MEDICARE B Update!

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

The *Medicare B Update!* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued beginning in 1997 are available at no cost from our provider education websites which may be accessed at: *http://medicare.fcso.com/*.

Routing Suggestions:

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The *Medicare B Update!* is published monthly by First Coast Service Options Inc. (FCSO) Provider Outreach and Education Division, to provide timely and useful information to Medicare Part B providers.

Questions concerning this publication or its contents may be faxed to 1-904-361-0723.

Third-party websites:
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THE FCSO MEDICARE B UPDATE!

About the FCSO *Medicare B Update!*

The *Medicare B Update!* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Part B providers in Florida, Puerto Rico, and U.S. Virgin Islands.

The Provider Outreach & Education Publications team distributes the *Medicare B Update!* on a monthly basis.

Important notifications that require communication in between publications will be posted to the FCSO Medicare provider education website, *http://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Update?*

Anyone may view, print, or download the *Update!* from our provider education Web site(s). Providers who cannot obtain the *Update!* from the Internet are required to register with us to receive a complimentary hardcopy or CD-ROM.

Distribution of the *Update!* in hardcopy or CD-ROM format is limited to individual providers and professional association (PA) groups who have billed at least one Part B claim to FCSO Medicare for processing during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed registration form to us*. Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription in hardcopy or CD-ROM format (see order form in the back of this issue). All issues published since 1997 may be downloaded from the Internet, free of charge.

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

Publication format

The *Update!* is arranged into distinct sections.

Following the table of contents, an administrative information section, the *Update!* content information is categorized as follows.

- The **claims** section provides claim submission requirements and tips.
- The **coverage/reimbursement** section discusses specific *CPT* and HCPCS procedure codes. It is arranged by *categories* (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.
- The section pertaining to **electronic data interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **local coverage determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **general information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.

In addition to the above, other sections include:

- **Educational resources**, and
- **Addresses,** and **phone numbers**, and **websites** for Florida and the U.S. Virgin Islands.

The *Medicare B Update!* represents formal notice of coverage policies

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

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform the public about:

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

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

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

Providers may join the CMS-QPU listserv to ensure timely notification of all additions to the QPU.

Advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient. For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the CMS-R131form as part of the Beneficiary Notices Initiative (BNI) The ABNs are designed to be beneficiary-friendly, readable and understandable, with patient options clearly defined.

There are two ABN forms - the General Use form (CMS-R-131G) and the Laboratory Tests form (CMS-R-131L). Both are standard forms that *may not be modified*; however, both contain customizable boxes for the individual requirements of users. Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *http://www.cms.gov/BNI/01_overview.asp#TopOfPage.*

Note: Beginning March 3, 2008, providers (including independent laboratories), physicians, practitioners, and suppliers may use the revised ABN (CMS-R-131 [03/08]) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the existing ABN-G (CMS-R-131G), ABN-L (CMS-R-131L), and NEMB (CMS-20007). Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid. Additional information is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM6136.pdf*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier **GA** (waiver of liability statement on file) or **GZ** (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier **GZ** may be used in cases where a signed ABN is *not* obtained from the patient; however, when modifier **GZ** is billed, the provider assumes financial responsibility if the service or item is denied.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier **GA** (wavier of liability statement on file).

Failure to report modifier **GA** in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable **must** have the patient's ***written consent*** for an appeal. Refer to the Address, Phone Numbers, and Websites section of this publication for the address in which to send written appeals requests.

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.*

CLAIMS

Supplemental article regarding services rendered in place of service home

This article is intended for paper claims only.

Effective with implementation of change request 6947, you will be required to enter the address of where services were performed, including the ZIP code, on claims for anesthesia services and services payable under the Medicare physician fee schedule (MPFS), for services provided in all places of service, including home (12). The ZIP code will be used to determine the correct payment locality. This change is effective for claims processed on/after January 1, 2011. Claims not meeting this requirement will be returned as unprocessable.

Please note that claims not meeting the requirement that were received prior to January 1, 2011, but not processed until after January 1, 2011, will be returned as unprocessable.

For additional information, see the *MLN Matters* article at *http://www.cms.gov/MLNMattersArticles/downloads/mm6947.pdf*. You may also review CR 6947 at *http://www.cms.gov/Transmittals/downloads/R2041CP.pdf*.

Source: CR 6947

Reminder about important timely filing requirement information

If you are a Medicare fee-for-service (FFS) physician, provider, or supplier submitting claims to Medicare for payment, this is very important information you need to know. Effective immediately, any Medicare FFS claim with date of service on or after January 1, 2010, must be received by your Medicare contractor no later than one calendar year (12 months) from the date of service on the claim or Medicare will deny the claim.

If you have Medicare FFS claims with a service dates from October 1, 2009, through December 31, 2009, those claims must be received by December 31, 2010, or Medicare will deny them. Claims with services dates from January 1, 2009, to October 1, 2009, keep their original December 31, 2010, deadline for filing.

When claims for services require reporting a line item date of service, the line item date will be used to determine the date of service. Change request 7080, issued on July 30, 2010, clarified that for institutional claims containing claim level span dates of service (i.e., a "From" and "Through" date span on the claim), the "Through" date on the claim shall be used to determine the date of service for claims filing timeliness. Conversely, professional claims containing claim level span dates of service (i.e., a "From" and "Through" date span on the claim), the "From" date on the claim shall be used to determine the date of service for claim filing timeliness.

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

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

You may also listen to a podcast on this subject by visiting *http://www.cms.gov/CMSFeeds/02_listofpodcasts.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 201011-22

Website Welcome screen – bookmark feature

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

Ambulance

Air ambulance services

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

Provider types affected

Air ambulance providers submitting claims to fiscal intermediaries (FI), carriers, and Part A/B Medicare administrative contractors (MAC) are affected.

Provider action needed

This article is based on change request (CR) 7161, which updates Chapter 10, Section 10.4.6 of the *Medicare Benefit Policy Manual* to better describe special payment limitations for air ambulance services. No new policy is announced by CR 7161. Please ensure that your staffs are aware of this clarification.

Background

Section 10.4.6, Special Payment Limitations, of the *Medicare Benefit Policy Manual* has been updated and states that:

"If a determination is made to order transport by air ambulance, but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport.
If the air transport was medically appropriate (that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital."

Additional information

The official instruction, CR 7161, issued to your FI, carrier, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R133BP.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: MM7161
Related Change Request (CR) #: 7161
Related CR Release Date: October 22, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R133BP
Implementation Date: January 3, 2011

Ambulatory Surgical Center

2011 hospital outpatient and ambulatory surgical center rates

Final rule eliminates out-of-pocket costs for most preventive services

Medicare beneficiaries will see a decline in their out-of-pocket costs for services they receive in hospital outpatient departments (HOPDs) in calendar year (CY) 2011 under provisions in a final rule with comment period issued by the Centers for Medicare & Medicaid Services (CMS). The final rule with comment period updates payment rates and policies for services furnished in HOPDs and ambulatory surgical centers (ASCs), and implements changes required by the Affordable Care Act of 2010.

The Affordable Care Act, which was enacted as the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, waives beneficiary cost-sharing for most Medicare-covered preventive services, such as screening mammograms and screening colonoscopies. This means that, for most preventive services, beneficiaries will not have to satisfy their Part B deductible before Medicare will pay. In addition, for these services, beneficiaries will not have to pay their co-payment (typically 20 percent of the Medicare payment amount) for the physician's or the facility's portion of the service.

"We hope that by eliminating these out-of-pocket costs, more beneficiaries will make full use of their Medicare preventive benefits," said CMS administrator Donald Berwick, M.D. "We know that prevention, early detection and early treatment of diseases can promote better outcomes for patients and lower long-term health spending."

The changes are included in a final rule with comment period which applies updates to the policies and payment rates for covered outpatient department services furnished on or after January 1, 2011, by HOPDs in more than 4,000 hospitals that are paid under the outpatient prospective payment system (OPPS). The final rule with comment period also updates policies and payment rates for services in approximately 5,000 Medicare-participating ASCs, under a payment system that aligns ASC payments with payments for the corresponding services in HOPDs. CY 2011 is the first year the revised ASC payment system rates will be fully implemented based on the ASC standard rate-setting methodology. CMS projects total Medicare payments of approximately $39 billion to HOPDs and $4 billion to ASCs for CY 2011.

2011 hospital outpatient and ambulatory surgical center rates (continued)

The final rule with comment period also implements the direct and indirect graduate medical education (GME/IME) provisions of the Affordable Care Act. The law requires CMS to identify unused residency slots and redistribute them to certain hospitals with qualified residency programs, with a special emphasis on increasing the number of primary care physicians. The law also requires CMS to redistribute residency slots from certain closed hospitals and hospitals that close down to other teaching hospitals, giving preference to hospitals in the same or a contiguous area as the closed hospital. In addition, the law specifies how hospitals should count hours a resident spends in certain training and research activities, and in patient care activities in a nonhospital setting, such as a physician's office.

This rule also implements a provision in the Affordable Care Act prohibiting the development of new physician-owned hospitals and the expansion of existing physician-owned hospitals.

The final rule with comment period will make several other significant changes in addition to those required by the Affordable Care Act. These changes include:

- Modifying a number of the supervision requirements for outpatient therapeutic services by:
    - Requiring direct physician supervision for only the initiation of certain services and allowing general supervision once the treating practitioner deems the patient medically stable. This two-tiered approach to supervision applies to a limited set of non-surgical extended duration services, including observation services.
    - Extending through CY 2011 the notice of non-enforcement regarding the direct supervision requirements for outpatient therapeutic services furnished in critical access hospitals (CAHs) and expanding the scope of the notice to include small rural hospitals with 100 or fewer beds.
    - Redefining direct supervision for all hospital outpatient services to require "immediate availability" without reference to the boundaries of a physical location.
- Committing to establish through future rulemaking an independent committee to consider on an annual basis industry requests for the assignment of supervision levels other than direct supervision for certain individual services and to make recommendations to the agency.
- Establishing four separate ambulatory payment classifications (APCs) for partial hospitalization programs (PHPs), two for community mental health center (CMHC) PHPs and two for hospital-based PHPs, while continuing to pay different per diem rates within each provider type depending on the number of PHP services provided each day; that is, one APC for three services and a separate one for four or more services.
- Paying for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status furnished in HOPDs at 105 percent of the manufacturers' average sales prices.
- Expanding the set of quality measures that must be reported by HOPDs to qualify for the full annual payment update factor. The final rule with comment period lists the measure set that will apply to the CY 2012, CY 2013, and CY 2014 payment updates. This new focus on a three year time period should assist hospitals in preparing for the changing reporting requirements and targeting their quality improvement efforts.

The CY 2011 OPPS/ASC final rule with comment period will appear in the Nov. 24, 2010, *Federal Register*. Comments on designated provisions are due by 5:00 p.m. ET on January 3, 2011. CMS will respond to comments in the CY 2012 OPPS/ASC final rule.

To view the rule and for more information on the final CY 2011 policies for the OPPS and ASC payment system, please see the CMS website at:

- OPPS: *http://www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?itemID=CMS1240960&*
- ASC payment system: *http://www.cms.gov/ASCPayment/ASCRN/itemdetail.asp?itemID=CMS1240939&*

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

Source: CMS PERL 201011-15

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/*.

Consolidated Billing

ESRD PPS and consolidated billing for limited Part B services

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

Note: This article was revised on November 18, 2010, to reflect the revised change request (CR) 7064 that was issued on November 17, 2010. CR 7064 was revised to reflect a revised end-stage renal disease (ESRD) PRICER layout, the deletion of several drugs, the identification of drugs that may be eligible for the ESRD outlier payment, to provide an additional list of laboratory tests that comprise the AMCC and to delete several laboratory tests. There were no changes in policy. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7064 were revised. All other information is the same. This information was previously published in the September 2010 *Medicare B Update!* pages 14-17.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment [DME] Medicare administrative contractors [MACs], fiscal intermediaries [FIs], and/or A/B MACs) for ESRD services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on CR 7064 which announces the implementation of an ESRD bundled prospective payment system (PPS) effective January 1, 2011.

Caution – what you need to know

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a four-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

Go – what you need to do

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the *Background* and *Additional information* sections of this article for further details regarding the ESRD PPS.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see *http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331*) requires the Centers for Medicare & Medicaid services (CMS) to implement an ESRD bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located
- Patient-level adjustments for case-mix
- An outlier adjustment (if applicable)
- Facility-level adjustments
- A training add-on (if applicable), and
- A budget neutrality adjustment during the transition period through 2013.

Patient-level adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier adjustment

ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

- ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B

ESRD prospective payment system and consolidated billing for limited Part B services (continued)

- ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B
- Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B, and
- Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level adjustments

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from core based statistical areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training add-on

Facilities that are certified to furnish training services will receive a training add-on payment amount of $33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments specific to pediatric patients

The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

ESRD PPS four-year phase-in period

The ESRD PPS provides ESRD facilities with a four-year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

The ESRD PPS four-year transition period blended rate determination

Calendar year	Blended rate
2011	75 percent of the old payment methodology, and 25 percent of new PPS payment
2012	50 percent of the old payment methodology, and 50 percent of the new PPS payment
2013	25 percent of the old payment methodology, and 75 percent of the new PPS payment
2014	100 percent of the PPS payment

For calendar year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

The ESRD PPS base rate is $229.63, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where:

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711. The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments
- Outlier adjustments
- Facility-level adjustments, and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

ESRD prospective payment system and consolidated billing for limited Part B services (continued)

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: Providers wishing to opt out of the transition period blended rate must notify their Medicare contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

Three new adjustments applicable to the adult rate

1. **Comorbid adjustments**: The new ESRD PPS provides for three categories of chronic comorbid conditions and three categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than four consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The three chronic comorbid categories eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia
   - Monoclonal gammopathy (in the absence of multiple myeloma), and
   - Myelodysplastic syndrome.

   The three acute comorbid categories eligible for a payment adjustment are:
   - Bacterial pneumonia
   - Gastrointestinal bleeding, and
   - Pericarditis.
2. **Onset of dialysis adjustment**: An adjustment will be made for patients that have Medicare ESRD coverage during their first four months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's common working file as provided on the CMS-2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.
3. **Low-volume facility adjustment**: Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year. The three years preceding treatment data should be reflected on the last two settled cost reports and the most recent must be filed. The provider must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment

Change in processing home dialysis claims

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate.

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility, and
- Will be processed as Method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the modifier AY.

