MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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

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THE FCSO MEDICARE A BULLETIN

About the *Medicare A Bulletin*

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

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

Who receives the *Bulletin*?

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

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

For additional copies, providers may purchase a separate annual subscription. A subscription order form may be found at the end of the *Educational Resources* section in each issue.

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. **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

The 2011 Medicare Contractor Provider Satisfaction Survey

In case you've forgotten or haven't heard, the Centers for Medicare & Medicaid Services (CMS) launched its annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This is a friendly reminder to encourage selected providers to take the survey. The survey offers Medicare fee-for-service (FFS) providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. As a result of past survey responses, Medicare FFS contractors have implemented changes to improve their communication processes and education and training of their staff.

The survey was sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who were selected to participate in the 2011 MCPSS were notified in December 2010. CMS understands that providers and suppliers may not to be able to respond directly to the survey but may have a staff member who can act as a proxy to respond on their behalf. The respondent can be anyone within the provider's organization who is knowledgeable of the Medicare claims process and is designated to respond to the MCPSS including but not limited to the business office manager, revenue cycle director or Medicare biller.

If you have received a survey letter, then you have been selected to participate. Please take the time to complete this important survey. CMS encourages providers and suppliers to complete the survey on the Internet via a secure website. Other modes of participation are available by mail, fax, or telephone. It will take no more than 20 minutes.

CMS is listening and wants to hear from you. To learn more about the MCPSS, please visit the CMS website at *www.cms.hhs.gov/MCPSS*. If you have any questions or concerns, please call our toll-free MCPSS provider helpline number at 800-654-1431 or send an email to *MCPSS_survey@scimetrika.com*.

If you've already completed and submitted your survey, we thank you for your feedback.

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

Source: CMS PERL 201103-02

Revised April 2011 average sales price files are now available

The Centers for Medicare & Medicaid Services (CMS) has posted revised average sales price (ASP) files for April 2011 and restated files for prior quarters. All are available for download at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

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

Source: CMS PERL 201103-46

Primary Care Incentive Payment eligibility data updated on contractor websites

Practitioners wishing to confirm Primary Care Incentive Payment (PCIP) eligibility for incentive payment year 2011 may now refer to the updated "Primary Care Incentive Payment eligibility" data files from CMS, available on contactor websites. For additional practitioner eligibility inquires, practitioners should call their Medicare claims processing contractor contact centers.

Source: CMS PERL 201103-19

Calendar year 2011 outpatient prospective payment system pricer file update

The Outpatient Prospective Payment System (OPPS) Pricer Web page was recently updated to include the January 2011 update for outpatient provider data. Users may now access the January provider data update at *http://www.cms.gov/PCPricer/OutPPS/list.asp* by selecting "2011", and then downloading "1st Quarter 2011 Files" from the OPPS Pricer Web 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 201103-07

April 2011 integrated outpatient code editor specifications version 12.1

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7344, which describes changes to the I/OCE and OPPS to be implemented in the April 2011, OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR 7344 describes changes to billing instructions for various payment policies implemented in the April 2011 OPPS update. The April 2011 Integrated Outpatient Code Editor (I/OCE) changes are also discussed in CR 7344.

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

A summary of the changes for April 2011 is within Appendix M of Attachment A of CR 7344 and that summary is captured in the following key points, effective April 1, 2011:

- Make Healthcare Common Procedures Coding System (HCPCS)/Ambulatory Payment Classification (APC)/Status Indicator (SI) changes (a summary of these data changes are attached to CR7344);
- Remove *Current Procedural Terminology (CPT)* code 88177 from the female-only procedures list. Edit 8 is affected;
- Add new modifier "33" to the valid modifier list. Edit 22 is affected;
- Implement version 17.0 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers). Edits 19, 20, 39, and 40 are affected; and
- Create 508-compliant versions of the specifications and summary of data changes documents for publication on the CMS website.

Additional information

The official instruction, CR 7344 issued to your Medicare MAC, RHHI or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2172CP.pdf* on the CMS website.

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

MLN Matters® Number: MM7344
Related Change Request (CR) #: 7344
Related CR Release Date: March 11, 2011
Effective Date: April 1, 2011
Related CR Transmittal #: R2172CP
Implementation Date: April 4, 2011

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.

New frequently asked questions about ICD-10 implementation

The Centers for Medicare & Medicaid Services (CMS) has posted two new frequently asked questions (FAQs) about ICD-10 national provider teleconferences and the partial code freeze.

To access these FAQs, please visit the CMS ICD-10 Web page at *http://www.cms.gov/ICD10*, select the Medicare Fee-for-Service Provider Resources link on the left side of the page, scroll down the page to the "Related Links Inside CMS" section, and select "ICD-10 FAQs."

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

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

Source: CMS PERL 201103-10

ICD-10 MS-DRG conversion project website – new information now available

The ICD-10 Medicare Code Editor v27 and a text version of the ICD-10-CM/PCS Medicare Severity-Diagnosis Related Group (MS-DRG) v28 Definitions Manual are now posted on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp* in the "Downloads" section. There are also links to order the MS Grouper with Medicare Code Editor ICD-10 Pilot Software Version 28 on CD-ROM from National Technical Information Service (NTIS) in the "Related Links Outside CMS" section of the Web page.

This update is part of the ICD-10 MS-DRG conversion project. In the conversion project, CMS is using the general equivalence mappings (GEMs) to convert CMS payment systems. CMS is sharing information learned from this project with other organizations facing similar conversion projects. Please note that the final ICD-10 MS-DRGs will be subject to formal rulemaking.

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

Source: CMS PERL 201103-33

No date set for expanded ordering/referring provider claim edit

It has come to the Centers for Medicare & Medicaid Services' (CMS) attention that there was an editorial oversight in the Office of Inspector General (OIG) Compendium of Unimplemented Recommendations (March 2011 Edition). The OIG report states that CMS will delay the implementation of Phase 2 of change request (CR) 6417 and CR 6421 until Tuesday, July 5, 2011. This is incorrect.

CMS has not yet determined when it will begin to apply the ordering/referring provider claim edit to ordering/referring providers that do not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). As previously stated, CMS will give providers ample notice before the ordering/referring provider claim edit is applied. Recent revisions to CRs 6417 and 6421 require Medicare administrative contractors (MAC) to delay rejecting claims until receiving further direction from CMS.

Source: CMS PERL 201103-43

Reminder – important information on the timely claims filing requirement

The Centers for Medicare & Medicaid Services (CMS) would like to remind Medicare fee-for-service physicians, providers, and suppliers submitting claims to Medicare for payment, as a result of the Patient Protection and Affordable Care Act (PPACA), effective immediately, all claims for services furnished on or after January 1, 2010, must be filed with your Medicare contractor no later than one calendar year (12 months) from the date of service – or Medicare will deny them.

In general, the start date for determining the one-year timely filing period is the date of service or "From" date on the claim. For institutional claims that include span dates of service (i.e., a "From" and "Through" date on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness. For claims submitted by physicians and other suppliers that include span dates of service, the line item "From" date is used for determining the date of service for claims filing timeliness.

For additional information about the new maximum period for claims submission filing dates, contact your Medicare contractor, or review the *MLN Matters* articles listed below related to this subject:

- MM6960 – "Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months" *http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf*.
- MM7080 – "Timely Claims Filing: Additional Instructions" *http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf*.
- MM7270 – "Changes to the Time Limits for Filing Medicare Fee-for-Service Claims" *http://www.cms.gov/MLNMattersArticles/downloads/MM7270.pdf*.

You can also listen to a podcast on this subject by visiting *http://www.cms.gov/CMSFeeds/02_listofpodcasts.asp* on the CMS website.

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

Source: CMS PERL 201103-38

Implementation of application fees for Medicare provider/supplier enrollment

Effective Friday, March 25, 2011, Medicare administrative contractors (MACs) will begin collecting application fees with certain provider/supplier enrollment applications (both paper and online applications) as described below. The application fee is currently $505 for calendar year 2011; however, this fee will vary from year-to-year based on adjustments made pursuant to the Consumer Price Index for Urban Areas (CPI-U).

Note that these **application fees do not apply to physicians, non-physician practitioners, physician organizations, and non-physician organizations.** All institutional providers of medical or other items or services or suppliers must pay the application fee. (''Institutional provider'' includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, not including physician and non-physician practitioner organizations; CMS-855S; or the associated Internet-based PECOS enrollment applications.)

All application fees must be submitted via paper check, until the Centers for Medicare & Medicaid Services (CMS) specifies a mechanism for submitting electronic funds at a future date. Note also that MACs will accept hardship exception requests from institutional providers; however, determinations on whether to grant these requests will be made on a case-by-case basis. CMS and its contractors will not be able to process any applications without the proper application fee having been paid and credited to the United States Treasury or an approved hardship exception. If the fee is not submitted, the application will be rejected or billing privileges revoked (as applicable) unless a hardship exception request is subsequently granted. If CMS has denied a hardship exception request, then an institutional provider has 30 days to submit the application fee to the CMS contractor.

For more information, please refer to the regulation published to the *Federal Register* at *http://www.GPO.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf*. And for additional clarification, look out for an official *MLN Matters Article* that will be released on the subject in the near future.

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

Source: CMS PERL 201103-08

Implementation of provider screening and risk-based categories for provider/supplier enrollment

It is the continuing goal of the Centers for Medicare & Medicaid Services (CMS) to reduce fraud, waste, and abuse through all available avenues. The Affordable Care Act requires CMS to determine the level of screening to be conducted during provider and supplier enrollment based on the level of risk posed to the Medicare system. With the enactment of the Affordable Care Act, CMS has the increased ability to focus its efforts on prevention, rather than simply acting after the fact. The use of risk categories and associated screening levels will help ensure that only legitimate providers and suppliers are enrolled in Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and that only legitimate claims are paid.

Effective Friday, March 25, 2011, newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories – limited, moderate, or high. These categories represent the level of risk for fraud, waste, and abuse to the Medicare program for the particular category of provider/supplier and determine the degree of screening to be performed by the Medicare administrative contractor (MAC) processing the enrollment application.

Providers/suppliers in the "limited" screening category will include:

- Physicians
- Non-physician practitioners other than physical therapists
- Medical groups or clinics
- Ambulatory surgical centers
- Competitive acquisition program/Part B vendors
- End-stage renal disease facilities
- Federally-qualified health centers
- Histocompatibility laboratories
- Hospitals (including critical access hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities)
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Pharmacies that are newly enrolling or revalidating via the CMS-855B application
- Radiation therapy centers
- Religious non-medical health care institutions
- Rural health clinics
- Skilled nursing facilities

Providers in the "moderate" screening category will include:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities (IDTFs)
- Physical therapists enrolling as individuals or as group practices
- Portable X-ray suppliers (PXRS)
- Revalidating home health agencies (HHAs)
- Revalidating durable medical equipment, prosthetics, and orthotics (DMEPOS) suppliers

Providers in the "high" screening category will include:

- Newly-enrolling DMEPOS suppliers
- Newly-enrolling HHAs
- Providers and suppliers reassigned from the "limited" or "moderate" categories due to triggering events. Triggering events include the following instances:
  - Imposition of a payment suspension within the previous 10 years;
  - A provider or supplier has been terminated or is otherwise precluded from billing Medicaid;
  - Exclusion by the Office of the Inspector General (OIG);
  - A provider or supplier has had billing privileges revoked by a Medicare contractor within the previous 10 years and such provider/supplier is attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establish billing privileges for a new practice location;

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Provider Screening...*continued*

- A provider or supplier has been excluded from any federal health care program;
- A provider or supplier has been subject to any final adverse action (as defined in 42 CFR 424.502) within the past 10 years; or
- Instances in which CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within six months from the date the moratorium was lifted.

The enrollment screening procedures will vary depending upon the categories described above. Screening procedures for the "limited" screening category will largely be the same as those currently in use; screening procedures for the "moderate" screening category will include all current screening measures, as well as a site visit; screening procedures for the "high" screening category will include all current screening measures, as well as a site visit and, at a future date a fingerprint-based criminal background check.

CMS will continuously evaluate whether we need to change the assignment of categories of providers and suppliers to the various risk categories. If CMS assigns certain groups of providers and/or suppliers to a different category, this change will be proposed in the *Federal Register*. However, CMS will not publish a notice or a proposed rule in the *Federal Register* that would include instances in which an individual provider/supplier is reassigned based upon meeting one or more of the triggering events.

For more information, please refer to the regulation published to the *Federal Register* at *http://www.GPO.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf*. And for additional clarification, look out for an official *MLN Matters Article* that will be released on the subject in the near future.

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

Source: CMS PERL 201103-09

Internet-based PECOS even more user-friendly

Health care providers who use or plan to use the Provider Enrollment, Chain, and Ownership System (PECOS) to file and track their Medicare enrollment record and specialty status have even more reason to enjoy the convenience of Internet-based PECOS. The Internet-based system received a series of enhancements during the month of January, including:

- An improved submission process, including simpler directions for signing up and a clearer process for follow-up
- A tracking bar for the application process, indicating progress through the system, and
- A new application status module on the website for checking whether enrollment applications have been:
  - Received by the MAC (Medicare administrative contractor);
  - Reviewed by the MAC;
  - Returned for additional information; or
  - Approved or rejected.

Additionally, providers now have 15 days to submit signed paperwork required to complete the enrollment process.

To access Internet-based PECOS, visit *https://pecos.CMS.hhs.gov/pecos/login.do*. To learn more about Medicare enrollment for providers and suppliers, visit *http://www.CMS.gov/MedicareProviderSupEnroll*. Additional informative fact sheets from the *Medicare Learning Network* about Internet-based PECOS are available for physicians and non-physician practitioners, provider and supplier organizations, and durable medical equipment, prosthetics, and orthotics (DMEPOS) suppliers.

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

Source: CMS PERL 201103-21

Implementation of provider enrollment provisions in CMS-6028-FC

Provider types affected

All providers and suppliers submitting enrollment applications to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC) are affected by this article.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*.

Caution – what you need to know

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

Go – what you need to do

This article is based on change request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.) Please ensure that your staffs are aware of these new provisions.

Background

CR 7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the *Medicare Program Integrity Manual*. Those manual sections are attached to CR 7350 and are summarized as follows:

Screening Processes

Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the *Program Integrity Manual* (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR 7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is $505.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

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Enrollment provisions...*continued*

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;
- An application that was rejected prior to the Medicare Contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR § 424.570.

The provider or supplier must pay the application fee electronically through Pay.gov (*https://www.pay.gov/paygov/*), either via credit card, debit card, or check. CMS will send to the contractor on a regular basis a listing of providers and suppliers (the "Fee Submitter List") that have paid an application fee via Pay.gov. However, providers and suppliers are strongly encouraged to submit with their application a copy of their Pay.gov receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship exception
A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider's application. CMS will communicate its decision to the institutional provider and the contractor via letter.

Important: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

Review of hardship exception request
As already stated, the application fee for CY 2011 is $505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship. The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a) Considerable bad debt expenses,

b) Significant amount of charity care/financial assistance furnished to patients,

c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request

Appeal of the denial of hardship exception decision
If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the

continued on next page

Enrollment provisions...*continued*

procedures outlined in Chapter 15, Section 19 of the *Program Integrity Manual*, which is attached to CR7350.

Temporary moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the *Federal Register*. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/ denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening. Additional Information The official instruction, CR 7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/transmittals/downloads/R371PI.pdf* on the CMS website. Attached to CR 7350, you will find the complete details, regarding this issue as defined in the PIM revisions. If you have any questions, please contact your FI, RHHI, carrier, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

MLN Matters® Number: MM7350
Related Change Request (CR) #: 7350
Related CR Release Date: March 23, 2011
Effective Date: March 25, 2011
Related CR Transmittal #: R371PI
Implementation Date: March 25, 2011

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 specif c statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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.

How institutional providers will pay the Medicare enrollment application fee beginning Friday, March 25

Section 6401(a) of the Affordable Care Act (ACA) requires the Secretary [of Health and Human Services] to impose a fee on each "institutional provider of medical or other items or services and suppliers." The fee is to be used by the Secretary to cover the cost of program integrity efforts including the cost of screening associated with provider enrollment processes, including those under section 1866(j) and section 1128J of the Social Security Act. The application fee is $505 for calendar year (CY) 2011; based upon provisions of the ACA this fee will vary from year-to-year based on adjustments made pursuant to the Consumer Price Index – All Urban Consumers (CPI-U). The application fee is to be imposed on institutional providers that are newly-enrolling, re-enrolling/re-validating, or adding a new practice location, for applications received on and after Friday, March 25, 2011. The Centers for Medicare & Medicaid Services (CMS) has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

Institutional providers applying to participate in the Medicare program must first submit a completed CMS-855 application. An enrollment application can be submitted in one of two ways:

1. Electronically, using Internet-based PECOS – once you have completed and submitted your enrollment application using Internet-based PECOS, you should then promptly pay the application fee through *www.Pay.gov*. Once you are on Pay.gov, type "CMS" in the search box under "Find Public Forms" and click the "GO" button. Click on the "CMS Medicare Application Fee" link. Complete the form and submit payment as directed. You will get a confirmation screen indicating that payment was successfully made. This confirmation screen is your receipt and should be printed for your records. We strongly recommend that this receipt be mailed to the Medicare contractor along with the certification statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid. The Medicare contractor will process the provider enrollment application in the order in which it was received. Normal processing timeframes apply to your provider enrollment application.
2. Complete the paper Medicare enrollment application (CMS-855) – once you have completed filling out the CMS-855 paper application, you should promptly pay the application fee through *www.Pay.gov*. Once you are on Pay.gov, type "CMS" in the search box under "Find Public Forms" and click the "GO" button. Click on the "CMS Medicare Application Fee" link. Complete the form and submit payment as directed. You will get a confirmation screen indicating your payment was successful. This confirmation screen is your receipt and should be printed for your records. We strongly recommend that this receipt be mailed to the Medicare contractor along with the completed CMS-855 application. CMS also notifies the Medicare contractor that your application fee has been paid. The Medicare Contractor will process your provider enrollment application in the order in which it was received. Normal processing timeframes apply to your provider enrollment application.

Pay.gov (https://www.pay.gov/paygov/) is operated by the U.S. Department of the Treasury and is a Web-based application that allows you to make online payments to government agencies by electronic check, credit card, or debit from your checking or savings account. Pay.gov accepts Visa, MasterCard, American Express, and Discover. Do not mail application fee payments. Pay.gov cannot accept payments by mail or phone. Please note that all fees must be paid via Pay.gov and that paper checks will not be accepted. Users need not worry about submitting the incorrect amount; CMS has pre-populated the field for the correct payment amount for the specific calendar year. Users may not make multiple payments in one transaction and must make separate payments for each application.

CMS has reviewed the security of Pay.gov and is confident in the measures used to protect its users. Pay.gov uses 128-bit SSL encryption to protect your transaction information while you're logged in to Pay.gov. In addition, any account numbers you set up in your profile are encrypted before being stored in our database. When you access your profile, any account numbers you have entered will be masked on-screen; each account number in your profile will be displayed as a group of asterisks followed by the last four digits of the account number.

Your Medicare application is processed by the Medicare contractor via the Provider Enrollment, Chain, and Ownership System (PECOS). The

continued on next page

Application fee...*continued*

application fee, paid electronically by check, debit card, or credit card, is processed through Pay.gov. Therefore, if you have problems submitting your application fee, you should use the Help Tools available on the Pay.gov site for questions specific to the payment processing. Other questions regarding payment policies and procedures may be sent to the Medicare provider and supplier enrollment e-mail account at *Dpse_admin@cms.hhs.gov*.

For more information, please refer to the regulation published to the *Federal Register* at *http://www.GPO.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf*. And for additional clarification, look out for an official *MLN Matters* article that will be released on the subject in the near future.

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

Source: CMS PERL 201103-48

March is National Nutrition Month

More than 16.8-million Americans, 65 years or older, are diagnosed with diabetes or renal disease. Medical nutrition therapy (MNT) that is provided by a registered dietitian or nutrition professional may result in improved diabetes and renal disease management, along with other health outcomes that may help delay these diseases. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that March is National Nutrition Month®, focusing on the importance of making informed food choices, developing sound eating and physical activity habits in order to promote a healthy lifestyle and improve good health.

Medicare coverage – Medicare provides MNT-coverage for beneficiaries diagnosed with diabetes and/or renal disease (except for those receiving dialysis) and post-renal transplant when referred by the treating physician and provided by a registered dietitian or nutrition professional. (The treating physician must indicate a diagnosis of diabetes or renal disease in order to receive this benefit.) Medicare provides coverage for three hours of MNT in the first year, two hours in subsequent years, and additional hours in certain situations.

Note that for the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate 13-50 ml/min/1.73m2).

What can you do? – CMS needs your help to ensure that all eligible people with Medicare take full advantage of the MNT benefit. MNT provided by a registered dietitian or nutrition professional can be an integral component of diabetes and renal disease management, which may result in improved health outcomes and delay in disease progression. Talk with your eligible Medicare patients about the benefits of managing diabetes and renal disease through MNT. As the treating physician, provide a written referral and encourage them to make an appointment with a registered dietitian or nutrition professional.

For more information:

- *Diabetes-Related Services* brochure – this resource provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, MNT, and supplies and other diabetes-related services. Read at *http://www.CMS.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.
- The CMS MNT website – provides health care professionals with information about Medicare coverage of MNT provided by a registered dietitian or nutrition professional. Read at *http://www.CMS.gov/MedicalNutritionTherapy*.
- The *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – this comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including MNT and other services for Medicare beneficiaries with diabetes. Read at *http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- National Nutrition Month® – visit the American Dietetic Association's website at *http://www.EatRight.org/NNM* to learn more about National Nutrition Month 2011.

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

Source: CMS PERL 201103-14

March is National Colorectal Cancer Awareness Month

Of cancers that affect both men and women, colorectal cancer is the second leading cancer killer in the United States, affecting men and women of all racial and ethnic groups. Colorectal cancer is most often found in people aged 50 years or older, and its risk of developing increases with age. Screening tests can find precancerous polyps, so that they can be removed before they turn into cancer; screening tests also can find colorectal cancer early, when treatment works best. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of certain colorectal cancer screenings for the early detection of colorectal cancer.

Medicare coverage – Medicare defines those at a high risk of developing colorectal cancer as someone who has one or more of the following risk factors: close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp, family history of familial adenomatous polyposis, family history of hereditary nonpolyposis colorectal cancer, personal history of adenomatous polyps, personal history of colorectal cancer, or personal history of inflammatory bowel disease (including Crohn's Disease and ulcerative colitis).

All Medicare beneficiaries age 50 and older who are not at high risk for colorectal cancer are covered for the following screening services:

- Fecal occult blood test (FOBT) every year;
- Flexible sigmoidoscopy once every 4 years (unless a screening colonoscopy has been performed, in which case Medicare may cover a screening sigmoidoscopy after at least 119 months);
- Screening colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed, in which case Medicare may cover a screening colonoscopy only after at least 47 months); and
- Barium enema (as an alternative to a covered screening flexible sigmoidoscopy).

All Medicare beneficiaries age 50 and older who are at high risk for colorectal cancer are covered for the following screening services:

- FOBT every year;
- Flexible sigmoidoscopy once every 4 years;
- Screening colonoscopy every 2 years (unless a screening flexible sigmoidoscopy has performed, in which case Medicare may cover a screening colonoscopy only after at least 47 months); and
- Barium enema (as an alternative to a covered screening colonoscopy).

What can you do? – CMS needs your help to promote early detection and prevention of colorectal cancer. As a provider of health care services to seniors and other people with Medicare, providers can help increase awareness and educate patients about risk factors, what they can do to reduce their risk, and prevention and early detection through colorectal cancer screening, as appropriate. Your recommendation can help save lives! Colorectal cancer is preventable, treatable, and beatable.

For more information – educate yourself with the following resources:

- Cancer screenings brochure – this tri-fold brochure provides health care professionals with an overview of Medicare-covered cancer screenings, including colorectal cancer screening. Download at *http://www.CMS.gov/MLNProducts/downloads/Cancer_Screening.pdf*.
- *Quick Reference Information:Medicare Preventive Services* – this double-sided chart contains coverage, coding, and payment information for the many Medicare-covered preventive services, including colorectal cancer screening. View at *http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- The *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health care Professionals* --this comprehensive resource contains coverage, coding, and payment information for the many Medicare-covered preventive services, including colorectal cancer screening. Visit *http://ww.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- The National Colorectal Cancer Roundtable website is available at *http://www.NCCRT.org*.
- Visit the Prevent Cancer Foundation website for National Colorectal Cancer Awareness Month at *http://www.PreventCancer.org/colorectal*.

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

Source: CMS PERL 201103-01

National Native HIV/AIDS Awareness and American Diabetes Alert Days

Sunday, March 20 is National Native HIV/AIDS Awareness Day

Sunday, March 20, marks the fifth annual National Native HIV/AIDS Awareness Day. The HIV/AIDS epidemic is a serious health threat to Native communities, and this national health observance recognizes the mounting impact of HIV/AIDS on our country's Native peoples – American Indians, Alaska Natives, and Native Hawaiians. The Centers for Medicare & Medicaid Services (CMS) ask that you join in this national effort to raise awareness of the risks of the disease to Native peoples and help them understand the dynamics contributing to those risks.

Medicare coverage

Screenings for HIV are covered by Medicare, for eligible beneficiaries:

- Who are categorized as grade A (strongly recommended) or grade B (recommended) ratings by the U.S. Preventive Services Task Force (USPSTF) and who meet certain other requirements. (Please refer to the CMS "NCD for Screening for HIV" and the USPSTF "Screening for HIV Recommendation Statement" listed below for additional details.)
- For both standard and Food and Drug Administration (FDA) approved HIV rapid screening tests.
- If screening is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

What can you do?

As a provider of health care services to Native populations, CMS asks that you help promote HIV/AIDS prevention and early detection by talking with your patients about the risks of HIV/AIDS and the importance of prevention, and encourage them to get screened for HIV. Your support can help further the efforts to decrease the occurrence of HIV/AIDS among Native people.

For more information

- CMS National Coverage Determination – NCD for screening for HIV *http://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId=229&ver=19&NcaName=Screening+for+the+Human+Immunodef ciency+Virus+(HIV)+Infection&bc=BEAAAAAAAAAA&*
- U.S. Preventive Services Task Force (USPSTF) – screening for HIV recommendation *http://www.uspreventiveservicestaskforce.org/uspstf05/hiv/hivrs.htm#clinical*
- Indian Health Service HIV/AIDS Program – *http://www.IHS.gov/MedicalPrograms/HIVAIDS*
- CDC National Native HIV/AIDS Awareness Day – *http://www.CDC.gov/Features/NativeHIVAIDS*
- National Native American AIDS Prevention Center – *http://www.NNAAPC.org/news/awareness-day.htm*

We have the ability to make a difference! Thank you for your support.

