Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

September 2011

In this issue

New 'Bundled Payments for Care Improvement' initiative will lower costs and help providers coordinate care

The U.S. Department of Health & Human Services (HHS) announced a new initiative to help improve care for patients while they are in the hospital and after they are discharged. Doctors, hospitals, and other health care providers can now apply to participate in a new program known as the Bundled Payments for Care Improvement initiative (bundled payments initiative). Made possible by the Affordable Care Act, it will align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately. Bundled payments will give doctors and hospitals new incentives to coordinate care, improve the quality of care, and save money for Medicare.

"Patients don't get care from just one person – it takes a team, and this initiative will help ensure the team is working together," said HHS Secretary Kathleen Sebelius. "The bundled payments initiative will encourage doctors, nurses, and specialists to coordinate care. It is a key part of our efforts to give patients better health, better care, and lower costs."

Currently in Medicare, hospitals, physicians, and other clinicians who provide care for beneficiaries bill and are paid separately for their services. This Centers for Medicare & Medicaid Services' (CMS) initiative will bundle care for a package of services patients receive to treat a specific medical condition during a single hospital stay and/or recovery from that stay; this is known as an episode of care. By bundling payment across providers for multiple services, providers will have a greater incentive to coordinate and ensure continuity of care across settings, resulting in better care for patients. Better coordinated care can reduce unnecessary duplication of services, reduce preventable medical errors, help patients heal without harm, and lower costs.

The bundled payments initiative is being launched by the new Center for Medicare and Medicaid Innovation (Innovation Center), which was created by the Affordable Care Act to carry out the critical task of finding new and better ways to provide and pay for health care to a growing population of Medicare and Medicaid beneficiaries.

The Innovation Center's request for applications (RFA) outlines four broad approaches to bundled payments. Providers will have flexibility to determine which episodes of care and which services will be bundled together. By giving providers the flexibility to determine which model of

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

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Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

Bundled...*continued*

bundled payments works best for them, it will be easier for organizations of different sizes and degrees of readiness to participate in this initiative.

"This bundled payment initiative responds to the overwhelming calls from the hospital and physician communities for a flexible approach to patient care improvement," said CMS Administrator Donald Berwick, M.D. "All around the country, many of the leading health care institutions have already implemented these kinds of projects and seen positive results."

The bundled payments initiative is based on research and previous demonstration projects that suggested this approach has tremendous potential. For example, a Medicare heart bypass surgery bundled payment demonstration saved the program $42.3 million, or roughly 10 percent of expected costs, and saved patients $7.9 million in coinsurance while improving care and lowering hospital mortality.

"From a patient perspective, bundled payments make sense. You want your doctors to collaborate more closely with your physical therapist, your pharmacist and your family caregivers. But that sort of common sense practice is hard to achieve without a payment system that supports coordination over fragmentation and fosters the kinds of relationships we expect our health care providers to have," said Dr. Berwick.

Organizations interested in applying to the Bundled Payments for Care Improvement initiative must submit a letter of intent (LOI) no later than September 22, 2011, for model 1 and November 4, 2011, for models 2, 3, and 4. For more information about the various models and the initiative itself, please see the Bundled Payments for Care Improvement initiative website at *http://innovations.cms.gov/areas-of-focus/patient-care-models/*.

Interested parties may obtain answers to specific questions by emailing CMS at: *BundledPayments@cms.hhs.gov*.

This initiative is part of a broader effort by the Obama Administration to improve health, improve care, and lower costs. A brief summary of other efforts, including those authorized by the Affordable Care Act, may be found at: *www.HealthCare.gov/news/factsheets/deliverysystem07272011a.html*.

For more information about the CMS Innovation Center, please visit: *http://www.innovations.cms.gov*.

Additional information

HHS fact sheet – *http://www.healthcare.gov/news/factsheets/bundling08232011a.html*.

Federal Register posting – *http://www.gpo.gov/fdsys/pkg/FR-2011-08-25/pdf/2011-21707.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 201108-44

2011 MCPSS results are in

The results of the sixth annual Medicare Contractor Provider Satisfaction Survey (MCPSS) conducted by the Centers for Medicare & Medicaid Services (CMS) are now available. This survey offers Medicare fee-for-service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. Specifically, respondents rated Medicare FFS contractors on seven key business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claim processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. The MCPSS was distributed to a random sample of 30,000 Medicare FFS providers and suppliers that serve Medicare beneficiaries across the country.

To learn more about the results, visit the CMS Web page at *www.cms.gov/MCPSS*.

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

Source: CMS PERL 201109-07

September is Prostate Cancer Awareness Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in raising awareness and knowledge about prostate cancer and the prostate cancer screenings covered by Medicare. Prostate cancer is the most common cancer in men and the second leading cause of cancer death among men in the United States, after lung cancer. Medicare provides coverage of two types of prostate cancer screenings.

Medicare provides coverage for digital rectal exams (DREs) and prostate-specific antigen (PSA) blood tests once every 12 months for all male beneficiaries aged 50 and older. The DRE must be performed by a physician or non-physician practitioner who is authorized under state law to perform the examination; the PSA blood test must be ordered by the patient's physician or qualified non-physician practitioner. Both screenings are covered under Medicare as a Part B benefit.

What can you do?

As a provider of health care to men with Medicare you can help your patients make an informed decision about prostate cancer screening:

- Talk with your patients about the nature and risk of prostate cancer.
- Share current information about prostate cancer screenings with them.
- Inform them about the prostate screenings covered by Medicare that may be appropriate for them.

For more information

The Guide to Medicare Preventive Services, Chapter 12

Medicare Preventive Services Quick Reference Information Chart

Cancer Screenings Brochure for Physicians, Providers, Suppliers, and Other Healthcare Professionals

Center for Disease Control and Prevention Prostate Cancer website

Prostate Cancer Awareness Month website

Source: CMS PERL 201109-16

Release of revised and new CMS-855 Medicare provider-supplier enrollment applications

The U.S. Office of Management and Budget recently approved changes to the Medicare provider-supplier enrollment applications (CMS-855) in order to update them from the 2008 versions, as well as the new CMS-855O application form used for the sole purpose of enrolling to order and refer items and/or services to Medicare beneficiaries. The revised and new forms are now available on the Centers for Medicare & Medicaid Services (CMS) provider-supplier website at *http://www.CMS.gov/CMSForms/CMSForms/list.asp?filtertype=dual&filtertype=keyword&keyword=855.*

Providers and suppliers enrolling for the sole purpose to order and refer are required to begin using the new CMS-855O form immediately. Providers and suppliers using the other CMS-855 forms to enroll in Medicare are encouraged to begin using the revised forms, though may continue to use the old forms through October 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 201108-40

Provider enrollment revalidation does not affect routine enrollment processes – continue to submit routine enrollment changes

Please note that the Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes – address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc. – as they always have. If you also receive a request for revalidation from the Medicare administrative contractor (MAC), respond separately to that request. Do not submit your revalidation until requested to do so by your MAC.

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will have their enrollment revalidated under new risk screening criteria required by the Affordable Care Act (section 6401a). Do **not** send in revalidated enrollment forms until you are notified to do so by your MAC. You will receive a notice to revalidate between now and March 2013.

For more information about provider enrollment revalidation, review the *Medicare Learning Network's*® *special edition article #SE1126* titled "Further Details on the Revalidation of Provider Enrollment Information."

Source: CMS PERL 201109-31

Delay in implementation of automated Medicare Secondary Payer adjustments (CR 6625)

On Friday, July 1, the Centers for Medicare & Medicaid Services (CMS) implemented change request (CR) 6625 that created a systematic process in which Medicare automatically reopens/adjusts certain Medicare Secondary Payer (MSP) claims when a beneficiary's MSP claims record was deleted or an end date was applied to an open beneficiary MSP record. This automated process no longer required physicians, providers, and suppliers to contact their Medicare contractors to adjust or reprocess these types of MSP claims. CMS informed physicians, providers, and suppliers of these changes through a Listserv message.

Due to systems issues currently affecting CR 6625, CMS directed its A/B Medicare administrative contractors, durable medical equipment Medicare administrative contractors, and legacy contractors (fiscal intermediaries (FIs) and carriers) to immediately suspend all actions on this CR. This means that our Medicare contractors are unable to automatically reopen/adjust claims when Medicare takes action to delete or terminate a previously existing MSP record. Physicians, providers, and suppliers must revert to the pre-July 1 process and contact their Medicare contractor to request re-openings/adjustments of claims that were previously considered MSP. Therefore, if you have claims that were processed since July 1 that need to be reopened/ adjusted due to Medicare now being the primary payer, you should contact your local Medicare contractor to request that action.

CMS will alert physicians, providers, and suppliers once the current issues tied to the implementation of CR 6625 have been resolved.

Source: CMS PERL 201109-35

Find your favorites fast – use Popular Links

Looking for the fastest way to find your favorite sections of our website? It's easy – just use the Popular Links navigational menu. Located on the left-hand side of every page, this convenient menu allows you to jump to the most popular pages on the site – with just one click. You'll find links to the Part A homepage as well as quick links to the procedure-diagnosis lookup tool, local coverage determinations (LCDs), fee schedules, publications, and more. Find out how easy is to find what you need fast – use Popular Links.

HHS proposes patient rights to access clinical lab test result reports

Overview

As part of the Department of Health and Human Services' (HHS) ongoing efforts to empower patients to be informed partners with their health care providers in making health care decisions, HHS has proposed rules that would give patients (and their authorized representatives) direct access to their own laboratory test result reports.

The proposed rule is being jointly issued by three agencies within HHS: The Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Office for Civil Rights (OCR). CMS and the CDC are responsible for laboratory regulation under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), and the OCR is responsible for administering the Privacy Rule that was issued under the Health Insurance Portability and Accountability Act of 1986 (HIPAA). The proposed rules are also consistent with a proposed regulation under the HITECH Act that would bolster patients' rights to access their information stored in electronic health records and that would help ease the transition to nationwide adoption of electronic health records.

Background

The proposed rules address the interplay between the CLIA rules, state laws governing direct disclosure to patients of their laboratory test results, and the Federal Privacy Rule, which currently defers to CLIA's disclosure provisions and which preempts contrary State laws on privacy and disclosure of personal health information. Under existing CLIA regulations, a laboratory may release patient test results directly to the patient only if (1) the ordering provider expressly authorizes the laboratory to do so at the time the test is ordered, or (2) state law expressly allows for it.

The current Privacy Rule generally requires certain health care providers such as most clinical laboratories to give individuals access to their health information on request. However, the Privacy Rule's access requirements, deferring to the CLIA rules, include an exception for direct access by patients to their laboratory test result reports. Therefore, patients who reside in the 26 states without laws authorizing direct disclosure of test results to patients and those who reside in the 13 states that expressly prohibit direct disclosure, do not have access to their complete medical information.

Provisions of the proposed rule

The proposed rule would amend the CLIA regulations to allow laboratories to give a patient his/her individual test result reports on request. At the same time, the proposed rule would eliminate the Privacy Rule's exception for an individual's access to laboratory test result reports. The amended Privacy Rule would, in turn, preempt contrary state laws governing a patient's direct access to lab result reports.

The proposed rule can be downloaded from the *Federal Register* Inspection Desk at *www.ofr.gov/inspection.aspx*. Comments will be accepted for 60 days, and a final rule, responding to comments will be published later this year.

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

Source: CMS PERL 201109-40

Try our E/M interactive worksheet

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our website feedback form, available at *http://medicare.fcso.com/Feedback/160958.asp*.

Medicare pilot project for electronic submission of medical documentation (esMD)

Provider types affected

This special edition (SE) affects all Medicare fee-for-service (FFS) providers who submit medical documentation to Medicare review contractors.

Provider action needed

Stop – impact to you

Each year, the Medicare FFS program makes billions of dollars in estimated improper payments. The Centers for Medicare & Medicaid Services (CMS) employs several types of Medicare review contractors to measure, prevent, identify, and correct these improper payments. Review contractors find the improper payments by requesting medical documentation from each provider who submitted a questionable claim. The review contractor then manually reviews the claims against the submitted medical documentation to verify the providers' compliance with Medicare's rules. Currently, review contractors request medical documentation by sending a paper letter to the provider. The provider has two options for submitting the requested records: 1) mail paper, or 2) send a fax.

Caution – what you need to know

Medicare's electronic submission of medical documentation (esMD) pilot project gives some providers a new mechanism for submitting medical documentation to review contractors. A list of review contractors that will accept esMD transactions can be found at *http://go.usa.gov/kr4*. The esMD pilot will begin in September of 2011. The primary intent of esMD is to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors. A secondary goal of esMD is to reduce costs and time at review contractors. In order to send medical documentation electronically to review contractors, Medicare providers, including physicians, hospitals, and suppliers, must obtain access to a CONNECT-compatible gateway.

- Certain larger providers, such as hospital chains, may choose to build their own gateway.
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a Health Information Handler (HIH) that offers esMD gateway services.

A list of HIHs that offer esMD services as of September 2011 can be found in the "Key Points" section of this article. An updated listing of the HIHs that have been approved by CMS to offer esMD services can also be found at *http://go.usa.gov/krg*. CMS does not set the price that an HIH may charge a provider for esMD services. Providers who believe it may be more efficient to respond to documentation requests electronically are encouraged to contact one or more of the HIHs to determine if esMD services are available at a reasonable price.

Go – what you need to do

You should know that esMD is completely voluntary. You may continue to mail or fax documentation to your review contractor.

The initial esMD system accepts portable document format (PDF) files, which means that even those providers who have paper records may utilize esMD services as long as there is a mechanism to scan the paper records into PDF files. Some HIHs may offer scanning services in addition to their esMD services.

Key points

The following are tentative schedules of when HIHs will be ready to offer esMD services and when review contractors will be ready to accept esMD:

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esMD...*continued*

HIH/Web address	Scheduled readiness*
HealthPort (*http://www.healthport.com*)	September 2011
IVANS (*http://www.ivans.com*)	September 2011
MRO (*http://www.mrocorp.com*)	September 2011
NaviNet (*http://www.navinet.net*)	September 2011
RISARC (*http://www.risarc.com*)	September 2011
eSolutions (*http://www.ecorpnet.com*)	November 2011
Cobius (*http://www.cobius.com*)	November 2011
IOD, Inc. (*http://www.iodincorporated.com*)	November 2011
Proficient Health (*http://www.proficienthealth.com*)	November 2011
Craneware (*http://www.craneware.com*)	November 2011
MDClick (*http://www.mdclick.com*)	November 2011
Medical Electronic Attachment (*http://www.mea-fast.com*)	November 2011
EHR Doctors (*http://www.ehrdoctors.com*)	November 2011
ApeniMED (*http://www.Apenimed.com*)	November 2011
HealthIT+ (*http://www.healthitplus.com*)	November 2011
ECC Technologies (*http://www.ecctec.com*)	January 2012
Stratice Healthcare (*http://straticehealthcare.com/*)	January 2012
AT&T (*http://www.att.com/healthcare*)	January 2012
CureMD (*http://www.curemd.com*)	January 2012
MediConnect (*http://www.mediconnect.net*)	January 2012
MediCopy (*http://www.medicopy.net*)	January 2012
Cal eConnect (*http://www.caleconnect.org*)	January 2012
LMRP Manager (*http://www.racmanager.com*)	January 2012
SSI (*http://www.thessigroup.com/*)	January 2012
Verisma Systems (*http://www.verismasystems.com*)	January 2012
Zydoc (*http://www.zydoc.com*)	January 2012
Ivertex (*http://www.ivertex.com*)	April 2012

Medicare review contractors include the recovery auditors (RACs), Medicare administrative contractors (MACs), the Comprehensive Error Rate Testing (CERT) contractor, the program error rate measurement (PERM) contractor, and zone program integrity (ZPIC) contractors. The following shows when some of these contractors will be accepting esMD transactions:

Review contractors	Scheduled readiness*
RAC A – Diversified Collection Services (DCS)	September 2011
RAC B – CGI Technologies and Solutions	September 2011
MAC J1 and J11 – Palmetto GBA	September 2011
MAC J3 – Noridian Administrative Services	September 2011
MAC J4 – Trailblazer Health Enterprises	September 2011
MAC J5 – Wisconsin Physicians Services Health Insurance Corporation	September 2011
MAC J9 – First Coast Service Options	September 2011
MAC J12 – Highmark Medicare Services	September 2011
MAC J14 – NHIC	September 2011
DME MAC A – NHIC	September 2011
DME MAC D – Noridian Administrative Services, LLC	September 2011
CERT – Livanta	September 2011

*These are anticipated dates and subject to change. Please check the esMD website (*http://www.cms.gov/ESMD*) for more information.

continued on next page

esMD...*continued*

Note: CMS expects that the Region C and D recovery auditors and remaining MACs will begin accepting esMD transactions within the next 12 months.

Additional information

If you have any questions, please contact the review contractor to which you wish to send esMD transactions. MAC toll-free numbers can be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

For more information, visit the esMD webpage at *http://www.cms.gov/esmd*. You might also try the Twitter Link, which is *@CMSGov* (Look for #CMS_esMD).

For more information on the Medicare recovery audit program, see the MLN Matters® article SE1024 at *http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf*. You may contact your recovery auditor for questions you have of them. Their contact information is at *http://www.cms.gov/RAC/Downloads/RACcontactinfo.pdf*.

MLN Matters® Number: SE1110
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

Get ready for DMEPOS competitive bidding

The Centers for Medicare & Medicaid Services (CMS) announced the next steps for the expansion of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program to include the round 2 and the national mail-order competitions.

Round 2

The round 2 product categories are:

- Oxygen, oxygen equipment, and supplies
- Standard (power and manual) wheelchairs, scooters, and related accessories
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Negative pressure wound therapy pumps and related supplies and accessories
- Support surfaces (group 2 mattresses and overlays)

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website, *www.dmecompetitivebid.com*; the specific ZIP codes in each round 2 competitive bidding area (CBA) are also available on the CBIC website.

National mail-order competition

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

To ensure that suppliers have ample time to prepare for the competition, CMS has announced the following next steps for the program:

Summer 2011

- CMS begins pre-bidding supplier awareness program

Fall 2011

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter 2012

- Bidding begins

continued on next page

DMEPOS...*continued*

If you are a supplier interested in bidding, prepare now – don't wait.

Update your contact information

The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:

- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and
- The correspondence address.

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the July 11, 2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website (*www.cms.gov/MEDICAREPROVIDERSUPENROLL/*) or reviewing the PECOS fact sheet at *www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf*. Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website (*www.palmettogba.com/nsc*) and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get licensed

Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a CBA, you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. It is very important that you make sure that current versions of all required licenses are in your enrollment file with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid. Suppliers bidding in the national mail-order competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Get accredited

Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at *www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Visit the CMS website at *www.cms.gov/DMEPOSCompetitiveBid* for the latest information on the DMEPOS competitive bidding program.

To view the press release, go to *www.cms.gov/apps/media/press_releases.asp*.

To view the fact sheet, go to *www.cms.gov/apps/media/fact_sheets.asp*.

The competitive bidding implementation contractor (CBIC) is the official information source for bidders. Stay informed – visit the CBIC website at *www.dmecompetitivebid.com* to subscribe to email updates and for the latest information on the DMEPOS competitive bidding 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 201108-39, 201109-02

DMEPOS competitive bidding program expansion announced

Provider types affected

This article is for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that wish to participate in the upcoming round 2 of the Medicare DMEPOS competitive bidding program and/or the national mail-order competition for diabetic testing supplies that will occur at the same time as round 2.

What you need to know

This article provides important information from the Centers for Medicare & Medicaid Services (CMS) regarding the next phase (Round 2 and national mail-order) of Medicare's competitive bidding program for DMEPOS. If you are interested in bidding, prepare now – don't wait!

