

# C Medicare A CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

December 2011



## The Obama administration has expanded its efforts to fight fraud

On Tuesday, December 13, the Obama administration announced recovery of over 5.6 billion in fraudulent payments in fiscal year 2011, a 167 percent increase from 2008. President Obama's health care reform law includes new resources and tools to help fight fraud in Medicare and Medicaid and to protect taxpayer dollars. In addition, the Centers for Medicare & Medicaid Services (CMS) is taking steps to strengthen controls to identify and prevent prescription drug fraud and abuse in the Medicare Part D program.

CMS released a notice to Part D prescription drug plan sponsors that contains information and guidance to immediately take steps to stop prescription drug misuse and fraud. Pain killers (e.g., OxyContin™) are the fifth most filled classes of drugs in Medicare, with spending in 2009 totaling 3.9 billion. The Government Accountability Office identified evidence of fraud and drug abuse in Medicare for these types of drugs, which pose a threat to public health as well as the federal budget. Among the messages conveyed to the plans:

- Investigate and stop payment for suspect claims
- Use tools to help manage proper utilization of drugs
- Limit prescriptions to 30-day doses

## In this issue

Health care law will allow patients to compare options and find best value.....	5
\$523 enrollment application fee for 2012 .....	7
Medicare deductible, coinsurance, and premium rates for 2012 .....	26
Prompt payment interest rate revisions .....	81
Improper payments and inpatient prepayment medical review.....	82
Annual update to therapy code list .....	89

These efforts build on significant progress already made by the Obama administration to fight fraud across the health care sector – progress that has been sped up by resources from the Affordable Care Act, the health care law of 2010. This progress has contributed to the 167 percent increase in fraud recoveries since 2008.

In addition, under a demonstration announced in November, Medicare will implement a prior authorization process for all power mobility device claims in seven high-risk states, guaranteeing that beneficiaries receive access to the services they need but preventing payment in cases where medical need has not been established. This will make it more difficult to get fraudulent claims through Medicare's claims payment systems.

You may read the full CMS fact sheet at <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4217>.

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

Source: CMS PERL 201112-28



medicare.fcso.com



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

## General Information

New demonstrations to help curb improper Medicare and Medicaid payments.....	3
New Affordable Care Act demonstration to provide care at home for patients .....	4
Health care law will allow patients to compare options and find best value.....	5
CMS has expanded its online presence.....	5
Final rule updates medical loss ratio.....	6
Information on clinical quality measures.....	6
Multi-stakeholder group input on quality measures for 2012.....	7
\$523 CY 2012 enrollment application fee.....	7
Transcript of 'Revalidation of Medicare Provider Enrollment' national call .....	7
All payments to be made by EFT .....	8
Guidance on completing the CMS-855A .....	8
Complete NPIs will no longer be included in CMS' ordering and referring reports .....	15
Unsolicited/voluntary refunds .....	15
2012 update to the AIC requirements for ALJ and Federal District Court appeals.....	15
Shared Savings program application.....	16
Get accredited now for ADI.....	16
Get ready for DMEPOS bidding .....	17
Registration reminder for DMEPOS competitive bidding.....	18
Bidding timeline and education efforts for DMEPOS competitive bidding program.....	19
Now available: New webcast for round 2 and national mail order.....	20

## Incentive Programs

Learn about CMS' PCIP with new FAQs .....	20
Notification of final PCIP files for 2012 .....	20
Arkansas, Delaware, Montana, New Jersey, New York, and North Dakota launched Medicaid EHR programs .....	21
Payment and registration data on Medicare and Medicaid EHR incentive programs .....	21
Meaningful use timeline changes .....	22
2012 eRx payment adjustment: Assessment and application.....	23

## General Coverage

Medicare deductible, coinsurance, and premium rates for 2012 .....	26
Screening and counseling for obesity.....	27
Therapy cap values for CY 2012 .....	28
Screening and counseling interventions in primary care to reduce alcohol misuse.....	29
Screening for depression in adults .....	32
IBT for cardiovascular disease .....	35

## Local Coverage Determinations

Contents .....	38
----------------	----

## Electronic Data Interchange

Important Medicare FFS statement regarding versions 5010 and D.0 .....	46
5010 enforcement discretion period .....	46
Medicare FFS policy – 90-day discretionary enforcement period.....	47
Additional HIPAA 837 5010 transitional changes and modifications to COBA.....	47
Version 5010 resources are available .....	49
Trading partners should install latest version of PC-ACE Pro32.....	50
Preparing for version 5010 deadline .....	51
Medicare FFS Part B editing of the NDC .....	52
Health care provider taxonomy code set .....	52

## Coding and Billing

Expansion of telehealth services for 2012... ..	53
2012 ICD-10-CM code updates available....	54
Release of a national provider comparative billing report on nerve conduction.....	54

Pharmacy billing for drugs provided "incident to" a physician service .....	55
Revised ASP template now available .....	56

## Claim and Inquiry Summary Data

Top inquiries, rejects, and RTPs.....	57
---------------------------------------	----

## Reimbursement

January 2012 I/OCE specifications .....	63
RY 2012 IPF PPS PC Pricer updates.....	64
Correction to 2012 IPF PPS PC Pricer.....	64
FY 2012 SNF PC Pricer updates.....	64
<i>How to Use the Searchable MPFS</i> .....	64
Temporary hold of claims for services paid under 2012 MPFS .....	65
January 2012 ASP files available .....	65
Reasonable charge update for splints, casts, and certain intraocular lenses.....	65
Annual update for lab fee schedule .....	67
Home health PPS rate update.....	71
Summary of policies in the MPFS final rule and the telehealth originating site fee.....	77
Prompt payment interest rate revision.....	81

## Hospitals

MAC J9 Part A improper payments and inpatient prepayment medical review .....	82
Off-cycle release of the IPPS 2012 Pricer ...	86
Correction – FY 2012 IPPS PC Pricer.....	87
Billing information for CAHs paid under optional method regarding PCIP .....	87
New short-term PEPPER now available.....	87
Holding of specific LTCH claims .....	88
Fact sheet updates from the MLN.....	88
<i>Medicare Disproportionate Share Hospital</i> fact sheet revised .....	88

## Rehabilitation Facilities

Annual update to the therapy code list .....	89
Outpatient rehabilitation fact sheet.....	90
IRF PPS PC Pricer updates .....	90
Corrected IRF PPS PC Pricer .....	90

## End-Stage Renal Disease Facilities

First results for new program to improve care for dialysis patients .....	91
Recoupment of incorrect payments made under ESRD PPS for low-volume .....	92
Cost report filing extensions .....	93

## Educational Resources

<b>Educational Events</b>	
Upcoming provider outreach and educational events – January 2012.....	94

## Other Educational Resources

Preventive services resources.....	95
National Influenza Vaccination Week .....	96
The Great American Smokeout .....	97
<i>Mass Immunizations and Roster Billing</i> fact sheet available.....	98
Tools to help people with Medicare compare health care options .....	98
Updates from the MLN .....	99
<i>Medicare Shared Savings Program: Notice of proposed Rulemaking Fact Sheets</i> .....	99
<i>Ambulance Fee Schedule</i> fact sheet.....	99
New podcast on 'Medicare Overpayment Collection Process' released .....	100
<i>Medicare Fraud &amp; Abuse: Prevention, Detection, and Reporting</i> fact sheet .....	100
<i>Medicare Secondary Payer</i> fact sheet.....	100
<i>CMS Electronic Mailing Lists</i> fact sheet .....	100

## Contact Information

Addresses, phone numbers, and websites.....	101
---	-----

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.

### Publication staff:

Cindi Fox  
Terri Drury  
Mark Willett  
Robert Petty

Fax comments about this publication to:

**Medicare Publications**  
**904-361-0723**

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.

*CPT five-digit codes, descriptions, and other data only are copyright 2011 by American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.*

*ICD-9-CM codes and their descriptions used in this publication are copyright 2010 under the Uniform Copyright Convention. All rights reserved.*

*This document contains references to sites operated by third parties. Such references are provided for your convenience only. Blue Cross and Blue Shield of Florida, Inc. and/or First Coast Service Options Inc. do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

*All stock photos used are obtained courtesy of a contract with www.shutterstock.com.*

## CMS announces new demonstrations to help curb improper Medicare and Medicaid payments

### Efforts will build on 2011 decreases in Medicare and Medicaid improper payments

In 2010, the President announced three goals for cutting improper payments by 2012: Reducing overall payment errors by \$50 billion, cutting the Medicare fee-for-service error rate in half, and recovering \$2 billion in improper payments.

To help achieve these goals, the Centers for Medicare & Medicaid Services (CMS) has announced it will launch demonstration programs beginning in January 2012 that will target some of the most common factors that lead to improper payments.

### Cost saving projects will help protect Medicare and Medicaid

Beginning January 1, 2012, CMS will conduct demonstration projects that will strengthen Medicare by aiming at eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sound future of the Medicare trust fund and protect Medicare beneficiaries who depend upon it such as:

- Recovery audit prepayment review
- Prior authorization for certain medical equipment
- Part A to Part B rebilling

This past May, the Department of Health and Human Services (HHS) announced a pilot project under the Partnership Fund for Program Integrity Innovation to test an automated tool to screen providers for the risk of fraud. Currently, HHS and states lack standardized Medicaid provider data, which hampers detection of potential fraud. If successful, this tool will not only help prevent improper payments by weeding out fraudulent providers, but it will help states focus their resources where fraud is most likely to occur.

### New projects build on 2011 savings

The 2012 projects announced will build on accomplishments in 2011 to reduce Medicare and Medicaid improper payment rates.

CMS is also reporting for the first time a composite improper payment rate for the Medicare Part D prescription drug program. The improper payment rate for the Children's Health Insurance Program (CHIP) will not be published until 2012.

While improper payment rates are not necessarily an indicator of fraud in Medicare, Medicaid, or CHIP, they do provide HHS, CMS, and states with a more complete assessment of factors leading to error rates and new ways to help prevent them.

CMS is continuing to invest time and resources to work with providers across the country and eliminate errors through increased and improved training, education, and outreach.

The full CMS fact sheet is available at <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4176>.

### Additional fact sheets issued November 15

- CMS prior authorization fact sheet – <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4168>
- CMS rebilling fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4169>
- CMS recovery audit (RAC) demo fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4170>
- CMS Medicaid fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4171>
- CMS Medicare D fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4172>
- CMS Medicare C fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4175>
- CMS Medicare improper payments fact sheet – <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4174>

Also, please see the *White House Press Release – We Can't Wait: Agencies Cut Nearly \$18 Billion in Improper Payments, Announce New Steps for Stopping Government Waste* – <http://www.whitehouse.gov/the-press-office/2011/11/15/we-can-t-wait-agencies-cut-nearly-18-billion-improper-payments-announce->.

- Agency improper payment data is being updated at [www.paymentaccuracy.gov](http://www.paymentaccuracy.gov).

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

Source: CMS PERL 201111-34

## New Affordable Care Act demonstration to provide care at home for Medicare patients

### Health care reform law demonstration to improve care, lower costs for seniors and people with disabilities

Up to 10,000 Medicare patients with chronic conditions will now be able to get most of the care they need at home under a new demonstration announced by the Centers for Medicare & Medicaid Services (CMS).



“This program gives new life to the old practice of house calls, but with 21st Century technology and a team approach,” said CMS Acting Administrator Marilyn Tavenner.

Created by the Affordable Care Act, the new Independence at Home Demonstration greatly expands the scope of in-home services Medicare beneficiaries can receive. The Independence at Home Demonstration will provide chronically ill patients with a complete range of primary care services. Participation in the demonstration is voluntary for Medicare beneficiaries.

“In my days as a practicing nurse, I saw many patients whose health improved when they were happier with their living conditions,” said Tavenner. “When a critically-

ill patient can remain in familiar surroundings, the benefits are many: the person retains greater control over their daily lives, families and caregivers report greater satisfaction with the care, and unnecessary hospitalizations are avoided.”

CMS will join with medical practices to test the effectiveness of delivering primary care services in a home setting on improving care for Medicare beneficiaries with multiple chronic conditions. Medical practices led by physicians or nurse practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations.

The demonstration will reward health care providers that show a reduction in Medicare expenditures through an incentive payment if they succeed in providing high-quality care while reducing costs. CMS will use quality measures to ensure beneficiaries experience high quality care.

Medical practices eligible to participate in the demonstration must include physicians or nurse practitioners who have experience delivering home-based primary care. Up to 50 practices will be selected and each must serve at least 200 Medicare fee-for-service beneficiaries with multiple chronic conditions and functional limitations. Practices in the demonstration will be responsible for coordinating patient care with other health and social service professionals.

The new demonstration is one of a series of CMS initiatives to build a Medicare program that offers beneficiaries better care and better health at an affordable cost. It will be supported by the CMS Innovation Center, which was created by the Affordable Care Act to develop and test new models of health care delivery and payment, and disperse best practices throughout the health care system.

Applications and letters of intent, if applicable, are due on February 6, 2012. Additional information about this demonstration, including how to apply, can be found at [http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH\\_FactSheet.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH_FactSheet.pdf).

Questions on this demonstration may be submitted to CMS at: [IndependenceAtHomeDemo@cms.hhs.gov](mailto:IndependenceAtHomeDemo@cms.hhs.gov).

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

Source: CMS PERL 201112-44

## Health care law will allow patients to compare options and find best value

Consumers and employers will have the health care information they need to make more informed choices about their care, thanks to the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) announced in a final rule.

The rule gives qualified organizations, like employers and consumer groups, access to data that can help them identify high quality health care providers or create online tools to help consumers make educated health care choices. Information that could identify specific patients, however, will not be publicly released and strong penalties will be in place for any misuse of data.

The final rule makes a number of important changes from the original proposed rule. The final rule makes this data less costly for qualified entities, gives qualified organizations more flexibility in their use of Medicare data to create performance reports for consumers, and extends the time period for health care providers to confidentially review and appeal performance reports before they become public. The rule also includes strict privacy and security requirements to protect patients, health care providers, and suppliers as well as stringent penalties for any misuse of Medicare data.

For more information on the final rule, visit <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4205>.

The final rule on “Availability of Medicare Data for Performance Measurement” is on display at the Office of the Federal Register at <http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31232.pdf> or <http://www.archives.gov/federal-register/public-inspection>.

To read the entire CMS press release, visit [http://www.CMS.gov/apps/media/press\\_releases.asp](http://www.CMS.gov/apps/media/press_releases.asp).

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

Source: CMS PERL 201112-13

---

## CMS has expanded and enhanced its online presence

The Centers for Medicare & Medicaid Services (CMS) is always looking for ways to make your experience with the Medicare, Medicaid, Children’s Health Insurance, and other healthcare programs better. On Monday, December 5, CMS expanded and enhanced their online presence at CMS. They’re debuting a new look and feel for [CMS.gov](http://www.CMS.gov) and launching a brand-new site for the Medicaid program, [Medicaid.gov](http://www.Medicaid.gov).

These changes reflect what CMS has heard from you – the users – and they are a response to what you’ve said you want to be able to do on the CMS website.

- A significantly-improved search engine that gets you to the information you’re looking for – fast
- More in-depth information about what CMS is doing to implement the Affordable Care Act and other new initiatives and details about how you can apply for new programs
- Up-to-date, real-time updates that reflect important developments and initiatives happening with CMS programs
- Medicaid program information that’s readily available, easy-to-find, and easy-to-use – and CMS will be continually looking for ways to enhance your experience on its site
- Easy-to-access links to Healthcare.gov, which will continue to be the primary site for consumer information

While CMS moved content around to make it easier to find, don’t worry that you’ll lose access to any of the current Medicare and Medicaid information you rely on now. CMS is launching an archive version of each of its websites too, so that historic information can remain online without adding clutter to its primary sites.

CMS thinks these changes are a good first step to improving its online presence and making information more accessible for all the patients, partners, providers, states, advocates, and others who interact with its programs. However, this is just the first step – CMS has plans for continuous, ongoing improvements.

Take a look around at the [www.CMS.gov](http://www.CMS.gov) and [www.Medicaid.gov](http://www.Medicaid.gov), and *let CMS know what you think*. CMS would like to use your feedback to help drive the direction of future website improvements.

Source: CMS PERL 201112-18

---

## Final rule updates medical loss ratio to account for ICD-10 conversion costs

The version 5010 and ICD-10 transitions require significant changes to software and database systems, and may necessitate training for these updated standards and new coding sets. The Centers for Medicare & Medicaid Services (CMS) understands these system conversions can be costly to implement. To help alleviate this financial concern, CMS has released a final rule that addresses medical loss ratio (MLR), which now includes provisions for ICD-10 conversion cost considerations.

### What is MLR?

MLR is the ratio of total losses paid in insurance claims divided by the total earned premiums collected by insurers. Regulations of MLR mandate that insurers may only spend 15 or 20 percent of revenue from premiums on expenses that are non-clinical, such as administrative costs, in order to reduce excessive spending. A minimum level of 85 percent of revenue for large group markets and 80 percent for small group markets has been set to be spent only on clinical costs.

### How does this change affect ICD-10?

Under this final rule, insurers may shift some of the costs associated with the ICD-10 conversion to the category of clinical cost, which will be considered as quality improvement activity.

This will allow up to 0.3 percent of earned premiums in the relevant state market to be counted as quality improvement activity. This specification of how the MLR is calculated will help covered entities cover some of the cost of ICD-10 implementation. ICD-10 maintenance costs and claims adjudication system costs are still considered to be administrative, and thus will fall under the MLR restriction on non-clinical spending limits.

This *final rule* will be effective on January 1, 2012, and will be open for public comment until January 6, 2012. The final rule addresses comments made in the interim rule published in January 2011.

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

Please visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation *widget* today.

Source: CMS PERL 201112-24

---

## Updated information on clinical quality measures

The Centers for Medicare & Medicaid Services (CMS) suggests that eligible professionals participating in the Medicare and Medicaid electronic health records (EHR) incentive programs **not select** "NQF 0084: Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation" as one of their additional clinical quality measures (CQMs) for meaningful use. As there are other FDA-approved medications available for use as an anticoagulant, CMS suggests this measure not be selected as one of the measures reported for the CQM objective.

CMS does not expect eligible professionals to change their certified EHR systems or purchase another system to replace this measure. Eligible professionals may continue to report NQF 0084 for the 2011-2012 program years if their certified EHR system uses a module that is only certified for nine CQMs with this measure included as one of the nine.

To view all 44 clinical quality measure specifications, please download the [EP Measure Specifications](#).

Additionally, the [Guide to Clinical Quality Measures](#) provides an overview of CQMs, how to choose the appropriate CQMs for meaningful use, and how CQMs are reported during attestation.

### Want more information about the EHR incentive programs?

Make sure to visit the [EHR Incentive Program website](#) for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201112-16



## Multi-stakeholder group input on quality measures for 2012

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a list of quality and efficiency measures being considered for adoption in calendar year 2012.

Per the statutory requirements of Section 3014 of the Affordable Care Act, a new federal “pre-rulemaking process” has been established. This process includes, but is not limited to, making publicly available by December 1 a list of measures currently under consideration for qualifying programs, including measures suggested by the public and subject to multi-stakeholder group review and input (as convened by the National Quality Forum).

For more information on this process, please visit [www.CMS.gov/QualityMeasures/MultiStakeholderGroupInput](http://www.CMS.gov/QualityMeasures/MultiStakeholderGroupInput).

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

Source: CMS PERL 201112-05

---

## \$523 calendar year 2012 enrollment application fee for institutional providers

Institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) must submit an application fee or hardship exception when initially enrolling, revalidating their enrollment; or adding a new Medicare practice location. The calendar year (CY) 2012 fee of \$523 is required with any Medicare enrollment application submitted on or after Sunday, January 1, 2012, and on or before Monday, December 31, 2012.

For more information about how the fee was calculated, see the [Federal Register Notice](#). See [MLN Article SE1130](#) to learn how to pay the fee for Medicare enrollment actions.

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

Source: CMS PERL 201112-17

---

## Transcript of ‘Revalidation of Medicare Provider Enrollment’ national provider call now available

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the Affordable Care Act (section 6401a). The Centers for Medicare & Medicaid Services (CMS) hosted a national provider call on Thursday, October 27, 2011, to discuss:

- The revalidation process
- Improvements to the Provider Enrollment, Chain and Ownership System (PECOS)
- Advanced diagnostic imaging and accreditation
- Application fees
- Changes to the 855A form

Don't miss this opportunity to hear from CMS experts on this important topic. Click on [National Provider Call on Revalidation of Medicare Provider Enrollment](#) to view the transcript. This transcript contains a number of post call clarifications – such as where to find the listing of providers which have received a notice to revalidate. The audio file will be posted in the near future.

Source: CMS PERL 201111-38

## All Medicare provider and supplier payments to be made by electronic funds transfer

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 (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 Centers for Medicare & Medicaid Services' (CMS) revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified and will be required to submit the CMS-588 EFT form with their provider enrollment revalidation applications.

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."

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

Source: CMS PERL 201112-14

## Guidance on completing the CMS-855A enrollment form

### Provider types affected

This *MLN Matters*® special edition article is intended for hospitals and other providers that complete the CMS-855A enrollment application. Specifically, this article applies to the following health care organizations:

- Community mental health centers;
- Comprehensive outpatient rehabilitation facilities;
- Critical access hospitals;
- End-stage renal disease facilities;
- Federally qualified health centers;
- Histocompatibility laboratories;
- Home health agencies;
- Hospices;
- Hospitals;
- Indian health services facilities;
- Organ procurement organizations;
- Outpatient physical therapy/occupational therapy/speech pathology services;
- Religious non-medical health care institutions;
- Rural health clinics; and
- Skilled nursing facilities.

### What you need to know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article solely as an educational guide to improve compliance with documentation requirements for the Medicare Enrollment Application for Institutional Providers, Form CMS-855A (07/11).

This article presents a brief guide that you may use when completing the CMS-855A application. **Please note that use of this guide is not mandatory and does not ensure Medicare enrollment.**

### Background

Getting started

#### What do I need to have to fill out the CMS-855A?

You should have the following before you start to fill out the application:

- Your Internal Revenue Service (IRS) document confirming your Employer Identification Number (EIN) - also known as the Federal Tax Identification Number (TIN) - and your legal business name;
- Your National Provider Identifier (NPI) document confirming your NPI number;

**Note:** If you do not have an NPI, you may apply online at <https://NPPES.cms.hhs.gov>;

- Your completed Electronic Funds Transfer Agreement (EFT) including your Bank Account Information (check or bank confirmation letter) or voided check with the legal business name matching the LBN on your IRS documentation (counter checks are not accepted); and,
- A copy of your organizational chart that details all of your direct and indirect owners.

#### Where can I get a copy of the CMS-855A application?

You may download and view the application at <https://www.cms.gov/cmsforms/downloads/cms855a.pdf>.

*continued on next page*



**CMS-855A...continued****What are the sections of the application?**

Below are the sections and brief explanations on filling them out.

**Section 1 – basic information****Section 1A – reason for application**

This section identifies the purpose of the application submission. Only one reason should be selected. Here is a description of the possible submission reasons:

- New enrollee
- Enrolling with another fee-for-service (FFS) Medicare contractor;
- Reactivating a prior enrollment;
- Change of ownership (CHOW)
- Acquisition/merger or consolidation
- Changing Medicare enrollment information – must include Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN) and NPI; or
- Revalidating Medicare enrollment information.

**Section 1B – check all that apply**

If Section 1A reports a change in Medicare enrollment information, indicate the sections in which the information is changing. Please remember that you are responsible for disclosing changes timely.

**Section 2 – identifying information****Section 2A – type of provider**

Indicate the type of provider enrolling/enrolled.

- You should make only one selection in Section 2A1 and you should not check “Other”;
- You must submit separate enrollment applications if multiple provider types are indicated in Section 2A1; and,
- If you indicate that the provider type is a hospital, be sure to check all applicable subgroups and units in Section 2A2; and answer the questions in Section 2A3 and 2A4.
- If you indicate that the provider type is a hospital–swing-bed approved; hospital – psychiatric unit or a hospital – rehabilitation unit and it is initially enrolling, a separate enrollment application is not needed. The applicant may simply list these units in Section 4A of the hospital’s application and check the applicable box in that section.

**Section 2B – identification information**

In this section, you should do the following:

- Enter the legal business name (LBN) as reported to the IRS (**Note:** Review your IRS documents to ensure that the correct name is indicated);
- Identify the type of organizational structure, as defined by the IRS. You may select from the following: corporation, limited liability company, partnership, sole proprietor or other. If other is indicated, please specify the type of organization;
- Enter the Tax Identification Number (TIN) on file with the IRS;
- For corporations, provide the incorporation date and state where incorporated;
- If applicable, specify any “other” name as noted in this section;
- Identify how your business is registered with the IRS by checking either proprietary or non-profit. If a selection is not made on the application, you will be listed in the system as proprietary;
- Enter your year-end cost report date;
- Indicate whether you are an Indian health facility enrolling with the designated Indian health service (IHS) MAC by checking yes or no;
- If state licensure information applies and is known at the time of enrollment, please provide the license number, state where issued, effective date, and expiration/renewal date. Otherwise, mark “Not Applicable”;
- If certification information applies and is known at the time of enrollment, please provide the certification number, state where issued, effective date and expiration/renewal date; otherwise, mark “Not Applicable”.

**Section 2C – correspondence address**

Provide an address where the applicant can be contacted directly. Be sure to include the entire ZIP code (ZIP Code + 4). This address cannot be the address of a billing agency, provider’s representative or the chain home office.

**Section 2D – accreditation**

Indicate whether the facility is accredited. If accredited, provide the date of accreditation, name of accrediting body, and type of accreditation or accreditation program.

**Section 2E – comments**

Provide any comments, if needed, to clarify a unique enrollment situation.

**Section 2F – change of ownership (CHOW) information**

*continued on next page*

**CMS-855A...continued**

- You should complete this section if the type of CHOW transaction described in the instructions on page 4 of the CMS-855A has occurred. The information provided in this section should be that of the seller/former owner.
- Provide the legal business name (LBN), doing business as name, Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN), and NPI of the seller/former owner;
- Indicate the effective date of transfer. This date can be a future date and must match the date on the final bill of sale.
- Indicate the name of the Medicare contractor for the seller/former owner.
- Indicate if the new owner will be accepting assignment of the current provider Agreement. If the answer is no, the application should not be completed as if a CHOW has occurred. The new owner should refer to the instructions in section 1A to apply as a New Enrollee.

**Section 2G – acquisitions/mergers**

- You should complete this section only if an acquisition/merger – as that term is described in the instructions on page 5 of the CMS-855A - has occurred.
- Provide the effective date of acquisition.
- Indicate in Section 2G1 the legal business name and Medicare contractor name of the provider being acquired.
- If the provider being acquired has separate Medicare PTANs/CCNs for any units or branches, be sure to provide the name/department, PTAN/CCN, and NPI of those units/branches.
- Indicate in Section 2G2 the LBN, PTAN/CCN, Medicare contractor name, and NPI of the acquiring provider.

**Section 2H – consolidations**

Complete this section only if a consolidation – as that term is described in the instructions on page 5 of the CMS-855A – has occurred.

- In Sections 2H1 - 3, as applicable, provide the LBN, Medicare Contractor name, and effective date of consolidation for each consolidating provider organization. If the provider has separate Medicare PTANs/CCNs for any units or branches, be sure to provide the name/department, PTAN/CCN, and NPI of those units/branches.
- Indicate in Section 2H3 the LBN and TIN of the newly created provider.

**Section 3 – final adverse actions/convictions**

Final adverse actions include, but are not limited to, felony convictions, licensure suspensions or revocations, or exclusions from participation in a federal or state health care program. A complete list of reportable adverse actions can be found on page 16 of the CMS-855A application. (You may download and view the CMS-855A at <http://www.cms.gov/cmsforms/downloads/cms855a.pdf>.)

- If the provider, under any current or former name or business identity, has had a reportable adverse action, mark Yes;
- Identify the final adverse action, date of action, federal or state agency or the court or administrative body that imposed the action and the resolution, if any, in this section;
- If no final adverse action exists, be sure to mark “No.” (**Note:** Do not indicate that this section is “Not Applicable.”)

**Section 4 – practice location information****Section 4A – practice location information**

All practice locations must be disclosed in this section. Please list the primary practice location first, and list the PTAN or CCN (if assigned) and NPI combination for each practice location. If a location has multiple NPIs, list each of the NPIs for the location in this section.

- The box labeled “Change” should only be marked if the information for a current practice location is changing. (**Note:** The change, add and delete boxes are for the practice location, not for the application itself). If the physical location of your facility has changed, please complete one section as an “Add” and one section as a “Delete” to ensure your Medicare records are appropriately updated.
- Provide the practice location name (indicate the doing business as name if it is different from the legal business name).
- Include the practice location street, any building identifiers (e.g., suites numbers), city, state and the entire ZIP code (ZIP Code + 4).
- Provide the telephone number, fax number (if applicable) and email address (if applicable).

Identify the type of practice location for hospitals and home health agencies (HHAs); for hospitals this includes provider types such as swing-bed unit; hospital – psychiatric unit or a hospital – rehabilitation unit.

*continued on next page*

**CMS-855A...continued**

**Section 4B – Where do you want remittance notices or specials payments sent?**

Medicare will issue payments via electronic funds transfer (EFT). Therefore, this address will be used for all other payment information (i.e., remittance notices, special payments).

