

C Medicare B CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

February 2012



In this issue

Determining eligibility for the Medicare HPSA physician bonus payment.....	5
April 2012 ASP Medicare Part B drug pricing update.....	7
Summary of policies in the CY 2012 MPFS final rule...	12
Delay of ICD-10 compliance date.....	31
5010 upgrade – questions to ask your vendor	35

Health care fraud prevention and enforcement efforts result in record-breaking recoveries totaling nearly \$4.1 billion

On Tuesday, February 14, Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius released a new report showing that the government's health care fraud prevention and enforcement efforts recovered nearly \$4.1 billion in taxpayer dollars in fiscal year (FY) 2011. This is the highest annual amount ever recovered from individuals and companies who attempted to defraud seniors and taxpayers or who sought payments to which they were not entitled.

These findings, in the annual Health Care Fraud and Abuse Control Program (HCFAC) report, are a result of President Obama making the elimination of fraud, waste, and abuse a top priority in his administration. The success of this joint Department of Justice and HHS effort would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste, and abuse in the Medicare and Medicaid programs, and to crack down on the fraud perpetrators who are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with the new tools and resources provided by the Affordable Care Act.

The recently-enacted Affordable Care Act provides additional tools and resources to help fight fraud that

will help boost these efforts, including an additional \$350 million for HCFAC activities. The administration is already using tools authorized by the Affordable Care Act, including enhanced screenings and enrollment requirements, increased data-sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

The departments also continued their successes in civil health care fraud enforcement during FY2011. Approximately \$2.4 billion was recovered through civil health care fraud cases brought under the False Claims Act (FCA). These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the FDA, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks. This marked the second year in a row that more than \$2 billion has been recovered in FCA health care matters and, since January 2009, the department has used the FCA to recover more than \$6.6 billion in federal health care dollars.

The fraud prevention and enforcement report announced Tuesday, February 14 coincided with the announcement of a proposed rule from CMS aimed at recollecting overpayments in the Medicare program. Before the Affordable Care Act, providers and suppliers did not face an explicit deadline for returning taxpayers' money. Thanks to the Affordable Care Act, there will be a specific timeframe by which self-identified overpayments must be reported and returned.

(continued page 38)



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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

About the Medicare B Connection

About the Medicare B Connection.....	3
Advance beneficiary notices.....	4
GA modifier and appeals.....	4

Claims

Determining eligibility for the Medicare HPSA physician bonus payment.....	5
----------------------------------------------------------------------------	---

Coverage/Reimbursement

Ambulance

Additional provider and supplier enrollment requirements for fixed wing and helicopter air ambulance operators.....	6
---------------------------------------------------------------------------------------------------------------------	---

Drugs and Biologicals

April 2012 ASP drug pricing files and revisions to prior quarterly pricing files.....	7
---------------------------------------------------------------------------------------	---

Durable Medical Equipment

Extension of licensure deadline for the round 2 and national mail-order competitions....	8
Bidding is now open for the round 2 and national mail-order competitions.....	9
Analysis of the competitive bidding program shows no changes in health outcomes.....	10
Education materials for round 2 and national mail-order bidders.....	10

Laboratory/Pathology

New waived tests.....	11
'Clinical Laboratory Fee Schedule' fact sheet.....	12

Medicare Physician Fee Schedule

Summary of CY 2012 MPFS final rule and telehealth services.....	12
-----------------------------------------------------------------	----

Preventive Services

Intensive behavioral therapy for obesity.....	16
Screening for sexually-transmitted infections and high-intensity behavioral counseling.....	20

Radiology

Interaction of the MPPR on imaging procedures and the OPPI cap on the TC.....	25
Reprocessing ADI claims denied in error.....	26

Surgery

Proposed NCD for transcatheter aortic valve replacement.....	26
--------------------------------------------------------------	----

General Coverage

Revised and clarified place of service coding.....	27
HHS announces intent to delay ICD-10.....	31

Electronic Data Interchange

PWK is coming.....	32
Resolution of the 5010 electronic claims submission 496 edit.....	33
Important update regarding HIPAA version 5010/D.0 implementation.....	34
5010 requirement changes for non-specific procedure codes.....	34
5010 upgrade – questions to ask your vendor.....	35
All payments to be made by EFT.....	35
Only one ERA recipient per NPI or legacy ID – beginning April 1.....	36
Claim status category and codes update.....	36
Use of unique numbering for 837 claims.....	37
ASC X12 decides against version 6020 as next version of standard under HIPAA.....	37

General Information

Fraud

The role of ZPICs.....	38
Prior authorization of power mobility devices demonstration and recovery audit prepayment review demonstration.....	41

Provider Enrollment

Major improvements to PECOS.....	41
2012 Medicare Part B Participating Physician and Supplier Directory.....	42
ADI accreditation enrollment procedures....	42

Incentive Programs

Physician Quality Reporting System update – measure #235 claims error.....	43
2012 Physician Quality Reporting System claims-based coding and reporting principles.....	44
New educational resources for the Physician Quality Reporting System.....	46
2012 eRx Incentive Program: Future payment adjustments.....	47
New educational resources for the eRx incentive program.....	51
New Web page on CQMs added to the EHR website.....	51
EHR incentive program messages.....	52
EHR highlights and resources.....	52
EHR self-serve options.....	54

General Information

Immediate recoupment for FFS claims overpayments.....	55
Proposed steps to protect taxpayer dollars – Affordable Care Act gives new authority to recover overpayments more quickly.....	56
Physician feedback program and quality and resource use reports: New website updates.....	57
Updates to the physician compare website.....	58
Updating information with the COBC.....	58
Affordable Care Act announcements.....	60
Physician self-referral prohibition: Additional information on exception process for physician-owned hospitals.....	60

Claim and Inquiry Summary Data

Top inquiries, denials, and return unprocessable claims.....	61
What to do when your claim is denied.....	62

Local Coverage Determinations

Contents.....	67
---------------	----

Educational Resources

Upcoming provider outreach and educational events – March 2012.....	69
---------------------------------------------------------------------	----

Preventive Services

Release of reports on improved access to preventive services.....	70
Medicare preventive services fact sheet.....	70
Tobacco-Use Cessation Counseling Services brochure revised.....	71
February is American Heart Month.....	71

Other Educational Resources

MLN Matters® articles search tips.....	72
New MLN® 'fast fact'.....	72
'Guidelines for Teaching Physicians, Interns, and Residents' fact sheet revised... ..	72
Physician volunteers needed to pilot test continuing education activities.....	72
CBR on advanced diagnostic imaging.....	73
MLN® provider exhibit program schedule.....	73

Contact Information

Florida Contact Information.....	74
U.S. Virgin Islands Contact Information.....	75

Order form

Order form for Part B materials.....	76
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The Medicare B Connection is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part B providers.

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

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About the Medicare B Connection

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

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

Who receives the Connection

Anyone may view, print, or download the Connection from our provider education website(s). Providers who cannot obtain the Connection from the Internet are required to register with us to receive a complimentary hardcopy.

Distribution of the Connection in hardcopy is limited to providers who have billed at least one Part B claim to FCSO Medicare 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 (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 Connection 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 Connection is arranged into distinct sections.

- 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
- **Contact information** for Florida and the U.S. Virgin Islands.

The Medicare B Connection represents formal notice of coverage policies

Articles included in each edition 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.



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 Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at <http://www.cms.gov/manuals/downloads/clm104c30.pdf#page=41>.

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/02_ABN.asp.

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.

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

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 (waiver 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 Contact Information section of this publication for the address in which to send written appeals requests.

Determining eligibility for the Medicare HPSA physician bonus payment

Physicians who may be eligible for the Medicare health professional shortage area (HPSA) bonus payment should be aware of the following information and educational resources regarding determining eligibility, in order to minimize errors during the post-payment review process.

- Information on the HPSA bonus, including the list of zip codes eligible for automatic payment, can be found at on the Centers for Medicare & Medicaid Services (CMS) website at http://www.CMS.gov/HPSApsaPhysicianBonuses/01_overview.asp.
- Two *MLN Matters*® articles are available which go into further detail:
 - “2012 Annual Update for the HPSA Bonus Payments” (MM7517) is available at <http://www.CMS.gov/MLNMattersArticles/downloads/MM7517.pdf>, and
 - “HPSA Bonus Payment Policy Reminders” (SE1202) is available at <http://www.CMS.gov/MLNMattersArticles/downloads/SE1202.pdf>.
- Websites to help determine existing designations and eligibility for the Medicare HPSA physician bonus include:
 - <http://HPSAfind.HRSA.gov/HPSAsearch.aspx> – to identify designations within a state,
 - <http://www.FFIEC.gov/geocode/default.aspx> – to identify census tracts by entering an address), and
 - <http://DataWarehouse.HRSA.gov/geoadvisor/ShortageDesignationAdvisor.aspx> – to see if an area is listed as being in an eligible area.

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

Source: CMS PERL 201202-08

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Ambulance

Additional provider and supplier enrollment requirements for fixed wing and helicopter air ambulance operators

Note: This article was revised on January 30, 2012, to provide clarification, based on the CMS-855B enrollment application, of the licensure and certification requirement. This information was previously published in the November 2011 *Medicare B Connection*, Page 6.

Provider types affected

Ambulance suppliers submitting claims for air ambulance services to Medicare carriers and A/B Medicare administrative contractors (A/B MACs) are affected by this article.

Provider action needed

This article, based on change request (CR) 7363, informs you that, on November 29, 2010, the Centers for Medicare & Medicaid Services (CMS) published a final rule that clarified the reporting requirements for air ambulance suppliers. The rule states that within 30 days of any revocation or suspension of a federal or state license or certification including Federal Aviation Administration (FAA) certification, an air ambulance supplier must report the revocation or suspension of its license or certification to the applicable Medicare contractor. Air ambulance suppliers must maintain either directly or through appropriate arrangements, compliance with all applicable Federal and State licenses, and certifications and report the following FAA certifications: Specific pilot certification, instrument and medical certifications, and air worthiness certification.



Background

Medicare contractors must ensure that the air ambulance suppliers remain in compliance with all licensure, and other pertinent federal and state requirements. The Medicare contractor evaluation process will include an evaluation of all documentation submitted with the CMS-855B Provider Enrollment Application, and as appropriate, verification with the FAA website.

Attachment 1 to the CMS-855B Medicare Enrollment Application (Clinics/Group Practices and Certain other Suppliers (07/11)) outlines the information that should be submitted with the initial or revalidation air ambulance application. (The CMS-855B application is available at <http://www.cms.gov/CMSforms/downloads/cms855b.pdf>.) In pertinent part Attachment 1 specifies the following additional information is to be submitted with the application:

- A written statement, signed by the president, chief executive officer or chief operating officer of the airport from where the aircraft is hangared that gives the name and address of the facility; and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) on the application.

