for Part B Influenza Billing at <http://www.cms.gov/MLNMattersArticles/downloads/MM5511.pdf>
- **MM4240:** Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at <http://www.cms.gov/MLNMattersArticles/downloads/MM4240.pdf>
- **MM5037:** Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of *Current Procedural Terminology (CPT) Code 90660* for the Reporting of the Influenza Virus Vaccine at <http://www.cms.gov/MLNMattersArticles/downloads/MM5037.pdf>

MLN seasonal influenza related products for health care professionals

- **Quick Reference Information: Medicare Part B Immunization Billing** – this two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf.
- The Medicare Preventive Services Series Part 1 Web-based training course (WBT) – this WBT contains lessons Medicare-covered preventive vaccinations, including the seasonal

2010-2011 seasonal influenza resources for health care professionals (continued)

influenza vaccine. To take the course, visit the Medicare Preventive Services Educational Products page at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp. Scroll down to “Related Links Inside CMS” and choose “Web-Based Training (WBT) Modules.”

- *Medicare Preventive Services Adult Immunizations Brochure* – this two-sided tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available as a downloadable PDF file at http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf.
- *Medicare Preventive Services Adult Immunizations brochure* – this two-sided tri-fold brochure provides health care professionals with an overview of Medicare’s coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available as a downloadable PDF file at http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf.
- *Quick Reference Information: Medicare Preventive Services* – this two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare’s preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes seasonal influenza, pneumococcal, and hepatitis B vaccines. Available in print or as a downloadable PDF file at http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- *MLN Preventive Services Educational Products Web Page* – this *Medicare Learning Network (MLN)* Web page provides descriptions of all *MLN* preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page http://www.cms.gov/MLNProducts/35_PreventiveServices.asp for easy access.

Other CMS resources

- CMS Adult Immunizations Web page is at <http://www.cms.gov/AdultImmunizations>.
- CMS frequently asked questions are available at http://questions.cms.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi.
- *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.4.2: Immunizations available at <http://www.cms.gov/manuals/downloads/bp102c15.pdf>.
- *Medicare Claims Processing Manual*: Chapter 18, Preventive and Screening Services available at <http://www.cms.gov/manuals/downloads/clm104c18.pdf>.
- Medicare Part B drug average sales price payment amounts influenza and pneumococcal vaccines pricing found at http://www.cms.gov/McrPartBDrugAvgSalesPrice/01_overview.asp.

Other resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009-2010 flu season:

- **Advisory Committee on Immunization Practices** are at <http://www.cdc.gov/vaccines/recs/acip/default.htm>.
- **American Lung Association’s Influenza (Flu) Center** is at <http://www.lungusa.org>. This website provides a flu clinic locator at <http://www.flucliniclocator.org>. Individuals may enter their ZIP code to find a flu clinic in their area. Providers may also obtain information on how to add their flu clinic to this site.

Other sites with helpful information include:

- **Centers for Disease Control and Prevention** – <http://www.cdc.gov/flu>
- **Flu.gov** – <http://www.flu.gov>
- **Food and Drug Administration** – <http://www.fda.gov>
- **Immunization Action Coalition** – <http://www.immunize.org>
- **Indian Health Services** – <http://www.ihs.gov/>
- **National Alliance for Hispanic Health** – <http://www.hispanichealth.org>
- **National Foundation For Infectious Diseases** – <http://www.nfid.org/influenza>
- **National Library of Medicine and NIH Medline Plus** – <http://www.nlm.nih.gov/medlineplus/immunization.html>
- **National Network for Immunization Information** – <http://www.immunizationinfo.org>
- **National Vaccine Program** – <http://www.hhs.gov/nvpo>
- **Office of Disease Prevention and Promotion** – <http://odphp.osophs.dhhs.gov>
- **Partnership for Prevention** – <http://www.prevent.org>
- **World Health Organization** – <http://www.who.int/en>.