- The “Change” box should be marked only if the information for a current special payments location is changing. (**Note:** The change, add and delete boxes are for the special payments location, not for the application itself)
- If you list only one address in Section 4A, and you will use that address as the special payments address, check the first block in Section 4B, write same in the address section and skip to Section 4C;
- If there are multiple addresses in Section 4A or the special payments address will be different from the address in Section 4A, check the second box in Section 4B and enter the special payments location street, any building identifiers (e.g., suites numbers), city, state and entire ZIP code (ZIP Code + 4).

**Section 4C – Where do you keep patients’ medical records?**

This section captures any address in which patient medical records are stored. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Sections 4A or 4D.

- The Change box should only be marked if the information for the medical records location is changing. (**Note:** The change, add and delete boxes are for the medical records location, not the application itself)
- If you store medical records at a location other than the addresses listed in sections 4A or 4D, provide the storage facility location street, any building identifiers (e.g., suites number), city, state and entire ZIP code (ZIP Code + 4).

**Section 4D – base of operations address for mobile or portable providers**

This section captures the location, if applicable, where personnel are dispatched, where mobile/portable equipment is stored, and where vehicles are parked when not in use.

- The “Change” box should only be marked if the information for the base of operations location is changing. (**Note:** The change, add and delete boxes are for the base of operations location, not the application itself);

- If applicable, provide the base of operations street address, any building identifiers (e.g., suites numbers), city, state and entire ZIP code (ZIP Code + 4);
- Provide the telephone number, fax number (if applicable) and email address (if applicable).

**Section 4E – vehicle information**

This section captures vehicle information, if applicable, for mobile health care services that are rendered inside the vehicle, like a van, mobile home, or trailer.

- The “Change” box should only be marked if the information for the base of operations location is changing. (Note: The change, add and delete boxes are for the practice location, not the application itself)
- Provide the type of vehicle and Vehicle Identification Number (VIN) for each vehicle.
- Submit copies of all health care related permits, licenses, and registrations for each vehicle.

**Section 4F – geographic location for mobile or portable providers where the base of operations and/or vehicle renders services**

For home health agencies (HHAs) and mobile or portable providers, this section captures geographic areas where health care services are rendered.

- For Section 4F1, Initial Reporting and/or Additions: If you are rendering services throughout the entire state, mark the box “Entire State Of” and provide the name of the state. If you are providing services in selected cities/towns, provide the locations areas (i.e., city/town, state, ZIP code).
- For Section 4F2, Deletions: If you are deleting previously disclosed services throughout the entire state, mark the box “Entire State Of” and provide the name of the state. If you are deleting previously disclosed services in selected cities/towns, provide the location areas (i.e., city/town, state, ZIP code).

**Section 5 – ownership interest and/or managing control information (organizations)**

Check the box “Not Applicable” if Section 5 does not apply to the provider listed in Section 2.

**Section 5A – organization with ownership interest and/or managing control – identification information**

If the provider identified in Section 2 is owned and/or operated by another organization, please provide identifying information and check type of organization in Sections 5A1 and 5A2.

*continued on next page*

**CMS-855A...continued****Section 5A – ownership/managing control identification information**

You must report all organizations that have any of the following interests in the enrolling provider. Check the types of interest that the entity has in the provider and complete all information for each type of ownership and/or managing control applicable:

- 5 percent or greater direct ownership interest;
- 5 percent or greater indirect ownership interest;
- 5 percent or greater mortgage or security interest;
- All general partnership interests, regardless of the percentage. This includes: (1) all interests in a non-limited partnership, and (2) all general partnership interests in a limited partnership;
- Limited partnership interests if the interest in the partnership is at least 10 percent; and
- Managing control.

For each organization, be sure to:

- Indicate the legal business name (LBN) that is displayed on the IRS document.
- Provide the street address, any building identifiers (e.g., suites numbers), city, state and entire ZIP code (ZIP Code + 4).

If a federal, state, county, city, or other level of government or Indian tribe will be legally and financially responsible for Medicare payments received, the name of that agency or organization must be listed as an owner and an attestation statement signed by an authorized official (as indicated in Section 15 of the CMS-855A) must be submitted.

If the provider is a non-profit, charitable or religious entity and is operated and/or managed by a Board of Trustees or governing body, the name of the Board of Trustees or governing body should be reported in this section. The organization is listed in Section 5. The individuals on the Board or governing body are listed in Section 6.

If applicable, the chain home office must be listed in Section 5 as well as in Section 7.

**Note that the following data elements in Section 5 need not be completed:**

- “Exact percentage of operational/managerial control this organization has in the provider”
  - “Other ownership or control/interest” if the organization/individual does not have an ownership, partnership, mortgage, security, or other quantifiable interest in the provider. (Otherwise, this data element must be completed.)

**Section 5B – adverse legal history**

Final adverse actions include, but are not limited to, felony convictions, licensure suspensions or revocations, or exclusions from participation in a federal or state health care program. A complete list of reportable final adverse actions can be found on page 16 of the CMS-855A application. (You may view the CMS-855A at <http://www.cms.gov/cmsforms/downloads/cms855a.pdf>.)

- Check the box “Change” in Section 5B only if there is a change to the entity’s final adverse action history.
- If the organization identified in Section 5A, under any current or former name or business identity, has had a reportable final adverse action, mark the box Yes and enter the final adverse action, date of action, the federal or state agency or the court or administrative body that took the action and the resolution in Section 5B.
- If no final legal adverse action exists, be sure to mark the box “No.” Do not indicate that this section is not applicable.

**Section 6 – ownership interest and/or managing control information (individuals)****Section 6A – individuals with ownership interest and/or managing control – identification information**

This section captures information on individuals with ownership interest and/or managing control of the provider.

- At least one managing employee must be listed in this section.
- The box “Change” should be marked only if the specific information related to the individual is changing (i.e., last name, relationship to provider).
- The name and date of birth of the individual must match what has been reported to the Social Security Administration (SSA).
- A middle initial must be supplied, or the individual should provide evidence that a middle name does not exist.
- Be sure to mark all relationship types in Section 6A. The box “Other Ownership or Control/Interest” cannot be the only box checked.
- The box “Partner” should be marked only if the provider’s organizational structure in Section 2B1 is Partnership.
- If the provider is a corporation, the provider’s

*continued on next page*

**CMS-855A...continued**

officers and directors must be reported in this section.

- If the provider is a non-profit, charitable or religious entity and is operated and/or managed by a Board of Trustees or governing body, the names of the individual board members should be reported in this section. The individuals are listed in Section 6 and the organization is listed in Section 5.
- Authorized and delegated officials must be reported in this section.
- Authorized and delegated officials cannot be contracted managing employees.
- The chain home office administrator (if any) must be reported in this section.
- Note that the following data elements in Section 6 need not be completed:
- “Exact percentage of control as an officer this individual has in the provider”
- “Exact percentage of control as a director this individual has in the provider”
- “Exact percentage of management control this individual has in the provider” (under the “W-2 Managing Employee” heading)
- “Exact percentage of this contracted managing employee’s control in the provider”
- “Exact percentage of operational/managerial control this individual has in the provider”
- “Other ownership or control/interest” if the organization/individual does not have an ownership, partnership, mortgage, security, or other quantifiable interest in the provider. (Otherwise, this data element must be completed.)

**Section 6B – adverse legal history**

Final adverse actions include, but are not limited to, felony convictions, licensure suspensions or revocations, and exclusions from participation in a federal or state health care program. A complete list of reportable final adverse actions can be found on page 16 of the CMS 855A application.

- If the individual identified in Section 6A, under any current or former name or business identity, has had a reportable final adverse action, mark the box Yes and enter the final adverse action, date of action, the federal or state agency or the court or administrative body that took the action and the resolution. .
- If no final adverse action exists, mark the box “No.” Do not indicate that this section is not applicable.

- Check the box “Change” in Section 6B only if there is a change to the entity’s final adverse action history.

**Section 7 – chain home office information**

This section applies to providers that are part of a chain organization. It should be completed in its entirety for providers enrolling in a chain, disassociating from a current chain or changing from one chain to another.

- Check the box “Not Applicable” if this does not apply to you.
- A middle initial for the administrator must be supplied, or the individual should provide evidence that a middle name does not exist.
- Enter the LBN that is displayed on the IRS document.
- Be sure to include the entire ZIP code (ZIP Code + 4).
- All home office information needs to be furnished in its entirety.

**Section 8 – billing agency information**

A billing agency is a company or individual that will process and submit claims on your behalf.

- Check the box “Not Applicable” if this section does not apply to you.
- Indicate the legal business name (LBN) that is displayed on the IRS document.
- Be sure to include the entire ZIP code (ZIP Code + 4).

**Section 12 – special requirements for home health agencies (HHAs)**

Check the box “Not Applicable” if this section does not apply to you.

**Section 13 – contact person**

This is the only person with whom the Medicare contractor can discuss this application, with the exception of the authorized or the delegated official. Multiple individuals can be listed in this section.

**Section 15 – certification statement**

This section is signed by the authorized official of the organization. Authorized officials must be identified in Section 6 of the application. A provider can have as many authorized officials as it desires, but must have at least one.

- Mark the box “Change” only if the information for the authorized official is changing. (**Note:**

*continued on next page*

**CMS-855A...continued**

The change, add, and delete boxes are for the authorized official, not the application itself.)

- The name and date of birth of the individual must match what has been reported to the Social Security Administration (SSA).
- A middle initial must be supplied, or the individual should provide evidence that a middle name does not exist.
- There must be at least one original signature for each authorized official who signs an application.

**Section 16 – delegated official(s) (optional)**

(**Note:** Authorized and delegated officials must be identified in Section 6 of the application.)

- Mark the box “Change” only if the information for the delegated official is changing. (**Note:** The change, add, and delete boxes are for the delegated official, not the application itself.)
- The name and date of birth of the individual must match what has been reported to the Social Security Administration (SSA).
- A middle initial must be supplied, or the individual should provide evidence that a middle name does not exist.
- There must be at least one original signature for each delegated official that signs an application.

**Section 17 – supporting documents**

Certain documents must be submitted with your application:

- An IRS document must be submitted for initial applications, revalidations, CHOWs (new owner). The Authorization Agreement for Electronic Funds Transfer, Form CMS-588, must be submitted with original signatures if you are not currently receiving funds electronically.
- Submit a written statement from the bank listed on the EFT if you have a lending relationship with them, stating that the bank has agreed to waive its right of offset for Medicare receivables.
- Submit a copy of the state license for complete applications or if updates to the licensure information are made.
- If the provider is a non-profit, charitable, or religious entity and there are no owners, the 501(c)(3) must be submitted.

**What are some tips for completing the EFT Authorization Agreement - Form CMS-588?**

Following are some tips for completing the CMS-588.

You may download and view this form at <http://www.cms.gov/cmsforms/downloads/CMS588.pdf>.

- Part II – the LBN should match your IRS documentation and be on the Provider/Supplier Legal Business Name line.
- Part V – the EFT form must be signed by an approved authorized or delegated official as identified in Section 15 or 16 of the CMS-855A. An original signature is required.
- An original, preprinted, voided check, or confirmation of account information on bank letterhead must be submitted with the EFT. The letter from the bank should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature. Ensure that the bank information completed on the CMS-588 form matches the information on the voided check or bank confirmation. (**Note:** The name on the bank account must match the provider's legal business name or the chain home office's legal business name; payment to the owning organization's bank account is not acceptable).
- A deposit slip cannot be accepted, as the routing number is sometimes incorrect.
- If payment is being made to the chain home office, a letter authorizing payment to the chain home office must be submitted. This letter must be signed by both the provider's authorized official (as identified in Section 15 of the CMS-855A) and by the home office's CEO/administrator.

**Additional information**

For more information about Medicare enrollment, visit the Medicare Provider-Supplier Enrollment Web page at <http://www.cms.gov/MedicareProviderSupEnroll>. 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: SE1135  
 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

*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.*

## Complete NPIs will no longer be included in CMS' ordering and referring reports

In response to concerns raised by the provider community, the Centers for Medicare & Medicaid Services (CMS) will include only the last four digits of the national provider identifier (NPI) of physicians and non-physician practitioners listed in its ordering and referring reports. The ordering and referring reports may be found in the "Downloads" section at [http://www.CMS.gov/MedicareProviderSupEnroll/06\\_MedicareOrderingandReferring.asp](http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp).

The following reports will be updated shortly to only contain the last four digits of the NPI:

- "Ordering/Referring Report"
- "Initial Physician Applications Pending Contractor Review"
- "Initial Non Physician Applications Pending Contractor Review"

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

Source: CMS PERL 201111-59

---

## Unsolicited/voluntary refunds

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

The Centers for Medicare & Medicaid Services reminds providers that:

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

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

---

## CY 2012 update to the AIC requirements for ALJ and Federal District Court appeals

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing (third level review) or Federal District Court (fifth level) review. The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2011, is \$130. This amount remains the same for calendar year 2012. The amount that must remain in controversy for Federal District Court review requests filed on or before December 31, 2011, is \$1,300. This amount increases to \$1,350 for appeals to Federal District Court filed on or after January 1, 2012.

Source: TDL 12113

### 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>.

## Medicare Shared Savings program application package now available on CMS' website

The Shared Savings program application Web page, located at [http://www.CMS.gov/sharedsavingsprogram/37\\_Application.asp](http://www.CMS.gov/sharedsavingsprogram/37_Application.asp), has been updated to include links to the notice of intent to apply (NOI) and the complete Shared Savings program application package. You will find links to the NOI and application in the Downloads section of the Web page. The complete application includes the following documents:

- Medicare Shared Savings Program application 2012
- Appendix A – electronic funds transfer (EFT) authorization agreement (CMS Form 588)
- Appendix B – participant list
- Appendix C – data use agreement (DUA)
- Appendix D – application reference guide

Submitting the NOI is the first step in the application process. The second step is submitting the application and the accompanying required documents.

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

Source: CMS PERL 201111-41

---

---

## Get accredited now for advanced diagnostic imaging

As a reminder, beginning Sunday, January 1, 2012, suppliers who furnish the technical component of advanced diagnostic imaging (ADI) must be accredited in order to bill Medicare for these services. ADI procedures include magnetic resonance imaging (MRI), computed tomography (CT), nuclear medicine imaging, and positron emission tomography. X-ray, ultrasound, fluoroscopy, and hospital outpatient procedures are excluded. The technical component of ADI services includes the performance of the imaging procedures, not the physician interpretation.

For dates of service on or after January 1, Medicare administrative contractors (MACs) will begin denying claims for the technical component of ADI that are submitted under the physician fee schedule by suppliers who have not yet been accredited. Once a supplier becomes accredited, they can begin billing Medicare for these services again.

For more information about ADI Accreditation, including a list of accrediting organizations and details of the accreditation process, please visit [http://www.CMS.gov/MedicareProviderSupEnroll/03\\_AdvancedDiagnosticImagingAccreditation.asp](http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp). An MLN special edition article on this subject – “Important Reminders about Advanced Diagnostic Imaging Accreditation Requirements” (MLN SE1122) – is also available at <http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.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 201112-08

### Medicare A Connection subscription

*Medicare A Connection* is published monthly and is available online in both *English* and *Spanish*. Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published from October 2011 through September 2012.

To order an annual subscription, complete the *Medicare A Connection Subscription Form*.



## Get ready for DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 2 and the national mail-order competitions are coming soon.

### Fall 2011

- The Centers for Medicare & Medicaid Services (CMS) announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and passwords begins

### Winter 2012

- Bidding begins

**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 CMS website ([www.cms.gov/MEDICAREPROVIDERSUPENROLL](http://www.cms.gov/MEDICAREPROVIDERSUPENROLL)) or reviewing the PECOS fact sheet at [www.cms.gov/MLNProducts/downloads/MedEnroll\\_PECOS\\_DMEPOS\\_FactSheet\\_ICN904283.pdf](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 ([www.palmettogba.com/nsc](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 competitive bidding area (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 the CMS website: [www.cms.gov/MedicareProviderSupEnroll/01\\_Overview.asp](http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp).

The competitive bidding implementation contractor (CBIC) is the official information source for bidders. Stay informed -- visit the CBIC website at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) to subscribe to email updates and for the latest information on the DMEPOS competitive bidding program.

**Each office visit is an opportunity.** Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that flu seasons are unpredictable and can be severe. Each year, it is estimated that 90 percent of seasonal flu-related deaths and more than 60 percent of seasonal flu-related hospitalizations occur in people 65 years and older. Please talk with your Medicare patients about

*continued on next page*

**DMEPOS...continued**

the importance of getting their annual flu vaccination. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get the flu vaccine – not the flu.

Remember – the flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at [http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10\\_VaccinesPricing.asp](http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp). Note that the flu vaccine is not a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit [http://www.CMS.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp) and <http://www.cms.gov/immunizations>.

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

Source: CMS PERL 201111-55

---

## Registration reminder for DMEPOS competitive bidding

The Centers for Medicare & Medicaid Services (CMS) like to remind all suppliers interested in participating in the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program that registration for user IDs and passwords is open. If you are interested in bidding, you must designate one authorized official (AO) (from those listed on your CMS-855S enrollment form) to act as your AO for registration purposes, and your AO must register.

**CMS strongly urges all AOs to register no later than December 22, 2011, to ensure that AOs have time to designate other supplier employees to use the DMEPOS online bidding system (DBidS).**

When bidding opens, suppliers will need to submit their bids using DBidS. To help ensure bid security and privacy, suppliers interested in bidding must first register all employees that will enter information in DBidS, and those employees must obtain a user ID and password through the individuals authorized access to CMS computer services (IACS) system. Only suppliers' employees that have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to bid.

After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as backup authorized officials (BAO). The AO and BAOs can designate other supplier employees as end users (EU). BAOs and EUs must also register for a user ID and password to be able to use the online bidding system. The name, date of birth, and Social Security number (SSN) of the AO and BAOs must match exactly with what is on file with the national supplier clearinghouse (NSC) to register successfully.

Registering now allows the AO and/or BAO time to correct the supplier's NSC records if their name, date of birth, and SSN does not match what is on file with the NSC. CMS recommends that BAOs register no later than **January 12, 2012**, so that they will be able to assist AOs with approving EU registration.

Registration will close **February 9, 2012, at 9 p.m. prevailing Eastern Time** – no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) and click on "Registration is Open" above the registration clock on the home page. Please review the *IACS Reference Guide* posted on the website for step-by-step instructions on registration. You will also find a registration checklist and quick step guides on the CBIC website. If you have any questions about the registration process, please contact the CBIC customer service center at 1-877-577-5331.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for email updates on the home page of the CBIC website. For information about round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under "Bidding Suppliers: Round 2 & National Mail-Order" on the CBIC website.

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

Source: CMS PERL 201112-40

## Bidding timeline and education efforts for DMEPOS competitive bidding program

### Bidding timeline

The Centers for Medicare & Medicaid Services (CMS) has announced the bidding timeline for the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program. To view the timeline, visit the Competitive Bidding Implementation Contractor (CBIC) website at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com).

### Education program

CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner. The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC website, [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com), features a comprehensive array of important information for suppliers, including bidding rules, user guides, policy fact sheets, checklists, and bidding information charts. The education program will also include webcasts that cover all the essential topics suppliers need to know in order to bid. These webcasts will be posted on the CBIC website and will be available 24 hours a day/7 days a week. When a webcast is posted, the CBIC will announce its availability through a CBIC email update announcement. To sign up to receive webcast announcements and other key registration and bidding information, visit the CBIC website at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) and subscribe to email updates.



In addition to viewing the information on the CBIC website, DMEPOS suppliers are encouraged to call the CBIC toll-free help desk, 1-877-577-5331, with their questions and concerns.

To view the press release, please click: [www.cms.gov/apps/media/press\\_releases.asp](http://www.cms.gov/apps/media/press_releases.asp).

To view the fact sheet, please click: [www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.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 201111-72

---

## *The Medicare DMEPOS Competitive Bidding Program Repairs and Replacements fact sheet revised*

On Monday, December 12, 2011, the Centers for Medicare & Medicaid Services (CMS) announced a revised repairs and replacement policy for the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The revised policy continues to allow any Medicare enrolled supplier to repair medically necessary, beneficiary-owned equipment when necessary to make the equipment serviceable. The policy now considers repair parts to include components that are needed to repair the base equipment, including batteries and tires. Additionally, the revised fact sheet provides guidance on billing the labor component and parts for the repair for beneficiaries who reside in competitive bid areas.

The revised *"The Medicare DMEPOS Competitive Bidding Program Repairs and Replacements"* fact sheet (ICN 905283) is designed to provide education on repairs and replacements under the DMEPOS competitive bidding program. It includes information on which items and services can be provided by contract versus non-contract suppliers.

Source: CMS PERL 201112-34

## Now available: New webcast for round 2 and national mail-order bidders

The first in a series of educational webcasts for the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program is now available on the Competitive Bidding Implementation Contractor (CBIC) website. This webcast, “Welcome to Round 2 and National Mail-Order,” provides background information on the program and information about the educational resources available to assist you in participating.

The webcast is available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcast, and a transcript is also posted on the website. To view the webcast, please go to the CBIC website at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) and select “Bidding Suppliers: Round 2 & National Mail-Order” and then choose “Education Events.”

The Centers for Medicare & Medicaid Services (CMS) will be issuing more webcasts later in the bidder education program. The upcoming webcasts will address topics such as financial documentation requirements, the national mail-order competition, general bidding requirements, and how to submit a bid in the online system, DBidS. As each webcast is posted, we will announce its availability through an email update. If you have not already done so, please register on the CBIC website to receive these announcements and other updates about the competitive bidding program.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9 a.m. to 9 p.m. ET, Monday through Friday, throughout the registration and bidding periods.

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

Source: CMS PERL 201112-43

## Incentive Programs

### Learn about CMS’ primary care incentive program with new FAQs

Per Section 5501(a) of the Affordable Care Act, the primary care incentive payment program (PCIP) authorizes an incentive payment of 10 percent of Medicare’s program payments to be paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015.

The Centers for Medicare & Medicaid Services (CMS) has posted 22 frequently-asked questions (FAQs) items related to the PCIP. These new FAQs can be found [here](#). Alternatively, these FAQ items can be found by visiting <http://questions.CMS.hhs.gov/> and searching for “PCIP” or “primary care incentive payment.”

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

Source: CMS PERL 201111-46

---

### Notification of final primary care incentive program files for payment year 2012

Primary care physicians and non-physicians practitioners may confirm 2012 primary care incentive payment eligibility (PCIP) by checking the “PCIP.Payment.CY2012” file to ensure their national provider identifier (NPI) is listed. Contractors will post the “PCIP.Payment.CY2012” file to their websites no later than January 31, 2012.

Source: CMS PERL 201111-47

## Arkansas, Delaware, Montana, New Jersey, New York, and North Dakota launched Medicaid EHR programs

On Monday, November 7, 2011, the Medicaid electronic health record (EHR) incentive program launched in Arkansas, Delaware, Montana, New Jersey, New York, and North Dakota. This means that eligible professionals (EPs) and eligible hospitals in these six states will be able to complete their incentive program registration. More information about the Medicaid EHR incentive program can be found on the [Medicare and Medicaid EHR Incentive Program Basics](#) page of the Centers for Medicare & Medicaid Services (CMS) EHR website.

If you are a resident of Arkansas, Delaware, Montana, New Jersey, New York, or North Dakota, and are eligible to participate in the Medicaid EHR incentive program, visit your state Medicaid agency website for more information on your state's participation in the Medicaid EHR incentive program. Click on a state below to access its website.

- [Arkansas](#)
- [Delaware](#)
- [Montana](#)
- [New Jersey](#)
- [New York](#)
- [North Dakota](#)

As of Monday, November 7, 2011, 39 states have launched Medicaid EHR incentive programs; and through October, 23 states have issued incentive payments to Medicaid EPs and eligible hospitals who have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months.

For a complete list of states that have already begun participation in the Medicaid EHR incentive program, see the [Medicaid State Information](#) page on the CMS EHR website.

### Want more information about the EHR incentive programs?

Make sure to visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201111-42

---

## Payment and registration data on Medicare and Medicaid EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) has created a new [Web page](#) where you can find Medicare and Medicaid Electronic Health Record (EHR) Incentive Program payment and registration data. The page includes up-to-date information about the programs through October 2011. The new page will be your resource for updates regarding the programs' registration, payment, and state Medicaid launches.

The *Data and Reports* page includes the following information:

- A map that illustrates a state breakdown of payments to Medicare and Medicaid providers
- A map that illustrates a state breakdown of registration by Medicaid and Medicare providers
- A map that illustrates a state breakdown of registration by Medicare providers
- A map that illustrates a state breakdown of registration by Medicaid providers
- Individual state report of registrants and payments
- Updates on state launches of Medicaid EHR program
- List of recipients of Medicare EHR incentive program payments

You can use the maps to see how your state compares to others in [registration](#) and [payment](#) totals for the EHR incentive programs.

*continued on next page*

EHR...continued

### October highlights

Below are some highlights about the EHR incentive programs from data through October 2011 that are now featured on the new page:

- Over 135,000 Medicare and Medicaid providers have registered for the programs
- Over \$525 million in Medicare payments have been provided to eligible professionals and eligible hospitals

Over \$710 million in Medicaid payment have been provided to eligible professionals and eligible hospitals

### Want more information about the EHR incentive programs?

Make sure to visit the [EHR incentive programs website](#) for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201112-15

## Proposed meaningful use timeline changes encourage adoption of EHRs

In response to significant input from multiple stakeholders, expert testimony, and countless hours of review, analysis and deliberation, the Department of Health & Human Services (HHS) [announced](#) its intention to delay the start of stage 2 [meaningful use](#) for the Medicare and Medicaid electronic health record (EHR) incentive programs for a period of one year for those first attesting to meaningful use in 2011. The Centers for Medicare & Medicaid Services (CMS) intends to propose such a delay in the stage 2 meaningful use notice of proposed rulemaking (NPRM), which is scheduled to be published in February 2012.

### Why did CMS make this decision?

Input from the vendor community and the provider community makes clear that the current schedule for compliance with stage 2 meaningful use objectives in 2013 poses a challenge for those who are [attesting](#) to meaningful use in 2011.

The current timetable would require EHR vendors to design, develop, and release new functionality, and for providers to upgrade, implement, and begin using the new functionality as early as October 2012.

### What are the benefits to the proposed delay?

CMS believes that a proposed delay will be beneficial for several reasons:

- CMS hopes that this will give vendors added time to develop certified EHR technologies for stage 2, as well as give providers additional time to implement new software and meet the new requirements of stage 2.
- CMS also intends to propose maintaining the current expectation for those first attesting to

meaningful use in 2012, so that all providers attesting to meaningful use in 2011 or 2012 will begin stage 2 in 2014.

- CMS believes this provides an added incentive for providers to attest to meaningful use in 2011 and rewards early participants.

Under the Medicare and Medicaid EHR incentive programs, providers who attest early receive greater incentives. And now those providers who first attest in 2011 are eligible for three payment years for meeting the stage 1 criteria, while those first attesting in 2012 can only have two payment years under stage 1 criteria.

### Are Medicaid program participants affected?

Because Medicaid providers can receive an incentive payment for adopting, implementing, or upgrading to certified EHR technology in their first year of [Medicaid EHR incentive program](#) participation, Medicaid providers will still be able to attest to stage 1 meaningful use for the next two years (first for a 90-day period, then for a 365-day period).

Therefore, most Medicaid providers do not attest to stage 2 requirements until 2014 at the earliest.

### Want more information about the EHR incentive programs?

Make sure to visit the [EHR incentive programs website](#) for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201112-21

## 2012 eRx payment adjustment: Assessment and application

### Provider types affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) electronic prescribing (eRx) incentive program are affected.

### What you need to know

This *MLN Matters*® special edition article describes how the 2012 eRx payment adjustment was 1) calculated and 2) applied for individual eligible professionals, and group practices participating in eRx group practice reporting option (GPRO).

Eligible professionals who met the eRx payment adjustment inclusion criteria, but who failed to meet the reporting requirements in 2011, may receive the 2012 eRx payment adjustment starting January 1, 2012. The 2012 eRx payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice participating in eRx GPRO receiving 99 percent (1 percent less) of their Medicare Part B physician fee schedule (PFS) amount that would otherwise apply to such services.

### Background

Under Section 1848(a)(5)(A) of the Social Security Act, eligible professionals who are not successful electronic prescribers under the eRx Incentive Program will be subject to a payment adjustment in 2012.

An eligible professional was included in the 2012 eRx payment adjustment analysis if they meet all of the following criteria:

- Was a physician (M.D., D.O., or podiatrist), nurse practitioner, or physician assistant as of June 30, 2011, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES);
- Had prescribing privileges from January 1-June 30, 2011;
- Had at least 100 cases containing an encounter code in the measure's denominator from January 1-June 30, 2011; and
- Had 10 percent or more of their Medicare Part B allowable charges (per Tax Identification Number (TIN)) from January-June 30, 2011 were for encounter codes in the measure's denominator

Eligible professionals were automatically excluded from the 2012 eRx payment adjustment analysis if they did NOT meet one of the above criteria.