Consolidated billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the modifier AY.

Other billing reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the modifier AY for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign group code CO.

ESRD prospective payment system and consolidated billing for limited Part B services (continued)

- All 72x claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp ® and ESRD-related epoetin alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, Section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2094CP.pdf*. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services
- Attachment 4, which is a list of DME ESRD supply HCPCS codes used in for ESRD PPS consolidated billing edits
- Attachment 5, which contains a list of DME ESRD Supply HCPCS codes that are NOT payable to DME suppliers
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes

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

MLN Matters® Number: MM7064 *Revised*
Related Change Request (CR) #: 7064
Related CR Release Date: November 17, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2094CP
Implementation Date: January 3, 2011

Durable Medical Equipment

Medicare DMEPOS rules to take effect in 2011

The Centers for Medicare & Medicaid Services (CMS) has announced that the following final rule is on display at the *Federal Register*: *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011*. The rule (CMS-1503-FC) may be viewed at *http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp*.

This final rule includes provisions regarding the following DMEPOS subjects that impact the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program:

- The establishment of an appeals process for competitive bidding contract suppliers that are notified that they are in breach of contract
- The subdivision of metropolitan statistical areas (MSAs) with populations over 8,000,000 into smaller competitive bidding areas (CBAs), in particular Chicago, New York, and Los Angeles
- The addition of 21 MSAs to the 70 MSAs already included in the Round 2 competitive bidding program, for a total of 91 MSAs
- The addition of the following policies affecting future competitions for diabetic testing supplies following Round 1:
  - Revision of the definition of a “mail order” item to include any item shipped or delivered to a beneficiary’s home, regardless of the method of delivery
  - Requirement that bidding suppliers demonstrate that their bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover at least 50 percent of the types of test strips products on the market

Medicare DMEPOS rules to take effect in 2011 (continued)

- Prohibition of contract suppliers from influencing or incentivizing beneficiaries to switch types of test strips or glucose monitors

- The exemption of off-the shelf orthotics from competitive bidding when provided by a physician to his or her own patients or a hospital to its own patients

- The elimination of the lump sum purchase option for standard power wheelchairs furnished on or after January 1, 2011, and adjustments to the amount of the capped rental payments for both standard and complex rehabilitative power wheelchairs

Appeals process

CMS finalized, in the final rule, an appeals process for suppliers who have been notified that they are in breach of their DMEPOS competitive bidding contract. Depending on the circumstances, suppliers initially will either be afforded a process for submitting a corrective action plan or request a hearing prior to termination of the contract. The appeals process will ensure that suppliers have appeal rights and that they receive an opportunity to be heard before their contract is terminated.

Subdivision of the metropolitan statistical areas

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) allows us to subdivide metropolitan statistical areas (MSAs) with populations over 8,000,000 into smaller CBAs. CMS will subdivide the three largest MSAs: Chicago-Naperville-Joliet, Ill.-Ind.-Wis.; Los Angeles-Long Beach-Santa Ana, Calif.; and New York-Northern New Jersey-Long Island, N.Y.-N.J.-Pa.. CMS finalized the regulation to subdivide MSAs along county lines as CMS believe county lines are well-defined and more static.

Addition of metropolitan statistical areas

The Affordable Care Act requires that CMS expand Round 2 of the competitively bidding program by adding an additional 21 of the largest MSAs based on total population to the original 70 already selected for Round 2. CMS have included this requirement in the regulation.

Diabetic testing supplies

MIPPA specifies that a national competition for mail order items and services is to be phased in after 2010. The regulation includes provisions to implement a national mail order competition for diabetic supplies in 2011 that includes all home deliveries while maintaining the local pharmacy pickup choice for beneficiaries. CMS are also implementing the special "50 percent rule" mandated by MIPPA and implementing an anti-switching requirement as part of the terms of the competitive bidding contract.

Exemption of off-the shelf orthotics

This regulation implements the MIPPA requirement to extend the competitive bidding exception to off-the shelf (OTS) orthotics furnished by: (1) a physician or other practitioner (as defined by the Secretary) to the physician's or practitioner's own patients as part of the physician's or practitioner's professional service; or (2) a hospital to the hospital's own patients during an admission or on the date of discharge from the hospital.

Elimination of additional rental payments

The regulation also solicited comments on whether to maintain the additional rental payments made to contract suppliers when a beneficiary does not continue to get capped rental or oxygen equipment from his or her current supplier. CMS received nine public comments on this rule and will take them under consideration for future proposed rulemaking.

In addition to the competitive bidding rules, this regulation addresses the following payment policies for power-driven wheelchairs and oxygen and oxygen equipment:

Lump sum purchase option for standard power wheelchairs

Sections 3136(a)(1) and (2) of the Affordable Care Act required revisions to the regulations to eliminate lump sum (up-front) purchase payment for standard power-driven wheelchairs and permit payment only on a monthly rental basis for standard power-driven wheelchairs. For complex rehabilitative power-driven wheelchairs, the regulations will continue to permit payment to be made on a lump sum purchase method or a monthly rental method. Also, payment adjustments required by the statute were made for power-driven wheelchairs under the Medicare Part B DMEPOS fee schedule to pay 15 percent instead of 10 percent) of the purchase price for the first three months under the monthly rental method and six percent (instead of 7.5 percent) for remaining rental months. Payment is based on the lower of the supplier's actual charge and the fee schedule amount. These changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of the Medicare DMEPOS competitive bidding program.

Oxygen and oxygen equipment

CMS have decided not to finalize this proposed revision for situations where a beneficiary relocates on or after the 18th month rental payment and before the 36-month rental at this time due to evidence that beneficiaries who relocate before the 36th month find suppliers to furnish the oxygen and oxygen equipment. CMS will consider implementing this regulatory change in the future if they determine that beneficiaries are having difficulty locating suppliers when they relocate during the 36-month rental period.

These provisions are found in Sections H, N, P, Q, and R of the 2011 physician fee schedule final rule, which is now on display at the Office of the Federal Register. The final rule (CMS-1503-FC) is available at *http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp*.

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

Source: CMS PERL 201011-09

Evaluation and Management

Incentive payment program for primary care services

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

Provider types affected

Physicians and nonphysician practitioners submitting claims to Medicare carriers and Part A/B Medicare administrative contractors (A/B MAC) for primary care services provided to Medicare beneficiaries are affected.

What you need to know

This article, based on change request (CR) 7060, explains that Section 5501(a) of The Affordable Care Act provides for an incentive payment for primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner. The incentive payment will be paid on a monthly or quarterly basis in an amount equal to 10 percent of the payment amount for such services under Part B. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

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

Specifically, the incentive payments will be made on a quarterly basis and will equal 10 percent of the amount paid for primary care services under the Medicare physician fee schedule for those services furnished during the bonus payment year. (For bonus payments to critical access hospitals paid under the optional method, see Chapter 4, Section 250.12 of the *Medicare Claims Processing Manual* at *http://www.cms.gov/manuals/downloads/clm104c04.pdf*)

Note: The new health professional shortage area (HPSA) surgical incentive payment program (HSIP) and the new primary care incentive payment program (PCIP) will be implemented in conjunction with one another for CY 2011. A separate article will be available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7063.pdf* upon release of CR 7063 for HSIP. The former "special HPSA remittance" will now be known as the "special incentive remittance." This change is necessary as the PCIP is open to all eligible primary care providers regardless of the geographic location in which the primary care services are being furnished.

Primary care practitioner defined

Section 5501(a)(2)(A) of The Affordable Care Act defines a primary care practitioner as:

- A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
- A nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under the physician fee schedule (PFS) for the practitioner in a prior period as determined appropriate by the Secretary of Health and Human services.

Primary care services defined

Section 5501(a)(2)(B) of The Affordable Care Act defines primary care services as those services identified by the following *Current Procedure Terminology* (*CPT*) codes as of January 1, 2009 (and as subsequently modified by the Secretary of Health and Human Services, as applicable):

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

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

Primary care services eligible for primary care incentive payments in CY 2011

CPT codes	Description
99201	Level 1 new patient office or other outpatient visit
99202	Level 2 new patient office or other outpatient visit
99203	Level 3 new patient office or other outpatient visit
99204	Level 4 new patient office or other outpatient visit
99205	Level 5 new patient office or other outpatient visit
99211	Level 1 established patient office or other outpatient visit
99212	Level 2 established patient office or other outpatient visit
99213	Level 3 established patient office or other outpatient visit
99214	Level 4 established patient office or other outpatient visit

Incentive payment program for primary care services (continued)

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

Primary care incentive payment program

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

CMS will provide Medicare contractors with a list of the national provider identifiers (NPIs) of the primary care practitioners eligible to receive the incentive payments. Eligible practitioners would be identified on a claim based on the NPI of the rendering practitioner. If the claim is submitted by a practitioner or group practice, the rendering practitioner's NPI must be included on the line-item for the primary care service (identified in the above table) in order for a determination to be made regarding whether or not the service is eligible for payment under the PCIP. In order to be eligible for the PCIP, physician assistants, clinical nurse specialists, and nurse practitioners must be billing for their services under their own NPI and not furnishing services incident to physicians' services. Regardless of the specialty area in which they may be practicing, these specific nonphysician practitioners are eligible for the PCIP based on their profession and historical percentage of allowed charges as primary services that equals or exceeds the 60 percent threshold.

Beginning in CY 2011, primary care practitioners will be identified based on their primary specialty of enrollment in Medicare and percentage of allowed charges for primary care services that equals or exceeds the 60 percent threshold from Medicare claims data two years prior to the bonus payment year. A provision to accommodate newly enrolled Medicare providers will be released in 2011.

Coordination with other payments

Section 5501(a)(3) of The Affordable Care Act provides payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under Section 1833(m) of The Social Security Act. Therefore, an eligible primary care physician furnishing a primary care service in a HPSA may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program beginning in CY 2011.

Additional information

If you have questions about this article, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction, CR 7060, issued to your Medicare carrier and/or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2039CP.pdf*.

Incentive payment program for primary care services (continued)

MLN Matters® Number: MM7060
Related Change Request (CR) #: 7060
Related CR Release Date: August 27, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2039CP
Implementation Date: January 3, 2011

Laboratory/Pathology

Annual clotting factor furnishing fee update 2011

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

Provider types affected

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

What you need to know

Change request (CR) 7168, from which this article is taken, announces that for calendar year 2011, the clotting factor furnishing fee of $0.176 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the on the average sales price (ASP) or not otherwise classified (NOC) drug. Please be sure your billing staffs are aware of this fee update.

Additional information

The official instruction, CR 7168 issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2068CP.pdf*.

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

MLN Matters® Number: MM7168
Related Change Request (CR) #: 7168
Related CR Release Date: October 15, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2068CP
Implementation Date: January 3, 2011

Try our E/M interactive worksheet

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

New waived tests

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

Provider types affected

This article is for clinical diagnostic laboratories billing Medicare carriers or Part A/B Medicare administrative contractors (MACs) for laboratory tests.

Provider action needed

Stop – impact to you

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare carrier or A/B MAC for a *Current Procedural Terminology* (*CPT*) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the Centers for Medicare & Medicaid Services (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 7184, from which this article is taken, informs carriers and MACs about the latest new *CPT* codes that are subject to CLIA edits.

Go – what you need to do

Make sure that your billing staffs are aware of these CLIA-related changes for 2010 and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The tests are valid as soon as they are approved. The *CPT* codes for the following new tests **must** have the modifier QW to be recognized as a waived test. Note, however, that the tests mentioned on the first page of the list attached to CR 7184 (i.e., *CPT* codes *81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013,* and *85651*) do not require a modifier QW to be recognized as a waived test.

***CPT* code**	**Effective date**	**Description**
G0430QW	January 1, 2010	American Screening Corporation one-screen drug test cups
*84443*QW	March 2, 2010	Aventir Biotech LLC, forsure TSH test (Whole Blood)
*84443*QW	March 4, 2010	BTNX, Inc Rapid Response thyroid stimulating hormone (TSH) test cassette
G0430QW	April 21, 2010	CLIA-waived, Inc. rapid drug test cup (OTC)
G0430QW	April 21, 2010	Millennium Laboratories Clinical Supply, Inc multi-drug pain med screen cup
G0430QW	May 10, 2010	US Diagnostics ProScreen drugs of abuse cup (OTC)
G0430QW	July 1, 2010	Ameditech, Inc ImmuTest drug screen cup
G0430QW	July 4, 2010	Quik Test USA, Inc. multi-drug of abuse urine test
G0430QW	July 4, 2010	Screen Tox multi-drug of abuse urine test
*82274*QW, G0328QW	July 8, 2010	Consult Diagnostics immunochemical fecal occult blood test (iFOBT)
G0430QW	July 19, 2010	Alfa Scientific Designs, Inc. instant-view drug of abuse urine cassette tests
G0430QW	July 19, 2010	Alfa Scientific Designs, Inc. instant-view drug of abuse urine cup test
G0430QW	July 19, 2010	American Screening Corporation Reveal multi-drug testing cups

Additional information

The official instruction, CR 7184 issued to your carrier or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2084CP.pdf*.

If you have any questions, please contact your 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: MM7184
Related CR Release Date: November 5, 2010
Related CR Transmittal #: R2084CP
Related Change Request (CR) #: 7184
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

January 2011 changes to the laboratory NCD edit software

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 7204, which announces the changes that will be included in the January 2011 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in October 2010.

These changes become effective for services furnished on or after January 1, 2011. The changes that are effective for dates of service on and after January 1, 2011 are as follows:

For thyroid testing

ICD-9-CM code 780.66 is added to the list of covered ICD-9-CM codes for the thyroid testing (190.22) NCD.

For gamma glutamyl transferase

ICD-9-CM code 780.66 is deleted from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD

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

Background

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

Additional information

The official instruction, CR 7204 issued to your carrier, FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2080CP.pdf*. If you have any questions, please contact your carrier, FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7204
Related Change Request (CR) #: 7204
Related CR Release Date: October 29, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2080CP
Implementation Date: January 3, 2011

Radiology

Multiple procedure payment reduction on the technical component of certain diagnostic imaging procedures

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

Provider types affected

This article is for physicians, clinical diagnostic laboratories, and other providers who bill Medicare contractors (carriers or Medicare administrative contractors [A/B MAC]) for providing diagnostic imaging services to Medicare beneficiaries.

Provider action needed

Change request 6993, from which this article is taken, announces that Medicare is changing the multiple procedure payment reduction (MPPR) on the technical component (TC) of certain diagnostic imaging procedures. You should make sure that your billing staffs are aware of these changes.