Tuesday, March 22 is American Diabetes Alert Day

Please join with CMS during American Diabetes Alert Day to help inform seniors and other people with Medicare about the seriousness of diabetes. Currently, 25.8 million Americans are living with diabetes and an additional 79 million (or one in three American adults) are at risk for developing type 2 diabetes. If left undiagnosed and untreated, diabetes may increase the risk for complications such as heart disease, stroke, blindness, kidney damage, amputations, and death related to pneumonia and flu.

Medicare coverage

Medicare provides coverage of the following diabetes-related services for qualified Medicare beneficiaries:

- Diabetes screening tests
- Diabetes self-management training (DSMT)
- Diabetes supplies
- Dilated eye exam (for diabetic retinopathy)
- Foot care
- Glaucoma screening
- Hemoglobin A1c tests
- Influenza and pneumococcal immunizations
- Medical nutrition therapy (MNT)

What can you do?

As a health care professional who provides services to seniors and other people with Medicare, CMS needs your help to ensure that all eligible Medicare beneficiaries take advantage of the diabetes screening tests as well as all of the other diabetes-related services they may be eligible to receive.

For more information

- *Diabetes-Related Services* brochure – this brochure provides Medicare fee-for-service

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HIV and Diabetes...*continued*

providers with an overview of Medicare-covered diabetes screening tests, DSMT, MNT, supplies and other services for Medicare beneficiaries. *http://www.CMS.gov/MLNProducts/downloads/DiabetesSvcs.pdf*

- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including diabetes-related services. *http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – this comprehensive resource provides coverage and coding information on the array of Medicare-covered preventive services and screenings, including diabetes-related services. *http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*
- The CMS Prevention website – provides health care providers with information on Medicare's coverage of diabetes-related services and screening tests. *http://www.CMS.gov/home/Medicare.asp*
- National Diabetes Education Program (NDEP) – NDEP is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations. NDEP has a number of resources including PowerPoint slides; fact sheets; public service announcements for print, television, and radio; logos; feature articles; and Web banners. *http://www.YourDiabetesInfo.org/AlertDay2011*
- American Diabetes Alert Day – visit the American Diabetes Association's website at *http://www.Diabetes.org/in-my-community/programs/alert-day* to learn more about American Diabetes Alert Day.

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

Source: CMS PERL 201103-28

Billing of annual wellness visit codes G0438 and G0439

Please note that current editing prevents the billing of G0438 and G0439 if they are the only services on the claim. Claims containing the annual wellness visit (AWV) along with other services are processing, but the AWV service is not being paid.

The Centers for Medicare & Medicaid Services (CMS) has instructed Medicare contractors to hold all claims containing AWV codes G0438 and G0439 submitted on Type of Bill (TOB) 12X and 13X with dates of service on and after Saturday, January 1 through Sunday, April 3, 2011. The Medicare contractors' systems will be ready to process claims containing codes G0438 and G0439 submitted on TOBs 12X and 13X no later than Monday, April 4.

For additional information, please see Transmittal 2159, change request 7079, issued on Friday, December 3, 2010.

Source: CMS PERL 201103-22

Correction to the preventive services table for *CPT codes 90471* and *90472*

Please note that a correction has been issued by the Centers for Medicare & Medicaid Services (CMS) to the preventive services table (via change request 7012), with specific regard to *Current Procedural Terminology (CPT) codes 90471* and *90472*. Beginning Friday, April 1, for services that were furnished on or after Saturday, January 1, 2011, when providers are furnishing hepatitis B vaccines in outpatient facility settings they must report HCPCS code G0010 (administration of hepatitis B vaccine) rather than *CPT code 90471* or *90472*. This is in order to ensure that cost-sharing waivers are correctly applied to vaccine administration. As of Friday, April 1, change request 7012 will no longer recognize *CPT codes 90471* and *90472* for applying cost-sharing waivers on claims submitted for preventive services.

Source: CMS PERL 201103-18

Payment update and common working file editing for influenza virus vaccine and pneumococcal vaccine codes

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers and A/B Medicare administrative contractors (MACs) for Medicare beneficiaries receiving influenza vaccines or pneumococcal vaccines (PPV) are affected.

What you need to know

The influenza virus vaccine Healthcare Common Procedure Coding System (HCPCS) code *90662 (inf uenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use)* and PPV HCPCS code *90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use)* are being added to existing edits to prevent payment duplication for claims processed on or after July 5, 2011. Make sure your coding and billing staff is aware of this change.

Background

In order to prevent duplicate payments for influenza virus vaccine and PPV claims by the same contractor, the Centers for Medicare & Medicaid Services (CMS) has implemented a number of edits that were effective for claims received on or after July 1, 2002.

Change request (CR) 7128 provides instructions for payment and common working file (CWF) edits to be updated to include influenza virus vaccine HCPCS code *90662* and PPV HCPCS code *90670* for claims processed on or after July 5, 2011.

Basis for influenza vaccine and PPV payments

- The payment for influenza virus vaccine HCPCS code *90662* and PPV HCPCS code *90670* to hospitals (Types of Bill (TOB) 12x and 13x), skilled nursing facilities (SNFs) (TOBs 22x and 23x), home health agencies (HHAs) (TOB 34x), hospital-based renal dialysis facilities (RDFs) (TOB 72x), and critical access hospitals (CAHs) (TOB 85x) is based on reasonable cost;
- The payment for influenza virus vaccine HCPCS code *90662* and PPV HCPCS code *90670* to Indian Health Service (IHS) hospitals (TOB 12x, 13x) and IHS CAHs (TOB 85x) is based on 95 percent of the average wholesale price (AWP); and
- The payment for influenza virus vaccine HCPCS code *90662* and PPV code *90670* to comprehensive outpatient rehabilitation facilities (TOB 75x) and independent renal dialysis facilities (RDF) (TOB 72x) is based on the lower of the actual charge or 95 percent of the AWP.

Contractors will not search their files to either retract payment for claims already paid or retroactively pay claims. However, they will adjust claims brought to their attention.

Additional information

The official instruction, CR 7128 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2154CP.pdf* on the CMS website. 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* on the CMS website.

MLN Matters® Number: MM7128
Related Change Request (CR) #: 7128
Related CR Release Date: February 11, 2011
Effective Date: October 1, 2010
Related CR Transmittal #: R2154CP
Implementation Date: July 5, 2011

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *http://medicare.fcso.com/PDS/.*

New home health claims reporting requirements for G-codes related to therapy and skilled nursing services

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 describes how clinical diagnostic laboratories should bill for certain types of tests that are covered under Medicare and paid based on the clinical laboratory fee schedule (CLFS). Specifically, the article addresses the billing of two CLFS Healthcare Common Procedure Coding System (HCPCS) test codes – G0431 (drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) – beginning January 1, 2011. HCPCS code G0434 is new for calendar year (CY) 2011. Please be certain that your billing staffs are aware of these changes.

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) hosts an annual public meeting to discuss test codes that have been established by the *Common Procedural Terminology (CPT)* committee, and may be covered by Medicare, and paid based on the CLFS in the upcoming calendar year.

During the 2009 annual public meeting, CMS introduced two new CY 2010 HCPCS codes for reporting qualitative drug screen testing – G0430 (drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure), which was reported once per procedure and G0431, which is reported once per drug class. (Please note that G0430 was deleted beginning January 1, 2011). After the introduction of these codes, CMS determined that it needed to further refine these drug screen testing codes and revise the descriptors to avoid unnecessary or excessive utilization of code G0431 for relatively simple point-of-care tests that screen for multiple substances. During the 2010 annual public meeting, CMS introduced code G0434 to report qualitative point-of-care drug screen testing and to limit billing for such testing to one time per patient encounter. CMS also revised the descriptor for code G0431 to emphasize that the code describes all screening for multiple drug classes per patient encounter.

CMS recognizes that there could be rare instances where a patient requires multiple, medically necessary screening tests for drugs of abuse to be performed in a single day. For instance, a patient seen in an outpatient pain clinic who requires a drug screening test as a part of his/her care is later admitted to an emergency department after an automobile accident and requires another medically necessary drug screening test. The use of "per patient encounter" will allow payment to be made for this rare circumstance.

Effective January 1, 2011, CMS will utilize two test codes to report drug screen testing:

- G0434 (drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) will be used to report very simple testing methods, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices). This code is also used to report any other type of drug screen testing using test(s) that are classified as Clinical Laboratory Improvement Amendments (CLIA) moderate complexity test(s), keeping the following points in mind:
  - G0434 includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc, that are not CLIA waived.
  - Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver shall bill using the QW modifier.
  - Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation do not append the QW modifier to claim lines.
  - Only one unit of service for code G0434 can be billed per patient encounter regardless of the number of drug classes tested and irrespective of the use or presence of the QW modifier on claim lines.
- G0431 (drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex

continued on next page

Home health...*continued*

testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. Note that the descriptor has been revised for CY 2011. This code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:

- G0431 may only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).
- CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.
- CLIA moderate complexity tests should be reported under test code G0434 with one (1) Unit of Service (UOS).
- G0431 may only be reported once per patient encounter.
- Laboratories billing G0431 must not append the QW modifier to claim lines.

CMS has also made changes to the following related tests:

- G0430 was deleted as of January 1, 2011;
- *Code 80100* has not been priced under Medicare effective January 1, 2011; and
- *Code 80104* has not been priced under Medicare effective January 1, 2011.

Also, please remember that code 80101 has not been priced under Medicare since July 1, 2010.

Additional information

CMS publishes a list of test products with CLIA waived status each quarter. Providers may use this list to determine if a particular test product can be appropriately performed by a laboratory with a CLIA waiver and is eligible to be billed using the QW modifier. Concerning CLIA moderate or high complexity tests, providers should confirm a test's status with the test manufacturer.

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* on the CMS website.

Additional information concerning the CLFS can be found at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the CMS website.

MLN Matters® Number: SE1105
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A
Medicare Drug Screen Testing

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The countdown has begun …

Are you ready for January 1?
Schedule your HIPAA-5010 testing today!
Call 888-670-0940, Option 1

Additional information on HIPAA-5010 at *http://medicare.fcso.com/HIPAA/*

New home health claims reporting requirements for G-codes related to therapy and skilled nursing services

Provider types affected

This *Special Edition MLN Matters*® article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The implementation of HIPAA 5010 and D.0 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that

Electronic data interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

Caution – what you need to know

Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This *Special Edition MLN Matters*® article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 version 5010 and NCPDP version D.0 standards. Remember that the HIPAA standards, including the ASC X12 version 5010 and version D.0 standards are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate *MLN Matters* articles will address the ICD-10 implementation.

Go – what you need to do

In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

More information about Medicare's EDI requirements can be found in the Medicare *Claims Processing Manual*, Chapter 24 – "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at *http://www.cms.gov/manuals/downloads/clm104c24.pdf* on the CMS website. Electronic billing and EDI transaction information can be found at *http://www.cms.gov/ElectronicBillingEDITrans/* on the CMS website. This section contains information on:

- EDI transaction and corresponding paper claims requirements;
- Links to those chapters of the *Medicare Claims Processing Manual* that contain further information on these types of transactions;
- The Administrative Simplification Compliance Act (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment;
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically; and
- EDI support furnished by Medicare contractors.

Current versions of the transaction standards (ASC X12 version 4010/4010A1 for health care transactions, and the NCPDP version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs.

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Therefore, on January 16, 2009, HHS announced a final rule that replaced the current version 4010/4010A and NCPDP Version 5.1 with version 5010 and Version D.0, respectively. The final rule (CMS-0009-F) titled, "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards," can be found at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf* on the US Government Printing Office (GSP) website.

Subsequently, CMS is performing activities to convert from processing the ASC X12 version 4010A1 to HIPAA ASC X12 version 5010, and the NCPDP version 5.1 to NCPDP version D.0.

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date of the regulation until January 1, 2012, the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."
- Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

The CMS Medicare fee-for-service implementation schedule is:

- Level I April 1, 2010, through December 31, 2010;
- Level II January 1, 2011, through December 31, 2011; and
- Fully compliant on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (version 4010/4010A1) with version 5010, and NCPDP EDI standards version 5.1 with version D.0. For more information see *http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp* on the CMS website.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare fee-for-service business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare fee-for-service. Maintenance will be performed without notification, as needed to support Medicare fee-for-service.

Readiness assessment 1 – Have you done the following to be ready for 5010/D.0?
Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit *http://www.cms.gov/Versions5010andD0/downloads/readiness_1.pdf* to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once. Be sure to start testing version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful Web links go to *http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp* on the CMS website.

Readiness assessment 2 – What do you need to have in place to test with your MAC?
Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.

- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:

- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted); and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 National Call presentation on Provider Outreach and Education – Transition Year Activities can be found at *http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf* on the CMS website.

Trading partners are encouraged to review the following:

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- Version 5010 and D.0. transaction resources can be found at *http://www.cms.gov/Versions5010andD0/* on the CMS website;
- Educational resources (i.e., MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at *http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp* on the CMS website; and
- The dedicated HIPAA 5010/D.0 Project Web page, which includes technical documents and communications at national conferences, can be found at *http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp* on the CMS website.

Errata requirements and testing schedule
HIPAA version 5010 has new errata, which can be found at *http://www.cms.gov/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf* on the CMS website. According to the published regulation (*Federal Register*, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. **Compliance with the errata must be achieved by the original regulation compliance date of January 1, 2012.**

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 Errata versions in April 2011.

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the "Downloads" section at *http://www.cms.gov/ElectronicBillingEDITrans/* on the CMS website.

CMS 5010 provider outreach and education materials
CMS has developed extensive information and educational resources pertaining to the topics listed below. This information is available on the CMS website:

- Version 5010 – the new version of the X12 standards for HIPAA transactions;
- Version D.0 – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation.

The information posted at *http://www.cms.gov/Versions5010andD0/01_overview.asp* on the CMS website may be applicable to the healthcare industry at large, or may be specifically Medicare-related information. The "Overview" Web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-related standards. The highlights and overview of these pages are as follows:

- Federal Regulation & Notices (http://www.cms.gov/Versions5010andD0/20_Federal_Regulation_and_Notices.asp)

  This Web page contains general information related to federal regulations and notices and contains the following link to the final rule for X12 5010, D.0 and 3.0 document. See *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf* on the GPO website.
- CMS Communications (*http://www.cms.gov/Versions5010andD0/30_CMS_Communications.asp*) This CMS communications Web page includes versions 5010 & D.0 implementation information and the following downloads:
  - 5010 Implementation Calendar [PDF, 325KB]; see *http://www.cms.gov/Versions5010andD0/Downloads/5010ImplementationCalendar.pdf* on the CMS website.
  - Readiness Assessment – What do you need to have in place to test with your MAC? [PDF, 241KB]; see *http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf* on the CMS website.
- Educational Resources (*http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp*) The Educational Resources Web page includes information designed to increase national awareness and assist in the implementation of versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:
  - Version 5010 Resource Card [PDF, 243KB] (see *http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf*);
  - *Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0* fact sheet [PDF, 1208KB] (see *http://www.cms.gov/Versions5010andD0/Downloads/w5010TransitionFctSht.pdf*);
  - *Checklist for Level I Testing Activities* [PDF, 324 KB] (see *http://www.cms.gov/Versions5010andD0/Downloads/*

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w5010PrepChklst.pdf);

- *Provider Action Checklist for a Smooth Transition* [PDF, 333KB] (see *http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf*); and
- Versions 5010 and D.0 *MLN Matters* articles [PDF, 31KB] (see *http://www.cms.gov/Versions5010andD0/Downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf* on the CMS website).

- 5010 National Calls (*http://www.cms.gov/Versions5010andD0/V50/*) Throughout the implementation of version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 Web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional information

A special edition *MLN Matters* article on the ICD-10 code set can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf* on the CMS website.

CMS is also using the open door forums and Listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the open door forums can be found at *http://www.cms.gov/OpenDoorForums/* on the CMS website. Information about Listservs (email updates) can be found at *http://www.cms.gov/AboutWebsite/EmailUpdates/* on the CMS website.

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

MLN Matters® Number: SE1106
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

This article has been rescinded and replaced by article MM7313, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7313.pdf* on the CMS website. This information was previously published in the December 2010 *Medicare A Bulletin*, page 35.

MLN Matters® Number: MM7239
Related Change Request (CR) #:7239
Related CR Release Date: December 3, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R2110CP
Implementation Date: January 3, 2011

Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

Provider types affected

Clinical laboratories submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for specimen collection services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7313 which revises the payment of travel allowances for specimen collection services when billed on a per mileage basis using Healthcare Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis, using HCPCS code P9604 for calendar year (CY) 2011.

Caution – what you need to know

The per mile travel allowance (P9603) is $0.96 per mile and the per flat-rate trip basis travel allowance (P9604) is $9.60. Payment of the travel allowance is made only if a specimen collection fee is also payable. Your Medicare contractor has the option of establishing a higher per mile rate in excess of the minimum $0.96 per mile if local conditions warrant it.

Go – what you need to do

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

Background

Change request (CR) 7313 revises the CY 2011 payment of travel allowances when billed on a:

- Per mileage basis using HCPCS code P9603, and
- Flat rate basis using HCPCS code P9604.

Note: Payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses.

Medicare contractors have the discretion to choose either the mileage basis or flat rate. In addition, your Medicare contractor can choose how to set each type of allowance. Also, many contractors established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip (for both Medicare and non-Medicare patients). This is done:

- At the time the claim is submitted by the laboratory, or
- When the flat rate is set by the Medicare contractor.

Per mile travel allowance (P9603) – the per mile travel allowance is a minimum of $0.96 per mile. This per mile travel allowance rate is:

- Used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and
- Prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile rate was computed using the Federal mileage rate of $0.51 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs for a total of $0.96 per mile.

The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the clinical laboratory fee schedule, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per flat-rate trip basis travel allowance (P9604) – the per flat-rate trip basis travel allowance is $9.60.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

Additional information

The official instruction, CR 7313, issued to your carriers, FIs, and A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2153CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

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* on the CMS website.

MLN Matters® Number: MM7313
Related Change Request (CR) #: CR 7313
Related CR Release Date: February 11, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2153CP
Implementation Date: March 14, 2011

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 specif c statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

April update to the 2011 Medicare physician fee schedule database

Note: This article was revised on March 20, 2011, to reflect the revised change request (CR) 7319 issued on March 18, 2011, to change the MPFS payment file names described in the Recurring Update Notification in the section titled: Revised MPFS Payment File Names. Also, the CR release date, transmittal number, and the Web address for accessing CR 7319 were changed. All other information remains the same. A previous update added the section with the heading of "Correction to Payment File OPPS Cap "Imaging Payment Amount" field for *CPT code 92227*." This information was previously published in the February 2011 *Medicare Bulletin*, pages 5-6.

Provider types affected

This article is for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (fiscal intermediaries, carriers or Part A/B Medicare administrative contractors, and regional home health intermediaries) for services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

What you need to know

Payment files were issued to contractors based upon the calendar year (CY) 2011 MPFS final rule, released on November 2, 2010, and published in the *Federal Register* on November 29, 2010. As previously described in CR 7300, these payment files were modified in accordance with the MPFS final rule correction notice released on December 30, 2010 and published in the *Federal Register* on January 11, 2011, and by relevant statutory changes applicable January 1, 2011, including the Physician Payment and Therapy Relief Act of 2010, and the Medicare and Medicaid Extenders Act of 2010.

This article is based on CR 7319, which details changes included in the April quarterly update to those payment files. Note that 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 7319. However, contractors will adjust claims brought to their attention. Please be sure to inform your staff of these changes.

Background

Medicare physician fee schedule database (MPFSDB) payment file revisions

In order to reflect appropriate payment policy in line with the CY 2011 MPFS final rule, some payment indicators and practice expense (PE) relative-value units (RVUs) have been revised. New MPFS payment files have been created that include these changes.

MPFSDB indicator changes

The following HCPCS codes have MPFSDB indicator changes:

HCPCS code	Short descriptor	Indicator
31579	*Diagnostic laryngoscopy*	Global surgery: 000
57155	*Insert uteri tandems/ ovoids*	Co-surgeons: 2
64613	*Destroy nerve neck muscle*	Bilateral surgery: 2
64614	*Destroy nerve extrem musc*	Bilateral surgery: 2
77071	*X-ray stress view*	Bilateral surgery: 2
92511	*Nasopharyngoscopy*	Global surgery: 000
93464 26	*Exercise w/ hemodynamic meas*	Multiple surgery: 0

PE RVU changes

The following HCPCS codes have PE RVU changes. A detailed description of these changes can be found in CR 7319.

HCPCS code	Short descriptor
93503	*Insert/place heart catheter*
93224	*Ecg monit/reprt up to 48 hrs*
93225	*Ecg monit/reprt up to 48 hrs*
93226	*Ecg monit/reprt up to 48 hrs*

Added HCPCS code

The following HCPCS code has been added, effective April 1, 2011. More information on this addition can be found in CRs 7319 and 7299.

HCPCS code	Short descriptor
Q2040	Incobotulinumtoxin A

Discontinued HCPCS codes

The following HCPCS codes are discontinued for dates of service on or after January 1, 2011, that are processed on or after April 4, 2011.

HCPCS code	Short descriptor
90470	*Immune admin H1N1 im/nasal*
90663	*Flu vacc pandemic H1N1*

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April update...*continued*

The following HCPCS codes are discontinued for dates of service on or after April 1, 2011, that are processed on or after April 4, 2011.

HCPCS code	Short descriptor
Q1003	Ntiol category 3
S2270	Insertion vaginal cylinder
S2344	Endosc balloon sinuplasty
S3905	Auto handheld diag nerv test

Correction to payment file OPPS cap "Imaging Payment Amount" field for *CPT code 92227*

Current Procedural Terminology (CPT) code 92227 (remote Dx retinal imaging), is subject to the OPPS payment cap determination and has an imaging cap indicator of 1. The CY 2011 MPFS Relative Value File correctly lists OPPS payment amounts (PE=0.53 and MP =0.02) for this code; however, these values were not carried over to the Imaging Payment Amount field in the Medicare contactor payment files, which listed the values as 0.00 for all carriers. This will be corrected in the MPFS payment files released for the April quarterly update, effective January 1, 2011.

Additional information

The official instruction, CR 7319, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/transmittals/downloads/R2180CP.pdf* on the CMS website. If you have any questions, please contact your FI, carrier, or A/B MAC, at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

MLN Matters® Number: MM7319 Revised
Related Change Request (CR) #: 7319
Related CR Release Date: March 18, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2180CP
Implementation Date: April 4, 2011

2011 annual update to the therapy code list

Provider types affected

Physicians, therapists, and providers of therapy services billing Medicare Carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for outpatient rehabilitation therapy services should take note of this article.

Provider action needed

This article is based on change request (CR) 7364, which updates the therapy code list for calendar year (CY) 2011 by adding *Current Procedural Terminology (CPT) code 95992 (standard Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day)* to the "Sometimes Therapy" list.

Background

CR 7364 updates the therapy code list by adding one "sometimes therapy" code for CY 2011 shown in the table below.

Therapy code	Descriptor
95992	*Standard Canalith repositioning procedure(s) (e.g,, Epley maneuver, Semont maneuver), per day.*

Additional information

You can also find more information about the therapy code lists at *http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage* on the CMS website.

The official instruction, CR 7364, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2175CP.pdf* on the CMS website.

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

MLN Matters® Number: MM7364
Related Change Request (CR) #: N/A
Related CR Release Date: March 18, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2175CP
Implementation Date: July 5, 2011

Emergency update to the 2011 Medicare physician fee schedule database

Note: This article was revised on March 20, 2011, to reflect a new change request (CR). That CR corrected the implementation date. The transmittal number, release date and Web address of the CR was also changed. All other information remains the same. This information was previously published in the January 2011 *Medicare A Bulletin*, pages 7-9.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], durable medical equipment Medicare administrative contractors [DME/MACs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on CR 7300, which amends payment files that were issued to Medicare contractors based on the 2011 MPFS Final Rule. This CR also reinstates three durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) HCPCS L-codes, as described below. Be sure your billing staff is aware of these changes.

Background

Payment files were issued based upon the Calendar Year (CY) 2011 MPFS Final Rule, issued on November 2, 2010, and published in the *Federal Register* on November 29, 2010. CR 7300 amends those payment files to include MPFS policy and payment indicator revisions described in the CY 2011 MPFS final rule correction notice, issued in December 30, 2010, (*http://www.ofr.gov/(X(1)S(zj23h5e5vs3xn5y2yjsecx03))/inspection.aspx?AspxAutoDetectCookieSupport=1*) to be published in the *Federal Register* on January 11, 2011, as well as relevant statutory changes applicable January 1, 2011. Therefore, new MPFS payment files have been created and are available. CR 7300 also reinstates three DMEPOS Healthcare Common Procedure Coding System (HCPCS) L-codes. Following is a summary of the changes as they impact providers:

Medicare Physician Fee Schedule revisions and updates

Some physician work, practice expense (PE) and malpractice (MP) relative value units (RVUs) published in the CY 2011 MPFS final rule have been revised to align their values with the CY 2011 MPFS Final Rule policies. These changes are discussed in the CY 2011 MPFS final rule correction notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS final rule correction notice public use data files located at *http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp* on the Centers for Medicare & Medicaid Services (CMS) website. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at *http://www.cms.gov/Transmittals/downloads/R833OTN.pdf* on the CMS website.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS final rule has been revised. This CF will be published in the CY 2011 MPFS final rule correction notice. Legislative changes subsequent to issuance of the CY 2011 MPFS final rule have led to the further revision of the values published in the CY 2011 MPFS final rule correction notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available.

A summary of the recent statutory provisions included in the revised MPFS payment files is as follows.

Physician Payment and Therapy Relief Act of 2010

On November 30, 2010, President Obama signed into law the Physician Payment and Therapy Relief Act of 2010. As a result of the Physician Payment and Therapy Relief Act of 2010 a new reduced therapy fee schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act,

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Emergency update...*continued*

CMS will apply the CY 2011 MPFS final rule policy of a 25 percent multiple procedure payment reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Social Security Act. This change is detailed in recently released CR 7050. CMS published *MLN Matters*® article 7050, related to CR 7050, which may be reviewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM7050.pdf*. This Act also made the therapy MPPR not budget neutral under the physician fee schedule (PFS) and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

Medicare and Medicaid Extenders Act (MMEA) of 2010

On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act (MMEA) of 2010. This new legislation contains a number of Medicare provisions which change or extend current Medicare fee-for-service program policies. A summary of MPFS-related provisions follows.

- **Physician payment update**

  Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS final rule. The MMEA provides for a zero percent update to the MPFS for claims with dates of service January 1, 2011, through December 31, 2011. While the MPFS update will be zero percent, other changes to the RVUs (e.g., miss valued code initiative and rescaling of the RVUs to match the revised Medicare economic index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011, is $33.9764.

  The calculation of the CY 2011 conversion factor is illustrated in the following table.

December 2010 conversion factor		$36.8729
MMEA "Zero Percent Update"	0.0 percent (1.000)	
CY 2011 RVU Budget Neutrality Adjustment	0.4 percent (1.0043)	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.3 percent (0.9175)	
CY 2011 Conversion Factor		$33.9764

The revised CY 2011 MPFS payment files will reflect this conversion factor.