The round 2 product categories are:

- Oxygen, oxygen equipment, and supplies;
- Standard (power and manual) wheelchairs, scooters, and related accessories;
- Enteral nutrients, equipment, and supplies;
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories;
- Hospital beds and related accessories;
- Walkers and related accessories;
- Negative pressure wound therapy pumps and related supplies and accessories; and
- Support surfaces (group 2 mattresses and overlays).

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the Round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

A list of the specific items in each product category is available on the competitive bidding implementation contractor (CBIC) website, *http://www.dmecompetitivebid.com*, and the specific ZIP codes in each round 2 competitive bidding area (CBA) are also available on the CBIC website.

Update your contact information: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update the following:

- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding)
- The correspondence address.

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the July 11, 2011, version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website at *http://www.cms.gov/MEDICAREPROVIDERSUPENROLL/* or reviewing the PECOS fact sheet at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf*.

Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website at *http://www.palmettogba.com/nsc* and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get licensed: Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a CBA, you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. **It is very important that current versions of all required licenses are in your enrollment file with the NSC before you bid.** If any required licenses are expired or missing from your enrollment file, CMS can reject your bid. Suppliers bidding in the National Mail-Order Competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Get accredited: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action NOW to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

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Bidding...*continued*

Current round 2 and mail-order schedule

CMS has announced the following next steps for the program to ensure that suppliers have ample time to prepare for the competition:

Summer 2011

- CMS begins pre-bidding supplier awareness program

Fall 2011

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

Winter 2012

- Bidding begins

Additional information

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed – visit the CBIC website at *http://www.dmecompetitivebid.com/* to subscribe to email updates and for the latest information.

For more information on the DMEPOS competitive bidding program, visit *http://www.cms.gov/dmeposcompetitivebid/*.

Information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at *http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

The press release about the expanded competitive bidding program may be found at *http://www.cms.gov/apps/media/press_releases.asp*. To view the Fact Sheet titled, *Next Steps For Expansion Of The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies,* go to *http://www.cms.gov/apps/media/fact_sheets.asp*.

MLN Matters® Number: SE1127
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Contractor entities at a glance: Who may contact you about specific CMS activities

Provider types affected

All physicians, providers, and suppliers who submit claims to Medicare contractors (as defined in this article) for services and supplies provided to Medicare beneficiaries are affected.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) has received calls from providers about the various entities that may contact them with questions and requests for medical records, documentation, or other information. CMS recognizes that shifts in contracting entities due to recent Medicare contracting reform may be confusing. CMS has prepared this special edition article to describe the current Medicare contracting environment. In addition, this article will list the entities responsible for activities in the Medicare program, as well as with some Medicaid claims, and explain the reasons why they may contact you. CMS has also prepared a quick reference table titled, *Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities*, that you may provide to your office staff for easy reference. The table is available at *http://www.cms.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf*.

CMS understands that several of these entities may contact you concurrently. You may question whether the efforts of these entities are coordinated and whether the burden placed upon providers can be reduced. CMS constantly strives to reduce the burden on providers. However, as this article explains, certain functions are performed by different entities by design. Sometimes different entities are involved because different skill sets are needed. For example, reviewing a provider enrollment application for correctness requires different skills than reviewing medical records to determine correct diagnosis and procedure coding. Also, sometimes certain functions must be performed by different entities to protect providers and the Medicare program. For example, appeals of claims decisions should be heard, at least at certain levels, by an entity that is separate and distinct from the entity that made the claims decision. Therefore, while CMS strives to coordinate efforts of these entities, there may be times when providers are contacted by several of the entities concurrently.

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Entities...*continued*

Background

Listed below are general categories of the current entities that CMS uses under the Medicare and Medicaid programs to handle claims processing and other functions. Some of the entities are new to these programs as part of Medicare Contracting Reform. This article and the table mentioned above display the new entities in **bold type**. The table also provides websites that are available should you need further information. Finally, we explain how CMS coordinates the work of these entities so that phone calls and letters requesting medical records, documentation, or other information related to a beneficiary's claims are minimized.

Claims processing contractors

CMS contracts with entities to process claims submitted by physicians, hospitals, and other health care providers/suppliers, and to make payment in accordance with Medicare regulations and policies. These entities, called carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and **Medicare administrative contractors (MACs)**, are also referred to as Medicare claims processing contractors. These entities are the entry point for participating in the Medicare program as they process provider enrollment applications.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the Secretary of the Department of Health and Human Services (DHHS) replace the current contracting authority under Title XVIII of the Social Security Act (SSA) with the new **MAC** authority.

MACs will be the central point in CMS' national fee-for-service (FFS) program.

- Carrier and FI workloads have or will be transitioned to **10 Part A/ B MAC** jurisdictions.
- Regional home health intermediary (RHHI) workloads are being transitioned to **4 HH MAC** jurisdictions.
- Durable medical equipment (DME) workloads have been transitioned to **4 DME MAC** jurisdictions.

You may access the most current Medicare contracting reform information to determine the effect of these changes on your practice and to view the list of current **MACs** for each jurisdiction at *http://www.cms.gov/MedicareContractingReform*.

MACs may contact you for a variety of reasons, such as:

- Resolving issues regarding your initial and renewal enrollment applications;
- Providing education and guidance on procedures for billing Medicare;
- Resolving issues regarding claims you submit;
- Requesting medical records related to the claims you submit for medical review;
- Paying you for approved claims and/or explaining why some claims are not processed or are denied; and
- Recovering overpayments on claims previously processed.

Program integrity contractors

CMS contracts with Program safeguard contractors (PSCs) and **zone program integrity contractors (ZPICs)**, who are responsible for identifying cases of suspected fraud and taking appropriate actions.

As a result of Medicare contracting reform, seven **ZPICs** were created based on the MAC jurisdictions. Eventually, PSCs will no longer exist and ZPICs will perform all benefit integrity work. ZPICs were created to perform program integrity for Medicare Parts A, B, C (Medicare Advantage or MA), D (prescription drugs, including MA-Drug Plans), durable medical equipment (DME), home health and hospice, and Medicare-Medicaid data matches, also referred to as Medi-Medi. Since these seven **ZPICs** focus on these different aspects of the Medicare Program, it is possible that providers could hear from more than one **ZPIC**, depending on the aspects of that **ZPIC's** review and/or the nature of the services for which the provider bills Medicare.

CMS also contracts with **recovery auditors** to identify and correct underpayments and overpayments. There are 4 **recovery auditors**. **Recovery auditors** responsibilities include working with providers to detect and correct Medicare improper payments. **Recovery auditors** conduct reviews of claims in the following ways:

- Automated (no medical records are needed);
- Semi-automated (medical records are supplied at the discretion of the provider to support a claim identified by data analysis as an improper payment); and
- Complex (medical record is required).

FFS recovery auditors contact providers to request additional documentation in support of potential improper payments. If an improper payment is determined, the **FFS recovery auditor** will send a review results letter, providing the decision and the accompanying reviewer rationale. A demand letter is issued to you by the **FFS recovery auditor** or the MAC

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Entities...*continued*

once the claim is adjusted. The **FFS recovery auditor** will offer you an opportunity to discuss the improper payment determination with the **FFS recovery auditor** (this is outside the normal appeal process).

The **Tax Relief and Health Care Act of 2006 (TRHCA)** authorizes the recovery audit program for Part A and Part B Medicare services. The Affordable Care Act expands the recovery audit program to Medicaid and Medicare Part C (Medicare Advantage or MA) and Part D (prescription drugs).

- Medicaid recovery auditors are responsible for identifying and recovering Medicaid overpayments and identifying underpayments.
- MA recovery auditors will ensure that MA plans have an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.
- Prescription drug plan (PDP) recovery auditors will ensure that each PDP under part D has an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.

CMS also reviews Medicare FFS claims nationally to identify improper payments, as required by the Improper Payment Information Act (IPIA) and the Improper Payments Elimination and Recovery Act (IPERA). This is accomplished through the **Comprehensive Error Rate Testing (CERT)** program. If a provider's claim is randomly chosen, the CERT program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly. If an improper payment is identified by the CERT program, your MAC will notify you and make the appropriate payment adjustment. Normal appeal rights apply to CERT-initiated denials and are handled through the routine appeal process.

CMS also reviews Medicaid and Children's Health Insurance Program (CHIP) claims to identify improper payments, as required by the IPIA and the IPERA. This is accomplished through the **Payment Error Rate Measurement (PERM) program**.

CMS reviews a sample of claims in one-third of the states each year to develop a national estimate of improper payments. PERM conducts two types of reviews on these claims:

- Medical review (medical record is required)
- Data processing reviews (this is a validation that the payment was processed correctly in a state's system)

If a provider's claim is randomly chosen, the PERM program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly.

Medicaid integrity contractors (MICs) are entities that contract with CMS to conduct audit-related activities for the Medicaid programs. There will be five MIC jurisdictions performing three primary functions:

- Review MICs, which analyze Medicaid claims data to investigate suspected/potential provider fraud, waste, or abuse;
- Audit MICs, which audit provider claims and identify overpayments; and
- Education MICs, which provide education to providers and others on payment integrity and quality-of-care issues.

Program integrity contractors may contact you to resolve problems they identify in your claims or to request medical records for claims under review.

Specialty medical review contractors

In an effort to continue the prevention and reduction of improper payments, CMS has contracted with a specialty medical review contractor to conduct medical review studies of Part A and B claims. Studies are conducted as fact-finding undertakings to allow CMS to better understand trends in billing behavior that may lead to improper payments. These studies occur on a quarterly basis and vary in topic. Claims chosen for review are selected randomly. The specialty medical review contractor may contact you to request medical records for claims under review. Also, CMS contracts with the Medicare coordination of benefits contractor (COBC), a single entity, to provide a centralized COB operation. Responsibilities of the COBC include all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The COBC may contact you to identify Medicare secondary payer (MSP) situations quickly and accurately. There is also a Medicare secondary payer recovery contractor (MSPRC) that performs post-payment recovery of funds paid where Medicare should not have been the primary payer. The MSPRC may contact you for information related to MSP recoveries and can issue demand letters to require payment recovery.

The last specialty contractor is the national supplier clearinghouse (NSC), which handles enrollment activities related to DME suppliers. The NSC may contact you about your enrollment information.

Appeals contractors and entities

CMS contracts with entities to conduct appeals of claims determinations. These include FIs, carriers,

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Entities...*continued*

RHHIs, and **MACs, who conduct first level appeals. Qualified independent contractors (QICs)** conduct reconsiderations, the second level of appeals. There are:

- Two Part A **QICs**,
- Two Part B **QICs**,
- One DME **QIC**,
- One Part C **QIC** for MA, and
- One Part D **QIC** for Medicare prescriptions drug plans (PDPs) and MA drug plans.

Other appeals-related entities include the administrative law judges (ALJs) within the HHS Office of Medicare Hearings and Appeals and the Medicare Appeals Council within the HHS Departmental Appeals Board conduct the next two levels of appeal. The ALJ will send you a notice of hearing to all parties to the appeal, indicating the time and place of the hearing. The ALJ will generally issue a decision or dismissal within 90 days of receipt of a valid appeal request. The Medicare Appeals Council will generally issue a decision or dismissal within 90 days of receipt of a valid appeals request.

ALJs in the Civil Remedies Division within the HHS Departmental Appeals Board also conduct hearings on provider and supplier enrollment issues, and hearings on civil money penalties and sanctions imposed against providers and suppliers by CMS and the HHS Office of the Inspector General. For appeals of enrollment issues, the ALJ will generally issue a decision within 180 days of receipt of your request. For other types of appeals, the ALJ will issue a decision as soon as practical after the close of the hearing.

The Provider Reimbursement Review Board (PRRB) is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary or the Centers for Medicare & Medicaid Services (CMS). The Medicare Geographic Classification Review Board (MGCRB) decides on requests of prospective payment system (PPS) hospitals for reclassification to another area (urban or in some cases rural) for the purposes of receiving a higher wage index.

The PRRB and the MGCRB provide appeals avenues for providers on specific matters, including cost report disputes. When you, or a beneficiary (or an appointed representative), appeal claims decisions, any of these appeals entities may request more information from you (or your representative).

Quality improvement contractors

Quality improvement organizations (QIOs) provide quality of care review services and conduct quality improvement projects. CMS contracts with one QIO in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. QIOs are private, mostly not-for-profit organizations, staffed by professionals, mostly doctors and other health care professionals, responsible for the review of services provided to beneficiaries enrolled in MA plans and in FFS Medicare, including:

- Conducting expedited Medicare coverage determinations of inpatient hospital discharges and provider service terminations;
- Reviewing beneficiary complaints about quality of care, including working with the provider and reviewing medical records as part of the complaint-resolution process;
- Working with providers to accomplish national quality improvement goals;
- Implementing improvements in the quality of care;
- Contacting providers to provide technical assistance and encouraging partnerships to achieve quality goals;
- Providing technical assistance with many of the CMS value-based purchasing programs; and
- Performing provider-requested higher-weighted diagnosis related group reviews.

Additional information

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

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Incentive Programs

Materials from July 14 EHR incentive program national call available

Did you know that providers received almost $400 million in Medicare and Medicaid electronic health records (EHR) incentive payments through July? Don't be left behind. Learn what you need to do to be eligible for an incentive.

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on Thursday, July 14, titled "Medicare & Medicaid EHR Incentive Program Basics for Eligible Professionals." The materials from this call are now available and include the presentation used during the call, call transcript, and the audio recording of the call.

The agenda for this call included:

- Who is eligible?
- How much are the incentives and how are they calculated?
- How does one get started?
- What are major milestones regarding participation and payment?
- How does one report on meaningful use?
- Where helpful resources are found?
- A question and answer session

All materials from this call may be found on the CMS EHR website on the Educational Materials page at *http://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Basics_for_July2011.zip*

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

Source: CMS PERL 201109-37

Presentation from the August 30 EHR webinar regarding CQMs

On August 30, the Centers for Medicare & Medicaid Services (CMS) held a webinar to discuss the clinical quality measures (CQMs) and how to successfully report them during Stage 1 of meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

A PDF of the webinar presentation is now available to download from the *Spotlight and Upcoming Events* section of the Medicare and Medicaid EHR Incentive Programs Web page.

The presentation included information on:

- An overview of the CQMs
- How to report CQMs during attestation
- Why CQMs are included in the EHR incentive programs

The webinar also included an hour-long question-and-answer session with CMS subject matter experts. In the coming weeks, a transcript with all of these questions and answers, along with a video of the webinar, will be made available online.

CMS plans to host another CQM webinar soon. Stay tuned for updates on how you can join this informational session.

Want more information about the EHR incentive programs?

Make sure to visit the *Medicare and Medicaid EHR Incentive Programs Web page* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201109-38

2010 eRx incentive program reports are now available for download

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the 2010 electronic prescribing (eRx) incentive program feedback reports are now available for download on the Physician and Other Health Care Professionals Quality Reporting Portal (the Portal) available at QualityNet at *http://www.qualitynet.org/pqri*.

Taxpayer identification number (TIN) level reports on the Portal require an Individuals Authorized Access to CMS Computer Services (IACS) account.

Eligible professionals can request their National Provider Identifier (NPI)-level reports through the alternate feedback report fulfillment process, by contacting their carrier or Medicare administrative contractor (MAC) to request individual NPI level reports.

The following CMS resource is available to help eligible professionals understand their 2010 eRx feedback report: *A Guide for Understanding the 2010 eRx Feedback Report [PDF 2MB]*.

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

Source: CMS PERL 201109-04

2011 Medicare eRx incentive program final rule published

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the *2011 Medicare electronic prescribing (eRx) incentive program final rule* was published in the *Federal Register* on September 6, 2011.

To help eligible professionals and group practices understand the key provisions and impact of the 2011 Medicare eRx incentive program final rule, *A Quick Reference Guide,* has been posted to the eRx incentive program website on the "Educational Resources" page. Frequently asked questions (FAQs) addressing the 2011 eRx final rule, as well as other information and resources about the eRx incentive program can be found at the eRx incentive program website at *http://www.cms.gov/ERxIncentive/*.

What are the key changes addressed in the final rule?

- The final rule modifies the eRx quality measure used for certain reporting periods in calendar year (CY) 2011.
- The final rule modifies the eRx quality measure used for certain reporting periods in calendar year (CY) 2011.
- The final rule provides additional significant hardship exemption categories for eligible professionals and group practices to request an exemption during 2011 for the 2012 eRx payment adjustment due to a significant hardship: (1) eligible professionals who register to participate in the Medicare or Medicaid EHR incentive program and adopt certified EHR technology; (2) eligible professionals who are unable to electronically prescribe due to local, state, or federal law or regulation; (3) eligible professionals who have limited prescribing activity; and (4) eligible professionals who have insufficient opportunities to report the eRx measure due to limitations of the measure's denominator.
- The two hardship exemptions already available to professionals are (1) eligible professional or group practice practices in rural areas with limited high speed internet access; and (2) eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.
- The final rule extends the deadline for requesting significant hardship exemptions to November 1, 2011.
- The final rule allows providers to report significant hardship exemptions to the 2012 eRx payment adjustment via a Web-based tool for eligible professionals or via a mailed letter for group practices that are participating in the eRx group practice reporting option for 2011.

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eRx...*continued*

What immediate impact does this have on me?

At this time, eligible professionals and group practices should determine if they are subject to the 2012 eRx payment adjustment. An eligible professional **will not** be subject to the 2012 eRx payment adjustment if **one** of the following applies:

- The eligible professional is not a physician (M.D., D.O., or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, (this determination is based on the primary taxonomy code in the National Plan and Provider Enumeration System (NPPES)) and does not generally have prescribing privileges, and reports g-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim prior to June 30, 2011;
- The eligible professional does not have at least 100 cases (i.e., claims for patient services) containing an encounter code that falls within the denominator of the eRx measure for dates of service between January 1, 2011, and June 30, 2011;
- The eligible professional's allowed charges for covered professional services submitted for the electronic prescribing measure's denominator codes is less than 10 percent of the eligible professional's total 2011 Medicare Part B PFS allowed charges;
- The eligible professional reported one of the two significant hardship code already finalized (see Bullet 2 under key changes above) by June 30, 2011, and CMS determines that the hardship code applies and is granted an exemption; or
- The eligible professional becomes a successful electronic prescriber for purposes of the 2012 payment adjustment by reporting the eRx measure via claims for at least 10 unique electronic prescribing events for patients in the denominator of the measure between January 1, 2011, and June 30, 2011.

A group practice that self-nominated and was selected to participate in the 2011 eRx group practice reporting option (GPRO) will not be subject to the 2012 eRx payment adjustment if **one** of the following applies:

- The group practice reported one of the two significant hardship code already finalized (see Bullet 2 under key changes above) in its 2011 self-nomination letter for participation in the eRx incentive program group practice reporting option and is granted an exemption; or
- The group practice becomes a successful electronic prescriber. The group practice becomes a successful electronic prescriber for purposes of the 2012 payment adjustment by reporting the eRx measure via claims for between 75-2,500 unique eRx events (depending on the group practice size) for patients in the denominator of the measure between January 1, 2011, and June 30, 2011.

What should I do if I believe I am subject to the 2012 eRx payment adjustment?

If you believe you are subject to the 2012 eRx payment adjustment, you should determine if you meet any of the hardship exemptions that CMS has finalized. If you do feel you meet one of the hardship exemptions, you have until November 1, 2011, to submit your hardship exemption request and rationale.

How do I submit a 2012 eRx payment adjustment significant hardship exemption request?

CMS is no longer accepting significant hardship exemption requests for the 2012 eRx payment adjustment via claims. However, we are accepting hardship exemption requests through other avenues. Below are the steps you need to take to request a significant hardship exemption. Please note that the action required is different depending on whether you are an individual eligible professional or a group practice.