If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany the enrollment application. In addition, Medicare contractors shall accept the following as acceptable proof:

- If the air ambulance supplier or provider owns the aircraft but contracts with an air services vendor to supply pilots, training and/or vehicle maintenance, the FAA Part 135 certificate must be issued in the name of the air services vendor. A certification from the supplier or provider must also attest that it has an agreement with the air services vendor and must list the date of that agreement. A copy of the FAA Part 135 Certificate must accompany the enrollment application.

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- If the air ambulance supplier or provider leases the aircraft from another entity, a copy of the lease agreement must accompany the enrollment application. The name of the company leasing the aircraft from that other entity must be the same as the supplier's or provider's name on the enrollment application.

Additional information

The official instruction, CR 7363 issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R400PI.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: MM7363 *Revised*

Related Change Request (CR) #: 7363

Related CR Release Date: November 21, 2011

Effective Date: February 3, 2012

Related CR Transmittal #: R400PI

Implementation Date: February 3, 2012

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Drugs and Biologicals

April 2012 quarterly average sales price Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider types affected

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

Provider action needed**Stop – impact to you**

Medicare will use the April 2012 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2012, with dates of service April 1, 2012, through June 30, 2012.

Caution – what you need to know

Change request (CR) 7734, from which this article is taken, instructs your Medicare contractors to download and implement the April 2012 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised January 2012, October 2011, July 2011, and April 2011 files.

Go – what you need to do

You should make sure that your billing staffs are aware of the release of these April 2012 ASP Medicare Part B drug files.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c); (see <http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf>) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.



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The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPSS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 [Part B Hospital [Including Inpatient Hospital Part B and OPSS]], Section 50 (Outpatient PRICER); see <http://www.cms.gov/manuals/downloads/clm104c04.pdf>.)

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

Files	Effective for dates of service
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011

Additional information

You can find the official instruction, CR 7344, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2396CP.pdf>. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7734

Related Change Request (CR) #: CR 7734

Related CR Release Date: January 26, 2012

Effective Date: April 1, 2012

Related CR Transmittal #: R2396CP

Implementation Date: April 2, 2012

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Durable Medical Equipment

Extension of licensure deadline for the round 2 and national mail-order competitions of the DMEPOS competitive bidding program

The Centers for Medicare & Medicaid Services (CMS) is extending the licensure deadline for the round 2 and national mail-order competitions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The original licensure deadline required suppliers to have all required state licenses on file with the national supplier clearinghouse (NSC) and indicated in the Provider Enrollment, Chain, and Ownership System (PECOS) before submitting a bid.

New deadline: Bidding suppliers must now ensure that copies of all applicable state licenses are **received** by the NSC on or before Tuesday, May 1, 2012.

Bids will be disqualified if a bidder does not meet all state licensure requirements for the applicable product categories and for every state in a competitive bidding area (CBA). Every supplier location is responsible for having all applicable license(s) for each state in which it provides services. For a multi-state CBA, the bidder must collectively have all applicable license(s) for every state in the CBA. Each location is not required to have licenses for every state in the CBA as long as each state has a bidding location licensed for the product category.

Please note that the extension of the licensure deadline does **not** change any other deadlines. All bids must be submitted in DBidS, the online bidding system, by 8:59:59 p.m. ET on Friday, March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be received by the competitive bidding implementation contractor (CBIC) on or before Friday, March 30, 2012.

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A licensure directory for each state, the District of Columbia, and the territories may be found on the NSC website at www.PalmettoGBA.com/NSC. Licensure requirements vary from state to state. The NSC licensure directory provides a good starting point to assist in identifying the licenses you need. State licensure requirements change periodically and may have exceptions, so the NSC's licensure directory serves only as a guide. It remains the bidding supplier's responsibility to ensure compliance with the most current state and federal laws and regulations.

For more information on licensure requirements, you may refer to the *"Licensure for Bidding Suppliers" fact sheet* and the *"Request for Bids (RFB) Instructions"*. If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9 a.m. and 9 p.m. ET during the registration and bidding periods.

Please note that the RFB instructions initially posted on the CBIC website contained the original licensure deadline. These instructions have now been updated to reflect the new licensure deadline shown in this announcement.

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

Source: CMS PERL 201202-07

Bidding is now open for the round 2 and national mail-order competitions of the DMEPOS competitive bidding program

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program.

All bids must be submitted in DMEPOS Bidding System (DBidS), the online bidding system, by 8:59:59 p.m. ET on March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be **received** by the competitive bidding implementation contractor (CBIC) on or before March 30, 2012. The contract period for the round 2 and national mail-order competitions is July 1, 2013-June 30, 2016.

All bidders must submit certain required hardcopy documents as specified in the *Request for Bids (RFB) Instructions*. CMS urges all bidders to take advantage of the covered document review process. Under this process, CMS will notify suppliers that submit their hardcopy financial documents by the covered document review date (CDRD) of any missing financial documents. The CDRD for the round 2 and national mail-order competitions was February 29, 2012 – financial documents must've been **received** on or before February 29, 2012, to qualify for the covered document review process. This process only determines if there are any missing financial documents. It does not indicate if the documents are acceptable, accurate, or meet applicable requirements. Suppliers that submit financial documents by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Suppliers are required to submit the missing financial document(s) within 10 business days of the notification.

Competitive bidding areas and product categories for the round 2 and national mail order competitions, DBidS information, bid preparation worksheets, educational materials, and complete RFB instructions can be found on the CBIC website. Suppliers should review this information prior to submitting their bids. CMS will send important bidding updates via email, so all suppliers interested in bidding are urged to sign up for email updates on the CBIC website (at www.DMECompetitiveBid.com). If you have any questions about the bidding process, please contact the CBIC customer service center at 1-877-577-5331.

The target registration dates for authorized officials (AOs) and backup authorized officials (BAOs) to register for a user ID and password in CMS' Individuals Authorized Access to the CMS Computer Services (IACS) system have passed. End users (EUs), as well as any AOs and BAOs who have not yet registered, should now be registering. Only suppliers that have registered in IACS and received a user ID and password will be able to access the online bidding system and submit bids. If the AO for your company has not already registered, we cannot guarantee that he or she will be able to complete the registration process before registration closes. If your AO does not register, you cannot bid and will not be eligible for a contract. In addition, suppliers whose AOs have not registered are at risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the CDRD.

Registration closed on February 9, 2012, at 9:00 p.m. ET – no AOs, BAOs, or EUs can register after registration closes. Suppliers that did not register cannot bid and are not eligible for contracts.

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(Bidding continued)

Registration is typically a quick and easy process if you follow the step-by-step instructions in the “IACS Reference Guide” posted on the [CBIC website](#). To register, visit the [CBIC website](#) and click on “REGISTRATION IS OPEN” above the registration clock on the homepage. You will also find a registration checklist and quick step guides on the [CBIC website](#). Please note that suppliers with multiple locations typically must register only one provider transaction access number (PTAN) that will submit the bid for all locations. If you have any questions about the registration process, please contact the CBIC customer service center.

To bid, visit the [CBIC website](#) and click on “BIDDING IS OPEN” above the clocks on the homepage.

Please note that the RFB instructions initially posted on the [CBIC website](#) contained target bid submission deadlines. CMS is in the process of updating these instructions to reflect the actual bid submission deadlines, which are shown in this announcement.

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

Source: CMS PERL 201201-52

Analysis of the DMEPOS competitive bidding program shows no changes in health outcomes

On January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) launched the first phase of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program in nine different areas of the country. Since the program’s implementation, CMS has used real-time claims analysis to track groups of Medicare beneficiaries potentially affected by the program. This analysis has consistently shown that the competitive bidding program preserves beneficiary health outcomes.

CMS has now released a broad-view analysis that compares the impact of the program on the general Medicare population as well as Medicare beneficiaries likely to use competitively-bid equipment based on their health conditions. For these groups, it compares rates of health outcomes (such as hospitalizations, length of hospital stays, and number of emergency department visits) in the competitive bidding areas to rates in regions without competitive bidding. The new analysis enables an easier comparison between subpopulations and between areas with competitive bidding and without competitive bidding. This results in a clearer depiction of the effect of the DMEPOS competitive bidding program on Medicare beneficiaries’ health outcomes. Consistent with prior analyses, CMS has found that beneficiary health outcomes are stable in competitive bidding areas. To view the results, please 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 201202-43

Education materials for round 2 and national mail-order bidders

Educational materials for the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program are available on the Competitive Bidding Implementation Contractor (CBIC) website at www.DMECompetitiveBid.com. The Centers for Medicare & Medicaid Services urges all bidders to take advantage of these materials as well as the many other helpful tools and resources on the CBIC website.

First, the [DBidS Reference Guide](#) has been issued. This guide provides step-by-step instructions for using the online bidding system, known as the DMEPOS Bidding System (DBidS).

Second, the final in a series of webcasts is now available. This webcast, titled How to Submit a Bid, explains how to submit a bid using the online bidding system, DBidS. All webcasts are available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcasts, and a transcript for each webcast is also posted on the website. To view the webcasts, please go to the [CBIC website](#), select Bidding Suppliers: Round 2 & National Mail-Order, and choose Education Events.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9:00 a.m. to 9:00 p.m. ET, Monday through Friday, throughout the registration and bidding periods.

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

Source: CMS PERL 201201-51

Laboratory/Pathology

New waived tests

Provider types affected

This *MLN Matters*[®] article is intended for clinical laboratories and providers who submit claims to Medicare contractors (carriers and Medicare administrative contractors [MACs]) for laboratory test services provided to Medicare beneficiaries are affected.

Provider action needed

Stop – impact to you

There are eleven newly waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Caution – what you need to know

Change request (CR) 7694 from which this article is taken announces that (effective April 2, 2012,) the Food and Drug Administration (FDA) has approved new waived tests under CLIA. The codes for these tests are in a table in the *Background* section.

Go – what you need to do

You should ensure that your billing staffs are aware of these new waived tests.

Background

CLIA regulations require a facility to be appropriately certified for each test that it performs. To ensure that Medicare and Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

CR 7694, from which this article is taken, announces the latest 11 tests approved by the FDA as waived tests under CLIA (effective April 2, 2012). The *Current Procedural Terminology (CPT)* codes for the following new tests must have the modifier QW, defined as CLIA waived test, to be recognized as a waived test. However, the tests displayed at the beginning of the following table (i.e., *CPT* codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

Tests granted waived status under CLIA

CPT code	Effective date	Description
82274QW, G0328QW	September 8, 2004	Hemosure one-step fecal occult blood test
81003QW	October 28, 2009	Acon Mission U120 urine analyzer
G0434QW	May 5, 2011	Premier Integrity Solutions P/Tox drug screen cup {OTC}
81003QW	June 2, 2011	BTNX Rapid Response U120 urine analyzer
G0434QW	July 7, 2011	Instant Technologies, Inc. iCassette DX drug screen test
G0434QW	July 19, 2011	Express Diagnostic Int'l Inc DrugCheck Waive RT (model 9308z)
80061QW, 82465QW, 82947QW, 82950QW, 82951QW, 82952QW, 83718QW, 84450QW, 84460QW, 84478QW	August 16, 2011	Alere Cholestech LDX {Whole Blood}
82055QW	September 13, 2011	Acon Laboratories Inc. Mission Saliva Alcohol Test Strip
G0434QW	September 13, 2011	Amedica Biotech Instant Test Cup
81003QW	September 26, 2011	Immunostics Inc., Detector Uristrip+ Analyzer
82055QW	October 4, 2011	Teco Diagnostics Saliva Alcohol Test

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(Waived continued)

CPT code	Effective date	Description
86386QW	January 1, 2012	Alere NMP22 BladderChek Test (prescription home use)
86386QW	January 1, 2012	Alere NMP22 BladderChek Test (professional use)

For 2012, the new *CPT* code 86386 was developed for the Nuclear Matrix Protein 22 (NMP22), qualitative test. Therefore, the *CPT* code assigned to the Matritech, Inc. NMP22® BladderCheck™ test for professional and prescription home use is changed to 86386QW with an effective date of January 1, 2012.