Background

Currently, the MPPR on diagnostic imaging services applies only to contiguous body parts (that is, within a family of codes, not across families). For example, the reduction does not apply to an MRI of the brain (*CPT 70552*) in code family 5, when performed during the same session, and on the same day, as an MRI of the neck and spine (*CPT 72142*) in code family 6.

Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) is consolidating the existing 11 advanced imaging families into a single family. This change applies: 1) When two or more services on the list are

Multiple procedure payment reduction on the technical component of certain diagnostic imaging .... (continued)

furnished to the same patient in a single session; and 2) Only to the TC portion of global services, not to the professional component (PC). Medicare will continue to make the full TC payment for the procedure with the highest priced TC, and at 50 percent each for the TC of each additional procedure on the same patient in the same session.

Additional information

You will find the complete list of codes subject to the MPPR on diagnostic imaging in Attachment 1 of CR 6993, which is the official instruction issued to your carrier or A/B MAC on this issue. CR 6993 is available at *http://www.cms.gov/Transmittals/downloads/R738OTN.pdf*.

If you have any questions, please contact your 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: MM6993
Related Change Request (CR) #: 6993
Related CR Release Date: July 30, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R738OTN
Implementation Date: January 3, 2011

New accreditation requirements for billing the TC of advanced diagnostic imaging services

Beginning January 1, 2012, suppliers furnishing the technical component of advanced diagnostic imaging services for which payment is made under the physician fee schedule must be accredited by a CMS-designated accreditation organization. In the case where a physician chooses to contract out those services to an accredited mobile unit, the physician must be accredited in order to bill Medicare for such services.

For more information regarding advanced diagnostic imaging, please visit *http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.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 201011-50

Therapy Services

Multiple procedure payment reduction for selected therapy services

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

Provider types affected

Physicians, nonphysician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs] for therapy services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule [MPFS]).

Provider action needed

This article is based on change request (CR) 7050, which announces that Medicare is applying a new multiple procedure payment reduction (MPPR) to the practice expense (PE) component of payment of select therapy services paid under the MPFS. Make sure your billing staff is aware of these payment reductions.

Background

Section 3134 of The Affordable Care Act added Section 1848(c)(2)(K) of The Social Security Act, which specifies that the Secretary of Health and Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a step in implementing this provision, Medicare is applying a new MPPR to the PE component of payment of select therapy services paid under the MPFS. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 MPFS final rule.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 75 percent payment for the PE.

For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines; for example, physical therapy, occupational therapy, or speech-language pathology.

Multiple procedure payment reduction for selected therapy services (continued)

The reduction applies to the HCPCS codes contained on the list of "always therapy" services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, home health agencies [HHAs], and comprehensive outpatient rehabilitation facilities [CORFs], etc.). The MPPR applies to the codes on the list of procedures included with CR 7050 as Attachment 1. CR 7050 is available at *http://www.cms.gov/Transmittals/downloads/R800OTN.pdf*. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example:

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Current Total Payment	Proposed Total Payment	Proposed Payment Calculation
Work	$7.00	$7.00	$11.00	$25.00	$25.00	no reduction
PE	$10.00	$10.00	$8.00	$28.00	$23.50	$10 + (.75 x $10) + (.75 x $8)
Malpractice	$1.00	$1.00	$1.00	$3.00	$3.00	no reduction
Total	$18.00	$18.00	$20.00	$56.00	$51.50	$18 + ($18-$10) + (.75 x $10) +($20-$8) + (.75 x $8)

Where claims are impacted by the MPPR, Medicare will return a claim adjustment reason code of 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) and a group code of contractual obligation (CO).

Additional information

The official instruction, CR 7050, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R800OTN.pdf*.

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

MLN Matters® Number: MM7050
Related Change Request (CR) #: 7050
Related CR Release Date: November 3, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R800OTN
Implementation Date: January 3, 2011

2011 outpatient therapy cap values

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

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) 7107, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for calendar year (CY) 2011. No change to the exceptions process is anticipated, if it should be extended into 2011. Be sure billing staff is aware of the updates.

Background

The Balanced Budget Act of 1997 set therapy caps, which change annually, for Part B Medicare patients. The Deficit Reduction Act of 2005 allowed CMS to establish a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended exceptions to therapy caps through December 31, 2010.

Therapy caps for 2011 will be $1870. The exceptions process will continue unchanged for the time frame directed by the Congress.

Note that the limitations 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, limitations 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 [7107], issued to your FI, carrier, A/B MAC, or RHHI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2073CP.pdf*.

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

Additional information concerning outpatient therapy services may be found at *http://www.cms.gov/therapyservices*.

2011 outpatient therapy cap values (continued)

MLN Matters® Number: MM7107
Related Change Request (CR) #: 7107
Related CR Release Date: October 22, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2073CP
Implementation Date: January 3, 2011

General Coverage

Payment for certified nurse-midwife services

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

Provider types affected

Certified nurse midwives (CNMs), submitting claims to Medicare contractors (carriers, fiscal intermediaries [FI], and Part A/B Medicare administrative contractors [A/B MACs]) for Medicare Part B services provided to Medicare beneficiaries are impacted by this article.

Provider action needed

This article is based on change request (CR) 7005, which explains that, effective on or after January 1, 2011, Medicare contractors will pay CNMs for their services at 80 percent of the lesser of the actual charge or 100 percent of the Medicare physician fee schedule (MPFS) amount that would be paid for the same service if furnished by a physician.

In addition, changes have been made regarding the services that CNMs furnish to patients in critical access hospitals (CAHs) paid under the optional method. These changes reflect the increase in payment for CNM services effective January 1, 2011, and specify the appropriate modifier that must be used when billing for CNM services furnished to patients in this setting.

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

Background

Section 3114 of the Affordable Care Act of 2009, increased the amount of payment that the Medicare program will make to CNMs for their personal professional services and for services furnished incident to their professional services. For services on or after January 1, 1992, through December 31, 2010, Medicare payment has been made at 80 percent of the lesser of the actual charge or 65 percent of the MPFS amount that would be paid for the same service furnished by a physician.

To summarize, for services on or after January 1, 1992, through December 31, 2010:

- Medicare contractors will pay CNMs for their services and services furnished incident to their professional services at 80 percent of the lesser of the actual charge or 65 percent of the physician fee schedule amount that would be paid to a physician for the same service.
- Contractors will pay CNMs for their care in connection with a global service at 65 percent of what a physician would have been paid for the total global fee.

For services on or after January 1, 2011:

- Medicare will pay CNMs for their services and services furnished incident to their professional services at 80 percent of the lesser of the actual charge or 100 percent of the physician fee schedule amount that would be paid to a physician for the same service.
- Medicare will pay CNMs for their care in connection with global services at 80 percent of the lesser of the actual charge or 100 percent of what a physician would have been paid for the total global fee.
- Medicare will pay for CNM services furnished to CAH patients paid under the optional method on TOB 85x with revenue code 96x, 97x, or 98x and modifier SB (certified nurse-midwife) based on the lesser of the actual charge or 100 percent of the MPFS amount as follows: [(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

Payment for CNM services is made directly to CNMs for their professional services and for services furnished incident to their professional services. CNMs are required to accept assigned payment for their services. Accordingly, when CNMs bill for their services under specialty code 42, billing does not have to flow through a physician or facility unless the CNM reassigns their benefits to another billing entity. For reassigned CNM services, the entity bills for CNM services using the specialty code 42 to signify that payment for CNM services is being claimed.

Payment for covered drugs and biologicals furnished incident to CNMs' services is made according to the Part B drug/biological payment methodology. Covered clinical diagnostic laboratory services furnished by CNMs are paid according to the clinical diagnostic laboratory fee schedule.

When CNMs furnish outpatient treatment services for mental illnesses, these services could be subject to the outpatient mental health treatment limitation (the limitation). The appropriate percentage payment reduction under the limitation is applied first to the approved amount

Payment for certified nurse-midwife services (continued)

for the mental health treatment services before the actual payment amount is determined for the CNMs' services. Please refer to the *Medicare Claims Processing Manual*, Chapter 12, Section 210, available at *http://www.cms.gov/manuals/downloads/clm104c12.pdf* to determine the appropriate percentage payment reduction under the limitation.

When a certified nurse-midwife is providing most of the care to a Medicare beneficiary that is part of a global service and a physician also provides a portion of the care for this same global service, the fee paid to the CNM for his or her care is based on the portion of the global fee that would have been paid to the physician for the care provided by the CNM.

For example, a CNM requests that the physician examine the beneficiary prior to delivery. The CNM has furnished the ante partum care and intends to perform the delivery and post partum care. The MPFS amount for the physician's total obstetrical care (global fee) is $1,000. The MPFS amount for the physician's office visit is $30. The following calculation shows the maximum allowance for the CNM's service:

MPFS amount for total obstetrical care	$1,000.00
MPFS amount for visit	- $30.00
Result	$970.00
Fee schedule amount for certified nurse-midwife (65 percent x $970, effective 1/1/1992-12/31/2010)	$630.50
Fee schedule amount for certified nurse-midwife (100 percent x 970, effective 1/1/2011)	$970.00

Therefore, the certified nurse-midwife would be paid no more than 80 percent of $630.50 or, 80 percent of $970.00 for services furnished on or after January 1, 2011, for the care of the beneficiary. This calculation also applies when a physician provides most of the services and calls in a certified nurse-midwife to provide a portion of the care.

Physicians and certified nurse midwives use reduced service modifiers to report that they have not provided all the services covered by the global allowance.

Additional information

If you have questions, please contact your Medicare carrier, FI, and/or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction issued to your Medicare carrier, FI, and/or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2024CP.pdf*.

MLN Matters® Number: MM7005
Related Change Request (CR) #: 7005
Related CR Release Date: August 6, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2024CP
Implementation Date: January 3, 2011

Healthcare Common Procedure Coding System code set update

The Centers for Medicare & Medicaid Services has announced the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at *http://www.cms.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp*. Changes are effective on the date indicated on the update.

Source: CMS PERL 201011-17

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Electronic Data Interchange

Deadline announced for requests for modifications to the ASC X12 implementation guides

On October 20, 2010, the Accredited Standards Committee X12 (ASC X12) announced that February 4, 2011, is the deadline to submit revision requests related to the ASC X12 005010 Type 3 technical reports (TR3), also known as implementation guides.

Requests for revisions to the ASC X12 technical reports mandated under HIPAA may be submitted via the Designated Standard Maintenance Organizations (DSMO) website at *http://www.hipaa-dsmo.org*.

Requests for revisions to other ASC X12 technical reports may be submitted to *http://www.x12.org/TR3ChangeRequest*.

To be considered for inclusion in the 006020 implementation guides, requests must include all of the detailed information requested on the on-line submission forms. Change requests submitted after the deadline will be considered for inclusion in a future version.

The ASC X12 Insurance Subcommittee (ASC X12N) has implemented a new process for managing change requests, beginning with this ASC X12 006020 maintenance cycle. The new process shortens the timeline for revisions to ASC X12 TR3s by as much as 15 months, to approximately 21 months.

For additional information, please visit *http://www.x12.org/dsmo/help* or contact *info@disa.org*.

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

Source: CMS PERL 201010-46

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Healthcare provider taxonomy code updates effective January 1, 2011

Effective January 1, 2011, the healthcare provider taxonomy codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of HPTC is available from the Washington Publishing Company website at *http://www.wpc-edi.com/codes/taxonomy*. If a HPTC is reported to Medicare, it should be a valid code or 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 submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system please contact your software support vendor.

Source: CR 7130

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Taking electronic billing and electronic data interchange to the next level

Now available to order in hardcopy format

The new *Medicare Learning Network*® product titled "5010: Taking Electronic Billing and Electronic Data Interchange (EDI) to the Next Level" is now available in both downloadable and hardcopy formats. This educational tool is designed to provide education on the upcoming implementation of Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.0, which will replace the current version that covered entities must use when conducting electronic HIPAA transactions. It includes a timeline and list of resources related to the implementation. This product is suggested for all Medicare fee-for-service providers. To order a hardcopy, free of charge, please visit *http://www.cms.gov/MLNGenInfo/* and click on "MLN Product Ordering Page" under the "Related Links Inside CMS" section at the bottom of the page.

This product is also available in downloadable format at *http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.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 201011-39

MREP software code update

This message is for Medicare fee-for-service professional providers and suppliers:
The latest claim adjustment reason codes and remittance advice remark codes are available in the "codes.ini" file for the Medicare Remit Easy Print (MREP) software. You may access this file in the zipped folder for "Medicare Remit Easy Print-Version 2.7" at *http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp*.

Source: CMS PERL 201011-20

Medicare Remit Easy Print enhancement

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

Provider types affected

This article is for physicians, providers, and suppliers using the MREP software supplied through Medicare contractors (carriers, fiscal intermediaries [FIs], DME Medicare administrative contractors [DME MACs] and/or Part A/B Medicare administrative contractors [MACs]).

What you need to know

The Centers for Medicare & Medicaid Services (CMS) announces in CR 7178, the following list of enhancements to the MREP:

- The MREP demo function has been updated to reflect current functionalities, and
- A report may be run now for Medicare secondary payer (MSP) claims to distinguish the Medicare secondary payments from the primary payments.

If you use the MREP software, be sure to obtain the new version in January and install it to begin benefiting from these enhancements.

Background

CMS developed the free MREP software to enable providers/suppliers to read and print the HIPAA-compliant electronic remittance advice (ERA), also known as transaction 835. MREP was first implemented in October 2005, and MREP has been enhanced continuously based on requests/comments received from users. These enhancements are based on requests received either through the carriers, MACs, DME MACs or through the CMS MREP website.

Additional information

The official instruction, CR 7178 issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2064CP.pdf*.

MLN Matters® Number: MM7178
Related Change Request (CR) #: 7178
Related CR Release Date: October 8, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2064CP
Implementation Date: January 3, 2011

Implementation of errata version 5010 of HIPAA transactions and updates

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

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7202 to alert and update providers about the Administrative Simplification provisions of HIPAA regulations that the Secretary of the Department of Health and Human Services (DHHS) is required to adopt regarding standard electronic transactions and code sets. Currently, CMS is in the process of implementing an errata version of 5010 of the HIPAA transactions as well as the updates to the 837I, 837P and 835 flat files. Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.