- **If you are participating as an individual eligible professional**: Use the new CMS provider Web page, called the *Quality Reporting Communication Support Page*, to enter the request and supporting rationale. Your request must be submitted by November 1, 2011. A *Quality Communications Support Page User Manual* is available to answer questions eligible professionals may have.
- **If you are participating using the group practice reporting option (GPRO):** Group practices selected for and participating in the 2011 GPRO I or II reporting option wishing to submit a 2012 exemption request should submit a letter to:

  Significant Hardship Exemptions, Centers for Medicare & Medicaid Services
  Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group
  7500 Security Boulevard, Mail Stop S3-02-01
  Baltimore, MD 21244-1850.

  This letter must be postmarked no later than **November 1, 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 201109-23

Greater flexibility in e-Prescribing means greater success

By Patrick Conway, M.D., MSc, CMS Chief Medical Officer and Director of the Office of Clinical Standards & Quality

Electronic prescribing plays a vital role in improving patient care and helping make our health care system more efficient. With electronic prescribing, providers can better manage patient prescriptions, reducing drug interactions or other preventable prescription errors. The Centers for Medicare & Medicaid Services (CMS) has made several changes in the newly released final rule for the 2011 electronic prescribing (eRx) incentive program that will encourage more doctors and other health care professionals to adopt this technology and give them the added flexibility to help them succeed. In particular, the changes will better recognize those circumstances when the ability of professionals to meet the eRx requirements is limited and when the requirements clearly pose a significant hardship.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required an adjustment to payments, beginning in 2012, for eligible professionals who aren't successful electronic prescribers. After we published the 2011 Medicare Physician Fee Schedule (MPFS) Final Rule last fall, CMS heard about additional circumstances that could keep physicians and other health professionals from being successful e-prescribers. For example, some providers weren't sure whether certified electronic health record (EHR) technology that the Medicare and Medicaid EHR incentive programs require is also a "qualified" electronic prescribing system as required by the Medicare eRx incentive program. Others providers brought up additional hardship situations that the 2011 MPFS final rule didn't address.

Here's how CMS is addressing those additional concerns:

- CMS is modifying the 2011 electronic prescribing measure to say that a qualified electronic prescribing system for the purpose of the Medicare eRx incentive program includes certified EHR technology under the Medicare and Medicaid EHR incentive programs.
- CMS is adding four additional significant hardship exemptions that will make professionals exempt from the 2012 payment adjustment:
    1. Eligible professionals who register to participate in the Medicare or Medicaid EHR incentive program and adopt certified EHR technology;
    2. Eligible professionals who are unable to electronically prescribe due to local, state, or federal law or regulation;
    3. Eligible professionals who have limited prescribing activity; and
    4. Eligible professionals who have insufficient opportunities to report the e-prescribing measure due to limitations of the measure's denominator.
- The two hardship exemptions already available to professionals are
    1. Eligible professional or group practice practices in rural areas with limited high speed internet access; and
    2. Eligible professional or group practice practices in an area with limited available pharmacies for electronic prescribing.

Links:

Federal Register URL: *http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22629.pdf*.

Blog URL:

http://blog.cms.gov/2011/08/31/greater-flexibility-in-e-prescribing-means-greater-success/.

The URL to the final rule on the eRx incentive program website: *http://www.cms.gov/ERXincentive/*.

View the *CMS Fact Sheet*.

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

Source: CMS PERL 201109-03

MRI in Medicare beneficiaries with FDA-approved implanted permanent pacemakers

Note: This article was revised on September 23, 2011, to reflect the release of an updated change request (CR) 7441. The transmittal number, CR release date and link to accessing the transmittal have been changed. All other information is the same.

Provider types affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), carriers, or A/B Medicare administrative contractors (A/B MAC)) for providing magnetic resonance imaging (MRI) services to Medicare beneficiaries are affected.

What you need to know

This article, based on CR 7441, informs you that Medicare believes that the evidence is adequate to conclude that MRIs improve health outcomes for Medicare beneficiaries with implanted pacemakers (PMs) when the

PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment. Effective for services on or after July 7, 2011, Medicare will allow coverage of MRIs for beneficiaries with implanted PMs when the PMs are used according to the FDA-approved labeling for use in an MRI environment.

Effective for claims with dates of service on or after July 7, 2011, you should include the following information on MRI claims for beneficiaries with implanted PMs that are FDA-approved for use in an MRI environment:

- Appropriate MRI code;
- KX modifier; and
- ICD-9 code V45.01 (cardiac pacemaker).

Inclusion of the KX modifier on the claim line(s) means that the provider attests that documentation is on file verifying that FDA-approved labeling requirements are met. For such claims without the KX modifier, Medicare will deny MRI line items using the following remittance advice messages:

- Group code of CO (contractual obligation); and
- Claim adjustment reason code (CARC) 188 (This product/procedure is only covered when used according to FDA recommendations.).

As described previously in the MLN Matters® article MM7296 (*http://www.cms.gov/MLNMattersArticles/downloads/MM7296.pdf*), Medicare posted a separate decision on February 24, 2011, that allows coverage of MRIs for beneficiaries with implanted PMs or implantable cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study. This policy is effective for claims with dates of service on and after February 24, 2011. Providers should follow the instructions issued in the MM7296 article and the additional instructions referenced.

The following information should be included on MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study:

- Appropriate MRI code;
- Q0 modifier;
- ICD-9 code V70.7 - Examination of participant in clinical trial (institutional claims only);
- Condition code 30 (institutional claims only); and
- ICD-9 code V45.02 (automatic cardiac defibrillator) or CPT code V45.01 (cardiac pacemaker).

MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study that do not include all the line items listed above will be denied using the following remittance messages:

- Group code of CO;
- CARC B5 (coverage/program guidelines were not met or were exceeded); and
- Remittance advice remarks code (RARC) N386 (This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have Web access, you may contact the contractor to request a copy of the NCD).

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MRI...*continued*

Providers are reminded that ICD-10 implementation occurs on October 1, 2013. At that time the ICD-9 codes mentioned above will be replaced by the appropriate ICD-10 codes, which are:

- ICD-10 - Z006 – Encounter for examination for normal comparison and control in clinical research program;
- ICD-10 - Z950 – Presence of cardiac pacemaker; and
- ICD-10 - Z95810 – Presence of automatic implantable cardiac defibrillator.

Medicare payment for these services is as follows:

- Professional claims (practitioners and suppliers) – based on the Medicare physician fee schedule (MPFS).
- Inpatient (type of bill (TOB) 11x) – prospective payment system (PPS), based on the diagnosis-related group.
- Hospital outpatient departments (TOB 13x) – outpatient PPS, based on the ambulatory payment classification.
- Rural health clinics (RHCs)/federally qualified health centers (FQHCs) (TOB 71x/77x) – All-inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRI. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bills their carrier or A/B MAC on the ANSI X12N 837P or hardcopy form CMS-1500 and payment is made under the MPFS.
- Critical access hospitals (CAHs) (85x) – for CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method, which is reasonable cost. The FI or A/B MAC pays the professional component at 115 percent of the MPFS.

Medicare will not adjust claims automatically that were processed prior to implementation of CR7441. However, they will adjust such claims that you bring to the attention of your Medicare contractor.

Please be sure that your staffs are aware of these changes.

Additional information

To view the article, MM7296, "Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with Implanted Permanent Pacemakers (PMs) or Implantable Cardioverter Defibrillators (ICDs)," visit *http://www.cms.gov/MLNMattersArticles/Downloads/MM7296.pdf*.

The official instruction, CR 7441, was issued to your FI, carrier, or A/B MAC regarding this change in two transmittals. The first modified the *National Coverage Determinations Manual* and is at *http://www.cms.gov/Transmittals/downloads/R135NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and is at *http://www.cms.gov/Transmittals/downloads/R2307CP.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*.

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Related Change Request (CR) #: 7441
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Related CR Transmittal #: R2307CP and R135NCD
Implementation Date: September 26, 2011

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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/index.asp.*

Changes to the laboratory NCD edit software for October 2011

Note: This article was revised on September 6, 2011, to reflect a revised change request (CR) 7507. The CR was revised to add some codes and delete some codes from the various NCDs. In addition, the CR release date, transmittal number, and the Web address for accessing the CR have been revised. This information was previously published in the August 2011 *Medicare A Connection*, pages 23-24.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider action needed

This article is based on CR 7507, which announces the changes that will be included in the October 2011 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in April 2011. Be sure billing staff know about these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, available at *http://www.cms.gov/manuals/downloads/clm104c16.pdf* on the Centers for Medicare & Medicaid Services (CMS) website, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 7507 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2011. These changes become effective for services furnished on or after October 1, 2011. The changes that are effective for dates of service on and after October 1, 2011 are as follows:

- For codes that are denied by Medicare for all 23 lab NCDs:
  - Delete ICD-9-CM code V19.1 from the list of ICD-9-CM codes that are denied by Medicare for all 23 lab NCDs.
  - Add ICD-9-CM codes V19.11 and V19.19 to the list of ICD-9-CM codes that are denied by Medicare for all 23 lab NCDs.
- For codes that are covered by Medicare for the HIV testing:
  - Add ICD-9-CM codes 512.81, 512.82, and 512.83 to the list of codes covered by Medicare for HIV testing (diagnosis) (190.14) NCD.
  - Delete ICD-9-CM code 512.8 from that same list.
- For codes that do not support medical necessity for the blood counts
  - Add ICD-9-CM codes 726.13, V40.31, V40.39, and V54.82 to the list of ICD-9-CM codes that do not support medical necessity for the blood counts (190.15) NCD.
  - Delete ICD-9-CM codes 718.60 and V40.3 from that list.
- For partial thromboplastin time
  - Delete ICD-9-CM codes 286.5, 444.0, and 596.8 from the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
  - Add ICD-9-CM codes 286.52, 286.53, 286.59, 444.01, 444.09, 596.81, 596.82, 596.83, and 596.89 to the list of ICD-9-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- For prothrombin time
  - Delete ICD-9-CM codes 286.5, 425.1, 444.0, 596.8, and 997.4 from the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
  - Add ICD-9-CM codes 286.52, 286.53, 286.59, 414.4, 415.13, 425.11, 425.18, 444.01, 444.09, 573.5, 596.81, 596.82, 596.83, 596.89, 997.41, 997.49, and V12.55 to the list of ICD-9-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- For serum iron studies
  - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.
  - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80,

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Lab...*continued*

- 173.92, 173.99, 282.40, 282.43, 282.44, 282.45, 282.46, 282.47, 286.52, 286.53, 286.59, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

- For blood glucose testing
  - Add ICD-9-CM codes 414.4, V23.42 and V23.87 to the list of ICD-9-CM codes that are covered by Medicare for the blood glucose testing (190.20) NCD.
- For glycated hemoglobin/glycated protein
  - Delete ICD-9-CM code V12.2 from the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
  - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- For thyroid testing:
  - Delete ICD-9-CM code V12.2 from the list of covered ICD-9-CM codes for the thyroid testing (190.22) NCD.
  - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.
- For lipids testing
  - Delete ICD-9-CM code 444.0 from the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.
  - Add ICD-9-CM codes 414.4, 444.01, 444.09, and573.5 to the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.
- For digoxin therapeutic drug assay:
  - Add ICD-9-CM codes 414.4, 425.11, 425.18, 444.01, 44.09, and 573.5 to the list of codes covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD.
- For Alpha-fetoprotein:
  - Delete ICD-9-CM codes 425.1 and 793.1 from the list of codes covered by Medicare for the Alpha-fetoprotein (190.25) NCD.
  - Add ICD-9-CM codes 414.4, 425.11, 425.18, 444.01, 444.09, 573.5, 793.11, and 793.19 to the same list of covered codes.
- For human chorionic gonadotropin
  - Delete ICD-9-CM code 631 from the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.
  - Add ICD-9-CM codes 631.0 and 631.8 to the list of ICD-9-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.
- For gamma glutamyl transferase:
  - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, and 173.9 from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD.
  - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the gamma glutamyl transferase (190.32) NCD.
  - Add ICD-9-CM code 573.5 to the list of codes covered by Medicare for the hepatitis panel/ acute hepatitis panel (190.33) NCD.
- For fecal occult blood test
  - Delete ICD-9-CM code 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.
  - Add ICD-9-CM codes 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.

Additional information

The official instruction, CR 7507 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2298CP.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: MM7507 Revised
Related Change Request (CR) #: 7507
Related CR Release Date: September 2, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2298CP
Implementation Date: October 3, 2011

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (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 Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

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 website is considered the notice date.

Contents

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. **Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **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 to LCDs

AJ1740: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – new LCD

LCD ID number: L32110 (Florida/Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) has been developed based on errors identified related to the use of certain intravenous (IV) bisphosphonates administered to male patients for the prevention and treatment of osteoporosis. It was determined that patients received IV Boniva instead of oral drugs even though there were no documented contraindications to the administration of oral medications. Some patients who received IV Boniva had normal bone mineral density test results. Additionally, certain IV bisphosphonates were administered to patients with a bone density T-score of -1.0 and -2.5 (osteopenia).

This LCD addresses certain IV bisphosphonates and outlines the indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. In addition, a "Coding Guidelines" LCD attachment has also been developed for these medications which includes billing information.

Effective date

This new LCD is effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

A22533: Lumbar spinal fusion for instability and degenerative disc conditions – new LCD

LCD ID number: L32074 (Florida/Puerto Rico/U.S. Virgin Islands)

Causes of low back pain stem from a wide variety of conditions, although in some cases no specific etiology is identified. The goal of lumbar spinal fusion, also referred to as lumbar arthrodesis, is to permanently immobilize the spinal column vertebrae surrounding the disc(s) that are causing the discogenic low back pain. Surgical techniques to achieve lumbar spinal fusion are numerous, and include different surgical approaches to the spine. Spinal fusion should only be considered as a last step in the treatment of back pain and is not recommended for all persons suffering from back pain.

A local coverage determination (LCD) has been developed as a result of errors found by the Comprehensive Error Rate Testing (CERT) when reviewing inpatient hospital claims for lumbar spinal fusion surgery. This LCD gives indications and limitations of coverage, *CPT* codes, documentation requirements, utilization guidelines, and coding guidelines for lumbar spinal fusion for instability and degenerative disc conditions.

Effective date

This new LCD is effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

A27130: Major joint replacement (hip and knee) – new LCD

LCD ID number: L32078 (Florida/Puerto Rico/U.S. Virgin Islands)

The November 2010 inpatient medical severity-diagnosis related group (MS-DRG) error rate for Part A Medicare administrative contractor (MAC) for jurisdiction 9 (J9) was 18.1 percent. This error rate is considerably higher than the national inpatient DRG rate. Based on comprehensive error rate testing (CERT) review findings, MS-DRG 470 (major joint replacement or reattachment of lower extremity) has been identified as being high risk for payment error, with a November 2010 payment error of 23.90 percent. 100 percent of the errors identified by CERT were due to failure of documentation in the hospital medical record to support the medical necessity of the procedure.

This local coverage determination (LCD) has been developed as a result of the CERT errors identified, when reviewing inpatient hospital claims for total hip and total knee replacement surgery. This LCD gives indications and limitations of coverage, *CPT* codes, documentation requirements, utilization guidelines, ICD-9-CM diagnosis codes, ICD-9-CM procedure codes and coding guidelines for major joint replacement (hip and knee).

Effective date

This new LCD is effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

A37221: Vascular stenting of lower extremity arteries – new LCD

LCD ID number: L32107 (Florida/Puerto Rico/U.S. Virgin Islands)

Medicare administrative contractor (MAC) jurisdiction 9 (J9) will consider vascular stenting of lower extremity arteries medically reasonable and necessary for a patient under any of the circumstances as outlined in the local coverage determination (LCD) for this service.

This LCD has been developed to provide indications and limitations of coverage and/or medical necessity, ICD-9-CM codes that support medical necessity, documentation requirements and utilization guidelines for vascular stenting of lower extremity arteries. A "Coding Guidelines" LCD attachment has also been developed for this service.

Effective date

This new LCD is effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

Get news about LCDs delivered to your inbox

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the FCSO *eNews* mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

A86849: Circulating tumor cell testing – new LCD

LCD ID number: L32096 (Florida/Puerto Rico/U.S. Virgin Islands)

Circulating tumor cells (CTCs) are rare malignant cells found in the peripheral blood which originate from the primary tumor or metastatic sites. The detection of CTCs has several proposed applications, some of which have been reported in well-designed observational studies (prospective and retrospective) of patients with metastatic cancers. There are also several controlled clinical trials in progress assessing the clinical utility of CTC results in the care of patients with metastatic cancers (application in clinical decision making that impacts patient outcomes). There are several methods of detecting CTCs which are in various stages of research and development. The low level of concentration of malignant epithelial cells in blood samples makes them difficult to detect though the push to improve surveillance and treatment of cancer patients makes CTC an area of research and development. The techniques that have been used to detect CTCs include direct methods (enrichment/detection) including Immunomagnetic Bead Separation, Immunohistochemistry (IHC), automated fluorescent methods, Dielectrophoresis and indirect methods (reverse-transcriptase polymerase chain reaction [RT-PCR] nucleic acid analysis).

This Medicare administrative contractor (MAC) jurisdiction 9 (J9) local coverage determination (LCD) addresses very limited coverage for one methodology, the CellSearch® assay (Veridex LLC, Warren, NJ) circulating tumor cell (CTC) assay. All other methods for CTC detection, including PCR (RT-PCR) assays, are non-covered. All assays of CTC are non-covered for all diagnoses for routine screening or prognostic statements (prediction of overall or progression free survival).

CTC testing per the CellSearch® assay can be covered for patients with metastatic breast, colorectal and prostate cancer when the criteria is met as outlined in this LCD, which has been developed to provide indications and limitations of coverage and/or medical necessity, ICD-9-CM codes that support medical necessity, documentation requirements and utilization guidelines for this service. In addition, a "Coding Guidelines" LCD attachment has also been developed for this service.

Effective date

This new LCD is effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

Revisions to LCDs

Magnetic resonance imaging (MRI) – revisions to the LCDs (Part A)

LCD ID number: L28904, L28905, L28906, L28907 (Florida)
LCD ID number: L28926, L28927, L28928, L28929 (Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) issued change request 7441, transmittals 134 and 2293 on August 26, 2011. This change request outlines new coverage requirements for magnetic resonance imaging (MRI) in those patients with implanted permanent pacemakers (PMs). CMS believes that the evidence is adequate enough to conclude that MRI improves health outcomes for Medicare beneficiaries with PMs when the PMs are used according to the Food and Drug Administration (FDA) labeling for use in an MRI environment. Other contraindications that may be present in any given beneficiary would continue to apply in patients with PMs. These other contraindications are listed in the national coverage decision (NCD) for cardiac pacemakers, pub 100-03, chapter 1, part 4, section 220.2.C.1. The following LCDs have been revised according to the new requirements found in change request 7441: 70551 (MRI of the brain); 70540 (MRI of the orbit, face and/or neck); 72141 (MRI of the spine); 73218 (MRI of upper extremity).

Effective date

These LCD revisions are effective for claims processed **on or after September 26, 2011, for services provided**

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MRI...*continued*

on or after July 7, 2011. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

ANCSVCS: Noncovered services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised on July 1, 2011. Since that time, a revision was made to the LCD. New Category III *CPT* codes from the Centers for Medicare & Medicaid Services (CMS) Annual 2011 HCPCS Update (Change Request [CR] 7121) and from the CMS July 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS (CR 7443) were evaluated and were determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, Category III *CPT* codes *0234T, 0235T, 0236T, 0237T*, *0238T, 0254T, 0255T, 0263T, 0264T, 0265T, and 0274T* were added to the noncovered services LCD.