- **Extension of Medicare physician work geographic adjustment floor**

  Current law requires the payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 3102 of the Affordable Care Act extended the 1.0 floor on the physician work geographic practice cost index (GPCI) for services furnished though December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. Updated CY 2011 GPCIs may also be found in the attachment to CR 7300 as noted previously.

- **Extension of MPFS mental health add-on**

  Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the Medicare & Medicaid Extenders Act (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy may also be found in the attachment to CR 7300.

- **Extension of exceptions process for Medicare therapy caps**

  Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continued the exceptions process through December 31, 2010. Section 104 of the MMEA extends the exceptions process for outpatient therapy

continued on next page

Emergency update...*continued*

caps through December 31, 2011. Outpatient therapy service providers may continue to submit claims with the modifier KX, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,870. For occupational therapy services, the limit is $1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

- **Extension of moratorium that allowed independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients**

  Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a MAC for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extended the payment to independent laboratories for the TC of certain physician pathology services furnished to hospital patients retroactive to January 1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011, through December 31, 2011.

Durable medical equipment, prosthetics, orthotics, and supplies updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

- L3660 – shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment (SD: Abduct restrainer canvas & web);
- L3670 – shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment (SD: Acromio/clavicular canvas & web); and
- L3675 – shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, and prefabricated includes fitting and adjustment (SD: Canvas vest SO).

These three "L" codes will continue to stay active codes for January 1, 2011. Instruction for billing and payment will remain the same for these three "L" codes. Medicare contractors will pay for codes L3660, L3670, and L3675 with dates of service on or after January 1, 2011, using the following 2011 DMEPOS fee schedule amounts:

	JURIS	CATG	L3660	L3670	L3675
AL	D	PO	$85.06	$118.57	$145.25
AR	D	PO	$85.06	$97.17	$145.24
AZ	D	PO	$100.69	$124.79	$141.00
CA	D	PO	$100.69	$124.79	$141.00
CO	D	PO	$111.02	$93.60	$146.04
CT	D	PO	$113.42	$93.60	$141.00
DC	D	PO	$85.06	$112.42	$141.00
DE	D	PO	$85.06	$112.42	$141.00
FL	D	PO	$85.06	$118.57	$145.25
GA	D	PO	$85.06	$118.57	$145.25
IA	D	PO	$106.53	$124.79	$143.74
ID	D	PO	$85.06	$97.28	$141.00
IL	D	PO	$85.06	$93.60	$144.48
IN	D	PO	$85.06	$93.60	$144.48
KS	D	PO	$106.53	$124.79	$143.74
KY	D	PO	$85.06	$118.57	$145.25
LA	D	PO	$85.06	$97.17	$145.24
MA	D	PO	$113.42	$93.60	$141.00
MD	D	PO	$85.06	$112.42	$141.00
ME	D	PO	$113.42	$93.60	$141.00
MI	D	PO	$85.06	$93.60	$144.48

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Emergency update...*continued*

	JURIS	CATG	L3660	L3670	L3675
MN	D	PO	$85.06	$93.60	$144.48
MO	D	PO	$106.53	$124.79	$143.74
MS	D	PO	$85.06	$118.57	$145.25
MT	D	PO	$111.02	$93.60	$146.04
NC	D	PO	$85.06	$118.57	$145.25
ND	D	PO	$111.02	$93.60	$146.04
NE	D	PO	$106.53	$124.79	$143.74
NH	D	PO	$113.42	$93.60	$141.00
NJ	D	PO	$87.06	$110.96	$141.00
NM	D	PO	$85.06	$97.17	$145.24
NV	D	PO	$100.69	$124.79	$141.00
NY	D	PO	$87.06	$110.96	$141.00
OH	D	PO	$85.06	$93.60	$144.48
OK	D	PO	$85.06	$97.17	$145.24
OR	D	PO	$85.06	$97.28	$141.00
PA	D	PO	$85.06	$112.42	$141.00
RI	D	PO	$113.42	$93.60	$141.00
SC	D	PO	$85.06	$118.57	$145.25
SD	D	PO	$111.02	$93.60	$146.04
TN	D	PO	$85.06	$118.57	$145.25
TX	D	PO	$85.06	$97.17	$145.24
UT	D	PO	$111.02	$93.60	$146.04
VA	D	PO	$85.06	$112.42	$141.00
VT	D	PO	$113.42	$93.60	$141.00
WA	D	PO	$85.06	$97.28	$141.00
WI	D	PO	$85.06	$93.60	$144.48
WV	D	PO	$85.06	$112.42	$141.00
WY	D	PO	$111.02	$93.60	$146.04
AK	D	PO	$100.22	$148.35	$141.00
HI	D	PO	$107.12	$158.62	$141.00
PR	D	PO	$82.83	$105.08	$169.21
VI	D	PO	$87.06	$110.96	$169.21

In accordance with the statutory Section 1834(a)(14) of the Social Security Act, the above fee schedule amounts were updated for CY 2011 by applying the CY 2011 -0.1 percent update factor to the CY 2010 fee schedule amounts. The CY 2011 payment amounts for codes L3660, L3670, and L3675 will be posted as a public use file at: *http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp*.

Additional information

The official instruction, CR 7300, issued to your carrier, FI, RHHI, DME MAC, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R833OTN.pdf* on the CMS website. If you have any questions, please contact your carrier, RHHI, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

MLN Matters® Number: MM7300 Revised
Related Change Request (CR) #:7300
Related CR Release Date: January 7, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R833OTN
Implementation Date: No later than January 14, 2011

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 specif c statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Reporting of recoupment for overpayment on the remittance advice

Note: This article was revised on March 4, 2011, to reflect changes made to change request (CR) 6870. The CR was changed to amend the implementation date to October 3, 2011, for claims processed by Medicare contractors using the Fiscal Intermediary Shared System (FISS). The article was changed accordingly. All other information is the same. This information was previously published in the April 2010 *Medicare A Bulletin,* pages 7-8.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries. CR 6870 does not apply to suppliers billing durable medical equipment (DME) MACs.

Provider action needed

This article is based on CR 6870 which instructs Medicare system maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national recovery audit contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You may review Section 1893 *http://www.ssa.gov/OP_Home/ssact/title18/1893.htm*. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. (See the *Medicare Learning Network* [*MLN*] *Matters* article related to CR 6183 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf*)

Under the scenario just described, the RAC has to report the actual recoupment in two steps:

Step I: Reversal and correction to report the new payment and negate the original payment (actual recoupment of money does not happen here).

Step II: Report the actual recoupment.

Recovered amounts reduce the total payment and are clearly reported in the remittance advice (RA) to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR 6870 instructs the Medicare system maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when:

- An overpayment is identified, and
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an internal control number (ICN) or document control number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I:
Claim level:
The original payment is taken back and the new payment is established

Provider level:
PLB03-1 – PLB reason code FB (forward balance)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#
PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the

continued on next page

Recoupment...*continued*

claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II:
Claim level:
No additional information at this step

Provider level:
PLB03-1 – PLB reason code WO (overpayment recovery)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Additional information

CMS provides more information including an overview of and recent updates for the RAC program at *http://www.cms.gov/RAC/*. You may find the guide "Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers" at *http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

The official instruction, CR 6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R866OTN.pdf*.

You may also want to review *MLN Matters*® article MM7068, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7068.pdf*. It instructs DME MACs to provide enough detail in the RA to enable DMEPOS suppliers to reconcile their claims.

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: MM6870 *Revised*
Related Change Request (CR) #: 6870
Related CR Release Date: March 4, 2011
Effective Date: July 1, 2010
Related CR Transmittal #: R866OTN
Implementation Date: July 6, 2010, except October 3, 2011, for claims processed by the FISS system used by FIs and A/B MACs

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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 botton line.

ELECTRONIC HEALTH RECORDS

New EHR incentive program frequently asked questions posted online

The Centers for Medicare & Medicaid Services (CMS) wants to help you find the answers you need about the electronic health record (EHR) incentive programs. Take a minute and review the new frequently asked questions (FAQs) about topics including eligibility, registration, meaningful use and attestation that have been posted to the FAQ section of the EHR incentive programs website.

A few of the new FAQs include:

1. *What is the def nition of "reasonable cost" for critical access hospitals (CAHs) under the Medicare and Medicaid EHR incentive programs?*

   The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Read the full answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10163/kw/10163*.

2. *How is hospital-based status determined for eligible professionals (EPs) in the Medicare and Medicaid HER incentive programs?*

   A hospital-based eligible professional (EP) is defined as an EP who furnishes 90 percent or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. Read the full answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10464/kw/10464*.

3. *For large practices, will there be a method to register all of the EPs at one time for the Medicare or Medicaid HER incentive programs? Can EPs allow another person to register or attest for them?*

   At this time there is no method available for a third party to register multiple EPs for the Medicare and Medicaid EHR incentive programs. Read the full answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10141/kw/10141*.

FAQ highlights: Registration questions

To help ensure that your registration process goes smoothly and for your easy reference, we have provided answers below to two of the most common registration questions from our FAQs found on the CMS website at *https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage*.

1. *How will EPs and eligible hospitals apply for incentives under the Medicare and Medicaid EHR incentive program?*

   Registration for the Medicare and Medicaid EHR incentive programs began on January 3, 2011. However, the Medicaid incentive program is rolled out on a state-by-state basis. An updated schedule of state-planned Medicaid incentive program start dates can be found on the CMS website.

2. *If a hospital is eligible to participate in both the Medicare and Medicaid EHR incentive programs, how should they register?*

   If a hospital meets all of the following qualifications, it is dually-eligible for the Medicare and Medicaid EHR incentive programs:

   - It is a subsection(d) hospital in the 50 U.S. states or the District of Columbia, or it is a Critical Access Hospital (CAH);
   - It has a CMS certification number ending in 0001-0879 or 1300-1399; and
   - It has 10 percent of patient volume derived from Medicaid encounters.

Any hospitals that meet these three qualifications, must register for "Both Medicare & Medicaid" when registering for the programs.

Want more information about the EHR incentive programs? Keep up to date! Go to *http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp* to join the CMS EHR incentive programs Listserv. Make sure to visit the CMS EHR incentive programs website *http://www.cms.gov/EHRIncentivePrograms/* for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201103-44

Update on health information technology and EHR incentive program

ONC explains how 2011 marks age of meaningful use

The latest public letter from Dr. David Blumenthal, National Coordinator for Health Information Technology, marks 2011 as the year when medical care entered a new era – the age of meaningful use of health information. The letter highlights the programs the Office of National Coordinator (ONC) has implemented in order to build an infrastructure to support meaningful use, and it also examines the role of meaningful use as a vision of how information can be used in innovative ways to revolutionize the work of health professionals and health care institutions.

Visit the ONC website (at *http://HealthIT.HHS.gov/portal/server.pt?open=512&mode=2&objID=3541)* to read the letter and learn more about the age of meaningful use.

Strong interest in Medicare and Medicaid EHR incentive programs

In a press release earlier this week, the Center for Medicare & Medicaid Services (CMS) announced that there has been strong interest in early registration for the Medicare and Medicaid EHR (electronic health record) incentive programs.

In January, more than 21,000 providers initiated registration for the programs, and four states began issuing Medicaid incentive payments, totaling $20,425,550. In particular, the press release highlighted the following successes:

- The Office of the National Coordinator for Health Information Technology announced that as of Friday, February 11, more than 45,000 providers requested information or registration help from 62 regional extension centers.
- On Wednesday, January 5, Kentucky made an initial payment of $2.86-million to a teaching hospital, University of Kentucky Healthcare. On the same day, Kentucky disbursed an incentive payment of $1.3-million to Central Baptist Hospital, and Oklahoma issued incentive payments to two physicians at the Gastorf Family Clinic of Durant, Oklahoma, totaling $42,500 ($21,250 each), for having adopted certified EHRs.
- On Wednesday, January 12, Louisiana announced a payment of $63,750 to Winn Community Health Center, the first federally-qualified health center in the nation to receive an incentive payment. The incentive payment consisted of $21,250 for each of three eligible professionals at the clinic.
- During the week of Monday, January 17, Iowa issued its first Medicaid EHR incentive payments in the amount of $21,250 each for two eligible professionals.

CMS Administrator Donald Berwick, M.D., said, “This strong early interest in the Medicare and Medicaid EHR incentive programs among providers and state Medicaid programs is most welcome and very encouraging. We encourage early adoption, and we’re seeing the registration numbers continue on an upward trajectory. The valuable feedback we’ve seen in these early weeks of the program helps us to fine-tune our list of frequently-asked-questions and other resources to increase providers’ understanding of the incentive programs and help them in getting signed up.”

Want more information about the EHR incentive programs? Visit the EHR incentive programs website at *http://www.cms.gov/EHRIncentivePrograms/* for the latest news and updates on the EHR incentive programs, and join the CMS EHR Listserv at *http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp* to stay up-to-date.

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

Source: CMS PERL 201102-47

Get motivated by Medicare …

Find out about Provider Incentive Programs

- e-Prescribing (eRx)
- Electronic Health Records (EHR)
- Physician Quality Reporting System
- Primary Care Incentive Program (PCIP)

Available at *http://medicare.fcso.com/Landing/191460.asp*

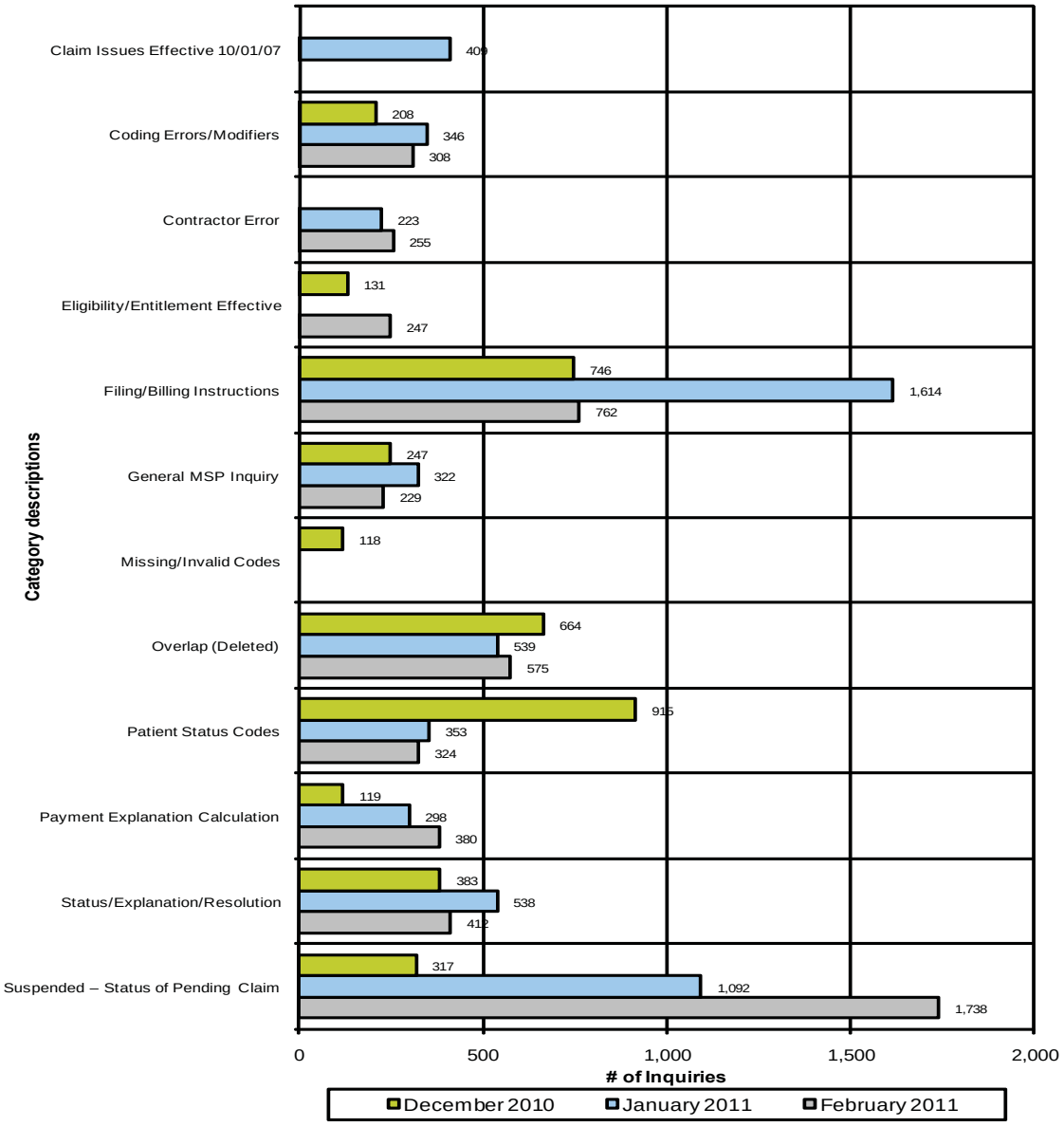
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims – December 2010-February 2011

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 December 2010-February 2011.

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 December 2010-February 2011



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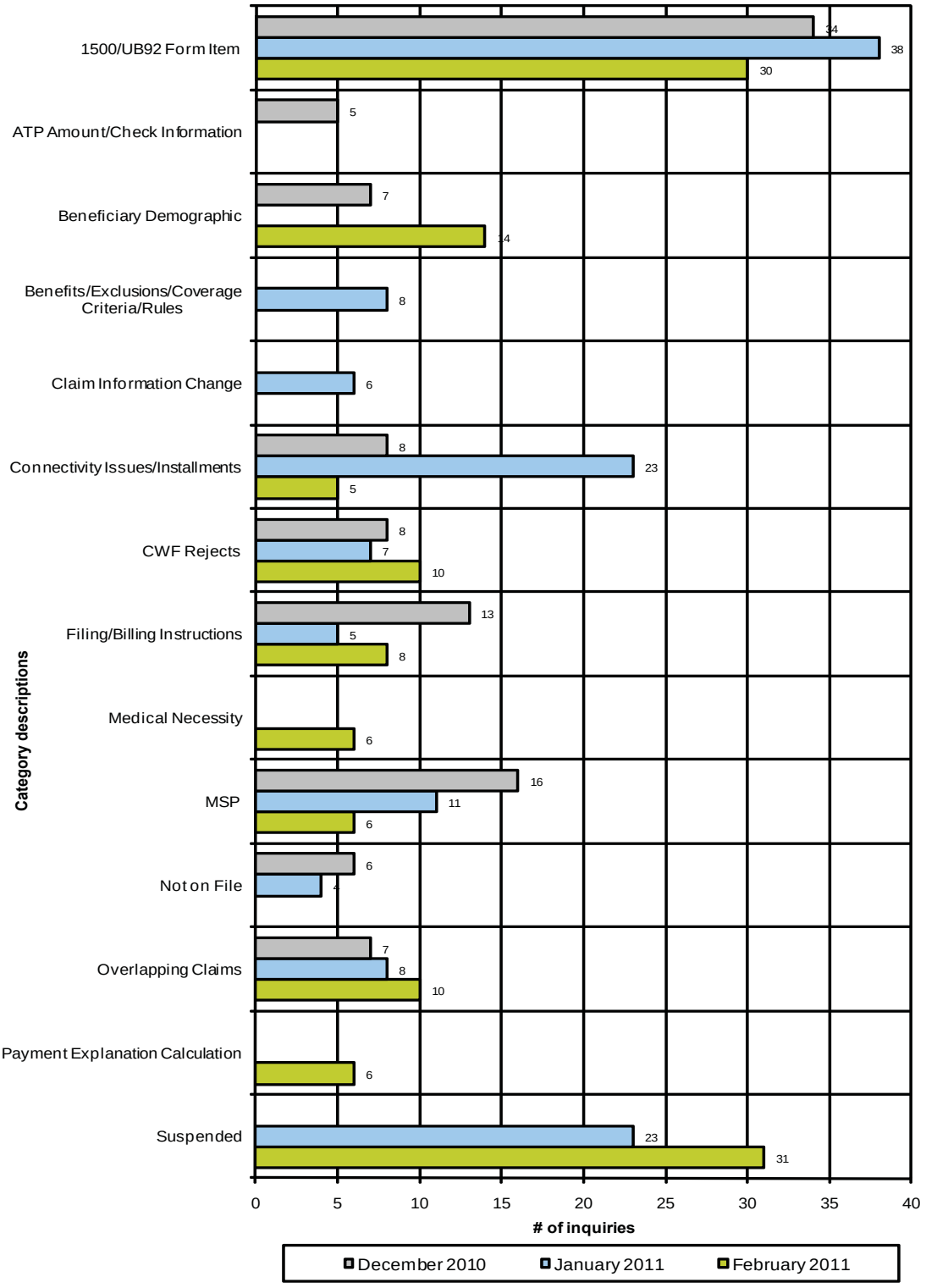
Inquiries, RTP, reject...*continued*

Puerto Rico and U.S. Virgin Islands Part A top inquiries for December 2010-February 2011



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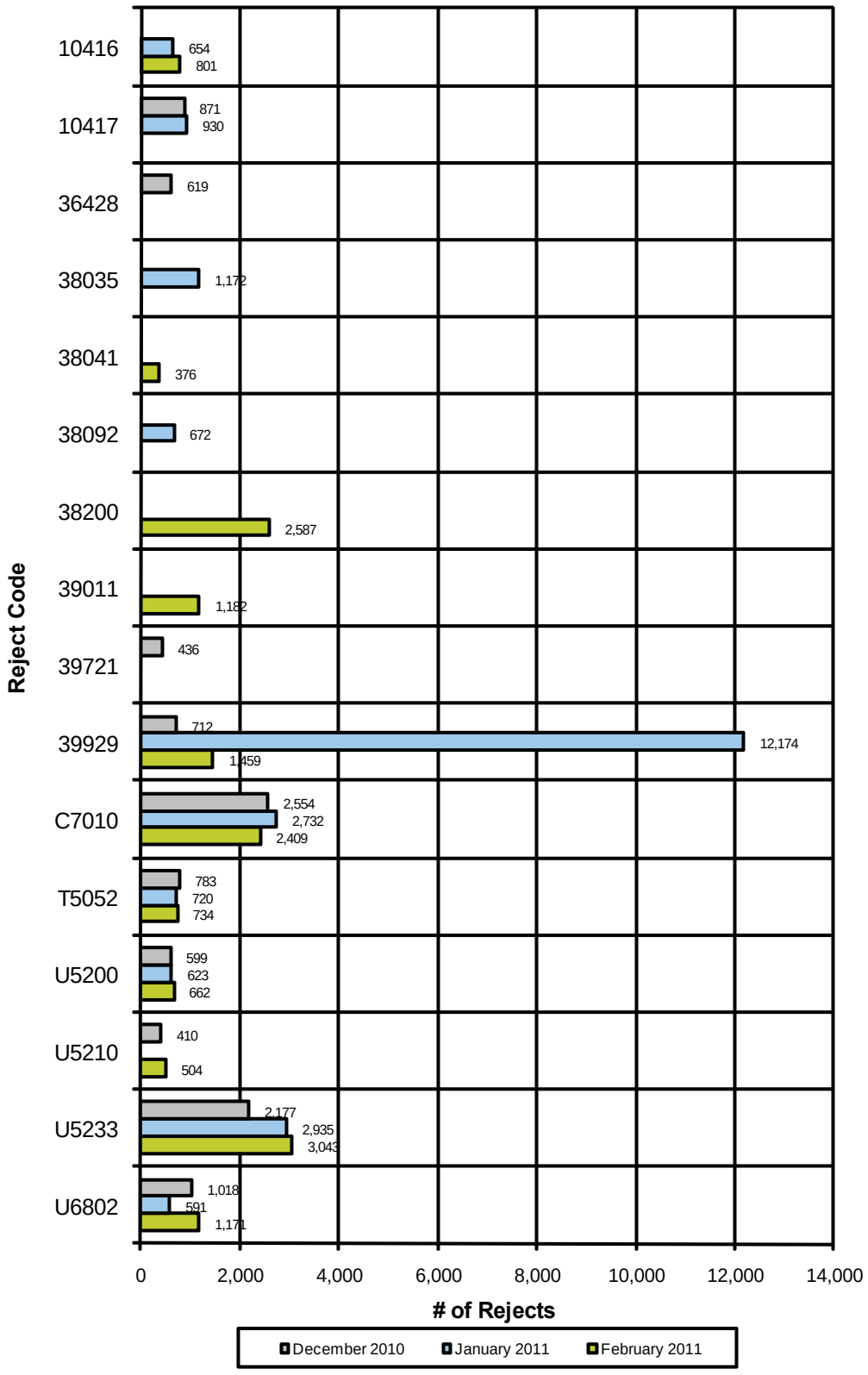
Inquiries, RTP, reject...*continued*

Florida Part A top rejects for December 2010-February 2011



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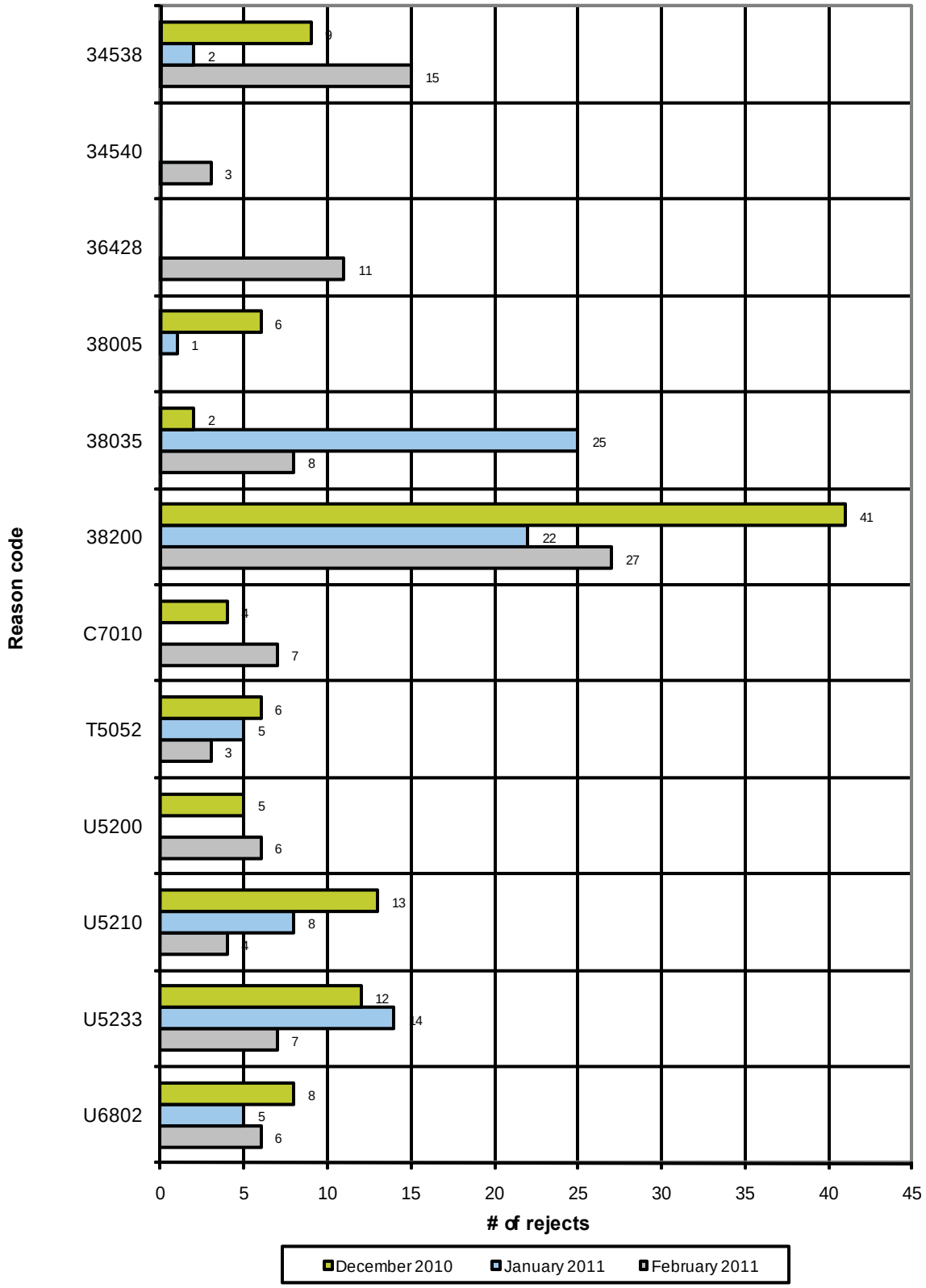
Inquiries, RTP, reject...*continued*