In addition, eligible professionals could have taken the following steps from to avoid the 2012 eRx payment adjustment:

- Submitted 10 or more 2011 eRx quality-data codes (G8553) for Medicare Part B PFS services via claims from January 1-June 30, 2011;
- Indicated that the eligible professional met criteria for a hardship exemption for either living in a rural area without sufficient high speed internet (G8642), or practiced in an area without sufficient pharmacies that can accept eRx (G8643) via claims from January 1-June 30, 2011;
- Indicated that the eligible professional did not have prescribing privileges (G8644) via claims from January 1-June 30, 2011; or
- Requested a hardship exemption via the Quality Reporting Communication Support page on or before November 8, 2011, and received CMS approval.



### Assessing and applying the 2012 eRx payment adjustment

#### 2012 eRx assessment

An eligible professional who meets the eRx program inclusion criteria will be subject to the 2012 eRx payment adjustment if (s)he did not submit the following:

- 10 valid 2011 eRx G-codes (G8553) via claims during the 6-month reporting period of January 1, 2011 – June 30, 2011; or
- A hardship exemption (G8642, G8643) via claims during the 6-month reporting period; or
- A G-code via claims indicating (s)he did not have prescribing privileges (G8644) during the 6-month reporting period; or
- (S)he requested and was granted a hardship exemption through the Quality Reporting Communication Support Page.

*continued on next page*

**eRx...continued**

CMS analysis of all valid 2011 eRx QDCs submitted with a date of service during the 6-month reporting period determines whether or not the payment adjustment applies to the eligible professional.

**Group practices participating in eRx GPRO** who would be subject to the payment adjustment is defined as a TIN who:

- Failed to meet the 2011 eRx criteria for successful reporting during the 6-month reporting period of January 1–June 30, 2011; or
- Failed to indicate a hardship or lack of prescribing privileges to CMS

The analysis of successful reporting for group practices that participate in eRx GPRO will be performed at the TIN level to identify the group's services and quality data. All NPIs under the TIN during the 6-month reporting period for 2011 (January 1–June 30, 2011) will receive the payment adjustment if the group practice participating in eRx GPRO is subject to the payment adjustment.

**For eligible professionals who submitted claims under multiple TINs**, CMS groups claims by unique TIN/NPIs for analysis and payment adjustment purposes. As a result, an eligible professional who submitted claims under multiple TINs may be subject to an eRx payment adjustment under one of the TINs and not the other(s), or may be subject to a payment adjustment under each TIN.

**Application**

- The eRx payment adjustment for not being a successful electronic prescriber will result in an individual eligible professional, or group practice participating in eRx GPRO, receiving 99% of his or her Medicare Part B PFS amount that would otherwise apply to such services (or 1% less reimbursement) for all charges with a date of service from January 1–December 31, 2012.
- Providers who receive the 2012 eRx payment adjustment will see the term "LE" on their Remittance Advice for all Medicare Part B services rendered January 1 – December 31, 2012. The remittance advice will also contain the following claim adjustment reason code (CARC) and remittance advice remark code (RARC):
  - CARC 237 – Legislated/regulatory penalty. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT).
  - RARC N545 – Payment reduced based on status as an unsuccessful e-prescriber per the electronic prescribing (eRx) incentive program.

- The TIN/NPI (or group practice participating in eRx GPRO TIN) will receive automatically-adjusted 2012 Medicare Part B reimbursements as (s)he normally would for Medicare Part B PFS covered professional services furnished to Medicare beneficiaries.
- The 2012 eRx payment adjustments will be applied separately from the 2011 eRx incentive program or any other CMS incentive program payments.
- If a TIN/NPI or group practice participating in eRx GPRO TIN submits claims to multiple Medicare claims processing contractors (carriers or Medicare administrative contractors [MACs]) and is subject to the eRx payment adjustment, each contractor will pay out 1 percent less for all the Medicare Part B PFS claims the contractor processes with a date of service from January 1 – December 31, 2012.

**Frequent concerns**

- If the TIN/NPI or group practice that participates in eRx GPRO TIN receives the payment adjustment in error, the claim will be reprocessed to return the 1.0 percent and the remittance advice for the reprocessed claim will include the following codes and messages:
  - CARC 237 – Legislated/regulatory penalty. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT).
  - RARC N546 – Payment represents a previous reduction based on the electronic prescribing (eRx) incentive program.
- If an individual eligible professional (TIN/NPI) or group practice participating in eRx GPRO submitted an eRx QDC G8553 indicating a valid eRx event in addition to submitting a hardship or lack of prescribing privileges code (or notifies CMS of a hardship or lack of prescribing privileges for group practices participating in eRx GPRO), the hardship/lack of prescribing privileges will take precedence.
- If the eligible professional is enrolled in Medicare, but does not "participate" (non-PAR) by accepting Medicare's allowed charge for services provided, (s)he should contact his/her Part B carrier or A/B MAC for instruction on how the 2012 eRx payment adjustment will be applied and the amount (s) he can initially charge the beneficiary when the service is provided.

*continued on next page*



eRx...continued

### Additional information

For more information about the 2012 eRx payment adjustment, please refer to the 'How to Get Started' and 'Payment Adjustment Information' sections of the CMS eRx Incentive Program website at <http://www.cms.gov/ERxIncentive> and the "2012 eRx Payment Adjustment Quick Reference Guide."

MLN Matters® special edition article SE1107, "2011 Electronic Prescribing (eRx) Incentive Program Update – Future Payment Adjustments," is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1107.pdf>.

"Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program" is available at <http://www.cms.gov/partnerships/downloads/11399-P.pdf>.

Additional assistance is also available from the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org) Monday-Friday from 7:00 a.m. to 7:00 p.m. CST.

MLN Matters® Number: SE1141  
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

*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.*

### Get motivated by Medicare ...

Find out about provider incentive programs

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

Available at <http://medicare.fcso.com/Landing/191461.asp>

## Update to Medicare deductible, coinsurance and premium rates for 2012

### Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 7567, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2012. Be sure billing staffs are aware of these updates.

### Background

#### 2012 Part A – hospital insurance (HI)

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

**Note:** An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness. **The 2012 inpatient deductible is \$1,156.00.** The coinsurance amounts are shown below in the following table:

Hospital coinsurance		Skilled nursing facility coinsurance
Days 61-90	Days 91-150 (lifetime reserve days)	Days 21-100
\$289.00	\$578.00	\$144.50

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10 percent penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2012 Part A premiums are as follows:

Voluntary enrollees Part A premium schedule for 2012	
Base premium (BP)	\$451.00 per month
Base premium with 10 percent surcharge	\$496.10 per month
Base premium with 45 percent reduction	248.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45 percent reduction and 10 percent surcharge	\$272.80 per month

#### 2012 Part B – supplementary medical insurance (SMI)

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

*continued on next page*

**Rates...continued**

- Standard premium: \$99.90 a month
- Deductible: \$140.00 a year
- Coinsurance: 20 percent

In addition, some beneficiaries may pay higher premiums based on their incomes. These amounts change each year. There may be a late-enrollment penalty.

**Additional information**

The official instruction, CR 7567, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R72GI.pdf>.

If you have any questions, please contact your carriers, 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: MM7567

Related Change Request (CR) #: CR 7567

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R72GI

Implementation Date: January 3, 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 covers screening and counseling for obesity

### Decision adds a new preventive service for Medicare beneficiaries

The Centers for Medicare & Medicaid Services (CMS) announced that Medicare is adding coverage for preventive services to reduce obesity. This adds to Medicare's existing portfolio of preventive services that are now available without cost sharing under the Affordable Care Act. It complements the Million Hearts initiative led jointly by CMS and the Centers for Disease Control and Prevention in partnership with other Health and Human Services (HHS) agencies, communities, health systems, nonprofit organizations, and private sector partners across the country to prevent one million heart attacks and strokes in the next five years.

"Obesity is a challenge faced by Americans of all ages, and prevention is crucial for the management and elimination of obesity in our country," said CMS Administrator Donald M. Berwick, MD. "It's important for Medicare patients to enjoy access to appropriate screening and preventive services."

Over 30 percent of both men and women in the Medicare population are estimated to be obese. Obesity is directly or indirectly associated with many chronic diseases, including those that disproportionately affect racial and ethnic minorities such as cardiovascular disease and diabetes. Addressing the prevention of obesity related disparities has the potential to reduce obesity prevalence while also closing the gap on health disparities among Medicare beneficiaries.

Screening for obesity and counseling for eligible beneficiaries by primary care providers in settings such as physicians' offices are covered under this new benefit. For a beneficiary who screens positive for obesity with a body mass index (BMI)  $\geq 30$  kg/m<sup>2</sup>, the benefit would include one face-to-face counseling visit each week for one month and one face-to-face counseling visit every other week for an additional five months. The beneficiary may receive one face-to-face counseling visit every month for an additional six months (for a total of 12 months of counseling) if he or she has achieved a weight reduction of at least 6.6 pounds (or 3 kilograms) during the first six months of counseling.

"This decision is an important step in aligning Medicare's portfolio of preventive services with evidence and addressing risk factors for disease," said Patrick Conway, MD, MSc, CMS Chief Medical Officer and Director of the Agency's Office of Clinical Standards and Quality. "We at CMS are carefully and systematically reviewing the best available medical evidence to identify those preventive services that can keep Medicare beneficiaries as healthy as possible for as long as possible."

*continued on next page*

**Obesity...continued**

Through the end of October, 22.6 million people with original Medicare have received one or more of the free covered preventive services this year.

To read the final decision on the new national coverage determination, visit the CMS website at: <http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAIAAA&NCAId=253&>.

For more information about Million Hearts, please visit [millionhearts.hhs.gov](http://millionhearts.hhs.gov).

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

Source: CMS PERL 201111-71

---

## Therapy cap values for calendar year 2012

### Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Medicare administrative contractors (MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 7529, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for calendar year (CY) 2012. Therapy caps for 2012 will be \$1880.00. Be sure your billing staff is aware of the update.

### Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 directed the Secretary to implement a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended the exceptions to therapy caps through December 31, 2010; and, the Medicare and Medicaid Extenders Act (MMEA) of 2010 extended the therapy caps exceptions through CY 2011. The exceptions process will continue unchanged for the time frame directed by Congress.

Note that the therapy caps apply to outpatient services and do not apply to skilled nursing facility (SNF) residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, therapy caps do not apply to any therapy services billed under the home health PPS, inpatient hospitals, or the outpatient department of hospitals, including critical access hospitals.

### Additional information

The official instruction, CR 7529 issued to your carrier, FI, RHHI and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2351CP.pdf>.

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

MLN Matters® Number: MM7529

Related Change Request (CR) #: 7529

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2351CP

Implementation Date: January 3, 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.*

## Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

### Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided for Medicare beneficiaries.

### Provider action needed

This article is based on Change Request (CR) 7633, which announces that effective with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol screening, and for those that screen positive, up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women. Make sure your billing staff is aware of these changes.

### Background

Pursuant to Section 1861 (ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the national coverage determination (NCD) process if all of the following criteria are met. They must be: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare program. CMS reviewed the USPSTF’s “B” recommendation and supporting evidence for “Screening and Behavioral Counseling Intervention in Primary Care to Reduce Alcohol Misuse” preventive services and determined that all three criteria were met.

According to the USPSTF (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems; and in the general adult population, risky or hazardous drinking is defined as >7 drinks per week or >3 drinks per occasion for women, and >14 drinks per week or >4 drinks per occasion for men. Harmful drinking describes those persons currently experiencing physical, social or psychological harm from alcohol use, but who do not meet criteria for dependence.

Effective for claims with dates of service October 14, 2011, and later, CMS shall cover annual alcohol screening, and for those that screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for

alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and,

- who are competent and alert at the time that counseling is provided; and,
- whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

**Risky or hazardous drinking = >7 drinks per week or >3 drinks per occasion for women; >14 drinks per week or >4 drinks for men.**

Each of the four behavioral counseling interventions must be consistent with the 5As approach that has been adopted by the USPSTF to describe such services:

1. **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior.
4. **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

**Note:** Two new G codes, G0442 (annual alcohol misuse screening, 15 minutes), and G0443 (brief face-to-face behavioral counseling for alcohol misuse,

*continued on next page*

**Alcohol...continued**

15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE). For claims with dates of service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443. Deductible and coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2102, with TOBs 13x, 71x, 77x, and 85x and release those claims beginning April 2, 2012.

For the purposes of this covered service, the following provider specialty types may submit claims for G0442 and G0443:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 42 – Certified nurse midwife
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

For purposes of this covered service, the following place of service (POS) codes are applicable:

- 11 – Physician’s office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 71 – State or local public health clinic

**Claims processing/payment information**

When claims for G0442 or G0443 are submitted with a Place of Service (POS) code that is not applicable, line-items on those claims will be denied using:

- Claim adjustment reason code (CARC) 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.” **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- Remittance advice remark code (RARC) N428: “Not covered when performed in this place of service.”
- Group code CO (contractual obligation)

Medicare will deny claims for G0442 or G0443 when provided by provider specialty types other than those

identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: “The rendering provider is not eligible to perform the service billed.” Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- RARC N95: “This provider type/provider specialty may not bill this service.”
- Group code CO.

Rural health clinics (RHCs) using type of bill (TOB) 71x and federally qualified health centers (FQHCs) using TOB 77x may submit additional revenue lines containing G0442 or G0443. Medicare will pay G0442 and G0443 in TOBs 71x and 77x based on the all-inclusive payment rate. However, Medicare will not pay G0442 or G0443 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply to claims for the initial preventive physical examination (IPPE), claims containing modifier 59, or to 77x claims containing diabetes self-management training or medical nutrition Therapy services. If G0442 or G0443 is billed when an encounter/visit with the same line item date of service, Medicare will assign:

- Group code CO to the G0442/G0443 revenue lines; and
- RARC 97: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0442 or G0443 services billed with revenue codes 096x, 097x, or 098x by

Method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 5: “The procedure code/bitt type is inconsistent with the place of service.” Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- RARC M77: “Missing/incomplete/invalid place of service.”

*continued on next page*

**Alcohol...continued**

- Group code CO.

Medicare will allow payment for both G0442 and G0443 on the same date (except in RHCs and FQHCs), but will not pay for more than one G0443 service on the same date. However, Medicare will allow both a claim for the professional service and, for TOB 13X and TOB 85X without a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0443 that exceed the limit of one on the same date of service will be denied using:

- CARC 151: "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."
- RARC M86: "Service denied because payment already made for same/similar procedure within set time frame."
- Group code CO.

Medicare will track payments for G0442 screening services and G0443 counseling services so as to not permit payment for G0442 more than once in a 12-month period, and for G0443 no more than four times in a 12-month period, beginning with the date of the G0442 service. Claim lines exceeding these limits will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group Code CO.

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) along with HICR changes.

**Additional information**

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

The official instruction, CR 7633, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the "National Coverage Determinations Manual" at <http://www.cms.gov/Transmittals/downloads/R138NCD.pdf> on the CMS Website. The second transmittal at <http://www.cms.gov/Transmittals/downloads/R2358CP.pdf> modifies the "Medicare Claims Processing Manual".

MLN Matters® Number: MM7633

Related Change Request (CR) #: 7633

Related CR Release Date: November 23, 2011

Effective Date: October 14, 2011

Related CR Transmittal #: November 23, 2011

Implementation Date: December 27, 2011, for local contractor system edits; April 2, 2012-for Medicare's shared system edits, July 2, 2012 for provider inquiry screens & HICR changes

*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.*

**Learn the secrets to billing Medicare correctly**

Who has the power to improve your billing accuracy and efficiency? You do -- visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly -- the first time. You'll find FCSO's most popular self-audit resources, including the E/M interactive worksheet, Provider Data Summary (PDS) report, and the Comparative billing report (CBR).

## Screening for depression in adults

### Provider types affected

Physicians, non-physician practitioners, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

### Provider action needed

#### Stop – impact to you

This article is based on change request (CR) 7637, which informs Medicare contractors that, effective for claims with dates of service on and after October 14, 2011, Medicare will cover annual depression screening for adults in the primary care setting.

#### Caution – what you need to know

Effective October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

Medicare contractors will recognize new Healthcare Common Procedure Coding System (HCPCS) code, G0444, annual depression screening, 15 minutes, as a covered service.

**Note:** This code will appear on the January 2012 Medicare physicians fee schedule update. The type of service (TOS) for HCPCS code G0444 is 1. Effective October 14, 2011, beneficiary coinsurance and deductibles do not apply to claim lines with annual depression screening, G0444. For dates of service on or after October 14, 2011, through December 31, 2011, Medicare contractors will use their pricing for paying G0444 and update their HCPCS files accordingly.

#### Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding this change. Be sure your staffs are aware of this change.

### Background

Among persons older than 65 years, one in six suffers from depression. Depression in older adults is estimated to occur in 25 percent of those with other illness including cancer, arthritis, stroke, chronic lung disease, and cardiovascular disease. Other stressful events, such as the loss of friends and loved ones, are also risk factors for depression. Opportunities are missed to improve health outcomes when mental illness is under-recognized and under-treated in primary care settings.

Older adults have the highest risk of suicide of all age groups. These patients are important in the

primary care setting because 50-75 percent of older adults who commit suicide saw their medical doctor during the prior month for general medical care, and 39 percent were seen during the week prior to their death. Symptoms of major depression that are felt nearly every day include, but are not limited to, feeling sad or empty; less interest in daily activities; weight loss or gain when not dieting; less ability to think or concentrate; tearfulness, feelings of worthlessness, and thoughts of death or suicide.

**Among persons older than 65, one in six suffers from depression.**

Section 1861(d)(4) of the Social Security Act permits the Centers for Medicare & Medicaid Services (CMS) to add coverage of “additional preventive services” through the National Coverage Determination (NCD) process if all of the following criteria are met:

- Reasonable and necessary for the prevention or early detection of illness or disability;
- Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
- Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Screening for depression in adults is recommended with a grade of B by the USPSTF. The CMS reviewed the USPSTF recommendations and supporting evidence for screening depression in adults preventive services and determined that the criteria listed above was met, enabling the CMS to cover these preventive services.

Thus, effective October 14, 2011, Medicare covers annual screening for adults for depression in a primary care setting, as defined below, that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD:

- A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation

*continued on next page*



**Depression...continued**

facilities, and hospice are not considered primary care settings under this definition.

- Effective for claims with dates of service on and after April 2, 2012, contractors shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):
  - 11 – Office
  - 22 – Outpatient hospital
  - 49 – Independent clinic
  - 50 – FQHCs
  - 71 – State or local public health clinic
  - 72 – RHCs
- At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient’s primary care physician.



- **Note:** Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and web-based counseling are not

separately reimbursable by Medicare and are not part of this NCD.

- Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place. Medicare coinsurance and Part B deductible are waived for this preventive service.

**Claims processing/payment information**

When claim line items for annual depression screening (G0444) are submitted with a POS code that is not applicable, they will be denied using:

- Claim adjustment reason code (CARC) 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.” **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- Remittance advice remark code (RARC) N428: “Not covered when performed in this place of service.”
- Group code PR (patient responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

RHCs using type of bill (TOB) 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0444 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0444 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply, however, to claims with the initial preventive physical examination (IPPE) containing modifier 59 or to 77x claims containing diabetes self-management training or medical nutrition training services. If G0444 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- Group code CO to the G0444 revenue line; and
- RARC 97: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 Service Payment Information REF), if present.

*continued on next page*

**Depression...continued**

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system (OPPS). Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0444 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 170: "Payment is denied when performed/ billed by this type of provider." Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- RARC N428: "Not covered when performed in this place of service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

For claims processed on or after April 2, 2012, Medicare will allow payment for G0444 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service, and, for TOB 13x, and TOB 85x when the revenue code is not 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0444 that exceed this limit will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) will display a next eligibility date for this service and the multi-carrier system desktop tool shall display the HCPCS G0444 depression screening sessions.

A MACs/FIs shall hold institutional claims received before April 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting HCPCS G0444.

**Additional information**

The official instruction, CR 7637, was issued to your carrier, FI, or A/B MAC regarding this change via two transmittals. The first transmittal updates the "National Coverage Determinations Manual" and is available at <http://www.cms.gov/Transmittals/downloads/R139NCD.pdf>. The second transmittal is at <http://www.cms.gov/Transmittals/downloads/R2359CP.pdf> and it updates the *Medicare Claims Processing Manual*.

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

MLN Matters® Number: MM7637

Related Change Request (CR) #: 7637

Related CR Release Date: November 23, 2011

Effective Date: October 14, 2011

Related CR Transmittal #: R139NCD and R2359CP

Implementation Date: April 2, 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.*

**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.

## Intensive behavioral therapy for cardiovascular disease

### Provider types affected

Primary care practitioners in a primary care setting such as the beneficiary's family practice physician, internal medicine physician, or nurse practitioner in the doctor's office who bill Medicare contractors (carriers, fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs)) for providing intensive behavioral therapy (IBT) for cardiovascular disease (CVD) to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 7636 which states that effective for claims with dates of service on and after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) covers IBT for CVD, inclusive of one face-to-face CVD risk reduction visit annually. The Medicare patient receiving this care must be competent and alert at the time the service is rendered and the service must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Ensure that your billing staffs are aware of this update.

### Background

According to Section 1861 of the Social Security Act, CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability;
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the USPSTF recommendations and supporting evidence for IBT for CVD and determined that the criteria listed above was met, enabling CMS to cover this preventive service.

Coverage of IBT for CVD, referred to as a CVD risk reduction visit, consists of the following three components:

1. Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
2. Screening for high blood pressure in adults age 18 years and older; and,
3. Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

### Key points

- A new HCPCS code, G0446, Annual, face-to-face IBT for CVD, individual, 15 minutes, will be included in the January 2012 updates of the Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE), effective for services on or after November 8, 2011.
- Medicare deductibles and coinsurance do not apply to claim lines containing HCPCS code G0446.
- For these services provided on or after November 8, 2011, through December 31, 2011, Medicare contractors will apply their pricing to claims for G0446 when billed for IBT for CVD.
- Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction visit annually for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.
- For the purposes of this covered service, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The following provider specialty types may submit claims for CVD risk reduction visits:
  - 01 – General practice
  - 08 – Family practice
  - 11 – Internal medicine
  - 16 – Obstetrics/gynecology
  - 37 – Pediatric medicine
  - 38 – Geriatric medicine
  - 42 – Certified nurse midwife
  - 50 – Nurse practitioner
  - 89 – Certified clinical nurse specialist
  - 97 – Physician assistant
- Medicare contractors will pay claims for G0446 only when services are provided for the following place of service (POS):
  - 11 – Physician's office;
  - 22 – Outpatient hospital;

*continued on next page*

## Cardiovascular...continued

- 49 – Independent clinic; or,
- 71 – State or local public health clinic.

**Note:** Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition. See below for information relative to these services billed on institutional claims by RHCs, type of bill (TOB) 71x, and FQHCs, TOB 77x.



- The behavioral counseling intervention for aspirin use and healthy diet should be consistent with the Five As approach that has been adopted by the USPSTF to describe such services:
  - **Assess:** Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
  - **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
  - **Agree:** Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
  - **Assist:** Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
  - **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

- Medicare contractors do not need to search their files for claims that may have been processed in error. However, contractors may adjust claims that are brought to their attention.

## Claims processing/payment information

When IBT for CVD claims are submitted with a POS code that is not applicable, they will be denied using:

- Claim adjustment reason code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N428: "Not covered when performed in this place of service."
- Group code PR (patient responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed (ABN) is not on file.

Medicare will deny claims for G0446 when provided by provider specialty types other than those identified above. When such claims are denied, Medicare will use the following messages:

- CARC 185: "The rendering provider is not eligible to perform the service billed." **Note:** Refer to the 835 healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95: "This provider type/provider specialty may not bill this service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

RHCs using TOB 71x and FQHCs using TOB 77x may submit additional revenue lines containing G0446 and Medicare will pay those lines based on the all-inclusive payment rate. However, Medicare will not pay G0446 separately with another encounter/visit on the same day billed on TOBs 71x or 77x. This does not apply, however, to claims with the Initial Preventive Physical Examination (IPPE) containing modifier 59 or to 77x

*continued on next page*

**Cardiovascular...continued**

claims containing diabetes self-management training or medical nutrition training services. If G0446 is billed when an encounter/visit is billed with the same line item date of service, Medicare will assign:

- Group code CO to the G0446 revenue line; and
- RARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."  
**Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.

Institutional claims billed by hospital outpatient departments (TOB 13x) will be paid based on the outpatient prospective payment system. Those billed by critical access hospitals (CAHs) on TOB 85x will be paid based on reasonable cost, except those G0446 services billed with revenue codes 096x, 097x, or 098x by method II CAHs will receive 115 percent of the lesser of the fee schedule amount or submitted charge. Institutional claims submitted on TOBs other than 13x, 71x, 77x, or 85x will be denied using the following:

- CARC 170: "Payment is denied when performed/billed by this type of provider." **Note:** Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.
- RARC N428: "Not covered when performed in this place of service."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

For claims processed on or after April 2, 2012, Medicare will allow payment for G0446 no more than once in a 12-month period. However, Medicare will allow both a claim for the professional service and, for TOB 13x and TOB 85x with a revenue code of 96x, 97x, or 98x, a claim for a facility fee. Claim lines for G0446 that exceed this limit will be denied using:

- CARC 119: "Benefit maximum for this time period or occurrence has been reached."
- RARC N362: "The number of days or units exceeds our acceptable maximum."
- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating a signed ABN is not on file.

As of July 2, 2012, provider inquiry screens (HUQA, HIQA, HIQH, ELGA, ELGB, ELGH) will display a next eligibility date for this service.

**Additional information**

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

The official instruction, CR 7636, was issued to your Medicare FI, carrier, or A/B MAC regarding this change via two transmittals. The first transmittal modifies the *National Coverage Determinations Manual* at <http://www.cms.gov/Transmittals/downloads/R137NCD.pdf>. The second transmittal at <http://www.cms.gov/Transmittals/downloads/R2357CP.pdf> modifies the *Medicare Claims Processing Manual*.

MLN Matters® Number: MM7636  
 Related Change Request (CR) #: 7636  
 Related CR Release Date: November 23, 2011  
 Effective Date: November 8, 2011  
 Related CR Transmittal #: R137NCD and R2357CP  
 Implementation Dates: December 27 for local Medicare Contractor system edits; April 2, 2012, for Medicare shared system edits; and July 2, 2012, CWF provider screens and HICR changes

*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.*

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

### Additions to LCDs

A64566: Posterior tibial nerve stimulation (PTNS).....	39
A76376: 3D interpretation and reporting of imaging studies .....	39

### Revisions to LCDs

ANCSVCS: Noncovered services.....	40
A17311: Mohs micrographic surgery (MMS) .....	40
A93922: Non-invasive physiologic studies of upper or lower extremity arteries .....	41
A93925: Duplex scan of lower extremity arteries ..	41

### Additional Information

J9033: Treanda (bendamustine hydrochloride) for injection, for intravenous infusion .....	42
YERVOY™ (ipilimumab) .....	42
2012 HCPCS LCD changes .....	44

### 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

### A64566: Posterior tibial nerve stimulation (PTNS) – new LCD

#### LCD ID number: L32306 (Florida/Puerto Rico/U.S. Virgin Islands)

Altering the function of the posterior tibial nerve with posterior tibial nerve stimulation (PTNS) is believed to improve voiding function and control. While the posterior tibial nerve is located near the ankle, it is derived from the lumbar-sacral nerves (L4-S3), which control the bladder detrusor and perineal floor. PTNS is a minimally invasive, office-based treatment for patients with overactive bladder that is not intended for first line therapy, but for patients who are refractory to behavioral and /or pharmacologic therapies.

A local coverage determination (LCD) has been developed to give indications and limitations of coverage and/or medical necessity, CPT code, ICD-9-CM codes, documentation requirements, utilization guidelines, and coding guidelines for PTNS.

#### Effective date

This new LCD is effective for services provided **on or after January 31, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the 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.

---

### A76376: 3D interpretation and reporting of imaging studies – new LCD

#### LCD ID number: L32314 (Florida/Puerto Rico/U.S. Virgin Islands)

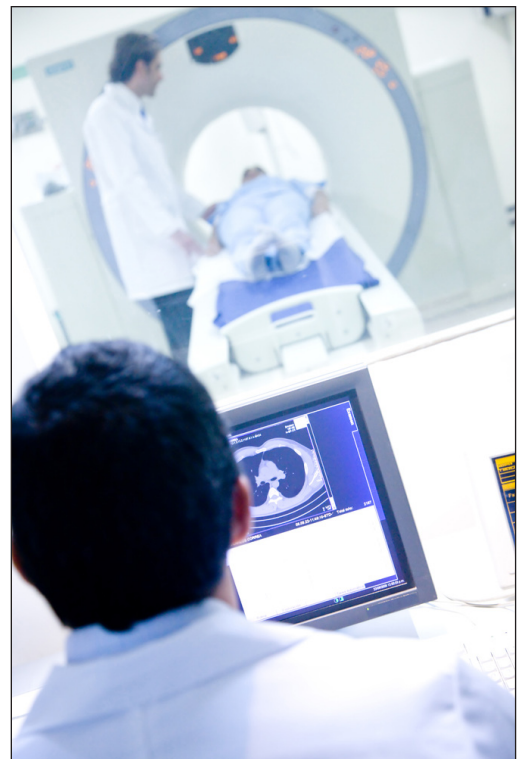
The technological approach of multi-slice imaging along with the enhanced imaging techniques has allowed for the generation of three-dimensional (3D) images known as 3D reconstruction or 3D rendering. Three-dimensional imaging has been applied to ultrasound, echocardiography, computed tomography (CT), magnetic resonance imaging (MRI), and other tomographic modalities. Applications of this technology include, for example, coronary artery imaging, visualization of central nervous system vasculature, and enhanced imaging of the thorax which includes, for example, aortic aneurysms, embolic disease, and inflammatory and neoplastic lesions.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, CPT codes, secondary ICD-9-CM diagnosis codes that support medical necessity, documentation requirements, and utilization guidelines.