Under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD, the following Category III *CPT* codes were added:

- *0234T - Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery*
- *0235T - Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel*
- *0236T - Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta*
- *0237T - Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel*
- *0238T - Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel*
- *0254T - Endovascular repair of iliac artery bifurcation (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using bifurcated endoprosthesis from the common iliac artery into both the external and internal iliac artery, unilateral;*
- *0255T - Endovascular repair of iliac artery bifurcation (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using bifurcated endoprosthesis from the common iliac artery into both the external and internal iliac artery, unilateral; radiological supervision and interpretation*
- *0263T - Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest*
- *0264T - Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest*
- *0265T - Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy*
- *0274T - Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method*

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ANCSVCS...*continued*

under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic

In addition, unlisted *CPT* code *47399* (Irreversible electroporation [e.g., NanoKnife System] - surgical ablation of soft tissue of the liver; other unlisted codes should be submitted based on the anatomical location performed) was evaluated and was determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, *CPT* code *47399* was added under the "CPT/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD.

Also, *CPT* codes *82172, 83090GY, 86618, 86628,* and *86631* were evaluated for coverage and it was determined to remove them from the "*CPT*/HCPCS Codes - Local Noncoverage Decisions – Laboratory Procedures" section of the LCD.

Effective date

The LCD revision to add *CPT* codes *0234T, 0235T, 0236T, 0237T*, *0238T, 0254T, 0255T, 0263T, 0264T, 0265T, 0274T, and 47399* is effective for services provided **on or after October 16, 2011**. The LCD revision to remove CPT codes *82172, 83090GY, 86618, 86628,* and *86631* is effective for services provided **on or after September 16, 2011**.

First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

A93303: Transthoracic echocardiography (TTE) – revision to the LCD

LCD ID number: L28997 (Florida)
LCD ID number: L29029 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for transthoracic echocardiography (TTE) was most recently revised on October 14, 2010. Since that time, revisions were made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, to update the application of coverage and clarify utilization of testing for the conditions and diagnoses listed. Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

A93922: Noninvasive physiologic studies of upper or lower extremity arteries – revision to the LCD

LCD ID number: L28938 (Florida)
LCD ID number: L28959 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noninvasive physiologic studies of upper or lower extremity arteries was most recently revised on January 1, 2011. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to add language to indicate that the transcutaneous oxygen tension measurements (Tp02) may be performed by personnel credentialed as a certified hyperbaric registered nurse (CHRN) or certified hyperbaric technologist (CHT) by the National Board of Diving and Hyperbaric Medical Technology (NBDHMT).

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A93922...*continued*

Effective date

This LCD revision is effective for services provided **on or after August 23, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

Retired LCDs

AJ3487: Zoledronic acid – retired LCD

LCD ID number: L29009 (Florida) L29041 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for zoledronic acid was most recently revised on February 11, 2010. Since that time, a new LCD titled "bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications" (AJ1740) has been developed which replaces the zoledronic acid LCD. Therefore, the zoledronic acid LCD is being retired.

Effective date

This LCD is retired effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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

AJ1740: Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – clarification to the LCD

LCD ID number: L32110 (Florida/Puerto Rico/U.S. Virgin Islands)

An article was posted to the Centers for Medicare & Medicaid Services' (CMS) website and to First Coast Service Options' (FCSO) provider website on September 2, 2011, to begin the notice period for this local coverage determination (LCD). Since that time, the dual diagnosis requirement (represented by ICD-9-CM diagnosis code E932.0 [Adrenal cortical steroids causing adverse effects in therapeutic use]) was removed for Prolia™.

Effective Date

This LCD is effective for services provided **on or after October 16, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the Centers for Medicare & Medicaid Services (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.

2012 ICD-9-CM coding changes (Part A)

The 2012 update to the ICD-9-CM diagnosis coding structure is effective for services provided **on or after October 1, 2011**. Providers are required to use the 2012-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring **on or after October 1, 2011**. Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) use the appropriate ICD-9-CM coding. In addition, the new diagnosis coding is used in hospital outpatient billing, as well as other non-OPPS providers that code diagnoses and procedures. First Coast Service Options Inc. (FCSO) has revised the LCDs for procedure codes with specific diagnosis criteria that are affected by the 2012 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2012 ICD-9-CM update:

LCD title	2012 changes
A17311 Mohs Micrographic Surgery (MMS)	Removed diagnosis codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, and 173.8 for procedure codes *17311, 17312, 17313, 17314,* and *17315*. Added diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, 173.40-173.49, 173.50-173.59, 173.60-173.69, 173.70-173.79 and 173.80-173.89 for procedure codes *17311, 17312, 17313, 17314*, and *17315*.
A43235 Diagnostic and Therapeutic Esophagogastroduodenoscopy	Removed diagnosis code 997.4 for procedure codes *43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255,* and *43258*. Added diagnosis code range 997.41-997.49 for procedure codes *43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255,* and *43258*.
A70544 Magnetic Resonance Angiography (MRA)	Removed diagnosis code 444.0 for procedure codes *74185,* C8900, C8901, and C8902. Added diagnosis code range 444.01-444.09 for procedure codes *74185,* C8900, C8901, and C8902.
A71275 Computed tomographic Angiography of the Chest, Heart and Coronary Arteries	Removed diagnosis codes 518.5 and 747.3 for procedure code *71275*. Added diagnosis code ranges 518.51-518.53 and 747.31-747.39 for procedure code *71275*. Added diagnosis code 414.4 for procedure codes *75571, 75572, 75573,* and *75574*.
A73218 Magnetic Resonance Imaging of Upper Extremity	Removed diagnosis code 173.6 for procedure codes *73218, 73219, 73220, 73221, 73222,* and *73223*. Added diagnosis code range 173.60-173.69 for procedure codes *73218, 73219, 73220, 73221, 73222,* and *73223*. Changed individual diagnosis codes 999.31 and 999.39 to diagnosis code range 999.31-999.39 to include new diagnosis codes 999.32-999.34 for procedure codes *73218, 73219, 73220, 73221, 73222,* and *73223*.
A75722 Renal Angiography	Removed diagnosis code 444.0 for procedure codes *75722* and *75724*. Added diagnosis code range 444.01-444.09 for procedure codes *75722* and *75724*.

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ICD-9...*continued*

LCD title	2012 changes
A77402 Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin	Removed diagnosis codes 173.0, 173.1, 173.2, 173.3, 173.5, 173.6, 173.7, and 173.9 for procedure codes *77401, 77402, 77403, 77404, 77406, 77785, 77786,* and *77789*. Added diagnosis codes 173.01, 173.02, 173.11, 173.12, 173.21, 173.22, 173.31, 173.32, 173.51, 173.52, 173.61, 173.62, 173.71, 173.72, 173.91, and 173.92 for procedure codes *77401, 77402, 77403, 77404, 77406, 77785, 77786,* and *77789*.
A78459 Myocardial Imaging, Positron Emission Tomography (PET) Scan	Added diagnosis code 414.4 for procedure codes *78459, 78491,* and *78492*.
A83735 Magnesium	Removed diagnosis code 998.0 for procedure code *83735*. Added diagnosis code range 998.00-998.09 for procedure code *83735*.
A86003 Allergy Testing	Changed descriptor for diagnosis code 995.0 for procedure codes *86003, 95004, 95010, 95015, 95024, 95027*, and *95028*. Changed descriptors for diagnosis codes 995.60, 995.61, 995.62, 995.63, 995.64, 995.65, 995.66, 995.67, 995.68, and 995.69 for procedure codes *86003, 86005, 86160, 86161, 86162,* and *95004*.
A90802 Interactive Psychiatric Services	Changed descriptors for diagnosis codes 317, 318.0, 318.1, and 318.2 for procedure codes *90802, 90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829,* and *90857*.
A90804 Individual Psychotherapy	Changed descriptors for diagnosis codes 317 and 318.0-318.2 for procedure codes *90804, 90806,* and *90808*.
A90847 Family Psychotherapy	Changed descriptors for diagnosis codes 317 and 318.0-318.2 for procedure codes *90846* and *90847*.
A90853 Group Psychotherapy	Changed descriptors for diagnosis codes 317 and 318.0-318.2 for procedure code *90853*.
A90862 Pharmacologic Medication Management for Psychotherapy Services	Changed descriptors for diagnosis codes 317 and 318.0-318.2 for procedure codes *90862* and *M0064*.
A92081 Visual Field Examination	Removed new diagnosis code range 365.70-365.74 from diagnosis code range 365.00-365.9 for procedure codes *92081, 92082,* and *92083* as they are not appropriate. Added diagnosis codes 365.05 and 365.06 for procedure codes *92081, 92082,* and *92083*.
A92132 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	Added diagnosis code 365.05 for procedure codes *92133* and *92134*. Added diagnosis code 365.06 for procedure code *92132, 92133,* and *92134*.
A92225 Ophthalmoscopy	Added diagnosis codes 365.05, 365.06, and 365.70-365.74 for procedure codes *92225* and *92226*.
A93224 External Electrocardiography Recording	Added diagnosis code 414.4 for procedure codes *93224, 93225, 93226,* and *93227*.

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ICD-9...*continued*

LCD title	2012 changes
A93303 Transthoracic Echocardiography (TTE)	Removed diagnosis code 998.0 for procedure codes *93306, 93307, 93308*, C8923, and C8924. Added diagnosis codes 414.4 and 998.00-998.09 for procedure codes *93306, 93307, 93308,* C8923, and C8924. Changed diagnosis code range 444.0-444.9 to diagnosis code range 444.01-444.9 for procedure codes *93306, 93307, 93308*, C8923, and C8924. Changed individual diagnosis codes 999.31 and 999.39 to diagnosis code range 999.31-999.39 to include new diagnosis codes 999.32-999.34 for procedure codes *93306, 93307, 93308,* C8923, and C8924.
A93312 Transesophageal Echocardiogram	Removed diagnosis code 747.3 for procedure codes *93312, 93313, 93314, 93315, 93316, 93317, 93318,* C8925, C8926, and C8927. Added diagnosis codes 414.4 and 747.31-747.39 for procedure codes *93312, 93313, 93314, 93315, 93316, 93317, 93318,* C8925, C8926, and C8927. Changed diagnosis code range 444.0-444.9 to diagnosis code range 444.01-444.9 for procedure codes *93312, 93313, 93314, 93315, 93316, 93317, 93318,* C8925, C8926, and C8927.
A93350 Stress Echocardiography	Added diagnosis code 414.4 for procedure codes *93350, 93351,* and *93352*.
A93701 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance	Added diagnosis code 414.4 for procedure code *93701*.
A93922 Non-Invasive Physiologic Studies of Upper or Lower Extremity Arteries	Removed diagnosis code 444.0 for procedure codes *93922, 93923,* and *93924*. Added diagnosis code range 444.01-444.09 for procedure codes *93922, 93923,* and *93924*.
A93925 Duplex Scan of Lower Extremity Arteries	Removed diagnosis code 444.0 for procedure codes *93925* and *93926*. Added diagnosis codes 444.01 and 444.09 for procedure codes *93925* and *93926*.
A93965 Non-Invasive Evaluation of Extremity Veins	Added diagnosis code 415.13 for procedure codes *93965, 93970,* and *93971*.
A93975 Duplex Scanning	Removed diagnosis code 444.0 for procedure codes *93978* and *93979*. Added diagnosis code range 444.01-444.09 for procedure codes *93978* and *93979*.
A94640 Diagnostic Aerosol or Vapor Inhalation	Removed diagnosis code 793.1 for procedure code *94640*. Added diagnosis code range 793.11-793.19 for procedure code *94640*.
AG0237 Respiratory Therapeutic Services	Removed diagnosis code 516.3 for procedure codes G0237, G0238, and G0239. Added diagnosis code range 516.30-516.37 for procedure codes G0237, G0238, and G0239.
AJ2820 Sargramostim (GM-CSF, Leukine®)	Added diagnosis code 996.88 for procedure code J2820.

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ICD-9...*continued*

LCD title	2012 changes
AJ7187 Hemophilia Clotting Factors	Removed diagnosis code 286.5 for procedure codes J7186, J7187, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7198, and Q2041. Added diagnosis code range 286.52-286.59 for procedure codes J7186, J7187, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7198, and Q2041.
AJ7308 Topical Photosensitizers used with PDT for Actinic Keratoses and Certain Skin Cancers	Removed diagnosis codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, and 173.8 for procedure codes J7308 and J7309. Added diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, 173.40-173.49, 173.50-173.59, 173.60-173.69, 173.70-173.79 and 173.80-173.89 for procedure codes J7308 and J7309.
AJ9171 Docetaxel (Taxotere®)	Removed diagnosis codes 173.0, 173.1, 173.2, 173.3, and 173.4 for procedure code J9171. Added diagnosis code ranges 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39, and 173.40-173.49 for procedure code J9171.
AJ9181 Etoposide, (Etopophos®, Toposar®, Vepesid®, VP-16	Changed diagnosis code range 173.0-173.9 to diagnosis code range 173.00-173.99 for procedure code J9181.
APHPPROG Psychiatric Partial Hospitalization Program	Changed descriptors for diagnosis codes 317 and 318.0-318.2 for procedure codes *90801, 90802, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90846, 90847, 90875, 90876, 96101, 96116, 96118, 97532, 97533,* G0129, G0176, G0177, G0410, and G0411.
APULMDIAGSVCS Pulmonary Diagnostic Services	Removed new diagnosis code range 516.61-516.69 from diagnosis code range 516.0-516.9 for procedure codes *93720, 93721, 93722, 94010, 94060, 94070, 94150, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725,* and *94750* as they are not appropriate. Removed diagnosis code 793.1 for procedure codes *93720, 93721, 93722, 94010, 94060, 94070, 94150, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725,* and *94750*. Added diagnosis codes 516.30-516.37, 516.4 and 516.5 for procedure codes *93720, 93721, 93722, 94010, 94060, 94070, 94150, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725,* and *94750*. Added diagnosis code range 793.11-793.19 for procedure codes *93720, 93721, 93722, 94010, 94060, 94070, 94150, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620, 94621, 94720, 94725,* and *94750*.

Are you prepared for version 5010?

Summer is coming to an end, and the version 5010 transition deadline is now only four months away. As the January 1, 2012, deadline approaches, your transition should be well underway. There are certain steps to be taking now during the fall to make sure you are on track for a smooth transition.

If you are a provider, you should:

- Continue external testing and making any revisions to systems based on previous internal testing
- Test those transactions that are used on a daily basis, such as claims and eligibility determinations

If you are a payer, you should:

- Continue to coordinate the transition to the new formats and testing with providers, clearinghouses, billing services, and other business partners
- Complete external testing and your version 5010 transition by Saturday, December 31, 2011, to achieve level II compliance

If you are a vendor, you should:

- Continue to conduct external trading partner testing of version 5010 with customers to achieve level II compliance
- Conduct solution rollout and provide customer support for the version 5010 transition through the January 1, 2012, compliance date

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

For more information visit the CMS website. Please visit *version 5010* for the most current information on all 5010 issues and visit *CMS ICD-10* for the latest news and resources on ICD-10 to help you prepare.

Source: CMS PERL 201109-33

Help planning for version 5010 and ICD-10 is available from CMS

Do you need help with the transition to version 5010 or planning for ICD-10? The Centers for Medicare & Medicaid Services (CMS) has created an *interactive timeline widget* that is now available on the CMS' ICD-10 and version 5010 compliance timelines page. This user-friendly tool can help you and your organization:

- Understand what you should be doing right now to prepare for the switches to version 5010 and ICD-10
- Know the steps you'll need to take in the future and when
- Stay on top of approaching transition deadlines to help manage the implementation process

The content of the widget is tailored with specific information for large and small provider practices, payers, and vendors. Also available are printer-friendly versions of the timeline information to download and use as check lists.

CMS also has other *new resources* to help you transition, including fact sheets and frequently asked questions for both version 5010 and ICD-10. With the version 5010 deadline fast approaching, it will be important to take advantage of these new resources now to ensure you are on the right track.

The transitions to version 5010 and ICD-10 involve significant preparations, and the transitions also require business and systems changes throughout health care industry. CMS is committed to helping you better prepare for version 5010 and ICD-10.

Keep up to date on version 5010 and ICD-10

Please visit CMS' *ICD-10 website* for the latest news and resources to help you prepare, and visit CMS' ICD-10 and version 5010 compliance timelines page to download and share the widget today.

Source: CMS PERL 201109-25

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.

Announcements

The HIPAA 5010 compliance date is fast-approaching. There are only five months left until full implementation on January 1, 2012. Please contact your local Medicare administrative contractor (MAC) and test now.

Reminders

January 1, 2011, marked the beginning of the 5010/D.0. transition year.

Versions 5010 & D.0 FAQs Now Available!
National Testing Day Message Now Available!
5010/D.0 Errata requirements and testing schedule can be found here
Contact your MAC for their testing schedule

Readiness assessment

Have you done the following to be ready for 5010/D.0.?
What do you need to have in place to test with your Medicare administrative contactor (MAC)?
Do you know the implications of not being ready?

Implementation calendar

Upcoming events

September 2011
September 14: CMS-hosted Medicare fee-for-service national call – question & answer session

October 2011
October 5: MAC hosted outreach and education session – last push for implementation
October 24-27: *WEDI 2011 fall conference* *

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*
June 30: *5010 national call -- 837 institutional claim transaction*

July 2010
July 28: *5010 national call -- 276/277 claim status inquiry and response transaction set*

August 2010
August 25: *5010 national call -- 835 remittance advice transaction*

September 2010
September 27: *5010 national call -- acknowledgement transactions (TA1, 999, 277CA)*

October 2010
October 13: *5010/D.0. errata requirements and testing schedule released*
October 27: *5010 national call -- NCPDP version D.0. transaction*

November 2010
November 4: *Version 5010 resource card published*
November 8: *WEDI 2010 fall conference* *
November 17: *5010 national call -- coordination of benefits (COB)*

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Calendar...*continued*

December 2010
December 8: *5010 national call -- MAC outreach and education activities and transaction-specific testing protocols*

January 2011
January 1: Beginning of transition year
January 11: *HIMSS 5010 industry readiness update* *
January 19: *5010 national call -- errata/companion guides*
January 25-27: *4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation* *

February 2011
February 20-24: *Healthcare Information and Management Systems Society (HIMSS) 11th Annual Conference & Exhibition* *

March 2011
March 1: New readiness assessment – *Do you know the implications of not being ready?*
March 30: *CMS-hosted 5010 national call -- provider testing and readiness* .

April 2011
April 4-11: Version 5010 test education week
April 27: MAC hosted outreach and education session -- are you ready to test?

May 2011
May 2-5: *20th Annual WEDI National Conference* *
May 25: *Medicare fee-for-service national call -- call to action -- test*

June 2011
June 15: National MAC Testing Day
June 29: *CMS-hosted Medicare fee-for-service national call -- question & answer session*

July 2011
July 20: MAC hosted outreach and education session -- troubleshooting with your MAC

August 2011
August 22-26: National MAC Testing Week
August 31: *CMS-hosted Medicare FFS national call -- MAC panel questions & answers*

September 2011
September 14: CMS-hosted Medicare FFS national call – question & answer session

For older national call information, please visit the *5010 National Calls section of CMS' versions 5010 & D.0. Web page.*

* 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.

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

Source: CMS PERL 201109-06

Get ready for 5010 – test now

Visit our HIPAA 5010 section of the provider website where you'll learn the latest news about HIPAA 5010, find out how to prepare for 5010 testing, and discover the resources you need to make your the transition to 5010 as smooth as possible. Don't wait – call FCSO's EDI to test now – 888-670-0940, option-5.