U.S. Virgin Islands Part A top rejects for December 2010-February 2011



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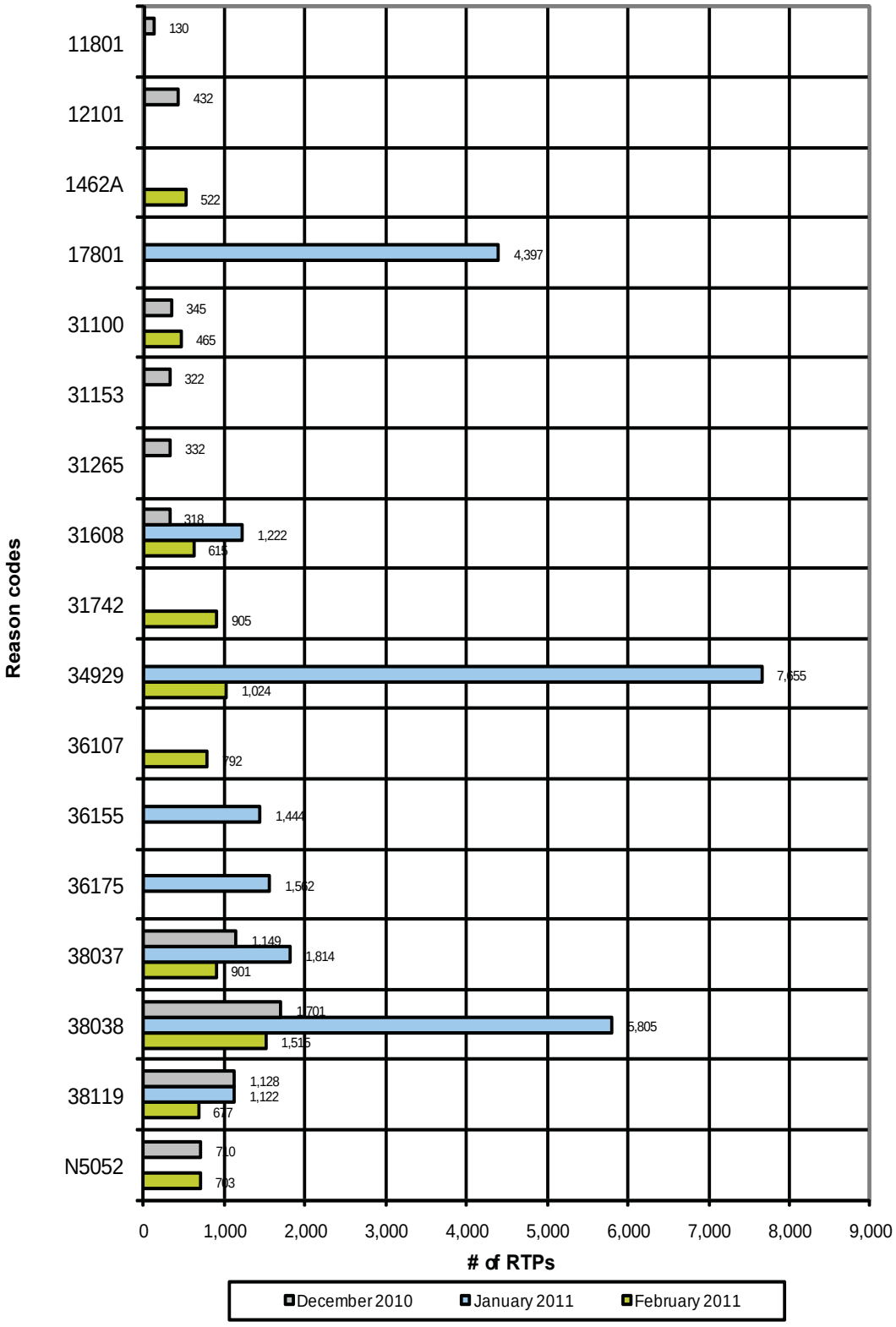
Inquiries, RTP, reject...*continued*

Florida Part A top return to providers (RTPs) for December 2010-February 2011



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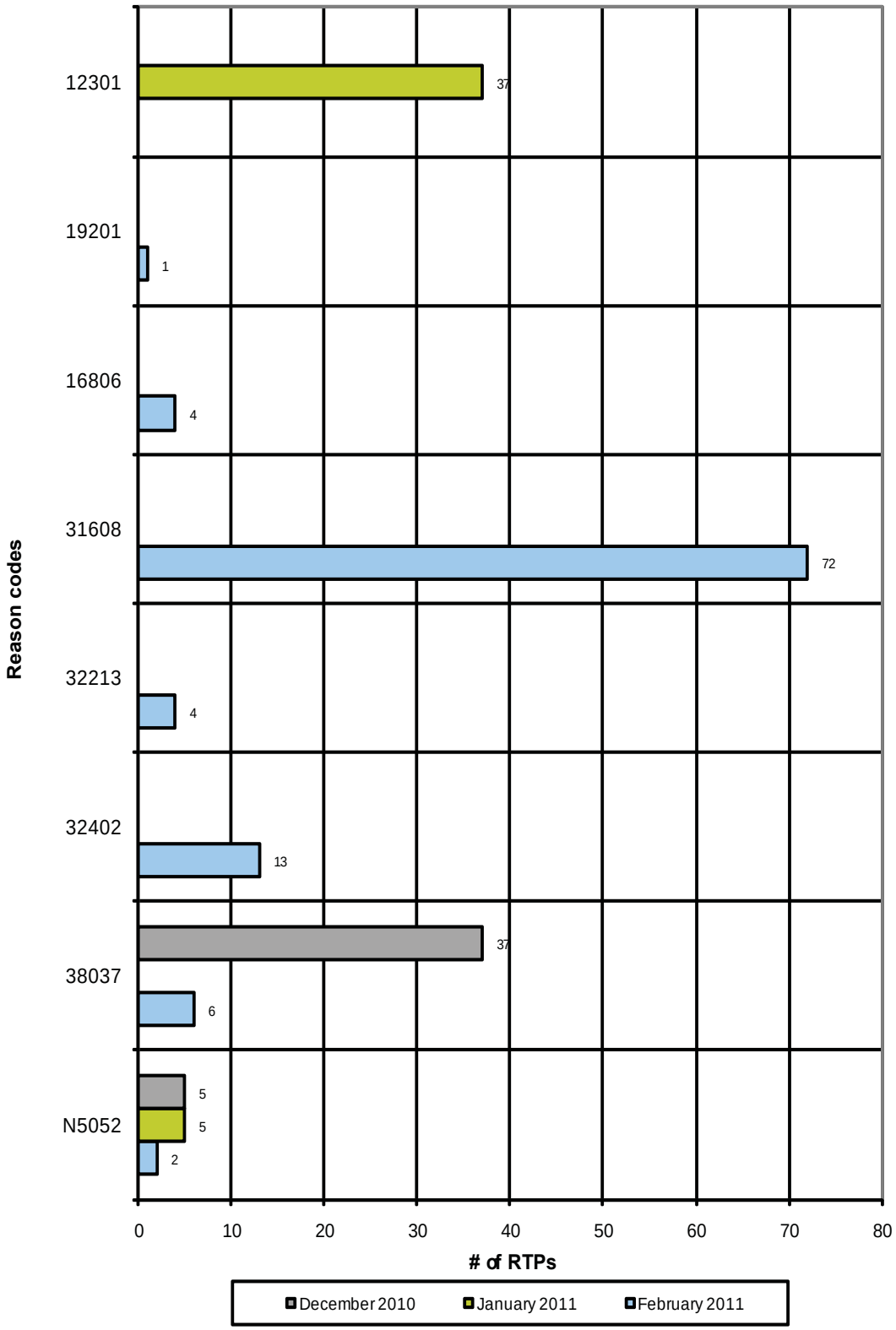
Inquiries, RTP, reject...*continued*

U.S. Virgin Islands Part A top return to providers (RTPs) for December 2010-February 2011



GENERAL COVERAGE

Smoking- and tobacco-use cessation counseling

Note: This article was revised on February 24, 2011, to add a reference to MM5878 in the Additional Information section. MM5878 announced replacement codes for the temporary G-codes discussed in this article. All other information remains the same. This information was previously published in the Fourth Quarter *Medicare A Bulletin*, pages 33-34.

Provider types affected

Physicians, other Medicare-recognized practitioners, and providers billing Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers for smoking and tobacco-use cessation counseling

Provider action needed

Stop – impact to you

Medicare Part B covers two new levels of counseling, intermediate and intensive, for smoking and tobacco-use cessation, effective March 22, 2005. The coverage is limited to beneficiaries who use tobacco and have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco-use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco-use as based on the Food and Drug Administration (FDA)- approved information. Patients must be competent and alert at the time that services are provided. Two attempts are covered each year; each attempt may include a maximum of four intermediate or intensive sessions. Maximum eight sessions in one year are covered.

Caution – what you need to know

The Centers for Medicare & Medicaid Services (CMS) has established two new "G-codes" for billing for the new levels of smoking and tobacco-use cessation counseling, effective for dates of service on or after March 22, 2005.

Note: For the interim period of March 22, 2005, through July 4, 2005, when billing for smoking and tobacco-use cessation counseling, use the unlisted code 99199. On and after July 5, 2005, when billing for this counseling, use the appropriate new G-codes. Include one unit per session in the unit's field of the claim.

Go – what you need to do

Make sure your billing staff is aware of the new codes and the interim coding requirements when submitting claims for the smoking and tobacco-use cessation counseling services you provide on or after March 22, 2005.

Based on a 2004 request from the Partnership for Prevention to review the issue for a national coverage determination (NCD), CMS determined that the evidence is adequate to conclude that smoking and tobacco-use cessation counseling, based on current Public Health Service (PHS) guidelines, is reasonable and necessary for certain individuals who use tobacco and have a disease or an adverse health effect caused or complicated by tobacco-use. Patients must be competent and alert at the time that services are provided.

What is covered

When certain coverage conditions, frequency and other limitations are met, smoking and tobacco cessation counseling is covered under Medicare Part B. Medicare Part B coverage includes two attempts each year. Each attempt may include a maximum of four intermediate or intensive sessions. A total of eight sessions are covered in a 12-month period. The qualified practitioner and the patient have flexibility to choose between intermediate or intensive cessation strategies for each session.

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Smoking...*continued*

Billing codes

The following two new Healthcare Common Procedure Coding System (HCPCS) codes have been created for billing for the two new levels of smoking and tobacco-use cessation counseling Medicare now covers:

- G0375 – smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. Short descriptor: Smoke/tobacco counseling 3-10.
- G0376 – smoking and tobacco-use cessation visit; intensive, greater than 10 minutes. Short descriptor: Smoke/tobacco counseling greater than 10.

Because these new G-codes will not be in the Medicare system until July 5, 2005, for the interim period of March 22, 2005, through July 4, 2005, use the unlisted code 99199 when billing for smoking and tobacco-use cessation counseling. Include one unit per session in the units field of the claim. Effective for claims received by Medicare on or after July 5, 2005, the claim should reflect HCPCS codes G0375 or G0376 (effective back to March 22, 2005, the effective date of the new coverage).

Note: Code *99199* is carrier priced. Also, providers whose claims are subject to payment under the Outpatient Prospective Payment System (OPPS) should use the G-codes instead of *99199*. Such claims will be held by your FI until July 5, at which time they will be processed.

This additional coverage, as described by the above HCPCS codes G0375 and G0376 does not change the existing coverage for minimal cessation counseling (defined as three minutes or less in duration) bundled into the normal evaluation and management (E/M) visit.

Smoking and tobacco-use cessation counseling claims are to be submitted with the appropriate diagnosis code. Diagnosis codes should reflect the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco.

Note: Providers are reminded that they should keep on file appropriate documentation in the patient's medical records to adequately demonstrate that Medicare coverage conditions were met for any services provided and billed to Medicare for smoking and tobacco-use cessation counseling.

Physicians and other Medicare-recognized practitioners who need to bill for E&M services on the same day as smoking cessation services are billed should use the appropriate HCPCS code in the *99201-99215* range and modifier 25 to show that the E&M service is a separately identifiable service from a smoking and tobacco-use cessation counseling service.

Claims from physicians or other providers where assignment was not taken are subject to the Medicare limiting charge, meaning charges to the beneficiary may be no more than 115 percent of the allowed amount.

Smoking and tobacco-use cessation counseling services may be billed to FIs and RHHIs on types of bills (TOB) 12x, 13x, 14x, 22x, 23x, 34x, 71x, 73x, 74x, 75x, 83x, and 85x. On TOBs 71x and 73x (rural health clinics (RHCs) and federally qualified health centers (FQHCs)), FIs will pay for claims with revenue code 052x. For TOB 13x (Indian Health Service (HIS)), FIs shall accept revenue code 0510. CAH method II providers should use the appropriate revenue code in the range of 096x through 098x when reporting smoking and tobacco-use cessation counseling services. For other TOBs, on claims received on or after July 5, 2005, FIs and RHHIs will pay for G0375 and G0376 codes when accompanied by revenue code 0942 (other therapeutic services; education/ training).

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Smoking...*continued*

Payment by FIs/RHHIs is as follows:

Type of facility	Method of payment
RHCs/FQHCs	All-inclusive rate (AIR) for the encounter
IHS/Tribally owned or operated hospitals and hospital based facilities	AIR
IHS/Tribally owned or operated non-hospital based facilities	Medicare Physician Fee Schedule (MPFS)
IHS/Tribally owned or operated critical access hospitals (CAHs)	Facility Specific Visit Rate
Hospitals subject to the Outpatient Prospective Payment System (OPPS)	Ambulatory Payment Classification (APC)
Hospitals not subject to OPPS	Payment is made under current methodologies
Skilled nursing facilities (SNFs) **Note**: Included in Part A PPS for skilled patients.	Medicare Physician Fee Schedule (MPFS)
Comprehensive outpatient rehabilitation facilities (CORFs)	MPFS
Home health agencies (HHAs)	MPFS
CAHs	**Method I:** Technical services are paid at 101% of reasonable cost; **Method II:** Professional services are paid at 115% of the MPFS Data Base
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 non-covered charges policies.

Additional information

Note: When these services are provided by a clinical nurse specialist in the RHC/FQHC setting, the services are considered "incident to" and do not constitute a billable visit. In addition, Medicare will not cover tobacco cessation services for patients in an inpatient hospital stay if tobacco cessation is the primary reason for the inpatient stay.

For complete details, please see the official instructions issued to your carrier/FI/RHHI regarding this change, which may be found by going to *http://www.cms.gov/Transmittals/downloads/R562CP.pdf* and *http://www.cms.gov/Transmittals/downloads/R36NCD.pdf* on the CMS website.

The file with transmittal number 36 will contain the NCD information and the one with transmittal number 562 will contain the changes to Medicare claims processing requirements.

You may want to review MM4104, which announced the implementation (effective April 1, 2006) of the capability for providers to access the Common Working File for viewing the number of smoking and tobacco-use cessation counseling sessions a beneficiary has received. That article may be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM4104.pdf* on the CMS website.

You may also want to review MM5878, which contains information on replacement codes for the temporary G codes discussed in this article. MM5878 is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM5878.pdf* on the CMS website.

If you have questions regarding this issue, contact your carrier/FI/RHHI on their toll-free number, which is available at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

MLN Matters Number: MM3834
Related Change Request (CR) #: 3834
Related CR Release Date: May 20, 2005
Effective Date: March 22, 2005
Related CR Transmittal #: 36 and 562
Implementation Date: July 5, 2005

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MRI in Medicare beneficiaries with implanted permanent pacemakers or implantable cardioverter defibrillators

Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, A/B Medicare administrative contractors (MACs) and durable medical equipment MACs or DME MACs) for magnetic resonance imaging (MRI) services to Medicare beneficiaries are affected.

What you need to know

Effective for claims with dates of service on or after February 24, 2011, the Centers for Medicare & Medicaid Services (CMS) will allow for coverage of MRI for Medicare beneficiaries with implanted permanent pacemakers (PMs) or implantable cardioverter defibrillators (ICDs) when those beneficiaries are enrolled in clinical studies that are approved by CMS for the purpose of gaining further evidence about the utility and safety of MRI exposure. Coverage under the Coverage with Evidence Development (CED) paradigm is contingent on all the criteria at Section 220.2.C.1 of the Medicare *National Coverage Determinations (NCD) Manual*, being met. That section of the *NCD Manual* is attached to CR 7296, which is available at *http://www.cms.gov/Transmittals/downloads/R132NCD.pdf* on the CMS website.

CMS contractors will use existing clinical trial coding conventions to help identify on a claim that MRI for beneficiaries with implanted PMs or ICDs was provided pursuant to a Medicare-approved clinical study under CED. Currently, there is a clinical trial pending approval for this purpose.

Subject to this one exception for beneficiaries in CMS-approved clinical studies with implanted PMs or ICDs, Medicare will continue to retain the current contraindications at 220.2.C.1 in the *NCD Manual*.

Background

CMS recently issued a 2010 NCD that merged the magnetic resonance angiography (MRA) NCD at Section 220.3 under the NCD for MRI at Section 220.2 in Chapter 1 of the *NCD Manual*. In addition, a 2009 NCD removed a contraindication from 220.2.C.2 of the *NCD Manual* concerning blood flow measurement. Currently, coverage is limited to MRI units that have received Food and Drug Administration (FDA) premarket approval, and such units must be operated within the parameters specified by the approval. Other uses of MRI for which CMS has not specifically indicated national coverage or national non-coverage are at the discretion of Medicare's local contractors.

As noted by the requester, payment for an MRI examination is not currently covered by Medicare if certain contraindications are present. These include cardiac PMs. In June 2010, CMS received an external request to remove the contraindications for MRI for patients with implanted permanent PMs, as well as to provide Medicare coverage for patients who undergo MRI with an ICD in a clinical trial setting.

As a result of the CMS review, CR 7296 allows for an exception in coverage for patients in clinical studies approved by CMS, but retains the contraindications in other circumstances.

Additional information

The official instruction, CR 7296 was issued to your FI, RHHI, A/B MAC, and/or DME/MAC via two transmittals. The first updates *NCD Manual*, and it is at *http://www.cms.gov/Transmittals/downloads/R132NCD.pdf* on the CMS website. The second transmittal updates Medicare Claims Processing Manual, and it is at *http://www.cms.gov/Transmittals/downloads/R2171CP.pdf* on the same site.

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

MLN Matters® Number: MM7296
Related Change Request (CR) #: 7296
Related CR Release Date: March 4, 2011
Effective Date: February 24, 2011
Related CR Transmittal #: R132NCD and R2171CP
Implementation Date: April 4, 2011

Clarification to change request No. 6686 - outpatient mental health treatment limitation

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and Part A/B Medicare administrative contractors (MACs)) for Medicare beneficiaries receiving outpatient mental health services.

What you need to know

With CR 7307, the Centers for Medicare & Medicaid Services (CMS) is amending one sentence in Section 210.1 D of the *Medicare Claims Processing Manual* to clarify policy regarding application of the outpatient mental health treatment limitation to ICD-9 diagnosis codes for Alzheimer's related disorders. This sentence was changed inadvertently in a prior manual update.

The amended sentence shows that Alzheimer's related disorders are identified by Medicare contractors under ICD-9 codes that are within the 290-319 code range (290.XX or others as your Medicare contractor determines appropriate) or outside the 290-319 code range as determined appropriate by your contractor.

Background

Section 210 of the Manual was revised initially under CR 6686 (issued 10-3-09) to implement Section 102 of the Medicare Improvements and Patient Protection Act (MIPPA). The MIPPA legislation authorized a reduction in the coinsurance percentage that Medicare patients are required to pay for certain outpatient mental health treatment services. In addition to including the changed coinsurance percentages for 2010-2014, changes were made to clarify the diagnoses/services to which the limitation does and does not apply.

For claims reported with a primary diagnosis of an Alzheimer's related disorder, Medicare contractors will look to the nature of the service rendered in determining whether it is subject to the limitation.

Additional information

The official instruction, CR 7307, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2166CP.pdf* on the CMS website.

You may want to review the *MLN Matters*® article related to CR 6686 (MM6686), which may be found at *https://www.cms.gov/MLNMattersArticles/downloads/MM6686.pdf* on the CMS website.

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

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Related CR Release Date: February 25, 2011
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Related CR Transmittal #: R2166CP
Implementation Date: March 25, 2011

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Diabetes self-management training services – clarification of national standards

For qualified RDs, RNs, or pharmacists

The Centers for Medicare & Medicaid Services (CMS) recently clarified payment policy regarding the quality standards applicable to diabetes self-management training (DSMT) providers. In particular, CMS instructed contractors about the differences between the quality standards for entities following the CMS quality standards and those following the National Standards for Diabetes Self-Management Training Program (national standards).

- CMS quality standards – DSMT providers following CMS quality standards generally require a multidisciplinary team approach to the provision of DSMT services (although there is an exception to this requirement which permits a registered dietitian who is also a certified diabetes educator to individually furnish DSMT services in a rural area). In addition, CMS has noted that a dietitian may not be the sole provider of the DSMT service. CMS has instructed contractors that this exception and special note are applicable only to those entities following the CMS quality standards.
- National standards – national standards no longer require a multidisciplinary team approach, although these quality standards note that DSMT services are most effective when delivered by multidisciplinary teams consisting of a registered dietitian (RD), registered nurse (RN), and pharmacist as the key primary instructors for diabetes educators assisting in the delivery of services. Current national standards require that at least one member of the team (or, if no team, the individual furnishing the training) must be an RD, an RN, or a pharmacist. The national standards continue to call for all of the instructor(s) on the diabetes team to be certified as diabetes educator(s) or have recent educational and experiential preparation in education and diabetes management. However, the review and approval of credentials of DSMT program instructors is solely the role of the accrediting organization (listed below).

Until the *Medicare Benefit Policy Manual* is revised, contractors have been instructed to recognize that DSMT services may be furnished by an individual RD, RN, or pharmacist when those services are billed by, or on behalf of, a DSMT entity accredited as meeting the National Standards by the American Diabetes Association, Indian Health Service, or the American Association of Diabetes Educators, which are all CMS-approved accrediting organizations that use the national standards for DSMT programs. This clarification does not affect who can qualify as "certified providers" to bill for DSMT services and, as such, payment for DSMT services may only be made to a physician, individual, or other provider that bills Medicare for other services for which direct Medicare payment may be made by CMS.

When following the National Standards, RDs may submit claims and be paid directly for DSMT services, as appropriate, because RDs are permitted to bill and receive payment for other Medicare services. However, since pharmacists and RNs cannot bill and receive payment directly from CMS for these types of services, the DSMT services they furnish to Medicare beneficiaries are billed by other certified providers, as appropriate, on their behalf.

Source: CMS PERL 201102-48

Waiver of coinsurance and deductible for preventive services

Note: This article was revised on March 3, 2011, as a result of revisions to change request (CR) 7012 made on March 2, 2011. In the article, the CR release date, transmittal number, and the Internet address for accessing CR 7012 were revised. All other information remains the same. This information was previously published in the December 2010 *Medicare A Bulletin* pages 9-10.

Provider types affected

This article is for physicians, hospitals, and other providers who submit claims to Medicare fiscal intermediaries (FI), carriers, or Medicare administrative contractors (A/B MAC), for providing preventive services to Medicare beneficiaries.

What you need to know

CR 7012, from which this article is taken, implements the changes in Section 4104 of The Affordable Care Act. The CR announces that (effective for dates of service on or after January 1, 2011) Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the initial preventive physical examination (IPPE), the annual wellness visit (AWV), and for those preventive services that: 1) are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and 2) are appropriate for the individual.

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Waiver...*continued*

Background

Sections of The Affordable Care Act amend sections of

The Social Security Act to require changes in payment (with respect to deductible and coinsurance/copayment) for identified preventive services:
In addition, The Affordable Care Act waives the deductible and coinsurance/copayment for the IPPE and the AWV. The changes apply in all settings in which the services are furnished.

The following preventive services are covered by Medicare:

- Pneumococcal, influenza, and hepatitis B vaccine and administration
- Screening mammography
- Screening PAP smear and screening pelvic examination
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training (DSMT)
- Bone mass measurement
- Screening for glaucoma
- Medical nutrition therapy (MNT) services
- Cardiovascular screening blood test
- Diabetes screening tests
- Ultrasound screening for abdominal aortic aneurysm (AAA), and
- Additional preventive services (identified for coverage through the national coverage determination (NCD) process.

Currently, these are limited to human immunodeficiency virus (HIV) testing.

Preventive services that do not have a USPSTF grade A or B
The Affordable Care Act waives the deductible and coinsurance/copayment for many of the preventive services listed above because those services have a recommendation grade of A or B by the USPSTF. In other cases, the deductible and coinsurance are waived because the preventive services are clinical laboratory tests to which the deductible and coinsurance do not apply according to another section of the statute.

Several preventive services covered by Medicare do not have a USPSTF recommendation grade of A or B. These include digital rectal examinations provided as prostate screening tests, glaucoma screening, DSMT services, and barium enemas provided as colorectal cancer screening tests. In the case of a screening barium enema, the deductible is waived under another section of the statute. The deductible continues to apply to the other services and coinsurance/copayment also continue to apply to all of them.

The table in CR 7012 provides a complete list of the Healthcare Common Procedure Coding System (HCPCS) codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the AWV. CR 7012 is available at *http://www.cms.gov/Transmittals/downloads/R864OTN.pdf*.

Extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic or therapeutic
The Affordable Care Act waives the Part B deductible for colorectal cancer screening tests that become diagnostic. The Medicare policy is that the deductible is waived for all surgical procedures (*Current Procedural Terminology* [*CPT*] code range of *10000* to *69999*) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. Modifier PT has been created effective January 1, 2011, and providers and practitioners should append the modifier PT to a least one *CPT* code in the surgical range of *10000* to *69999* on a claim for services furnished in this scenario.

Additional information

You may find more information about the waiver of coinsurance and deductible for preventive services by going to CR 7012, located at *http://www.cms.gov/Transmittals/downloads/R864OTN.pdf*.

If you have any questions, please contact your FI, carrier, 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: MM7012 *Revised*
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Related CR Transmittal #: R864OTN
Implementation Date: January 3, 2011

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Annual wellness visit including personalized prevention plan services

Note: This article was revised on February 17, 2011, to reflect changes made to change request (CR) 7079. The changes made were the deletion of "voluntary advance care planning" as a specified element of the AWV, clarification that payment methodology for types of bill (TOB) 12x and 13x is based on the Medicare physician fee schedule, and that for TOBs 71x and 77x, the AWV does not qualify for separate payment with another encounter. The CR transmittal numbers, CR release date, and the Web addresses for accessing CR 7079 have also changed. All other information remains the same. This information was previously published in the December 2010 *Medicare A Bulletin,* pages 7-9.

Provider types affected

This article is for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Medicare administrative contractors [MACs], and/or fiscal intermediaries [FIs] for services provided to Medicare beneficiaries.

Provider action needed

The Affordable Care Act provides for an annual wellness visit (AWV), including personalized prevention plan services (PPPS) for Medicare beneficiaries as of January 1, 2011. CR 7079 provides the requirements for the AWV, which are summarized in this article. Make sure billing staff are aware of these services and how to bill for them.

Background

Pursuant to section 4103 of the Affordable Care Act of 2010 , the Centers for Medicare & Medicaid Services (CMS) amended sections 411.15(a)(1) and 411.15 (k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This amendment's expanded coverage is subject to certain eligibility and other limitations that allow payment for an AWV, including PPPS, for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply to the AWV. The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B.

Who is eligible to provide the AWV with PPPS?

- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act)
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in Section 1861(aa)(5) of the Act), or
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) of a physician as defined in the first bullet point of this section.

What is included in an initial AWV with PPPS?

The initial AWV providing PPPS provides for the following services to an eligible beneficiary by a health professional:

- Establishment of an individual's medical/family history.
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
- Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.
- Review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

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Wellness visit...*continued*

- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.
- Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
- Any other element(s) determined appropriate by the Secretary of Health and Human Services through the national coverage determination (NCD) process.

What would be included in a subsequent AWV/ PPPS?

In subsequent AWVs, the following services would be provided to an eligible beneficiary by a health professional:

- An update of the individual's medical/family history.
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS.
- Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- An update to the written screening schedule for the individual, as that schedule is defined in this section, that was developed at the first AWV providing PPPS.
- An update to the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWV providing PPPS.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.
- Any other element(s) determined by the Secretary through the NCD process.

Billing requirements

Two new HCPCS codes, G0438 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit, (Short descriptor – Annual wellness first) and G0439 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit, (Short descriptor – Annual wellness subseq) will be implemented January 1, 2011, through the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE).

Effective for services on or after January 1, 2011, Medicare contractors will pay claims containing these codes provided the requirements for coverage and eligibility are met. Institutional providers need to submit these claims via types of bill (TOB) 12x, 13x, 22x, 23x, 71x, 77x, or 85x. Institutional providers will be paid as follows:

- For services performed on a 12x TOB and 13x TOB, hospital inpatient Part B and hospital outpatient, payment shall be made based on the MPFS.
- For TOBs 22x and 23x, skilled nursing facilities will be paid based on the MPFS.
- Rural health clinics (TOB 71x) and federally qualified health centers (TOB 77x) will be paid based on the all-inclusive rate. However, for TOBs 71x and 77x, the AWV does not qualify for separate payment with another encounter.
- For services performed on an 85x TOB, critical access hospital (CAH), pay based on reasonable cost.
- CAHs claims (submitted on TOB 85x with revenue codes 096x, 097x, and 098x) will be paid based on MPFS.
- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

continued on next page

Wellness visit...*continued*

Other billing requirements

Remember that G0438 is for the first AWV only. Thus, submission of G0438 for a beneficiary for whom a claim with code G0438 has already been paid will result in a denial of the later G0438 with a claim adjustment reason code (CARC) of 149 (Lifetime benefit maximum has been reached for the service/ benefit category.) and a remittance advice remarks code (RARC) of N117 (This service is paid only once in a patient's lifetime.).

Remember also that the G0438 or G0439 must not be billed within 12 months of a previous billing of a G0402 (IPPE), G0438, or G0439 for the same beneficiary. Such subsequent claims will be denied with a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) and a RARC of N130 (Consult plan benefit documents/guidelines for information about restrictions for this service).

If a claim for a G0438 or G0439 is submitted within the first 12 months after the effective date of the beneficiary's first Medicare Part B coverage, it will also be denied as that beneficiary is eligible for the IPPE or "Welcome to Medicare" physical. Such claims with G0438 or G0439 will be denied with a CARC of 26 (Expenses incurred prior to coverage) and a RARC of N130.

Additional information

The official instruction, CR 7079, was issued to your carrier, FI, or A/B MAC via two transmittals. The first modified the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R2159CP.pdf*. The second transmittal updates the *Medicare Benefit Policy Manual*, which is at *http://www.cms.gov/Transmittals/downloads/R138BP.pdf.* See these two transmittals for more complete details regarding this benefit.

If you have 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: MM7079 *Revised*
Related Change Request (CR) #: 7079
Related CR Release Date: February 15, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R138BP and R2159CP
Implementation Date: April 4, 2011

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 specif c statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Screening for the human immunodeficiency virus infection

Note: This article was revised on February 24, 2011, to reflect the revised CR 6786, which was issued on February 23, 2011. The change request (CR) (and this article) were revised to change the three human immunodeficiency virus (HIV) screening G code descriptors to align with the respective descriptors in the official code files. The CR transmittal numbers, release date, and the Web address for accessing the transmittals were also changed. All other information is the same. This information was previously published in the May 2010 *Medicare A Bulletin*, pages 27-28.

Provider types affected

This article is for all physicians, providers, and clinical diagnostic laboratories submitting claims to Medicare contractors (fiscal intermediaries [FI], carriers, and Part A/B Medicare administrative contractors [A/B MAC]) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has issued a new national coverage determination (NCD) that the evidence is adequate to conclude that screening for HIV infection is reasonable and necessary for prevention or early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Caution – what you need to know

Effective for claims with dates of service on and after December 8, 2009, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries, subject to the criteria in the *National Coverage Determination (NCD) Manual*, Sections 190.14 and 210.7, and the Medicare *Claims Processing Manual* (CPM), Chapter 18, Section 130. These manual sections are attached to the transmittals, which comprise CR 6786. This article is based on CR 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.

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HIV...*continued*

Go – what you need to do

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

Background

Effective January 1, 2009, the CMS is authorized to add coverage of "additional preventive services" through the NCD process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act (MIPPA). One of those requirements is that the services be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

Consequently, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786.

  Note: 11 full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.

- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

  Note: Three tests will be covered for each term of pregnancy beginning with the date of the first test.

The USPSTF guideline upon which this policy is based contains eight increased-risk criteria. The first seven require the presence of both diagnosis codes V73.89 (Special screening for other specified viral disease) and V69.8 (Other problems related to lifestyle) for the claim to be paid. The last criterion, which covers persons reporting no increased risk factors, only requires diagnosis code V73.89 for the claim to be paid.

Note: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following three new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 outpatient code editor and the January 2011 clinical laboratory fee schedule (CLFS) updates:

- G0432 - Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
- G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening, and
- G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening.

Claims for the annual HIV screening must contain one of the new HCPCS along with a primary diagnosis code of V73.89, and when increased risk factors are reported, a secondary diagnosis code of V69.8. For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030X for claims for HIV screening.

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered.). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached.) will be used.

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (types of bills 12x, 13x, or 14x) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.

Prior to inclusion of the new G Codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code *87999* may be used when paying for these services.

Note that for HIV screening claims with dates of service on or after December 8, 2009, through July 6, 2010, and processed before CR 6785 is implemented, Medicare will not adjust such claims automatically. However, your Medicare contractor will adjust such claims that you bring to their attention.

Additional information

CR 6786 consists of two transmittals, the first of which is at *http://www.cms.gov/Transmittals/downloads/R2163CP.pdf* and that transmittal updates the *Medicare Claims Processing Manual*. The other transmittal updates Medicare's *NCD manual* and that

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HIV...*continued*

is at *http://www.cms.gov/Transmittals/downloads/R131NCD.pdf*.

If you have questions, please contact your Medicare FI, carrier, 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: MM6786 *Revised*
Related Change Request (CR) #: 6786
Related CR Release Date: February 23, 2010
Effective Date: December 8, 2009
Related CR Transmittal #: R2163CP and R131NCD
Implementation Date: July 6, 2010

2011 ambulance inflation factor and productivity adjustment

Note: This article was revised on February 17, 2011, to include the last note in the *Background* section regarding important information for provider-based ambulance services that have not converted to the 5010 format. All other information remains the same. This information was previously published in the December 2010 *Medicare A Bulletin*, pages 23-24.

Provider types affected

This article is for providers and suppliers of ambulance services who bill Medicare contractors (carriers, fiscal intermediaries [FIs], or Part A/B Medicare administrative contractors [A/B MACs]) for those services.

What you need to know

Change request (CR) 7065, from which this article is taken, provides a new procedure for reporting fractional mileage amounts on ambulance claims, effective for claims for dates of service on or after January 1, 2011. Prior to that date, mileage is reported by rounding the total mileage up to the nearest whole mile. Be sure billing personnel are aware of this change that requires ambulance providers and suppliers to report to the nearest tenth of a mile for total mileage of less than 100 miles on ambulance claims as of January 1, 2011.

Background

Currently, the Medicare *Claims Processing Manual*, Chapter 15, Sections 30.1.2 and 30.2.1 require that ambulance providers and suppliers submitting claims to Medicare contractors use the appropriate Healthcare Common Procedure Coding System (HCPCS) code for ambulance mileage to report the number of miles traveled during a Medicare-reimbursable trip for the purpose of determining payment for mileage. According to these instructions from the Centers for Medicare & Medicaid Services (CMS), providers and suppliers are required to round the total mileage up to the nearest whole mile, including trips of less than one whole mile. For example, if the total number of round trip miles traveled equals 9.5 miles, the provider or supplier enters 10 units on the claim form or the corresponding loop and segment of the ANSI X12N 837 electronic claim. For ambulance suppliers submitting claims to the Medicare carriers or A/B MACs, the Medicare *Claims Processing Manual*, Chapter 26, Section10.4 additionally states that at least one (1) unit must be billed in Item 24G on the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12N 837P electronic claim. Therefore, if a supplier travels less than one mile during a covered trip, the supplier would enter one unit on the claim form with the appropriate HCPCS code for mileage.

In the CY 2011 Medicare physician fee schedule (MPFS) final rule, CMS established a new procedure for reporting fractional mileage amounts on ambulance claims to improve reporting and payment accuracy. The final rule requires that, effective January 1, 2011, all Medicare ambulance providers and suppliers bill mileage that is accurate to a tenth of a mile.

Note: Currently the hardcopy UB-04 form cannot accommodate fractional billing, therefore, hardcopy billers will continue to use previous ambulance billing instructions provided in effect prior to January 1, 2011, that is, providers that are permitted to file paper UB-04 claims will continue to round up to the nearest whole mile until further notice from CMS.

Effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers must report mileage units rounded up to the nearest tenth of a mile for all claims (except hard copy billers

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Ambulance inf ation...*continued*

that use the UB-04) for mileage totaling less than 100 covered miles. Providers and suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). Medicare contractors will truncate mileage units with fractional amounts reported to greater than one decimal place (e.g., 99.99 will become 99.9 after truncating the hundredths place).

For trips totaling 100 miles and greater, suppliers must continue to report mileage rounded up to the nearest whole number mile (e.g., 999). Medicare contractors will truncate mileage units totaling 100 and greater that are reported with fractional mileage; (e.g., 100.99 will become 100 after truncating the decimal places).

For mileage totaling less than one mile, providers and suppliers must include a "0" prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Medicare contractors will automatically default "0.1" unit when the total mileage units are missing in Item 24G of the CMS-1500 claim form.

Note: The remittance advice for provider-based ambulance services will indicate whole units, rather than fractions, for providers that have not transitioned to the 5010 format. However, the payment reported on the remittance advice may be paid based off fractional mileages as reported on the institutional claim.

Additional information

The official instruction, CR 7065, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2103CP.pdf*.

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

MLN Matters® Number: MM7065 *Revised*
Related Change Request (CR) #: 7065
Related CR Release Date: November 19, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2103CP
Implementation Date: January 3, 2011

Manual updates – ambulance claims billing instructions and fee schedule payment rates

Note: This article was revised on February 23, 2011, to reflect the revised change request (CR) 7018 issued on February 21, 2011. In this article, the CR transmittal number, release date, effective date, implementation date, and the Web address for accessing CR 7018 were revised. All other information remains the same. This information was previously published in the January 2011 *Medicare A Bulletin*, page 39.

Provider types affected

Ambulance providers/suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for ambulance services provided to Medicare beneficiaries.

What you need to know

This article is based on CR 7018, which updates the Medicare *Claims Processing Manual* to note provisions extending several ambulance payment rate increases that were recently enacted by the Affordable Care Act of 2010. Specifically, the Affordable Care Act extends the increases of 3 percent for rural services and 2 percent for urban services through December 31, 2010. These increases had been initially required by the Medicare Modernization Act and were extended by the Medicare Improvements for Patients and Providers Act of 2008. CR 7018 also corrects the same manual's Chapter 15, Section 30.1.2 to specify that the correct field for reporting the ZIP code of the point-of-pickup of an ambulance trip on a CMS-1500 claim form is Item 23, instead of item 32 as previously mentioned in that manual section.

If entities billing for ambulance services choose to submit claims in the 5010 837P electronic claim format on or after January 1, 2011, they must comply with the requirement that a diagnosis code be included on the claim. CMS will not be capable of accepting claims submitted under the 5010 version of the 837P that do not comply with this requirement. (See *MLN Matters* article SE1029, released September 24, 2010, at *http://www.cms.gov/MLNMattersArticles/downloads/SE1029.pdf* for details.) In addition, the

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Manual updates...*continued*

loaded ambulance trip's destination information will be required on the 5010 837P electronic claim format. CR 7018 amends Chapter 15 to include these instructions.

Additional information

The official instruction, CR 7018, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2162CP.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: MM7018 *Revised*
Related Change Request (CR) #: 7018
Related CR Release Date: February 22, 2011
Effective Date: March 21, 2011
Related CR Transmittal #: R2162CP
Implementation Date: March 21, 2011

Affordable Care Act – Section 3113 – laboratory demonstration for certain complex diagnostic tests

Note: This article was revised on March 29, 2011, to reflect a revised CR 7278, which was issued on March 10, 2011. In this article, the transmittal date, transmittal numbers, and the Web addresses for accessing the transmittals were revised. All other information is the same. This information was previously published in the February 2011 *Medicare A Bulletin,* pages 7-8.

Provider types affected

Clinical laboratories, hospitals and physicians submitting claims for certain complex diagnostic tests provided to Medicare beneficiaries to fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs) may be affected by this article.

Provider action needed

Stop – impact to you

Section 3113 of the Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years beginning July 1, 2011, or until the one hundred million dollar ($100,000,000) payment ceiling established for the demonstration has been reached.

Caution – what you need to know

The demonstration will establish a separate payment method for the demonstration tests with a date of service (DOS) that would, under standard Medicare rules, be bundled into the payment for an associated hospital inpatient stay. Under the demonstration, independent and hospital-based laboratories may bill separately for demonstration tests that are ordered within a 14 day period after a hospital discharge.

Note: Outpatient prospective payment system (OPPS) services, provided as part of an outpatient encounter, are currently separately payable and are, therefore, excluded from this demonstration.

Go – what you need to do

Change request (CR) 7278, on which this article is based, explains how to bill for the demonstration tests. Please read the *Background* section for billing information for these claims. Be sure your staff is aware of these changes.

Background

The Affordable Care Act requires CMS to conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years, beginning July 1, 2011, or until the one hundred million dollar ($100,000,000) payment ceiling has been reached. The demonstration will establish a separate payment method for these tests with a DOS that would, under standard Medicare rules, be bundled into the payment for an associated hospital inpatient stay.

Complex diagnostic laboratory test defined

Under this demonstration, the term "complex diagnostic laboratory" means a diagnostic laboratory test that is:

- An analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay
- Determined by the Secretary of Health and Human Services to be a laboratory test for which there is not an alternative test having equivalent performance characteristics
- Billed using a Health Care Procedure Coding

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Affordable Care Act...*continued*

System (HCPCS) code other than a not otherwise classified code under the Coding System

- Approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act, and
- Described in Section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)). This section of the Social Security Act may be found at *http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm*.

DOS rule

The DOS rule determines whether or not the laboratory service, under standard Medicare rules, is bundled into the diagnosis-related group (DRG) payment made to the hospital. In general, the DOS must be the date the specimen was collected.

- The test/service is bundled into the DRG if: 1) the test/service is ordered by the patient's physician less than 14 days following the date of the patient's discharge from the hospital; 2) the specimen was collected while the patient was undergoing a hospital surgical procedure; 3) it would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted; 4) the results of the test/service do not guide treatment provided during the hospital stay; and 5) the test/service was reasonable and medically necessary for treatment of an illness.
- The test/service is not bundled into the DRG if the test/service is ordered by the patient's physician greater than 14 days following the date of the patient's discharge from the hospital, allowing laboratories to directly bill Medicare Part B for the service.

Under the demonstration, CMS will allow independent and hospital-based laboratories to bill separately for certain complex diagnostic laboratory services that are ordered within a 14-day period after a hospital discharge. The DOS of the clinical diagnostic laboratory service must also be within the demonstration period, which runs from July 1, 2011, through June 30, 2013, inclusive, unless the dollar threshold is reached prior to June 30, 2013. Claims may be rejected if the DOS is greater than 14 days following the date of the patient's discharge from a covered hospital stay.

Section 3113 Demonstration Fee Schedule

All HCPCS codes included in this demonstration will be identified on a "Section 3113 Demonstration Fee Schedule". This fee schedule will be used to pay for HCPCS codes included in the demonstration and billed, using the demonstration project identifier 56, which needs to be entered:

- In item 19 on the CMS-1500 form
- In locator 63 on the UB04 form
- On the electronic claim in X12 837 Professional Claim (HIPAA version) in Loop 2300, REF02, REF01+P4, and
- On the X12 837 Institutional claim (HIPAA version) in Loop 2300, REF02, G1 in REF01 DE 128.

Claims submitted with the 56 project identifier without a HCPCS code involved in the demonstration will be rejected with a reason code 96 (Non-covered charge(s)) and a remark code of M114 (This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a demonstration project. For more information regarding these projects, contact your local contractor.) Claims submitted with the project identifier 56 with a DOS outside the date range of the demonstration or after the $100,000,000 limit is reached will be rejected with these same codes.

Payment under the demonstration is voluntary and available to any laboratory nationwide. There will be no locality variation on the Section 3113 Demonstration Fee Schedule.

HCPCS codes included in the demonstration project will be posted at *http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1240611&intNumPerPage=10* on the CMS website.

By submitting a claim with the Section 3113 Demonstration Project Identifier 56, the laboratory agrees to cooperate with the independent evaluation and the implementation contractors selected by CMS for purposes of this demonstration project. This may include providing data needed to assess the impact of the demonstration and participating in surveys and/or site visits as requested by these contractors.

Announcements and updates

Announcements and updates about this demonstration will be made via the project listserv available at: *https://list.nih.gov/cgi-bin/wa.exe?SUBED1=MEDICARE_LAB_DEMO&A=1*.

Note: Claims with the demonstration project identifier 56 may be rejected after the one hundred million dollar ($100,000,000) payment ceiling has been met.

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Affordable Care Act...*continued*

Additional information

The official instruction, CR 7278, was issued to your FI, carrier, and A/B MAC regarding this change in two transmittals. One transmittal revised the *Medicare Claims Processing Manual* and it may be viewed at *http://www.cms.gov/Transmittals/downloads/R2173CP.pdf*. The other transmittal revised the *Demonstrations Manual* and it is available at *http://www.cms.gov/Transmittals/downloads/R70DEMO.pdf*.

MLN Matters® Number: MM7278 *Revised*
Related Change Request (CR) #: 7278
Related CR Release Date: March 10, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2173CP & R70DEMO
Implementation Date: July 5, 2011

Expansion of Medicare telehealth services for calendar year 2011

Note: This article was revised on March 1, 2011, to reflect a revised CR 7049 that was issued on February 28, 2011. The CR was revised to show that implementation will not occur until April 4, 2011, by fiscal intermediaries and A/B MACs that use the Fiscal Intermediary Shared System to process claims. Also, Medicare contractors will not reprocess claims that are processed prior to the implementation dates above. They will adjust such claims that you bring to their attention. The CR release date, transmittal numbers, and the Internet address for accessing the CR have been revised. All other information remains the same. This information was previously published in the December 2010 *Medicare A Bulletin,* pages 15-17.

Provider types affected

This article is for physicians, non-physician practitioners (NPPs), hospitals, and skilled nursing facilities (SNFs) submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for telehealth services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7049 to alert providers that 14 Healthcare Common Procedure Coding System (HCPCS) codes were added to the list of Medicare telehealth services for:

- Individual and group kidney disease education (KDE) services;
- Individual and group diabetes self-management training (DSMT) services;
- Group medical nutrition therapy (MNT) services;
- Group health and behavior assessment and intervention (HBAI) services; and
- Subsequent hospital care and nursing facility care services.

Make sure your billing staffs are aware of these changes.

Background

As noted in the 2011 "Medicare Physician Fee Schedule Final Rule" published on November 29, 2010, CMS is adding 14 codes to the list of Medicare distant site telehealth services for individual and group KDE services, individual and group DSMT services, group MNT services, group HBAI services, and subsequent hospital care and nursing facility care services. Payment for these services will be made at the applicable physician fee schedule (PFS) payment amount for the service of the physician or practitioner. CR 7049 adds the relevant policy instructions to the Medicare *Claims Processing Manual* and the Medicare *Benefit Policy Manual* and those changes may be reviewed by consulting CR 7049 at *http://www.cms.gov/Transmittals/downloads/R2168CP.pdf* and *http://www.cms.gov/Transmittals/downloads/R140BP.pdf* .

Key points of CR 7049

CMS is adding the following requested services to the list of Medicare telehealth services for CY 2011:

- Individual and group KDE services:
  - HCPCS code G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour)
  - HCPCS code G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour)
- Individual and group DSMT services (with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training):

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Telehealth...*continued*

- HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes)
- HCPCS code G0109 (Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes)

- Group MNT and HBAI services, *Current Procedural Terminology* (*CPT*) codes:
  - *97804 (Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes)*
  - *96153 (Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)*
  - *96154 (Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present))*
- Subsequent hospital care services, with the limitation of one telehealth visit every three days; *CPT* codes:
  - *99231 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital f oor or unit)*
  - *99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication)*
  - *99233(Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a signif cant complication or a signif cant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital f oor or unit)*
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days, *CPT* codes:
  - *99307 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 10 minutes at the bedside and on the patient's facility f oor or unit)*
  - *99308 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the* nature of the problem(s) and the patient's *and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility f oor or unit)*
  - *99309 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a signif cant complication or a signif cant new problem. Physicians typically spend 25 minutes at the bedside and on the patient's facility f oor or unit)*

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Telehealth...*continued*

- *99310 (Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a signif cant new problem requiring immediate physician attention. Physicians typically spend 35 minutes at the bedside and on the patient's facility f oor or unit*

Note: The frequency limitations on subsequent hospital care and subsequent nursing facility care delivered through telehealth do not apply to inpatient telehealth consultations. Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS codes (G0406, G0407, G0408, G0425, G0426, or G0427) when reporting consultations furnished via telehealth.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner.

- For dates of service (DOS) on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GQ or GT.
- For dates of service on or after January 1, 2011, Medicare contractors will accept and pay the added codes according to the appropriate physician or practitioner fee schedule amount when submitted with a modifier GQ or GT by critical access hospitals (CAHs) that have elected Method II on TOB 85x.

Additional information

Your Medicare contractor will not search their files to reprocess any impacted claims that were processed prior to the implementation dates above. However, they will adjust such claims that you bring to their attention.

If you have questions, please contact your Medicare A/B MAC, carrier and/or FI at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. CR 7049 adds the relevant policy instructions to the *Medicare Claims Processing Manual* and the "*Medicare Benefit Policy Manual*" and those changes may be reviewed by consulting CR 7049 at *http://www.cms.gov/Transmittals/downloads/R2168CP.pdf* and *http://www.cms.gov/Transmittals/downloads/R140BP.pdf*.

MLN Matters® Number: MM7049 *Revised*
Related Change Request (CR) #: 7049
Related CR Release Date: February 28, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2168CP and R140BP
Implementation Date: January 3, 2011, (for those billing carriers or A/B MACs); April 4, 2011, (for those billing fiscal intermediaries or A/B MACs)

Hospice benefit policy manual update – new certification requirements and revised conditions of participation

Note: This article was changed on March 21, 2011, to change the URL for the podcast (*http://www.cms.gov/MLNProducts/MLM/list.asp*) in the News Flash. All other information remains the same.

Provider types affected

This article is for hospice providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 7337, from which this article is taken, announces changes/clarifications in the *Medicare Benefit Policy Manual*, including updates to the hospice Conditions of Participation (CoP) section (related to bereavement, the establishment of the plan of care, personnel requirements, physician contracting requirements, core services, and non-core services), and the certification section, along with some minor technical edits..

You should make sure that these clarifications are incorporated into your care of hospice patients.

Background

Under Section 1861(dd) of the Social Security Act (the Act), the Secretary of Health and Human Services is responsible for ensuring that the Conditions of Participation (CoP), and their enforcement are adequate to protect the health and safety of individuals under hospice care. The hospice CoPs were originally published in the *Federal Register* on December 16, 1983, (48 FR 56008), and were amended on December 11, 1990, (55 FR 50831) largely to implement provisions of Section 6005(b) of the Omnibus Budget Reconciliation Act of 1989; revised CoPs were published in the June 5, 2008, Hospice Conditions of Participation Final Rule (73 FR 32088).

The August 6, 2009, Hospice Wage Index Final Rule (74 FR 39384) required that certifications and re-certifications include a brief narrative describing the clinical basis for the patient's prognosis.

Finally, with passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners (NPs) to have a face-to-face encounter with Medicare hospice patients prior to the 180th-day recertification and every recertification thereafter, and to attest that the encounter occurred. The Centers for Medicare & Medicaid Services (CMS) implemented the policies related to this new requirement (which became effective on January 1, 2011,) in the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372).