Please note that your carrier or A/B MAC will not search their files to either retract payment or retroactively pay claims; however, should adjust claims you bring to their attention.

Additional information

The official instruction, CR 7694, issued to your carrier and A/B MAC regarding this change may be viewed <http://www.cms.gov/transmittals/downloads/R2408CP.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: MM7694

Related Change Request (CR) #: 7694

Related CR Release Date: February 3, 2012

Effective Date: April 1, 2012

Related CR Transmittal #: R2408CP

Implementation Date: April 2, 2012

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Revised ‘Clinical Laboratory Fee Schedule’ fact sheet

The “*Clinical Laboratory Fee Schedule*” fact sheet (ICN 006818) has been revised and is now available in downloadable format. This fact sheet includes background information as well as information coverage of clinical laboratory services and how payment rates are set.

Source: CMS PERL 201202-42

Medicare Physician Fee Schedule Database

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

Note: This article was revised on February 2, 2012, to reflect a revised change request (CR) 7671 issued on January 18, 2012. The CR was revised to amend language in the summary of the multiple procedure payment reduction and revisions to the practice expense geographic adjustment policies described below in the *Background* section of this article. In addition, the article now reflects a new transmittal number, CR release date, and a revised Web address for accessing the CR. All other information remains the same. This information was previously published in the December 2011 *Medicare B Connection*, Pages 18-21.

Provider types affected

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

What you need to know

This article is based on change request (CR) 7671, which summarizes the policies in the CY 2012 Medicare physician fee schedule final rule and announces the telehealth originating site facility fee payment amount for CY

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(MPFS continued)

2012. Please be sure that your staffs are aware of these changes.

Background

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

- The Centers for Medicare & Medicaid Services (CMS) issued a final rule with comment period on November 1, 2011, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in CY 2012.
- The final rule (published in the *Federal Register* on November 28, 2011) addresses Medicare public comments on payment policies that were described in two separate proposed notices earlier this year:
 - The *Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule* (published in the *Federal Register* on June 6, 2011), and
 - The *Medicare Program: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012* (published in the *Federal Register* on July 19, 2011).
- The final rule also addresses interim final values established in the CY 2011 MPFS final rule with comment period (published in the *Federal Register* on November 29, 2010).
- Finally, the final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2012 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until January 3, 2012.

Updated policies**Summary of policies in the CY 2012 Medicare physician fee schedule (MPFS)****Misvalued codes under the physician fee schedule**

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

Multiple procedure payment reduction policy

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures performed on the same patient by the same physician or group practice in the same session, based on efficiencies in the practice expense (PE) and pre- and post-surgical physician work. Beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction (MPPR) for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session. For CY 2012, CMS is applying the MPPR to the professional component (PC) of certain diagnostic imaging services. The MPPR currently applies only to the technical component (TC). The procedure with the highest PC and TC payment would be paid in full. Beginning CY 2012, the PC payment will be reduced for subsequent procedures furnished to the same patient, by the same physician, in the same session. Although the final rule also applies this policy to procedures furnished to the same patient in the same session by physicians in the same group practice, CMS is not applying the imaging MPPR to group practices for 2012 due to operational considerations.

Revisions to the practice expense geographic adjustment

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

CMS is applying several changes to the GPCIs as a result of additional analyses conducted both in accordance with section 3102 (b) of the Affordable Care Act and commitments made in the CY 2011 final rule with comment

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(MPFS continued)

period. For CY 2012, CMS will use the Bureau of Labor Statistics Occupational Employment Statistics specific to the offices of physicians industry to calculate the PE employee wage index. In addition, CMS is replacing the U.S Department of Housing and Urban Development rental data as the proxy for physician office rent with rent data from the 2006-2008 American Community Survey. Lastly, CMS is creating a purchased service index to account for the labor-related industries within the “all other services” and “other professional expenses” Medicare Economic Index (MEI) categories. These changes result in very little change to the GPCIs and indicate that the data CMS has used to adjust for geographic variation is consistent and accurate. However, the expiration of statutory provisions, including a floor of 1.0 for the work GPCI and the limited recognition of cost differences for employee wage and office rent in the PE GPCI, will result in some payment reductions in the areas that benefitted from them in 2010 and 2011. Congress may choose to extend one or both of these provisions for CY 2012 subsequent to the release of this CR. In the event that Congress decides to extend either of these provisions for CY 2012, CMS will update the GPCIs for all impacted areas appropriately.

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

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

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

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

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

Annual wellness visit providing a personalized prevention plan

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

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

- History of health risk assessments,
- Defining the HRA framework and rationale for its use

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(MPFS continued)

- Use of HRAs and follow-up interventions that evidence suggests can influence health behaviors; and
- A suggested set of HRA questions.

As discussed in the preamble to the CY 2012 physician fee schedule final rule, CMS believes it is important that health professionals have the flexibility to address additional topics as appropriate, based on patient needs, consistent with the final rule. Thus, there is not only one type of HRA that will meet the CDC guidelines.

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

Molecular pathology procedure codes

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

For payment purposes under the PFS and CLFS, these 101 new molecular pathology procedure codes will be assigned a MPFS procedure status indicator of “B” (Bundled Code). Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (for example, a telephone call from a hospital nurse regarding care of a patient)). While these services would traditionally be assigned a procedure status indicator of “I” (Not Valid for Medicare purposes Medicare uses another code for the reporting of, and the payment for these services.), assigning these *CPT* codes a procedure status of B will allow CMS to gather claims information important to evaluating eventual pricing of these new molecular pathology *CPT* codes.

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

Telehealth services

CMS is adding smoking and tobacco cessation counseling to the list of Medicare telehealth services. These services are similar to other services, such as kidney disease education (KDE) counseling services and medical nutrition therapy (MNT) services, already on the telehealth list. In addition, CMS is changing the criteria for adding codes to the list of Medicare telehealth services under the “category 2” methodology (“category 1” are services that are similar to services already on the telehealth list). Currently, CMS requires evidence of similar diagnostic findings or therapeutic interventions of a requested service via telehealth to an in-person service prior to adding it to the telehealth list under category 2. In the 2012 final rule with comment period, CMS eases the standard by no longer requiring telehealth services to demonstrate equivalence to the same service provided face-to-face and instead requires that the service demonstrate clinical benefit when furnished through telehealth. The refined category 2 review criteria are effective for services requested to be added to the telehealth benefit beginning in CY 2013.

Telehealth originating site facility fee payment amount

Section 1834(m) of the Social Security Act established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20.00. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased, as of the first day of the year, by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for CY 2012 is 0.6 percent.

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

Additional information

For more information and access to the CY 2012 final rule, go to the “Physician Fee Schedule” available at http://www.cms.gov/PhysicianFeeSched/01_Overview.asp. The official instruction, CR 7671, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2379CP.pdf>.

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

MLN Matters® Number: MM7671 *Revised*

Related Change Request (CR) #: 7671

Related CR Release Date: January 18, 2012

Effective Date: January 1, 2012

Related CR Transmittal #: R2379CP

Implementation Date: January 3, 2012

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Preventive Services

Intensive behavioral therapy for obesity

Provider types affected

This *MLN Matters*® article is intended for primary care physicians and other primary care practitioners billing Medicare contractors (carriers, fiscal intermediaries [FIs] and A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries in a primary care setting.

Provider action needed**Stop – impact to you**

This article is based on change request (CR) 7641, which informs Medicare contractors about implementing coverage of intensive behavioral therapy (IBT) for obesity.

Caution – what you need to know

Effective for claims with dates of service November 29, 2011, and later, Medicare beneficiaries with obesity, defined as body mass index (BMI) equal to or greater than 30 kg/m², who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting, are eligible for:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6, and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first six months.

Medicare coinsurance and Part B deductible are waived for this service.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding this change. Be sure your staffs are aware of this new coverage determination and that Healthcare Common Procedure Coding System (HCPCS) code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes) will be used to bill for these services.

This code was effective November 29, 2011, and will appear in the January 2012 quarterly update of the Medicare physician fee schedule database (MPFSDB) and the integrated outpatient code editor (IOCE).

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(Obesity continued)

Background

Based upon authority in the Social Security Act to cover “additional preventive services” for Medicare beneficiaries if certain statutory requirements are met, and the services are reasonable and necessary for the prevention or early detection of illness or disability, the Centers for Medicare & Medicaid Services (CMS) initiated a new national coverage analysis on IBT for obesity. Screening for obesity in adults is a “B” recommendation by the U.S. Preventive Services Task Force (USPSTF) and is appropriate for individuals entitled to benefits under Medicare Part A and Part B.

In 2003, the USPSTF found good evidence that BMI “is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity.” The USPSTF also found fair to good evidence that high intensity counseling combined with behavioral interventions in obese adults (as defined by a BMI ≥ 30 kg/m²) “produces modest, sustained weight loss.”

Effective for claims with dates of service on or after November 29, 2011, Medicare beneficiaries with obesity (BMI ≥ 30 kg/m²), who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6, and
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months as discussed below.

At the six-month visit, a reassessment of obesity and a determination of the amount of weight loss should be performed. To be eligible for additional face-to-face visits occurring once a month for months 7-12, beneficiaries must have achieved a reduction in weight of at least 3kg (6.6 lbs.), over the course of the first six months of intensive therapy. **This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice.** For beneficiaries who do not achieve a weight loss of at least 3kg (6.6 lbs.) during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six-month period.

IBT for obesity consists of the following:

1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m²)
2. Dietary (nutritional) assessment, and
3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Intensive behavioral intervention for obesity should be consistent with the 5-A framework:

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

Billing requirements

Diagnostic codes

Effective for claims with dates of service on or after November 29, 2011, Medicare will recognize HCPCS code G0447, face-to-face behavioral counseling for obesity, 15 minutes. **G0447 must be billed along with 1 of the ICD-9 codes for BMI 30.0 and over (V85.30-V85.39, V85.41-V85.45).** The type of service (TOS) for G0447 is 1. (ICD-10 codes will be Z68.30-Z68.39, Z68.41- Z68.45)

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(Obesity continued)

Effective for claims with dates of service on or after November 29, 2011, Medicare contractors will deny claims for HCPCS G0447 that are not submitted with the appropriate diagnostic code (V85.30-V85.39, V85.41-V85.45).