#### Effective Date

This new LCD is effective for services provided **on or after January 31, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the 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

### 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 January 1, 2012. Since that time, a revision was made to the LCD. The following codes were evaluated and determined not to be medically reasonable and necessary at this time based on the current published evidence (e.g., peer-reviewed medical literature, published studies): HCPCS code C1749 (Endoscope, retrograde imaging/illumination colonoscopic device (implantable); e.g. Third Eye Retroscope®) based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 7117 and HCPCS code C1840 (Lens, intraocular [telescopic]) based on CMS CR 7545. Category III CPT codes 0276T (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe*) and 0277T (*Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes*) were also evaluated and determined to be not medically reasonable and necessary at this time. The following codes were added to the “CPT/HCPCS Codes, Local Noncoverage Decisions – Devices” section of the LCD: C1749 and C1840. The following codes were added to the “CPT/HCPCS Codes, Local Noncoverage Decisions – Procedures” section of the LCD: 0276T and 0277T.

#### Effective date

This LCD revision is effective for services provided **on or after January 31, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the 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.

---

### A17311: Mohs micrographic surgery (MMS) – draft revision to the LCD

#### LCD ID number: L28932 (Florida)

#### LCD ID number: L28953 (Puerto Rico/U.S. Virgin Islands)

A draft revision of the local coverage determination (LCD) was published on October 7, 2011, to clarify coverage criteria regarding the appropriate use of Mohs micrographic surgery (MMS). The current LCD that is in play has been effective since 1998 before the jurisdiction 9 (J9) transition in 2009, and has had minor revisions (not considered more restrictive to the community). The current draft is a **major revision** (new requirements). The majority of the comments received addressed the “Limitations” section of the LCD, specifically the training requirements, and the issue of limiting the procedure to physicians with certain training, given that Medicare’s reasonable and necessary definition includes language requiring the service be ordered and furnished by qualified personnel. Additionally, there were comments on the language requiring digital photos of the defects to be available upon request (noted in the “Documentation Requirements” section of the LCD). The comment summary is available on the First Coast Service Options Inc. (FCSO) website.

Medicare administrative contractor (MAC) J9’s major revision will remain under consideration until further notice. It is anticipated that additional information in the public domain will be available in early 2012 for consideration in the draft.

FCSO LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.



## A93922: Non-invasive 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 non-invasive physiologic studies of upper or lower extremity arteries was most recently revised on October 1, 2011. Since that time, the LCD has been revised to add indications relative to follow-up studies for postoperative conditions and to update language within the sections listed below:

- Indications and limitations of coverage and/or medical necessity
- Documentation requirements
- Utilization guidelines
- Sources of information and basis for decision

The “Methods Not Acceptable for Reimbursement” and the “Training Requirements” sections of the LCD have been relocated within the LCD. The LCD “Coding Guidelines” attachment has also been revised.

### Effective date

This LCD revision is effective for services provided **on or after January 31, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the 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.

---

---

## A93925: Duplex scan of lower extremity arteries – revision to the LCD

**LCD ID number: L28829 (Florida)**

**LCD ID number: L28862 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for duplex scan of lower extremity arteries was most recently revised on October 1, 2011. Since that time, the LCD has been revised to add indications relative to follow-up studies for postoperative conditions and to update language within the sections listed below:

- Indications and limitations of coverage and/or medical necessity
- Documentation requirements
- Utilization guidelines
- Sources of information and basis for decision

The “Methods Not Acceptable for Reimbursement” and the “Training Requirements” sections of the LCD have been relocated within the LCD. The LCD “Coding Guidelines” attachment has also been revised.

### Effective date

This LCD revision is effective for services provided **on or after January 31, 2012**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section...” drop-down menu at the top of the 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

### J9033: Treanda® (bendamustine hydrochloride) for injection, for intravenous infusion-clarification on billing

Treanda® for injection is an alkylating drug which was approved by the food and drug administration (FDA) on March 20, 2008, for the following indications:

- Chronic lymphocytic leukemia (CLL)
- Indolent B-cell non-Hodgkin's lymphoma (NHL) that has progressed during or within six months of treatment with rituximab or a rituximab containing regimen.

The Medicare administrative contractor (MAC) for jurisdiction 9 (J9) has a local coverage determination (LCD) on label and off-label coverage of outpatient drugs and biologicals. This LCD outlines general coverage criteria for drugs approved for marketing by the FDA-labeled use as well as the off-labeled use in the absence of a national coverage determination (NCD) or a MAC J9 LCD addressing a specific drug. Currently there is not a MAC J9 LCD for Treanda®.

MAC J9 considers ICD-9-CM diagnosis codes **200.00-200.88; 202.00-202.98, 204.10, 204.11, and 204.12** to be in support of the above indications of CLL and NHL. The MAC J9 plans to develop an LCD in the near future that will address both the label and off-label indications for Treanda®.

---

### YERVOY™ (ipilimumab)

Melanomas are malignant neoplasms of melanocytes that develop predominantly in the skin but occasionally develop from the eyes, mucous membranes, and the central nervous system (CNS). Among the three types of skin cancer, melanoma is the most aggressive and also the most serious. Metastatic melanoma refers to a disease that has spread from its original lesion site to deeper parts of the skin, and eventually to other parts of the body distant to the primary lesion site.

YERVOY™ (ipilimumab) is indicated by the Food and Drug Administration (FDA) for the treatment of unresectable or metastatic melanoma.

The recommended dose of YERVOY (ipilimumab) is 3 mg/kg administered intravenously over 90 minutes every three weeks for a total of four doses.

**Effective for claims with dates of service March 25, 2011, through October 15, 2011**, YERVOY can be considered for coverage, assuming documentation supports the reasonable and necessary indications when requested for the following ICD-9-CM codes:

ICD-9-CM codes	Descriptors for ICD-9-CM codes
154.2	Malignant neoplasm of anal canal
154.3	Malignant neoplasm of anus, unspecified
172.0-172.9	Malignant melanoma of skin
184.0	Malignant neoplasm of vagina
184.1	Malignant neoplasm of labia majora
184.2	Malignant neoplasm of labia minora
187.1	Malignant neoplasm of prepuce
187.4	Malignant neoplasm of penis, part unspecified
187.7	Malignant neoplasm of scrotum
187.9	Malignant neoplasm of male genital organ, site unspecified
190.0	Malignant neoplasm of eyeball, except conjunctiva, cornea, retina, and choroid

*continued on next page*

**YERVOY...continued**

ICD-9-CM codes	Descriptors for ICD-9-CM codes
190.1	Malignant neoplasm of orbit
190.2	Malignant neoplasm of lacrimal gland
190.3	Malignant neoplasm of conjunctiva
190.5	Malignant neoplasm of retina
190.6	Malignant neoplasm of choroid
190.9	Malignant neoplasm of eye, part unspecified

**Effective for claims with dates of service on or after October 16, 2011**, in addition to consideration for coverage for the above indications and above ICD-9-CM codes, the following compendia indications and additional ICD-9-CM codes will also be considered for coverage for YERVOY (ipilimumab) as a single agent:

- Unresectable stage III intransit metastases
- Local/satellite and/or intransit unresectable recurrence
- Incompletely resected nodal recurrence
- Limited recurrence or metastatic disease
- Disseminated recurrence or metastatic disease in patients with good performance status
- Reinduction in select patients who experience no significant systemic toxicity during prior ipilimumab therapy and who relapse after initial clinical response or progress after stable disease greater than three months.

ICD-9-CM codes	Descriptors for ICD-9-CM codes
198.3	Secondary malignant neoplasm of brain and spinal cord
199.0	Malignant neoplasm without specification of site, disseminated
199.1	Other malignant neoplasm without specification of site
V10.82	Personal history of malignant neoplasm of malignant melanoma of skin

For dates of service prior to January 1, 2012, the unlisted HCPCS codes C9399 or C9284 should be billed for YERVOY™ (ipilimumab). On or after date of service January 1, 2012, HCPCS code J9228 should be billed for

### 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.

## 2012 HCPCS LCD changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2012 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD title	Changes
ABOTULINUM TOXINS Botulinum Toxins	<b>Deleted</b> HCPCS code Q2040 <b>Added</b> HCPCS code J0588
AJ0129 Abatacept	<b>Descriptor change</b> for HCPCS code J0129
AJ1459 Intravenous Immune Globulin	<b>Deleted</b> HCPCS code C9270 <b>Added</b> HCPCS code J1557
AJ1740 Bisphosphonates (Intravenous [IV]) and Monoclonal Antibodies in the Treatment of Osteoporosis and Their Other Indications	<b>Deleted</b> HCPCS code C9272 <b>Removed</b> HCPCS code J3590 <b>Added</b> HCPCS code J0897 <b>Changed</b> "Contractor's Determination Number" to AJ0897
AJ7186 Hemophilia Clotting Factors	<b>Deleted</b> HCPCS code Q2041 <b>Added</b> HCPCS code J7183 <b>Changed</b> "Contractor's Determination Number" to AJ7183
ANCSVCS Noncovered Services	<b>Descriptor change</b> for CPT codes 90644, 90867, and 90868  <b>Deleted</b> CPT codes 0155T, 0156T, 0157T, and 0158T (replaced with CPT code 43659)  <b>Removed</b> CPT code 46999 and replaced with CPT code 0288T  Added CPT code 90869
APULMDIAGSVCS Pulmonary Diagnostic Services	<b>Deleted</b> CPT codes 93720, 93721, 93722, 94240, 94260, 94350, 94360, 94370, 94720, and 94725  <b>Added</b> CPT codes 94726, 94727, 94728, and 94729
ASKINSUB Skin Substitutes	<b>Deleted</b> HCPCS code C9365  <b>Added</b> HCPCS code Q4124  <b>Added</b> HCPCS codes C9366, Q4122, Q4123, Q4125, Q4126, Q4127, Q4128, Q4129, and Q4130 to "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products" section of the LCD  <b>Deleted</b> application CPT code range 15100-15431, CPT codes 15170, 15171, 15175, 15176, 15340, 15341, 15360, 15361, 15365, 15366, 15430, and 15431 and HCPCS codes G0440 and G0441 from the "Coding Guidelines" attachment  <b>Added</b> CPT codes 15271-15278 to the "Coding Guidelines" attachment
ATHERSVCS Therapy and Rehabilitation Services	<b>Descriptor change</b> for CPT code 96111  <b>Added</b> information related to therapy cap (Change Request 7529)

continued on next page

HCPCS...continued

LCD title	Changes
AXiaflex® Collagenase clostridium histolyticum (Xiaflex®)	<b>Removed CPT code 26989</b> <b>Added CPT codes 20527 and 26341</b>
A01991 Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services <b>(Coding Guidelines only)</b>	<b>Descriptor change</b> for CPT codes 27096, 62310 and 62311
A22533 Lumbar Spinal Fusion for Instability and Degenerative Disc Disease	<b>Descriptor change</b> for CPT code 22612 <b>Added CPT codes 22633 and 22634</b>
A32491 Lung Volume Reduction Surgery	<b>Descriptor change</b> for CPT code 32491
A61885 Vagal Nerve Stimulation (VNS) for Intractable Depression	<b>Descriptor change</b> for CPT codes 64585, 95970, 95974, and 95975
A75722 Renal Angiography	<b>Deleted CPT codes 75722 and 75724</b> <b>Added CPT codes 36251, 36252, 36253, and 36254</b> <b>Changed</b> "Contractor's Determination Number" to A36251
A77078 Bone Mineral Density Studies	<b>Deleted CPT codes 77079 and 77083</b>
A86849 Circulating Tumor Cell Testing	<b>Removed CPT code 86849</b> <b>Added CPT codes 0279T and 0280T</b> <b>Changed</b> "Contractor's Determination Number" to A0279T
A93875 Non-invasive Extracranial Arterial Studies	<b>Deleted CPT code 93875</b> <b>Changed</b> "Contractor's Determination Number" to A93880
A95860 Electromyography and Nerve Conduction Studies	<b>Added CPT codes 95885, 95886, and 95887</b>
A95990 Implantable Infusion Pump for the Treatment of Chronic Intractable Pain	<b>Descriptor change</b> for CPT codes 62367, 95990, and 95991 <b>Added CPT codes 62369 and 62370</b>

Source: Pub 100-04, transmittal, change request 7540

**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.

## Important Medicare FFS statement regarding versions 5010 and D.0

On November 17, 2011, the CMS Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement action until Saturday, March 31, 2012, with respect to any HIPAA-covered entity that is not in compliance with the ASC X12 version 5010 (version 5010), NCPDP Telecom D.0 (NCPDP D.0), and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains Sunday, January 1, 2012 (small health plans have until Tuesday, January 1, 2013, to comply with NCPDP 3.0).

**Medicare fee-for-service (FFS) will soon issue direction to the Medicare administrative contractors (MACs) on how these transactions are to be processed beginning January 2, 2012.** Further guidance related to Medicare FFS will be available via listserv messages and the Centers for Medicare & Medicaid Services website.

Source: CMS PERL 201111-49

---

## Version 5010 enforcement discretion period

### How version 5010 changes modify your transition

#### 90-day period of enforcement discretion for compliance with version 5010 deadline

The Centers for Medicare & Medicaid Services (CMS) recently announced a 90-day enforcement discretion period for all HIPAA-covered entities regarding the version 5010 (ASC X12 version 5010) transition.

The compliance deadline for implementation of version 5010 is still January 1, 2012; however, CMS will not initiate enforcement action until March 31, 2012. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades for this transition.

CMS encourages you to continue internal and external testing of version 5010 transactions with trading partners to ensure compliance for version 5010. Although enforcement action will not be taken prior to March 31, 2012, it is important that you continue to move forward to meet version 5010 requirements as soon as possible.

During the 90-day enforcement discretion period, the Office of E-Health Standards and Services (OESS) will continue to accept complaints associated with compliance with version 5010, NCPDP D.0 and NCPDP 3.0 transaction standards beginning January 1, 2012. HIPAA-covered entities that are subject to these complaints must produce evidence of either compliance or an established plan to become compliant within the enforcement discretion period. In addition to testing, if you have not yet created a transition plan for version 5010, you should do so in order to meet these compliance deadlines.

Please visit the CMS ICD-10 website [Latest News](#) page for additional resources and more information on this [enforcement discretion period](#).

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

Please visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

Source: CMS PERL 201112-01

**Have you transitioned to 5010?**

*Don't wait until it's too late ...*

Call FCSO EDI -- 888-670-0940, option-5

## Medicare fee-for-service policy – 90-day discretionary enforcement period for non-compliant HIPAA covered entities

The Centers for Medicare and Medicaid Services (CMS) has *announced* it would not initiate enforcement action with respect to any HIPAA-covered entity that is non-compliant with version 5010, NCPDP, NCPDP D.0, and 3.0 standards until 90 days after the upcoming **January 1, 2012**, compliance date. Although compliance will not be enforced for version 5010 until April 1, 2012, it is important to **continue to take the necessary steps to complete your transition to version 5010 as soon as possible.**

### What the 90-day discretionary enforcement period means for Medicare fee-for-service (FFS)

Medicare FFS has experienced significant increases in 5010 production transactions during the last few months. However, there are many submitters that have tested but have not taken the step to move into production for 5010 and D.0. In addition, there are many submitters that have not yet initiated testing with their Medicare administrative contractor (MAC). Therefore, to ensure that submitters and receivers continue to make progress, Medicare FFS is planning to take the following steps for submitters and receivers of Medicare Part B and durable medical equipment (DME) transactions:

- In December, submitters and receivers that have tested and been approved for 5010/D.0 will be notified that they have 30 days to cutover to the 5010/D.0 versions.
- Submitters and receivers that have not yet tested will be notified in December that they must submit their transition plans and timelines to their MAC within 30 days.

MACs will notify the submitters and receivers, **but submitters/receivers have the responsibility to notify the providers they service.**

**Note:** Submitters and receivers of Medicare Part A transactions will follow the same action plan starting 30 days after Part B and DME.

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

Please visit [the CMS ICD-10 website](#) for the latest news and resources, and to download and share the implementation *widget* today.

Source: CMS PERL 201112-48

---

## Additional HIPAA 837 5010 transitional changes and modifications to the COBA national crossover process

### Provider types affected

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

### What providers need to know

Supplemental payers are transitioning to the Health Insurance Portability and Accountability Act (HIPAA) 5010 or National Council for Prescription Drug Programs (NCPDP) D.0 under the National Crossover Process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national Coordination of Benefits Agreement (COBA) crossover process from their production version 4010A1 HIPAA 837 claims to HIPAA versions 5010A1 and 5010A2 837 claims.

As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their “pre-HIPAA 5010” production version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to illustrate this point:

Payer A moved to HIPAA 5010 production on November 7, 2011. Medicare will then systematically transfer to Payer A all “clean” electronically received 4010A1 claims that are already on the payment floor and tagged for crossover as of November 3 and 4, 2011. Beginning with claims that CMS’ coordination of benefits contractor (COBC) received that have a file date of November 22, 2011, Medicare, through the COBC, will no longer be able to transfer production 4010A1 claims to payer A. This is because 14 full calendar days have elapsed since Payer A moved into production on the HIPAA 5010 claim formats.

*continued on next page*

**Transitional...continued**

**Note:** The same premise will hold for inbound version 5.1 batch National Council for Prescription Drug Programs (NCPDP) claims when a supplemental payer moves into production on the NCPDP D.0, version 5.2 batch format for receipt of crossover claims.

COBA supplemental payers must continue to accept 4010A1 claims for 14 full calendar days after their transition to 5010A1 and A2 formats.

As provided in CMS Change Requests (CRs) 6658\* and 6664\*, the COBC activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226 – “4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims.”
- N22230 – “NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims.”

\*To review the entire CR 6658, visit <http://www.cms.gov/transmittals/downloads/R1844CP.pdf>.

\*To review the entire CR 6664, visit <http://www.cms.gov/transmittals/downloads/R1841CP.pdf>.

Providers, physicians, and suppliers should note that they will see the foregoing edit codes on the special provider notification letters that Medicare mails to them at their on-file correspondence address when Medicare is unable to send various claims for crossover purposes. Receipt of these codes on the special provider notification letters denotes that:

1. The patient’s supplemental payer has moved into HIPAA 5010 or NCPDP D.0 production receipt for all Medicare crossover claims; and
2. For a limited timeframe (likely 30 days after a supplemental payer cuts over to version 5010 for crossover claims receipt), providers, physicians, and suppliers will need to file the affected claims directly with their patients’ supplemental payers.

**Key points**

- Your Medicare contractor will not attempt to repair claims that the COBC returns via the COBC error

reports with error codes N22226 through N22229, regardless of error percentage.

- Your Medicare contractor will create special provider letters to their affiliate suppliers in association with “production” claims that the COBC rejects with error code N22226 or N22228. Per CMS instruction, these letters indicate that Medicare cannot cross the listed patient-specific claims over to patient’s supplemental payer and include a specific “222” error code and accompanying description. *MLN Matters*® article MM3709 details the initial CMS instructions to contractors and may be reviewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM3709.pdf>.
- Complete details of the COBA error notification process are included in the official instruction issued to your Medicare contractor and may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf>.
- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

**Additional information**

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

If you have any questions about electronic data interchange (EDI) Medicare, customers may call their regional EDI Helpline to access information. These regional toll free numbers may be found in the “Downloads” section of the Electronic Billing & EDI Transactions Web page at <http://www.cms.gov/ElectronicBillingEDITrans/>.

MLN Matters® Number: SE1137  
 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

*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.*



## Version 5010 resources are available to help your transition

### The version 5010 transition deadline is only 39 days away

The transition to version 5010 is only 39 days away and involves important business and systems changes throughout the health care industry. As the January 1, 2012, deadline approaches, the Centers for Medicare & Medicaid Services (CMS) is committed to helping you better prepare for the version 5010 transition by providing resources on the CMS ICD-10 website to understand and manage your transition.

### Compliance timelines and widget

CMS has created an interactive [widget](#), and corresponding printer-friendly compliance timelines, to help you remember important action items and meet milestones for the switches to version 5010 and ICD-10. The widget and timelines are tailored to help manage the implementation processes for:

- [Large provider practices](#)
- [Small provider practices](#)
- [Payers](#)
- [Vendors](#)

### Implementation handbooks

CMS has developed four implementation handbooks which provide detailed information for planning and executing the version 5010 and ICD-10 transition processes. These guides and their corresponding customizable templates can help you to clarify staff roles, set deadlines, and assess vendor readiness. Choose the handbook most relevant for you based upon your organization:

- [Large provider practices](#)
- [Payers](#)
- [Small hospitals](#)
- [Small/medium provider practices](#)

### Version 5010 testing readiness fact sheet

CMS has also developed a [version 5010 testing readiness fact sheet](#), which explains the version 5010 transition and necessary phase I internal and phase II external testing. This fact sheet can assist you to determine steps to successfully complete testing phases for version 5010, and help ensure you are compliant by January 1, 2012.

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

Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today.

Source: CMS PERL 201111-61



### Find out first: Subscribe to FCSO eNews

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

## Trading partners should install the latest version of PC-ACE Pro32™ no later than January 1, 2012

### What is PC-ACE Pro32™?

PC-ACE Pro32™ is a “stand alone” software package that creates a patient database and allows your office to electronically submit claims to Medicare Part A and Part B. It is available as a free download from Medicare administrative contractors (MACs) upon request for use by Medicare providers for billing Medicare claims. **Note:** CD-ROM versions are available at cost.

### How is PC-ACE Pro32™ becoming compliant with ACS X12 5010 on Sunday, January 1, 2012?

Effective Sunday, January 1, 2012, the only available output format for PC-ACE Pro32™ versions 2.32.0.100 and 2.34.0.100 will be the 5010 version. The Sunday, January 1, 2012, changeover was established as part of the version 2.32 (ASC X12 5010) update, prior to issuance of the Centers for Medicare & Medicaid Services (CMS) Office of E-Health Standards and Services (OESS) 90-day discretionary enforcement announcement. The PC-ACE Pro32™ (versions 2.32.0.100 and 2.34.0.100) update file includes software changes necessary to ensure your PC-ACE Pro32™ claims are submitted in the ASC X12 837 v5010 format. All trading partners should be on the current version of PC-ACE Pro32™ as the software is set up to automatically expire every eight months; therefore, requiring the new version to be downloaded/installed no later than January 1, 2012.

### PC-ACE Pro32™ software versions 2.32.0.100 and 2.34.0.100 for ASC X12 v5010 have several CMS Medicare mandates and enhancements:

- The current Pro32 upgrade is applicable to 1.82.0.100 (January 2007) and later versions for the PC-ACE Pro32™ software
- ASC X12 version 5010 errata production software changes:
  - ASC X12 version 4010A1 no longer an option after January 1, 2012
  - ZIP code requires full 9-position value (**Note:** 9-digit patient ZIP code is optional)
  - Billing provider must include physical address and ZIP code (full nine-position value). Post office and lock boxes are not permitted. **Note:** Pay-to-provider may indicate post office and lock boxes.
  - ZIP code on all facility reference file records must include full nine-position value

## 5010/D.0 implementation calendar

### Past events

For a complete list of past 5010 national provider calls, please visit the [5010 National Provider Calls section of our Versions 5010 & D.0](#) Web page.

Links to more information on version 5010, NCPDP D.0, and NCPDP 3.0 are available at [www.CMS.gov/Versions5010andD0](http://www.CMS.gov/Versions5010andD0).

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

Source: CMS PERL 201112-26

### Your feedback matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our Website highlights page at <http://medicare.fcso.com/Feedback/201743.asp>. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with FCSO's Web team.

## Preparing for version 5010 – deadline Sunday, January 1, 2012

The compliance deadline for the transition to version 5010 is less than one week away. Although the Centers for Medicare & Medicaid Services (CMS) announced an enforcement discretionary period of 90 days for version 5010 compliance, the deadline remains January 1, 2012. Enforcement will not be exercised until April 1, 2012; however, it is important that organizations continue to complete the transition to version 5010 as soon as possible, if they have not done so already.

### Version 5010 resources

CMS is committed to helping organizations make a smooth transition to version 5010 and ICD-10. The CMS ICD-10 website has been updated to include a new [Web page](#) dedicated to version 5010 information and resources. CMS has also posted a new [fact sheet](#), which discusses steps providers should be taking now to ensure a timely transition to version 5010 by January 1, 2012.

Other materials on version 5010 include the following fact sheets:

- [FAQs: Versions 5010 and D.0 Transition Basics](#)
- [Versions 5010, D.0, and 3.0 overview](#)
- [Version 5010: Testing Readiness, What You Need to Know](#)
- [Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices](#)

### Additional resources

Stay on top of deadlines and action items for version 5010 and ICD-10 by referencing the following resources on the CMS ICD-10 website:

- [Interactive widget](#): A user-friendly tool that outlines the steps to take to ensure compliance with version 5010 and ICD-10.
- **Timelines**: Printer-friendly checklists that complement the widget, which are available for the following:
  - [Large providers](#)
  - [Small providers](#)
  - [Payers](#)
  - [Vendors](#)
- **Implementation handbooks**: Detailed step-by-step guides on how to implement ICD-10, which have been customized for different audiences, which includes the following:
  - [Small/medium provider practices](#)
  - [Large provider practices](#)
  - [Small hospitals](#)
  - [Payers](#)

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

Please visit the CMS' [ICD-10 Web page](#) to find the latest news and helpful resources and to download and share the implementation [widget](#).

Source: CMS PERL 201112-50



## Medicare FFS Part B editing of the NDC

Effective December 9 Medicare fee-for-service (FFS) turned off the current ASC X12 version 5010 common edit and enhancements module (CEM) national drug code (NDC) validation edit for Medicare Part B. The specific NDC edit being turned off is the loop ID 2410 LIN03 and requires that the NDC be validated against the Food and Drug Administration's (FDA) NDC code list. A replacement NDC edit will be implemented in the Part B CEM for the January 2012 shared system quarterly release, which will perform syntactical editing only of the NDC submitted in loop ID 2410 LIN03.

A similar announcement will be disseminated when the Part A NDC edit is deactivated.

### Background of the national drug code

The NDC is a unique product identifier used for drugs intended for human use and is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting or adjudication processes. The Drug Listing Act of 1972 requires registered drug establishments to provide the FDA with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. Drug products are identified and reported using the NDC.

The NDC is a unique number expressed in three sections. This numeric identifier is assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The sections identify the labeler or vendor, the product (within the scope of the labeler), and the type of package (of this product). The ASC X12 TR3 documents stipulate that the 5-4-2 expression of NDC values must be used. However, the FDA does not have a version of the NDC in this (5-4-2) format. Therefore, the Centers for Medicare & Medicaid Services (CMS) has created a version of the NDC in the 11-byte numeric NDC derivative, which pads the product code (four positions) or package code (two positions) sections of the NDC with a leading zero thus resulting in a fixed length 5-4-2 configuration.

Additional information on version 5010, NCPDP D.0, and NCPDP 3.0 is available at [www.CMS.gov/Versions5010andD0](http://www.CMS.gov/Versions5010andD0).

Source: CMS PERL 201112-37

---

## Health care provider taxonomy code set update: Effective January 1, 2012

Effective January 1, 2012, the health care provider taxonomy code (HPTC) set, which allows providers to indicate their specialty, will be updated. The National Uniform Claim Committee (NUCC) updates the code set twice a year with changes effective April 1 and October 1. The latest version of the HPTC set is available from the Washington Publishing Company's website at: [www.wpc-edi.com/codes/taxonomy](http://www.wpc-edi.com/codes/taxonomy). If an invalid HPTC is reported to Medicare, a batch and/or claim-level deletion (rejection) may occur. To ensure you do not receive a claim or file-level rejection, it is recommended that you verify the HPTC is valid (i.e., included in the most recent HPTC set) before submitting. If you require assistance with updating the taxonomy code set in your practice management system, please contact your software support vendor.

Source: CR 7530

### 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>.

## Expansion of Medicare telehealth services for CY 2012

### Provider types affected

Physicians, hospitals (including critical access hospitals (CAH)), and other providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare administrative contractors (A/B MAC) for providing telehealth services to Medicare beneficiaries will be affected by this article.

### Provider action needed

#### Stop – impact to you

Effective January 1, 2012, you may begin billing your FI, carrier, or A/B MAC for CPT codes 99406 – 99407 and HCPCS codes G0436 – G0437 for smoking cessation services furnished as Medicare telehealth services when all other Medicare telehealth qualifications have been met. Change request (CR) 7504 also announces that the initial telehealth consultation codes (G0425 – G0427) used for hospital inpatients may also be billed for telehealth services with a place of service (POS) code for the emergency department when all other Medicare telehealth qualifications have been met

#### Caution – what you need to know

CR 7504, from which this article is taken, announces that (effective January 1, 2012) the Centers for Medicare & Medicaid Services (CMS) is adding four smoking cessation services codes to the list of Medicare telehealth services for CY 2012.