CR 7337, from which this article is taken, announces that Chapter 9 (Coverage of Hospice Services Under Hospital Insurance) of the *Medicare Benefit Policy Manual* is being revised to include the existing policies described above (which were implemented through notice-and-comment rulemaking), and to make a few technical corrections to the manual.

The manual revisions are attached to CR7337, which is available at *http://www.cms.gov/Transmittals/downloads/R141BP.pdf* on the CMS website. A synopsis of the major manual revisions and technical edits is as follows:

Manual revisions

- **Section 20.1 (Timing and Content of Certif cation)**

  Initial certifications may be completed up to 15 days before hospice care is elected, and for the subsequent periods, re-certifications may be completed up to 15 days before the next benefit period begins.

  In addition, as of October 1, 2009, physicians must briefly synthesize the clinical information supporting the terminal diagnosis in a narrative, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The certifications or recertifications must be signed and dated by the physician(s), and provide the benefit period dates that the certification or recertification covers.

  The physician's brief narrative explanation of the clinical findings that supports a life expectancy of six months or less must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.

  The narrative must be included as part of the certification and recertification forms, or as an addendum to the certification and recertification

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forms. If the narrative is part of the certification or recertification form, it must be located immediately above the physician's signature, or if it is an addendum to the certification or recertification form, (in addition to the physician's signature on the certification or recertification form), the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.

For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement, and the patient would cease to be eligible for the benefit.

Also for recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification (and every subsequent recertification) must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.

The face to face encounter must meet the following criteria:

1. Timeframe – the encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter; except as noted in item 4 below.
2. Attestation requirements – a hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a NP performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course.
3. Practitioners who can perform the encounter – a hospice physician or a hospice NP can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice, however a hospice nurse practitioner must be employed by the hospice. (A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.)
4. Timeframe for exceptional circumstances – in cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face to face encounter which occurs within two days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face to face encounter, a face to face encounter can be deemed as complete.

- **Section 40.2.3 Bereavement Counseling**

  Bereavement counseling consists of counseling services provided to the individual's family both before and after the individual's death.

- **Section 40.3 Physician Contracting**

  A hospice may contract for physician services as specified in the CoPs. The hospice medical director must supervise all physician employees, as well as those under contract.

- **Section 40.4 (Core Services)**

  The following are hospice core services:

  - Physician services;
  - Nursing services, (routinely available and/or on call on a 24-hour basis, seven days a week) provided by or under the supervision of a registered nurse (RN) functioning within a plan of care developed by the hospice interdisciplinary group (IDG) in consultation with the patient's attending physician, if the patient has one;

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- Medical social services by a qualified social worker under the direction of a physician; and
- Counseling (including, but not limited to, bereavement, dietary, and spiritual counseling) with respect to care of the terminally ill individual and adjustment to death. (The hospice must make bereavement services available to the family and other individuals identified in the bereavement plan of care up to one year following the death of the patient.)

Except for physician services, your employees must routinely provide substantially all of the core services, and in a manner consistent with acceptable standards of practice. However, under extraordinary or other non-routine circumstances, you may use contracted staff (if necessary) to supplement your employees in order to meet patients' needs. Arranged services must be supported by written agreements that require that all services be: 1) Authorized by the hospice; 2) Furnished in a safe and effective manner by qualified personnel; and 3) Delivered in accordance with the patient's plan of care. To ensure the provision of quality care, the hospice must retain administrative and financial management, and oversight of all arranged staff and services.

Highly specialized nursing services
You may contract for the services of a registered nurse if the services are highly specialized and provided non-routinely, and so infrequently that the direct provision of such services would be impracticable and prohibitively expensive. Highly specialized services are determined by the nature of the service and the nursing skill level required to be proficient in the service. For example, you may need to contract with a pediatric nurse if you care for pediatric patients infrequently and if employing a pediatric nurse would be impracticable and expensive.

Note: Continuous care is not a highly specialized service, because while time intensive, it does not require highly specialized nursing skills.

Waivers for certain circumstances
Hospices are prohibited from contracting with other hospices and non-hospice agencies for the provision of the core services of nursing, medical social services and counseling to hospice patients; but may enter into arrangements with another hospice program or other entity for the provision of these core services in extraordinary, exigent, or other non-routine circumstances.

An extraordinary circumstance would generally be an unanticipated, short-term, temporary event such as periods of high patient loads, caused by an unexpectedly large number of patients requiring continuous care simultaneously, temporary staffing shortages due to illness, receiving patients evacuated from a disaster such as a hurricane or a wildfire, or temporary travel of a patient outside the hospice's service area.

You must maintain evidence of the extraordinary circumstances that required you to contract for the core services and comply with the following:

1. You must ensure that contracted staff is providing care that is consistent with the hospice philosophy and the patient's plan of care and is actively participating in the coordination of all aspects of the patient's hospice care;
2. You may not routinely contract for a specific level of care (e.g., continuous care) or for specific hours of care (e.g., evenings and week-ends); and
3. You must maintain professional management responsibility for all services provided under arrangement or contract at all times and in all settings.

Waiver for certain core nursing services
The CoPs allow CMS to waive the requirement that a hospice provide nursing services directly, if you are located in a non-urbanized area (as determined by the Bureau of the Census). In seeking this waiver, you must provide evidence to CMS that you have made a good faith effort to hire enough nurses to provide services.

Note: The location of a hospice that operates in several areas is considered to be the location of its central office.

- **Section 40.5 (Non-Core Services)**

In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), you must also provide the following services, either directly or under arrangements, to meet the your patients' and their families' needs:

- Physical and occupational therapy and speech-language pathology services;
- Hospice aide services - A hospice aide employed by a hospice, either directly or under contract, must meet the qualifications required by Section 1891(a)(3) of the Social Security Act (*http://www.socialsecurity.gov/OP_Home/ssact/title18/1891.htm*) and implemented at 42CFR418.76;

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Hospice...*continued*

- Homemaker services;
- Volunteers;
- Medical supplies (including drugs and biologicals on a 24-hour basis) and the use of medical appliances related to the terminal diagnosis and related conditions; and
- Short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid participating facility.

Section 1861(dd)(5) of the Social Security Act (*http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm*) allows CMS to permit certain waivers of the requirements that the hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling available (as needed) on a 24-hour basis. CMS is also allowed to waive the requirement that hospices provide dietary counseling directly.

As with the waivers mentioned in the section above, these are available only to an agency or organization that is located in an area which is not an urbanized area (as defined by the Bureau of Census) and that can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel.

Manual technical edits

The following edits to the manual are not policy changes, but rather are technical corrections to manual sections that were either outdated or incorrect:

- Language from 42 CFR 418.24 was added to Section 20.2 to note that in electing the hospice benefit, the patient should have a full understanding of the palliative rather than curative nature of the treatment;
- Language in Section 40.1.2 that referred to the "treatment of the patient's medical condition or to the patient's rate of recovery" was removed and replaced with language referring to the "palliation and management of the patient's terminal illness and related conditions;" and two references to the patient's recovery were removed;
- Policy in Section 40.1.9 describing ambulance transports which occur on the effective date of election was clarified to note that the transports must be to the patient's home to be covered by the ambulance benefit;
- Example 1.B in Section 40.2.1 was corrected to increase the hours of continuous care provided by a nurse, so that the total continuous home care (CHC) hours were predominantly nursing hours, in keeping with existing CHC policy;
- Outdated language related to the establishment of the plan of care was removed; and
- Terminology was updated throughout the manual, as home health aides are now known as hospice aides, and licensed vocational nurses (LVNs) were not previously mentioned.

Additional information

You can find more information about the updates to the hospice benefit policies by going to CR 7337, located at *http://www.cms.gov/Transmittals/downloads/R141BP.pdf* on the CMS website. You can find the updated *Medicare Benefit Policy Manual*, Chapter 9 as an attachment to that CR.

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

MLN Matters® Number: MM7337
Related Change Request (CR) #: 7337
Related CR Release Date: March 2, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R141BP
Implementation Date: March 23, 2011

Local Coverage Determinations

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

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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.**

ADDITIONS/REVISIONS TO EXISTING LCDS

ABotulinum Toxins: Botulinum toxins – revision to the LCD

LCD ID number: L28788 (Florida)
LCD ID number: L28790 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised on September 13, 2010. Since that time, there have been several revisions to this LCD.

- The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised in the "Food and Drug Administration (FDA) Indications for Botox®" section to add: prophylaxis of headaches in adult patients with chronic migraine (> 15 days per month with headache lasting 4 hours a day or longer). The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised in the section "Procedure Code J0585-Injection, onabotulinumtoxina, 1 unit" to add ICD-9-CM codes 346.71 and 346.73, and the "Documentation Requirements" section of the LCD has also been revised in relation to this new FDA approved indication for Botox®.

Effective date

The above revisions to the LCD are effective for claims processed **on or after March 10, 2011,** for services provided **on or after October 15, 2010.**

- The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has also been revised to add language regarding incobotulinumtoxina (Xeomin®) and a new section was added, "FDA Indications for Xeomin®". The "CPT/HCPCS Codes" section of the LCD has been revised to add HCPCS code C9399 – Unclassified drugs or biologicals and HCPCS code C9278 - Injection, incobotulinumtoxin a, 1 unit. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add a new section, "HCPCS code C9399 (effective 07/30/10-12/31/10 to report incobotulinumtoxina (Xeomin®) and HCPCS code C9278 - Injection, incobotulinumtoxin a, 1 unit (effective 01/01/11)". In addition, the "Sources of Information and Basis for Decision" section of the LCD has been updated. The LCD "Coding Guidelines" attachment has also been revised to add coding and billing information for incobotulinumtoxina (Xeomin®).

Effective date

The above revisions to the LCD are effective for claims processed **on or after March 10, 2011**, for services provided **on or after July 30, 2010**, for HCPCS code C9399 and claims processed **on or after March 10, 2011**, for services provided **on or after January 1, 2011**, for HCPCS code C9278. LCDs are available through the CMS Medicare coverage database at: *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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.

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_f nd_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.

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 most recently revised on October 1, 2010. Since that time, the LCD has been revised to add a dual diagnosis requirement for ICD-9-CM codes 279.00 (Hypogammaglobulinemia, unspecified) and V87.41 (Personal history of antineoplastic chemotherapy) under the "ICD-9 Codes that 'Support Medical Necessity" section of the LCD. The "Coding Guidelines" attachment was also updated to include the new dual diagnosis requirement. In addition, under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD new off label indications for patients with Hypogammaglobulinemia and NNI (non neutropenic infection) induced by certain chemotherapy agents were added.

All the following criteria must be met:

1. Recent treatment with rituximab in combination with cytotoxic chemotherapy.
2. Laboratory proven hypogammaglobulinemia and an absolute neutrophil count over 1,000.
3. Acute infection requiring hospitalization or an infection lasting over 2 weeks in spite of antibiotics or an infection relapsing immediately after discontinuation of antibiotics.
4. Dose: 400-600 mg/kg one time that can be repeated at a standard interval based on laboratory assessment of IG levels and persistence of non neutropenic infection.

Effective date

This LCD revision is effective for services provided **on or after April 7, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*

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 page.

ASKINSUB: Skin substitutes – revision to the LCD

LCD ID number: L28985 (Florida)
LCD ID number: L29327 (Puerto Rico/U.S Virgin Islands)

This local coverage determination (LCD) for skin substitutes was most recently revised on January 1, 2011. Since that time, under the "CPT/HCPCS Codes" section of the LCD, language was revised/added to clarify that new services must be evaluated by First Coast Service Options, Inc. (FCSO) Medicare administrative contractor (MAC) jurisdiction 9 (J9) to determine if they are medically reasonable and necessary, and that the not separately payable HCPCS codes are considered "not medically reasonable and necessary products." In addition, information was added regarding an advance beneficiary notice (ABN).

Effective date

This LCD revision is effective for services provided **on or after February 13, 2011**. FCSO LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*

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. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

ADDITIONAL INFORMATION

J1740: Boniva® (ibandronate sodium) injection program vulnerability

The Centers for Medicare & Medicaid Services (CMS) Miami Field Office recently identified a program vulnerability related to the use of Boniva® injection administered intravenously to male patients for the prevention and treatment of osteoporosis. Patients reported receiving Boniva® injection (intravenous - IV) instead of oral drugs for the treatment of osteoporosis even though there were no contraindications to the administration of oral medications, including oral Boniva®. Reportedly, patients were given Boniva® IV as prophylaxis for osteoporosis. Some patients who received Boniva® IV reported they had normal bone mineral density test results, while others were told they were being given Boniva® IV for osteopenia, rather than for osteoporosis. Patients also reported that they were not offered other treatment alternatives that are approved by the Food and Drug Administration (FDA) for males with osteoporosis.

Boniva® (ibandronate sodium) injection is a nitrogen-containing bisphosphonate that inhibits osteoclast-mediated bone resorption. Boniva® injection is administered intravenously and is approved by the FDA for the treatment of osteoporosis in postmenopausal women.

In order to be covered by Medicare, a drug or biological must be safe and effective and otherwise reasonable and medically necessary. Drugs and biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the FDA labeling. The labeling lists the safe and effective indications, dosage, and frequency of the agents.

The CMS *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50 indicates the following:

The Medicare program provides limited benefits for outpatient drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Generally, drugs and biologicals are covered only if all of the following requirements are met:

- *They meet the def nition of drugs or biologicals;*
- *They are of the type that are not usually self-administered;*
- *They meet all the general requirements for coverage of items as incident to a physician's services;*
- *They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice;*
- *They are not excluded as noncovered immunizations; and*
- *They have not been determined by the FDA to be less than effective.*

Section 50.2 of the above chapter provides guidance on determining self-administration of a drug or biological and assists with interpretation of Medicare's requirement that the drug is "not usually self-administered by the patient." This section further reflects the following:

Contractors must continue to apply the policy that not only the drug is medically reasonable and necessary for any individual claim, but also that the route of administration is medically reasonable and necessary. That is, if a drug is available in both oral and injectable forms, the injectable form of the drug must be medically reasonable and necessary as compared to using the oral form.

The following excerpt from the *Medicare Program Integrity Manual*, Pub. 100-08, Chapter 13, Section 13.5.1 indicates the following:

In order to be covered under Medicare, a service shall be reasonable and necessary. Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is all of the following:

- *Safe and effective; and*
- *Not experimental or investigational; and*
- *Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:*
  1. *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
  2. *Furnished in a setting appropriate to the patient's medical needs and condition;*
  3. *Ordered and furnished by qualif ed personnel;*

continued on next page

J1740...*continued*

4. *One that meets, but does not exceed, the patient's medical need; and*
5. *At least as beneficial as an existing and available medically appropriate alternative.*

In addition to FDA approved indications, Medicare may consider coverage of off-label uses based on guidance provided in the *Medicare Benefit Policy Manual*, Pub. 100-02, chapter 15, section 50.4.2. This manual section indicates the following:

Unlabeled Use of Drug:

FDA approved drugs used for indications other than what is indicated on the off cial label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice.

These decisions are made by the contractor on a case-by-case basis.

The Clinical Pharmacology Compendia lists the following off-label indications for Boniva® injection:

- Paget's disease,
- Osteolytic metastases in patients with prostate cancer,
- Hypercalcemia of malignancy, and
- Corticosteroid-induced osteoporosis.

Based on the CMS Miami Field Office findings which indicate Medicare is making payment for claims for male patients who are receiving Boniva® IV which does not meet FDA label or approved compendia off-label indications, a prepayment edit will be implemented in the near future. The prepayment edit will result in requests for medical records for Boniva® IV claims to allow review of the medical record documentation prior to payment for male patients. First Coast Service Options Inc. (FCSO) anticipates the publication of a draft local coverage determination (LCD) later this year for drugs used in the treatment of osteoporosis which will define FCSO's coverage indications and limitations for these medications. In the interim, Medicare providers should ensure that claims submitted to Medicare for Boniva® IV meet CMS' requirements related to intravenous versus oral administration and that patients meet FDA label or CMS approved compendia off-label indications.

Providers may have recently received requests for records for Boniva® IV claims submitted for both male and female patients. The provider must respond to these requests for documentation and submit medical records that support the services billed to the Medicare program.

64999: Blood brain barrier osmotic disruption for treatment of brain tumors – national coverage determination

The national coverage determination (NCD) for blood brain barrier osmotic disruption for treatment of brain tumors (*Medicare National Coverage Determinations Manual*, Pub. 100-03, chapter 1, section 110.20) was effective for services provided on or after March 20, 2007. According to the NCD, the Centers for Medicare & Medicaid Services (CMS) determined that the use of osmotic blood brain barrier disruption is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors. First Coast Service Options Inc. has identified the following diagnoses as not reasonable and necessary based on this NCD.

- 191.0-191.9 (malignant neoplasm of brain)
- 198.3 (secondary malignant neoplasm of brain and spinal cord)

Effective date

This article serves as a 45-day notice that blood brain barrier osmotic disruption is considered not reasonable and necessary when billed with diagnoses 191.0-191.9 or 198.3 effective for services provided **on or after April 22, 2011**.

HOSPITAL SERVICES

Important graduate medical education notices for teaching hospitals

Attention all teaching hospitals: The purpose of this article is to inform you of two notices regarding graduate medical education (GME) that the Centers for Medicare & Medicaid Services (CMS) issued in the Federal Register.

A. Interim final rule with comment period on Medicare GME affiliation agreements

An interim final rule with comment period went on display on March 11, 2011, at the Office of the Federal Register, and can be viewed at *http://www.ofr.gov/OFRUpload/OFRData/2011-05960_PI.pdf.* This interim final rule with comment period (IFC) implements section 203 of the Medicare and Medicaid Extenders Act (MMEA) of 2010, which amended section 5503 of the Affordable Care Act, relating to the treatment of teaching hospitals that are members of a Medicare graduate medical education affiliated group for the purpose of determining possible full time equivalent resident cap reductions. This IFC will be published in the *Federal Register* on March 14, 2011. Section 203 of the MMEA is enacted as if it is part of Section 5503 of the Affordable Care Act, and therefore, like Section 5503, it will be effective on July 1, 2011. The comment period for this IFC will close on April 13, 2011. If you wish to submit a comment, please refer to the instructions in the IFC for doing so. Once published, this interim final rule with comment period will be visible on the CMS website for direct graduate medical education at (*http://www.cms.gov/AcuteInpatientPPS/06_dgme.asp*).

B. Calendar year (CY) 2011 outpatient prospective payment system (OPPS) correction notice

On March 10, 2011, CMS issued a correction notice in the *Federal Register* (CMS-1504-CN) to correct technical errors that appeared in the CY 2011 OPPS final rule published on November 24, 2010 (75 FR 71800). The correction notice can be found at *http://www.gpo.gov/fdsys/pkg/FR-2011-03-11/pdf/2011-5674.pdf*. While this correction notice makes corrections relevant to the OPPS, there are also important changes to the GME portion of the November 24, 2010, final rule. A summary of the GME corrections follows.

Effective date: This correction notice is effective on January 1, 2011.

Summary of GME corrections:

1. On page 72223 of the November 24, 2010, OPPS final rule, in the first column, in the first full paragraph, in lines 14 through 23 the sentence starting with the word "Therefore," is corrected as follows:

   "Therefore, because applications under section 5506 are program-specific, we believe that a hospital that is applying for slots for use in a geriatrics program should not be precluded from also applying for slots for other programs (although the requests for those other programs, even other primary care or surgery programs, would fall under other Ranking Criteria)."

   Under this correction, if a hospital applies for slots for only a geriatrics program and other primary care (or general surgery) programs, rather than the other primary care (or general surgery) request falling under Ranking Criterion #7, the primary care (or general surgery) request for slots may now fall under Ranking Criteria #s 5 or 6, as applicable. The request for geriatrics slots would continue to fall under Ranking Criterion #4.

2. On page 72230 of the November 24, 2010, OPPS final rule, we made five corrections to the table titled, "List of teaching hospitals that have closed on or after March 23, 2008, and before August 3, 2010." These changes include changing Muhlenberg Regional Medical Center's CBSA from 35620 to 35084; adding Cherry Hospital and attending information to the table, as depicted below; changing the IME cap for Touro Rehabilitation Center from "2.99" to "0.00"; and changing the IME cap for Mid-Missouri Mental Health Center from "1.25" to "0.00."

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Graduate medical education...*continued*

Here is the corrected table:

Provider No.	Provider Name	Terminating Date	DGME Cap	IME Cap	Sec. 422 Increase/ Decrease DGME	Sec. 422 Increase/ Decrease IME	CBSA
01-0064	Physicians Carraway Medical Center	11/01/2008	65.08	65.08	-4.5	-4.5	13820
03-0017	Mesa General Hospital	05/31/2008	20.52	13.33	0.00	0.00	38060
14-0075	Michael Reese Hospital	06/11/2009	199.52	200.82	0.00	0.00	16974
15-0029	St. Joseph Hospital Mishawaka	07/01/2008	13.43	7.68	-3.79	-1.23	43780
19-3034	Touro Rehabilitation Center	12/31/2009	3.20	**0.00**	0.00	0.00	35380
26-4011	Mid-Missouri Mental Health Center	06/30/2009	5.33	**0.00**	0.00	0.00	17860
31-0063	Muhlenberg Regional Medical Center	08/13/2008	30.17	30.17	0.00	0.00	**35084**
31-0088	William B Kessler Memorial Hospital	03/12/2009	2.00	2.00	0.00	0.00	12100
33-0133	Cabrini Medical Center	06/16/2008	134.01	124.1	-21.36	-23.83	35644
33-0357	Caritas Health Care, Inc.	03/06/2009	190.23	190.23	-9.40	-9.40	35644
33-0390	North General Hospital	07/10/2010	57.17	54.29	-6.23	-4.08	35644
34-4003	**Cherry Hospital**	**09/01/2008**	**1.00**	**0.00**	**0.00**	**0.00**	**24140**
39-0023	Temple East Hospital	06/28/2009	2.36	2.36	0.00	0.00	37964
39-0169	Geisinger South Wilkes-Barre	07/10/2009	4.00	3.33	0.98	1.67	42540
42-0006	Charleston Memorial Hospital	11/25/2008	40.88	40.83	0.00	0.00	16700

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

Source: CMS PERL 201103-24

Medicare Dependent Hospital publication now available in print

The revised publication titled *Medicare Dependent Hospital* (revised January 2011), which is designed to provide education about Medicare dependent hospital (MDH) classification criteria and MDH payments, is now available in print format from the *Medicare Learning Network*®. To place your order, visit the "MLN Product Ordering Page" link at *http://www.CMS.gov/MLNGenInfo*.

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

Source: CMS PERL 201103-50

Fiscal year 2011 inpatient rehabilitation facility prospective payment system PC Pricer update

The fiscal year 2011 inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC Pricer has been updated with the latest provider data. The PC Pricer is ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPricer/06_IRF.asp*. If you use the IRF PPS PC Pricers, please go to the page above and download the latest version of the 2011 Pricer, posted March 10, 2011, in the Downloads 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 201103-17

January 2011 hospital outpatient prospective payment system update

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 provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 7271 which provides the January 2011 update for the OPPS, describes changes to and billing instructions for various payment policies implemented in the 2011 OPPS updates, and includes instructions addressing hold harmless payment. The January 2011 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 7271. Be sure your billing staff is aware of these changes.

Background

The Medicare and Medicaid Extenders Act of 2010 (MMEA) extends the Outpatient Hold Harmless Provision for small rural hospitals with 100 or fewer beds and all sole community and essential access hospitals and reclassification wage indices originally authorized under Section 508 of MMA. CR 7271 also includes instructions addressing hold harmless payment. The Centers for Medicare & Medicaid Services (CMS) will issue a separate notification to address the extension of Section 508 reclassification wage indices.

The January 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7252, Transmittal 2114, "January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0." The related article is at *http://www.cms.gov/MLNMattersArticles/downloads/MM7252.pdf* on the CMS website.

Key changes to and billing instructions for various payment policies implemented in the January 2011 OPPS update are detailed below.

Key OPPS updates for January 2011

Changes to device edits for January 2011

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Since January 1, 2007, CMS also has required 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 device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS rate-setting.

The most current edits for both types of device edits can be found at *http://www.cms.gov/HospitalOutpatientPPS/* on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

Payment for multiple imaging composite ambulatory payment classifications (APCs)

Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality are paid by applying a composite APC payment methodology. The services are paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The I/OCE logic determines the assignment of the composite APCs for payment. Prior to January 1, 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session.

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The composite APC payment methodology for multiple imaging services utilizes three imaging families (ultrasound, CT and CTA, and MRI and MRA) and five composite APCs: APC 8004 (ultrasound composite); APC 8005 (CT and CTA without contrast composite); APC 8006 (CT and CTA with contrast composite); APC 8007 (MRI and MRA without contrast composite); and APC 8008 (MRI and MRA with contrast composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) is assigned.

CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes. Specifically, CMS added *Current Procedural Terminology (CPT) code 74176 (computed tomography, abdomen and pelvis; without contrast material), CPT code 74177 (computed tomography, abdomen and pelvis; with contrast material(s)),* and *CPT code 74178 (computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions)* to the CT and CTA family. These codes are new for calendar year (CY) 2011. CMS also added HCPCS codes C8931 (magnetic resonance angiography with contrast, spinal canal and contents), C8932 (magnetic resonance angiography without contrast, spinal canal and contents), C8933 (magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents), C8934 (magnetic resonance angiography with contrast, upper extremity), C8935 (magnetic resonance angiography without contrast, upper extremity), and C8936 (magnetic resonance angiography without contrast followed by with contrast, upper extremity), to the MRI and MRA family. These codes were recognized for OPPS payment in the October 2010 OPPS update (Transmittal 2061, CR 7117, dated September 17, 2010). See *http://www.cms.gov/Transmittals/downloads/R2061CP.pdf* on the CMS website.

The specified HCPCS codes within the three imaging families and five composite APCs for CY 2011 are provided in Table 1 of CR 7271.

Partial hospitalization APCs

For CY 2011, CMS is creating four separate PHP per diem payment rates: two for CMHCs (for Level I and Level II PH services based on only CMHC data), and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). CMS will be implementing a two-year transition for the two CMHC PHP per diem rates to mitigate their payment reduction. The APCs for the CMHCs are: APC 0172 (Level I partial hospitalization (3 services)) and APC 0173 (Level II partial hospitalization (4 or more services)). The APCs for the hospital-based PHPs are: APC 0175 (Level I partial hospitalization (3 services)) and APC 0176 (Level Level II partial hospitalization (4 or more services)).

When a community mental health center (CMHC) provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, when a hospital-based PHP provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital-based PHP would be paid through APC 0175. When the CMHCs provide four or more services of partial hospitalization services and meet all other partial hospitalization payment criteria, the CMHC would be paid through APC 0173 and the hospital-based PHP providing four or more services would be paid through APC 0176.