Claims submitted with HCPCS G0447 that are not submitted with these diagnosis codes will be denied with the following messages:

- Claim adjustment reason code (CARC) 167 – “This (these) diagnosis(es) is (are) not covered. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Remittance advice remark code (RARC) N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Per *MLN Matters*® article MM7228, when modifier GZ is used, contractors will use CARC 50 (These services are non-covered services because this is not deemed a “medical necessity” by the payer.). This is true with all denials noted below that have the group code CO. MM7228 may be found at <http://www.cms.gov/MLN MattersArticles/downloads/MM7228.pdf>.

Specialty codes

Effective for services on or after November 29, 2011, Medicare will pay claims for G0447, only when services are submitted by the following provider specialty types found on the provider’s Medicare enrollment record:

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

If your specialty type is not one of the above, your claim will be denied using the following codes:

- CARC of 185 – “The rendering provider is not eligible to perform the service billed. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N95 – “This provider type/provider specialty may not bill this service.”
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Place of service (POS) codes

Effective for services on or after November 29, 2011, Medicare will pay for obesity counseling claims containing HCPCS G0447 only when services are provided with the following POS codes:

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

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(Obesity continued)

Line items on claims for G0447 will be denied if not performed in these POS using the following codes:

- CARC 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid POS. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N428 – “Not covered when performed in this place of service.”
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Frequency limitation

Effective July 2, 2012, for claims processed with dates of service on or after November 29, 2011, Medicare will pay for G0447 with an ICD-9 code of V85.30-V85.39, V85.41-V85.45, no more than 22 times in a 12-month period. Line items on claims beyond the 22 limit will be denied using the following codes: **(Note: When applying this frequency limitation, a claim for the professional service and a claim for a facility fee will be allowed.)**

- CARC 119 – “Benefit maximum for this time period or occurrence has been reached.”
- RARC N362 – “The number of days or units of service exceeds our acceptable maximum.”
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file), and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Your contractor will not search their files for claims that may have been paid in error. However, contractors may adjust claims that are brought to their attention.

Institutional claims notes

Claims submitted with either a type of bill (TOB) 13x or TOB 85x (where the revenue code is not 096x, 097x, or 098x) will be identified as facility fee service claims.

Claims submitted with TOBs 71x, 77x, or 85x (where the revenue code is 096x, 097x, or 098x) will be identified as professional service claims.

Medicare will pay for G0447 on institutional claims in hospital outpatient departments TOB 13x based on OPPI and in critical access hospitals TOB 85x based on reasonable cost.

The CAH method II payment is for G0447 with revenue codes 096x, 097x, or 098x is based on 115 percent of the lesser of the fee schedule amount or submitted charge. Deductible and coinsurance do not apply.

Medicare will line-item deny any claim submitted with G0447 when the TOB is not 13x, 71x, 77x, or 85x with the following:

- CARC 5 – “The procedure code/bill type is inconsistent with the Place of Service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC M77 – “Missing/incomplete/invalid place of service.”
- Group code PR (patient responsibility), assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file) and
- Group code CO (contractual obligation), assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: Medicare will hold institutional claims received before July 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting G0447.

Rural health clinics and federally qualified health centers claims notes

Rural health clinics, using TOB 71x, and federally qualified health centers, using TOB 77x, must submit HCPCS code G0447 on a separate service line to ensure coinsurance and deductible are not applied to this service. Such claims will be paid based on the all-inclusive payment rate.

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(Obesity continued)

For RHC and FQHC services that contain HCPCS code G0447 with another encounter/visit with the same line item DOS, the service line with HCPCS G0447 will be denied with the following messages:

- Claim adjustment reason code (CARC) 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF) if present” and
- Group code CO (contractual obligation)

Note: Obesity counseling is **not** separately payable with another encounter/visit on the same day. This does not apply for initial preventive physical examination (IPPE) claims, claims containing modifier 59, and 77x claims containing diabetes self-management training and medical nutrition therapy services.

Additional information

The official instruction, CR 7641, issued to your FI, carrier, and A/B MAC regarding this change, was issued in two transmittals at <http://www.cms.gov/transmittals/downloads/R2409CP.pdf> and <http://www.cms.gov/transmittals/downloads/R142NCD.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: MM7641

Related Change Request (CR) #: 7641

Related CR Release Date: February 3, 2012

Effective Date: November 29, 2011

Related CR Transmittal #:R2409CP, R142NCD

Implementation Date: March 6, 2012 for non-shared system edits, July 2, 2012 for shared system edits, CWF provider screen, HICR, and MCSDT changes

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

Screening for sexually transmitted infections and high-intensity behavioral counseling for prevention

Provider types affected

This *MLN Matters*® article is intended for all physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and A/B Medicare administrative contractors [MACs]) for Medicare beneficiaries.

Provider action needed

Effective for dates of service on or after November 8, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover screening for sexually-transmitted infections (STIs) – specifically chlamydia, gonorrhea, syphilis, and hepatitis B – with the appropriate Food and Drug Administration (FDA)-approved/cleared laboratory tests when ordered by the primary care provider. The tests must be used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations and performed by an eligible Medicare provider for these services.

In addition, Medicare will cover high-intensity behavioral counseling (HIBC) to prevent STIs. Ensure that your billing staffs are aware of these changes.

Background

Pursuant to Section 1861(ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the national coverage determination (NCD) process. The preventive services must be:

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

CMS reviewed the USPSTF recommendations and supporting evidence for screening for STIs and HIBC to prevent STIs and determined that the criteria listed above were met, enabling CMS to cover these preventive services. Therefore, effective November 8, 2011, CMS will cover screening for the indicated STIs and HIBC to

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(Screening continued)

prevent STIs. The covered screening lab tests must be ordered by the primary care provider. The HIBC must be provided by primary care providers in primary care settings such as by the beneficiary's family practice physician, internal medicine physician, or nurse practitioner (NP) in the doctor's office.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0445 (high-intensity behavioral counseling to prevent sexually transmitted infections, face-to-face, individual, includes: education, skills training, and guidance on how to change sexual behavior, performed semi-annually, 30 minutes), has been created for use when reporting HIBC to prevent STIs, effective November 8, 2011. This code is included in the January 2012 Medicare physician fee schedule database (MPFSDB) and integrated outpatient code editor (IOCE) updates.

This code may be paid on the same date of service as an annual wellness visit (AWV), evaluation and management (E&M) code, or during the global billing period for obstetrical care, but only one G0445 may be paid on any one date of service. If billed on the same date of service with an E&M code, the E&M code should have a distinct diagnosis code other than the diagnosis code used to indicate high/increased risk for STIs for the G0445 service. An E&M code should not be billed when the sole reason for the visit is HIBC to prevent STIs.

The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient's medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior - as required for coverage.

The appropriate screening diagnosis code (ICD-9-CM V74.5 [screening bacterial – sexually transmitted] or V73.89 [screening, disease or disorder, viral, specified type NEC]), when used with the screening lab tests identified by change request (CR) 7610, will indicate that the test is a screening test covered by Medicare.

Diagnosis code V69.8 (other problems related to life style) is used to indicate that the beneficiary is at high/increased risk for STIs. Providers should also use V69.8 for sexually active adolescents when billing G0445 counseling services.

Diagnosis codes V22.0 (supervision of normal first pregnancy), V22.1 (supervision of other normal pregnancy), or V23.9 (supervision of unspecified high-risk pregnancy) are also to be used when appropriate.

For services provided on an annual basis, this is defined as a 12-month period.

Further details

CMS will cover screening for:

- Chlamydia (86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800 [used for combined Chlamydia and gonorrhea testing])
- Gonorrhea (87590, 87591, 87850, 87800 [used for combined Chlamydia and gonorrhea testing], syphilis (86592, 86593, 86780), and
- Hepatitis B [hepatitis B surface antigen] 87340, 87341) with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the CLIA regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services.

As per the requirements, the presence of V74.5 or V73.89 and V69.8, denoting STI screening and high-risk behavior, respectively, and/or V22.0, V22.1, or V23.9, denoting pregnancy as appropriate, must also be present on the claim for STI services along with one of the procedure codes above.

Screening for chlamydia and gonorrhea

- Pregnant women who are 24 years old or younger when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test;
- Pregnant women who are at increased risk for STIs when the diagnosis of pregnancy is known and then repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test; and
- Women at increased risk for STIs annually.

Screening for syphilis

- Pregnant women when the diagnosis of pregnancy is known and then repeat screening during the third trimester and at delivery if high-risk sexual behavior has occurred since the previous screening test; and
- Men and women at increased risk for STIs annually.

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(Screening continued)**Screening for hepatitis B**

- Pregnant women at the first prenatal visit when the diagnosis of pregnancy is known and then re-screening at the time of delivery for those with new or continuing risk factors.

Coverage for HIBC

CMS will also cover up to two, individual, 20- to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries for HIBC to prevent STIs (G0445) for all sexually active adolescents and for adults at increased risk for STIs (V69.8), if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. HIBC is defined as a program intended to promote sexual risk reduction or risk avoidance which includes each of these broad topics, allowing flexibility for appropriate patient-focused elements:

- Education
- Skills training, and
- Guidance on how to change sexual behavior.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- Multiple sex partners
- Using barrier protection inconsistently
- Having sex under the influence of alcohol or drugs
- Having sex in exchange for money or drugs
- Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea)
- Having an STI within the past year
- IV drug use (hepatitis B only)
- In addition, for men – men having sex with men (MSM) and engaged in high-risk sexual behavior, but no regard to age

Community social factors such as high prevalence of STIs in the community populations should also be considered in determining high/increased risk for chlamydia, gonorrhea, syphilis, and in recommending HIBC.

High/increased risk sexual behavior for STIs is determined by the primary care provider by assessing the patient's sexual history which is part of any complete medical history, typically part of an AWV or prenatal visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

For the purposes of this NCD, a primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers (ASCs), independent diagnostic testing facilities, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

For the purposes of this NCD, a "primary care physician" and "primary care practitioner" will be defined consistent with existing sections of the Social Security Act (Sections 1833(u)(6), 1833(x)(2)(A)(i)(I) and 1833(x)(2)(A)(i)(II)), as follows:

- 1833(u) (6) Physician Defined: For purposes of this paragraph, the term "physician" means a physician described in Section 1861(r)(1) and the term "primary care physician" means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.
- 1833(x)(2)(A)(i) (I) is a physician (as described in Section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or
- (II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in Section 1861(aa)(5)).