#### Go – what you need to do

You should make sure that your billing staffs are aware of these additional smoking cessation codes for Medicare telehealth services for CY 2012.

### Background

In the calendar year 2012 physician fee schedule final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) is added four smoking cessation services codes to the list of Medicare distant site telehealth services. The additional codes, effective January 1, 2012, are:

- CPT codes 99406 (*Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*); and 99407 (*Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*); and
- HCPCS codes G0436 (*Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes*); and G0437 (*Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes*).

CMS is also revising the initial inpatient telehealth consultation code descriptors to allow practitioners to report these services furnished to emergency department patients. The code descriptors, effective January 1, 2012, are:

- HCPCS code G0425 (*Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth*)
- HCPCS code G0426 (*Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth*)
- HCPCS code G0427 (*Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth*)



For your claims with dates of service on or after January 1, 2012:

- Your carrier or A/B MAC will accept and pay these codes according to the appropriate physician or practitioner fee schedule amount when submitted with a GQ modifier (Via asynchronous telecommunications system) or GT modifier (Via interactive audio and video telecommunications system);
- Your FI or A/B MAC will accept and pay such claims when submitted with a GQ or GT modifier by CAHs that have elected method II on type of bill (TOB) 85x; and
- Your carrier or A/B MAC will pay initial inpatient telehealth consultation codes G0425-G0427 with the GT or GQ modifier when billed with place of service (POS) emergency department in addition to inpatient hospital or skilled nursing facility.

continued on next page

Telehealth...continued

### Additional information

Further information regarding telehealth is available in the *Telehealth Services Fact Sheet* at <http://www.cms.gov/MLNProducts/downloads/TelehealthSrvcsfctsh.pdf>.

You can find more information about the new Smoking Cessation codes for telehealth services by going to CR 7504, which was issued via two transmittals. The first transmittal revises the *Medicare Benefit Policy Manual* and is at <http://www.cms.gov/Transmittals/downloads/R151BP.pdf> and the second updates the *Medicare Claims Processing Manual* and is at <http://www.cms.gov/Transmittals/downloads/R2354CP.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: MM7504

Related Change Request (CR) #: CR 7504

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R151BP and R2354CP

Implementation Date: January 3, 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.*

## 2012 ICD-10-CM code updates now available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2012 ICD-10-CM code updates to the CMS website, including the 2012 ICD-10-CM index and tabular, code titles, addendum, general equivalence mappings (GEMs), and reimbursement mappings files. The 2012 ICD-10-CM files contain information on the new diagnosis coding system, ICD-10-CM, that is being developed as a replacement for ICD-9-CM, volumes 1 and 2. These files are available on the 2012 ICD-10-CM and GEMs Web page at [http://www.cms.gov/ICD10/11b14\\_2012\\_ICD10CM\\_and\\_GEMs.asp](http://www.cms.gov/ICD10/11b14_2012_ICD10CM_and_GEMs.asp). To access the files, scroll to the bottom of the page to the "Downloads" section.

The 2012 ICD-10-PCS (procedure) files were posted in June on the 2012 ICD-10-PCS and GEMs Web page at [http://www.cms.gov/ICD10/11b15\\_2012\\_ICD10PCS.asp](http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.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 201112-11

## Release of a national provider comparative billing report on nerve conduction studies

On Tuesday, December 6, 2011, the Centers for Medicare & Medicaid Services (CMS) will release a national provider comparative billing report (CBR) addressing nerve conduction studies.

CBRs produced by Safeguard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers located in their state and across the nation.

These reports are not available to anyone except the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers conform to Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the CBR on nerve conduction studies, please visit the CBR Services website, located at [www.cbrservices.com](http://www.cbrservices.com), or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

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

Source: CMS PERL 201111-40

## Pharmacy billing for drugs provided “incident to” a physician service

**Note:** This article was revised on December 16, 2011, to reflect the revised change request (CR) 7397 issued on December 15. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR 7397 were revised. All other information remains the same. This information was previously published in the October 2011 *Medicare A Connection*, pages 23-24.

### Provider types affected

Pharmacies that submit claims for drugs to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), A/B Medicare administrative contractors (A/B MACs), and durable medical equipment MACs) are affected.

### What You Should Know

This article is based on change request (CR) 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided “incident to” a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined.

This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

### Background

#### Pharmacies billing drugs

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the durable medical equipment Medicare administrative contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician’s service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.



### When drugs may not be billed by pharmacies to Medicare Part B

Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration “incident to” a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician’s office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered “incident to” a physician’s service and pharmacies may not bill Medicare Part B under the “incident to” provision.

### Payment limits

The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B drug pricing file or not otherwise classified (NOC) pricing file are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under the outpatient prospective payment system (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

### Additional information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at <http://www.cms.gov/Transmittals/downloads/T2368CP.pdf>.

*continued on next page*

**Pharmacy...continued**

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

The following manual sections regarding billing drugs and biological and “incident to” services may be helpful:

- *Medicare Claims Processing Manual*, chapter 17, sections 20.1.3 and 50.B, available at <http://www.cms.gov/manuals/downloads/clm104c17.pdf> and
- *Medicare Benefit Policy Manual*, chapter 15, sections 50.3 and 60.1, available at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>.

MLN Matters® Number: MM7397 Revised  
Related Change Request (CR) #: 7397  
Related CR Release Date: December 15, 2011  
Effective Date: January 1, 2013  
Related CR Transmittal #: R2368CP  
Implementation Date: January 1, 2013

*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.*

---

## Revised average sales price template now available

The revised average sales price (ASP) template is now available at <http://www.cms.gov/McrPartBDrugAvgSalesPrice/>. Manufacturers should use this template for submitting ASP to the Centers for Medicare & Medicaid Services (CMS) beginning January 2012.

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

Source: CMS PERL 201112-41

### Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do -- visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly -- the first time. You'll find FCSO's most popular self-audit resources, including the E/M interactive worksheet, Provider Data Summary (PDS) report, and the Comparative billing report (CBR).

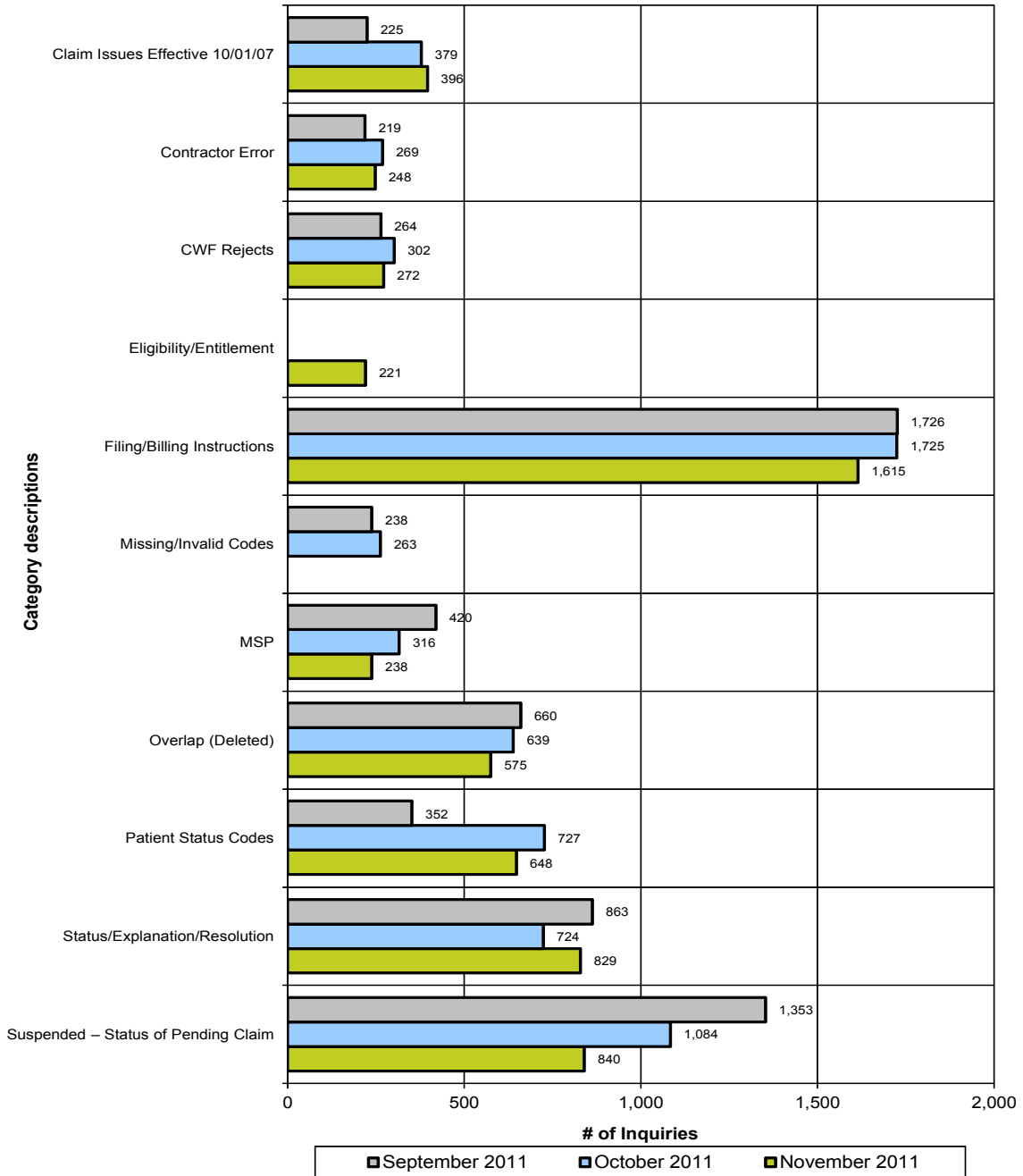


## Top inquiries, rejects, and return to provider claims – September-November 2011

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 September-November 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](http://medicare.fcso.com/inquiries_and_denials/index.asp).

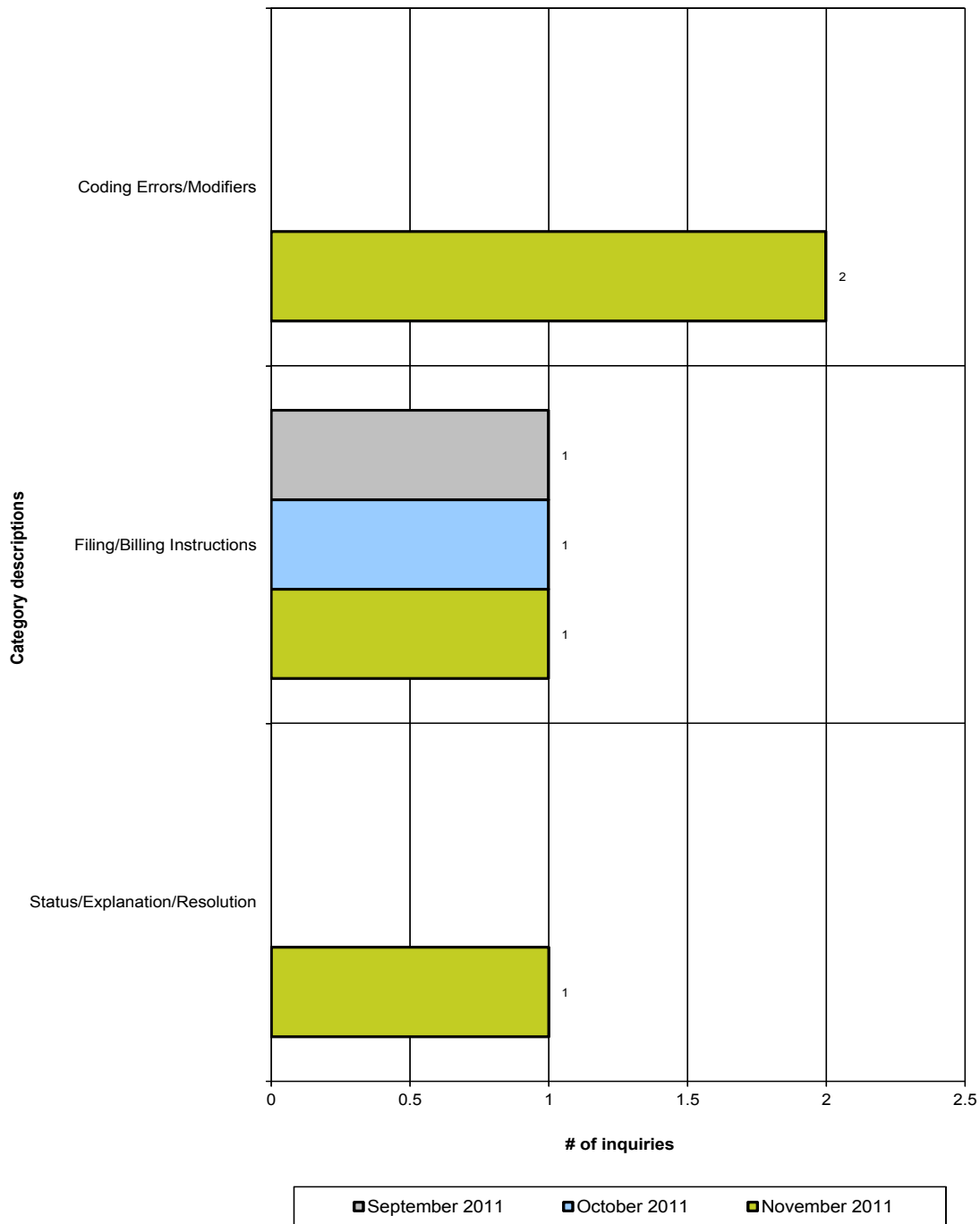
### Florida Part A top inquiries for September-November 2011



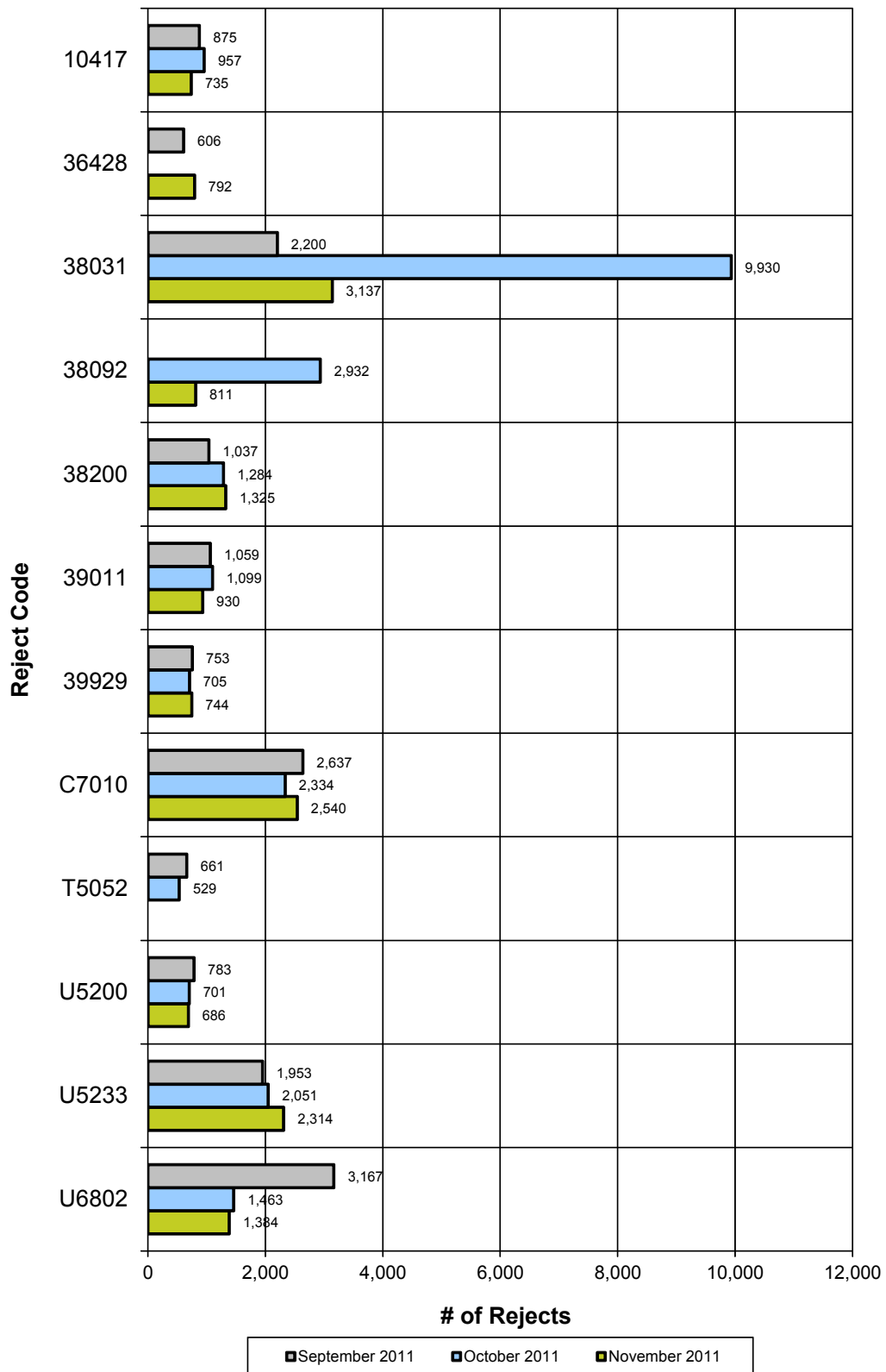
continued on next page

Inquiries...continued

## U.S. Virgin Islands Part A top inquiries for September-November 2011



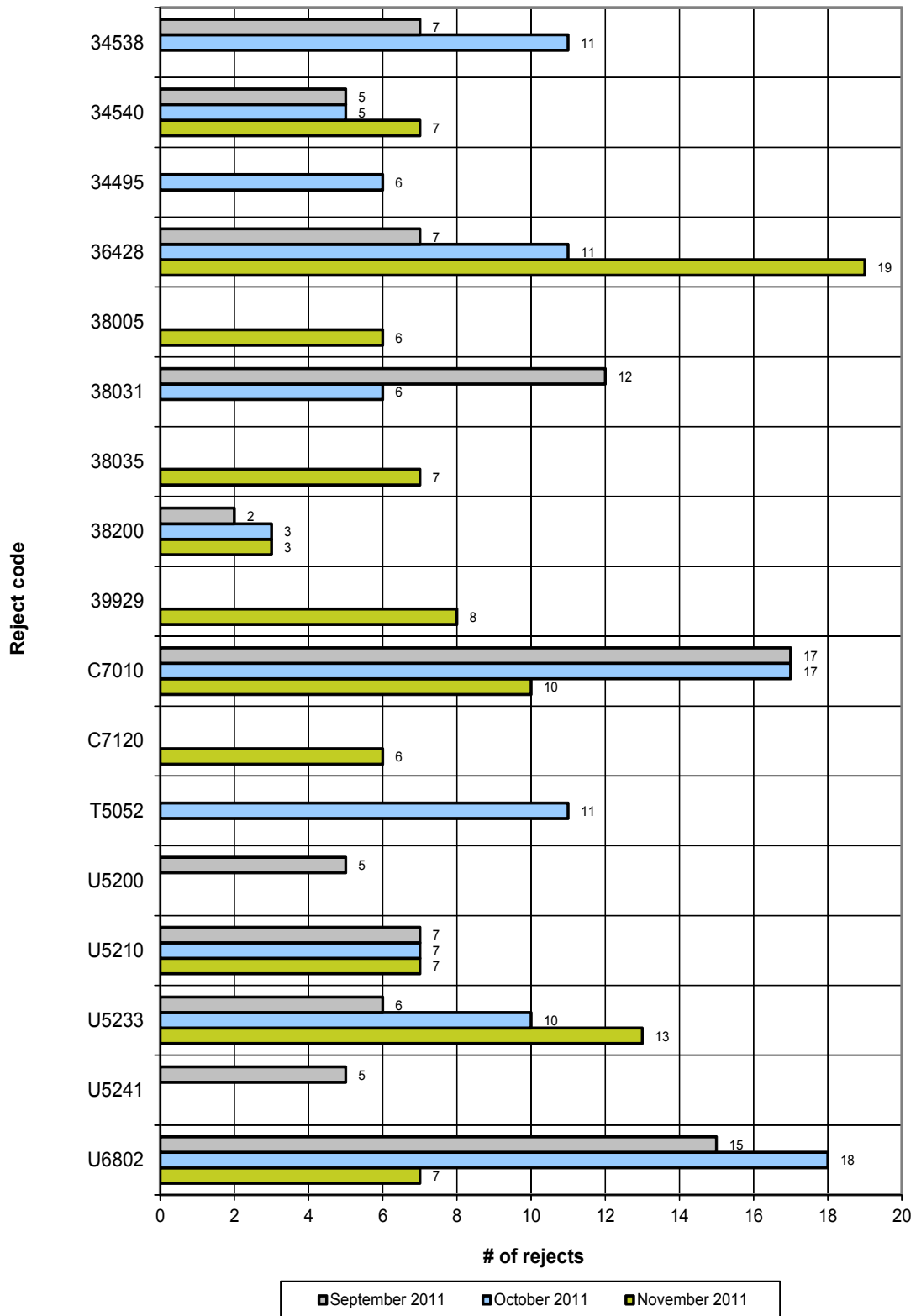
## Florida Part A top rejects for September-November 2011



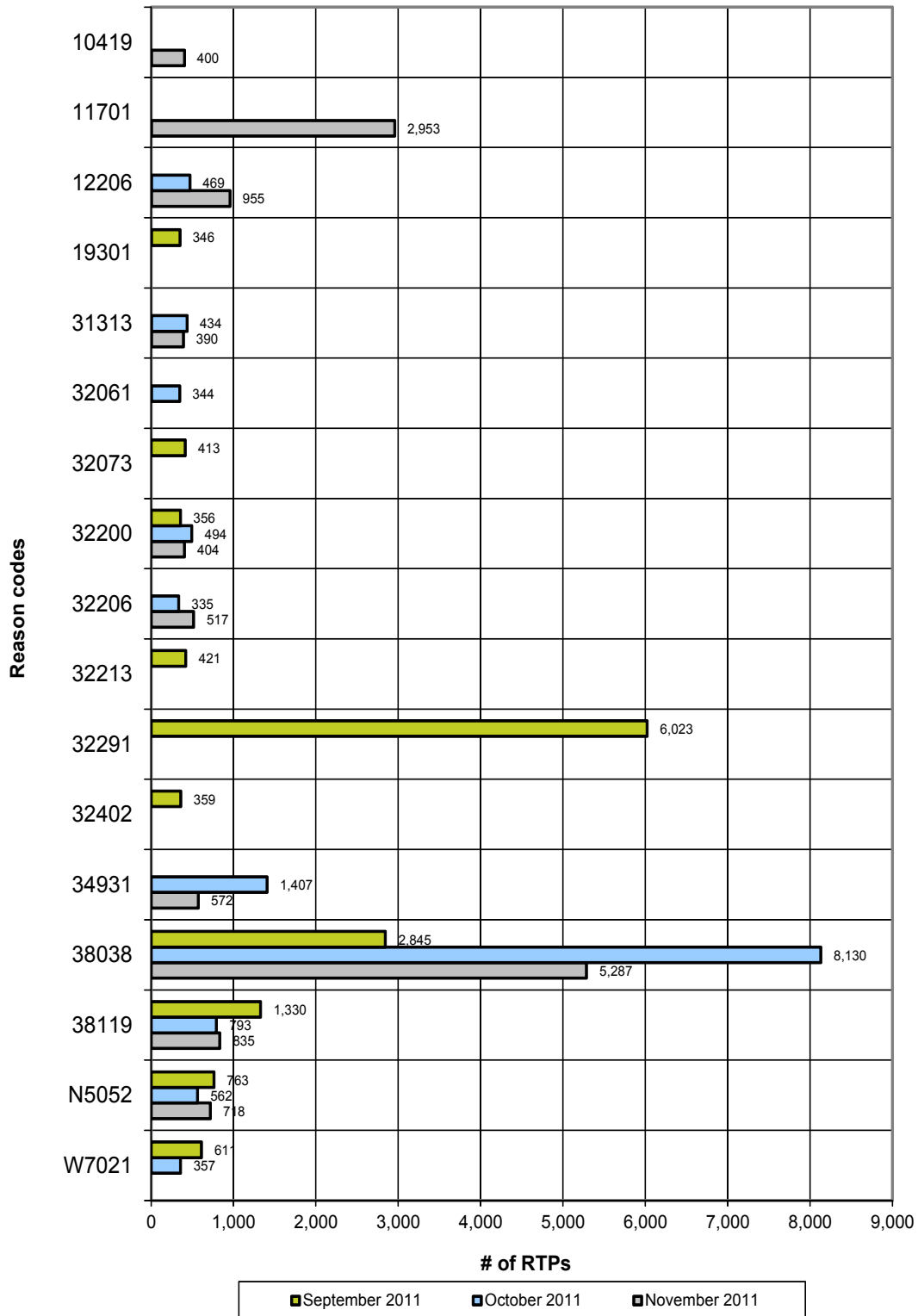
continued on next page

Rejects...continued

## U.S. Virgin Islands Part A top rejects for September-November 2011



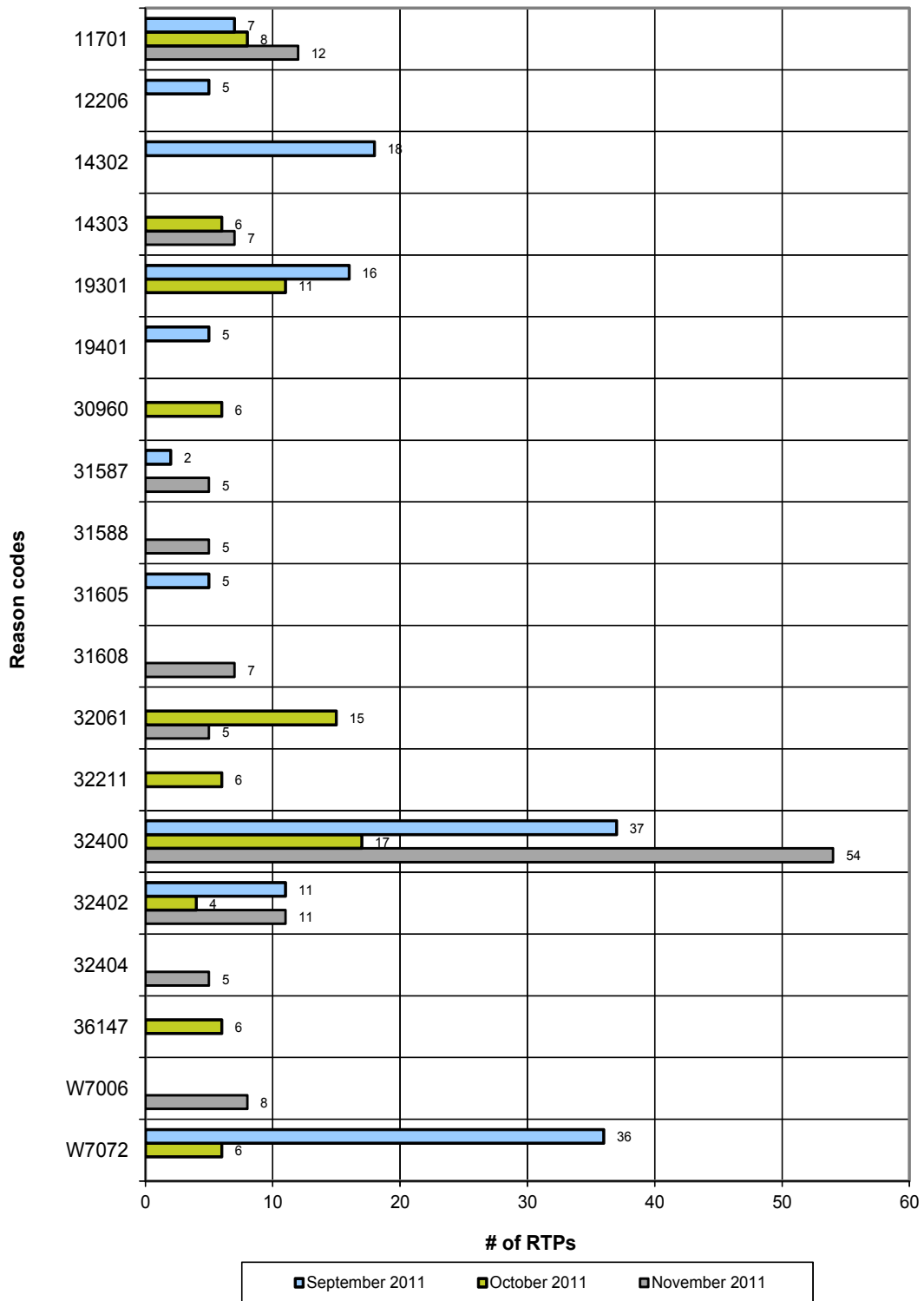
## Florida Part A top return to providers (RTPs) for September-November 2011



*continued on next page*

RTPs...continued

## U.S. Virgin Islands Part A top return to providers (RTPs) for September-November 2011



## January 2012 I/OCE specifications version 13.0

### 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) 7668, which describes changes to the I/OCE and OPPS to be implemented in the January 2012 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

### Background

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

A summary of the changes for January 2012 is within Appendix M of Attachment A of CR 7668 and that summary is captured in the following key points.