The tables below provide the updated per diem payment rates:

CY 2011 median per diem costs for CMHC PHP services plus transition

APC	Group title	Median per diem costs plus transition
0172	Level I partial hospitalization (3 services) for CMHCs	$128.25
0173	Level II partial hospitalization (4 or more services) for CMHCs	$162.67

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CY 2011 median per diem costs for hospital-based PHP services

APC	Group title	Median per diem costs
0175	Level I partial hospitalization (3 services) for hospital-based PHPs	$202.71
0176	Level II partial hospitalization (4 or more services) for hospital-based PHPs	$235.79

Changes to regulations to incorporate provisions of the Health Care and Education Reconciliation Act (HCERA) 2010

Section 1301 (a) and (b) of HCERA 2010 established new requirements for CMHCs and amended the definition of a PHP. Section 1301 (a) of HCERA revised the definition of a CMHC by adding a requirement that the CMHC must provide at least 40 percent of its services to non-Medicare beneficiaries, effective April 1, 2010. Section 1301 (b) of HCERA amends the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment program offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting".

Mental health services composite APC 0034

Since CY 2009, CMS has set the annual payment rate for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment. For CY 2011, CMS is adapting a provider-specific two tiered payment approach for partial hospitalization services that distinguishes payment made for services furnished in a community mental health center (CMHC) from payment made for services furnished in a hospital. CMS has modified the titles of APCs 0172 (Level I partial hospitalization (3 services) for CMHCs) and 0173 (Level II partial hospitalization (4 or more services) for CMHCs) to solely reflect CMHC-based partial hospitalization services. Additionally, CMS has created APCs 0175 (Level I partial hospitalization (3 services) for hospital-based partial hospitalization programs (PHPs)) and 0176 (Level II partial hospitalization (4 or more services) for hospital-based PHPs) to pay for hospital-based partial hospitalization services. In accordance with CMS policy to pay for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment, for CY 2011, CMS will use the hospital-based partial hospitalization APC 0176 as the daily payment cap for less intensive mental health services provided in hospital outpatient departments and will set the CY 2011 payment rate for APC 0034 at the same rate as APC 0176. CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 10.2.1 to reflect this change. This Manual update is included as an attachment to CR 7271.

The I/OCE will continue to determine whether to pay specified mental health services individually or to make a single payment at the same rate as the APC 0176 per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. Through the I/OCE, when the payment for the specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the maximum per diem partial hospitalization payment, those specified mental health services would be assigned to APC 0034 (mental health services composite), which has the same payment rate as APC 0176, and the hospital would be paid one unit of APC 0034.

Reporting hospital critical care services under the OPPS

For CY 2010 and in prior years, the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel has defined critical care *CPT codes 99291 (critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes)* and *99292 (critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service))* to include a wide range of ancillary services such as electrocardiograms, chest X-rays and pulse oximetry. As CMS has stated in its manual instructions, hospitals should report in accordance with *CPT* guidance unless CMS instructs otherwise. For critical care in particular, CMS instructs hospitals that any services that the CPT Editorial Panel indicates are included in the reporting of *CPT code 99291* (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by the CPT Editorial Panel) should not be billed separately. Instead, hospitals should report charges for any services provided as part of the critical care services.

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Beginning January 1, 2011, under revised AMA CPT Editorial Panel guidance, hospitals that report in accordance with the *CPT* guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care. CMS will continue to recognize the existing *CPT* codes for critical care services and is establishing a payment rate based on its historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE logic will conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services will not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 160.1, to reflect the revised critical care reporting guidelines and OPPS payment policy and that revised manual chapter is included as an attachment to CR 7271.

Waiver of cost-sharing for preventive services

The Affordable Care Act waives any copayment and deductible that would otherwise apply for the defined set of preventive services to which the U.S. Preventive Services Task Force (USPSTF; see *http://www.ahrq.gov/clinic/cps3dix.htm* on the Internet) has given a grade of A or B, as well as, the Initial Preventive Physical Examination (IPPE), and the annual wellness visit (AWV) providing Personalized Preventive Plan Services (PPPS). These provisions are effective for services furnished on and after January 1, 2011. CMS is revising the *Medicare Claims Processing Manual*, Chapter 4, Section 30, which references the 25 percent copayment for screening colonoscopies and screening flexible sigmoidoscopies, effective prior to January 1, 2011, to reflect this change. This Manual revision is included as an attachment to CR 7271. Further information on the implementation of waiver of cost- sharing for preventive services as prescribed by the Affordable Care Act can be found in CR7012, Transmittal 739, issued on July 30, 2010.

Billing for tobacco cessation counseling

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. To implement this recent coverage determination, CMS created new C-codes and G-codes to report tobacco cessation counseling service. The long descriptors for both the C-codes and G-codes appear in the following table:

APC	Group title	Median per diem costs	APC Group	title
0175	Level I partial hospitalization (3 services) for hospital-based PHPs	$202.71	0175	Level I partial hospitalization (3 services) for hospital-based PHPs
0176	Level II partial hospitalization (4 or more services) for hospital-based PHPs	$235.79	0176	Level II partial hospitalization (4 or more services) for hospital-based PHPs

For dates of service between August 25, 2010, through December 31, 2010, hospital outpatient facilities must have reported either HCPCS code C9801 or C9802 for tobacco cessation counseling services. HCPCS codes C9801 and C9802 will be deleted December 31, 2010, and replaced with HCPCS codes G0436 and G0437, respectively, effective January 1, 2011. Both HCPCS codes G0436 and G0437 have been assigned to the same status indicators and APC assignments as their predecessor C-codes. Further reporting guidelines on tobacco cessation counseling services can be found in the *Medicare Claims Processing Manual*, Chapter 18, Section 150 and in CR 7133 (see the related *MLN Matters*® article at *http://www.cms.gov/MLNMatters/downloads/MM7133.pdf* on the CMS website).

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Inpatient only services

With CR 7271, CMS is adding Section 180.7 Inpatient Only Services to the *Medicare Claims Processing Manual*, Chapter 4, to clarify that OPPS does not pay hospitals for an inpatient only procedure and related ancillary services provided on the same day. The Section 180.7 added to Chapter 4 of the *Medicare Claims Processing Manual* is included as an attachment to CR 7271.

Billing for drugs, biologicals, and radiopharmaceuticals

a. Reporting HCPCS codes for all 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.

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

CMS notes that it makes packaging determinations for drugs and biologicals annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPPS payment rates for drugs and biologicals improves when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not. It is the CMS standard rate-setting methodology to rely on hospital cost and charge information as it is reported to CMS by hospitals through the claims data and cost reports. Precise billing and accurate cost reporting by hospitals allow CMS to most accurately estimate the hospital costs for items and services upon which OPPS payments are based.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a “new” drug as regulated by the 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.

b. New CY 2011 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For CY 2011, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in the following table:

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New CY 2011 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

CY 2011 HCPCS code	CY 2011 long descriptor	CY 2011 SI	CY 2011 APC
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	G	9274
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	G	9275
C9276	Injection, cabazitaxel, 1 mg	G	9276
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	G	9277
C9278	Injection, incobotulinumtoxin A, 1 unit	G	9278
C9279	Injection, ibuprofen, 100 mg	G	9279
J0638	Injection, canakinumab, 1 mg	K	1311
J1559	Injection, immune globulin (Hizentra), 100 mg	K	1312
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg	N	N/A
J2358	Injection, olanzapine, long-acting, 1 mg	K	1331
J7196	Injection, antithrombin recombinant, 50 IU	K	1332
J7309	Methyl aminolevulinate (mal) for topical administration, 16.8%, 10 mg	K	1338
Q4118	Matristem micromatrix, 1 mg	K	1342
Q4121	Theraskin, per square centimeter	K	1345

c. Other changes to CY 2011 HCPCS and *CPT* codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and *CPT* codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and *CPT* code descriptors that will be effective in CY 2011. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2010, and replaced with permanent HCPCS codes in CY 2011. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2011 HCPCS and *CPT* codes. The changes are detailed in Table 6 of CR 7271.

d. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2011

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the first quarter of CY 2011, 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 postponed beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2011, 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 2011 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2011, payment rates for many drugs and biologicals have changed from the values published in the CY 2011 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2010. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2011 release of the OPPS Pricer. CMS is not publishing the updated payment rates in CR 7271. However, the updated payment rates effective January 1, 2011, can be found in the January 2011 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp* on the CMS website.

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

The payment rates for several HCPCS codes were incorrect in the July 2010 OPPS Pricer. The corrected payment rates are listed in the following table below and have been installed in the January 2011 OPPS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Your Medicare contractor will adjust any claims that you bring to their attention which were processed for these service dates prior to implementation of the corrected Pricer.

Updated payment rates for certain HCPCS codes effective July 1-September 30, 2010

CY 2010 HCPCS code	CY 2010 SI	CY 2010 APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
A9543	K	1643	Y90 ibritumomab, rx	$30,581.01	$6,116.20
J0150	K	0379	Injection adenosine 6 MG	$13.74	$2.75
J0641	G	1236	Levoleucovorin injection	$0.73	$0.14
J2430	K	0730	Pamidronate disodium /30 MG	$15.61	$3.12
J2850	K	1700	Inj secretin synthetic human	$26.97	$5.39
J9065	K	0858	Inj cladribine per 1 MG	$24.12	$4.82
J9178	K	1167	Inj, epirubicin hcl, 2 mg	$2.06	$0.41
J9185	K	0842	Fludarabine phosphate inj	$112.61	$22.52
J9200	K	0827	Floxuridine injection	$42.31	$8.46
J9206	K	0830	Irinotecan injection	$4.23	$0.85
J9208	K	0831	Ifosfomide injection	$30.95	$6.19
J9209	K	0732	Mesna injection	$4.96	$0.99
J9211	K	0832	Idarubicin hcl injection	$40.09	$8.02
J9263	K	1738	Oxaliplatin	$4.37	$0.87
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$44.07	$8.81

f. New vaccine *CPT* codes

One new vaccine code is effective for services provided beginning January 1, 2011. That code is *90654 (inf uenza virus vaccine, split virus, preservative free, for intradermal use)* with a CY 2011 SI of E.

g. Correct reporting of biologicals when used as implantable devices

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

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

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h. Correct reporting of units for drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be one. 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 four. 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 one 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 Manua*l, 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.

i. Payment for therapeutic radiopharmaceuticals

Beginning in CY 2010, nonpass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data is unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, for January 1, 2011, the status indicator for separately payable therapeutic radiopharmaceuticals is “K” to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Nonpass-through separately payable therapeutic radiopharmaceuticals for January 1, 2011

CY 2011 HCPCS code	CY 2011 long descriptor	Final CY 2011 APC	Final CY 2011 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

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

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procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

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

When a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under the Social Security Act (Section 1861(w)(1); see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm* on the Internet), and as discussed in 42 CFR 410.28(a)(1) (See *http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr410.28.pdf* on the Internet) and defined in 42 CFR 409.3 (See *http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr409.3.pdf* on the Internet), where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and CMS would expect both services to be performed together.

k. Implementation of the FB modifier for diagnostic radiopharmaceuticals

As discussed in the CY 2011 OPPS/ASC final rule with comment period, beginning on January 1, 2011, CMS is extending the use of the "FB" modifier ("Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples") to diagnostic radiopharmaceuticals received free of charge or with full credit. Hospitals should report diagnostic radiopharmaceuticals received free of charge (including free samples or trial diagnostic radiopharmaceuticals received free of charge) by reporting the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table 10 below. In addition, hospitals should report a token charge of less than $1.01 for diagnostic radiopharmaceuticals received free of charge or with full credit. The payment amount for the procedures in the APCs listed in Table 10 below will be reduced by the full "policy-packaged" offset amount appropriate for diagnostic radiopharmaceuticals.

l. Payment offset for pass-through diagnostic radiopharmaceuticals

Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in the April 2009 OPPS CR 6416 (Transmittal 1702; see *https://www.cms.gov/transmittals/downloads/R1702CP.pdf* on the CMS website), pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used.

Effective April 1, 2009, the diagnostic radiopharmaceutical reported with HCPCS code A9582 (Iobenguane, I-123, diagnostic, per study dose, up to 15 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G". HCPCS code A9582 will continue on pass-through status for CY 2011 and therefore, when HCPCS code A9582 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code A9582 by the corresponding nuclear medicine procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

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The "policy-packaged" portions of the CY 2011 APC payments for nuclear medicine procedures may be found on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage* in the download file labeled 2011 OPPS Offset Amounts by APC.

CY 2011 APCs to which nuclear medicine procedures are assigned and for which CMS expects a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in the following table:

APCs to which nuclear medicine procedures are assigned for CY 2011

CY 2011 APC	CY 2011 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial Positron Emission Tomography (PET) imaging
0377	Level II Cardiac Imaging
0378	Level II Pulmonary Imaging
0389	Level I Non-imaging Nuclear Medicine
0390	Level I Endocrine Imaging
0391	Level II Endocrine Imaging
0392	Level II Non-imaging Nuclear Medicine
0393	Hematologic Processing & Studies
0394	Hepatobiliary Imaging
0395	GI Tract Imaging
0396	Bone Imaging
0397	Vascular Imaging
0398	Level I Cardiac Imaging
0400	Hematopoietic Imaging
0401	Level I Pulmonary Imaging
0402	Level II Nervous System Imaging
0403	Level I Nervous System Imaging
0404	Renal and Genitourinary Studies
0406	Level I Tumor/Infection Imaging
0408	Level III Tumor/Infection Imaging
0414	Level II Tumor/Infection Imaging

m. Payment offset for pass-through contrast agents

Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a "policy-packaged" drug amount greater than $20 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPPS CR 6751 (Transmittal 1882; see *http://www.cms.gov/transmittals/downloads/R1882CP.pdf* on the CMS website), CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made.

CY 2011 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 11 of CR 7271. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used. For CY 2011, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in Table 11 of CR 7271 on the same date of service, a specific pass-through payment offset determined by the procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

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For CY 2011, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. In addition, HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) describes a contrast agent that has been granted pass-through status beginning January 1, 2011, and will be subject to the payment offset methodology for contrast agents. Both HCPCS codes A9583 and C9275 will be assigned status indicator "G". Therefore, in CY 2011, CMS will reduce the payment for HCPCS code A9583 and C9275 by the estimated amount of payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast-enhanced procedure reported on the same claim on the same date as HCPCS code A9583 or C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in Table 11 below. The "policy-packaged" portions of the CY 2011 APC payments that are the offset amounts may be found on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage* in the download file labeled 2011 OPPS Offset Amounts by APC.

When HCPCS code A9583 or C9275 is billed on a claim on the same date of service as one or more procedures assigned to an APC listed in Table 11 of CR 7271, the OPPS Pricer will identify the offset amount or amounts that apply to the contrast-enhanced procedures that are reported on the claim. Where there is a single contrast-enhanced procedure reported on the claim with a single occurrence of either HCPCS code A9583 or C0275, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index value that applies to the hospital submitting the claim. Where there are multiple contrast procedures on the claim with a single occurrence of the pass-through contrast agent, the OPPS Pricer will select the contrast-enhanced procedure with the single highest offset amount and adjust the selected offset amount by the wage index value of the hospital submitting the claim. When a claim has more than one occurrence of either HCPCS code A9583 or C9275, the OPPS Pricer will rank potential offset amounts associated with the units of contrast-enhanced procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through contrast agent on the claim and adjust the total offset amount by the wage index value of the hospital submitting the claim. The adjusted offset amount will be subtracted from the APC payment for the pass-through contrast agent reported with either HCPCS code A9583 or C9275. The offset will cease to apply when each of these contrast agents expires from pass-through status. Table 11 of CR 7271 is as follows:

APCs to which a pass-through contrast agent offset may be applicable for CY 2011

CY 2011 APC	CY 2011 APC title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Transcatheter Placement of Intravascular Shunts
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration

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CY 2011 APC	CY 2011 APC title
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

Clarification of coding for drug administration services

CMS revised the Medicare *Claims Processing Manual*, Chapter 4, Section 230.2, to clarify the correct coding of drug administration services. This Manual revision is included as an attachment to CR 7271. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Although new *CPT* guidance has been issued for reporting initial drug administration services, Medicare contractors are to continue to follow the guidance given in this manual.

Changes to OPPS Pricer logic

a. Rural sole community hospitals (SCHs) and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with the Social Security Act (Section 1833(t)(13)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm* on the Internet), as added by Section 411 of Pub. L. 108-173.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2011. All copayments amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2011 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2011. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. However, there will be a change in the fixed-dollar threshold in CY 2011. The estimated cost of a service must be greater than the APC payment amount plus $2,025 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2010 was $2,175.

e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2011. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective January 1, 2011, one device is eligible for pass-through payment in the OPPS Pricer logic. Category C1749 for new Endoscope, retrograde imaging/illumination colonoscope device (implantable) has an offset amount of $0 because CMS is not able to identify a portion of the APC payment amount associated with the cost of the device. For outlier purposes, when C1749 is billed with a service included in APC 0143 or APC 0158 it will be associated with specific HCPCS in those APCs for outlier eligibility and payment.

g. Effective January 1, 2011, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2011, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2011 APC payments for nuclear medicine procedures and may be found on the CMS website.

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i. Effective January 1, 2011, there will be two contrast agents receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the "policy-packaged" portions of the CY 2011 APC payments for procedures using contrast agents and may be found on the CMS website.

j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

k. Effective January 1, 2011, CMS is adopting the Fiscal Year (FY 2011) inpatient prospective payment system (IPPS) post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of Pub. L. 108-173 to non-IPPS hospitals.

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries (FIs) or Medicare administrative contractors (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.

Outpatient provider specific file (OPSF)

CR 7271 also provides instructions to Medicare contractor on updating the OPSF.

Updating the OPSF for expiration of transitional outpatient payments (TOPs)

Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) extends the Outpatient Hold Harmless provision from January 1, 2011, through December 31, 2011, for rural hospitals with 100 or fewer beds at 85 percent of the hold harmless amount and to all SCHs and (EACHs, regardless of bed size, at 85 percent of the hold harmless amount from January 1, 2011, through December 31, 2011. Cancer and children's hospitals are permanently held harmless under Section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive transitional outpatient payments (TOPs)TOPs payments through CY 2011.

For CY 2011, small rural hospitals with 100 or fewer beds and all SCHs (and EACHs) remain eligible for a TOPS adjustment. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) requirements

Effective for OPPS services furnished on or after January 1, 2009, hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2011, Medicare contractors will maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field.

Updating the OPSF for the outpatient cost to charge ratio (CCR)

As stated in Pub 100-04, Medicare *Claims Processing Manual*, Chapter 4, Section 50.1, Medicare contractors maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider CCRs. The file of OPPS hospital upper limit CCRs and the file of statewide CCRs are located at *www.cms.hhs.gov/HospitalOutpatientPPS* under "Annual Policy Files." A spreadsheet listing the statewide CCRs also can be found in the file containing the preamble tables that appears in the most recent OPPS/ASC final rule.

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Additional information

The official instruction, CR 7271, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2141CP.pdf* on the CMS website.

The January 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7252 titled "January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0". A *Medicare Learning Network (MLN) Matters*® article MM7252, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7252.pdf* on the CMS website.

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

Related Change Request (CR) #: 7271
Related CR Release Date: January 24, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2141CP
Implementation Date: January 3, 2011

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April 2011 hospital outpatient prospective payment system update

Provider types affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Medicare administrative contractors (MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 7342 which describes changes to the OPPS to be implemented in the April 2011 OPPS update. Be sure your billing staffs are aware of these changes.

Background

Change request (CR) 7342 describes changes to and billing instructions for various payment policies implemented in the April 2011 OPPS update. The April 2011 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 this notification.

Note that the April 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7344, "April 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.1." An *MLN Matters*® article is available for that CR at *http://www.cms.gov/MLNMattersArticles/downloads/MM7344.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. The key changes in the April update are as follows:

Drugs and biologicals with payments based on average sales price (ASP) effective April 1, 2011

For calendar year (CY) 2011, payment for non pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of average sales price (ASP) plus five percent (ASP + 5 percent), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, a single payment of ASP plus six percent (ASP + 6 percent) for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the second quarter of CY 2011, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2011, CMS would again use the Part

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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 2011 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter average sales price (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 April 2011 release of the OPPS Pricer. The updated payment rates, effective April 1, 2011, will be included in the April 2011 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp* on the CMS website.

Drugs and biologicals with OPPS pass-through status effective April 1, 2011

Three drugs and biologicals have been granted OPPS pass-through status effective April 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 1 below.

Table 1 - Drugs and biologicals with OPPS pass-through status effective April 1, 2011

HCPCS code	Long descriptor	APC	Status indicator effective April 1, 2011
C9280	Injection, eribulin mesylate, 1 mg	9280	G
C9281	Injection, pegloticase, 1 mg	9281	G
C9282	Injection, ceftaroline fosamil, 10 mg	9282	G

New HCPCS codes effective for certain drugs and biologicals

One new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for April 1, 2011. This code is listed in Table 2 below and is effective for services furnished on or after April 1, 2011. HCPCS code Q2040 is replacing HCPCS code C9278 beginning on April 1, 2011.

Table 2 - New HCPCS codes effective for certain drugs and biologicals effective April 1, 2011

HCPCS Code	Long descriptor	APC	Status indicator effective April 1, 2011
Q2040	Injection, incobotulinumtoxin A, 1 unit	9278	G

Updated payment rates for certain HCPCS codes effective October 1 - December 31, 2010

The payment rates for several HCPCS codes were incorrect in the October 2010 OPPS Pricer. The corrected payment rate is listed in Table 3 below and has been installed in the April 2011 OPPS Pricer, effective for services furnished on October 1, 2010, through implementation of the January 2011 update. Claims already processed and impacted by these updates will be adjusted, as you bring such claims to the attention of your Medicare contractor.

Table 3 - Updated payment rates for certain HCPCS codes effective October 1- December 31, 2010

HCPCS Code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J0833	K	0835	Cosyntropin injection NOS	$51.32	$10.26
J1451	K	1689	Fomepizole, 15 mg	$7.14	$1.43
J3030	K	3030	Sumatriptan succinate / 6 MG	$45.71	$9.14
J7502	K	1292	Cyclosporine oral 100 mg	$3.04	$0.61
J7507	K	0891	Tacrolimus oral per 1 MG	$3.18	$0.64
J9185	K	0842	Fludarabine phosphate inj	$162.67	$32.53
J9206	K	0830	Irinotecan injection	$7.45	$1.49
J9218	K	0861	Leuprolide acetate injection	$4.50	$0.90

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April OPPS...*continued*

Updated payment rate for HCPCS code Q4118 effective January 1 - March 31, 2011

The payment rate for HCPCS code Q4118 was incorrect in the January 2011 OPPS Pricer. The corrected payment rate is listed in Table 4 below and has been installed in the April 2011 OPPS Pricer, effective for services furnished on January 1, 2011, through implementation of the April 2011 update. Claims already processed and impacted by these updates will be adjusted, as you bring such claims to the attention of your Medicare contractor.

Table 4 - Updated payment rates for HCPCS code Q4118 effective January 1 - March 31, 2011

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
Q4118	K	1342	Matristem micromatrix	$3.19	$0.64

Adjustment to status indicator for HCPCS code Q4119 effective January 1, 2011

In the CY 2011 OPPS/ASC Final Rule with comment period, CMS assigned HCPCS code Q4119, Matristem wound matrix, per square centimeter, a status indicator of "E" for services billed on or after January 1, 2011, indicating that the service is not paid by Medicare when submitted on outpatient claims. For services furnished on or after January 1, 2011, CMS is changing the status indicator for HCPCS code Q4119 to "K" to indicate that separate payment may be made for this product. HCPCS code Q4119 is assigned to APC 1351 (Matristem wound matrix, per square centimeter) with a payment rate of $5.62 and a minimum unadjusted copayment rate of $1.12 for the first quarter of CY 2011. The January 2011 price for HCPCS code Q4119 will be incorporated into the April 2011 OPPS Pricer. Claims already processed and impacted by these updates will be adjusted, as you bring such claims to the attention of your Medicare contractor.

Category I H1N1 vaccine codes

As stated in the July 2010 update of the hospital OPPS that was published in CR 6996, CMS assigned status indicator "E" to *Current Procedural Terminology (CPT) codes 90663* and *90470*. (A related *MLN Matters*® article for CR 6996 is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6996.pdf* on the CMS website) As of December 31, 2011, the American Medical Association discontinued the use of these codes. Therefore, effective January 1, 2011, *CPT codes 90663* and *90470* are being assigned a status indicator of "D" under the OPPS, to indicate that these codes are discontinued and are no longer paid under the OPPS or any other Medicare payment system.

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* (Pub.100-04, Chapter 17, Section 40; see *http://www.cms.gov/manuals/downloads/clm104c17.pdf* on the CMS website), 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.

continued on next page

April OPPS...*continued*

Reporting of outpatient diagnostic nuclear medicine procedures

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

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

Where a hospital or a non-hospital location administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under Section 1861(w)(1) of the Social Security Act and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3 where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

Use of HCPCS code C9399

As stated in the Medicare *Claims Processing Manual* (Pub. 100-04, Chapter 17, Section 90.3; see *http://www.cms.gov/manuals/downloads/clm104c17.pdf* on the CMS website), hospitals are to report HCPCS code C9399, unclassified drug or biological, solely for new outpatient drugs or biologicals that are approved by the FDA on or after January 1, 2004, and that are furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned. It is not appropriate to report HCPCS code C9399 for drugs and biologicals that are defined as usually self-administered drugs by the patient as defined in the Medicare *Benefit Policy Manual* (Chapter 15, Section 50.2; see *http://www.cms.gov/manuals/Downloads/bp102c15.pdf* on the CMS website).

New service

The following new service is assigned for payment under the OPPS:

Table 5 - New service assigned for payment under the OPPS

HCPCS	Short descriptor	Long descriptor	SI	APC	Payment rate
C9729	Percut lumbar lami	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar	T	0208	$3,535.92

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April OPPS...*continued*

Adjustment to status indicator for HCPCS code G0010 effective January 1, 2011

HCPCS code G0010 (Administration of hepatitis B vaccine) was erroneously assigned status indicator "B" effective January 1, 2011, in the January 2011 update issued in CR 7271. (An *MLN Matters*® article related to CR 7271 is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7271.pdf* on the CMS website). Therefore, retroactively effective January 1, 2011, the status indicator for HCPCS code G0010 will change from status indicator "B" (codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x)) to status indicator "S" (significant procedure, not discounted when multiple). Beginning January 1, 2011, HCPCS code G0100 will be assigned to APC 0436.

In order to ensure correct waiver of coinsurance and deductible for the administration of hepatitis B vaccines, providers should report HCPCS G0010 for billing under the OPPS rather than *CPT code 90471 (immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid))* or *CPT code 90472 (immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure))* for services performed beginning January 1, 2011.

HCPCS code Q1003 deleted effective April 1, 2011

HCPCS code Q1003 (new technology intraocular lens category 3) is currently packaged under the OPPS and is being deleted for dates of service effective April 1, 2011. For more information on the deletion of this HCPCS code, refer to the *MLN Matters*® article related to CR 7271, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7271.pdf* on the CMS website.