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(Screening continued)

Billing reminders

- Institutional providers should note that coverage requires services be performed in a primary care setting. Consequently, if STI services are billed on types of bill (TOB) other than 13x, 14x and 85x (when the revenue code on the 85x is not 096x, 097x, or 098x), OR, if G0445 is submitted on a TOB other than 13x, 71x, 77x, or 85x, payment for the services will be denied using the following:
 - Claim adjustment reason code (CARC) 170 – “Payment is denied when performed/billed by this type of provider. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
 - Remittance advice remark code (RARC) N428 – “This service was denied because Medicare only covers this service in certain settings.”
- When applying frequency limitations to HIBC services, contractors will allow both a claim for the professional service and a claim for the facility fee. Institutional claims may be identified as facility fee claims for screening services if they contain G0445, and TOB 13x or TOB 85x (when the revenue code is not 096x, 097x, or 098x). All other claims should be identified as professional service claims for HIBC services (professional claims, and institutional claims with TOB 71x or 77x, or 85x when the revenue code is 096x, 097x, or 098x).
- Contractors will allow institutional claims, TOBs 71x and 77x, to submit additional revenue lines on claims with G0445. Also, HCPCS G0445 will not pay separately with another encounter/visit on the same day for TOBs 71x and 77x with the exception of: initial preventive physical claims, claims containing modifier 59, and 77x claims containing diabetes self-management training and medical nutrition therapy services. If HCPCS G0445 is present on revenue lines along with an encounter/visit with the same line-item date of service, contractors will assign group code CO and reason code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Services Payment Information REF), if present.”
- G0445 on institutional claims in hospital outpatient departments (TOB 13x) are paid based on OPPTS, in critical access hospitals (TOB 85x, not equal to 096x, 097x, or 098x) based on reasonable cost. HCPCS G0445 with revenue codes 096x, 097x, or 098x, when billed on TOB 85x method II is paid based on 115 percent of the lesser of the MPFS amount or submitted charge.
- Medicare will enforce the frequency requirement for STI services, as mentioned above. Medicare will deny line items that exceed the coverage frequency requirements using the following:
 - CARC 119 – “Benefit maximum for this period or occurrence has been reached.”
 - RARC N362 – “The number of days or units of service exceeds our acceptable maximum.”
- Medicare will deny line items on claims submitted for screening for STIs if the claim lacks the appropriate ICD-9-CM code as mentioned earlier. Such services will be denied payment using:
 - CARC 50 – “These are non-covered services because this is not deemed a “medical necessity” by the payer. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
 - RARC N386 – “This decision was based on a National Coverage Determination (NCD), An NCD provides a coverage determination as to whether a specific item or service is covered. A copy of this policy is available at <http://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- The presence of ICD-9 code V74.5 or V73.89 identifies STI laboratory tests as screening lab tests payable under CR 7610 rather than as diagnostic tests.
- Screening for STIs must be ordered by a primary care provider, and HIBC services, G0445, must be performed by a primary care provider in a primary care setting, with one of the following specialty codes:
 - 01 – General practice
 - 08 – Family practice
 - 11 – Internal medicine
 - 16 – Obstetrics/gynecology
 - 37 – Pediatric medicine
 - 38 – Geriatric medicine

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(Screening continued)

- 42 – Certified nurse midwife
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant
- STI screenings ordered by other than the above types of providers will be denied payment when submitted on professional claims using:
 - CARC 184 – “The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Medicare will deny line items for G0445 if performed by other than the above types of providers when submitted on professional claims using:
 - CARC 185 – “The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
 - RARC N95 – “This provider type/provider specialty may not bill this service.”
- Claims for G0445 must be for services performed in the following places of service (POS):
 - 11 – Physician office
 - 22 – Outpatient hospital
 - 49 – Independent clinic
 - 71 – State or local public health clinic
- Medicare will deny line items for G0445 if the POS code is other than 11, 22, 49, or 71, using the following:
 - CARC 58 – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
 - RARC N428 – “Not covered when performed in this Place of Service.”
- Upon full implementation in Medicare systems on July 2, 2012, providers may submit eligibility inquiries in order to identify the next eligible date that beneficiaries may receive these services.
- Until systems are implemented, contractors will hold institutional claims received before July 2, 2012, with TOBs 13x, 71x, 77x, and 85x reporting HCPCS G0445, or TOBs 13x, 14x, and 85x, when the revenue code is not 096x, 097x, or 098x, for STI services.
- Effective for dates of service on or after November 8, 2011, contractors will not apply deductible or coinsurance to claim lines containing HCPCS G0445, HIBC services.
- Contractors will load HCPCS G0445 to their HCPCS file with an effective date of November 8, 2011.

Additional information

The official instruction, CR 7610, was issued to your FI, carrier and A/B MAC regarding this change via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R2402CP.pdf>. The second transmittal conveys the NCD and it is at <http://www.cms.gov/Transmittals/downloads/R141NCD.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: MM7610

Related Change Request (CR) #: 7610

Related CR Release Date: January 26, 2012

Effective Date: November 8, 2011

Related CR Transmittal #: R2402CP and R141NCD

Implementation Date: July 2, 2012 for full implementation

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Radiology

Interaction of the multiple procedure payment reduction on imaging procedures and the OPSS cap on the technical component of imaging procedures

Provider types affected

Physicians, providers, and suppliers submitting professional claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors [A/B MACs]) for providing diagnostic imaging services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7703 which announces that, effective January 1, 2012, the Centers for Medicare & Medicaid Services (CMS) is discontinuing the use of the “global cap” amount in calculating global payments of certain diagnostic imaging procedures. Medicare implemented the multiple procedure payment reduction (MPPR) rule on the TC of certain diagnostic imaging procedures effective January 1, 2006, and CR 7703 is a reminder that effective January 1, 2012, the MPPR will also be applied to the professional component (PC) of such services.

Caution – what you need to know

The MPPR rule applies to PC-only services, to TC-only services, and to PC and TC portions of global services. Full payment is made for the PC service with the highest payment under the Medicare physician fee schedule (MPFS). Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

Go – what you need to do

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

Background

The Deficit Reduction Act of 2005 (Section 5102(b); see <http://www.govtrack.us/congress/billtext.xpd?bill=s109-1932>) provided for capping the payment for the TC of certain diagnostic imaging procedures based on the outpatient prospective payment system (OPSS) payment.

The MPPR rule on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day, and it is applied prior to the application of the OPSS cap. Medicare implemented the MPPR on the TC of certain diagnostic imaging procedures effective January 1, 2006, and effective January 1, 2012, the MPPR is also applied to the PC of such services.

Currently, global services are compared against a “global cap” derived from adding the TC capped amount to the PC. However, with the implementation of the MPPR on the PC, this could result in a situation where, although the global payment amount is lower than the “global cap” amount, the TC is higher than the TC cap amount and is not appropriately being reduced. Therefore, CR 7703 announces that CMS is discontinuing calculation and use of the “global cap” amount.

The TC of global services, and TC-only services, will be compared to the OPSS cap amount on the TC to determine the lower of the two.

Full payment is made for the PC service with the highest payment under the MPFS. Payment is made at 75 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day. The individual PC and TC services with the highest payments under the MPFS of globally billed services must be determined in order to calculate the reduction.

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Additional information

The official instruction, CR 7703, issued to your carriers and A/B MACs, regarding this change, may be viewed at <http://www.cms.gov/transmittals/downloads/R1040OTN.pdf>.

If you have any questions, please contact your carriers 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: MM7703

Related Change Request (CR) #: CR 7703

Related CR Release Date: February 3, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R1040OTN

Implementation Date: July 2, 2012

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Reprocessing advanced diagnostic imaging claims denied in error

The Centers for Medicare & Medicaid Services (CMS) has received reports indicating that providers are receiving denials for advanced diagnostic imaging (ADI) services that they have been accredited to perform. CMS has taken action to correct the situation. CMS has instructed all contractors to review each ADI claim denial and reprocess those claims that were deemed to be incorrectly denied in a timely manner. Providers do not need to take any action at this time.

Source: CMS PERL 201202-55

Surgery

Proposed national coverage determination for transcatheter aortic valve replacement

On Thursday, February 2, the Centers for Medicare & Medicaid Services (CMS) proposed that Medicare patients across the country have access to a new procedure, known as “transcatheter aortic valve replacement” (TAVR).

The result of an unprecedented level of collaboration between CMS, the Food and Drug Administration, the Agency for Healthcare Research and Quality, the American College of Cardiology, the Society of Thoracic Surgeons and Edwards Lifesciences, this proposed coverage decision memorandum for TAVR continues CMS’s commitment to cross-agency collaboration and ensuring patients have access to the latest and best medical technology.

CMS is requesting public comments on this proposed determination pursuant to Section 1862(l) of the Social Security Act. CMS is specifically interested in public comments on the use of coverage with evidence development (CED) in this decision. After considering the public comments, CMS will make a final determination and issue a final decision memorandum.

The proposed decision will be open for 30 days of public comment before CMS issues a final decision later this year. To read the full proposal, visit <http://www.CMS.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=257>.

The full text of this excerpted blog post can be found on the CMS blog at <http://blog.CMS.gov/2012/02/02>.

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

Source: CMS PERL 201202-11



General Coverage

Revised and clarified place of service coding instructions

Provider types affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare administrative contractors [A/B MACs]) for services paid for under the Medicare physician fee schedule (MPFS). This article also applies to certain services provided by independent laboratories.

What you need to know

This article is based on change request (CR) 7631. It revises and clarifies national policy for place of service (POS) code assignment. Instructions are provided in CR 7631 regarding the assignment of POS for all services paid under the MPFS and for certain services provided by independent laboratories. In addition to establishing a national policy for the correct assignment of POS codes, instructions are provided for the interpretation or professional component (PC) and the technical component (TC) of diagnostic tests. Please make sure your billing staff is aware of these changes.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction includes a POS code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). Under Medicare, the correct POS code assignment is also required on the paper CMS-1500 claim form (or its electronic equivalent). While CMS currently maintains the national POS code set, it is used by all other public and private health insurers, including Medicaid.

At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear.



The importance of this national policy is underscored by consistent findings, in annual and/or biennial reports from calendar year (CY) 2002 through CY 2007, by the Office of the Inspector General (OIG) that physicians and other suppliers frequently incorrectly report the POS in which they furnish services. This improper billing is particularly problematic when physician and other suppliers furnish services in outpatient hospitals and in ambulatory surgical centers (ASCs). In a sample of paid services (for services possessing both non-facility and facility practice expenses), the OIG found a significant percent of the sampled physician/practitioner claims were incorrectly reported by physician/practitioners as occurring in the office POS when those services were furnished in outpatient hospitals or ASCs. As such, these claims were paid by the Medicare contractor at the non-facility rate – rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs.

The OIG has called on CMS to strengthen the education process and reemphasize to physicians (including non-physician practitioners and other suppliers) and their billing agents the importance of correctly coding the POS. Consequently, CR 7631 adds special considerations provisions regarding use of POS codes 22 and 24, for outpatient hospitals and ASCs.

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(POS continued)

A previous CMS instruction, Transmittal 1873 (now rescinded) regarding the assignment of POS codes, instructed physicians to use the 2-digit POS code to describe where he/she was physically when rendering the service; in this instance, the POS code corresponded to the service location. (CMS-1500 claim form items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information). The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable “locality” and geographic practice cost index (GPCI)-adjusted payment for each service paid under the MPFS.