- Effective January 1, 2011, correct the logic for assignment of PAF #4 on the PT modifier – to apply only when the PT modifier is present on a CPT code in the range of 10000 – 69999.
- Effective May 9, 2011, Medicare will change the mid-quarter FDA approval date from May 10, 2011 to May 9, 2011 for code 90654. Edit 67 is affected.
- Effective October 1, 2011, Medicare will add new G-codes (G0442 – G0447) to the list of preventive services for payment adjustment flag (PAF) 9.
- Effective October 14, 2011, Medicare will add new codes G0442, G0443, G0444 with a mid-quarter national coverage determination (NCD) approval date of October 14, 2011. Edit 68 is affected.
- Effective November 8, 2011, Medicare will add new codes G0445 and G0446 with a mid-quarter NCD approval date of 11/8/11. Edit 68 is affected.
- Effective November 29, 2011, Medicare will add new codes G0447 with a mid-quarter approval date of November 29, 2011. Edit 68 is affected.
- Effective January 1, 2012, Medicare will:
  - Make HCPCS/APC/SI changes (data change files);
  - Implement version 18.0 of the NCCI (as modified for applicable institutional providers). Edits 19, 20, 39 and 40 are affected. [To bring

NCCI version current with IOCE version; effective date of NCCI = IOCE version date];

- Update procedure/device and device/procedure edit requirements. Edits 71 and 77 are affected;
- Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS website;
- Update modifier FB/FC device reduction amounts & crosswalk;
- Update Nuclear medicine/radio labeled product edit requirements. Edit 78 is affected;
- Update composite ambulatory payment classification (APC) 34 requirements – add code G0451 (replacement for 96110);
- Modify the logic such that if procedure codes 33249 and 33225 are submitted on the same date of service:
  - Assign 33249 to standard APC for payment, package 33225 (change SI to N); and
  - Ignore FB or FC modifier on 33225 if the SI has been changed to N;
- Change SI for 33249 to T; change SI for 33225 to T when it is not submitted with 33249 on the same day.
- Add new edit 84 – claim lacks required primary code (Return to Provider RTP)).
  - Criteria: Add-on code 33225 is submitted without one of the following primary codes on the same day: 33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33222, 33234, 33235, 33240, 33249;
- Add new edit 85 – claim lacks required device code or required procedure code (RTP).
  - Criteria: Code C9732 and C1840 not submitted together on the same day. (Code for insertion of ocular telescopic lens submitted without the code for the lens, or vice versa).

### Additional information

The official instruction, CR 7668 issued to your Medicare MAC, RHHI, or FI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2370CP.pdf>.

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

*continued on next page*

**I/OCE...continued**

MLN Matters® Number: MM7668  
Related Change Request (CR) #: 7668  
Related CR Release Date: December 16, 2011  
Effective Date: January 1, 2012  
Related CR Transmittal #: R2370CP  
Implementation Date: January 3, 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.*

---

## **RY 2012 inpatient psychiatric facility PPS PC Pricer updates**

The inpatient psychiatric facility (IPF) PPS PC Pricer for rate year (RY) 2012 (claims dates from July 1-September 30, 2011, and from October 1, 2011-September 30, 2012), has been posted to the Centers for Medicare & Medicaid Services (CMS) website with October 2011 provider data. If you use the IPF PPS PC Pricer for RY 2012, please go to the page, [http://www.cms.gov/PCPricer/09\\_inppsy.asp](http://www.cms.gov/PCPricer/09_inppsy.asp), under the Downloads section, and download the latest versions of the IPF PPS PC Pricer, posted December 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 201112-02

---

## **Correction to RY 2012 inpatient psychiatric facility PPS PC Pricer**

A typo was discovered and corrected in the inpatient psychiatric facility (IPF) PPS PC Pricer for rate year (RY) 2012 for claims dates from October 1, 2011, to September 30, 2012. The correction has been posted to the Centers for Medicare & Medicaid Services (CMS) website. If you use the IPF PPS PC Pricer for RY 2012, please go to the page, [http://www.cms.gov/PCPricer/09\\_inppsy.asp](http://www.cms.gov/PCPricer/09_inppsy.asp), under the “Downloads” section, and download the latest version posted December 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 201112-12

---

## **FY 2012 skilled nursing facility PC Pricer updates**

The fiscal year (FY) 2012 skilled nursing facility (SNF) PC Pricer has been posted to the Centers for Medicare & Medicaid Services (CMS) website at [http://www.cms.gov/PCPricer/04\\_SNF.asp](http://www.cms.gov/PCPricer/04_SNF.asp), under the “Skilled Nursing Facilities (SNF PPS) PC Pricer.” If you use the FY 2012 SNF PC Pricer, please download the Pricer from the page above.

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

Source: CMS PERL 201111-69

---

## **How to Use the Searchable Medicare Physician Fee Schedule booklet available**

The new “*How to Use the Searchable Medicare Physician Fee Schedule*” booklet (ICN 901344) is designed to provide education on how to use the Medicare Physician Fee Schedule (MPFS). It includes steps to search for payment information, pricing, relative value units (RVUs), and payment policies.

If you like the MPFS booklet, check out “*How to Use the Medicare Coverage Database*” and *How to Use the National Correct Coding Initiative (NCCI) Tools* from the Medicare Learning Network®.

Source: CMS PERL 201112-07



## Temporary hold of claims for services paid under 2012 MPFS

The negative update under current law for the 2012 Medicare physician fee schedule is scheduled to take effect on January 1, 2012, eight business days from December 19, 2011. Consequently, as it has on previous occasions, the Centers for Medicare & Medicaid Services (CMS) will instruct Medicare claims administration contractors (MAC) to hold claims containing 2012 services paid under the MPFS for the first 10 business days of January (i.e., January 1, 2012, through January 17, 2012). The hold should have minimal impact on provider cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.

MPFS claims for services rendered on or before December 31, 2011, are unaffected by the 2012 claims hold and will be processed and paid under normal procedures and time frames.

The administration is disappointed that Congress has failed to pass a solution to eliminate the sustainable growth rate (SGR) formula-driven cuts and has put payments for health care for Medicare beneficiaries at risk. CMS continues to urge Congress to take action to ensure these cuts do not take effect.

CMS will notify providers on or before January 11, 2012, with more information about the status of congressional action to avert the negative update and next steps regarding the claims hold.

Source: CMS PERL 201112-39

---

## January 2012 average sales price files now available

The Centers for Medicare & Medicaid Services (CMS) has posted the January 2012 average sales price (ASP) and not otherwise classified (NOC) pricing files, crosswalks, and updated pricing files for October 2011 and July 2011. 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 201112-25

---

## Reasonable charge update for 2012 for splints, casts, and certain intraocular lenses

### Provider types affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, fiscal intermediaries (FIs), and Medicare administrative contractors (MACs)) for splints, casts, and certain intraocular lenses.

### What providers need to know

Change request (CR) 7628, on which this article is based, announces that payment of claims for splints, casts, and for intraocular lenses implanted in a physician's office (codes V2630, V2631, V2632) continues to be made on a reasonable charge basis subject to certain payment limits. CR 7628 also announces that the update factor for the inflation indexed charge (IIC) for 2012 is 3.6 percent.

### Background

Payment continues to be made on a reasonable charge basis for splints, casts, and intraocular lenses (codes V2630, V2631, and V2632) implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

CR 7628 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2012. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501.

The inflation indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the consumer price index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June

*continued on next page*

**Reasonable...continued**

30, 2011. The 2012 payment limits for splints and casts will be based on the 2011 limits that were announced in CR 7225 last year, increased by 3.6 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2011. (You can read the *MLN Matters*<sup>®</sup> article associated with CR 7225 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7225.pdf>.) The IIC update factor for 2012 is 3.6 percent.

A list of the 2012 payment limits for splints and casts are listed in the table that follows.

2012 payment limits for splints and casts							
A4565	\$8.12	Q4013	\$14.88	Q4026	\$111.41	Q4039	\$7.78
Q4001	\$46.21	Q4014	\$25.08	Q4027	\$17.85	Q4040	\$19.44
Q4002	\$174.65	Q4015	\$7.44	Q4028	\$55.72	Q4041	\$18.88
Q4003	\$33.19	Q4016	\$12.54	Q4029	\$27.29	Q4042	\$32.23
Q4004	\$114.91	Q4017	\$8.60	Q4030	\$71.83	Q4043	\$9.45
Q4005	\$12.24	Q4018	\$13.71	Q4031	\$13.64	Q4044	\$16.12
Q4006	\$27.58	Q4019	\$4.31	Q4032	\$35.91	Q4045	\$10.96
Q4007	\$6.13	Q4020	\$6.86	Q4033	\$25.45	Q4046	\$17.63
Q4008	\$13.79	Q4021	\$6.36	Q4034	\$63.30	Q4047	\$5.47
Q4009	\$8.17	Q4022	\$11.48	Q4035	\$12.72	Q4048	\$8.82
Q4010	\$18.39	Q4023	\$3.20	Q4036	\$31.66	Q4049	\$2.00
Q4011	\$4.08	Q4024	\$5.74	Q4037	\$15.53	Q4012	\$9.20
Q4025	\$35.68	Q4038	\$38.90				

**Additional information**

You can find the official instruction, CR 7628, issued to your carrier, FI, MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2349CP.pdf>.

Detailed instructions for calculating:

1. **Reasonable charges** are located in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);
2. **Customary and prevailing charges** are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and
3. The **IIC** are located in *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

Chapter 23 of the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>.

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

MLN Matters<sup>®</sup> Number: MM7628  
 Related Change Request (CR) #: CR 7628  
 Related CR Release Date: November 18, 2011  
 Effective Date: January 1, 2012  
 Related CR Transmittal #: R2349CP  
 Implementation Date: January 3, 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.*

## CY 2012 annual update for clinical laboratory fee schedule and services subject to reasonable charge payment

### Provider types affected

Clinical diagnostic laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) are affected.

### What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7654, which provides instructions to Medicare contractors for the calendar year (CY) 2012 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure your staffs are aware of these updates.

### Background

#### Annual updates to fees

The annual update to the local clinical laboratory fees for CY 2012 is 0.65 percent. The annual update to local clinical laboratory fees for CY 2012 reflects an additional multi-factor productivity adjustment and a -1.75 percentage point reduction as described by the Affordable Care Act.

The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2012 is 3.6 percent (See 42 Code of Federal Regulations (CFR) 405.509(b)(1)).

The Social Security Act (the Act), Section 1833(a)(1)(D) provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA).

For a cervical or vaginal smear test (Pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (Pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

This update is in accordance with Section 1833(h)(2)(A)(i) of the Act, as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act.

#### National minimum payment amounts

For a cervical or vaginal smear test (Pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2012 national minimum payment amount is \$14.97 (\$14.87 plus 0.65 percent update for CY 2012). The affected codes for the national minimum payment amount are shown in the following table:

88142	88143	88147	88148	88150
88152	88153	88154	88164	88165
88166	88167	88174	88175	G0123
G0144	G0145	G0147	G0148	P3000

#### National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

#### Public comments

On July 18, 2011, CMS hosted a public meeting to solicit input on the payment relationship between CY 2011 codes and new CY 2012 CPT codes. Notice of the meeting was published in the *Federal Register* on February 25, 2011, and on the CMS website on or about June 15, 2011. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at <http://www.cms.hhs.gov/ClinicalLabFeeSched> at the CMS website. Additional written comments from the public were accepted until

*continued on next page*

**Laboratory...continued**

October 28, 2011. CMS has posted a summary of the public comments and the rationale for the final payment determinations on the CMS website.

**Molecular pathology procedure test codes**

Beginning January 1, 2012, there will be 101 additional molecular pathology procedure test codes released by the American Medical Association. For payment purposes under the clinical laboratory fee schedule, these test codes will be assigned a “B” indicator – “Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).”

However, each of these new molecular pathology Procedure test codes represents a test that is currently being used and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understands that existing *Current Procedural Terminology (CPT)* test codes are “stacked” to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare as follows in order to represent the performance of the entire test:

83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time).

If the new *CPT* test coding structure were active, Laboratory A would bill Medicare the new, single *CPT* test code that corresponds to the test represented by the “stacked” codes in the example above rather than billing each component of the test separately.

As of January 1, 2012, Medicare requests that Medicare claims for Molecular Pathology Procedures reflect both the existing *CPT* “stacked” test codes that are required for payment and the new single *CPT* test code that would be used for payment purposes if the new *CPT* test codes were active.

Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment, as follows:

83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time) along with the new, single *CPT* test code that corresponds to the test represented by the “stacked” test codes.

While the allowed charge amount will be \$0.00 for the new molecular pathology procedure test codes that carry the “B” indicator, Medicare requests that Medicare claims also reflect a charge for the non-payable service.

The table below contains the CY 2012 molecular pathology procedure test codes:

81200	81205	81206	81207	81208
81209	81210	81211	81212	81213
81214	81215	81216	81217	81220
81221	81222	81223	81224	81225
81226	81227	81228	81229	81240
81241	81242	81243	81244	81245
81250	81251	81255	81256	81257
81260	81261	81262	81263	81264
81265	81266	81267	81268	81270
81275	81280	81281	81282	81290
81291	81292	81293	81294	81295
81296	81297	81298	81299	81300
81301	81302	81303	81304	81310
81315	81316	81317	81318	81319
81330	81331	81332	81340	81341
81342	81350	81355	81370	81371
81372	81373	81374	81375	81376

*continued on next page*

Laboratory...continued

81377	81378	81379	81380	81381
81382	81383	81400	81401	81402
81403	81404	81405	81406	81407
81408				

Access to data file

Internet access to the CY 2012 clinical laboratory fee schedule data file will be available after November 21, 2011, at <http://www.cms.hhs.gov/ClinicalLabFeeSched>. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the CY 2012 clinical laboratory fee schedule, which will be available in multiple formats: Excel, text, and comma delimited.

Pricing information

The CY 2012 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes, P9603 and P9604, are updated annually. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2012, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2012 clinical laboratory fee schedule also includes codes that have a “QW” modifier, defined as CLIA Waived Test, to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or disease oriented panel codes

As in to prior years, the CY 2012 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

- New code 86386 is priced at the same rate as code 82487.
- New code 87389 is priced at the same rate as code 86703 plus 50 percent of code 87390.
- Reconsidered code G0434 is priced at the same rate as code G0430.
- Reconsidered code G0435 is priced at the same rate as code 87804.
- Reconsidered code 83861 is priced at the same rate as code 84081.
- Reconsidered code 87906 is priced at the same rate as 50 percent of code 87901.
- Reconsidered code 86481 is priced at the same rate as code 86480 plus code 83520.
- For CY 2012, there are no new test codes that need to be gap filled.

Laboratory costs subject to reasonable charge payment in CY 2011

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2012 is 3.6 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, Chapter 23, Sections 80 through 80.8. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. **Note:** The Medicare manuals noted in this article are available at <http://www.cms.gov/Manuals/IOM/list.asp>.

continued on next page

## Laboratory...continued

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Chapter 8, Section 60.3, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

### Blood product codes

These codes are:

P9010	P9011	P9012	P9016	P9017
P9019	P9020	P9021	P9022	P9023
P9031	P9032	P9033	P9034	P9035
P9036	P9037	P9038	P9039	P9040
P9044	P9050	P9051	P9052	P9053
P9054	P9055	P9056	P9057	P9058
P9059	P9060			

Also, payment for the following codes are applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Sections 20.5 through 20.5.4:

P9010	P9016	P9021	P9022	P9038
P9039	P9040	P9051	P9054	P9056
P9057	P9058			

**Note:** Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

### Transfusion medicine codes

86850	86860	86870	86880	86885
86866	86890	86891	86900	86901
86903	86904	86905	86906	89920
86921	86922	86923	86927	86930
86931	86932	86945	86950	86960
86965	86970	86971	86972	86975
86976	86977	86978	86985	

### Reproductive medicine procedure codes

89250	89251	89253	89254	89255
89257	89258	89259	89260	89261
89264	89268	89272	89280	89281
89290	89291	89335	89342	89343
89344	89346	89352	89353	89354
89356				

## Additional information

The official instruction, CR 7654, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2365CP.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>.

*continued on next page*

**Laboratory...continued**

MLN Matters® Number: MM7654

Related Change Request (CR) #: 7654

Related CR Release Date: December 9, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2365CP

Implementation Date: January 3, 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.*

---

## Home health PPS rate update for CY 2012

### Provider types affected

Home health agencies (HHAs) submitting claims to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (A/B MACs) for Medicare beneficiaries are affected.

### Provider action needed

This article informs you that change request (CR) 7657 directs Medicare contractors to update the 60-day national episode rates, national per-visit rates, low utilization payment adjustment (LUPA) add-on amount, and non-routine supplies (NRS) payment amounts under the home health prospective payment system (HH PPS) for calendar year (CY) 2012. The information included below applies to Chapter 10, Section 10.1.6 of the *Medicare Claims Processing Manual*. Please be sure to inform your staff of the information in the *Background* and *Policy* sections below.

### Background

The Affordable Care Act of 2010 mandated several changes to Section 1895(b) of the Social Security Act and hence the HH PPS Update for CY 2011.

Section 1895 (b)(3)(B)(v) of Social Security Act provides that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2012. Section 3401(e) of the Affordable Care Act amended Section 1895(b)(3)(B) of the Social Security Act by adding a new clause (vi) which states, "After determining the home health market basket percentage increase ... the Secretary (of Health and Human Services) shall reduce such percentage ... for each of 2011, 2012, and 2013, by 1 percentage point." The home health market basket percentage increase for CY 2012 is 2.4 percent. However, after reducing it by 1 percentage point as required by the Affordable Care Act, the CY 2012 HH PPS payment update percentage becomes 1.4 percent.

In addition, Section 1895 (b)(3)(B)(v) of the Social Security Act requires that Home Health Agencies (HHAs) report such quality data as determined by the Secretary. HHAs that do not report the required quality data will receive a 2 percent reduction to the home health market basket percentage increase of 2.4 percent. That percentage (0.4 percent) is further reduced by 1 percentage point as required by the Affordable Care Act, for a final HH PPS payment update of -0.6 percent for CY 2012 for HHAs that do not report the required quality data.

In addition, Section 3131(c) of the Affordable Care Act amended Section 421(a) of the Medicare Modernization Act (MMA), which was amended by Section 5201(b) of the Deficit Reduction Act. The amended Section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Social Security Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Social Security Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

### Policy updates for CY 2012

#### 1. Market basket update

The home health market basket percentage increase for CY 2012 is 2.4 percent. After reducing it by 1 percentage point as required by the Affordable Care Act, the CY 2012 HH PPS payment update percentage

*continued on next page*

Home...continued

becomes 1.4 percent. HHAs that do not report the required quality data will receive a 2 percent reduction to the home health market basket update of 2.4 percent, further reduced by 1 percentage point per the Affordable Care Act, for a final HH PPS payment update of -0.6 percent for CY 2012.

**2. Outlier payments**

Section 3131(b) of the Affordable Care Act requires the following outlier policy:

- Target to pay no more than 2.5 percent of estimated total payments for outliers and
- Apply a 10 percent agency-level cap on outlier payments as a percentage of total HH PPS payments.

For CY 2012 and subsequent calendar years, the total amount of the additional payments or payment adjustments made may not exceed 2.5 percent of the total payments projected or estimated to be made based on the PPS in that year as required by Section 1895(b)(5)(A) of the Social Security Act as amended by Section 3131(b)(2)(B) of the Affordable Care Act. Per Section 3131(b)(2)(C) of the Affordable Care Act, outlier payments to HHAs will be capped at 10 percent of that HHA's total HH PPS payments.

The fixed dollar loss ratio of 0.67 and the loss-sharing ratio of 0.80, used to calculate outlier payments for CY 2011, remain unchanged for CY 2012.

**3. Rural add-on**

As stipulated in Section 3131(c) of the Affordable Care Act, the 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and non-routine medical supply (NRS) conversion factor when home health services are provided in rural (non-core based statistical area (CBSA)) areas.

**4. Payment calculations and rate tables**

In order to calculate the CY 2012 national standardized 60-day episode payment rate, CMS will update the payment amount by the CY 2012 HH PPS payment update percentage of 1.4 percent (the 2.4 percent home health market basket update percentage minus 1 percentage point, per Section 3401(e)(2) of the Affordable Care Act).

CMS' updated analysis of the change in case-mix that is not due to an underlying change in patient health status reveals additional increase in nominal change in case-mix. Therefore, CMS will next reduce rates by 3.79 percent resulting in an updated CY 2012 national standardized 60-day episode payment rate. The updated CY 2012 national standardized 60-day episode payment rate for an HHA that submits the required quality data is shown in Table 1. These payments are further adjusted by the individual episode's case-mix weight and wage index.

**Table 1** – for HHAs that do submit quality data – national 60-day episode amounts updated by the home health market basket update for CY 2012 before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary

Total CY 2011 national standardized 60-day episode payment rate	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	Reduce by 3.79% for nominal change in case-mix	CY 2012 national standardized 60-day episode payment rate
\$2,192.07	X 1.014	X 0.9621	\$2,138.52

The updated CY 2012 national standardized 60-day episode payment rate for an HHA that does not submit the required quality data is subject to a HH PPS payment update percentage of 1.4 percent reduced by 2 percentage points as shown in Table 2. These payments are further adjusted by the individual episode's case-mix weight and wage index.

**Table 2** – For HHAs that do not submit quality data – national 60-day episode payment amount updated by the home health market basket update (minus 2 percentage points) for CY 2012 before case-mix adjustment and wage adjustment based on the site of service for the beneficiary

continued on next page



Home...continued

<b>CY 2011 national standardized 60-Day episode payment rate</b>	<b>Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)</b>	<b>Reduce by 3.79 percent for nominal change in case-mix</b>	<b>CY 2012 national standardized 60-day episode payment rate.</b>
\$2,192.07	x 0.994	X 0.9621	\$2,096.34

In calculating the CY 2012 national per-visit rates used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations, the CY 2011 national per-visit rates are updated by the CY 2012 HH PPS payment update percentage of 1.4 percent for HHAs that submit quality data, and by 1.4 percent minus 2 percentage points (-0.6 percent) for HHAs that do not submit quality data.

The CY 2012 national per-visit rates per discipline are shown in Table 3. The six HH disciplines are as follows:

- Home health aide (HH aide);
- Medical social services (MSS);
- Occupational therapy (OT);
- Physical therapy (PT);
- Skilled nursing (SN); and
- Speech language pathology therapy (SLP).

**Table 3** – national per-visit amounts for LUPAs (not including the LUPA add-on amount for a beneficiary’s only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the HH PPS payment update percentage, before wage index adjustment

Home health discipline type	CY 2011 per-visit amounts per 60-day episode	For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
		Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	CY 2012 per-visit payment	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)	CY 2012 per-visit payment
HH Aide	\$50.42	X 1.014	\$51.13	X 0.994	\$50.12
MSS	\$178.46	X 1.014	\$180.96	X 0.994	\$177.39
OT	\$122.54	X 1.014	\$124.26	X 0.994	\$121.80
PT	\$121.73	X 1.014	\$123.43	X 0.994	\$121.00
SN	\$111.32	X 1.014	\$112.88	X 0.994	\$110.65
SLP	\$132.27	X 1.014	\$134.12	X 0.994	\$131.48

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. The CY 2012 LUPA add-on payment is updated in Table 4.

continued on next page

Home...continued

**Table 4 – CY 2012 LUPA add-on amounts**

	For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
CY 2011 LUPA add-on amount	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	CY 2012 LUPA add-on amount	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)	CY 2012 LUPA add-on amount
\$93.31	X 1.014	\$94.62	X 0.994	\$92.75

Payments for NRS are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. The NRS conversion factor for CY 2012 payments is updated in Table 5a.

**Table 5a – CY 2012 NRS Conversion factor for HHAs that do submit the required quality data**

CY 2011 NRS conversion factor	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	CY 2012 NRS conversion factor
\$52.54	X 1.014	\$53.28

The payment amounts for the various NRS severity levels based on the updated conversion factor from Table 5a, above, are shown in Table 5b.

**Table 5b – relative weights for the 6-severity NRS system for HHAs that do submit quality data**

Severity level	Points (Scoring)	Relative weight	NRS payment amount
1	0	0.2698	\$14.37
2	1 to 14	0.9742	\$51.91
3	15 to 27	2.6712	\$142.32
4	28 to 48	3.9686	\$211.45
5	49 to 98	6.1198	\$326.06
6	99+	10.5254	\$560.79

The NRS conversion factor for HHAs that do not submit quality data is shown in Table 6a.

**Table 6a - CY 2012 NRS conversion factor for HHAs that do not submit the required quality data**

CY 2011 NRS conversion factor	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)	CY 2012 NRS conversion factor
\$52.54	X 0.994	\$52.22

The payment amounts for the various NRS severity levels based on the updated conversion factor from Table 6a, above, are shown in Table 6b.

continued on next page

Home...continued

**Table 6b** – relative weights for the 6-severity NRS system for HHAs that do not submit quality data

Severity level	Points (scoring)	Relative weight	NRS payment amount
1	0	0.2698	\$14.09
2	1 to 14	0.9742	\$50.87
3	15 to 27	2.6712	\$139.49
4	28 to 48	3.9686	\$207.24
5	49 to 98	6.1198	\$319.58
6	99+	10.5254	\$549.64

The 3 percent rural add-on, per Section 3131(c) of the Affordable Care Act, is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when home health services are provided in rural (non-CBSA) areas. Refer to Tables 7 thru 10b for these payment rates.

**Table 7** – CY 2012 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustment

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2012 national standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	Total CY 2012 national standardized 60-day episode payment rate	CY 2012 national standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	Total CY 2012 national standardized 60-day episode payment rate
\$2,138.52	X 1.03	\$2,202.68	\$2,096.34	X 1.03	\$2,159.23

**Table 8** – CY 2012 per-visit amounts for services provided in a rural area, before wage index adjustment

Home health discipline type	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
	CY 2012 per-visit rate For HHAs that DO submit quality data	Multiply by the 3 percent rural add-on	Total CY 2012 per-visit rate for rural areas	CY 2012 per-visit rate For HHAs that DO NOT submit quality data	Multiply by the 3 percent rural add-on	Total CY 2012 per-visit rate for rural areas
HH aide	\$51.13	X 1.03	\$52.66	\$50.12	X 1.03	\$51.62
MSS	\$180.96	X 1.03	\$186.39	\$177.39	X 1.03	\$182.71
OT	\$124.26	X 1.03	\$127.99	\$121.80	X 1.03	\$125.45
PT	\$123.43	X 1.03	\$127.13	\$121.00	X 1.03	\$124.63
SN	\$112.88	X 1.03	\$116.27	\$110.65	X 1.03	\$113.97
SLP	\$134.12	X 1.03	\$138.14	\$131.48	X 1.03	\$135.42

continued on next page

Home...continued

**Table 9** – total CY 2012 LUPA add-on amounts for services provided in rural areas

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2012 LUPA add-on amount for HHAs that DO submit quality data	Multiply by the 3 percent rural add-on	Total CY 2012 LUPA add-on amount for rural areas	CY 2012 LUPA add-on amount for HHAs that DO NOT submit quality data	Multiply by the 3 percent rural add-on	Total CY 2012 LUPA add-on amount for rural areas
\$94.62	X 1.03	\$97.46	\$92.75	X 1.03	\$95.53

**Table 10a** – total CY 2012 conversion factor for services provided in rural areas

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2012 conversion factor For HHAs that DO submit quality data	Multiply by the 3 percent rural add-on	Total CY 2012 conversion factor for rural areas	CY 2012 conversion factor for HHAs that DO NOT submit quality data	Multiply by the 3 percent rural add-on	Total CY 2012 conversion factor for rural areas
\$53.28	X 1.03	\$54.88	\$52.22	X 1.03	\$53.79

**Table 10b** – relative weights for the 6-severity NRS system for services provided in rural areas

Severity level	Points (scoring)	For HHAs that DO submit quality data (NRS conversion factor=\$54.88)		For HHAs that DO NOT submit quality data (NRS conversion factor=\$53.79)	
		Relative weight	Total NRS payment amount for rural areas	Relative weight	Total NRS payment amount for rural areas
1	0	0.2698	\$14.81	0.2698	\$14.51
2	1 to 14	0.9742	\$53.46	0.9742	\$52.40
3	15 to 27	2.6712	\$146.60	2.6712	\$143.68
4	28 to 48	3.9686	\$217.80	3.9686	\$213.47
5	49 to 98	6.1198	\$335.85	6.1198	\$329.18
6	99+	10.5254	\$577.63	10.5254	\$566.16

These changes are to be implemented through the home health pricer software found in the intermediary standard systems.

**Additional information**

The official instruction, CR 7657 issued to your FI, RHHI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2356CP.pdf>.

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

continued on next page

Home...continued

MLN Matters® Number: MM7657

Related Change Request (CR) #: 7657

Related CR Release Date: November 23, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2356CP

Implementation Date: January 3, 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.*

---

## Summary of policies in the CY 2012 MPFS final rule and the telehealth originating site facility fee payment amount

### Provider types affected

Physicians and non-physician practitioners who submit claims to Fiscal Intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs) are affected by this article.

### What you need to know

This article is based on change request (CR) 7671, which summarizes the policies in the calendar year (CY) 2012 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount for CY 2012. Please be sure that your staffs are aware of these changes.