Medicare fee-for-service claims processing guidance for ICD-10

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the International Classification of Diseases, 10th Edition (ICD-10) code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key points of CR 7492

- **General reporting of ICD-10**

  As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to *http://www.cms.gov/ICD10* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

- **General claims submissions information**

  ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

- **Claims that span the ICD-10 implementation date**

  The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the

  services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

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ICD-10...*continued*

Table A – institutional providers

Bill type(s)	Facility type/services	Claims processing requirement	Use FROM or THROUGH date
11X	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long-term care hospitals (LTCHs), critical access hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B hospital services	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
13X	Outpatient hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14X	Non-patient laboratory services	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18X	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled nursing (inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled nursing facilities (inpatient Part B)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23X	Skilled nursing facilities (outpatient)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

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ICD-10...*continued*

Bill type(s)	Facility type/services	Claims processing requirement	Use FROM or THROUGH date
32X	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home health – request for anticipated payment (RAPs)*	* Note – RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34X	Home health – (outpatient)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
71X	Rural health clinics	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
72X	End-stage renal disease (ESRD)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
73X	Federally qualified health clinics (prior to 4/1/10)	N/A – always ICD-9 code set.	N/A
74X	Outpatient therapy	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75X	Comprehensive outpatient rehab facilities	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

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ICD-10...*continued*

Bill type(s)	Facility type/services	Claims processing requirement	Use FROM or THROUGH date
76X	Community mental health clinics	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
77X	Federally qualified health clinics (effective 4/4/10)	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
81X	Hospice – hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
82X	Hospice – non hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83X	Hospice – hospital based	N/A	N/A
85X	Critical access hospital	Split claims – require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B – special outpatient claims processing circumstances

Scenario	Claims processing requirement	Use FROM or THROUGH date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

continued on next page

ICD-10...*continued*

Table C – professional claims

Type of claim	Claims processing requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	FROM

Table D – supplier claims

Supplier type	Claims processing requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	FROM

Additional information

The official instruction, CR 7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R950OTN.pdf*.

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

MLN Matters® Number: MM7492
Related Change Request (CR) #: 7492
Related CR Release Date: August 19, 2011
Effective Date: October 1, 2013
Related CR Transmittal #: R950OTN
Implementation Date: January 1, 2012

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.

Medicare Billing Information for Rural Providers and Suppliers publication revised

The *Medicare Billing Information for Rural Providers and Suppliers* publication, which is designed to provide education on Medicare rural billing, has been revised and is available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/RuralChart.pdf*.

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

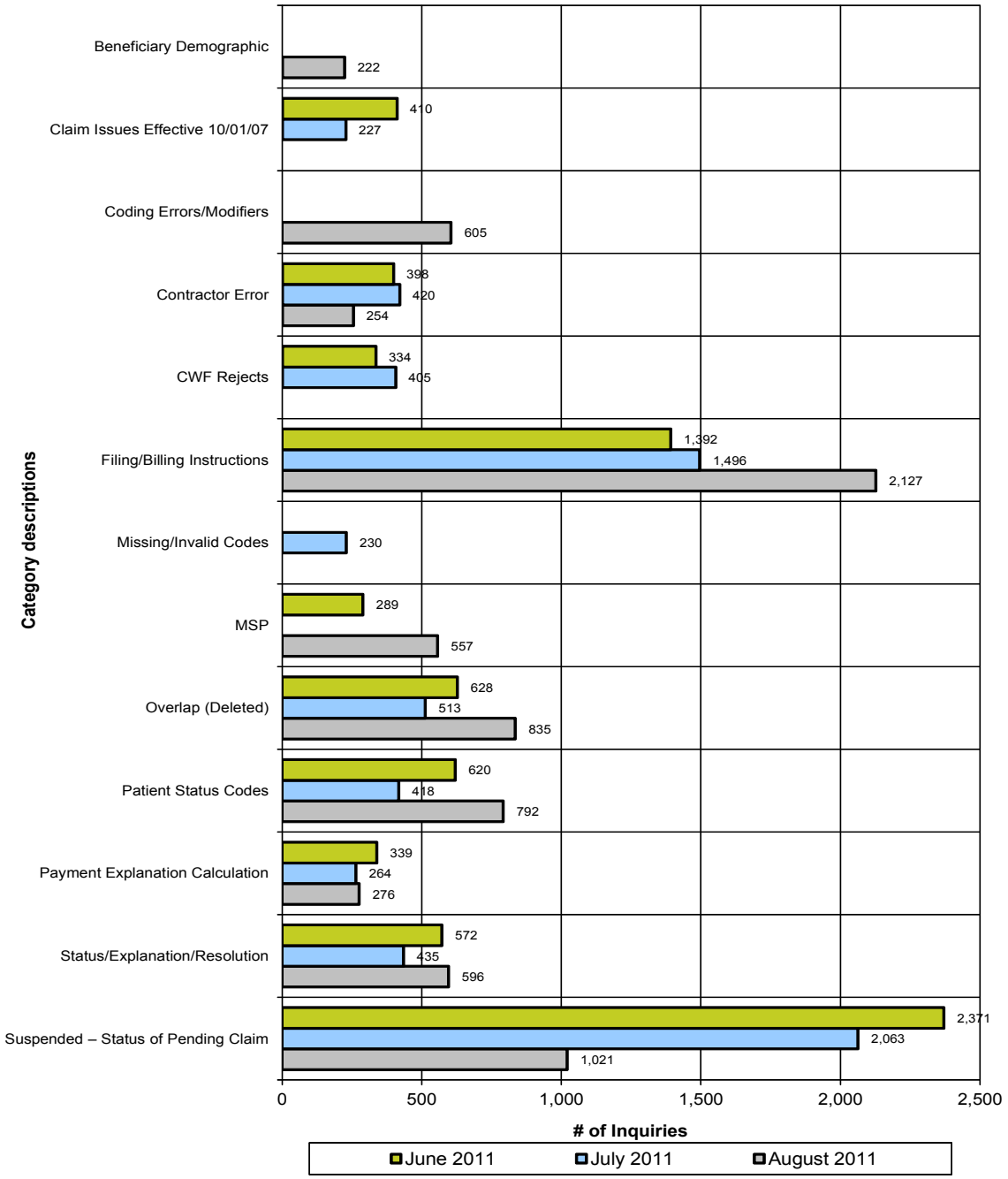
Source: CMS PERL 201108-42

Top inquiries, rejects, and return to provider claims – June-August 2011

The following charts demonstrate the available top number of inquiries, rejected claims, and reason codes for return to providers (RTPs) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during June-August 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 June-August 2011



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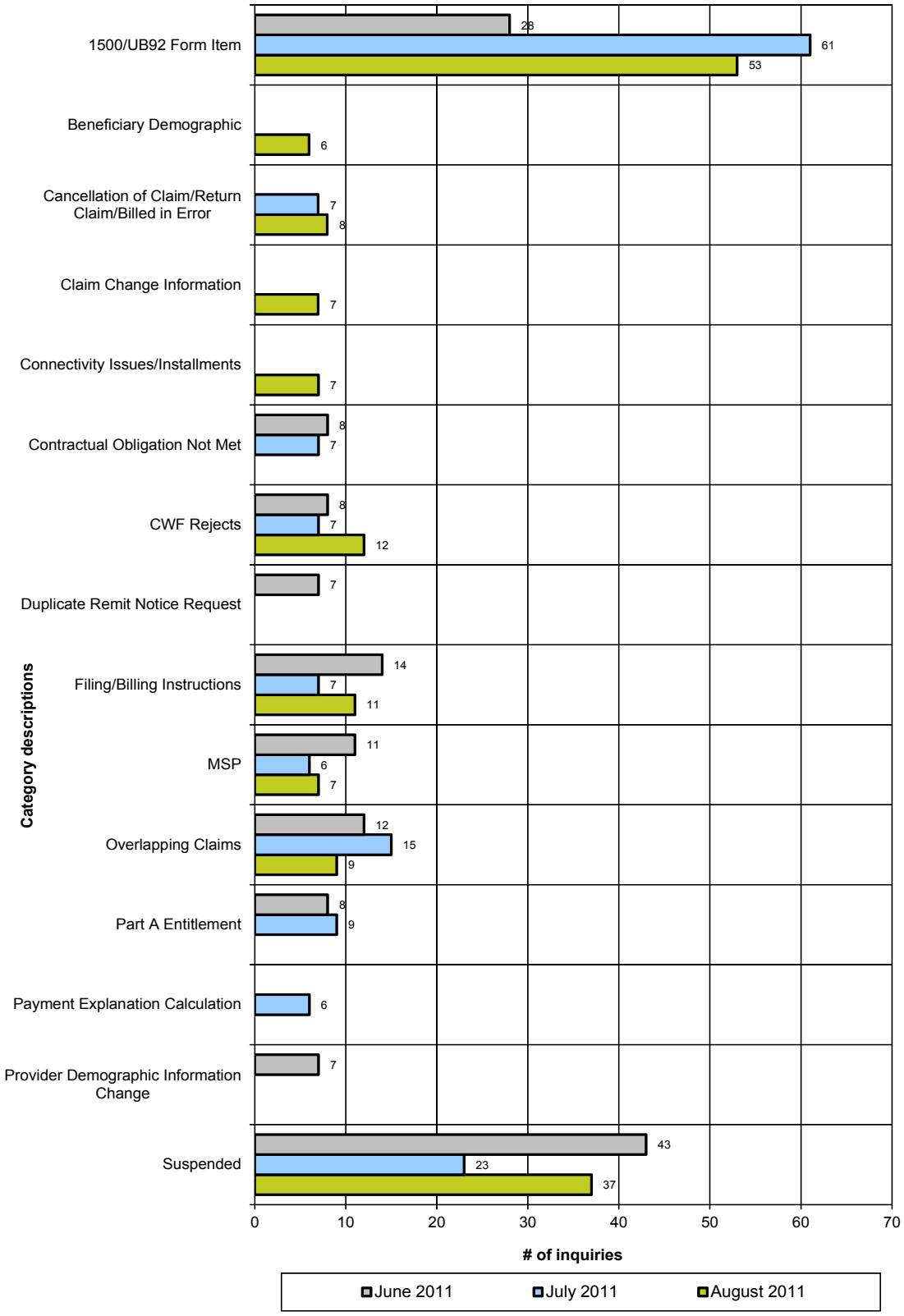
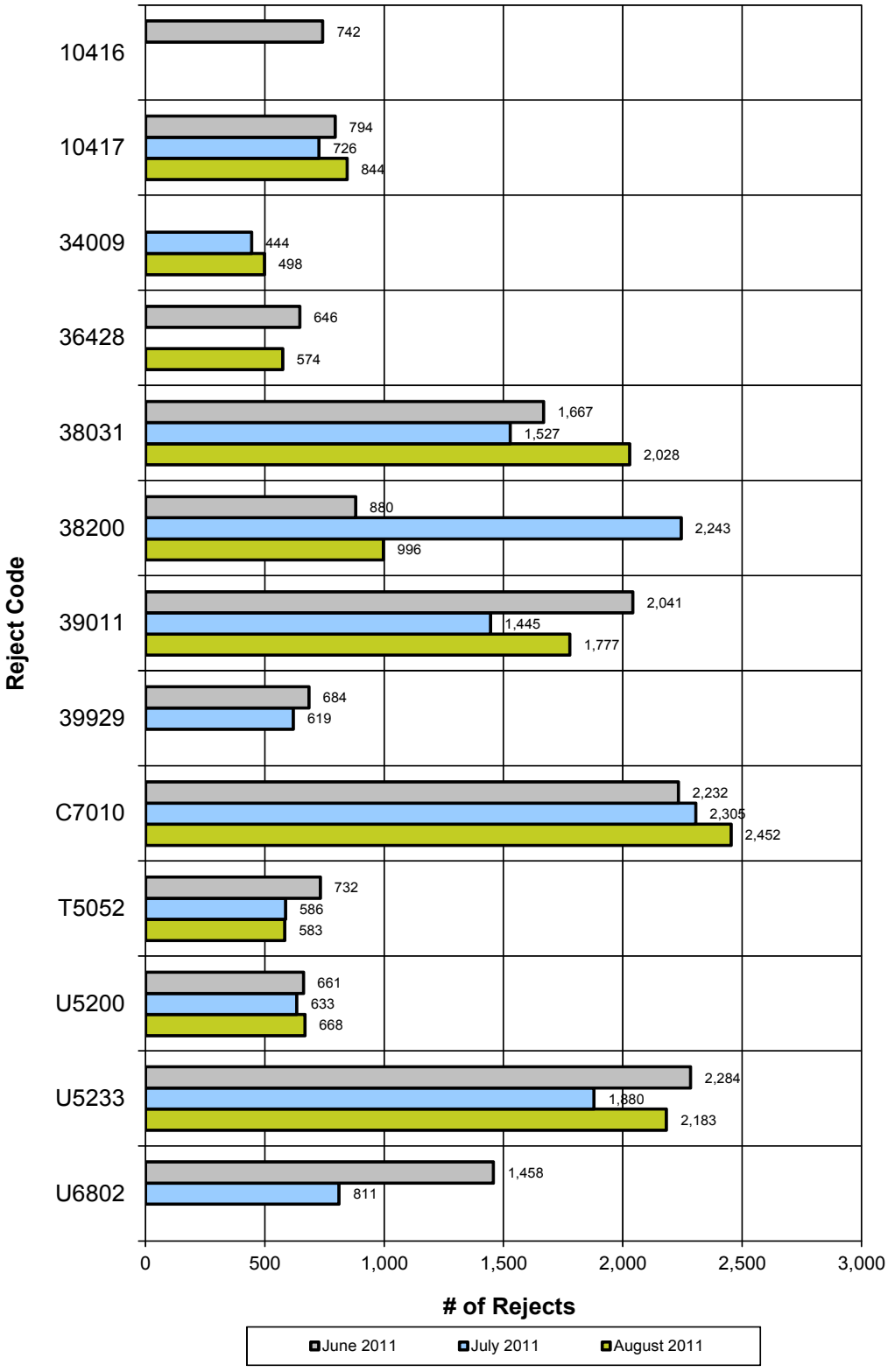
Inquiries...*continued*

Puerto Rico and U.S. Virgin Islands Part A top inquiries for June-August 2011



Florida Part A top rejects for June-August 2011



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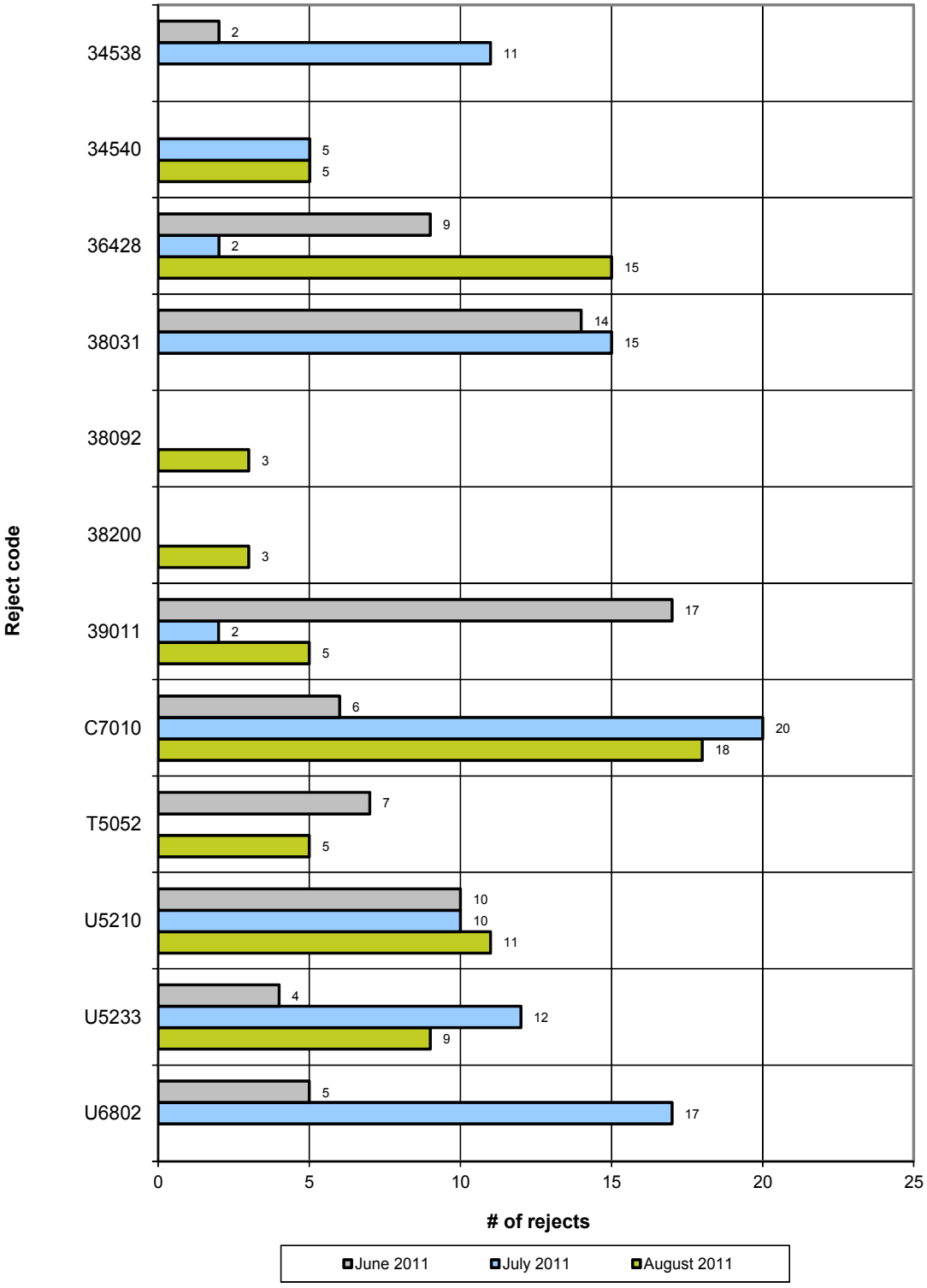
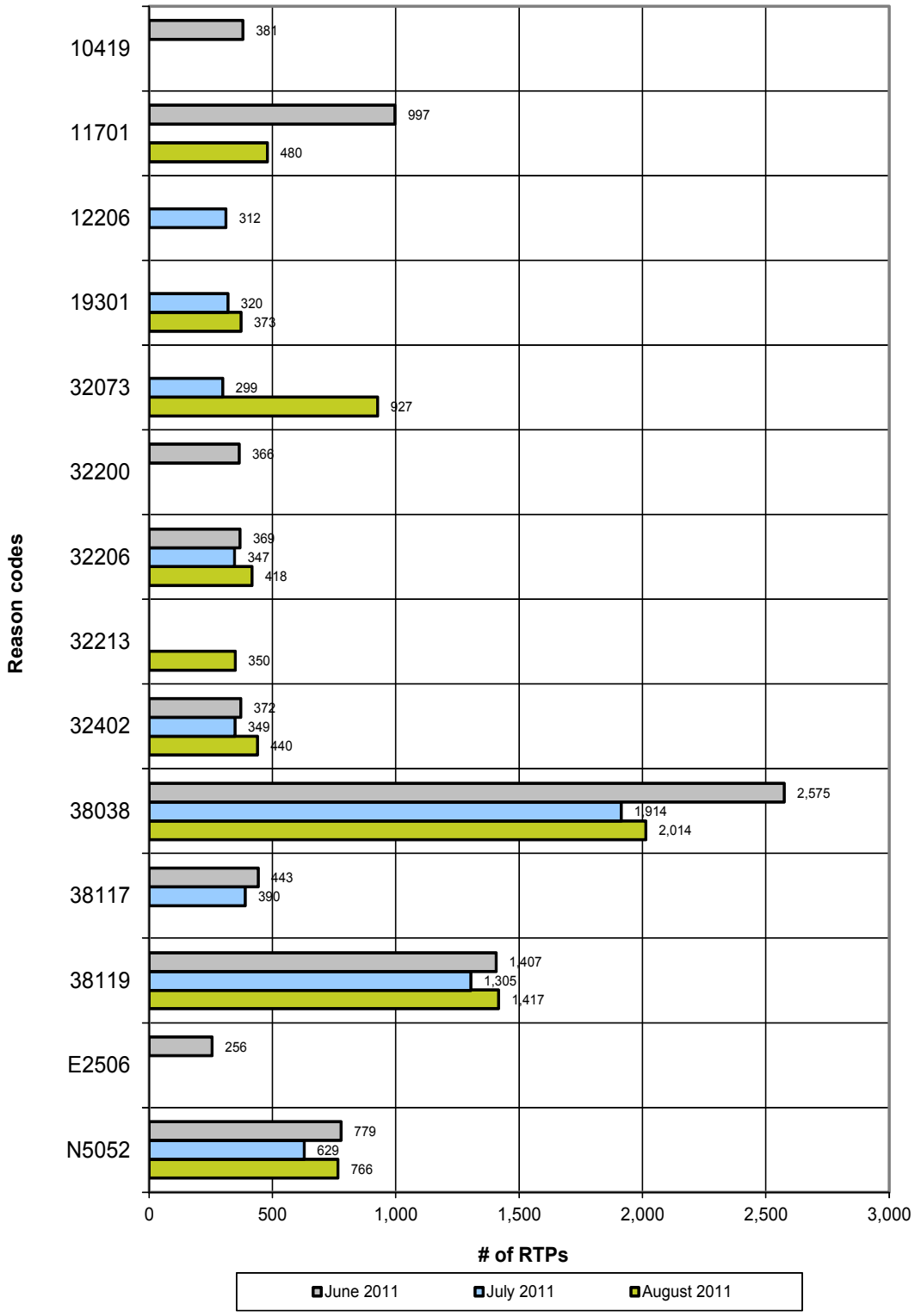
Rejects...*continued*