Background

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

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

To review the explanation of these levels you may go to an earlier MLN Matters® article, MM6975 on the Additional Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 5010 for Transaction 835-Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR) at *http://www.cms.gov/MLNMattersArticles/downloads/MM6975.pdf*.

Key points of CR 7202

CMS is working with your Medicare contractors to implement the new HIPAA standard (version 5010) correctly and:

- CMS expects that external testing will start on January 2011, but no sender/receiver will be migrated to 5010A1 production before April 2011

Implementation of errata version 5010 of HIPAA transactions and updates (continued)

- During the transition period January-March 2011, Medicare contractors will be ready to receive/send transactions in version 4010A1 as well as test in version 5010. From April-December 2011, contractors will be ready to receive/send transactions in version 4010A1 as well as test and receive/send all transactions in version 5010 or the appropriate errata versions, and
- All Medicare claims processing systems will use appropriate X12 based flat file layouts for transactions 837I, 837P, and 835, as attached to CR 7202. (To review the file descriptions, go to *http://www.cms.gov/Transmittals/downloads/R2090CP.pdf*)
- Over the past year, there has been discussion about modifications needed to implement 5010 correctly. As a result, X12N released the errata modifications, and they were adopted by DHHS. CMS will implement the changes that impact Medicare and update the relevant flat files even if specific modifications do not impact Medicare.
- The errata are basically modifications to some of the TR3s. For Medicare the following TR3 name changes will be required per:
  - 005010X279A1 270/271 Health Care Eligibility Benefit Inquiry and Response (a separate CR will be issued for the 270/271)
  - 005010X221A1 835 Health Care Claim Payment/Advice
  - 005010X222A1 837 Health Care Claim: Professional
  - 005010X223A2 837 Health Care Claim: Institutional, and
  - 005010X231A1 999 Implementation Acknowledgment for Health Care Insurance.

Additional information

The official instruction, CR 7202 issued to your carrier, A/B MAC, and RHHI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2090CP.pdf*.

If you have any questions, please contact your carrier, 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: MM7202
Related Change Request (CR) #:7202
Related CR Release Date: November 10, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2090CP
Implementation Date: April 4, 2011

Implementation of the PWK (paperwork) segment for X12N version 5010

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

Note: This article was revised on November 12, 2010, to reflect a revised change request (CR) 7041 issued on November 10, 2010. The effective and implementation dates have been changed. In addition, the CR transmittal number, release date, and the Web address for accessing CR 7041 were revised. All other information is the same. This information was previously published in the September 2010 *Medicare B Update!* pages 22-23.

Provider types affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors [MACs], durable medical equipment [DME] MACs, and fiscal intermediaries [FIs] including regional home health intermediaries).

Provider action needed

This article is based on CR 7041 which announces the implementation of the PWK (paperwork) segment for X12N bersion 5010. Be sure your billing staff is aware of these changes.

Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key points for Medicare billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at *http://www.cms.gov/Transmittals/downloads/R763OTN.pdf*.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.

Implementation of the PWK (paperwork) segment for X12N version 5010 (continued)

- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the coordination of benefits contractor.

Additional information

If you have questions, please contact your Medicare MAC and/or FI/carrier at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.
The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at *http://www.cms.gov/Transmittals/downloads/R806OTN.pdf*.

MLN Matters® Number: MM7041 *Revised*
Related Change Request (CR) #: 7041
Related CR Release Date: November 10, 2010
Effective Date for Providers: July 1, 2011
Related CR Transmittal #: R806OTN
Implementation Date: July 5, 2011

CMS is here to help in the transitions to HIPAA version 5010 and ICD-10

Have questions about the Health Insurance Portability and Accountability Act (HIPAA) version 5010 and the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) transition? The Centers for Medicare & Medicaid Services (CMS) is here to help

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

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

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

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

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

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

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

Source: CMS PERL 201011-47

Electronic Health Records

New modifier for the electronic health record incentive program

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

Provider types affected

Physicians, dentists, and other providers who participate in the Centers for Medicare & Medicaid Services (CMS) electronic health record (EHR) incentive program, and render services in a dental health professional shortage area (HPSA) should be aware of this information.

Provider action needed

Change request (CR) 7035, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) has developed a new EHR HPSA modifier AZ, which will allow eligible professionals (EP) to report claims rendered in a dental HPSA when the ZIP code does not fully fall within that dental HPSA.

You should make sure that your billing staffs are aware of this new modifier. It is described in the *Background* section.

Background

The American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), which authorized the establishment of the EHR incentive program, authorizes CMS to make EHR incentive payments for certain Medicare EPs who are meaningful users of certified EHR technology. EPs that are eligible to participate in the EHR incentive program include the following Medicare physicians:

- Doctor of medicine
- Doctor of osteopathy
- Doctor of podiatric medicine
- Doctor of optometry
- Doctor of oral durgery
- Doctor of dental medicine
- Doctor of chiropractic

Note: All publicly available information on the EHR incentive program (which will begin in calendar year 2011) may be found at *http://www.cms.gov/Recovery/11_HealthIT.asp*, including a link to the proposed rule.

HPSA information

An EP who furnishes services predominately in a HPSA is eligible for a 10 percent increase in the maximum EHR incentive payment amount, regardless of the type of HPSA in which the services were rendered. This means that any EP can perform services in any type of HPSA (primary care, mental health, or dental) and receive the increase in the maximum EHR HPSA incentive payment amount, as long as 50 percent or more of his/her services are performed in a HPSA.

Note: This definition of an EHR HPSA provider is different from the definition for Medicare fee-for-service (FFS) HPSA bonus payments.

For purposes of the EHR incentive program, services rendered in a HPSA will be identified either through the ZIP code on the claim, or through a modifier on the claim line. Providers currently reporting the non-dental HPSA modifier should continue to do so; this modifier will also be read for purposes of the EHR incentive payment increase.

In order to allow EPs to report claims rendered in a dental HPSA when the ZIP code does not fully fall within that dental HPSA, EPs must use the new EHR HPSA modifier, AZ ("Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment"), which is effective for dates of service on or after January 1, 2011. The new modifier will not affect the payment or calculation of the FFS geographic quarterly HPSA bonus. The CMS will be responsible for determining which EPs are due the EHR HPSA incentive payment increase and determining the amount of the payment.

Additional information

For complete details regarding this CR please see the official instruction (CR 7035) issued to your Medicare contractor. That instruction may be viewed by going to *http://www.cms.gov/Transmittals/downloads/R724OTN.pdf*.

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

MLN Matters Number: MM7035
Related Change Request (CR) #: 7035
Related CR Release Date: July 2, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R724OTN
Implementation Date: January 3, 2011

Electronic health record incentive program – certified product list

Providers must use certified electronic health record (EHR) technology in order to earn incentives under the Medicare and Medicaid EHR incentive programs. How to be sure which EHR technology has been certified?

The Office of the National Coordinator for Health Information Technology (ONC) has published the Certified Health IT Product List (CHPL), a comprehensive listing of complete EHRs and EHR modules that have been tested and certified under the temporary certification program. Each complete EHR and EHR module included in the CHPL has been tested and certified by an ONC-Authorized Testing and Certification Body (ATCB), and reported to ONC by an ONC-ATCB, with reports validated by ONC. Only those EHR technologies appearing on the ONC-CHPL may be granted the reporting number that will be accepted by CMS for purposes of attestation under the EHR incentive programs.

The listing will be updated as additional products are certified by ONC-ATCBs and reported to ONC for validation. For more information about this product listing, please visit *http://healthit.hhs.gov/CHPL*. For more information on the Medicare and Medicaid EHR incentive programs, visit *http://www.cms.gov/EHRIncentivePrograms*.

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

Source: CMS PERL 201011-03

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Provider Enrollment

Provider education for handling national provider identifier issues related to deceased providers

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

Provider types affected

This article is relevant for claims of physicians, nonphysician practitioners, and other providers/suppliers who are deceased and for whom claims are submitted to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs] and Part A/B MACs) for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 6984 and explains how claims should be submitted by representatives of deceased providers who had obtained an national provider identifier (NPI) prior to death. A claim submitted after May 23, 2007, for a deceased provider who had an NPI will be rejected by Medicare because the provider's NPI was deactivated in the Medicare claims processing system due to the provider's death. When a deceased provider's claim is rejected by a Medicare contractor because of the absence of an NPI, the claim submitter is expected to contact the Medicare contractor to discuss payment of the claim and the provider's death.

The Medicare contractor will ask the representative of the provider's estate to submit the claim in paper format and will instruct the representative that Item 19 of the Form CMS-1500 claim must be annotated to state that the provider is deceased.

Additional information

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

The official instruction, CR6984, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.gov/Transmittals/downloads/R799OTN.pdf*.

MLN Matters® Number: MM6984
Related Change Request (CR) #: 6984
Related CR Release Date: November 5, 2010
Effective Date: Claims processed on or after April 4, 2011
Related CR Transmittal #: R799OTN
Implementation Date: April 4, 2011

Specialty code for advanced diagnostic imaging services

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

Provider types affected

This article is for physicians, providers, and suppliers who submit claims to Medicare carriers, fiscal intermediaries [FI], or Medicare administrative contractors (A/B MAC) for providing diagnostic imaging services to Medicare beneficiaries.

What you need to know

Change request (CR) 7175, from which this article is taken announces that (effective April 1, 2011) the Centers for Medicare & Medicaid Services (CMS) will establish a new specialty code (specialty code 95) for advanced diagnostic imaging (ADI) accreditation. (Note: Previously, CMS had designated this specialty code for the Competitive Acquisition Program for drugs project, the code will now be used for ADI accreditation.) You should ensure that your billing staffs are aware of this new specialty code for ADI accreditation.

Additional information

The official instruction, CR 7175, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2079CP.pdf*.

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

MLN Matters® Number: MM7175
Related Change Request (CR) #: 7175
Related CR Release Date: October 29, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2079CP
Implementation Date: April 4, 2011

Indian Health Service facilities and tribal provider's use of PECOS

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

Provider types affected

Tribal or Indian Health Service (IHS) providers wanting to enroll or who are currently enrolled in the Medicare program.

Provider action needed

This article is based on change request (CR) 7174, which informs Indian Health Service (IHS) facilities and tribal providers initially enrolling in the Medicare program or submitting changes of enrollment information that they may use the Internet-based provider enrollment, chain and ownership system (PECOS) to do so.

Background

Currently, Indian Health Service (IHS) facilities and tribal providers are permitted to enroll in Medicare Part A and B using the paper enrollment process only. The Internet-based PECOS routes enrollment applications to the correct Medicare contractor based on the provider/supplier type and their practice location, but it is not currently designed to route IHS and tribal enrollment applications to TrailBlazer Health Enterprises, LLC (TrailBlazer), the single designated Medicare contractor responsible for enrolling this provider type. For this reason, IHS facilities and tribal providers have not been able to use Internet-based PECOS.

CR 7174 is establishing an interim process to allow IHS facilities and tribal providers to use Internet-based PECOS to initially enroll in the Medicare program or submit changes of information.

If IHS facilities or tribal providers choose to use Internet-based PECOS, they will be responsible for mailing to TrailBlazer the following as part of the interim process:

- A cover letter to indicate they are seeking to enroll as an IHS facility or tribal provider or updating their current enrollment information
- The Internet-based PECOS certification statement
- Any other applicable supporting documentation.

The Trailblazers addresses are as follows:

Part A
Part A Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650458
Dallas, TX 75265-0458

Part B
Part B Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650544
Dallas, TX 75265-0544

This interim process shall remain in effect until PECOS system changes are implemented to route all electronic enrollment applications received from IHS facilities and tribal providers directly to TrailBlazers.

Indian Health Service facilities and tribal provider's use of PECOS (continued)

Additional information

The official instruction, CR 7174, issued to your carriers, fiscal intermediaries (FIs), and Part A/Part B Medicare administrative contractors (A/B MACs) regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R358PI.pdf*.

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

MLN Matters® Number: MM7174
Related Change Request (CR) #: 7174
Related CR Release Date: October 28, 2010
Effective Date: November 29, 2010
Related CR Transmittal #: R358PI
Implementation Date: November 29, 2010

Clarification on processing appeals via facsimile or via secure Internet portal

Change request (CR) 6958 updates the current instructions in Chapter 29 of the *Medicare Claims Processing Manual*, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application. Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must obtain prior approval from the Centers for Medicare & Medicaid Services (CMS).

Even though First Coast Service Options Inc. is not utilizing these methods at this time, Chapter 29 changes are not limited to facsimile and Internet portal submissions. Therefore, providers must adhere to all changes not related to facsimile and Internet portal submissions addressed in CR 6958.

For additional information, see the *MLN Matters* article at *http://www.cms.gov/MLNMattersArticles/downloads/mm6958.pdf*.

You may also review CR 6958 at *http://www.cms.gov/Transmittals/downloads/R1986CP.pdf*.

Source: Change Request 6958

E-prescribing/PQRI Initiative

2010 e-prescribing measurement code reporting update

All eligible professionals (EPs) are encouraged to follow the current 2010 e-prescribing (eRx) incentive program requirements. EPs should check the measure specifications at the beginning of each year because they may change. The correct measurement code to bill in 2010 for calculations of the 2010 eRx incentive payment is G8553.

The 2009 eRx measurement codes have been accepted for processing by the Medicare claims systems. However, in October, a temporary change occurred that led to the rejection of 2009 eRx codes. EPs cannot resubmit claims that may have been rejected with the 2009 eRx measurement codes. Submissions reported using a qualified registry or a qualified electronic health record will not be affected by this situation.

All EPs should work with their vendors and clearinghouses to make sure they are aware of any measure specification changes. Current information, as well as the requirements, may be found at *http://www.cms.gov/ERXincentive*. To access the requirements, click on *E-Prescribing Measure* on the left-hand side of the page; scroll down to the *Downloads* section of the page and click to view the *2010 eRx Measure Specification & Release Notes and Claims Based Reporting Principles for 2010 eRx.*

EPs with any additional questions may contact the Quality Net help desk at 866-288-8912 or the TTY line 877-715-6222 from 7:00 a.m.-7:00 p.m. CT.

Source: CMS PERL 201011-33

2011 eRx incentive program update – payment adjustments in 2012

The Centers for Medicare & Medicaid Services announced that beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment or penalty. Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx incentive program.

The payment adjustment in 2012, with regard to all of the eligible professionals' Part B-covered professional services, will result in the eligible professional or group practice receiving 99 percent of the physician fee schedule (PFS) amount that would otherwise apply to such services. In 2013, eligible professionals will receive 98.5 percent of their covered Part B-eligible charges if they aren't successful electronic prescribers. In 2014, the penalty for not being a successful electronic prescriber is 2 percent, resulting in eligible professionals receiving 98 percent of their covered Part B charges.