2010-2011 seasonal influenza resources for health care professionals (continued)

Beneficiary information

For information to share with your Medicare patients, please visit <http://www.medicare.gov>.

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Source: CMS Special Edition *MLN Matters*® Article SE1031

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¹ Flu.gov. 2010. About the Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2010 [cited 16 August 2010]. Available from the World Wide Web: <http://www.flu.gov/individualfamily/about/index.html>

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October flu shot reminder

Vaccination is the best protection against the flu. This year, the Centers for Disease Control and Prevention (CDC) is encouraging everyone six months of age and older to get vaccinated against the seasonal flu. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. And remember, vaccination is particularly important for health-care workers, who may spread the flu to high-risk patients. Don't forget to immunize yourself and your staff. Protect your patients.

Protect your family. Protect yourself. Get your flu vaccine – not the flu.

Remember: Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health-care professionals and their staff, please visit <http://www.cms.gov/AdultImmunizations/>.

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Source: CMS PERL 201010-20

October is National Breast Cancer Awareness Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered screening mammograms and other preventive services covered by Medicare. Medicare provides coverage for an annual screening mammogram for all female beneficiaries age 40 or older. Medicare also provides coverage for one baseline mammogram for female beneficiaries between the ages of 35 and 39.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered screenings, including screening mammograms that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered screening mammograms. They are all available, free of charge, from the *Medicare Learning Network*®:

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for *Medicare Learning Network*® (MLN) educational products for health care professionals related to Medicare-covered preventive services, including screening mammograms.
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings, including screening mammograms.
http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

October is National Breast Cancer Awareness Month (continued)

- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including screening mammograms. http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- The Medicare Preventive Services Series: Part 3 Web-Based-Training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including screening mammograms. To access the course, please visit the MLN home page at <http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “Web Based Training (WBT) Modules.”
- *The Cancer Screenings brochure* – this brochure provides information on coverage for Medicare-covered cancer screenings, including screening mammograms. http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf

Please visit the *Medicare Learning Network* at <http://www.cms.gov/MLNGenInfo> for more information on these and other Medicare fee-for-service educational products. For more information on National Breast Cancer Awareness Month, please visit the official website at <http://www.nbcam.org>.

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Source: CMS PERL 201010-03

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World Osteoporosis Day and National Mammography Day

October 20 was World Osteoporosis Day and October 22 was National Mammography Day. The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered bone mass measurements and screening mammograms.

Medicare provides coverage for bone mass measurements for qualified Medicare patients once every two years. Medicare also provides coverage for an annual screening mammogram for all female beneficiaries age 40 or older, and coverage for one baseline mammogram for female beneficiaries between the ages of 35 and 39.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered screenings, including bone mass measurement and screening mammography that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered bone mass measurements. They are all available, free of charge, from the *Medicare Learning Network*[®]:

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for MLN educational products for health care professionals related to Medicare-covered preventive services, including bone mass measurements and screening mammograms. Visit http://www.cms.gov/MLNProducts/35_PreventiveServices.asp.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings, including bone mass measurements and screening mammograms. Visit http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including bone mass measurements and screening mammograms. Visit http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- The Medicare Preventive Services Series: Part 3 Web-Based-Training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including bone mass measurements and screening mammograms. To access the course, please visit the MLN home page at <http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “Web Based Training (WBT) Modules.”
- *The Bone Mass Measurements brochure* – this brochure provides information on coverage for Medicare-covered bone mass measurements. Visit http://www.cms.gov/MLNProducts/downloads/bone_mass.pdf.
- *The Cancer Screenings brochure* – this brochure provides information on coverage for Medicare-covered cancer screenings, including screening mammograms. Visit http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf.

World Osteoporosis Day and National Mammography Day (continued)

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products. For more information on World Osteoporosis Day, please visit the International Osteoporosis Foundation website at <http://www.iofbonehealth.org/about-iof/iof-programs/outreach-education/world-osteoporosis-day.html>. For more information on National Mammography Day, please visit American Cancer Society at <http://www.cancer.org>.