CR 7631 establishes that for all services – with two (2) exceptions – paid under the MFPS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician / practitioner will be the setting in which the beneficiary received the TC of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary’s MRI from his/her office location – POS code 22 will be used on the physician’s claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a hospital inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). The *Medicare Claims Processing Manual* already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and CR 7631 clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

Facility and non-facility payment assignments

The list of settings where a physician’s services are paid at the facility rate include:

- Inpatient hospital (POS code 21)
- Outpatient hospital (POS code 22)
- Emergency room-hospital (POS code 23)
- Medicare-participating ambulatory surgical center (ASC) for a Healthcare Common Procedure Coding System (HCPCS) code included on the ASC approved list of procedures (POS code 24)
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24)
- Skilled nursing facility (SNF) for a Part A resident (POS code 31)
- Hospice – for inpatient care (POS code 34)
- Ambulance – land (POS code 41)
- Ambulance – air or water (POS code 42)
- Inpatient psychiatric facility (POS code 51)
- Psychiatric facility – partial hospitalization (POS code 52)
- Community mental health center (POS code 53)
- Psychiatric residential treatment center (POS code 56), and
- Comprehensive inpatient rehabilitation facility (POS code 61).

Physicians’ services are paid at non-facility rates for procedures furnished in the following settings:

- Pharmacy (POS code 01)
- School (POS code 03)
- Homeless shelter (POS code 04)

(continued on next page)

(POS continued)

- Prison/correctional facility (POS code 09)
- Office (POS code 11)
- Home or private residence of patient (POS code 12)
- Assisted living facility (POS code 13)
- Group home (POS code 14)
- Mobile unit (POS code 15)
- Temporary lodging (POS code 16)
- Walk-in retail health clinic (POS code 17)
- Urgent care facility (POS code 20)
- Birthing center (POS code 25)
- Nursing facility and skilled nursing facilities (SNFs) to Part B residents - (POS code 32)
- Custodial care facility (POS code 33)
- Independent clinic (POS code 49)
- Federally qualified health center (POS code 50)
- Intermediate health care facility/mentally retarded (POS code 54)
- Residential substance abuse treatment facility (POS code 55)
- Non-residential substance abuse treatment facility (POS code 57)
- Mass immunization center (POS code 60)
- Comprehensive outpatient rehabilitation facility (POS code 62)
- End-stage renal disease treatment facility (POS code 65)
- State or local health clinic (POS code 71)
- Rural health clinic (POS code 72)
- Independent laboratory (POS code 81), and
- Other place of service (POS code 99).

Special guidance for selected POS codes

CR 7631 adds clarifying or special consideration provisions for other settings as well. Those provisions are as follows:

Special considerations for mobile unit settings (code 15)

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a SNF. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the mobile unit POS code 15. Medicare will apply the non-facility rate to payments for services designated as being furnished in POS code 15 and apply the appropriate facility or non-facility rate for the POS code designated when a code other than the mobile unit code is indicated.

A physician or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health professional shortage area as defined under Section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a metropolitan statistical area as defined in Section 1886(d)(2)(D) of the Social Security Act, the originating physician's office should use POS code 11 (Office) in order to ensure appropriate payment for services on the list of Medicare telehealth services.

Special considerations for walk-in retail health clinic (code 17) (Effective no later than May 1, 2010)

It should be noted that, while some entities in the industry may elect to use code 17 to track the setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in Chapter

(continued on next page)

(POS continued)

18, Section 10 of the *Medicare Claims Processing Manual* found at <http://www.cms.gov/manuals/downloads/clm104c18.pdf>. Providers and suppliers of immunizations must continue to follow these Medicare billing rules. However, Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

Special considerations for inpatient hospital (code 21)

In the case of a physician/practitioner/supplier who provides services to a patient who is an inpatient of a hospital, the inpatient hospital POS code 21 will be used irrespective of the setting where the patient actually receives the face-to-face encounter.

Special considerations for outpatient hospital (code 22)

Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department (including in a provider-based department of that hospital) or under arrangement to a hospital will use POS code 22.

Note: Physicians/practitioners who perform services in a hospital outpatient department will use POS code 22 (outpatient hospital) unless the physician maintains separate office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.65. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.6. Use of POS code 11 (office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

Special consideration for ambulatory surgical centers (code 24)

When a physician/practitioner furnishes services to a patient in a Medicare-participating ASC, the POS code 24 (ASC) will be used.

Note: Physicians/practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC). Physicians are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the “distinct entity” criteria defined in the *ASC State Operations Manual* that precludes the ASC and an adjacent physician office from being open at the same time – and the physician service was actually performed in the office suite portion of the facility. That information is in Appendix L of that manual which is at http://www.cms.gov/manuals/Downloads/som107ap_l_ambulatory.pdf.

Special considerations for hospice (code 34)

When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

When a beneficiary is in an “inpatient” respite or general “inpatient” care stay, the POS code 34 (hospice) will be used. When a beneficiary who has elected coverage under the hospice benefit is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (hospice) will be used to designate the POS on the claim.

For services provided to a hospice beneficiary in an outpatient setting, such as the physician/nonphysician practitioner’s office (POS 11); the beneficiary’s home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital [POS 22]), the patient’s physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, will assign the POS code that represents that setting, as appropriate.

There may be use of nursing homes as the hospice patient’s “home,” where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating “houses” or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and nonphysician practitioners, including the patient’s independent attending physician or nurse practitioner, will use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

Additional information

The official instruction, CR 7631 issued to your carrier and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2407CP.pdf>.

If you have any questions about the correct POS code to use, 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>.

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(POS continued)

MLN Matters® Number: MM7631
Related Change Request (CR) #: 7631
Related CR Release Date: February 3, 2012
Effective Date: April 1, 2012
Related CR Transmittal #:R2407CP
Implementation Date: April 2, 2012

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HHS announces intent to delay ICD-10 compliance date

As part of President Obama's commitment to reducing regulatory burden, Health and Human Services Secretary Kathleen G. Sebelius announced on February 16 that the Department of Health and Human Services (HHS) will initiate a process to postpone the date by which certain health care entities have to comply with International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10).



The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of October 1, 2013, – a delay of two years from the compliance date initially specified in the 2008 proposed rule. HHS will announce a new compliance date moving forward.

“ICD-10 codes are important to many positive improvements in our health care system,” said HHS Secretary Kathleen Sebelius. “We have heard from many in the provider community who have concerns about the administrative burdens they face in the years ahead. We are committing to work with the provider community to reexamine the pace at which HHS and the nation implement these important improvements to our health care system.”

ICD-10 codes provide more robust and specific data that will help improve patient care and enable the exchange of our health care data with that of the rest of the world that has long been using ICD-10. Entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

Source: CMS PERL 201202-45

Try our E/M interactive worksheet

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

PWK is coming

PWK will allow documentation to be submitted for an initial claim

Effective April 2, 2012, First Coast Service Options Inc. (FCSO) will implement the PWK (paperwork) segment of the X12N version 5010. This will allow for voluntary submission of supporting documentation for a version 5010 electronic claim via mail or fax (PWK 02 segment, BM [by mail] or FX [by fax] qualifier, respectively).

PWK is a segment within the 2300/2400 Loop of the 837 Professional and Institutional electronic transactions that provides the link between electronic claims and additional documentation. PWK will allow providers to submit electronic claims that require additional documentation and, through the dedicated PWK process, have the documentation imaged to be available during the claims adjudication. Eliminating the need for costly development and allowing providers and Medicare contractors to utilize efficient, cost-effective electronic data interchange (EDI) technology will create a significant cost savings.

FCSO will make available a fax/mail coversheet that providers or trading partners shall use to submit the unsolicited additional documentation. The FCSO fax/mail coversheet will be an interactive form posted to our website. Providers or trading partners will complete required data elements and then be able to print a hardcopy of the form to mail or fax with their documentation. Modifications to the fax/mail coversheet will not be permitted. Separate forms will be provided for Part A and B. FCSO will also provide secure faxation numbers for those providers or trading partners who elect to fax the additional documentation.

PWK Fax/mail coversheets

FCSO is requiring the following section of the form to be completed with valid information to ensure the paperwork documentation is appended to the pending claim in our system: ACN (Attachment Control Number (submitted in the PWK06 segment)), DCN (document control number [Part A]), ICN (internal control number [Part B] located in the 277CA, loop 2200D, REF02 segment -1K qualifier), the beneficiary's health insurance claim number (HICN)/ Medicare number, Billing provider's name and NPI (national provider identifier).

FCSO will return PWK coversheets with missing or inaccurate data. The coversheet will be returned based on how it was received (fax or mail).

Note: FCSO will not return any paperwork documentation that accompanies a rejected PWK coversheet; nor will the documentation be used for adjudication of the claim.

PWK documentation may not be submitted prior to submission of a claim. Submitters must send all relevant PWK data at the same time for the same claim. Thus, if the claim was submitted with multiple PWK iterations, all PWK data for the claim must be submitted together under one coversheet.

If the PWK segment is completed and additional documentation is needed for adjudication, FCSO will allow seven calendar "waiting" days (from the claim date of receipt) for the paperwork documentation to be faxed or ten calendar waiting days to be mailed.

If the PWK data is not received within the waiting timeframe and additional documentation is needed, a development request will be sent. If documentation is received after the timeframe has elapsed, the coversheet will be returned and the documentation will not be used for adjudication of the claim. Thus, the paperwork will need to then accompany our request for additional documentation to prevent possible claim denials.

Claims submitted with a PWK segment, that would not otherwise suspend for review and/or require additional development, will process routinely and will not be held for the seven or ten day waiting period.

Medicare Part A fax/mail cover sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete ONE Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim. Please use ALL CAPS for your entries. **Note:** this form may not be altered.

ACN (Exactly as entered in the PWK loop on the claim) DCN

Beneficiary last name First name HICN

Date(s) of service From To Total Claim Billed Amount

Billing provider's name Contact and phone number

NPI

State where services were provided Total number of documentation pages (including cover sheet)

Please provide a complete return mailing address if documentation is being mailed:

Medicare Part B fax/mail cover sheet

Complete all fields and fax or mail the form to the applicable address/number provided at the bottom of the page. Complete ONE Medicare Fax/Mail Cover Sheet for each electronic claim for which documentation is being submitted. This form should not be submitted prior to filing the claim. Please use ALL CAPS for your entries. **Note:** this form may not be altered.

ACN (Exactly as entered in the PWK loop on the claim) ICN

Beneficiary last name First name HICN

Date(s) of service From To Total Claim Billed Amount

Billing provider's name Contact and phone number

NPI

State where services were provided Total number of documentation pages (including cover sheet)

Please provide a complete return mailing address if documentation is being mailed:

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(PWK continued)

Faxination numbers

FCSO will provide designated faxination lines to expedite receipt of the PWK coversheets/attachments, depending on the provider’s line of business and location (Part A or Part B; Florida, Puerto Rico, or the U.S. Virgin Islands).

Each fax/mail coversheet will include the appropriate FCSO return mailing address and faxination number, based on the provider’s selection.