For purposes of determining which eligible professionals or group practices are subject to the payment adjustment in 2012, CMS will analyze claims data from January 1-June 30, 2011, to determine if the eligible professional has submitted at least 10 electronic prescriptions during the first six months of calendar year 2011. Group practices reporting as a GPRO I or GPRO II in 2011 must report all of their required electronic prescribing events in the first six months of 2011 to avoid the payment adjustment in 2012.

For more information, see the "Getting Started" Web page at *http://www.cms.gov/erxincentive*; or download the Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program under Educational Resources.

If an eligible professional or selected group practice wishes to request an exemption to the eRx incentive program and the payment adjustment, there are two "hardship codes" that can be reported via claims should one of the following situations apply:

- G8642 – the eligible professional practices in a rural area without sufficient high speed Internet access and requests a hardship exemption from the application of the payment adjustment under Section 1848(a)(5)(A) of the Social Security Act.
- G8643 – the eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under Section 1848(a)(5)(A) of the Social Security Act.

Additionally, there will be a G code that can be used by eligible professionals to indicate that they do not have prescribing privileges. Reporting this G code will prevent the eligible professional from being subjected to a payment adjustment in 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 201011-46

2009 PQRI and eRx feedback reports

The Centers for Medicare & Medicaid Services (CMS) would like to share this important information with participants in the 2009 Physician Quality Reporting Initiative (PQRI) or Electronic Prescribing (eRx) Incentive Program.

After beginning the release of the 2009 PQRI feedback reports, CMS temporarily halted production of the files to investigate some conflicting field information in the reports. The 2009 PQRI and eRx Incentive Program feedback reports will soon be made available on the PQRI portal. CMS anticipates that the taxpayer identification number (Tax ID number, or TIN) level reports, which include the national provider identifier or NPI level reports, will be available the week of November 22 on the PQRI portal. Individual NPI reports will be made available shortly afterward and may be requested via your carrier or Medicare administrative contractor.

Feedback reports are compiled at the TIN level, with individual-level reporting national provider identifier (NPI) information for each eligible professional who reported at least one valid PQRI and/or eRx quality-data code (QDC) on a claim submitted under that TIN for services furnished during the reporting period. The TIN or NPI must be the one used by the eligible professional to submit Medicare claims and valid PQRI and/or eRx QDCs.

If a 2009 PQRI and/or eRx incentive program feedback report is available for your organization's TIN or NPI, there are two ways to access your report:

Individuals Authorized Access to the CMS Computer Services (IACS): Eligible professionals can log into the secure Physician and Other Health Care Professionals Quality Reporting Portal on QualityNet at *http://www.qualitynet.org/pqri*, to access their feedback report(s) based on their TIN or for a group. Access to the portal requires registration in the IACS system to obtain a user ID and password. Information on creating and/or updating an IACS account is included later in this message.

Alternative feedback report method: An individual eligible professional may simply call their respective carrier or Medicare administrative contractor (MAC) provider contact center to request confidential 2009 PQRI or eRx feedback reports that will contain information based on the eligible professional's individual NPI. If an eligible professional is part of a group practice, each eligible professional in the group practice must individually call their respective carrier/MAC provider contact center to request a feedback report based on the individual NPI. To obtain a list of provider contact centers, visit the CMS website at *http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*. In addition to reporting information, these reports will provide individual eligible professionals with information on their Medicare Part B physician fee schedule (PFS) allowed charges for the 2009 reporting period, upon which an incentive payment is based.

2009 PQRI and eRx feedback reports (continued)

Additional information about this alternative feedback report request process can be found by accessing special edition *Medicare Learning Network* (*MLN*) article SE0922 – Alternative Process for Individual Eligible Professionals to Access Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (E-Prescribing) Feedback Reports".

The IACS home page for the Provider/Supplier user Community, which includes eRx and PQRI is at *http://www.cms.gov/IACS/04_Provider_Community.asp*. Provider community users should direct questions or concerns to the QualityNet Help Desk at 1-866-288-8912, (Monday-Friday 7:00 a.m.-7:00 p.m. CST) or via e-mail at *qnetsupport@sdps.org*.

Resources

The IACS account management page is at *https://applications.cms.hhs.gov/category.html?name=acctmngmt*. Click on "My Profile" to login, change your password, or use the "Forgot Password?" option.

The physician and other health care professional quality reporting portal is available at *http://www.qualitynet.org/pqri*. Although the "Forgot Password" link on the portal sends users to the IACS website, IACS and the portal are two separate websites.

Who to call for help

Users who still have questions or need assistance should contact the QualityNet Help Desk at 1-866-288-8912 (Monday-Friday 7:00 a.m.-7:00 p.m. CST) or *qnetsupport@sdps.org*.

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

Source: CMS PERL 201011-44

2009 eRx incentive payment update

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the 2009 Electronic Prescribing (eRx) Incentive Program were made to eligible professionals (EPs) who met the criteria for successful reporting.

The 2009 eRx incentive payments are currently being processed and distributed by carriers and Medicare administrative contractors (MACs). Distribution of the 2009 eRx incentive payments were completed by October 22.

eRx incentives earned by individual participating physicians and other eligible professionals are paid as a lump-sum to the taxpayer identification number (TIN) under which the EP's claims were submitted. It is then up to the TIN to decide how to distribute the incentive within the practice.

Effective January 2010, CMS revised the manner in which incentive payment information is communicated to eligible professionals receiving electronic remittance advices. CMS has instructed Medicare contractors to use a new indicator of LE to indicate incentive payments instead of LS. LE will appear on the electronic remittance advice. Additionally the paper remittance advice will read "This is an eRx incentive payment." It will not include the year and indicator LE in the paper remittance. In an effort to further clarify the type of incentive payment issued (either PQRI or eRx incentive), CMS created a four-digit code to indicate the type of incentive and reporting year. For the 2009 eRx incentive payments, the four-digit code is RX09. This code will be displayed on the electronic remittance advice along with the LE indicator. For example, eligible professionals will see LE to indicate an incentive payment, along with RX09 to identify that payment as the 2009 eRx incentive payment.

2009 eRx feedback reports

The 2009 eRx feedback reports will be available on the Physician and Other Health Care Professionals Quality Reporting Portal at *http://www.qualitynet.org/pqri*, starting the second week of November. TIN-level reports on the portal require an Individuals Authorized Access to CMS Computer Services (IACS) account. Participants may also contact their carrier or MAC to request individual NPI-level reports via an alternate feedback report fulfillment process, please visit *http://www.cms.gov/MLNMattersArticles/downloads/SE0922.pdf*.

Contact information

If you have questions about the status of your eRx incentive payment (during the distribution timeframe), please contact your provider contact center. The contact center directory is available at *http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

Feel free to contact the QualityNet Help Desk with any of the following:

- Physician Quality Reporting Initiative (PQRI) portal password issues
- PQRI/eRx feedback report availability and access
- PQRI-IACS registration questions
- PQRI-IACS login issues

The QualityNet Help Desk is available Monday through Friday from 7:00 a.m.-7:00 p.m. CT at 1-866-288-8912 or via *qnetsupport@sdps.org*. They can also assist with program and measure-specific questions.

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

Source: CMS PERL 201011-23

ONC reaches out to vendor community to help reduce health disparities

The Office of the National Coordinator for Health Information Technology (ONC) and the Office of Minority Health (OMH) believe that electronic health records (EHRs) can help improve health care for low-income and minority communities who remain disproportionately affected by chronic illnesses. However, EHR adoption rates among providers who serve these communities remain low.

In an effort to prevent health disparities caused by a "digital divide," Dr. David Blumenthal, National Coordinator for Health Information Technology, and Dr. Garth Graham, Director of the OMH, encourage vendors to work together to help providers serving low-income and minority communities adopt EHRs. Read more in Dr. Blumenthal's new letter to the vendor community, available at *http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3197*.

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

Source: CMS PERL 201010-45

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General Information

Partial code freeze prior to ICD-10 implementation

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

Provider types affected

This *MLN Matters*® special edition article affects all Medicare fee-for-service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What you need to know

At the ICD-9-CM Coordination & Maintenance (C&M) Committee meeting, held on September 15, 2010, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013.

Considerable interest was expressed in dramatically reducing the number of annual updates to both coding systems. It was suggested that such a reduction in code updates would allow vendors, providers, system maintainers, payers, and educators a better opportunity to prepare for the implementation of ICD-10. Additional public comments on this issue were received prior to this meeting. The partial freeze will be implemented as follows:

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

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended. To view the transcript of the meeting, go to *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp*. From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the "091510_Morning_Transcript" file. This section appears on page 4 of the 78 page document. To view the summary report of the meeting, go to: *http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp*. From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the "091510_ICD9_Meeting_Summary_report.pdf" file. Information on the code freeze begins on page 5.

Additional information

CMS has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at *http://www.cms.gov/ICD10*. In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare fee-for-service provider resources Web page** – this site links Medicare FFS providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark *http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp* and check back regularly for access to ICD-10 implementation information of importance to you.

Partial code freeze prior to ICD-10 implementation (continued)

Note: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

- **CMS-sponsored national provider conference calls** – during the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage*.
- **Frequently asked questions (FAQs)** – to access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at *http://www.cms.gov/ICD10/*, select the "Medicare Fee-for-Service Provider Resources" link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs." Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange (WEDI)** *http://www.wedi.org*
- **Health Information and Management Systems Society (HIMSS)** *http://www.himss.org/icd10*

MLN Matters® Number: SE1033
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

Ambulance services comparative billing report

In November, the Centers for Medicare & Medicaid Services (CMS) released its third national provider comparative billing report (CBR). This report is centered on emergency transports and non-emergency transports related to end-stage renal disease provided by ambulance providers. The CBRs will be released to approximately 5,000 ambulance providers nationwide.

The CBRs, produced by SafeGuard Services under contract with CMS, provide comparative data on how an individual health care provider compares to other providers by looking at utilization patterns for services, beneficiaries, and diagnoses billed. 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.

These reports are not available to anyone but the provider who receives 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 comply with Medicare billing rules and improve the level of care they furnish to their Medicare patients. For more information and to review a sample of the ambulance CBR, please visit the CBR Services website (*www.cbrservices.com*), or call the SafeGuard Services' Provider Help Desk CBR Support Team (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 201011-37

New Web page – physician feedback/value modifier program

The Centers for Medicare & Medicaid Services (CMS) uses claims data to create confidential reports measuring the resources and quality of care involved in furnishing care. In 2010, the physician feedback program is limited to physicians and groups that have been notified – and if you have not received notification then you will not receive a report. Feedback reports will be distributed in a multi-year, phased, implementation schedule to medical professionals and medical group practices.

To learn more about these reports and the legislatively-mandated value modifier, visit the new CMS Web page at *http://www.cms.gov/PhysicianFeedbackProgram*.

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

Source: CMS PERL 201011-37

Information regarding ACOs and the Medicare shared saving program

The Affordable Care Act seeks to improve the quality of health care services and to lower health care costs by encouraging providers to create integrated health care delivery systems. The integrated systems will test new reimbursement methods intended to create incentives for health care providers to enhance health care quality and lower costs. The Medicare shared savings program under Section 3022 of the Affordable Care Act, which promotes the formation and operation of accountable care organizations (ACOs) is one important delivery system reform where groups or providers meeting the criteria specified by the Secretary may work together to manage and coordinate care for Medicare beneficiaries through an ACO. In addition, Section 3021 of the Affordable Care Act establishes a Center for Medicare & Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Service (CMS), which is authorized to test innovative payment and service delivery models.

As CMS develops its initial rulemaking for the shared savings program and begins the development of potential models in CMMI, they are seeking request for comments regarding certain aspects of the policies and standards that will apply to accountable care organizations (ACOs) participating in the Medicare program under Section 3021 or 3022 of the Affordable Care Act. To be assured consideration, comments must've been received no later than December 3.

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

Source: CMS PERL 201011-35

DMEPOS contract suppliers announced

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the Round 1 rebid of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program.

The list of contract suppliers is now available at *http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp#TopOfPage*. Visit the CMS website at *http://www.cms.gov/DMEPOSCompetitiveBid/* to view additional information.

To view the press release, please click: *http://www.cms.gov/apps/media/press_releases.asp*. To view the fact sheet, please click: *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 201011-08

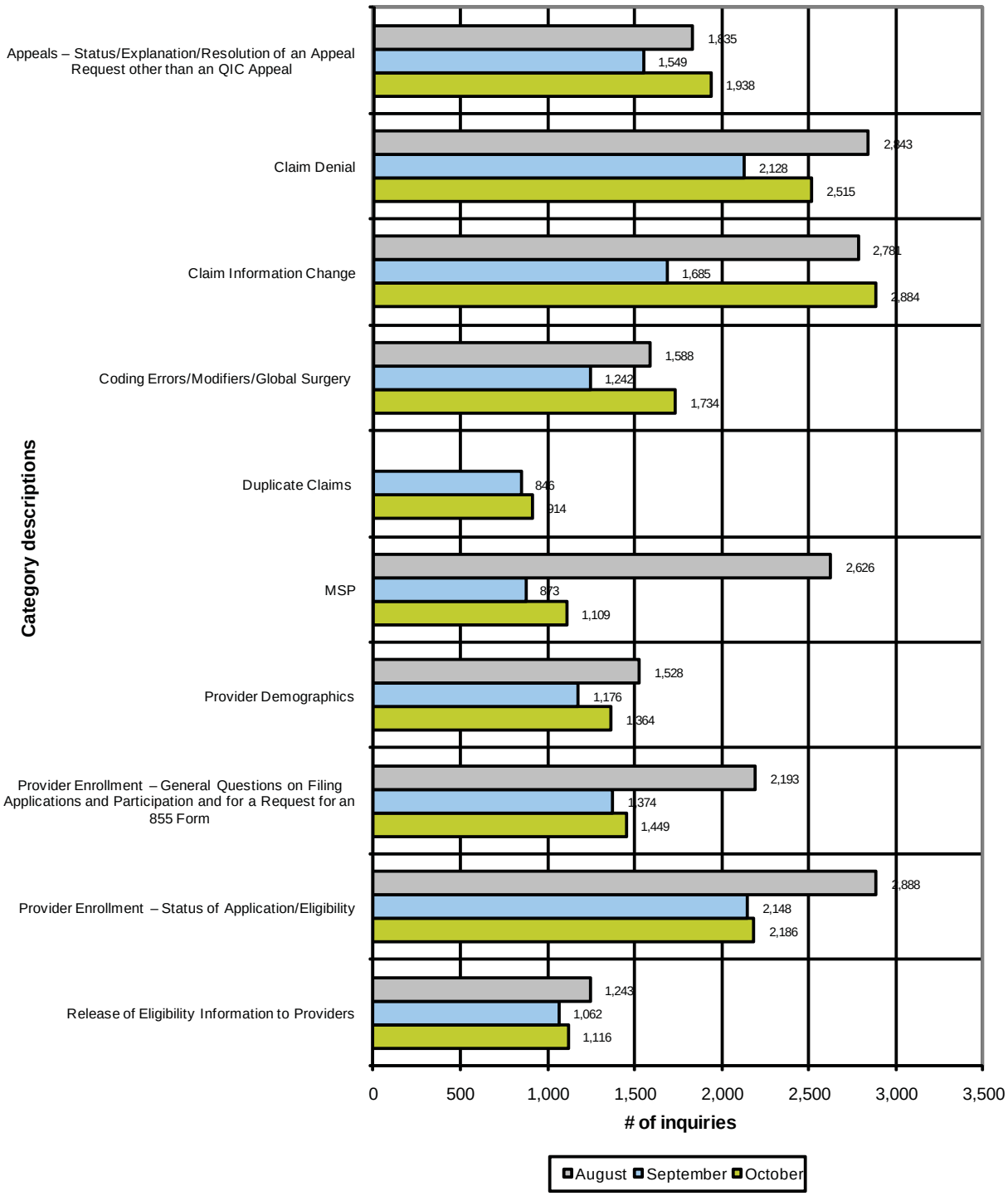
Take advantage of FCSO's exclusive PDS report