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September 29 is National Women’s Health and Fitness Day

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services. Medicare provides coverage for several preventive services to help keep women with Medicare healthy, including bone mass measurements, screening Pap tests, screening pelvic exams, and screening mammograms.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered preventive services that are appropriate for them.

Additional information

CMS has developed several educational products related to Medicare-covered preventive services. They are all available, free of charge, from the *Medicare Learning Network*®:

- The MLN Preventive Services Educational Products Web page: The page provides descriptions and ordering information for *Medicare Learning Network*® (MLN) educational products for health care professionals related to Medicare-covered preventive services.
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*: This guide provides comprehensive coverage and coding information on Medicare-covered preventive services.
http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- *The Cancer Screenings brochure*: This brochure provides information on coverage for Medicare-covered cancer screenings, including screening mammograms.
http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf
- *The Bone Mass Measurements brochure*: This brochure provides information on coverage for Medicare-covered bone mass measurements.
http://www.cms.gov/MLNProducts/downloads/bone_mass.pdf
- The Medicare Preventive Services Series: Part 3 Web-Based Training Course (WBT): This WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, Pap tests, pelvic exams, and bone mass measurements. 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 “WBT Modules”.

Please visit the *Medicare Learning Network*® for more information on these and other Medicare fee-for-service educational products. For more information on National Women’s Health and Fitness Day, please visit <http://www.fitnessday.com>.

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September 26 is World Heart Day

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services. Medicare provides coverage for several preventive services to help keep patients with Medicare healthy, including cardiovascular screenings, ultrasound screening for abdominal aortic aneurysms (AAA), and smoking and tobacco-use cessation counseling for eligible beneficiaries.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered preventive services that are appropriate for them.

Additional information

CMS has developed several educational products related to Medicare-covered preventive services. They are all available, free of charge, from the *Medicare Learning Network*[®]:

- The MLN Preventive Services Educational Products Web Page: The page provides descriptions and ordering information for *Medicare Learning Network*[®] (MLN) educational products for health care professionals related to Medicare-covered preventive services.
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*: This guide provides comprehensive coverage and coding information on Medicare-covered preventive services.
http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf
- *Quick Reference Information: Medicare Preventive Services*: This chart provides coverage and coding information on Medicare-covered preventive services.
http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
- *The Expanded Benefits brochure*: This brochure provides information on coverage for cardiovascular screening blood tests and AAA screening.
http://www.cms.gov/MLNProducts/downloads/Expanded_Benefits.pdf
- *The Smoking and Tobacco-Use Cessation brochure*: This brochure provides information on coverage for smoking and tobacco-use cessation services.
<http://www.cms.gov/MLNProducts/downloads/smoking.pdf>
- The Medicare Preventive Services Series: Part 2 Web-Based Training Course (WBT): This WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including cardiovascular screening blood tests, AAA screening, and smoking and tobacco-use cessation counseling. 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 “WBT Modules”

Please visit the *Medicare Learning Network*[®] for more information on these and other Medicare fee-for-service educational products. For more information on World Heart Day, please visit <http://www.worldheart.org>.

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Discover your passport to Medicare training

- Register for live events
- Explore online courses
- Find CEU information
- Download recorded events

Learn more on FCSO’s Medicare training website.

OTHER EDUCATIONAL RESOURCES

New PECOS enrollment fact sheets from the Medicare Learning Network

If you are a Medicare fee-for-service (FFS) provider or supplier who is currently enrolled or required to enroll in the Medicare program, the *Medicare Learning Network*® (MLN) can help you understand and follow the Medicare enrollment process. The MLN has released the next in a series of fact sheets designed to educate FFS providers about important Medicare enrollment information, including how to use Internet-based provider enrollment, chain and ownership system (PECOS) to enroll in the Medicare program and maintain your enrollment information. These fact sheets are available in downloadable format on the Centers for Medicare & Medicaid Services (CMS) website at the URLs listed below.