5010 Companion Guide

Additional information on the PWK segment is available in the X12 Version 5010 837I and 837P Companion Guides.

- [Part A: 837 Institutional Claim Transaction Specific Information](#)
- [Part B: 837 Professional Claim Transaction Specific Information](#)

Source: Pub 100-08, Transmittal 396, change request 7330

Resolution of the 5010 electronic claims submission 496 edit

With the implementation of Accredited Standards Committee (ASC) X12 version 5010, the Medicare administrative contractors (MACs) have received a large increase in calls from billers regarding the 496 edit, more commonly referred to as “the linkage problem.” In some cases, the problem may be the result of a provider not being properly linked to a clearinghouse/vendor submitter in Medicare’s system; however, the problem may also be the result of billing errors. The tips that follow will assist you in determining the reason for receipt of a 496 edit and help you understand the resolution of the edit.

Since the 4010 versus 5010 electronic claim formats are not the same, you cannot assume a successful provider and clearinghouse/vendor you should be successfully were initially made nearly a Medicare & Medicaid Services large clearinghouses that sold, and combined are now

Prior to the implementation enhancement module contractors maintained their (EDI) edits. Now that the 5010 to ensure that all linkages are being stopped for bad linkage.

In addition to the provider and issue, the 496 edit can also national provider identifier

- Using a rendering provider’s NPI instead of the billing provider NPI (rendering provider is not associated with the clearinghouse/vendor submitter)
- Billing Part B services for a provider associated with a group under his/her individual NPI when it should be billed under the group NPI

Resolution of the 496 edit requires evaluation of the health care claims acknowledgement message (277CA) and all edits incurred in addition to it. While generally a 496 edit may indicate a simple linkage issue, additional edits might focus on the submission of an inappropriate or incorrect NPI as a result of improper billing.

The 277CA, if delivered back to the provider from the clearinghouse/vendor, will have the following message components in the status segment (STC) related to a 496 edit:

- **First part:** Claim status category code = “A8” – acknowledgement / rejected for relational field error
- **Second part:** Claim status code = “496” – submitter not approved for electronic claim submissions on behalf of this entity
- **Third part:** Entity identifier code = “85” – billing provider



submitter linkage in 4010 means linked in 5010. Some linkages decade ago. The Centers for (CMS) has found that several have been repeatedly bought, using new submitter numbers.

of the common edits and (CEM) software, Medicare own electronic data interchange format has a definitive CEM edit valid, invalid submitter IDs are

clearinghouse/vendor linkage occur because of the following (NPI) billing issues:

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(Resolution continued)

This message, "A8:496:85," utilizes the Washington Publishing Company (WPC)-maintained national code values and relays that the claim was rejected for a relationship error between the submitter and the billing providers NPI. You will receive this same set of codes for a linkage problem and an improper billing problem (use of rendering versus billing provider NPI, for example, as described above).

Clearinghouse/vendor evaluation of all edits received should be completed before asking for linkage problem resolution from your MAC.

Contact your MAC EDI support line after researching the nature of your 496 edits for assistance with the provider and clearinghouse/vendor submitter linkage and the collection of the CMS-required provider authorization to bill for each customer. The MAC EDI support lines are available at http://www.CMS.gov/ElectronicBillingEDITrans/03_EDISupport.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 201202-59

Important update regarding HIPAA version 5010/D.0 implementation

The Centers for Medicare & Medicaid Services (CMS) has posted a new document titled *Important Update Regarding HIPAA Version 5010/D.0 Implementation* to CMS' "Versions 5010 & D.0 & 3.0" Web page: http://www.CMS.gov/versions5010andd0/01_overview.asp. The document includes descriptions used for interpreting the 277CA responses as well as links to the common edits and enhancement module (CEM) error description documents.

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

Source: CMS PERL 201202-46

Medicare FFS version 5010 requirement changes for non-specific procedure codes

Medicare fee-for-service (FFS) has amended the not otherwise classified (NOC) code set listing effective Monday, January 16, 2012. Thus, it has been determined that anesthesia codes that include the phrase "not otherwise specified" in their code descriptors (procedure codes 00100 through 01996) do not meet the criteria of a non-specified procedure code and do not require a description to be supplied in the SV101-7/SV202-7 data elements. Anesthesia procedure code 01999, "Unlisted anesthesia procedure(s)" meets the requirements of a non-specified code and continues to require additional information to be supplied in the SV101-7 data element.

Additionally, various pathology and laboratory codes identified in procedure code section 8800 and a variety of other NOC codes have been removed. These codes do not meet the criteria of a non-specified procedure code and do not require a description to be supplied in the SV101-7/SV202-7 data elements.

The majority of procedure codes impacted and removed from the NOC code list are anesthesia codes, laboratory/pathology codes, and physicians quality reporting system codes.

Medicare FFS's complete listing of the NOC codes can be found at http://www.CMS.gov/ElectronicBillingEDITrans/40_FFSEditing.asp. Medicare will be updating the code set, at minimum, on a quarterly basis (January, April, July, and October) as the NOC list is refined and the parent code sets are updated. Please check back to the [website](#) frequently for the most updated list.

For more information on version 5010 and D.0, please visit <http://www.CMS.gov/Versions5010andD0>.

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

Source: CMS PERL 201201-46

Preparing for the version 5010 upgrade – questions to ask your vendor

The compliance deadline to upgrade to version 5010 from version 4010/4010A was January 1. The Center for Medicare & Medicaid Services (CMS) announced an enforcement discretion period for 90 days until Saturday, March 31, during which it would not initiate enforcement action with respect to any HIPAA-covered entity that is non-compliant with the ASC X12 version 5010 (version 5010), NCPDP Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. However, you should continue to upgrade your systems as promptly as possible in order to meet this deadline.

In order to ensure a smooth upgrade prior to April, you will need to complete both phase I internal and phase II external testing of version 5010 transactions. As part of your external testing, you will need to conduct tests with outside trading partners, which include vendors, clearinghouses, billing services, and payers. Your vendor is a critical partner in achieving version 5010 compliance.

You should take the following steps to evaluate your vendor and vendor products to ensure a timely version 5010 upgrade:

- Establish a tracking system and timeline for milestones
- Review existing and new contractual obligations with vendors
- Coordinate vendor capabilities with your practice needs and expectations
- Evaluate ease of use of vendor products

You might want to also ask your vendor some of the following questions about the version 5010 upgrade to help assess your readiness for this upgrade:

- Have they upgraded their systems to meet version 5010 standards?
- If they have not yet upgraded, when will they do so?
- What will be the cost for each upgrade?
- What versions of their software will be upgraded, and will these upgrades require any additional hardware upgrades?
- How often will updates occur and what is the delivery method?
- How are issues logged and how will they be addressed?
- Is there training available for new system changes and/or functionalities?

Please visit the CMS ICD-10 website for additional information and resources about the [version 5010](#) upgrade.

Keep up to date on version 5010 and ICD-10. Please visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

Source: CMS PERL 201202-16

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

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

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

Source: CMS PERL 201202-17

Only one ERA recipient per NPI or legacy ID – beginning April 1

Prior to the implementation of HIGLAS (the Healthcare Integrated General Ledger Accounting System), Medicare's multi-carrier system (MCS) created just one check per sender, national provider identifier (NPI), or legacy ID. Each sender/NPI/legacy ID was able to have multiple receivers of the electronic remittance; MCS would use the sender ID submitting each claim to aid in determining to whom the remit should be sent. For each check that was created, MCS also created an electronic remittance advice (ERA), which accurately reported the payment amount for that ERA.

When a Medicare administrative contractor (MAC) transitions to HIGLAS, only one check can be produced per NPI/legacy ID. The old MCS system logic, which took the sender information into account when generating the remit, was not changed when MACs began their transition to HIGLAS; in some instances, the result was a remittance advice that did not contain all of the claims processed in a given cycle or a remittance advice containing payments that did not total to the Electronic Funds Transfer (EFT) or check amount/check amount.

In order to accurately produce electronic remittance advices to match the EFT/check amount, MCS will be changing their logic effective Sunday, April 1, 2012 – and will no longer consider the sender information when creating the ERA files. MACs will allow only one receiver of an electronic remittance per NPI/legacy ID regardless of whether the provider submits their inbound files under different sender IDs.

If your profile indicates multiple ERA receivers, your assigned MAC will contact you to request that you select one receiver for your electronic remittance.

Source: CMS PERL 201202-01

Claim status category and claim status codes update

Provider types affected

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

What providers need to know

This article, based on change request (CR) 7670, explains that the claim status and claim status category codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 were updated during the February 2012 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at <http://www.wpc-edi.com/content/view/180/223/> on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 2, 2012. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

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

The official instruction, CR 7670, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at <http://www.cms.gov/transmittals/downloads/R2371CP.pdf>.

MLN Matters® Number: MM7670 *Revised*

Related Change Request (CR) #: 7670

Related CR Release Date: December 22, 2011

Effective Date: April 1, 2012

Related CR Transmittal #: R2371CP

Implementation Date: April 2, 2012

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Use of unique numbering recommended for key data elements in inbound 837 claims

With the implementation of Accredited Standards Committee (ASC) X12 version 5010 transactions for acknowledgements (TA1, 999, and 277CA), Medicare fee-for-service is recommending the use of unique numbering for several enveloping control/reference numbers built into the version 5010 claims transactions. Using unique numbering for the IAS13, ST02, and BHT03 data elements on the inbound 837 institutional and professional claims will allow Medicare trading partners to easily match submitted claims with the acknowledgement transactions.

Examples of those pairing include:

- 837 ISA13 is mapped to the TA1 response transaction and located in the TA101 data element
 - The implementation guide for the TA1 (ASC X12 TA1 TR3) states for TA101: “This is the value in ISA13 from the interchange to which this TA1 is responding.”
- 837 ST02 is mapped to the 999 response in the 2000.AK202 data element
 - The implementation guide for the 999 (ASC X12 999 TR3) states for AK202: “Use the value in ST02 from the transaction set to which this 999 transaction set is responding.”
- 837 BHT03 is mapped to the 277CA response in the 2200B.TRN02 data element
 - The implementation guide for the 277CA (ASC X12 277CA TR3) states for TRN02: “This element contains the value submitted in the BHT03 data element from the 837.”

Source: CMS PERL 201202-03

ASC X12 decides against proposing version 6020 for consideration as next version of standard under HIPAA

The Accredited Standards Committee X12 (ASC X12) recently announced that it will not propose version 6020 for consideration as the next version of the standard under the Health Insurance Portability and Accountability Act (HIPAA). In its press release, ASC X12 stated that after listening to and reviewing testimony to the National Committee on Vital Health Statistics (NCVHS), holding discussions with health care industry stakeholders and the Centers for Medicare & Medicaid Services’ (CMS) representatives, and acknowledging the many health IT initiatives underway, it decided not to recommend its version 6020 TR3s to the designated standards maintenance organizations (DSMO). ASC X12’s decision removes the option that this version would be considered for adoption under HIPAA.