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

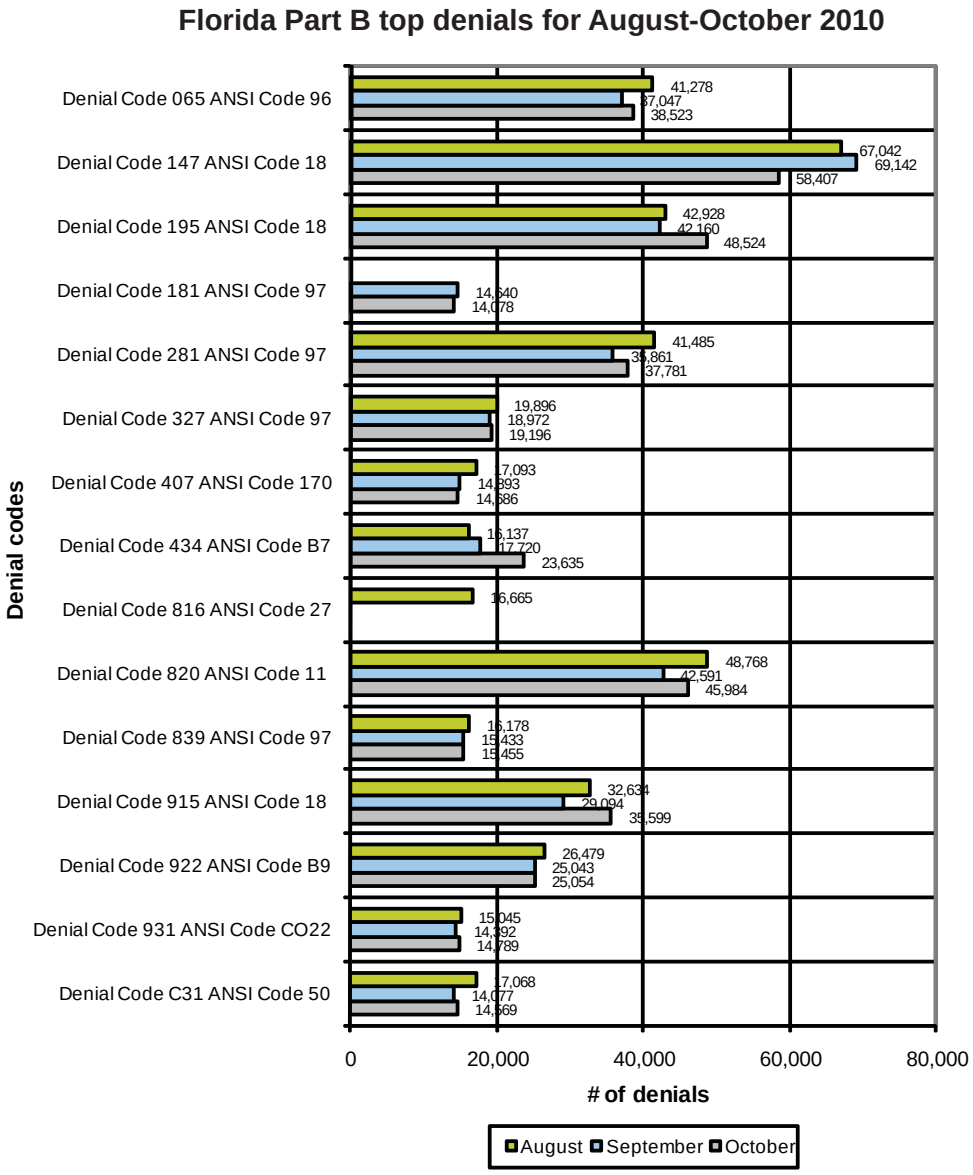
Top inquiries, denials, and return unprocessable claims for August-October

The following charts demonstrate the top inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during August-October 2010. For tips and resources to help you avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part B top inquiries for August-October 2010



Top inquiries, denials, and return unprocessable claims for August-October 2010 (continued)



Tips for avoiding duplicate denials

Before resubmitting a claim, check claims status through the Part B interactive voice response (IVR) system. Do not resubmit an entire claim when partial payment made; when appropriate, resubmit denied lines only. View frequently-asked questions (FAQs) regarding duplicate claims at *http://medicare.fcso.com/FAQs/138013.asp*.

Regarding evaluation and management (E/M) services, physicians in the same group practice of the same specialty must bill and be paid as though they were a single physician.

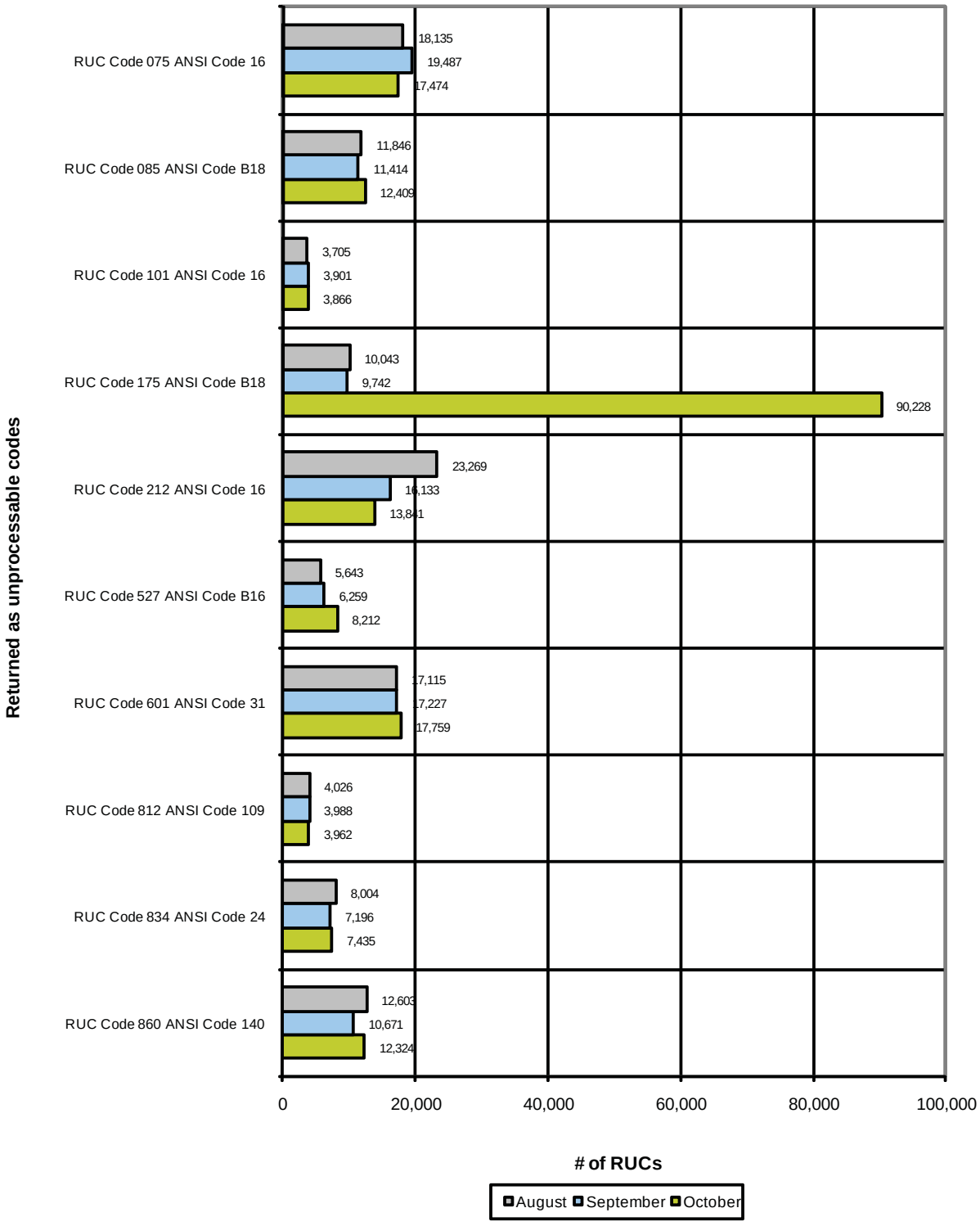
- Only one E/M service may be reported per patient, per day by a physician or by more than one physician of the same specialty in the same group, unless the evaluation and management services are for unrelated problems.
- If more than one face-to-face E/M is provided on the same day to the same patient by the same physician or by more than one physician of the same specialty in the same group, instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.
- Physicians in the same group practice but who are in different specialties (e.g., a cardiologist and a general practice physician) may bill and be paid without regard to their membership in the same group.

FCSO also offers free educational sessions throughout the year, focused on particular billing issues you may be experiencing. These may include webcasts or seminars on avoiding duplicate claims for Part B.

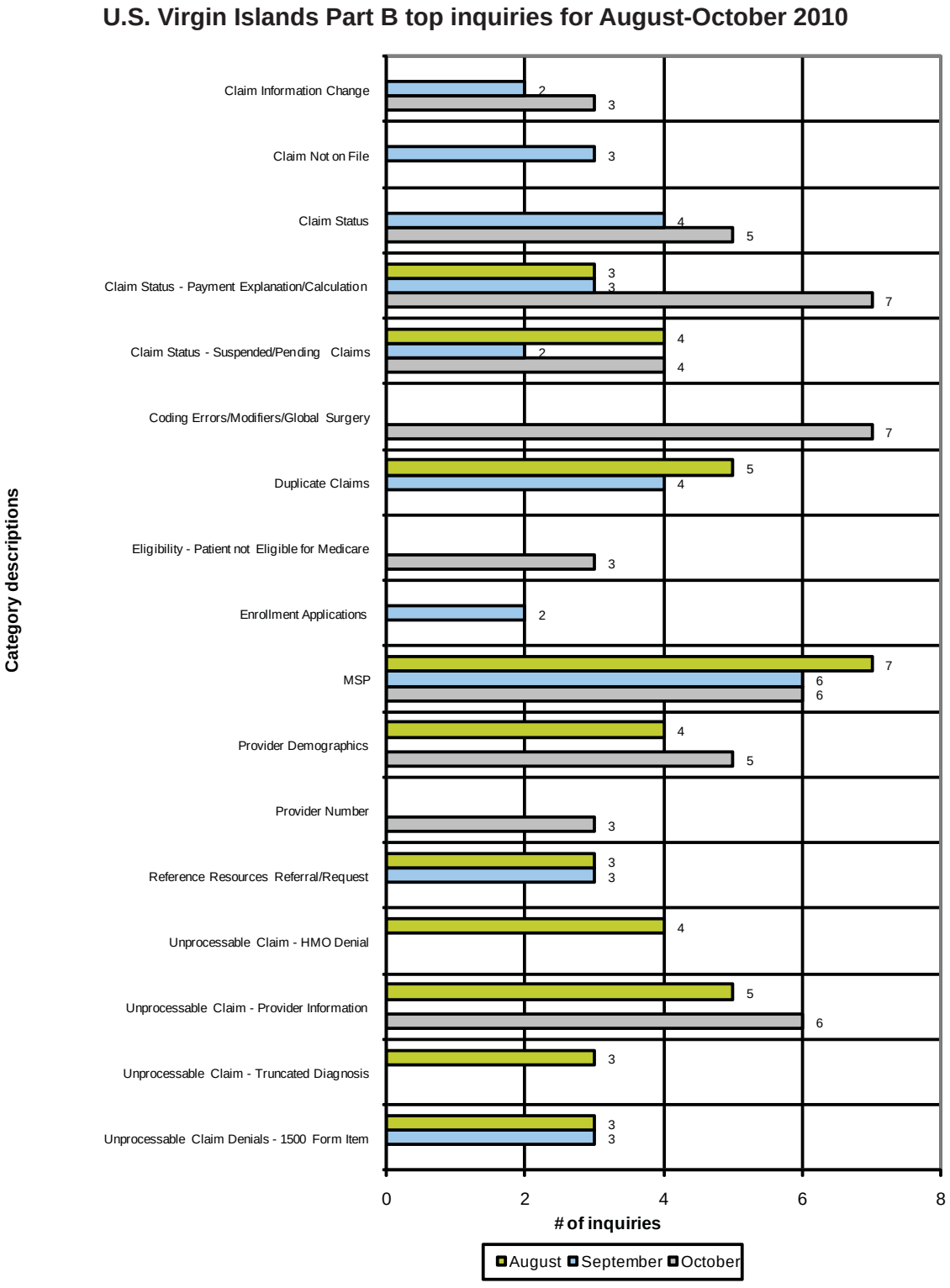
Visit the FCSO Events page at *http://medicare.fcso.com/Events/* to learn about upcoming events and link to our online learning system to review encore presentations of webcasts conducted on this topic.