U.S. Virgin Islands Part A top rejects for June-August 2011



Florida Part A top return to providers (RTPs) for June-August 2011



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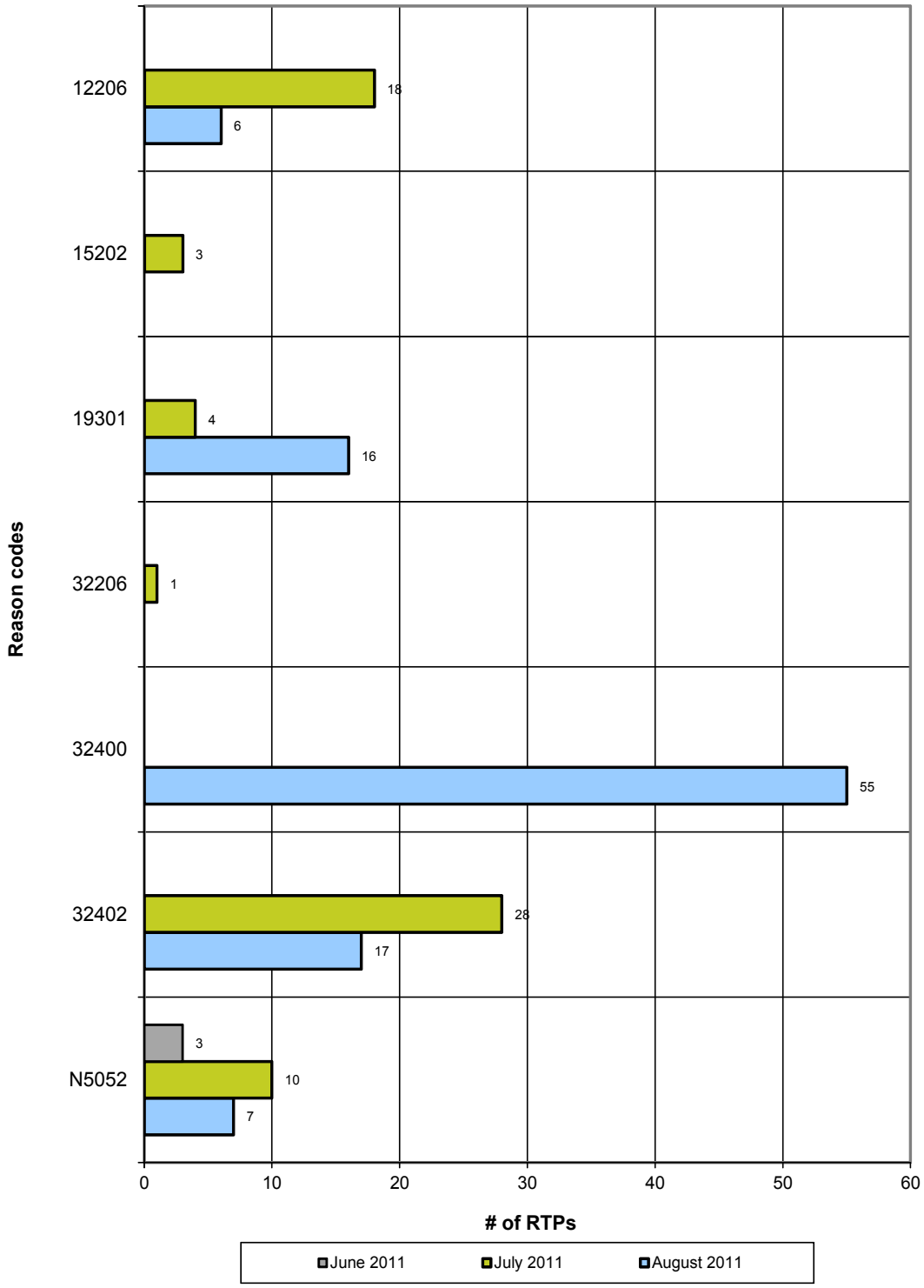
RTPs...*continued*

U.S. Virgin Islands Part A top return to providers (RTPs) for June-August 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

This article is based on change request (CR) 7526, which revises the payment of travel allowances for specimen collection services when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis, using HCPCS code P9604 for Calendar Year (CY) 2011.

The per mile travel allowance (P9603) for services on or after July 1, 2011, is $1.01 per mile and the per flat-rate trip basis travel allowance (P9604) is $10.05. 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 $1.01 per mile (actual total of $1.005 rounded up to reflect systems capabilities) if local conditions warrant it. Be sure your staffs are aware of these changes.

Background

CR 7526 revises the CY 2011 payment of travel allowances when billed either on a:

- Per mileage basis using HCPCS code P9603, or
- 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 either:

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

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

Per mile travel allowance (P9603) – the per mile travel allowance is a minimum of $1.01 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 is 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 $0.555 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs for a total of $1.01 per mile (actual total of $1.005 rounded up to reflect systems capabilities). 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 $10.05.

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 7526, issued to your FI, Carrier and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2306CP.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: MM7526
Related Change Request (CR) #: 7526
Related CR Release Date: September 16, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2306CP
Implementation Date: November 29, 2011

October update to the CY 2011 Medicare physician fee schedule database

Provider types affected

Physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), 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 change request (CR) 7528 and instructs Medicare contractors to download and implement a new Medicare physician fee schedule database (MPFSDB) as of October 3, 2011. Affected providers should be aware that Medicare contractors will only adjust claims brought to their attention. Please make sure your billing staff is aware of these changes.

Background

Section 1848 (c) (4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. In order to reflect appropriate payment policy in line with the CY 2011 MPFS Final Rule, the MPFSDB has been updated effective January 1, 2011, and new payment files have been created.

The original payment files were issued to Medicare contractors based upon the CY 2011 MPFS Final Rule, published in the *Federal Register* on November 29, 2010, as modified by the Final Rule Correction Notice, published in the *Federal Register* on January 11, 2011, and relevant statutory changes applicable January 1, 2011. CR7528 amends those payment files.

For the October 2011 update, there are no new or deleted Healthcare Common Procedure Coding System (HCPCS) codes. However, there are a number of HCPCS codes with MPFS payment indicator changes. Those changes are listed in the table attached to CR 7528, which is available at *http://www.cms.gov/transmittals/downloads/R2276CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare contractors will not search their files to adjust claims already processed prior to implementation of these changes. However, they will adjust any impacted claims that you bring to their attention.

Additional information

The official instruction, CR 7528 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2276CP.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: MM7528
Related Change Request (CR) #: 7528
Related CR Release Date: August 19, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2276CP
Implementation Date: October 3, 2011

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CY 2011 home health PPS PC Pricer updates

The calendar year (CY) 2011 home health prospective payment system (HH PPS) PC Pricer provider data has been updated with July 2011 provider data and is now available for download. The HHA PC Pricer is on the Web page, *http://www.cms.gov/PCPricer/05_HH.asp*, under the Downloads section. If you use the CY 2011 HHA PPS PC Pricer, please go to the page above and download the latest version of the PC Pricer.

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

Source: CMS PERL 201109-20

October 2011 integrated outpatient code editor specifications version 12.3

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) 7541, which describes changes to the integrated outpatient code editor (I/OCE) and OPPS to be implemented in the October 2011 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR 7541 describes changes to billing instructions for various payment policies implemented in the October 2011 OPPS update. The October 2011 I/OCE changes are also discussed in CR 7541.

Note: The full list of I/OCE specifications can now be found at *http://www.cms.gov/OutpatientCodeEdit/*.

A summary of the changes for October 2011 is within Appendix M of Attachment A of CR7541 and that summary is captured in the following key points.

Key points of CR 7541 based on Appendix M of the I/OCE specifications

- Effective January 1, 2008, Medicare will:
  - Add new modifier 92 to the valid modifier list. Edit 22 is affected.
- Effective July 1, 2011, Medicare will:
  - Update nuclear medicine/radio labeled product edit requirements. Edit 78 is affected.
- Effective May 10, 2011, Medicare will:
  - Apply a mid-quarter Food and Drug Administration (FDA) approval date to code 90654.
- Effective October 1, 2011, Medicare will:
  - Make HCPCS/APC/SI changes (data change files);
  - Implement version 17.2 of the National Correct Coding Initiative (NCCI) edits (as modified for applicable institutional providers). Edits 19, 20, 39, and 40 are affected;
  - Update procedure/device and device/procedure edit requirements. Edit 77 is affected;
  - Create 508-compliant versions of the specifications & summary of data changes documents for publication on the CMS website;
  - Add new diagnosis codes (29420, 29421, 31081, & 31089) to the list of mental health (MH) diagnoses used for partial hospitalization;
  - Update the valid diagnoses code list with ICD-9-CM changes. Edit 1 is affected; and
  - Updated diagnosis/age and diagnosis/sex conflict edits with Medical Code Editor (MCE) changes. Edits 2 and 3 are affected.

Additional information

The official instruction, CR 7541 issued to your Medicare MAC, RHHI or FI regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2277CP.pdf*. 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*.

MLN Matters® Number: MM7541
Related Change Request (CR) #: 7541
Related CR Release Date: August 19, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2277CP
Implementation Date: October 3, 2011

Annual clotting factor furnishing fee update 2012

Provider types affected

This article is for physicians and other providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider action needed

Change request (CR) 7543, from which this article is taken, announces that for calendar year 2012, the clotting factor furnishing fee of $0.181 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

Section 1842(o)(5)(C) of the Social Security Act (added by the Medicare Modernization Act Section 303(e)(1)) requires, beginning January 1, 2005, that a clotting factor furnishing fee be paid separately if you furnish clotting factor; unless the costs associated with furnishing the clotting factor are paid through another payment system.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the ASP Medicare Part B drug pricing file, or the NOC pricing file; your carrier, FI, RHHI, or A/B MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

The clotting factor furnishing fee is updated each calendar year (CY) based on the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year. The clotting factor furnishing fees applicable for dates of service in each CY are listed below:

Clotting factor furnishing fee	
CY 2005	$0.140 per unit
CY 2006	$0.146 per unit
CY 2007	$0.152 per unit
CY 2008	$0.158 per unit
CY 2009	$0.164 per unit
CY 2010	$0.170 per unit
CY 2011	$0.176 per unit
CY 2012	**$0.181 per unit**

For dates of service January 1, 2012, through December 31, 2012, the clotting factor furnishing fee of $0.181 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the ASP or NOC drug pricing files.

Additional information

You can find the official instruction, CR 7543, issued to your carrier, FI, RHHI, or A/B MAC by visiting *http://www.cms.gov/transmittals/downloads/R2279CP.pdf*. If you have any questions, please contact your carrier, FI, RHHI, 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: MM7543
Related Change Request (CR) #: CR 7543
Related CR Release Date: August 19, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2279CP
Implementation Date: January 3, 2012

Laboratory demonstration for certain complex diagnostic tests – (CR 7413 fully rescinds and replaces CR 7278)

Note: This article was rescinded and replaced on August 29, 2011, by *MLN Matters*® article MM7516, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7516.pdf* on the Centers for Medicare & Medicaid Services website. All other information remains the same. This information was previously published in the June 2011 *Medicare A Connection*, pages 56-57.

MLN Matters® Number: MM7413 Rescinded
Related Change Request (CR) #: 7413
Related CR Release Date: July 15, 2011
Effective Dates: January 1, 2012
Related CR Transmittal #: R2226CP and R74DEMO
Implementation Date: January 3, 2012

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October 2011 average sales price files now available

The Centers for Medicare & Medicaid Services (CMS) has posted the October 2011 average sales price (ASP) and not otherwise classified (NOC) pricing files and crosswalks. The ASP pricing files and crosswalks for July 2011, April 2011, January 2011, and October 2010, have also been updated. All are available for download at: *http://www.cms.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

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

Source: CMS PERL 201109-42

Rate year 2011 inpatient psychiatric facility PPS PC Pricer updates

The inpatient psychiatric facility (IPF) prospective payment system (PPS) PC Pricer for rate year (RY) 2011 for claims dates from October 1, 2010, to June 30, 2011, has been posted to the Centers for Medicare & Medicaid Services (CMS) website with July provider data. If you use the IPF PPS PC Pricer for RY 2011.2, 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 PC Pricers, posted September 9, 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 201109-27

Rate year 2012 inpatient psychiatric facility PPS PC Pricer updates

The inpatient psychiatric facility (IPF) PPS PC Pricer for rate year (RY) 2012 for claims dates from July 1, 2011, to September 30, 2011 has been posted to the Centers for Medicare & Medicaid Services (CMS) website. If you use the IPF PPS PC Pricer for RY 2012.A, 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 PC Pricers, posted September 2, 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 201109-09

2011-2012 influenza vaccine prices are now available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011-2012 seasonal influenza vaccine payment limits at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp*.

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

Source: CMS PERL 201109-41

All Medicare provider and supplier payments to be made by EFT

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act of 2010 (ACA) further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of the revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS-588 EFT form with the provider enrollment revalidation application.

Source: CMS PERL 201109-29

Medicare cost report filing update

The Centers for Medicare & Medicaid Services (CMS) has provided additional instructions on filing the new Medicare hospital cost report (form CMS 2552-10), the new Medicare skilled nursing facility cost report (form CMS 2540-10), and the new Medicare independent renal dialysis facility cost report (form CMS 265-11) including additional cost report filing extensions.

Form CMS 2552-10

All providers with full 12 months or greater cost reporting periods, which begin on or after May 1, 2010, (and end on or after April 30, 2011), shall file on the form CMS 2552-10 subject to the following filing extension schedule:

Cost reporting FYE	Current due date	Revised due date	Extension
04/30/2011	09/30/2011	11/30/2011	60 days
05/31/2011	10/31/2011	11/30/2011	30 days
06/30/2011	11/30/2011	01/31/2012	60 days
07/31/2011	12/31/2011	01/31/2012	30 days
08/31/2011	01/31/2012	02/29/2012	30 days
09/30/2011	02/29/2012	03/31/2012	30 days
10/31/2011	03/31/2012	03/31/2012	None
11/30/2011	04/30/2012	04/30/2012	None

Hospitals with hospital-based end-stage renal disease (ESRD) facilities and/or departments are subject to the same filing extension schedule as indicated above. Hospitals with hospital-based ESRDs shall submit their cost reports, using the current form CMS 2552-10 with the existing worksheet I series. The cost reports of hospitals with hospital-based ESRDs that claim Medicare bad debts shall not be settled until a revised worksheet I series is published incorporating the new bad debt calculation.

All providers with less than a 12-month cost reporting period, beginning on or after May 1, 2010, but ending prior to April 30, 2011, must file on form CMS 2552-96, and will be final settled on form CMS 2552-96. These cost reports are due the latter of 30 days from the date of this notification or five months following the close of the cost reporting period. This includes hospitals with hospital-based ESRDs.

Form CMS 2540-10

Form CMS 2540-10 is effective for cost reporting periods beginning on or after December 1, 2010. Providers shall continue to file on the form CMS 2540-96 for any short period cost reports beginning on or after December 1, 2010, and ending November 30, 2011. No filing extensions are granted at this time.

continued on next page

Report...*continued*

Form CMS 265-11

Form CMS 265-11 is effective for cost reporting periods that overlap or begin on or after January 1, 2011, and are subject to the following filing extension schedule:

Cost reporting FYE	Current due date	Revised due date	Extension
01/31/2011	06/30/2011	11/30/2011	150 days
02/28/2011	07/31/2011	11/30/2011	120 days
03/31/2011	08/31/2011	11/30/2011	90 days
04/30/2011	09/30/2011	11/30/2011	60 days
05/31/2011	10/31/2011	11/30/2011	30 days

Source: TDL 11452

FY 2012 IPPS and long-term care hospital PPS changes

Provider types affected

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

What you need to know

This article is based on change request (CR) 7508, which provides:

- Fiscal year (FY) 2012 updates to the inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) prospective payment system (PPS);
- FY 2012 updates to the Medicare severity diagnosis related groups (MS-DRGs) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding; and
- Changes to payment for CAH ambulance services.

These changes are effective for hospital discharges occurring on or after October 1, 2011, unless otherwise noted.

All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2011, unless otherwise noted. Be sure your staffs are aware of these changes.

Background

This article, based on CR 7508, outlines changes to the IPPS for acute care hospitals and the PPS for long-term care hospitals (LTCHs) for FY 2012. The policy changes for FY 2012 appeared in the *Federal Register* on August 1, 2011.

The websites for the final rule, tables and data files noted are as follows:

- The FY 2012 IPPS final rule is available at *http://www.cms.gov/AcuteInpatientPPS/FR2012/list.asp#TopOfPage* on the Centers for Medicare & Medicaid Services (CMS) website.
- The IPPS tables for the final rule are available at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*. Click on the link on the left side of the screen titled, "FY 2012 IPPS Final Rule Home Page" or "Acute Inpatient – Files for Download."
- The LTCH PPS tables for the FY 2012 final rule are available under the list item for Regulation Number CMS-1518-F at *http://www.cms.gov/LongTermCareHospitalPPS/LTCHPPSRN/list.asp*.

This article also addresses the FY 2012 update to the MS-DRGs and ICD-9-CM coding.

All items covered in this article are effective for hospital discharges occurring on or after October 1, 2011, unless otherwise noted. A summary of the changes is as follows:

ICD-9-CM changes

The ICD-9-CM coding changes are effective October 1, 2011. The new ICD-9-CM codes are listed, along with their MS-DRG classifications in Tables 6a and 6b of the August 1, 2011, *Federal Register*. The ICD-9-CM codes that have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f.

A new MS-DRG Grouper, version 29.0, software package was introduced and is effective for discharges on or after October 1, 2011. The GROUPER 29.0 assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The Medicare Code Editor (MCE) version 28.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2011.