### Background

The purpose of this article is to inform you about the CR 7671, which summarizes the policies in the CY 2012 Medicare physician fee schedule (MPFS) and announces the telehealth originating site facility fee payment amount. Section 1848(b)(1) of the Social Security Act requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians' services for the subsequent year.

- The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2011, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in CY 2012.
- The final rule (published in the *Federal Register* on November 28, 2011) addresses Medicare public comments on payment policies that were described in two separate proposed notices earlier this year:
  - The Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule (published in the *Federal Register* on June 6, 2011), and
  - The Medicare Program: Payment Policies under the Physician Fee Schedule and Other

Revisions to Part B for CY 2012 (published in the *Federal Register* on July 19, 2011).

- The final rule also addresses interim final values established in the CY 2011 MPFS final rule with comment period (published in the *Federal Register* on November 29, 2010).
- Finally, the final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2012 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 3, 2012.

### Updated policies

#### Summary of policies in the CY 2012 MPFS

##### Misvalued codes under the physician fee schedule

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule adopts coding changes and revisions to values for about 300 services that have been identified as misvalued, reducing payments for these services by approximately \$100 million. CMS also identified additional categories of services that may be misvalued, including some of the highest expenditure codes in each specialty that have not been reviewed in the past five years.

##### Multiple procedure payment reduction policy

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures performed on the same patient by the same physician or group practice in the same session, based on efficiencies in the practice expense (PE) and pre- and post-surgical physician work. Beginning on July 1, 2010, the Affordable Care Act increased

*continued on next page*

**MPFS...continued**

the established MPFS multiple procedure payment reduction (MPPR) for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session. For CY 2012, CMS is applying the MPPR to the professional component (PC) of certain diagnostic imaging services. The MPPR currently applies only to the technical component (TC). The procedure with the highest PC and TC payment would be paid in full. Beginning CY 2012, the PC payment will be reduced for subsequent procedures furnished to the same patient, by the same physician, in the same session. Although the final rule also applies this policy to procedures furnished to the same patient in the same session by physicians in the same group practice, CMS is not applying the imaging MPPR to group practices for 2012 due to operational considerations.

**Revisions to the practice expense geographic adjustment**

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice cost components of each of more than 7,000 types of physician services. The Affordable Care Act revised the methodology for calculating the PE GPCIs for CY 2010 and CY 2011 so that the employee compensation and rent components of the PE GPCIs reflect only one-half of the relative cost differences for each locality compared to the national average while CMS studied the changes that are being undertaken in the 2012 physician fee schedule final rule.

CMS is applying several changes to the GPCIs as a result of additional analyses conducted both in accordance with section 3102 (b) of the Affordable Care Act and commitments made in the CY 2011 final rule with comment period. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics specific to the offices of physicians industry to calculate the PE employee wage index. In addition, CMS is replacing the U.S. Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the 2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the “all other services” and “other professional expenses” Medicare Economic Index (MEI) categories. These changes result in very little change to the GPCIs and indicate that the data CMS has used to adjust for geographic variation is consistent and accurate. However, the expiration of statutory provisions,

including a floor of 1.0 for the work GPCI and the limited recognition of cost differences for employee wage and office rent in the PE GPCI, will result in some payment reductions in the areas that benefitted from them in 2010 and 2011. Congress may choose to extend one or both of these provisions for CY 2012 subsequent to the release of this CR. In the event that Congress decides to extend either of these provisions for CY 2012, CMS will update the GPCIs for all impacted areas appropriately.

CMS is additionally basing the GPCI cost share weights on the revised and rebased 2006 MEI finalized by OACT in the CY 2011 final rule with comment period. CMS opted not to adopt the 2006-based MEI for GPCI cost share weights in the 2011 final rule in response to public comments. CMS subsequently addressed many of these commenters concerns in the CY 2012 final rule through the changes that are described above.

The Institute of Medicine (IOM) also has been evaluating the accuracy of the geographic adjustment factors used for Medicare physician payment. Their first report released in full in September includes an evaluation of the accuracy of geographic adjustment factors for the hospital wage index and the GPCIs and the methodology and data used to calculate them. CMS already is implementing many of the IOMs recommendations through the revisions to the GPCIs adopted in the CY 2012 final rule with comment period. Some IOM recommended revisions to the GPCIs will require a change in law.

**Implementation of the 3-day payment window policy in wholly-owned or wholly-operated entities**

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) was enacted. Section 102 of this Act, entitled “Clarification of 3-Day Payment Window,” clarified when certain non-diagnostic services furnished to Medicare beneficiaries in the three days (or, in the case of a hospital that is not a subsection (d) hospital, (e.g. psychiatric, inpatient rehabilitation, or long-term care) during the one day) preceding an inpatient admission should be considered “operating costs of inpatient hospital services” and therefore included in the hospital’s payment under the hospital inpatient prospective payment system (IPPS). This policy is generally known as the “3-day payment window,” and a hospital must include on the inpatient claim for a Medicare beneficiary’s inpatient stay, the technical portion of all outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

*continued on next page*

**MPFS...continued**

When a physician’s office or clinic that is wholly owned or wholly operated by a hospital furnishes a service subject to the 3 day payment window policy, Medicare will pay the professional component of services with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split. Once a physician’s office or practice has received confirmation of a beneficiary’s inpatient admission from the admitting hospital, it should, for services furnished during the 3 day payment window, append CMS payment modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days) to all claim lines for diagnostic services and for those non-diagnostic services that have been identified as related to the inpatient stay. The new modifier will be available for use on January 1, 2012, and CMS encourages wholly owned or wholly operated physician offices and entities to begin to use the modifier when services are subject to the 3 day payment window policy. CMS will delay implementation of the policy until July 1, 2012, so that physician’s offices and entities may coordinate their internal claims and payment practices. Physician non-diagnostic services that are unrelated to the hospital admission are not subject to the payment window and should be billed without the payment modifier.

**Annual wellness visit providing a personalized prevention plan**

The Affordable Care Act provided for Medicare coverage for an Annual Wellness Visits (AWV) providing personalized prevention plan services. The statute required that a Health Risk Assessment (HRA) be included and taken into account in the provision of personalized prevention plan services as part of the annual wellness visit. As a result, CMS included the HRA as a part of the AWV.

The Centers for Disease Control and Prevention (CDC) published “A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries.” This framework includes sections on:

- History of health risk assessments,
- Defining the HRA framework and rationale for its use
- Use of HRAs and follow-up interventions that evidence suggests can influence health behaviors; and
- A suggested set of HRA questions.

As discussed in the preamble to the CY 2012 physician fee schedule final rule, we believe it is

important that health professionals have the flexibility to address additional topics as appropriate, based on patient needs, consistent with the final rule. Thus, there is not only one type of HRA that will meet the CDC guidelines.

CMS is providing payment for the AWV through the same Level II HCPCS codes as were used in CY 2011 and is adjusting the payment rate for these HCPCS codes to accommodate the additional physician office staff time that is expected to be expended in assisting a beneficiary with the completion of the HRA.



**Molecular pathology procedure codes**

Beginning January 1, 2012, there will be 101 additional molecular pathology procedure codes released by the American Medical Association (AMA). However, each of these new molecular pathology procedure codes represents a test that is currently being furnished and which may be billed to Medicare. When these types of tests are billed to Medicare, the existing CPT codes are “stacked”, or billed in combination with each other, to represent one given test. Under the new CPT coding structure for these molecular pathology services, a physician or laboratory would bill Medicare the new, single CPT procedure code that corresponds to the test represented by the “stacked” codes rather than billing each component of the test separately. CMS notes that not all of the current “stacked” molecular pathology CPT codes represent physicians’ services paid on the physician fee schedule (PFS); many are only payable on the clinical laboratory fee schedule (CLFS).

For payment purposes under the PFS and CLFS, these 101 new molecular pathology procedure codes will be assigned a MPFS procedure status indicator of “B” (Bundled Code). Payments for covered services are always bundled into payment for other services

*continued on next page*

**MPFS...continued**

not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (for example, a telephone call from a hospital nurse regarding care of a patient)). While these services would traditionally be assigned a procedure status indicator of "I" (Not Valid for Medicare purposes Medicare uses another code for the reporting of, and the payment for these services.), assigning these CPT codes a procedure status of B will allow CMS to gather claims information important to evaluating eventual pricing of these new molecular pathology CPT codes.

To that end, as of January 1, 2012, Medicare requests that Medicare claims for molecular pathology procedures reflect both the existing "stacked" CPT codes that are required for payment and the new single CPT code that would be used for payment purposes if the new CPT codes were active. While the allowed charge amount will be \$0.00 for the new molecular pathology procedure codes that carry the procedure status indicator of B, Medicare requests that Medicare claims also reflect a charge for the non-payable service. Please note that these CPT codes are listed in the CY 2012 PFS final rule as having a procedure status indicator of I--the CY 2012 final rule text and accompanying files will be corrected to reflect the procedure status indicator of B for these 101 molecular pathology CPT codes.

**Telehealth services**

CMS is adding smoking and tobacco cessation counseling to the list of Medicare telehealth services. These services are similar to other services, such as kidney disease education (KDE) counseling services and medical nutrition therapy (MNT) services, already on the telehealth list. In addition, CMS is changing the criteria for adding codes to the list of Medicare telehealth services under the "category 2" methodology ("category 1" are services that are similar to services already on the telehealth list). Currently, CMS requires evidence of similar diagnostic findings or therapeutic interventions of a requested service via telehealth to an in-person service prior to adding it to the telehealth list under category 2. In the 2012 final rule with comment period, CMS eases the standard by no longer requiring telehealth services to demonstrate equivalence to the same service provided face-to-face and instead requires that the service demonstrate clinical benefit when furnished through telehealth.

The refined category 2 review criteria are effective for services requested to be added to the telehealth benefit beginning in CY 2013.

**Telehealth originating site facility fee payment amount**

Section 1834(m) of the Social Security Act established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased, as of the first day of the year, by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for CY 2012 is 0.6 percent.

For CY 2012, the **payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or \$24.24.** The beneficiary is responsible for any unmet deductible amount or coinsurance.

**Additional information**

For more information and access to the CY 2012 Final Rule, go to the "Physician Fee Schedule" available at [http://www.cms.gov/PhysicianFeeSched/01\\_Overview.asp#TopOfPage](http://www.cms.gov/PhysicianFeeSched/01_Overview.asp#TopOfPage). The official instruction, CR7671, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2371CP.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: MM7671 Revised  
 Related Change Request (CR) #: 7671  
 Related CR Release Date: January 4, 2012  
 Effective Date: January 1, 2012  
 Related CR Transmittal #: R2371CP  
 Implementation Date: January 3, 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.*



## Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2011, must be paid before the end of business on March 31, 2011.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page <http://fms.treas.gov/prompt/rates.html> for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

### **The new rate of 2.0 percent is in effect through June 30, 2012.**

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

**Note:** The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Source: Publication 100-04, Chapter 1, Section 80.2.2

### Find fees faster: Try FCSO's fee schedule lookup

Find the fee schedule information you need fast – with FCSO's fee schedule lookup, located at [http://medicare.fcso.com/Fee\\_lookup/fee\\_schedule.asp](http://medicare.fcso.com/Fee_lookup/fee_schedule.asp). This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

## MAC J9 Part A improper payments and inpatient prepayment medical review

As the Medicare administrative contractor (MAC) for jurisdiction 9 (J9), First Coast Service Options Inc. (FCSO) is committed to assisting the Centers for Medicare & Medicaid Services (CMS) in reaching the goal of reducing the national Medicare fee-for-service (FFS) paid claims error rate. Although FCSO has been successful in maintaining exceptional Part A error rates in the past, there are challenges that are impacting FCSO's ability to achieve CMS' current error rate reduction goal. As reflected in CMS' November 15, 2011, press release ([http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp)), the overall national improper payment rate was 8.6 percent with an inpatient hospital payment error rate of 7.9 percent. The projected November 2011 MAC J9 overall Part A error rate and inpatient hospital specific error rate are significantly higher than the national rates and are driven by J9 hospitals (with the exception of Puerto Rico and U.S. Virgin Islands hospitals). The purpose of this article is to provide additional information regarding J9 payment errors, including insight into the reasons for these errors.

Throughout 2011, FCSO has conducted an aggressive provider outreach approach and has performed significant prepayment medical record reviews related to Medicare severity-diagnosis-related-group (MS-DRG) services in an effort to reduce the MAC J9 Part A paid claims error rate.

FCSO's provider education and outreach has included:

- Numerous articles (please refer to references below)
- 13 hospital onsite sessions which represented 43 unique facilities
- Three webcasts
- Three face-to-face educational sessions during FCSO's Medifest symposium
- Four association meetings
- 42 provider-specific letters to targeted hospitals, providing detailed hospital specific error rate information

In addition to education and outreach efforts, FCSO provided notice to the provider community and implemented prepayment medical record review for targeted MS-DRGs (see MS-DRG breakdown below) throughout 2011. Unfortunately, the number of comprehensive error rate testing (CERT) findings show that error rates related to inpatient admissions are not improving and that high-dollar MS-DRG medical necessity denials involving surgical procedures and short-stay MS-DRG admissions

were driving J9 payment errors. Therefore, FCSO continued to partner with key stakeholders to provide open communication and published an article in the November 2011, Part A publication (see article references below), which provided notice regarding upcoming additional prepayment medical review for 15 targeted MS-DRGs. As noted in the November article, FCSO plans to take a staggered approach to implementing additional prepayment edits. As Part A errors significantly decrease for the MS-DRGs identified in the J9 prepayment error prevention strategy, prepayment medical review of those MS-DRGs will be decreased or discontinued. Also, as individual providers' performance shows consistent compliance with requirements, which results in low error rates, those providers will be removed from prepayment medical review of the applicable MS-DRG code(s). FCSO will continue to educate hospitals with persistent high error rates. If a provider fails to correct their compliance issues and billing practices, it may lead to 100 percent review for high error-prone MS-DRGs.

FCSO will continue to provide education and feedback on the prepayment review process and will partner with associations, medical societies, and provider groups in order to successfully lower the error rates. Hospitals should consider this information when evaluating internal coding and billing processes. Hospitals should also work with the physicians associated with these services to ensure they have a clear understanding of inpatient level of care requirements and the importance of documentation to support the medical necessity of services (particularly medical necessity for procedures and any related national coverage determination (NCD) and/or local coverage determination (LCD) requirements). FCSO will continue to provide outreach and education to the physician associations and Part B providers associated with high payment error risk MS-DRG services.

Effective February 1, 2012, FCSO will also perform post-payment review/recoupment of the admitting physician's and/or surgeon's Part B services. For services related to inpatient admissions that are denied because they do not meet an inpatient level of care (i.e., services could have been provided in a less intensive setting such as outpatient or observation), FCSO will review the hospital record and if the physician service was reasonable and necessary just not at an inpatient level of care, the service will be recoded to the appropriate outpatient evaluation and management service. For services where the patient's

*continued on next page*

**Prepayment...continued**

history and physical (H&P), physician's progress notes or other hospital record documentation does not support the medical necessity for performing the procedure, postpayment recoupment will occur for the performing physician's Part B service.

The following provides detailed information related to MS-DRG services currently on FCSO's prepayment medical review MS-DRG strategy. The MAC J9 CERT payment error findings are included for claims sampled in the November 2010 and November 2011 report periods. Denial information is also provided for those services previously subject to FCSO medical review activities.

**226 – Cardiac defibrillator implant without (w/o) cardiac catheter with (w/) major complications or comorbidities (MCC); Applicable NCD: 20.4**

CERT error findings:

- 60 percent did not meet the NCD criteria for the procedure, and the admission was not medically reasonable and necessary for an inpatient level of care
- 20 percent did not meet the NCD criteria for the procedure, but the admission was reasonable and necessary, and the patient met inpatient level of care. The admission was allowed with a revised MS-DRG code after removal of the denied procedure
- 20 percent met the NCD criteria and inpatient level of care, but the MS-DRG was re-coded based on complications or comorbidities

**227 – Cardiac defibrillator implant w/o cardiac catheter w/o MCC; Applicable NCD: 20.4**

CERT error findings:

- 70 percent met the NCD criteria for the procedure, but the admission was not reasonable and necessary for an inpatient level of care
- 20 percent did not meet the NCD criteria for the procedure, and the admission was not reasonable and necessary for an inpatient level of care
- 10 percent did not meet the NCD criteria for the procedure, but the admission was reasonable and necessary for an inpatient level of care. The admission was allowed with a revised MS-DRG code after removal of the denied procedure

**242 – Permanent cardiac pacemaker implant with MCC; Applicable NCD: 20.8**

CERT error findings:

- 86 percent did not meet the NCD criteria for the procedure, but the admission was reasonable

and necessary for an inpatient level of care. The admission was allowed with a revised MS-DRG code after removal of the denied procedure

- 14 percent did not meet the NCD criteria for the procedure, and the admission was not reasonable and necessary for an inpatient level of care.

**243 – Permanent cardiac pacemaker implant with CC; Applicable NCD: 20.8**

CERT error findings:

- 100 percent did not meet the NCD criteria for the procedure, but the admission was reasonable and necessary for an inpatient level of care. The admission was allowed with a revised MS-DRG code after removal of the denied procedure

**244 – Permanent cardiac pacemaker implant w/o CC or MCC; Applicable NCD: 20.8**

CERT error findings:

- 69 percent did not meet the NCD criteria for the procedure, but the admission was reasonable and necessary for an inpatient level of care. The admission was allowed with a revised MS-DRG code after removal of the denied procedure
- 19 percent did not meet the NCD criteria for the procedure, and the admission was not reasonable and necessary for an inpatient level of care.
- 6 percent met the NCD criteria for the procedure, and the admission was reasonable and necessary for an inpatient level of care; however, there was miscoding in the DRG and the service was recoded
- 6 percent met the NCD criteria for the procedure, but the admission was not reasonable and necessary for an inpatient level of care.

**245 – Automatic implantable cardiac defibrillator (AICD) generator procedures; Applicable NCD: 20.4**

CERT error findings:

- 100 percent met the NCD criteria for the procedure, but the admission was not reasonable and necessary for an inpatient level of care.

**247 – Percutaneous cardiovascular procedure with drug-eluting stent w/o MCC; Applicable NCD: 20.7**

CERT error findings:

- 100 percent met the NCD criteria for the procedure, but the admission was not reasonable and necessary for an inpatient level of care

**251 – Percutaneous cardiovascular procedure w/o coronary artery stent w/o MCC; Applicable NCD: 20.7**

*continued on next page*

**Prepayment...continued**

CERT error findings:

- 100 percent met the NCD criteria for the procedure, but the admission was not reasonable and necessary for an inpatient level of care

**253 – Other vascular procedures with CC;**

Applicable NCD: N/A

CERT error findings:

- There were no MAC J9 error findings; however, nationally, most services were denied as the admission was not reasonable and necessary for an inpatient level of care

**264 – Other circulatory system O.R. procedures;**

Applicable NCD: N/A

CERT error findings:

- In 100 percent of these cases, the procedure was reasonable and necessary, but the admission was not reasonable and necessary for an inpatient level of care

**287 – Circulatory disorders except acute myocardial infarction (AMI), with cardiac catheter w/o MCC; Applicable NCD: 20.7**

CERT error findings:

- In 80 percent of these cases, the procedure was reasonable and necessary, but the admission was not reasonable and necessary for an inpatient level of care
- In 20 percent of these cases, the procedure was not considered reasonable and necessary, and the admission was not reasonable and necessary for an inpatient level of care

**313 – Chest pain; Applicable NCD: N/A**

CERT error findings:

- 100 percent were denied as the admission was not reasonable and necessary for an inpatient level of care

FCSO prepayment review findings:

- 30 percent prepayment edit implemented on March 1, 2011, with an 81.6 percent denial rate to date
- Most were denied as the admission was not reasonable and necessary for an inpatient level of care

**392 – Esophagitis, gastroenteritis, and miscellaneous digestive disorders w/o MCC;**

Applicable NCD: N/A

CERT error findings:

- 100 percent were denied as the admission was not reasonable and necessary for an inpatient level of care

**458 – Spinal fusion except cervical with spinal curve/malign/infection or 9+ fusions w/o CC/MCC**  
Applicable NCD: N/A; Applicable LCD: Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L32074)

CERT error findings:

- In 100 percent of these cases, the procedure was reasonable and necessary, but the admission was not reasonable and necessary for an inpatient level of care (the billed spinal fusion procedure code was not on the inpatient-only list)

**460 – Spinal fusion except cervical w/o MCC;**  
Applicable NCD: N/A; Applicable LCD: Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L32074)

CERT error findings:

- In 60 percent of these cases, the documentation did not support that the procedure was reasonable and necessary
- In 20 percent of these cases, the procedure was reasonable and necessary, but there was no physician's order for admission
- In 20 percent of these cases, the procedure was reasonable and necessary, but the admission was not reasonable and necessary for an inpatient level of care (the billed spinal fusion procedure codes were not on the inpatient-only list)

FCSO prepayment review findings:

- 30 percent prepayment edit implemented on June 23, 2011, with a 41 percent denial rate to date
- Most were denied as the documentation did not support that the procedure was reasonable and necessary

**470 – Major joint replacement or reattachment of lower extremity w/o MCC; Applicable NCD: N/A;**  
Applicable LCD: Major Joint Replacement (Hip and Knee) (L32078)

CERT error findings:

- In 92 percent of these cases, the documentation did not support that the procedure was reasonable and necessary
- In 8 percent of these cases, the procedure was reasonable and necessary, but the admission was not reasonable and necessary for an inpatient level of care (the billed knee replacement

*continued on next page*

**Prepayment...continued**

procedure code was not on the inpatient-only list)

FCSO prepayment review findings:

- 30 percent prepayment edit implemented on June 1, 2011, with a 62 percent denial rate to date
- Most were denied as the documentation did not support that the procedure was reasonable and necessary

**490 – Back and neck procedures except spinal fusion with CC/MCC or disc device/neurostimulator; Applicable NCD: N/A**

CERT error findings:

- In 100 percent of these cases, the procedure was reasonable and necessary, but the admission was not reasonable and necessary for an inpatient level of care

**552 – Medical back problems w/o MCC; Applicable NCD: N/A**

CERT error findings: N/A

FCSO prepayment review findings:

- 30 percent prepayment edit implemented on April 1, 2011, with a 70 percent denial rate to date
- Most were denied as the admission was not reasonable and necessary for an inpatient level of care

**641 – Miscellaneous disorders of nutrition, metabolism, fluids/electrolytes w/o MCC; Applicable NCD: N/A**

CERT error findings:

- 100 percent were denied as the admission was not reasonable and necessary for an inpatient level of care

**NCD References:**

- *Medicare National Coverage Determinations Manual, Chapter 1, Part 1 (Sections 10 -- 80.12)*  
[http://www.cms.gov/manuals/downloads/ncd103c1\\_Part1.pdf](http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf)
  - NCD 20.4 – Implantable Automatic Defibrillators
  - NCD 20.7 – Percutaneous Transluminal Angioplasty (PTA)
  - NCD 20.8 – Cardiac Pacemakers

**LCD references:**

- Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L32074) – effective for dates of service on or after October 16, 2011
- Major Joint Replacement (Hip and Knee) (L32078) – effective for dates of service on or after October 16, 2011
- FCSO MAC J9 LCDs can be accessed through the FCSO Medicare provider website at the following address: <http://medicare.fcso.com/Landing/139800.asp>

**Recent related FCSO articles:**

- September 2011 (pages: 25-26) – [http://medicare.fcso.com/Publications\\_A/222510.pdf](http://medicare.fcso.com/Publications_A/222510.pdf)
- June 2011 (page 26) – [http://medicare.fcso.com/Publications\\_A/209320.pdf](http://medicare.fcso.com/Publications_A/209320.pdf)
- April 2011 (page 24) – [http://medicare.fcso.com/Publications\\_A/202150.pdf](http://medicare.fcso.com/Publications_A/202150.pdf)
- February 2011 (pages: 3 and 40) – [http://medicare.fcso.com/Publications\\_A/194857.pdf](http://medicare.fcso.com/Publications_A/194857.pdf)



## Off-cycle release of the IPPS FY 2012 Pricer

### Provider types affected

Hospitals that submit claims to Medicare contractors (fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC)) for services to Medicare beneficiaries are affected.

### What you need to know

This article is based on change request (CR) 7666, which informs Medicare contractors about corrections to make for several IPPS Pricer problems. Contractors will reprocess affected claims from October 1, 2011, through the implementation of the revised Pricer.

### Background

#### Pricer problems

The Centers for Medicare & Medicaid Services (CMS) was recently made aware of several inpatient prospective payment system (IPPS) Pricer problems that will be corrected by CR 7666.

- ICD-9-CM diagnosis code 191.5 was omitted from the FY 2012.0 IPPS Pricer list of diagnosis codes valid for the new technology add-on payment for AutoLITT™.
- Medical Severity Diagnosis Related Group (MS-DRG) code 009 was inadvertently included in the FY 2010 IPPS Pricer table of invalid MS-DRG codes. CR 7666 corrects the 2010 Pricer and is also correcting other minor changes to the table of invalid MS-DRG codes in the FY 2010, FY 2011, and FY 2012 Pricers.
- A problem was discovered with the revised FY 2003 and FY 2004 IPPS Pricers installed into the lump sum utility as instructed by CR7244. MM7244 discusses CR 7244 and is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7244.pdf>.

#### Corrective actions

CMS has instructed Medicare contractors to do the following to correct these Pricer problems:

- 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 4 (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.
- In addition to removing MS-DRG code 009 from the table of invalid MS-DRG codes in the FY 2010 IPPS Pricer, CMS is adding MS-DRG codes 014, 015, 888, 889, and 890 to the table.

- CMS is also adding MS-DRG codes 888, 889, and 890 to the table of invalid MS-DRG codes in the FY2011 IPPS Pricer.
- In the FY 2012 IPPS Pricer, CMS is adding MS-DRG codes 015, 888, 889 and 890, and removing MS-DRG codes 016, 017, 570, 571 and 572 from the table of invalid MS-DRG codes.
- As a result of a U.S. District Court decision, CMS was ordered to apply a revised labor-related share (LRS) percentage to IPPS claims with discharges during FY 2003 and FY 2004 for specified hospitals. To abide by the court order and provide a lump-sum payment to each of the affected hospitals, CMS instructed contractors in CR 7244 to run applicable claims through the “lump-sum payment utility” which included the revised FY 2003 and FY 2004 IPPS Pricer with the correct LRS percentage for applicable hospitals. CMS has corrected the FY 2003 and FY 2004 IPPS Pricers.
- Medicare contractors will identify claims with ICD-9-CM diagnosis code 191.5 and ICD-9-CM procedure code 17.61 with a discharge date on or after October 1, 2011 through January 1, 2012, and reprocess impacted claims.
- Claims that received Pricer Return Code 54/ Reason Code 37002 with MS-DRG 009 and a discharge date on or after October 1, 2009 through September 30, 2010 or a discharge date on or after October 1, 2011, will be accepted and processed when you bring such claims to the attention of your contractor after January 3, 2012.

### Additional information

The official instruction, CR 7666, issued to your FI and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2366CP.pdf>.

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

MLN Matters® Number: MM7666  
 Related Change Request (CR) #: 7666  
 Related CR Release Date: December 9, 2011  
 Effective Date: October 1, 2011  
 Related CR Transmittal #: R2366CP  
 Implementation Date: January 3, 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.*

## Correction – FY 2012 inpatient PPS PC Pricer

The fiscal year (FY) 2012 inpatient (INP) PPS PC Pricer has been corrected on the Centers for Medicare & Medicaid Services (CMS) website. If you use the FY 2012 INP PPS PC Pricer, please go to the CMS Web page at [http://www.cms.gov/PCPricer/03\\_inpatient.asp](http://www.cms.gov/PCPricer/03_inpatient.asp), and download the latest version. This PC Pricer is for claims dated from October 1, 2011, to September 30, 2012. The update is dated December 8, 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 201112-20

---

## Billing information for critical access hospitals paid under the optional method regarding primary care incentive payment program

Critical access hospital (CAH) providers were instructed to submit their National Provider Identifiers (NPIs) using the “other provider” field located in loop 2310C on the 4010A1 electronic claim format effective Friday, April 1, 2012.

With the implementation activities to convert from the Accredited Standards Committee (ASC X12) version 4010A1 to the version 5010A2 format, loop 2310C was redefined to mean “other operating physician”. For providers using the 837I 5010A2 format, the correct loop is 2310D, “rendering physician,” however, Medicare systems are not updated to assign primary care incentive payment program (PCIP) bonus payments to the NPI reported in this field. As a result, the Centers for Medicare & Medicaid Services (CMS) plans to update system and billing instructions to address this change.

In the meantime, to ensure there is not a delay in the PCIP bonus payments, providers shall continue to submit claims using the “other provider” field, loop 2310C rather than in loop 2310D until further notice from CMS.

Source: CMS PERL 201111-45

---

## New short-term PEPPER now available

A new release of the short-term (ST) acute care program for evaluating payment patterns electronic report (PEPPER), with statistics through the third quarter of fiscal year (FY) 2011, is available for short-term acute care hospitals nationwide as of Thursday, June 30. PEPPER files were distributed in late November 2011 through a My QualityNet secure file exchange to hospital QualityNet administrators and user accounts with the PEPPER recipient role. This release of PEPPER includes a new report, the “National High Outlier Ranking Report,” which ranks hospitals by the total number of high outliers as compared to all other hospitals in the nation. A new training session reviewing the new report is available at [PEPPERresources.org](http://PEPPERresources.org).