Additional information

The official instruction, CR 7342, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2174CP.pdf* on the CMS website.

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

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Related CR Release Date: March 18, 2011
Effective Date: April 1, 2011
Related CR Transmittal #: R2174CP
Implementation Date: April 4, 2011

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CRITICAL ACCESS HOSPITAL SERVICES

Incentive payment program for primary care services paid under the optional method

Note: This article was revised on March 11, 2011, to add a reference to MM7267 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7267.pdf*) that informs providers that the Primary Care Incentive Payment Program (PCIP) is being amended to include the participation of newly enrolled primary care physicians and NPPs who do not have a prior two year claims history with which to determine eligibility. All other information is the same. This information was previously published in the December 2010 *Medicare A Bulletin*, pages 51-53.

Provider types affected

Critical access hospitals (CAHs) under the optional method that provide primary care services to Medicare beneficiaries and bill Medicare administrative contractors (A/B MACs) or fiscal intermediaries (FIs) are impacted by this issue.

Provider action needed

Stop – impact to you

The Affordable Care Act provides for a 10 percent Medicare incentive payment for primary care services effective 2011 through 2015. Payments will be made on a quarterly basis.

Caution – what you need to know

The Affordable Care Act defines a primary care practitioner as: (1) a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (2) a nurse practitioner, clinical nurse specialist, or physician assistant, and in all cases, for whom primary care services accounted for at least 60 percent of the allowed charges under the Medicare physician fee schedule (MPFS) for the practitioner in a prior period as determined appropriate by the Secretary.

Go – what you need to do

See the *Background* section below for specifics.

Background

Section 5501(a) of The Affordable Care Act revises section 1833 of The Social Security Act and will add a new paragraph "Incentive Payments for Primary Care Services". The Social Security Act now states that in the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, there also shall be paid on a monthly or quarterly basis an amount equal to 10 percent of the payment amount for such services under the MPFS.

Note: The former "Quarterly Health Professional Shortage Area (HPSA) and Scarcity Report for Critical Access Hospital (CAHs)" is now known as the "Special Incentive Remittance for CAHs". This change is necessary as PCIP payments are made for all primary care services furnished by eligible primary care practitioners, regardless of the geographic location where the primary care services are furnished.

The PCIP payments will be based on 10 percent of 115 percent of the MPFS amount that the CAH was paid for the professional service.

Primary care services

The Affordable Care Act defines primary care services as those services identified by the following *CPT* codes:

- *99201* through *99215* for new and established patient office or other outpatient evaluation and management (E/M) visits;
- *99304* through *99340* for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home (e.g., boarding home), or custodial care E/M services; and domiciliary, rest home (e.g., assisted living facility), or home care plan oversight services; and
- *99341* through *99350* for new and established patient home E/M visits.

These codes are displayed in the table below. All of these codes remain active in calendar year (CY) 2011 and there are no other codes used to describe these services.

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PCIP...*continued*

Primary care services eligible for PCIP in CY 2011

CPT code	Description
99201	*Level 1 new patient off ce or other outpatient visit*
99202	*Level 2 new patient off ce or other outpatient visit*
99203	*Level 3 new patient off ce or other outpatient visit*
99204	*Level 4 new patient off ce or other outpatient visit*
99205	*Level 5 new patient off ce or other outpatient visit*
99211	*Level 1 established patient off ce or other outpatient visit*
99212	*Level 2 established patient off ce or other outpatient visit*
99213	*Level 3 established patient off ce or other outpatient visit*
99214	*Level 4 established patient off ce or other outpatient visit*
99215	*Level 5 established patient off ce or other outpatient visit*
99304	*Level 1 initial nursing facility care*
99305	*Level 2 initial nursing facility care*
99306	*Level 3 initial nursing facility care*
99307	*Level 1 subsequent nursing facility care*
99308	*Level 2 subsequent nursing facility care*
99309	*Level 3 subsequent nursing facility care*
99310	*Level 4 subsequent nursing facility care*
99315	*Nursing facility discharge day management; 30 minutes*
99316	*Nursing facility discharge day management; more than 30 minutes*
99318	*Other nursing facility services; evaluation and management of a patient involving an annual nursing facility assessment.*
99324	*Level 1 new patient domiciliary, rest home, or custodial care visit*
99325	*Level 2 new patient domiciliary, rest home, or custodial care visit*
99326	*Level 3 new patient domiciliary, rest home, or custodial care visit*
99327	*Level 4 new patient domiciliary, rest home, or custodial care visit*
99328	*Level 5 new patient domiciliary, rest home, or custodial care visit*
99334	*Level 1 established patient domiciliary, rest home, or custodial care visit*
99335	*Level 2 established patient domiciliary, rest home, or custodial care visit*
99336	*Level 3 established patient domiciliary, rest home, or custodial care visit*
99337	*Level 4 established patient domiciliary, rest home, or custodial care visit*
99339	*Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes*
99340	*Individual physician supervision of a patient in home, domiciliary or rest home recurring complex and multidisciplinary care modalities; 30 minutes or more*
99341	*Level 1 new patient home visit*
99342	*Level 2 new patient home visit*
99343	*Level 3 new patient home visit*
99344	*Level 4 new patient home visit*
99345	*Level 5 new patient home visit*
99347	*Level 1 established patient home visit*
99348	*Level 2 established patient home visit*
99349	*Level 3 established patient home visit*
99350	*Level 4 established patient home visit*

continued on next page

PCIP...*continued*

Eligibility for payment under the PCIP

For primary care services furnished on or after January 1, 2011, and before January 1, 2016, a 10 percent incentive payment will be provided to primary care practitioners, identified as: (1) in the case of physicians, enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics; or (2) in the case of non-physician practitioners, enrolled in Medicare with a primary care specialty designation of 50-nurse practitioner, 89-certified clinical nurse specialist, or 97-physician assistant; and (3) for whom the primary care services displayed in the above table accounted for at least 60 percent of the allowed charges under the MPFS (excluding hospital inpatient care and emergency department visits) for such practitioner during the time period that has been specified by the Secretary of Health and Human Services.

If a claim for a primary care service is submitted by a CAH paid under the optional method for an eligible primary care physician's or non-physician practitioner's professional services, the "other provider" field on the claim must be populated by the eligible primary care practitioner's national provider identifier (NPI) in order for the primary care service to qualify for the incentive payment. Primary care services potentially eligible for the incentive payment and furnished on different days must be submitted on separate CAH claims so a determination about the eligibility of the service based on the rendering practitioner can be made. If the CAH claim for a single date of service includes more than one primary care professional service, the incentive payment for all primary care services for that date, shall be made to the CAH on behalf of the eligible primary care practitioner based on the NPI in the "other provider" field. In addition to the CAH NPI, the "other provider" NPI shall be shown on the special incentive remittance for CAHs.

PCIP payments to critical access hospitals

Physicians and non-physician practitioners billing on type of bill (TOB) 85x for professional services rendered in a CAH paid under the optional method have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the CAH, payment is made to the CAH for professional services (revenue codes (RC) 96x, 97x or 98x).

The 10 percent PCIP payment is payable to a CAH billing under the optional method for the primary care professional services of eligible primary care physicians and non-physician practitioners who have reassigned their billing rights to CAH. The incentive payment is paid based on 10 percent of the 115 percent of the MPFS amount paid to the CAH for those professional services. PCIP payments are calculated by Medicare contractors and made quarterly on behalf of the eligible primary care physician or non-physician practitioner to the CAH for the primary care services furnished by the practitioner in that quarter.

The Affordable Care Act authorizes payment under the PCIP beginning in CY 2011 as an additional payment amount for specified primary care services without regard to any additional payment for the service under the existing health professional shortage area (HPSA) physician bonus payment program. Therefore, eligible primary care physicians and non-physician practitioners furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011.

Additional information

The official instruction, CR 7115 issued to your A/B MAC or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2169CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. You may also want to review *MLN Matters*® article MM7060, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7060.pdf*, for information on the incentive payment for primary care services enacted in Section 5501 of the Affordable Care Act. If you have any questions, please contact your A/B MAC or FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

MLN Matters® Number: MM7115 Revised
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Related CR Release Date: March 3, 2011
Effective Date: April 1, 2011
Related CR Transmittal #: R2169CP
Implementation Date: April 4, 2011

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SKILLED NURSING FACILITY SERVICES

Corrections to skilled nursing facility consolidated billing codes

When change request 7159 (2011 Annual Update of Healthcare Common Procedure Code System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update) was implemented in January 2011, a few codes were not included in the claim processing system edits. A correction to add the codes listed below to the claims processing system edits was implemented on Monday, March 14, 2011.

Providers who submitted claims for these services before Monday, March 14, 2011, may have had claims incorrectly denied. Providers who believe they received an incorrect denial should contact their Medicare carrier or Medicare administrative contractor (MAC) to have the claims reopened and reprocessed. Claims containing any of the codes below that were processed on or after Monday, March 14, 2011, will process correctly. Additional questions should be directed to your Medicare carrier or MAC.

The affected HCPCS codes are as follows: *76519, 76529, 76536, 76604, 76645, 76700, 76705, 76770, 76775, 76800, 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828, 76830, 76831, 76856, 76857, 76870, 76872, 76873, and 76876*.

Source: CMS PERL 201103-42

OUTPATIENT REHABILITATION SERVICES

Correction to Chapter 5, Section 20.2 of the Internet-only *Claims Processing Manual* provider types affected

Providers submitting claims to Medicare contractors (Medicare administrative contractors (A/B MACs) fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs)) for outpatient rehabilitation and comprehensive outpatient rehabilitation facility/ outpatient therapy (CORF/OPT) services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

This article is informational and is based on change request (CR) 7315 that corrects a cross reference mentioned twice in Pub. 100-04, Chapter 5, Section 20.2 of the Internet-only Medicare C*laims Processing Manual*.

Caution – what you need to know

The first reference states: "Pub. 100-02, Chapter 15, Section 230.3B, Treatment Notes, indicates that the amount of time for each specific intervention/ modality provided to the patient is not required to be documented in the Treatment Note." The second reference states: "For documentation in the medical record of the services provided see Pub. 100-02, Chapter 15, Section 230.3, Documentation, Treatment Notes."

Both cross references are incorrect as stated and should refer to Pub. 100-02, Chapter 15, Section 220.3, Treatment Notes of the Medicare *Benefit Policy Manual* versus Chapter 15, Section 230.3.

Go – what you need to do

See the official instruction attached to CR 7315. The attachment includes the corrected version of the Medicare *Claims Processing Manual* Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services; Section 20.2 Reporting of Service Units with Healthcare Common Procedure Coding System (HCPCS).

Additional information

The official instruction, CR 7315, issued to your Medicare A/B MAC, FI and RHHI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2160CP.pdf* on the CMS website.

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

MLN Matters® Number: MM7315
Related Change Request (CR) #:7315
Related CR Release Date: February 18, 2011
Effective Date: May 19, 2011
Related CR Transmittal #: R2160CP
Implementation Date: May 19, 2011

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PSYCHIATRIC SERVICES

Implementation of edits for the IPF PPS emergency department adjustment policy

Note: This article was revised on February 14, 2011, to reflect a revised change request (CR) 7072 issued on February 11, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information is the same. This information was previously published in the November 2010 *Medicare A Bulletin*, page 35.

Provider types affected

Critical access hospitals (CAH) inpatient psychiatric facilities (IPF) under the prospective payment system (PPS) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and Medicare administrative contractors (MAC)) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on CR 7072, which implements system edits to verify that the emergency department (ED) adjustment policy is correctly applied. As specified in 42 CFR 412.424(d)(1)(v)(B), the ED adjustment is not made where an inpatient is discharged from an acute care hospital or critical access hospital (CAH) and the date of such discharge is the same as the date of admission on a claim from the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in these cases because the costs associated with ED services are reflected in the diagnosis-related group (DRG) payment to the acute

Background

Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) mandated that the Secretary of Health and Human Services develop a per diem prospective payment system (PPS) for inpatient hospital services furnished in psychiatric hospitals and psychiatric units. The IPF PPS was implemented January 2005. One aspect of the IPF PPS included an ED adjustment policy.

Recently, the Office of Inspector General drafted a report, entitled: Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007, (A-01-09-00504). Based on findings in this report, CMS is implementing edits for ED adjustments where the costs for the emergency department services are already covered by another Medicare payment.

Additional information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website. The official instruction, CR 7072, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2157CP.pdf* on the CMS website.

MLN Matters® Number: MM7072
Related Change Request (CR) #: 7072
Related CR Release Date: February 11, 2011
Effective Date: April 1, 2011
Related CR Transmittal #: R2157CP
Implementation Date: April 4, 2011

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2011 inpatient psychiatric facility PPS PC Pricer update

The inpatient psychiatric facility (IPF) prospective payment system (PPS) PC Pricer has been enhanced with "Prior Days" field and logic for rate year (RY) 2011, and has been updated on the Centers for Medicare & Medicaid Services (CMS) website for claims dates from October 1, 2010, to June 30, 2011. If you use the IPF PPS PC Pricer for RY 2011, please go to the page, *http://www.cms.gov/PCPricer/09_inppsy.asp*, under the *Downloads* section, and download the latest versions of the IPF PPS RY 2011 PC Pricers, posted March 16, 2011.

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

Source: CMS PERL 201103-39

ELECTRONIC DATA INTERCHANGE

HIPAA 5010 & D.0 – implementation calendar and important reminders

During the transition to Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.0., you will be periodically reminded of important items and dates that may be of specific interest to the Medicare fee-for-service (FFS) provider/supplier community. Please see below to learn about current, upcoming, and past events that have taken placed during this implementation process.

Important implementation reminders

Announcement: January 1, 2011, marked the beginning of the 5010/D.0. transition year
Reminder: 5010/D.0. errata requirements and testing schedule can be found at *http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf*
Reminder: Contact your MAC for their testing schedule *http://www.cms.gov/Versions5010andD0/Downloads/Reminder-Contact_MAC.pdf*
Readiness assessment: Have you done the following to be ready for 5010/D.0? *http://www.cms.gov/Versions5010andD0/Downloads/Readiness_1.pdf*
Readiness assessment: What do you need to have in place to test with your Medicare administrative contractor (MAC)? *http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf*
Readiness assessment: Do you know the implications of not being ready? **(New)** *http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf*

Implementation calendar

Current events

March 2011
March 1: New readiness assessment – Do you know the implications of not being ready? *http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf*
March 30: 5010 National Call – Provider Testing and Readiness *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1244551&intNumPerPag* – in order to receive call-in information, you must register for this call. Please follow this link for details and registration information. Registration will close at 2 p.m. ET on March 29, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

Upcoming events

April 2011
TBD: MAC hosted outreach and education session -- are you ready to test?

May 2011
May 2-5: 20th Annual WEDI National Conference* *http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11917000006F1*
May 25: 5010 national call – topic to be determined (TBD)

June 2011
TBD: National MAC testing day (for vendors, clearinghouses, and billing services, etc.)

July 2011
TBD: MAC hosted outreach and education session – troubleshooting with your MAC

August 2011
August 31: 5010 national call – MAC panel
TBD: National MAC testing day (for providers)

October 2011
TBD: MAC hosted outreach and education session (last push for implementation)
October 24-27: WEDI 2011 fall conference* *http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11927000002B1*

December 2011
December 31: End of the transition year, and the beginning of 5010 production environment

Past events

June 2010
June 15: 5010 national call – ICD-10/5010 national provider call *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237787&intNumPerPage=10*
June 30: 5010 national call – 837 institutional claim transaction *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1236487&intNumPerPage=10*

continued on next page

Calendar...*continued from page 97*

July 2010
July 28: 5010 national call – 276/277 claim status inquiry and response transaction set *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237767&intNumPerPage=10*

August 2010
August 25: 5010 national call – 835 remittance advice transaction *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1238739&intNumPerPage=10*

September 2010
September 27: 5010 national call – acknowledgement transaction (TA1, 999, 277CA) *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1239741&intNumPerPage=10*

October 2010
October 13: 5010/D.0 errata requirements and testing schedule released *http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf*
October 27: 5010 national call – NCPDP version D.0 transaction *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1240794&intNumPerPage=10*

November 2010
November 4: Version 5010 resource card published *http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf*
November 8: WEDI 2010 fall conference* *http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=C31C0000002C*
November 17: 5010 national call – coordination of benefits (COB) *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241427&intNumPerPage=10*

December 2010
December 8: 5010 national call – MAC outreach and education activities and transaction-specific testing protocols *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241855&intNumPerPage=10*

January 2011
January 1: Beginning of transition year
January 11: HIMSS 5010 industry readiness update* *http://www.himss.org/asp/UnknownContent.asp?type=evt*
January 19: 5010 national call – errata/companion guides *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1243131&intNumPerPage=10*
January 25-27: 4th WEDI 5010 and ICD-10 implementation forums – advancing down the implementation highway: Moving forward with testing to attain implementation* *http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?f lterType=none&f lterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1243131&intNumPerPage=10*

February 2011
February 20-24: Healthcare Information and Management Systems Society (HIMSS) 11th annual conference & exhibition* *http://www.himss.org/ASP/eventsHome.asp*

For older national call information, please visit the 5010 National Calls section of CMS' versions 5010 & D.0. Web page at *http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage*.

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

*Information about events in which the Centers for Medicare & Medicaid Services (CMS) Medicare FFS staff participates may be applicable to the health care industry at large, though it is geared toward the Medicare FFS audience.

Source: CMS PERL 201103-15

Claim status category code and claim status code update

Provider types affected

All physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, A/B Medicare administrative contractors (MACs), durable medical equipment MACs (DME MACs) and the DME Common Electronic Data Interchange (CEDI) contractor for Medicare beneficiaries are affected.

What you need to know

This article, based on change request (CR) 7348, 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 will be updated during the June 2011 meeting of the national Code Maintenance Committee. Code changes approved at that meeting will be posted at *http://www.wpc-edi.com/content/view/180/223/* on or about July 1, 2011. 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 July 5, 2011.

Background

The Health Insurance Portability and Accountability Act (HIPPA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee 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 7348 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2177CP.pdf* on the CMS website.

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

MLN Matters® Number: MM7348
Related Change Request (CR) #: 7348
Related CR Release Date: March 18, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2177CP
Implementation Date: July 5, 2011

The countdown has begun …

Are you ready for January 1?
Schedule your HIPAA-5010 testing today!
Call 888-670-0940, Option 1

Additional information on HIPAA-5010 at *http://medicare.fcso.com/HIPAA/*

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events

May 2011

Bimonthly Medicare Part A ACT: Medicare changes and hot issues

When: Tuesday, May 10

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

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

Bimonthly Medicare Part A ACT: Medicare data and CMS initiatives

When: Tuesday, May 17

Time: 2:00 – 3:30 p.m. ET **Delivery language:** English

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

Two easy ways to register

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

PREVENTIVE SERVICES

Updated *Quick Reference Information: Medicare Immunization Billing* chart

The *Quick Reference Information: Medicare Immunization Billing* chart, which provides Medicare fee-for-service physicians, providers, suppliers, and other healthcare professionals quick information to assist with filing claims for influenza vaccine, pneumococcal vaccine, and hepatitis V virus (HBV) vaccine and the administration, has been updated and is available to download, free of charge, from the *Medicare Learning Network*®. You may view the chart at *http://www.CMS.gov/MLNProducts/downloads/qr_immun_bill.pdf*. Hardcopies will be available at a later date.

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

Source: CMS PERL 201103-32

OTHER EDUCATIONAL RESOURCES

Revised resources from the *Medicare Learning Network*

Medicare Learning Network Products Catalog

The March 2011 version of the *Medicare Learning Network*® Products Catalog is now available. The MLN Products Catalog is a free interactive downloadable document that lists all MLN products by media format. Access the catalog at *http://www.CMS.gov/MLNGenInfo* and select the "MLN Products Catalog" in the *Downloads* section. Once you have opened the catalog, you may either click on the title of a product or the type of "Formats Available."

Section 1011 fact sheet revised

The revised publication titled *Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens* (revised February 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Section_1011_Fact_Sheet.pdf*. This factsheet is designed to provide education on available funding, eligibility, and program enrollment requirements to undocumented aliens, as detailed in Section 1011 of the Medicare Modernization Act of 2003 (MMA). It also includes information about which states have exhausted payment under Section 1011 and what services are reimbursable under the program.

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

Source: CMS PERL 201103-32

Medicare Contractor Provider Satisfaction Survey fact sheet

The *Medicare Learning Network* has released a new fact sheet on the Medicare Contractor Provider Satisfaction Survey (MCPSS). The MCPSS offers Medicare fee-for-services providers and suppliers the opportunity to provide feedback on their interactions with Medicare contractors. The fact sheet is available in downloadable format and may be viewed at *http://www.CMS.gov/MLNProducts/Downloads/MCPSS_FactSheet.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 201103-50

Medicare Learning Network opinion page and revised fact sheet on dual eligibles

Medicare Learning Network opinion page

The *Medicare Learning Network*® (MLN) is interested in what you have to say. Regardless of whether you have an MLN account or not, you can evaluate the MLN products, services, and activities that you have participated in, received, or downloaded.

If you don't have an MLN account or don't want to log in, don't worry; the MLN offers a new anonymous evaluation function that allows you to complete an evaluation without logging in. Visit the MLN opinion page (*http://www.CMS.gov/MLNProducts/85_Opinion.asp*) and click on "MLN Opinion Page" in the "Related Links Inside CMS" section at the bottom of the page. Click on the underlined title of the product, service, or activity you want to evaluate and click on the "Take the anonymous evaluation for this product" link that will appear on the right-hand side. A new window will open containing the product evaluation.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services, and activities and to develop products, services, and activities that better meet your educational needs. If you have any suggestions related to MLN product topics or formats, please send them to *MLN@cms.hhs.gov*.

Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance fact sheet revised

The revised publication titled *Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance* (revised December 2011) is now available from the *Medicare Learning Network* at *http://www.CMS.gov/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf*.

Source: CMS PERL 201103-16

February 2011 *Quarterly Provider Compliance Newsletter* released

The *Medicare Learning Network*® (MLN) has released the February 2011 issue of the *Medicare Quarterly Provider Compliance Newsletter*, which is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. In this issue, a number of recovery audit findings that affect inpatient hospitals, physicians, and durable medical equipment (DME) suppliers are presented. This publication is issued on a quarterly basis and highlights the top issues of that particular quarter, as identified through a variety of sources. The current issue may be downloaded at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN905712.pdf*. An archive and searchable index of previously-issued newsletters are also now available at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.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 201102-49

The National Provider Identif er: What You Need to Know booklet revised

The booklet titled *The National Provider Identif er (NPI): What You Need to Know* (revised February 2011) has been revised and is available in downloadable format. This booklet was created to help you become more familiar with the national provider identifier (NPI) (established by final rule on January 23, 2004). Covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are required by regulation to use NPIs to identify health care providers in HIPAA standard transactions. This publication may be downloaded at *http://www.CMS.gov/MLNProducts/downloads/NPIBooklet.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 201103-32

Revised *Medicare Physician Fee Schedule* fact sheet

The revised publication titled *Medicare Physician Fee Schedule* (revised February 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*. This fact sheet is designed to provide education on the Medicare physician fee schedule (MPFS), including physician services, therapy services, MPFS payment rates, and the MPFS rates formula.

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

Source: CMS PERL 201103-32

Revised *Clinical Laboratory Fee Schedule* fact sheet

The revised publication titled *Clinical Laboratory Fee Schedule* (revised February 2011), is now available in downloadable format from the *Medicare Learning Network* at *http://www.CMS.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf*. This fact sheet is designed to provide education on the clinical laboratory fee schedule, including background information, coverage of clinical laboratory services, and how payment rates are set.

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

Source: CMS PERL 201103-50

Rural Referral Center publication now available in print

The revised publication titled *Rural Referral Center* (revised January 2011), which is designed to provide education on the rural referral center program that was established to support high-volume rural hospitals that treat a large number of complicated cases, is now available in print format from the *Medicare Learning Network*®. To place your order, visit the "MLN Product Ordering Page" link at *http://www.CMS.gov/MLNGenInfo*.

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

Source: CMS PERL 201103-50

Home Health Prospective Payment System fact sheet revised

The *Home Health Prospective Payment System* fact sheet (revised January 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/HomeHlthProsPaymt.pdf*. This fact sheet is designed to provide education on the home health prospective payment system (HH PPS) including background information and consolidated billing requirements, coverage of home health services, elements of the HH PPS, and additional requirements.

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

Source: CMS PERL 201102-49

Updated online educational resources for home health agencies

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of updated educational resources on Section 6407 of the Affordable Care Act (ACA) of 2010 to the home health agency Web page at *http://www.cms.gov/center/hha.asp*.

Section 6407 of the Affordable Care Act (ACA) of 2010 established a physician face-to-face encounter requirement for certification of eligibility for home health services. Before a physician can certify a patient's eligibility for Medicare home health services, the law mandates that the physician must document that he or she, or a non-physician practitioner working with the certifying physician, has had a face-to-face encounter with the patient. This provision is a requirement for home health payment.

The educational resources added to the Web page include a PowerPoint slide presentation, a special edition *MLN Matters* article, and questions and answers related to this provision.

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

Source: CMS PERL 201102-46

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		
Language preference for subscription: **English [ ] Español [ ]**				

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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

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Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

MSPRC DPP debt recovery
Automobile accident cases
Settlements/lawsuits
Other liabilities
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

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

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

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

OVERPAYMENT COLLECTIONS
Repayment plans for Part A Participating providers
Cost reports (original and amended)
Receipts and acceptances
Tentative settlement determinations
Provider statistical and reimbursement (PS&R) reports
Cost report settlement (payments due to provider or program)
Interim rate determinations
TEFRA target limit and SNF routine Cost limit exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

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

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

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

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Jacksonville, FL 32202-4914

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Hospice claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

RAILROAD MEDICARE
Railroad retiree medical claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable medical equipment claims
Orthotic and prosthetic device claims
Take home supplies
Oral anti-cancer drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone numbers

PROVIDERS
Customer service center toll-free
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Interactive voice response (IVR)
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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
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Transaction support

Option 2
PC-ACE support

Option 3
Direct data entry (DDE) support

Option 4
Enrollment support

Option 5
Electronic funds (check return assistance only)

Option 6
Automated response line

PROVIDER EDUCATION & OUTREACH
Seminar registration hotline
1-904-791-8103

Seminar registration fax number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

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

Medicare websites

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

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

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Complaint Processing Unit
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CMS-855 Applications
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Jacksonville, FL 32231-4021

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American Diabetes Association certif cates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

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Jacksonville, FL 32202-4914

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Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable medical equipment claims
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Oral anti-cancer drugs
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1-877-602-8816

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Fax
1-904-361-0359

Medicare websites

PROVIDERS
U.S.V.I. Medicare contractor
medicare.fcso.com
Centers for Medicare & Medicaid Services
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BENEFICIARIES
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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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♦ ATTENTION BILLING MANAGER ♦