Top inquiries, denials, and return unprocessable claims for August-October 2010 (continued)

Florida Part B top return as unprocessable claims (RUC) for August-October 2010

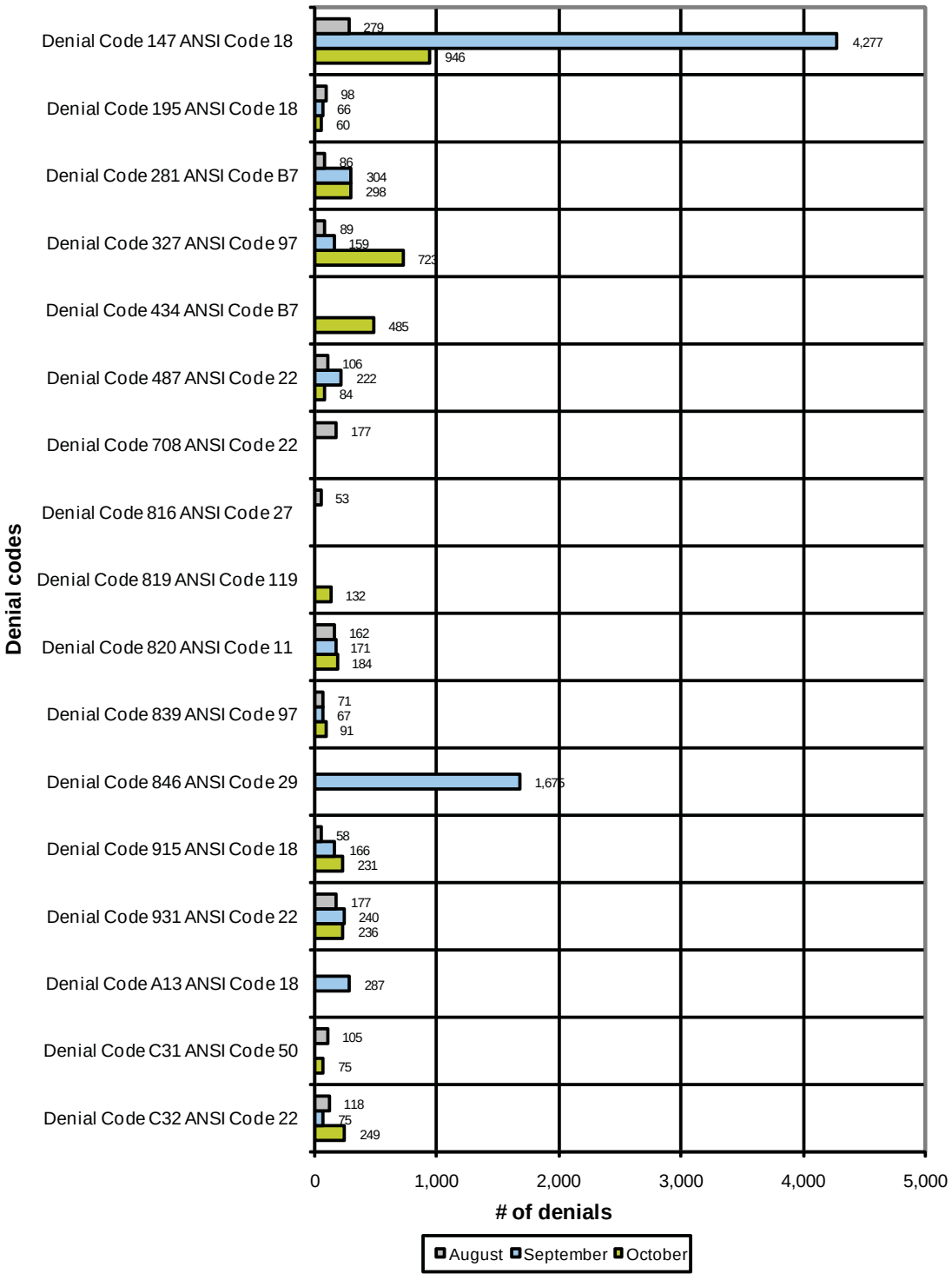


Top inquiries, denials, and return unprocessable claims for August-October 2010 (continued)



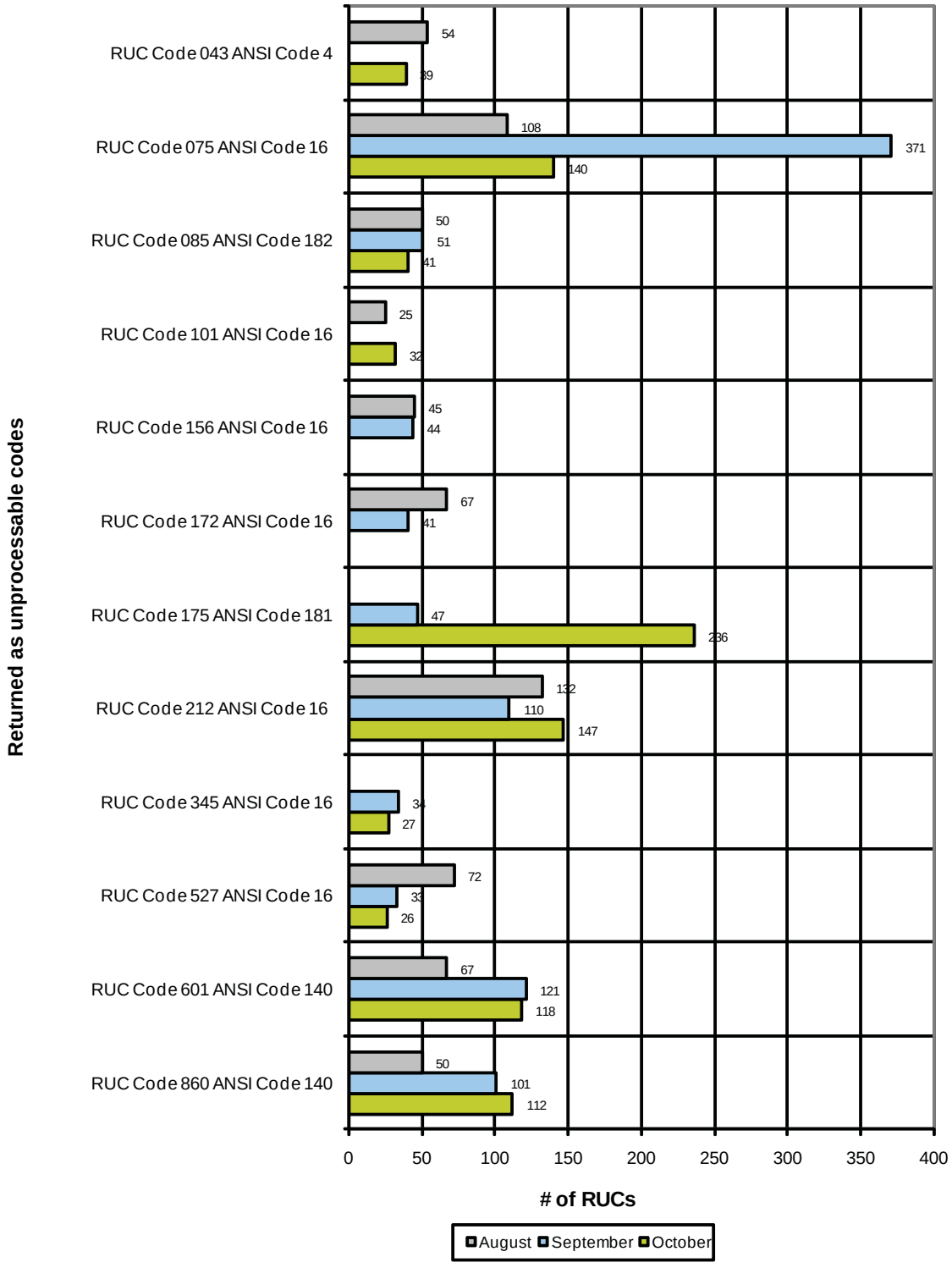
Top inquiries, denials, and return unprocessable claims for August-October 2010 (continued)

U.S. Virgin Islands Part B top denials for August-October 2010



Top inquiries, denials, and return unprocessable claims for August-October 2010 (continued)

U.S. Virgin Islands Part B top return as unprocessable claims (RUC) for August-October 2010



Local Coverage Determinations

This section of the *Medicare B Update!* 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 that the carrier's LCDs and review guidelines are consistent with accepted standards of medical practice.

In accordance with publication requirements specified by the Centers for Medicare & Medicaid Services (CMS), contractors no longer include full text local coverage determinations (LCDs) to providers in the *Update!* Summaries of revised and new LCDs are provided instead. Providers may obtain full-text of final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date of service (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.

Electronic notification

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

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Local Coverage Determinations – Table of Contents

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Modifier GA must be used when 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 must append the billed service with modifier GA or GZ.

Looking for LCDs?

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

Revisions to LCDs

J9355: Trastuzumab (Herceptin®) – revision to the LCD

LCD ID number: L29297 (Florida)
LCD ID number: L29482 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for trastuzumab (Herceptin®) was effective for services rendered on or after February 2, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, language in the LCD has been revised/updated to include categories and testing for human epidermal growth factor receptor 2 (HER2) tumors and to add current off-label indications for breast cancer as outlined in the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium. Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after October 26, 2010**.

In addition, language in the LCD has been revised/updated under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to include the Food and Drug Administration (FDA) indications for metastatic gastric or gastro esophageal junction adenocarcinoma.

Under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, ICD-9-CM code range 150.0-150.9 for malignant neoplasm of esophagus, and ICD-9-CM code 151.0 for malignant neoplasm of cardia were added.

Also, the "CMS National Coverage Policy" and "Sources of Information and Basis for Decision" sections of the LCD were updated.

Effective date

This LCD revision is effective for claims processed **on or after November 11, 2010**, for services rendered **on or after October 20, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare administrative contractor. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education website. It's very easy to do. Simply go to our website *http://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

Educational Events

Upcoming provider outreach and educational events
January 2011

Hot Topics: Bimonthly Medicare Part B ACT: Medicare changes and hot issues

When: Wednesday, January 12
Time: 11:30 a.m.-1:00 p.m.

Hot Topics: Bimonthly Medicare Part B ACT: Medicare data and CMS initiatives

When: Wednesday, January 19
Time: 2:00 p.m.-3:30 p.m.

Note: Unless otherwise indicated, all FCSO educational offerings are considered to be "ask-the-contractor" events, "webcast" type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training website at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

Preventive Services

Medicare improves access to preventive services for 2011

New physician payment policies emphasize role of primary care

The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period that will implement key provisions in the Affordable Care Act of 2010 that expand preventive services for Medicare beneficiaries, improve payments for primary care services, and promote access to health care services in rural areas. The new policies will apply to payments under the Medicare physician fee schedule (MPFS) for services furnished on or after January 1, 2011.

The final rule with comment period implements provisions in the Affordable Care Act that expand beneficiary access to preventive services and, for the first time, provide coverage under the traditional fee-for-service program for an annual wellness visit beginning January 1, 2011. This visit augments the benefits of the initial preventive physical examination (IPPE or "Welcome to Medicare Visit") with an annual visit that allows the physician and patient to develop a personalized prevention plan that considers not only the age-appropriate preventive services generally available to Medicare beneficiaries, but additional services that may be appropriate because of the patient's individual health status.

CMS will accept comments on certain aspects of the final rule with comment period until January 3, 2011.

To view the rule and supporting documentation, go to: *http://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?itemID=CMS1240932&*.

Read the entire CMS press release at *http://www.cms.gov/apps/media/press_releases.asp*. CMS also issued fact sheets with additional details at *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 201011-16

Flu shot reminder

Every office visit is an opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90 percent of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. 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 your flu vaccine - not the flu.

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

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

Source: CMS PERL 201011-06

Lung Cancer Awareness Month and the Great American Smokeout

The Centers for Medicare & Medicaid Services (CMS) asks the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered smoking and tobacco use cessation and counseling to prevent tobacco use services.

Tobacco continues to be the leading cause of preventable death in the United States. Smoking can attribute to and exacerbate lung disease, including lung cancer, as well as other diseases, such as heart disease, stroke, hypertension and diabetes. Medicare provides coverage for smoking and tobacco-use cessation counseling services for certain symptomatic beneficiaries. In addition, effective August 25, 2010, Medicare began covering counseling to prevent tobacco use for certain asymptomatic beneficiaries.

What providers can do?

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

For more information

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

- The MLN Preventive Services Educational Products Web page – provides descriptions and ordering information for *Medicare Learning Network*® educational products for health care professionals related to Medicare-covered preventive services. Visit *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*.

Lung Cancer Awareness Month and the Great American Smokeout (continued)

- *MLN Matters* article MM7133 Counseling to Prevent Tobacco Use – this educational article provides coverage, coding and payment information on counseling to prevent tobacco use for asymptomatic beneficiaries. Available as a downloadable PDF only at *http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf*.
- *The Smoking and Tobacco-Use Cessation Counseling Services brochure* – this brochure provides information on coverage for smoking and tobacco-use cessation counseling services for symptomatic beneficiaries. This product is available in hardcopy or as a downloadable PDF at *http://www.cms.gov/MLNProducts/downloads/smoking.pdf*.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings. Available as a downloadable PDF only at *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.
- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services. Visit *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- The Medicare Preventive Services Series: Part 2 Web-based-training course – includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including smoking and tobacco use cessation counseling services for symptomatic beneficiaries. To access the course, please visit the MLN home page at *http://www.cms.gov/MLNGenInfo*, scroll down to "Related Links Inside CMS," and click on "Web-Based Training (WBT) Modules."

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

For more information on Lung Cancer Awareness Month, please visit the Lung Cancer Alliance's official page at *http://www.lungcanceralliance.org/involved/lcam_month.html*.

For additional information on the Great American Smokeout, celebrated on Thursday November 18, please visit the American Cancer Society's official page at *http://www.cancer.org/Healthy/StayAwayfromTobacco/GreatAmericanSmokeout/index*.

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

Source: CMS PERL 201011-22

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

National Diabetes Awareness Month and Diabetic Eye Disease Month

November is National Diabetes Awareness Month and Diabetic Eye Disease Month. Diabetes can lead to severe complications such as heart disease, stroke, and kidney failure. It is also a significant risk factor for developing glaucoma.