### About PEPPER

PEPPER provides hospital-specific data statistics for Medicare severity diagnosis-related groups and discharges at risk for improper payments. It is distributed by TMF® Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS). Visit [PEPPERresources.org](http://PEPPERresources.org) to access resources for using PEPPER, including [user's guides](#), recorded training sessions, information about QualityNet accounts, [frequently asked questions](#) and examples of how other hospitals are using PEPPER.

If you have questions or comments about PEPPER or need help obtaining your report, please visit the PEPPER help desk. You may provide your feedback or suggestions regarding the report through the PEPPER [feedback form](#).

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

Source: CMS PERL 201111-58

## Holding of specific long-term care hospital claims

A payment calculation problem affecting some long-term care hospital (LTCH) claims was discovered in the fiscal year (FY) 2012 LTCH Pricer. The Centers for Medicare & Medicaid Services (CMS) has corrected the problem and has reissued a revised Pricer. Until the corrected FY 2012 LTCH Pricer has been successfully installed, your claims administration contractor will hold new LTCH claims with a discharge date on or after Sunday, October 1. This is expected to occur no later than Monday, December 5. In addition, after the corrected FY 2012 LTCH Pricer has been installed, your contractor will automatically reprocess any affected FY 2012 LTCH claims processed before the corrected Pricer's installation.

Source: CMS PERL 201111-70

---

## Fact sheet updates from the *Medicare Learning Network*<sup>®</sup>

### **Sole Community Hospital fact sheet (ICN 006399) revised**

The revised [Sole Community Hospital](#) fact sheet (ICN 006399) includes the following information: sole community hospital (SCH) classification criteria, SCH payments, and hospital reclassifications.

### **Medicare Dependent Hospital fact sheet (ICN 901683) revised**

The revised [Medicare Dependent Hospital](#) fact sheet (ICN 901683) includes the following information: Medicare Dependent Hospital (MDH) classification criteria and MDH payments.

### **Hospital-Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPA) Hospitals fact sheet revised**

The revised [Hospital-Acquired Conditions \(HAC\) in Acute Inpatient Prospective Payment System \(IPPA\) Hospitals](#) fact sheet (ICN 901045) is designed to provide education on the Deficit Reduction Act of 2005 which requires a quality adjustment in Medicare severity diagnosis related group payment for certain hospital acquired conditions (HAC). This fact sheet lists all 10 categories of HAC to help providers learn more about the HAC program. It also provides an overview of DRA and types of affected and exempted hospitals and provides a table of HACs and codes.

### **Present on Admission (POA) Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals fact sheet available**

The [Present on Admission \(POA\) Indicator Reporting by Acute Inpatient Prospective Payment System \(IPPS\) Hospitals](#) fact sheet (ICN 901046) is designed to provide clarity for providers on how to apply the present on admission (POA) indicator to the final set of diagnosis codes that have been assigned in accordance with sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been added.

Source: CMS PERL 201112-07

---

## **Medicare Disproportionate Share Hospital fact sheet revised**

The revised [Medicare Disproportionate Share Hospital](#) fact sheet (ICN 006741) includes the following information: background; methods to qualify for the Medicare disproportionate share hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005 provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH payment adjustment formulas.

Source: CMS PERL 201112-34



## 2012 annual update to the therapy code list

### Provider types affected

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

### Provider action needed

This article is based on change request (CR) 7648, which updates the therapy code list for calendar year (CY) 2012 with one “always therapy” code 92618, *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)*. Please make sure your billing and coding staff are aware of this change.

### Background

The Social Security Act (Section 1834(k)(5); (see [http://www.ssa.gov/OP\\_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/*Current Procedural Terminology* 2012 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

CR 7648 updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2011 and 2012 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, Fourth Edition (HCPCS/CPT-4). The list of codes can be found at [http://www.cms.gov/TherapyServices/05\\_Annual\\_Therapy\\_Update.asp#TopOfPage](http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage) on the Centers for Medicare & Medicaid Services (CMS) website.

CR 7648 updates the therapy code list by adding one “always therapy” code for CY 2012 shown in the table below.

Therapy code	Descriptor
92618	<i>Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)</i>

### Additional information

The official instruction, CR 7648, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2350CP.pdf>.

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

MLN Matters® Number: MM7648

Related Change Request (CR) #: 7648

Related CR Release Date: November 18, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2350CP

Implementation Date: January 3, 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.*

## *Outpatient Rehabilitation Services: Complying with Documentation Requirements* fact sheet revised

The *Outpatient Rehabilitation Services: Complying With Documentation Requirements fact sheet (ICN 905365)* is designed to provide education on comprehensive error rate testing program errors related to outpatient rehabilitation therapy services. It includes information on the documentation needed to support a claim submitted to Medicare for outpatient rehabilitation therapy services.

Source: CMS PERL 201111-44

---

## 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 October provider data. The FY 2012 IRF PPS PC Pricer has also been added. The PC Pricers are ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at [http://www.cms.gov/PCPricer/06\\_IRF.asp](http://www.cms.gov/PCPricer/06_IRF.asp).

If you use the IRF PPS PC Pricers, please go to the page above and download the latest version of the FY 2011 (updated December 3, 2011) and FY 2012 IRF PC Pricers (posted December 5, 2011), in the Downloads section.

Source: CMS PERL 201112-06

---

## Corrected inpatient rehabilitation facility PPS PC Pricer

The fiscal year (FY) 2012 inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC Pricer has been corrected. The corrected FY 2012 IRF 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](http://www.cms.gov/PCPricer/06_IRF.asp).

If you use the IRF PPS PC Pricers, please go to the page above and download the latest version of the FY 2012 IRF PC Pricer posted December 6, 2011, in the Downloads section.

Source: CMS PERL 201112-10



## First results for new program to improve care for dialysis patients

The Centers for Medicare & Medicaid Services (CMS) released the first results for a new federal pay-for-performance or “value-based purchasing” program for dialysis facilities that is designed to give facilities payment incentives to improve the quality of care furnished to patients diagnosed with end-stage renal disease (ESRD). Nearly 70 percent of dialysis facilities that were evaluated under the program will receive no payment reduction in payment year (PY) 2012, while the remaining 30 percent will receive reductions ranging from 0.5 percent to 2.0 percent depending on their final performance scores.

The ESRD quality incentive program (QIP) evaluates dialysis facility performance on a set of quality measures which reflect key areas of dialysis care. Facilities that fail to meet the QIP performance standards during a performance year received a reduction in their payment rates for dialysis services under the ESRD prospective payment system (PPS) in the upcoming year.

Authorized by the Medicare Improvements for Patients and Providers Act of 2008, the ESRD QIP enables Medicare to pay dialysis facilities based on the quality of care provided to Medicare patients with ESRD, rather than simply based on the amount of care provided. This release includes quality data that reflects the performance of dialysis facilities in 2010 and is designed to complement existing CMS initiatives that seek to incentivize improved clinical outcomes by measuring the quality of care provided to Medicare patients on dialysis.

“The real purpose of value-based purchasing is to raise the bar on quality and that’s exactly what CMS is aiming to do for Medicare patients who have ESRD,” said CMS Acting Administrator Marilyn Tavenner. “This is one of many efforts CMS is making to drive quality improvement in all settings in communities across the country.”

### **For the PY 2012 program, CMS assessed a facility’s performance during 2010 on a total of three quality measures: two measures of anemia management and one of dialysis adequacy:**

- Percentage of Medicare patients with an average hemoglobin less than 10 grams per deciliter (g/dL) (low percentage desired)
- Percentage of Medicare patients with an average hemoglobin greater than 12 g/dL (low percentage desired)
- Percentage of Medicare patients with an average urea reduction ratio (URR) of at least 65 percent (high percentage desired)

For the first year of the ESRD QIP, the performance of each facility on each measure in 2010 was assessed

against the lesser of the performance “norm” for dialysis facilities across the country during 2008 or the facility’s own performance during 2007.

Facilities that fail to meet the performance standards will receive a Medicare payment reduction of up to 2 percent during 2012. Medicare patients, as well as their families and caregivers, will benefit from this program and will have access to the performance results through public reporting.

For the PY 2012 ESRD QIP, 4,939 facilities were assessed and received a total performance score, which determines if the facility met the requirements under the program and can avoid receiving a payment reduction. Of these facilities, over two-thirds (69.1 percent) will receive no payment reduction as a result of achieving a high enough total performance score, which for 2012 is 26 out of 30 points.

### **The payment reductions for the remaining facilities are as follows:**

- 16.6 percent will receive a 0.5 percent reduction
- 6.0 percent will receive a 1.0 percent reduction
- 7.7 percent will receive a 1.5 percent reduction
- 0.6 percent will receive a 2.0 percent reduction

An additional 625 facilities (11.2 percent of all facilities) did not receive a total performance score due to insufficient data. These facilities will not receive a payment reduction.

Each dialysis facility is required to post a certificate displaying its performance on the ESRD QIP measures in a prominent location accessible to the public. In addition, performance information will be posted on the Dialysis Facility Compare website (link below). CMS encourages Medicare beneficiaries to discuss these results with their dialysis care team and hopes that this information will help these patients to make informed decisions about their care.

“The ESRD QIP program’s overarching goal is the continual improvement of dialysis care provided to Medicare beneficiaries nationwide to drive better outcomes,” said Patrick Conway, M.D., Chief Medical Officer and Director of the CMS Office of Clinical Standards and Quality. “The ESRD QIP will evolve over time to include additional measures that promote high quality of care and outcomes for Medicare beneficiaries.”

The data for the PY 2012 ESRD QIP can be found at: <https://www.cms.gov/center/esrd.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 201112-38

## Recoupment of incorrect payments made under the ESRD PPS for the low-volume payment adjustment

### Provider types affected

End-stage renal disease (ESRD) providers submitting claims subject to the low-volume payment adjustment to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected by this article.

### What you need to know

This article is based on change request (CR) 7626, which notifies FIs and A/B MACs that they are to perform the necessary claim adjustments to rescind the low volume payment adjustment for ESRD facilities not meeting the criteria to receive the low-volume payment adjustment.

Medicare contractors must validate the ESRD facility's eligibility for the low volume adjustment. If a Medicare contractor determines that an ESRD facility has received the low volume adjustment in error, the contractor is required to adjust all of the ESRD facility's affected claims to remove the adjustment within six months of finding the error.

ESRD facilities subjected to recoupment of low-volume adjustment overpayments as a result of failing to meet the low-volume adjustment eligibility criteria will not be eligible to receive the low volume payment until it has met the eligibility criteria. Be sure to inform your billing staffs of these changes.

### Background

The Medicare Improvements for Patients and Providers Act (MIPPA) requires the implementation of an ESRD PPS, effective January 1, 2011, and requires that the ESRD PPS establish a low-volume payment adjustment. On August 12, 2010, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the final rule implementing the ESRD PPS (75 FR 49030). In the ESRD PPS final rule for calendar year (CY) 2011 (75 FR 49200), CMS finalized 42 CFR Section 413.232, which specifies the eligibility criteria for an ESRD facility to qualify for the low-volume payment adjustment. An ESRD facility is eligible for the low-volume payment adjustment only when it has met these criteria.

Each year, ESRD facilities will need to submit the low-volume attestation no later than November 1. However, for CY 2012, because the ESRD PPS final rule was not published in enough time to give the ESRD facilities notification of this mandatory deadline, CMS is extending the deadline to January 3, 2012. This will provide the FI or A/B MACs enough time to

perform low-volume eligibility verifications and update the applicable provider specific files for attestations received on or before that date, because the first claim submissions will not occur until early February 2012.

An ESRD facility that is subjected to recoupment of low-volume adjustment overpayments as a result of failing to meet the low-volume adjustment eligibility criteria will not be eligible to receive the low volume payment until it has met the eligibility criteria as specified in 42 CFR Section 413.232.

### Additional information

You may wish to review the criteria for a low volume facility and instructions on how to receive the ESRD low volume adjustment for low volume facilities by going to *MLN Matters*<sup>®</sup> article MM7388, "End Stage Renal Disease (ESRD) Low Volume Adjustment and Establishing Quarterly Updates to the ESRD Prospective Payment System (PPS)," available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7388.pdf>.

MLN article MM7064, "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services," is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf>.

More information on the ESRD PPS is available at [http://www.cms.gov/ESRDPayment/01\\_Overview.asp](http://www.cms.gov/ESRDPayment/01_Overview.asp).

The official instruction, CR 7626, issued to your FIs and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2347CP.pdf>.

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

MLN Matters<sup>®</sup> Number: MM7626  
 Related Change Request (CR) #: 7626  
 Related CR Release Date: November 18, 2011  
 Effective Date: January 1, 2012  
 Related CR Transmittal #: R2347CP  
 Implementation Date: January 3, 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.*

## Cost report filing extensions – independent renal dialysis facilities, form CMS 265-11

Form CMS 265-11 is effective for cost reporting periods that overlap or begin on or after Saturday, January 1, 2011, and are subject to the following filing extension schedule. The due date for cost reports ending Monday, January 31, through Thursday, June, 30, 2011, is extended until Tuesday, January 31, 2012. The due date for cost reports ending Sunday, July 31, 2011, and Wednesday, August 31, 2011, is extended until Wednesday, February 29, 2012.

Source: CMS PERL 201111-33

### Be proactive: Use the PDS report

- Identify negative billing patterns
- Benefit from peer comparisons
- Prevent recurring billing issues
- Improve your bottom line

Accessible through FCSO's PDS portal at <http://medicare.fcso.com/PDS/index.asp>

## Educational Events

### Upcoming provider outreach and educational events – January 2012

#### Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Rehabilitation Facility (ORF) coverage and billing (Part A)

**When:** Thursday, January 26

**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

#### Two easy ways to register

1. **Online** – Visit our provider training website at [www.fcsouniversity.com](http://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.fcsso.com](http://medicare.fcsso.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.fcsso.com](http://medicare.fcsso.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](http://www.fcsouniversity.com).

## Other Educational Resources

### Preventive services educational resources for health care professionals

#### Provider types affected

This *MLN Matters*® special edition articles is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide Medicare-covered preventive services to Medicare beneficiaries.

#### What you need to know

- Use this article as a reference to available educational resources related to Medicare-covered preventive services.
- Make each office visit an opportunity to encourage your patients to receive preventive services for which they are eligible.

#### Introduction

Medicare covers a wide variety of preventive services and screenings for eligible beneficiaries.

#### Educational products for health care professionals

The *Medicare Learning Network*® (MLN) offers a variety of educational products to help you understand coverage, coding, reimbursement, and billing information related to these services.

##### 1. *MLN preventive services products for health care professionals*

- The *Guide to Medicare Preventive Services, Fourth Edition* – this guide is designed to provide education on Medicare’s preventive benefits. It is available as a downloadable PDF at [http://www.cms.gov/MLNProducts/downloads/mps\\_guide\\_web-061305.pdf](http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf).
- *Quick Reference Information: Preventive Services* – this educational tool is designed to provide education on the Medicare-covered preventive services. It is available as a downloadable PDF at [http://www.cms.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf).
- *Quick Reference Information: Medicare Part B Immunization Billing* – this educational tool is designed to provide education on Medicare-covered preventive immunizations. It is available in print and as a downloadable PDF at [http://www.cms.gov/MLNProducts/downloads/qri\\_immun\\_bill.pdf](http://www.cms.gov/MLNProducts/downloads/qri_immun_bill.pdf). This product is also available in hardcopy as part of the *Quick Reference Information Resources* hardcopy booklet.

- *Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination* – this educational tool is designed to provide education on the initial preventive physical examination, also known as the IPPE. It is available as a downloadable PDF at [http://www.cms.gov/MLNProducts/downloads/MPS\\_QRI\\_IPPE001a.pdf](http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf).
- *Quick Reference Information: The ABCs of Providing the Annual Wellness Visit* – this educational tool is designed to provide education on the on the CMS website.
- *Annual Wellness Visit (AWV)*. It is available as a downloadable PDF at [http://www.cms.gov/MLNProducts/downloads/AWV\\_Chart\\_ICN905706.pdf](http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf).
- Preventive brochures and fact sheets – In addition, the MLN offers the following brochures and fact sheets:
  - *Annual Wellness Visit,*
  - *Bone Mass-Measurements,*
  - *Cancer Screenings,*
  - *Diabetes-Related Services,*
  - *Expanded Benefits,*
  - *Human Immunodeficiency Virus Screening,*
  - *Mass Immunizers and Roster Billing,*
  - *Preventive Immunizations, and*
  - *Tobacco-Use Cessation Counseling Services.*

To view the downloadable PDFs for these products, visit the Preventive Services Educational Products PDF page at [http://www.cms.gov/MLNProducts/Downloads/education\\_products\\_prevserv.pdf](http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf).

**Note:** To order hardcopy products, please visit the Preventive Services MLN Educational Products Web page at [http://www.cms.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.gov/MLNProducts/35_PreventiveServices.asp) and go to the “Related Links Inside CMS” section and select “MLN Product Ordering Page.”

- *MLN Preventive Services Educational Products Web page* – this *MLN* web page provides descriptions of all MLN preventive service-related educational products and resources designed specifically for Medicare FFS health

*continued on next page*

**Preventive...continued**

care professionals. This Web page is available at [http://www.cms.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.gov/MLNProducts/35_PreventiveServices.asp).

**2. Other CMS resources**

- Prevention General Information Overview Web page is available at <http://www.cms.gov/PrevntionGenInfo>.
- CMS Frequently Asked Questions are available at [http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std\\_alp.php?p\\_sid=I3ALEdhi](http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEdhi).

**3. Additional preventive services**

Under the Affordable Care Act, CMS has the authority to cover additional preventive services that meet certain criteria through the national coverage determination process. In addition to the websites above, please visit the CMS press release Web page at [http://www.cms.gov/apps/media/press\\_releases.asp](http://www.cms.gov/apps/media/press_releases.asp).

**Beneficiary information**

Please visit the Medicare.gov web page at <http://www.medicare.gov> for beneficiary-related information and resources you may share with your Medicare patients.

MLN Matters® Number: SE1142  
 Related Change Request (CR) #: NA  
 Related CR Release Date: NA  
 Effective Date: NA  
 Related CR Transmittal #: NA  
 Implementation Date: NA

*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.*

---

## December 4-10 is National Influenza Vaccination Week

**Get the flu vaccine, not the flu**

National Influenza Vaccination Week (NIVW) is a national observance that was established by the Centers for Disease Control and Prevention (CDC) in 2005 to highlight the importance of continuing influenza vaccination -- as well as fostering greater use of flu vaccine -- after the holiday season into January and beyond. For the 2011-



2012 season, NIVW is scheduled for December 4-10. This year's events will encourage everyone six months and older to "get the flu vaccine, not the flu."

Influenza is among the most common respiratory illnesses in the United States, infecting millions of people every flu season. An annual flu vaccination is the best way to prevent the flu and the flu-related complications that could lead to hospitalization and even death. Also, since flu viruses are constantly changing and immunity can decline over time, annual vaccination is needed for optimal protection.

Influenza can cause severe illness and even death for anyone, regardless whether or not they have high risk conditions. However, people with certain long-term

health conditions are at much greater risk of suffering from serious flu complications, as demonstrated last season when 80 percent of adults hospitalized from flu complications had a long-term health condition (asthma, diabetes, and chronic heart disease were the most common).

**What can you do?**

National Influenza Vaccination Week presents a great opportunity for healthcare providers to educate seniors and others with Medicare that a flu vaccine is the first and best way to prevent influenza, and that it's particularly important in people who are at higher risk of serious flu complications. It is also a great time to inform those with Medicare about other preventive services covered by Medicare that may be appropriate for them.

**Additional information**

- [The CMS Guide to Medicare Preventive Services](#)

*continued on next page*



**Influenza...continued**

- [Medicare Immunizations Billing Quick Reference Chart](#)
- [CMS Adult Immunizations Brochure](#)
- [Medicare Preventive Services Quick Reference Information Chart](#)
- [The CDC Vaccines and Immunizations Web Page](#)

**Remember:** The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-2012 Provider Seasonal Flu Resources](#) and [Immunizations](#). For the 2011-2012 seasonal flu vaccine payment limits, visit [http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10\\_VaccinesPricing.asp](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 201111-66

---

## Join CMS in observing the Great American Smokeout

The Centers for Medicare & Medicaid Services (CMS) would like Medicare providers to join in communicating the message of this year's Great American Smokeout, Thursday, November 17, 2011. The Great American Smokeout spotlights the dangers of tobacco use and the challenges of quitting, and has set the stage for change in social norms related to smoking – the leading cause of preventable disease and death in the United States – since 1977. Quitting smoking is the single most important action smokers can take to protect their own health and their families' health, as it can contribute to and worsen heart disease, stroke, lung disease, cancer, diabetes, hypertension, osteoporosis, macular degeneration, abdominal aortic aneurysms, and cataracts. Smoking harms nearly every organ of the body and generally diminishes the health of smokers.



Quitting tobacco use can be difficult, but Medicare can help through its coverage under Medicare Part B of tobacco-use cessation counseling for beneficiaries:

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

Medicare Part B covers two tobacco cessation counseling attempts (four intermediate or intensive sessions per attempt) per 12-month period. Both the coinsurance and deductible are waived. Medicare's Part D prescription drug benefit also covers smoking and tobacco-use cessation agents prescribed by a physician.

### What can you do?

Talk with your Medicare patients about the smoking and tobacco-use cessation benefits Medicare makes available to them. Encourage your patients to participate in national health observances such as the Great American Smokeout that for many can be a first step toward quitting tobacco use. It's never too late to quit smoking, and with the cessation benefits provided under Medicare, and your recommendation, you can help your patients become tobacco free and reduce their risk of suffering from smoking-related diseases. Encourage those eligible to take advantage of Medicare-covered smoking and tobacco-use cessation and counseling services.

### For more information:

[The Guide to Medicare Preventive Services for Healthcare Professionals \(see Chapter 15\)](#)

*continued on next page*

**Smokeout...continued**

[Medicare Preventive Services Quick Reference Information Chart](#)

["Counseling to Prevent Tobacco Use" MLN Matters article \(MM7133\)"](#)

[Tobacco-Use Cessation Counseling Services brochure](#)

[The MLN Preventive Services Educational Products Web page](#)

[The Great American Smokeout official Web page](#)

Thank you for joining with CMS to help increase awareness and educate about smoking, smoking and tobacco-use cessation, counseling, the Great American Smokeout, and related preventive health services now covered by Medicare.

Source: CMS PERL 201111-43

---

## ***Mass Immunizers and Roster Billing* fact sheet available**

The new [Mass Immunizers and Roster Billing](#) fact sheet (ICN 907275) is designed to provide education on mass immunizers and roster billing. It includes information on simplified billing procedures for the influenza and pneumococcal vaccinations.

Source: CMS PERL 201112-07

---

## **Tools to help people with Medicare and their caregivers compare health care options**

The Centers for Medicare & Medicaid Services (CMS) has created the [Quality Care Finder](#) as a collection of helpful tools on the [Medicare.gov](#) website to help consumers research their health care options. These online research tools can help your Medicare patients and their caregivers compare healthcare providers, facilities, health and drug plans, equipment suppliers and more.

[Quality Care Finder](#) includes the following tools:

- **Hospital Compare:** Compare Medicare-certified hospitals locally and throughout the country based on the quality of their care.
- **Nursing Home Compare:** Find Medicare-certified nursing homes and the special services each nursing home offers, like dementia care, ventilators or rehabilitation, then compare their star ratings and the quality of care they give.
- **Home Health Compare:** Find Medicare-certified home health agencies based on services like skilled nursing care, physical therapy, speech therapy and home health aides. Then, compare each home health agency based on the quality of their care.
- **Dialysis Facility Compare:** Find Medicare-certified dialysis facilities and their services. Then, compare each facility based on quality of care.
- **Physician Compare:** Find doctors, and other medical professionals, based on location, specialty, clinical training, foreign languages spoken, and more. Check to see if a doctor accepts the Medicare-approved amount as full payment.
- **Medicare Plan Finder:** Get detailed, personalized information about the cost and benefits of available Medicare health and drug plans, and compare the quality of the services they provide.

CMS has developed several publications about the [Quality Care Finder](#) tools that can be shared with your Medicare patients and their caregivers:

- [Find and Compare High-Quality Healthcare Options \(Pub. # 11580\)](#)
- [Quality Care Finder: Find High-Quality Healthcare Options \(Pub. # 11581\)](#)

These publications may be downloaded or ordered from the [Medicare.gov Publications](#) page.

Source: CMS PERL 201112-30

---

## Updates from the *Medicare Learning Network*<sup>®</sup> (MLN)

### “Contractor Entities At A Glance” educational tool available in hard copy

*The Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities* educational tool (ICN 906983) is designed to provide education on the definitions and responsibilities of entities involved in claims adjudication activities. It includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers, especially fee-for-service providers. To place an order for a hard-copy version, go to <http://www.CMS.gov/MLNProducts> and click on “MLN<sup>®</sup> Product Ordering Page” under “Related Links Inside CMS” at the bottom of the page.

### New fast fact on MLN<sup>®</sup> provider compliance Web page

A new fast fact on *MLN provider compliance* is now available. This Web page provides the latest educational products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new “fast fact” is added each month.

### Medicare billing certificate programs coming soon to the MLN<sup>®</sup>

*The Medicare Billing Certificate Program for Part A Providers* and *The Medicare Billing Certificate Program for Part B Providers* are coming soon to the MLN<sup>®</sup>. Learn about the Medicare program with a special focus on Medicare billing specific to your billing or provider type, and you’ll receive a certificate in Medicare billing from the Centers for Medicare & Medicaid Services (CMS). Look for these programs to become available in early 2012.

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

Source: CMS PERL 201111-57

---

## *Medicare Shared Savings Program: Notice of Proposed Rulemaking Fact Sheets* booklet discontinued

The *Medicare Shared Savings Program: Notice of Proposed Rulemaking Fact Sheets* booklet (ICN 907663) has been discontinued. To alleviate confusion, the *Medicare Learning Network*<sup>®</sup> (MLN) has decided to discontinue its recently-published booklet, which contained fact sheets that were issued at the time that the “Medicare Shared Savings Program (MSSP) notice of proposed rulemaking” was released.

However, the MLN has released several fact sheets on the final rule:

- [Accountable Care Organizations: What Providers Need to Know](#)
- [Improving Quality of Care for Medicare Patients: Accountable Care Organizations](#)
- [Advance Payment Accountable Care Organization \(ACO\) Mode](#)
- [Medicare Shared Savings Program and Rural Providers](#)
- [Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program](#)
- [Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program](#)

Source: CMS PERL 201112-34

---

## *Ambulance Fee Schedule* fact sheet revised

The revised *Ambulance Fee Schedule fact sheet* (ICN 006835) includes the following information:

- Background
- Ambulance providers and suppliers
- Ambulance services payments
- How payment rates are set

Source: CMS PERL 201111-65

---

## New podcast on the ‘Medicare Overpayment Collection Process’ released

The *Medicare Learning Network*® (MLN) has released the next in a series of podcasts designed to provide education on how to avoid common billing errors and comply with requirements of the Medicare program. The new “*Medicare Overpayment Collection Process*” podcast (ICN 907563), posted Thursday, December 8, 2011, is designed to provide education on the Medicare overpayment collection process. It includes information from the MLN® fact sheet titled *The Medicare Overpayment Collection Process*, which describes the collection of Medicare physician and supplier overpayments.

Visit the [MLN® Multimedia Web page](#) to download this and other podcasts from the MLN®. CMS also encourages providers to visit the [MLN® Provider Compliance Web page](#) for the latest educational products. This page is designed to help Medicare fee-for-service providers understand and avoid common billing errors and other improper activities identified through claim review programs. Stay tuned for future podcasts from the MLN®.

Source: CMS PERL 201112-34

---

## Medicare Fraud & Abuse: Prevention, Detection, and Reporting fact sheet revised

The *Medicare Fraud & Abuse: Prevention, Detection, and Reporting* fact sheet (ICN 0006827) is designed to provide education on preventing, detecting, and reporting Medicare fraud and abuse. It includes definitions of as well as information on laws, partnerships with other organizations, and resources for additional information.

Source: CMS PERL 201111-57

---

## Medicare Secondary Payer fact sheet

The *Medicare Secondary Payer fact sheet (ICN 006903)* is designed to provide education on the Medicare secondary payer (MSP) provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the coordination of benefits contractor.

Source: CMS PERL 201111-44

---

## CMS Electronic Mailing Lists fact sheet

The *CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed fact sheet (ICN 006785)* is designed to provide education on the various Centers for Medicare & Medicaid Services (CMS) fee-for-service (FFS) electronic mailing lists. It includes information about how to register for the service and receive the latest news regarding important FFS initiatives.

Source: CMS PERL 201111-44

### Discover your passport to Medicare training

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

Learn more on FCSO’s Medicare training website,  
[www.fcsouniversity.com](http://www.fcsouniversity.com).

## 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  
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)

DME, 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

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

#### 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](http://medicare.fcso.com)

#### Centers for Medicare & Medicaid Services

##### Providers:

[www.cms.gov](http://www.cms.gov)

##### Beneficiaries:

[www.medicare.gov](http://www.medicare.gov)