The IPPS FY 2012 update

The FY 2012 IPPS Pricer will be provided to Medicare's fiscal intermediary shared system (FISS) for discharges occurring on or after October 1, 2011. It includes all pricing files for FY 2006 through FY 2012 to process bills with discharge dates on or after October 1, 2005.

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IPPS...*continued*

FY 2012 IPPS rates

Standardized amount update factor	1.019 (for hospitals that do submit quality data) 0.999 (for hospitals that do not submit quality data)
Hospital Specific update factor	1.019 (for hospitals that do submit quality data) 0.999 (for hospitals that do not submit quality data)
Common fixed loss cost outlier threshold	$22,385
Federal capital rate	$421.42
Puerto Rico capital rate	$203.86
Outlier offset-operating national	0.94899
Outlier offset-operating Puerto Rico	0.953549
IME formula (no change for FY12)	1.35 x [(1 + resident to bed ratio).405 – 1]
MDH/SCH budget neutrality factor	0.997903
MDH/SCH documentation and coding adjustment factor	0.9528
MDH/SCH adjustment for restoration of rural floor budget neutrality	1.009

Operating rates

Operating rates with full market basket and wage index > 1	
National labor share	$3,584.30
National non labor share	$1,625.44
PR national labor share	$3,584.30
PR national non labor share	$1,625.44
Puerto Rico specific labor share	$1,553.29
Puerto Rico specific non labor share	$947.98
Operating rates with full market basket and wage index < or = 1	
National labor share	$3,230.04
National non labor share	$1,979.70
PR national labor share	$3,230.04
PR national non labor share	$1,979.70
Puerto Rico specific labor share	$1,550.79
Puerto Rico specific non labor share	$950.48
Operating rates with reduced market basket and wage index > 1	
National labor share	$3,513.95
National non labor share	$1,593.54
PR national labor share	$3,584.30
PR national non labor share	$1,625.44
Puerto Rico specific labor share	$1,553.29
Puerto Rico specific non labor share	$947.98
Operating rates with reduced market basket and wage index < or = 1	
National and PR national labor share	$3,166.64
National and PR national non labor share	$1,940.85
PR national labor share	$3,230.04
PR national non labor share	$1,979.70
Puerto Rico specific labor share	$1,550.79
Puerto Rico specific non labor share	$950.48

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IPPS...*continued*

Post-acute transfer and special payment policy

The following MS-DRGs will be listed as qualifying for post-acute transfer policy status as of FY 2012:

- MS-DRG 023 (craniotomy with major device implant or acute complex CNS PDX with MCC);
- MS-DRG 024 (craniotomy with major device implant or acute complex CNS PDX without MCC);
- MS-DRG 570 (skin debridement with MCC);
- MS-DRG 571 (skin debridement with CC); and
- MS-DRG 572 (skin debridement without CC/MCC).

The following MS-DRGs will no longer be listed as qualifying for post-acute transfer policy status as of FY 2012:

- MS-DRG 228 (other cardiothoracic procedures with MCC),
- MS-DRG 229 (other cardiothoracic procedures with CC); and
- MS-DRG 230 (other cardiothoracic procedures without CC/MCC).

The following MS-DRGs will be listed as qualifying for special payment policy status as of FY 2012:

- MS-DRG 216 (cardiac valve & other major cardiothoracic procedure with cardiac catheterization with MCC);
- MS-DRG 217 (cardiac valve & other major cardiothoracic procedure with cardiac catheterization with CC); and
- MS-DRG 218 (cardiac valve & other major cardiothoracic procedure without CC/MCC).

A listing of all post-acute and special post-acute MS-DRGs may be found in Table 5 of the FY 2012 IPPS final rule.

New technology add-on payments

The following item is eligible for new-technology add-on payments in FY 2012:

- **Continue payments for the AutoLITT** – cases involving the AutoLITT™ that are eligible for the new technology add-on payment will be identified by assignment to MS-DRGs 25, 26 and 27 with an ICD-9 procedure code of 17.61 (ICD-10-PCS codes D0Y0KZZ and D0Y1KZZ) in combination with one of the following primary ICD-9 diagnosis codes: 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9 (ICD-10-CM codes C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, and C71.9). The maximum add-on payment for a case involving the AutoLITT™ is $5,300.

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

National rural floor budget neutrality adjustment factors

The wage table loaded for the FY 2012 Pricer contains wage index values already adjusted by the national rural floor budget neutrality factor of 0.991007.

Cost of living adjustment (COLA) update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLA factors for FY 2012. A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2011, can be found in the FY 2012 IPPS PPS final rule.

Expiration of Section 508 reclassifications

Section 508 of the 2003 Medicare Modernization Act and as extended by both the Affordable Care Act and the Medicare and Medicaid Extenders Act of 2010 (MMEA) will no longer be in effect beginning October 1, 2011.

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IPPS...*continued*

Section 505 Hospital (out-commuting adjustment)
Attachment A to the CR 7508 (Section 505) shows the IPPS providers that will be receiving a "special" wage index for FY 2012 (i.e., receive an out-commuting adjustment under section 505 of the MMA).

Hospitals waiving Lugar redesignation for the out-migration adjustment
A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status and is considered rural for all IPPS purposes. Below is the list of Lugar hospitals that accepted the out-migration adjustment and are therefore rural for all IPPS purposes for FY 2012:

Medicare CMS certification number (CCN)	Provider name
010164	Coosa Valley Medical Center
360096	East Liverpool City Hospital
390150	Southwest Regional Medical Center
390201	Pocono Medical Center

Hospital-specific (HSP) rate update for sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs)
For FY 2012, the HSP rates for SCHs and MDHs will continue to be entered in FY 2007 dollars. As noted above, the HSP rate market basket update for FY 2012 is 1.9 percent (or -0.10 percent for hospitals that do not submit quality data) and the budget neutrality factor for DRG reclassification and recalibration is 0.997903. For FY 2012, a cumulative documentation and coding adjustment factor of 0.9528 will be applied to the HSP rates (this factor includes the permanent 2.9 percent reduction implemented in FY 2011 and the additional permanent 2.0 percent reduction implemented beginning in FY 2012). Beginning in FY 2012, a permanent adjustment for restoring rural floor budget neutrality of 1.009 will also be applied to the HSP rates.

Low-volume hospitals – criteria and payment adjustments for FY 2012
Sections 3125 and 10314 of the Affordable Care Act amended the low-volume hospital adjustment in Section 1886(d)(12) of the Social Security Act by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations at section 412.101 in the FY 2011 IPPS final rule (75 FR 50238 through 50275).

In the FY 2012 IPPS final rule, CMS established that for FY 2012 the low-volume payment adjustment will be determined using FY 2012 Medicare discharge data from the March 2011 update of the Medicare Provider Analysis and Review (MEDPAR) files. In Table 14 of the Addendum to the final rule, CMS provided a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2011 update of the FY 2010 MedPAR files. However, this list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criterion; that is, to qualify for the low-volume adjustment, the hospital also must be located more than 15 road miles from any other IPPS hospital. **In order to receive the applicable low-volume percentage add-on payment for FY 2012, a hospital must meet both the discharge and mileage criteria.**

CMS established a procedure for a hospital to request low-volume hospital status for FY 2012 in the FY 2012 IPPS final rule, which is similar to the procedure established for the FY 2011 low-volume payment adjustment (see MM7134, October 1, 2010, available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7134.pdf*).

- For FY 2012, a hospital should make its request for low-volume hospital status in writing to its FI or MAC and provide documentation that it meets the mileage criterion by September 1, 2011, so that the applicable low-volume percentage add-on can be applied to payments for its discharges occurring on or after October 1, 2011.
- A hospital that qualified for the low-volume payment adjustment in FY 2011 may continue to receive a low-volume payment adjustment in FY 2012, without reapplying, if it continues to meet the Medicare discharge criterion, based on the FY 2010 MedPAR data (shown in Table 14 of the Addendum to the final rule) and the distance criterion. However, the hospital must verify in writing to its FI or MAC that it continues to be more than 15 miles from any other "subsection (d)" hospital no later than September 30, 2011.

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- For requests for low-volume hospital status for FY 2012 received after September 1, 2011, if the hospital meets the criteria to qualify as a low-volume hospital, the FI or MAC will apply the applicable low-volume payment adjustment in determining payments to the hospital's FY 2012 discharges prospectively within 30 days of the date of the FI's or MAC's low-volume status determination.

The applicable low-volume percentage add-on payment is based on and is in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), Indirect Medical Education (IME) and outliers. For SCHs and MDHs, the applicable low-volume percentage add-on payment is based on and is in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital quality initiative
Hospitals that will receive the quality initiative bonus are listed at *http://www.qualitynet.org/*. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website. A list of hospitals not receiving the 2.0 percent RHQDAPU annual payment update for FY 2012 will be available in September.

Capital PPS payment for certain providers redesignated under section 1886(d)(8)(B) of the act
42 Code of Federal Regulations (CFR) 412.64(b)(II)(D)(3) implements Section 1886(d)(8)(B) of the Social Security Act, available at *http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr412.64.pdf* which re-designates certain rural counties (commonly referred to as "counties") adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. Accordingly, hospitals located in these "Lugar counties" (commonly referred to as "Lugar hospitals") are deemed to be located in an urban area and receive the Federal payment amount for the urban area to which they are redesignated.

Treatment of certain urban hospitals reclassified as rural hospitals under Section 412.103 for purposes of capital PPS payments
Hospitals reclassified as rural under Section 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see Section 412.320(a)(1)). Similarly, the Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under Section 412.103 is determined from the applicable statewide rural wage index.

Frontier wage index rural floor budget neutrality (RFBN)
The Affordable Care Act established an adjustment to create a wage index floor of 1.00 for all hospitals located in states determined to be "frontier states," beginning in FY 2012.

For the final FY 2012 IPPS wage indices, CMS identified the following frontier states that will receive the floor adjustment for FY 2012: Montana, Nevada, North Dakota, South Dakota, and Wyoming.

Section 1109
Section 1109 of the Health Care and Education Reconciliation Act of 2010 provides for additional payments for FYs 2011 and 2012 to "qualifying hospitals." Section 1109(d) defines a "qualifying hospital" as a "subsection (d) hospital . . . that is located in a county that ranks, based upon its ranking in age, sex and race adjusted spending for benefits under parts A and B . . . per enrollee within the lowest quartile of such counties in the United States."

In the FY 2011 IPPS final rule, CMS provided tables with a list of qualifying hospitals, their payment weighting factors and eligible counties. As finalized in the FY 2011 IPPS final rule, CMS expects to distribute $150 million for FY 2011 and $250 million for FY 2012 to qualifying hospitals.

CMS' payment distribution process uses a single Medicare contractor that will directly pay all of the qualifying hospitals annually for FY 2011 and for FY 2012. CMS distributed $150 million for FY 2011 in July 2011 and plans on distributing the remaining $250 million for FY 2012 sometime after November 1, 2011, to qualifying hospitals.

LTCH PPS FY 2012 update

FY 2011 LTCH PPS rates

Federal Rate	$40,222.05
High Cost Outlier Fixed-Loss Amount	$17,931
Labor Share	70.199%
Non-Labor Share	29.801%

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IPPS...*continued*

MS-LTC-DRG update
The LTCH PPS Pricer has been updated with the version 29.0 Medicare Severity Long-Term Care-Diagnosis Related Group (MS-LTC-DRG) table and weights, effective for discharges occurring on or after October 1, 2011, and on or before September 30, 2012.

Cost of living adjustment (COLA) update for LTCH PPS
The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. **There are no changes to the COLA factors for FY 2012.** A table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2011, can be found in the FY 2012 IPPS final rule.

Core-based statistical area (CBSA)-based labor market definition changes
There are no changes to the Core-Based Statistical Area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2012. The CBSAs definitions and codes that will continue to be effective October 1, 2011 can be found in Table 12A to the Addendum of the FY 2012 IPPS final rule.

Inclusion of Medicare Advantage (MA) days in the average length of stay calculation
The average length of stay (ALOS) calculation at 42 CFR 412.23(e)(3) specifies that all data on all Medicare inpatient days, including MA inpatient days, must be included in the average length of stay calculation. When evaluating whether an LTCH meets the average ALOS requirement at Section 412.23(e)(3), based upon a policy clarification included in the FY 2012 IPPS final rule, no LTCH should lose its exclusion from the IPPS (i.e., its status as an LTCH) because of the inclusion of MA inpatient days in the calculation of its ALOS until LTCH cost reporting periods beginning on or after January 1, 2012.

Additional LTCH policy changes for FY 2012
In the FY 2012 IPPS final rule, the moratorium on the increase in number of beds has been extended to also apply to LTCHs and LTCH satellites that were established under one of the exceptions to the moratorium provided in Section 114(d) of the MMSEA. Specifically, the number of beds in those LTCHs and LTCH satellites must not be beyond the number certified by Medicare on October 1, 2011.

Changes to payment for CAH ambulance services

Effective with dates of service on or after October 1, 2011, in order for a CAH or a CAH-owned and operated entity to be paid 101 percent of reasonable costs for its ambulance services, there can be no other provider or supplier of ambulance services located within a 35-mile drive of the CAH. Prior to October 1, 2011, the regulations required that there be no other provider or supplier of ambulance services within a 35-mile drive of the CAH or the entity.

Effective with dates of service on or after October 1, 2011, if there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH but there is a CAH-owned and operated entity located more than a 35-mile drive from the CAH, that CAH-owned and operated entity can only be paid 101 percent of reasonable costs for its ambulance services, if it is the closest provider or supplier of ambulance services to the CAH.

Additional information

The official instruction, CR7508, issued to your FI and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R2291CP.pdf*.

The FY 2012 IPPS final rule, including data files and tables, is available at *http://www.cms.gov/AcuteInpatientPPS/FR2012/list.asp#TopOfPage*.

The IPPS tables for the final rule are available at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*. Click on the link on the left side of the screen titled, “FY 2012 IPPS Final Rule Home Page” or “Acute Inpatient – Files for Download.”

The LTCH PPS tables for the FY 2012 final rule are available, under the list item for Regulation Number CMS-1518-F at *http://www.cms.gov/LongTermCareHospitalPPS/LTCHPPSRN/list.asp*.

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

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MLN Matters® Number: MM7508
Related Change Request (CR) #: 7508
Related CR Release Date: August 26, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2291CP
Implementation Date: October 3, 2011

October 2011 update of the hospital OPPS

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 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) 7545 which describes changes to the OPPS to be implemented in the October 2011 update. Be sure your billing staffs are aware of these changes.

Background

CR 7545 describes changes to and billing instructions for various payment policies implemented in the October 2011 OPPS update. The October 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, status indicator (SI), and revenue code additions, changes, and deletions identified in this notification.

Note that the October 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7541, "October 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.3." An MLN Matters article is available for that CR at *http://www.cms.gov/MLNMattersArticles/downloads/MM7541.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. The key changes in the October update to the hospital OPPS are as follows:

Changes to device edits for October 2011

Device-to-procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. **CMS is adding procedure code *64569*** (*Revision or replacement of cranial nerve (e.g., vagus nerve) neurostimulator electrode array, including connection to existing pulse generator*) as an appropriate procedure for device code C1778 (lead, neurostimulator) because the procedure may be appropriately reported on the same claim with the device code. CMS is adding it to the file with an effective date of January 1, 2011, because the procedure code is effective for services furnished on and after January 1, 2011. Any claims with dates of service after January 1, 2011, that were submitted prior to this update and returned to providers may be resubmitted.

Procedure-to-device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Procedures for which both a device A and a device B are specified require that at least one each of device A and device B be present on the claim (i.e., there must be some combination of a device A with a device B in order to pass the edit). Device B can be reported with any device A for the same procedural HCPCS code. CMS is not adding C1778 as a required device for procedure code *64569* because the device is not essential to the procedure described by the code *64569*.

The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at *http://www.cms.gov/HospitalOutpatientPPS/*.

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New device pass-through categories

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

CMS is establishing two new categories as of October 1, 2011. The following table provides a listing of new coding and payment information concerning the new device categories for transitional pass-through payment.

Table 1 – New device pass-through codes

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Device offset from payment
C1830	10/01/11	H	1830	Power bone marrow bx needle	Powered bone marrow biopsy needle	$0
C1840	10/01/11	H	1840	Telescopic intraocular lens	Lens, intraocular (telescopic)	$221.71

Billing instructions for C1840: C1840 is to be billed and paid for, when provided, with *Current Procedural Terminology (CPT) codes 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage)*, or *66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)*). These codes are assigned to APC 0246.

Device offset from payment: The Social Security Act (Section 1833(t)(6)(D)(ii); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that CMS deducts from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that it is not able to identify a portion of the APC payment amount associated with the cost of C1830 in APC 0003, bone marrow biopsy/aspiration. The device offset from payment represents this deduction from pass-through payments for category C1830, when it is billed with a service included in APC 0003. Therefore, CMS is establishing an offset amount for C1830 of $0 and will not make any deductions from pass-through payment for category C1830.

CMS has also determined that it is able to identify a portion of the APC payment amount associated with the cost of C1840 in APC 0246, cataract procedures with IOL insert. The device offset for APC 0246 is $221.71. The device offset from payment represents this deduction from pass-through payments for category C1840, when it is billed with a service included in APC 0246. Therefore, CMS is establishing an offset amount for C1830 of $221.71.

Billing for drugs, biologicals, and radiopharmaceuticals

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

Hospitals are reminded 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 only for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, and for which a specific HCPCS code has not been assigned.

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Unless otherwise specified in the long descriptor, HCPCS descriptors 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.

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

For calendar year (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 cost 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 cost of these pass-through items. CMS notes that for the fourth 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, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals that 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. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2011 release of the OPPS PRICER. The updated payment rates, effective October 1, 2011, will be included in the October 2011 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp*.

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

Two drugs and biologicals have been granted OPPS pass-through status effective October 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – drugs and biologicals with OPPS pass-through status effective October 1, 2011

HCPCS code	Long descriptor	APC	Status indicator effective 10/01/11
C9286*	Injection, belatacept, 1 mg	9286	G
J0638	Injection, canakinumab, 1 mg	1311	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective October 1, 2011.

Updated payment rate for HCPCS Code J9185 effective July 1-September 30, 2011

The payment rate for HCPCS code J9185 was incorrect in the July 2011 OPPS Pricer. The corrected payment rate is listed in Table 3 below and has been installed in the October 2011 OPPS Pricer, effective for services furnished on July 1, 2011, through implementation of the October 2011 update. Any claims already processed with the incorrect amount will be adjusted, but only if you bring such claims to the attention of your Medicare contractor.

Table 3 – updated payment rates for HCPCS code J9185 effective July 1-September 30, 2011

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9185	K	0842	Fludarabine phosphate inj	$104.52	$20.90

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

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OPPS...*continued*

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 as a device, a separate payment for the 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.

Correct reporting of units for drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient; hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

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

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.

continued on next page

OPPS...*continued*

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*), 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*, Pub. 100-02, Chapter 15, Section 50.2. See *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*.

Calculation of overall cost to charge ratios (CCRs) for cost reporting periods on or after May 1, 2010 based on form CMS-2552-10

CR 7545 updates the *Medicare Claims Processing Manual* (Chapter 4, Section 10.11 (Calculation of Overall Cost to Charge Ratios (CCRs) for Hospitals Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS)). Specifically, Sections 10.11.7.1 and 10.11.8.1 are added which contain worksheet/column/line edits and reflect the new Hospital and Hospital Health Care Complex Cost Report, Form CMS-2552-10. This does not replace Sections 10.11.7 and 10.11.8 as these existing instructions are relevant for cost report form CMS-2552-96.