The Centers for Medicare & Medicaid Services (CMS) asks the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered diabetes-related services. Medicare provides coverage of several diabetes-related preventive services for eligible beneficiaries, including:

- Diabetes screening tests
- Diabetes self-management training
- Medical nutrition therapy
- Diabetes-related supplies, and
- Glaucoma screening

What can you do?

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

Additional information

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

- The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network*® (*MLN*) educational products for health care professionals related to Medicare-covered preventive services. Visit *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*
- *The Diabetes-Related Services brochure* – provides information on coverage for Medicare-covered diabetes-related services. This product is available in hardcopy or as a downloadable PDF. Visit *http://www.cms.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.
- *The Glaucoma Screening brochure* – provides information on coverage for Medicare-covered glaucoma screening. This product is available in hardcopy or as a downloadable PDF. Visit *http://www.cms.gov/MLNProducts/downloads/glaucoma.pdf*.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings. Available as a downloadable PDF only. Visit *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*.

National Diabetes Awareness Month and Diabetic Eye Disease Month (continued)

- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services. Visit *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.
- The Medicare Preventive Services Series: Part 2 Web-Based-Training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including diabetes-related services. To access the course, please visit the MLN homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules."
- The Medicare Preventive Services Series: Part e Web-Based-Training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including glaucoma screening. To access the course, please visit the MLN homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules."

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products. For more information on National Diabetes Awareness Month, please visit the American Diabetes Association's official page at *http://www.diabetes.org/in-my-community/programs/american-diabetes-month*. For additional information on National Diabetes Awareness Month, please visit the National Diabetes Education Program (NDEP) website at *http://ndep.nih.gov/whats-new/posting.aspx?id=23*. For more information on diabetic eye disease, please visit the Prevent Blindness America website at *http://www.preventblindness.org*. For more information to share with your patients about diabetes, please visit the NDEP website at *http://www.ndep.nih.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 201011-04

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

Other Educational Resources

New DMEPOS competitive bidding program fact sheets now available

The following new fact sheets related to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program are now available in downloadable format from the *Medicare Learning Network*®.

- *DMEPOS Competitive Bidding Program Traveling Beneficiary Fact Sheet*
- *DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers Fact Sheet*
- *DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers Fact Sheet*

On January 1, 2011, when the DMEPOS Competitive Bidding Program goes into effect in nine competitive bidding areas (CBAs), beneficiaries with original Medicare who obtain competitively bid items in CBAs must obtain those items from a contract supplier in order for Medicare to pay, unless an exception applies.

To learn more, view the fact sheets at *http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp* and click on the appropriate links in the "Downloads" section.

For more information about the DMEPOS Competitive Bidding Program, including a list of the first nine CBAs and items included in the program, visit *http://www.cms.gov/DMEPOSCompetitiveBid*.

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

Source: CMS PERL 201010-42

Sign up to our *eNews* electronic mailing list

Join our ***eNews*** mailing list and receive urgent and other critical information issued by First Coast Service Options, Inc. (FCSO), your Medicare administrative contractor. By signing up, you will receive automatic e-mail notification when new or updated information is posted to the provider education website. It's very easy to do. Simply go to our website *http://medicare.fcso.com*, click on the "***eNews***" link located on the upper-right-hand corner of the page and follow the prompts.

Release of additional DMEPOS Competitive Bidding Program fact sheets

The *Medicare Learning Network*® has released three new fact sheets related to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program:

- *The DMEPOS Competitive Bidding Program Non-Contract Supplier Fact Sheet* – designed to educate suppliers on a broad variety of requirements for non-contract suppliers under the DMEPOS competitive bidding program.
- *The DMEPOS Competitive Bidding Program Enteral Nutrition Fact Sheet* – designed to educate suppliers on rules for providing enteral nutrition under the DMEPOS competitive bidding program.
- *The DMEPOS Competitive Bidding Program Mail Order Diabetic Supplies Fact Sheet* – designed to educate suppliers on rules regarding providing mail order diabetic supplies under the DMEPOS competitive bidding program.

To learn more, please visit the DMEPOS Competitive Bidding Educational Resources page at *http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp*, then select the "DMEPOS Competitive Bidding Fact Sheets" link in the "Downloads" section.

Also, CMS would like to remind all non-contract suppliers that furnish competitively-bid rented durable medical equipment (DME) or oxygen and oxygen equipment to beneficiaries in competitive bidding areas (CBAs) of the following upcoming deadlines:

- A non-contract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary who resides in a CBA and is currently renting competitively bid oxygen and oxygen equipment or DME from that supplier. These notifications must be sent by November 17. A non-contract supplier that elects to become a grandfathered supplier must also provide written notification to the Centers for Medicare & Medicaid Services (CMS) of this decision by November 17.
- A non-contract supplier that elects not to become a contract supplier is required to pick-up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a two-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting competitively-bid DME or oxygen and oxygen equipment and who reside in a CBA. The 30-day written notification to the beneficiary must be sent by November 17.

For more information on grandfathering requirements, please see the DMEPOS Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet, which is now available, free of charge, from the *Medicare Learning Network*® at *http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp* in the "Downloads" section.

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

Source: CMS PERL 201011-25

DMEPOS competitive bidding program traveling beneficiary fact sheet

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Traveling Beneficiary Fact Sheet* is now available, free of charge, from the *Medicare Learning Network*®.

Once the DMEPOS competitive bidding program becomes effective on January 1, 2011, beneficiaries with original Medicare who obtain competitively-bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. This includes beneficiaries who do not live in a CBA but who obtain competitively-bid items while traveling to a CBA. This fact sheet contains helpful information on competitive bidding program rules that apply when a beneficiary travels.

To learn more, please visit the DMEPOS Competitive Bidding Educational Resources page at *http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp*. Select the link titled "DMEPOS Competitive Bidding Fact Sheets [PDF, 40KB]" in the "Downloads" section to obtain a list of all fact sheets related to the DMEPOS Competitive Billing program.

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

Source: CMS PERL 201010-44

'Caregiving Education' publications

A new publication titled "Caregiving Education" (September 2010) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/MLN_CaregivingEducation.pdf*. Medicare will pay for certain types of caregiver education when it is provided as part of a patient's medically necessary face-to-face visit.

This publication provides information on how to bill for caregiver education under Medicare Parts A and B.

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

Source: CMS PERL 201011-22

DMEPOS grandfathering requirements for non-contract supplier fact sheet

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet* is now available, free of charge, from the *Medicare Learning Network®*.

Once the DMEPOS competitive bidding program becomes effective on January 1, 2011, beneficiaries with original Medicare who obtain competitively-bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies.

All non-contract suppliers that furnish competitively bid rented durable medical equipment (DME) or oxygen and oxygen equipment to beneficiaries in CBAs must decide if they will elect to become grandfathered suppliers, notify beneficiaries of their grandfathering decisions, and fulfill other requirements. A non-contract supplier that elects to become a grandfathered supplier must provide written notification to the Centers for Medicare & Medicaid Services (CMS) of this decision by November 17.

This fact sheet contains helpful information on competitive bidding program rules and requirements related to grandfathering. To learn more, please visit the DMEPOS Competitive Bidding Educational Resources page at *http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp* on the CMS website and scroll to the "Downloads" section.

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

Source: CMS PERL 201011-21

Fact sheets on walker exceptions to the DMEPOS competitive bidding program

The *Medicare Learning Network®* has released the following two fact sheets related to exceptions for walkers under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program:

- *DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers* fact sheet
- *DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers* fact sheet

Under the DMEPOS competitive bidding program, beneficiaries with original Medicare who obtain competitive bidding items in designated competitive bidding areas (CBAs) are required to obtain these items from a contract supplier, unless an exception applies. For the first phase of competitive bidding, which is effective January 1, 2011, one of these exceptions allows hospitals to furnish competitively bid walkers in a CBA to their own patients, without submitting a bid and being selected as a contract supplier. Similarly, another of these exceptions allows physicians and other treating practitioners who are enrolled Medicare DMEPOS suppliers to furnish competitively bid walkers in a CBA to their own patients without submitting a bid and being selected as a contract supplier.

To learn more and download these fact sheets, please visit the DMEPOS Competitive Bidding Educational Resources page at *http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp*, then select the appropriate link in the "Downloads" section.

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

Source: CMS PERL 201011-02

Medicare information for advanced practice nurses and physician assistants

A new *Medicare Learning Network®* booklet titled "*Medicare Information for Advanced Practice Nurses and Physician Assistants*" (September 2010), which is designed to provide education on Medicare requirements for advanced practice nurses (APN) and physician assistants (PA), is now available in downloadable format at *http://www.cms.gov/MLNProducts/downloads/Medicare_Information_for_APNs_and_PAs_Booklet_ICN901623.pdf* .

This publication provides information about required qualifications, coverage criteria, billing, and payment for Medicare services furnished by APNs and PAs.

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

Source: CMS PERL 201011-22

Mail directory

Claims submissions

Routine paper claims
Medicare Part B
P. O. Box 2525
Jacksonville, FL 32231-0019

Participating providers
Medicare Part B participating providers
P. O. Box 44117
Jacksonville, FL 32231-4117

Chiropractic claims
Medicare Part B chiropractic unit
P. O. Box 44067
Jacksonville, FL 32231-4067

Ambulance claims
Medicare Part B ambulance dept.
P. O. Box 44099
Jacksonville, FL 32231-4099

Medicare secondary payer
Medicare Part B secondary payer dept.
P. O. Box 44078
Jacksonville, FL 32231-4078

ESRD claims
Medicare Part B ESRD claims
P. O. Box 45236
Jacksonville, FL 32232-5236

Communication

Redetermination requests
Medicare Part B claims review
P.O. Box 2360
Jacksonville, FL 32231-0018

Fair hearing requests
Medicare hearings
P.O. Box 45156
Jacksonville FL 32232-5156

Freedom of Information Act
Freedom of Information Act requests
Post office box 2078
Jacksonville, Florida 32231

Administrative law judge hearing
Q2 Administrators, LLC
Part B QIC South Operations
P.O. Box 183092
Columbus, Ohio 43218-3092
Attn: Administration manager

Status/general inquiries
Medicare Part B correspondence
P. O. Box 2360
Jacksonville, FL 32231-0018

Overpayments
Medicare Part B financial services
P. O. Box 44141
Jacksonville, FL 32231-4141

Durable medical equipment (DME)

DME, orthotic or prosthetic claims
Cigna Government Services
P.O. Box 20010
Nashville, Tennessee 37202

Electronic media claims (EMC)

Claims, agreements and inquiries
Medicare EDI
P. O. Box 44071
Jacksonville, FL 32231-4071

Additional development

Within 40 days of initial request:
Medicare Part B Claims
P. O. Box 2537
Jacksonville, FL 32231-0020

Over 40 days of initial request: Submit the charge(s) in question, including information requested, as you would a new claim, to:
Medicare Part B Claims
P. O. Box 2525
Jacksonville, FL 32231-0019

Miscellaneous

Provider participation and group membership issues; written requests for UPINs, profiles & fee schedules:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address:
Medicare Enrollment
P. O. Box 44021
Jacksonville, FL 32231-4021
and
Provider Enrollment Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32203-1109

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Limiting charge issues:
Processing errors:
Medicare Part B
P. O. Box 2360
Jacksonville, FL 32231-0048

Refund verification:
Medicare Part B
Compliance Monitoring
P. O. Box 2078
Jacksonville, FL 32231-0048

Medicare claims for Railroad retirees:
Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse
First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Phone numbers

Providers

Toll-Free
Customer Service:
1-866-454-9007

Interactive Voice Response (IVR):
1-877-847-4992

E-mail address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary

Toll-Free:
1-800-MEDICARE
Hearing Impaired:
1-800-754-7820

Note: The toll-free customer service lines are reserved for Medicare beneficiaries only. Use of this line by providers is not permitted and may be considered program abuse.

Education event registration (not toll-free):

1-904-791-8103

Electronic data interchange (EDI)

1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - Electronic funds (check return assistance only)

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Medicare websites

Provider

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Mail directory

Claims, additional development, general correspondence

First Coast Service Options Inc.
P. O. Box 45098
Jacksonville, FL 32232-5098

Flu rosters

First Coast Service Options Inc.
P. O. Box 45031
Jacksonville, FL 32232-5031

Electronic data interchange (EDI)

First Coast Service Options Inc.
P. O. Box 44071
Jacksonville, FL 32231-4071

Part B debt recovery, MSP inquiries and overpayments, and cash management

First Coast Service Options Inc.
P.O. Box 45013
Jacksonville, FL 32232-5013

Provider enrollment

Where to mail provider/supplier applications
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Provider change of address
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

and

Provider Registration Department
Blue Cross Blue Shield of Florida
P. O. Box 41109
Jacksonville, FL 32231-1109

Redeterminations

First Coast Service Options Inc.
P. O. Box 45024
Jacksonville, FL 32232-5091

Redetermination overpayment

First Coast Service Options Inc.
P. O. Box 45091
Jacksonville, FL 32232-5091

Freedom of Information Act requests (FOIA)

First Coast Service Options Inc.
P. O. Box 45073
Jacksonville, FL 32232-5073

Congressional inquiries

First Coast Service Options Inc.
Attn: Carla-Lolita Murphyt
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevailing charges or fee schedule:
Medicare Part B
Provider Outreach and Education
P. O. Box 2078
Jacksonville, FL 32231-0048

Education event registration:
Medicare Part B
Medicare Education and Outreach
P. O. Box 45157
Jacksonville, FL 32232-5157

Medicare claims for railroad retirees

Palmetto GBA
Railroad Medicare Part B
P. O. Box 10066
Augusta, GA 30999-0001

Fraud and abuse

First Coast Service Options Inc.
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Local coverage determinations

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

Post pay medical review

First Coast Service Options Inc.
P. O. Box 44288
Jacksonville, FL 32231-4288

Overnight mail and/or other special courier services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Medicare websites

Provider

First Coast Service Options Inc. (FCSO), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
www.medicare.gov

Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

E-mail address: *AskFloridaB@fcso.com*

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
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1-904-791-8103

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DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-866-270-4909

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to FCSO Account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2010 through September 2011.	40300260	Hardcopy $33		
		CD-ROM $55		
2011 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 11, 2011, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies or a CD-ROM are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publications.	40300270	Hardcopy $12		
		CD-ROM $6		
Language preference: **English** [ ] **Español** [ ]				
	Please write legibly		Subtotal	**$**
			Tax (***add % for your area***)	**$**
			Total	**$**

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE B Update!

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

♦ ATTENTION BILLING MANAGER ♦