- *The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement*
Provides general Medicare enrollment information to those physicians who are required to enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries and therefore, are not required to send claims to Medicare contractors for the services they furnish. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_Phys_Infreq_Reimb_FactSheet_ICN006881.pdf
- *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners*
Advises physicians and nonphysician practitioners on how to enroll in the Medicare program and maintain their enrollment information using Internet-based PECOS. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.
- *Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information*
Provides contact information for technical assistance with Internet-based PECOS. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf.
- *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations*
Advises provider and supplier organizations on how to enroll in the Medicare program and maintain their enrollment information using Internet-based PECOS. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf.
- *The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers*
Explains general Medicare enrollment information specific to physicians and other Part B suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PhysOther_FactSheet_ICN903768.pdf.
- *The Basics of Medicare Enrollment for Institutional Providers*
Provides general Medicare enrollment information specific to institutional providers, such as community mental health centers (CMHCs), home health agencies (HHAs), hospitals, skilled nursing facilities (SNFs), and hospices. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_InstProv_FactSheet_ICN903783.pdf.
- *The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers*
Educates DMEPOS suppliers on how to enroll in the Medicare program and maintain their enrollment information using Internet-based PECOS. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf.

In addition, the *Medicare Learning Network* previously released two fact sheets concerning privacy and protection of Medicare enrollment records that may also be of interest:

- *Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record*
Advises FFS physicians and nonphysician practitioners on how to ensure their enrollment records are up-to-date and secure. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnrollPrivcy_FactSheet_ICN903765.pdf.
- *How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)*
Provides step-by-step instructions to help FFS providers protect their identity while using Internet-based PECOS. This fact sheet is available on the CMS website at http://www.cms.gov/MLNProducts/downloads/MedEnroll_ProID_FactSheet_ICN905103.pdf.

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Source: CMS PERL 201010-03

Medicare quarterly provider compliance newsletter – first edition released

Just a reminder that the *Medicare Learning Network*® (MLN) has developed a new educational tool, the *Medicare Quarterly Provider Compliance Newsletter*, to advise physicians, suppliers, and other fee-for-service (FFS) providers about how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. The newsletter will be issued on a quarterly basis and highlight the “top” issues of that particular quarter.

In this first edition, a number of issues that impact a variety of provider types are presented in order to introduce the newsletter to a wide audience of providers. For more information, please read the first edition of the newsletter on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf.

Please watch for the second edition, which will be released in January 2011.

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Source: CMS PERL 201010-30

Fact sheet for Medicare secondary payer

The *Medicare Secondary Payer Fact Sheet, for Provider, Physician, and Other Supplier Billing Staff* (revised May, 2010), is now available in hardcopy from the *Medicare Learning Network*®. This resource provides a general overview of the Medicare secondary payer (MSP) provisions for individuals involved with admission or billing procedures in provider, physician, and other supplier settings.

To order your copy, free of charge, please visit the MLN Products page at http://www.cms.gov/MLNProducts/01_Overview.asp.

From this page, scroll down to the “Related Links Inside CMS” section and select the “MLN Product Ordering Page” link. To view the online version, please visit http://www.cms.gov/MLNProducts/downloads/MSP_Fact_Sheet.pdf.

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Source: CMS PERL 201009-39

New product titled ‘Medicare Outpatient Therapy Billing’

A new publication titled *Medicare Outpatient Therapy Billing* (August 2010) is now available in downloadable format from the *Medicare Learning Network*® at http://www.cms.gov/MLNProducts/downloads/Medicare_Outpatient_Therapy_Billing_ICN903663.pdf.

This publication provides information about Medicare outpatient physical therapy, occupational therapy, and speech-language pathology (therapy services) coverage requirements; calendar year 2010 therapy codes and dispositions; and billing measures for therapy services.