The revised sections of the *Medicare Claims Process Manual* (Chapter 4, Sections 10.11.7.1 and 10.11.8.1) are included as an attachment to CR 7545.

Clarifications to condition code 44 policy (when a patient's status may be changed from inpatient to outpatient)

CR 7545 updates the *Medicare Claims Processing Manual* (Chapter 50, Section 3.1 (Background) and Section 3.2 (Policy and Billing Instructions for Condition Code 44)) to clarify several CMS manual requirements for changing a patient's status from inpatient to outpatient (using condition code 44). CMS is clarifying that the practitioner who is responsible for the care of the patient must concur with any decision by the hospital's utilization review committee to change a patient's status from inpatient to outpatient. Also CMS is clarifying that the condition code 44 policies apply to critical access hospitals as well as other types of hospitals.

These revised sections of the *Medicare Claims Process Manual* are included as an attachment to CR 7545.

Coverage determinations

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

Additional information

The official instruction, CR 7545, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2296CP.pdf*.

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*.

MLN Matters® Number: MM7545
Related Change Request (CR) #: CR 7545
Related CR Release Date: September 2, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2296CP
Implementation Date: October 3, 2011

Corrected fiscal year 2011inpatient PPS PC Pricer available

The corrected third quarter provider data is now available for the fiscal year (FY) 2011 inpatient (INP) prospective payment system (PPS) personal computer (PC) Pricer. If you use the FY 2011 INP PPS PC Pricer, please go to the Centers for Medicare & Medicaid Services' (CMS) Web page at *http://www.cms.gov/PCPricer/03_inpatient.asp*, and download the latest version of the FY 2011 PC Pricer. The update is for claims dated from October 1, 2010, to September 30, 2011. The update is dated September 7, 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 201109-19

October quarterly update to 2011 HCPCS codes used for SNF consolidated billing enforcement

Note: This article was revised to reflect the revised change request (CR) 7444 issued on September 23, 2011. The article was revised to add HCPCS codes J9033 and G0121 to the bullet points on page 2. Also, the CR transmittal number, release date, and the Web address for accessing the CR were revised. All other information is the same. This information was previously published in the June 2011 *Medicare A Connection*, page 81.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs),) for skilled nursing facility (SNF) services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 7444 which provides the October quarterly update to the 2011 Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (CB) enforcement. CR 7444 instructs the Medicare system maintainers to add HCPCS code J0894 (injection, decitabine, 1 mg) to the File 1 coding list for SNF CB and to Major III.A chemotherapy services list in the FI/A/B MAC file for dates of service on or after January 1, 2011.

Background

The Social Security Act (Section 1888; see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm*) codifies the skilled nursing facility prospective payment system (SNF PPS) and CB, and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. No additional services are added by these routine updates. New updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

Services excluded from the SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to Medicare contractors, including durable medical equipment (DME) MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR7444 instructs Medicare systems maintainers to:

- Add HCPCS code J0894 to the File 1 coding list for SNF CB for dates of service on or after January 1, 2011;
- Add HCPCS code J9033 to the File 1 coding list for SNF CB for dates of service on or after October 1, 2011;
- Add HCPCS code J0894 to Major Category III. A chemotherapy services list in the FI/A/B MAC file effective January 1, 2011;
- Add HCPCS code J9033 to Major Category III. A chemotherapy services list in the FI/A/B MAC file effective for dates of service on or after October 1, 2011; and
- Add HCPCS code G0121 to Major Category IV services effective January 1, 2011.

Note that Medicare contractors will reprocess claims affected by CR 7444 when brought to their attention.

Additional information

The official instruction, CR 7444, issued to your carriers, FIs, or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2300CP.pdf*.

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

MLN Matters® Number: MM7444
Related Change Request (CR) #: CR 7444
Related CR Release Date: September 13, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2300CP
Implementation Date: October 3, 2011

2012 annual update of HCPCS codes for SNF consolidated billing

Provider types affected

Physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

What you need to know

This article is based on change request (CR) 7552 which provides the 2012 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing facility consolidated billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2011:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled "2012 Carrier/A/B MAC Update") will be posted at *http://www.cms.gov/SNFConsolidatedBilling/* on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill fiscal intermediaries or A/B MACs are advised that new Excel and PDF files (entitled "2011 FI/A/B MAC Update") will be posted to *http://www.cms.gov/SNFConsolidatedBilling/*.

It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at *http://www.cms.gov/manuals/downloads/clm104c06.pdf*.

Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional information

You can find the official instruction, CR7552, issued to your carrier, FI, A/B MAC, or DME MAC by visiting *http://www.cms.gov/Transmittals/downloads/R2286CP.pdf*.

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/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7552
Related Change Request (CR) #: CR 7552
Related CR Release Date: August 26, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2286CP
Implementation Date: January 3, 2012

FY 2011 skilled nursing facility PPS PC Pricer updates

The fiscal year (FY) 2011 skilled nursing facility prospective payment system (SNF PPS) PC Pricer has been updated with July 2011 provider data at *http://www.cms.gov/PCPricer/04_SNF.asp*, under the "Skilled Nursing Facilities (SNF PPS) PC Pricer." If you use the FY 2011 SNF PPS PC Pricer, please go to the page above and download the version posted September 9, 2011, with the more current provider data.

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

Source: CMS PERL 201109-24

FY 2012 skilled nursing facility PPS Pricer update

Provider types affected

This article is for skilled nursing facilities (SNFs) billing Medicare contractors (fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs)) for services paid under the skilled nursing facility prospective payment system (SNF PPS).

Provider action needed

This article is based on change request (CR) 7522 which describes the updates to the payment rates used under the PPS for SNFs for FY 2012, as required by statute. Be sure your billing staff is aware of these rate changes.

Background

Annual updates to the PPS rates are required by Section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

The Centers for Medicare & Medicaid Services (CMS) published the SNF payment rates for FY 2012 (that is, beginning October 1, 2011, through September 30, 2012), in the *Federal Register* on August 8, 2011 (76 FR 48486). The update methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with AIDS. This update includes new case-mix indexes using the recalculated case-mix adjustments based on actual RUG-IV data. The statute mandates an update to the federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2011.

Additional information

The official instruction, CR 7522, issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2292CP.pdf*.

If you have any questions, please contact your 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: MM7522
Related Change Request (CR) #: 7522
Related CR Release Date: August 26, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2292CP
Implementation Date: October 3, 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.

Inpatient rehabilitation facility annual update: PPS Pricer changes for fiscal year 2012

Note: This article was revised on September 14, 2011, to reflect the revised change request (CR) 7510. The CR was revised to correct the fixed loss amount from $10,660 to $10,713. Also, the CR transmittal number, release date, and the Web address for accessing the CR were changed. All other information remains the same. This information was previously published in the August 2011 issue of *Medicare A Connection*, page 50.

Provider types affected

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

Provider action needed

This article is based on CR 7510 which provides updated rates used to correctly pay inpatient rehabilitation facility prospective payment system (IRF PPS) claims for fiscal year (FY) 2012. Be sure your billing staff is aware of these changes.

Key points of CR 7510

The FY 2012 IRF PPS update notice published on July 29, 2011, sets forth the prospective payment rates applicable for IRFs for FY 2011. A new IRF Pricer software package will be released prior to October 1, 2011, which will contain the updated rates that are effective for claims with discharges that fall within October 1, 2011, through September 30, 2012.

Pricer updates: For IRF PPS FY 2011 (October 1, 2011 – September 30, 2012)

- The standard federal rate is $14,076;
- The fixed loss amount is $10,713;
- The labor-related share is 0.70199;
- The non-labor related share is 0.29801;
- Urban national average cost-to-charge ratio (CCR) is 0.520;
- Rural national average CCR is 0.669;
- The low income patient (LIP) adjustment is 0.4613;
- The teaching adjustment is 0.6876; and
- The rural adjustment is 1.184.

Additional information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction (CR7510) issued to your Medicare MAC and/or FI is available at *http://www.cms.gov/Transmittals/downloads/R2301CP.pdf*.

MLN Matters® Number: MM7510 Revised
Related Change Request (CR) #: 7510
Related CR Release Date: September 13, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2301CP
Implementation Date: October 3, 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.

FY 2011 inpatient rehabilitation facility PPS PC Pricer updates

The fiscal year (FY) 2011 inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC Pricer has been updated with corrected July 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 Pricer, please go to the page above and download the latest version of the FY 2011 Pricer with corrected provider data, posted September 20, 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 201109-44

Implementation of the ESRD quality incentive program

Note: This article was revised on September 26, 2011, to reflect a new change request (CR) 7460, which corrected the definition of the hemodialysis Kt/V that is used in the calculation of the Kt/V value (page 4). The article was previously changed to include a statement on page 3 to assist providers with coding hemoglobin or hematocrit with 99.99 when a value is not available for a patient, a statement on page 4 to assist providers in coding a date for a Kt/V reading when submitting a value of 8.88 prior to April 1, 2012, and a statement on page 4 to assist providers with the coding of vascular access type modifiers on hemodialysis claims. The transmittal number, CR release date and link to the transmittal were also changed. All other information remains the same. This information was previously published in the August 2011 *Medicare A Connection*, pages 54-55.

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for end-stage renal disease (ESRD) services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on CR 7460 which announces the implementation of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; Section 153c) end-stage renal disease (ESRD) quality incentive program (QIP) and other requirements for ESRD claims.

Caution – what you need to know

MIPPA (Section 153c) requires the Centers for Medicare & Medicaid Services (CMS) to implement an ESRD QIP effective January 1, 2012, that will result in payment reductions to providers of services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures.

Go – what you need to do

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

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA; Section153c) requires the Centers for Medicare & Medicaid Services (CMS) to implement a quality based payment program for dialysis services with payment consequences effective January 1, 2012. This QIP will result in payment reductions to providers of ESRD services and dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for certain specified measures. The ESRD QIP is the first Medicare program which will link payments to performance based on outcomes as assessed through specific quality measures. These measures are defined in the annual dialysis facility report (DFR) that each provider receives in addition to the final rule. The payment reductions will:

- Apply to payment for renal dialysis services furnished on or after January 1, 2012;
- Be up to 2.0 percent of payments otherwise made to ESRD facilities;
- Apply only to the year involved for an ESRD facility; and
- Not be taken into account when computing future payment rates for the impacted facility.

In addition to implementing the QIP, CMS will require ESRD facilities to provide the following on all ESRD claims with dates of service on or after January 1, 2012:

- The hemoglobin and/or hematocrit value(s);
- The route of administration of erythropoiesis stimulating agents (ESAs) using the JA or JB modifier code for any claim indicating the administration of ESAs;
- The Kt/V (calculated using a specified formula) indicating the measurement of dialysis adequacy.

Note: Failure to include the JA or JB modifier for ESA route of administration when reporting Q4081 or J0882 on a 72x type of bill will result in that bill being returned to the provider.

CMS is making these changes to assess:

- The management of anemia for ESRD patients;
- The safety of the administration of ESAs; and
- The adequacy of the dialysis provided to ESRD patients using a standardized methodology for the calculation of Kt/V.

These changes will enable CMS to meet the intent of the MIPPA (Section 153c) legislation to monitor safety and outcomes delivered by ESRD providers for the entire ESRD population as part of the QIP. QIP

continued on next page

ESRD...*continued*

reductions, where appropriate, will be applied to ESRD prospective payment system (PPS) payments (and composite rate portion of the payment for transitioning providers). In addition, any QIP reduction will also apply to ESRD related separately billable services for ESRD facilities under the ESRD PPS transitional payment through December 31, 2013.

Reporting hemoglobin and/or hematocrit

CMS will require the submission of the most recent hemoglobin or hematocrit lab value taken prior to the start of the billing period on all ESRD claims irrespective of ESA administration. Failure to submit a hemoglobin and/or hematocrit value on all ESRD claims will adversely impact a facility's QIP score and public reporting on dialysis facility compare (DFC). **Note:** The blood sample for the hemoglobin reading must be obtained before the dialysis treatment. If a hemoglobin value is not available the value 99.99 shall be entered.

Required reporting for ESA route of administration

When reporting the administration of ESAs, CMS will require the reporting of modifiers JA (intravenous administration) or JB (subcutaneous administration) indicating the route of administration on all ESRD claims with dates of service on or after January 1, 2012.

ESRD claims that do not contain modifier JA or JB (when ESA administration is indicated) will be returned to the provider for correction. Patients with ESRD receiving administrations of ESAs (such as epoetin alfa (EPO) and Darbepoetin alfa (Aranesp)) for the treatment of anemia may receive intravenous administration or subcutaneous administrations of the ESA. Existing instructions require that ESRD facilities submit each administration on a separate line item. Renal dialysis facility claims including administrations of the ESAs by both methods must report the appropriate route of administration for each line item.

Calculation of the Kt/V value

CMS will require the use of the following Kt/V calculations based on the dialytic modality when entering value code D5 on ESRD claims.

- **Hemodialysis:** For in-center and home-hemodialysis patients prescribed for three or fewer treatments per week, the last Kt/V obtained during the month must be reported. Facilities must report single pool Kt/V using the preferred National Quality Forum (NQF) endorsed methods for deriving the single pool Kt/V value:
  - Daugirdas II or
  - Urea kinetic modeling (UKM).

Note: The reported Kt/V should not include residual renal function.

A value of 8.88 should be entered on the claim, for patients routinely prescribed and receiving four or more hemodialysis treatments per week for a medically justified and documented clinical need. The 8.88 value is not to be used for patients who are receiving "extra" treatments for temporary clinical need (e.g., fluid overload). A medical justification must be submitted for patients receiving greater than 13 treatments per month

When reporting a value of 8.88 the date of a Kt/V reading is not required. However, the standard system will require a date until April 1, 2012. Providers that do not have a date to report may use any date within the billing period until April when the date will no longer be required.

- **Peritoneal dialysis:** When measured, the delivered weekly total Kt/V (dialytic and residual) should be reported.

Coding for vascular access on hemodialysis claims

Modifier V5 must be entered if a vascular catheter is present even if it is not being used for the delivery of the hemodialysis. In this instance 2 modifiers should be entered, V5 (any vascular catheter (alone or with any other vascular access)) for the vascular catheter and either V6 (arteriovenous graft (or other vascular access not including a vascular catheter in use with two needles)) or V7 (arteriovenous fistula only (in use with two needles)) for the access that is being used for the delivery of hemodialysis.

Note: All other requirements associated with ESRD claims will remain unchanged.

Additional information

The official instruction, CR 7460, issued to your FI or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2311CP.pdf*. If you have any questions, please contact your 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: MM7460 Revised
Related Change Request (CR) #: CR 7460
Related CR Release Date: September 23, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2311CP
Implementation Date: January 3, 2012

Educational Events

Upcoming provider outreach and educational events – October 2011

Bimonthly Medicare Part A ACT: Medicare changes and hot issues

When: Tuesday, October 11
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

Provider Website Enhancements

When: Thursday, October 13
Time: 11:30 a.m. – 12:30 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, October 18
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

1. **Online** – Visit our provider training website at *www.fcsouniversity.com*, logon 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 a New Account" 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.

2. **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: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

If you 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 *medicare.fcso.com*, 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. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at *www.fcsouniversity.com*.

Other Educational Resources

Medicare Learning Network® provider exhibit program schedule

Mark your calendars. The *Medicare Learning Network*® will be exhibiting at the following health care provider conferences in the coming weeks:

2011 Congress of Neurological Surgeons Annual Meeting
Saturday, October 1 through Thursday, October 6
Walter E. Washington Convention Center, Washington, DC
Booth #704

National Association for Home Care & Hospice 30th Annual Meeting & Exposition
Saturday, October 1 through Wednesday, October 5
Mandalay Bay Resort and Casino, Las Vegas, NV
Booth #362

American Health Information Management Association Conference
Sunday, October 2 through Wednesday, October 5
Salt Palace Convention Center, Salt Lake City, UT
Booth #1631

2011 American Medical Billing Association Conference
Wednesday, October 13 through Friday, October 14
Planet Hollywood Resort and Casino, Las Vegas, NV
Booth #11

West Virginia Rural Health Conference
Wednesday, October 26 through Friday October 28
Lakeview Golf Resort & Spa, Morgantown, WV

Please make note of these dates and locations and add them to your calendar. If you are interested in having a *Medicare Learning Network* exhibit at your event, please contact us at *MLNexhibits@cms.hhs.gov*.

Source: CMS PERL 201109-12

Medicare Enrollment Guidelines for Ordering/Referring Providers fact sheet revised

The publication titled *Medicare Enrollment Guidelines for Ordering/Referring Providers*, which is available from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*, was revised to remove "Doctors of Chiropractic Medicine" from the list of providers who are eligible to order/refer, as indicated in technical direction that Centers for Medicare & Medicaid Services (CMS) issued on Friday, August 12. CMS will re-issue the related policies as soon as possible. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A home health agency, Part B, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) beneficiary services.

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

Source: CMS PERL 201109-01

The Medicare Overpayment Collection Process fact sheet revised

The Medicare Overpayment Collection Process fact sheet, which includes the definition of a physician or supplier overpayment and information about the overpayment collection process, has been revised and is now available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/OverpaymentBrochure508-09.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 201108-42

Updates from the *Medicare Learning Network®*

Contractor Entities At A Glance educational tool released

The *Medicare Learning Network®* (*MLN*) has released a new product titled *Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities* to provide education about the definitions and responsibilities of entities involved in various claims adjudication activities. This educational tool, which is available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf*, includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers. This product will be available in hard copy format from the MLN® at a later date.

Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B booklet revised

This booklet is designed to provide education on the ABN. It includes information on when an ABN should be used and how it should be completed. To place your order, visit the MLN Product Ordering page at *http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs*. The booklet may be found under the "General Medicare Program Information" section (ICN 006266).

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

Source: CMS PERL 201109-28

Tobacco-Use Cessation Counseling Services brochure available in hard copy

The *Tobacco-Use Cessation Counseling Services* brochure is now available in a hard copy format from the *Medicare Learning Network®*. This brochure is designed to provide education on tobacco-use cessation counseling services. To place your order, visit *http://www.CMS.gov/MLNGenInfo* on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

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

Source: CMS PERL 201109-01

Preventive Immunizations brochure revised

This brochure is designed to provide education on Medicare's influenza vaccine, pneumococcal vaccine, and hepatitis B vaccine benefits. To place your order for a hard copy, visit the *Medicare Learning Network®* (MLN) Product Ordering page at *http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs*. The brochure may be found under the "Medicare Preventive Services" section (ICN 006435).

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

Source: CMS PERL 201109-28

Materials from initial preventive physical exam and annual wellness visit national provider call now available

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on Thursday, July 21, entitled "The ABCs of the Initial Preventive Physical Examination and Annual Wellness Visit." Materials from this call are now available and include the presentation used during the national provider call, CMS responses to outstanding questions, call transcript (note that several post-call clarifications are included within the transcript to clarify information provided during the call), and the audio recording of the call.

All materials from this call can be found in the "Downloads" section at *http://www.CMS.gov/MLNProducts/MLM/itemdetail.asp?itemID=CMS1249934*.

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

Source: CMS PERL 201109-17

Addresses

First Coast Service Options

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

Claims/correspondence
Florida:
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

Electronic claim filing
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

Freedom of Information Act requests
(relative to cost reports and audits)

Provider Audit and Reimbursement (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
General information, conditional payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections
Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

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

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail and courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)
Durable medical equipment, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CIGNA Government Services
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health and hospice intermediary
Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Provider audit and reimbursement
904-791-8430

Provider education and outreach
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites

First Coast Service Options Inc. (Florida and U.S. Virgin Islands Medicare contractor)
medicare.fcso.com

Centers for Medicare & Medicaid Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

Medicare Part A Connection subscription form

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