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Source: CMS PERL 201010-30

Substance (other than tobacco) abuse and brief intervention service fact sheet

The *Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services fact sheet*, which provides helpful information for providers that provide SBIRT services to their Medicare patients, is available for download on the *Medicare Learning Network*® at http://www.cms.gov/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf. Hard copies will be available at a later date.

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Source: CMS PERL 201010-20

Updates from the Medicare Learning Network

The *Medicare Learning Network*[®] has the following Medicare fee-for-service educational products among many other products and tools to assist providers in learning about the Medicare program.

Respiratory Care Week and Lung Health Day

Sunday, October 24 through Saturday, October 30 is Respiratory Care Week and Wednesday, October 27 is Lung Health Day. The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered smoking and tobacco-use cessation counseling services. Medicare provides coverage of two smoking cessation attempts per year for qualified patients. Each attempt may include a maximum of four counseling sessions.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your patients by encouraging them to take advantage of Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services that are appropriate for them.

For more information, CMS has developed several educational products related to Medicare-covered smoking and tobacco-use cessation counseling services. They are all available, free of charge, from the *Medicare Learning Network*[®]:

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for *Medicare Learning Network*[®] (MLN) educational products for health care professionals related to Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services. Visit http://www.cms.gov/MLNProducts/35_PreventiveServices.asp.
- The *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings, including smoking and tobacco-use cessation counseling services. Visit http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf.
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services. Visit http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- The Medicare Preventive Services Series: Part 2 Web-Based-Training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including smoking and tobacco-use cessation counseling services. To access the course, please visit the MLN home page at <http://www.cms.gov/mlngeninfo/>. Scroll down to “Related Links Inside CMS” and click on “Web Based Training (WBT) Modules.”
- The Smoking and Tobacco-Use Cessation Counseling Services brochure – this brochure provides information on coverage for Medicare-covered smoking and tobacco-use cessation counseling services. Visit <http://www.cms.gov/MLNProducts/downloads/smoking.pdf>.

Hospice payment system fact sheet

The revised *Medicare Learning Network*[®] publication titled “Hospice Payment System” (September 2010) is now available in downloadable format at http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf.

This publication provides information about the coverage of hospice services, certification requirements, the election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and the hospice option for Medicare Advantage enrollees.

Please visit the Medicare Learning Network for more information on these and other Medicare fee-for-service educational products.

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

Source: CMS PERL 201010-38

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.

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 2010 through September 2011.	40-500-150	Hardcopy \$33		
		CD-ROM \$55		
Language preference for subscription: English [<input type="checkbox"/>] Español [<input type="checkbox"/>]				
<i>Please write legibly</i>			Subtotal	\$
			Tax (<i>add % for your area</i>)	\$
			Total	\$

Mail this form with payment to:
First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

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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

Other important addresses

REGIONAL HOME HEALTH &

HOSPICE INTERMEDIARY

Home health agency claims
Hospice claims

Palmetto Government Benefi t
 Administrators
 Medicare Part A
 P.O. Box 100238
 Columbia, SC 29202-3238

RAILROAD MEDICARE

Railroad retiree medical claims
 Palmetto Government Benefi t
 Administrators
 P. O. Box 10066
 Augusta, GA 30999-0001

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

DURABLE MEDICAL EQUIPMENT

REGIONAL CARRIER (DMERC)
Durable medical equipment claims
Orthotic and prosthetic device claims
Take home supplies
Oral anti-cancer drugs
 CIGNA Government 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](http://www.medicare.fcso.com)

Centers for Medicare & Medicaid
 Services
www.cms.gov

BENEFICIARIES

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P. O. Box 45071
Jacksonville, FL 32232-5071

REDETERMINATION and REDETERMINATION OVERPAYMENTS

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

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Palmetto Government Benefit Administrators
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P.O. Box 100238
Columbia, SC 29202-3238

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Palmetto Government Benefit Administrators
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Augusta, GA 30999-0001

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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

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532 Riverside Av.
Jacksonville, FL 32202-4914

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U.S. V I Medicare contractor

[medicare.fcso.com](http://www.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 ♦