In announcing its decision, ASC X12 noted that the health care industry is better served by focusing on upgrading to version 5010 standards this year. Lessons learned from this implementation will generate better information that can be applied to changes to the next version of the standard. Furthermore, industry participation in that process will be more robust. CMS supports ASC X12’s caution that even though the 6020 version will not be recommended for adoption, stakeholder input is still imperative. The 6020 version will still serve as the basis for the next version, but industry will have much-needed time to determine changes that are needed.

CMS will continue to support the work of ASC X12, the DSMO, other standards development organizations, operating rule entities, and industry stakeholders to improve the process for developing, adopting and maintaining standards and implementation specifications. Please visit the [ASC X12 website](#) for more information on this decision.

Keep up to date on version 5010 and ICD-10. Visit the [ICD-10 website](#) for the latest news and resources to help you prepare, and to download and share the implementation [widget](#) today.

Source: CMS PERL 201202-37



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.

Fraud

(Health care continued)

The HCFAC annual report can be found at <http://oig.HHS.gov/publications/hcfac.asp>. More information on the fraud prevention accomplishments under the Affordable Care Act can be found at <http://www.Healthcare.gov/news/factsheets/2012/02/medicare-fraud02142012a.html>.

The full text of this excerpted HHS press release (issued Tuesday, February 14) can be found at <http://www.HHS.gov/news/press/2012pres/02/20120214a.html>.

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

Source: CMS PERL 201202-52

The role of zone program integrity contractors (ZPICs)

Provider types affected

This special edition *MLN Matters*[®] article is intended for all physicians, providers, and suppliers who submit claims to Medicare contractors (fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], carriers, A/B Medicare administrative contractors [MACs], durable Medical equipment [DME] MACs, and home health and hospice [HH+H] MACs for services and supplies provided to Medicare beneficiaries.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen the Centers for Medicare & Medicaid Services' (CMS') ability to detect and deter potential fraud, waste, and abuse in the Medicare program. MIP allows CMS to carry out program safeguard functions effectively and efficiently. As part of this program, CMS created new entities, program safeguard contractors (PSCs), to perform program integrity functions.

On December 8, 2003, the Medicare Modernization Act (MMA) was signed into law. Section 911 of the MMA directed implementation of Medicare fee-for-service contracting reform. This required CMS to use competitive procedures to replace its current FIs and carriers with a uniform type of administrative entity, referred to as Medicare administrative contractors (MACs).

As a result of these changes, seven program integrity zones were created based on the newly-established MAC jurisdictions. New entities entitled zone program integrity contractors (ZPICs) were created to perform program integrity functions in these zones for Medicare Parts A, B, durable medical equipment prosthetics, orthotics, and supplies, home health and hospice and Medicare-Medicaid data matching. Medicare Part C and D program integrity efforts are handled separately by one national contractor known as the Medicare drug integrity contractor (MEDIC) (Health Integrity, LLC is the current MEDIC). The ZPICs and the MEDIC work under the direction of the Center for Program Integrity(CPI) in CMS.

The following table lists all of the ZPICs and their zones.

ZPIC	Zone	States in zone
Safeguard Services (SGS)	1	California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
AdvanceMed	2	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska
Cahaba	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
Health Integrity	4	Colorado, New Mexico, Texas, and Oklahoma
AdvanceMed	5	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia
Under Protest	6	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut
Safeguard Services (SGS)	7	Florida, Puerto Rico, Virgin Islands

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(ZPICs continued)**Medicare fraud**

Fraud frequently arises from false statements or misrepresentations made that are material to entitlement or payment under the Medicare program. A violator may be a provider, a beneficiary, or an employee of a provider or some other business entity including a billing service. Providers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud committed against the program may be prosecuted under various provisions of the United States code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a wide range of administrative sanctions (such as deactivation or revocation of Medicare enrollment or billing privileges, suspension of payments, or exclusion from participation in the Medicare program) and civil monetary penalties may be imposed when facts and circumstances warrant such action. An investigation that demonstrates potential fraud may be referred to law enforcement for further investigation.

Contacts for reporting potential fraud

Beneficiaries may report Medicare fraud by calling 1-800-MEDICARE or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) hotline at 1-800-HHS-TIPS (1-800-447-8477). Providers may report fraud by calling the DHHS Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

ZPIC functions

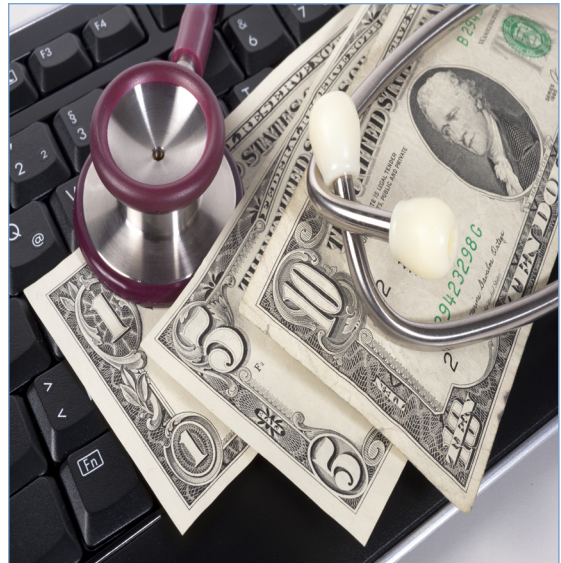
The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare trust fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare program include:

- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement
- Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System
- Performing medical review, as appropriate
- Performing data analysis in coordination with CPI's Fraud Prevention System
- Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits, and
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

In performing these functions, ZPICs may, as appropriate:

- Request medical records and documentation
- Conduct an interview
- Conduct an onsite visit
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments, and
- Refer cases to law enforcement.

ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider. Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at <http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf>.



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(ZPICs continued)**Non-ZPIC functions**

The following are some of the major functions that the ZPICs do not perform. These functions are performed by the MAC:

- Claim processing, including paying providers/suppliers
- Provider outreach and education
- Recouping monies lost to the Trust Fund (the ZPICs identify these situations and refer them to the MACs for the recoupment)
- Medical review not for benefit integrity purposes
- Complaint screening
- Claim appeals of ZPIC decisions
- Claim payment determination
- Claim pricing, and
- Auditing provider cost reports.

Additional information

More information about Medicare contracting reform is available at <http://www.cms.gov/MedicareContractingReform>.

The *Medicare Learning Network*® (MLN) brochure titled “The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers,” which is designed to provide education on the Medicare Part A and B administrative appeals process, is available at <http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf>.

The MLN fact sheet titled “Medicare Fraud & Abuse: Prevention, Detection, and Reporting,” which is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse, is available at http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf.

For the latest educational products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities, please visit the MLN Provider Compliance Web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp.

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

Find out whether you have been sent a revalidation request by using the search option featured on First Coast Service Options' popular enrollment status lookup. You may search for revalidation requests by entering your NPI or your PTAN.

Prior authorization of power mobility devices demonstration and recovery audit prepayment review demonstration

On Tuesday, November 15, 2011, the Centers for Medicare & Medicaid Services (CMS) announced three demonstration projects that aim to strengthen Medicare by eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sustainability of the Medicare trust funds and protect beneficiaries who depend upon the Medicare program.

CMS is pleased to announce that the prior authorization of power mobility devices (PMDs) demonstration and the recovery audit prepayment review demonstration – which were delayed from their initial Sunday, January 1 start-date – are expected to move forward on or after Friday, June 1, 2012. For additional information on these demonstrations, please visit <http://go.CMS.gov/cert-demos>.

These demonstrations will begin after receipt of a Paperwork Reduction Act (PRA) Office of Management and Budget control number. CMS posted a PRA notification for these demonstrations on Friday, February 3 at <http://www.CMS.gov/PaperworkReductionActof1995/PRAL/list.asp>.

CMS significantly revised the prior authorization of PMDs demonstration in response to provider and supplier concerns. For more information on the adopted changes please visit <http://go.CMS.gov/PAdemo>.

The Part A to Part B rebilling demonstration began on Sunday, January 1, 2012.

To view the relevant *Federal Register* notice, visit <https://s3.amazonaws.com/public-inspection.federalregister.gov/2012-02821.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 201202-10

Provider Enrollment

Major improvements to Medicare online enrollment system

During the past year, the Centers for Medicare & Medicaid Services (CMS) has listened to your feedback about the Medicare online enrollment system: Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). As a result, CMS has made upgrades in order to reduce data entry time and increase access to information.

Providers and staff using Internet-based PECOS will now see the following improvements:

- Electronic signature – you now have the ability to digitally sign and certify the application.
- Access to more information – now you can see if a request for revalidation has been sent by your Medicare administrative contractor (MAC).
- Multiple views of your information – switch between topic view and fast track view:
 - The fast track view allows you to quickly review all enrollment information on a single screen.
- Overall usability – CMS is making the system easier to use:
 - You can access previously-used address information when completing an application.
 - You can quickly update and resubmit an application returned for correction via Internet-based PECOS as part of any application submission.
 - You will have fewer screens and steps to navigate when you are changing information or revalidating your application(s).

Learn more about Internet-based PECOS at <https://PECOS.CMS.hhs.gov>, and be on the look-out for more enhancements in the coming months!

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

Source: CMS PERL 201202-47

2012 Medicare Part B Participating Physician and Supplier Directory

The Medicare Part B Participating Physician and Supplier Directory (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing will be available no later than March 15 on the FCSO Medicare website at <http://medicare.fcso.com/MEDPARD/>.

Source: Pub 100-04, Transmittal 2319, CR 7573

Advanced diagnostic imaging accreditation enrollment procedures – fully rescinds and replaces CR 7177

Note: This article was revised on February 10, 2012, to reflect the revised change request (CR) 7681 issued on February 9, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR 7681 were revised. All other information is the same. This information was previously published in the January 2012 *Medicare B Connection*, Page 47.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or A/B Medicare administrative contractors [A/B MACs]) for advanced diagnostic imaging (ADI) services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on CR 7681 which fully rescinds and replaces CR 7177.

Caution – what you need to know

CR 7177 established that ADI providers/suppliers would need to provide their ADI accreditation information by completing an Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) application or a CMS-855 application. CR 7681 changes this requirement and allows for the accrediting organizations to provide the listing of who is accredited through a weekly file. Since this change, providers/suppliers no longer need to complete the ADI information in Internet-based PECOS or on a CMS-855 form(s).

Go – what you need to do

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

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA - Section 135(a); see <http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf>) amended the Social Security Act (Section 1834(e); see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) and required the Secretary of the U.S. Department of Health and Human Services (HHS) to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners, and independent diagnostic testing facilities, that furnish the technical component (TC) of ADI services.

MIPPA specifically defines advanced diagnostic imaging (ADI) procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging (NMI) such as positron emission tomography (PET). The law also authorizes the HHS Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, providers/suppliers must be accredited by January 1, 2012.

The Centers for Medicare & Medicaid Services (CMS) implemented (effective January 1, 2012) the requirement that ADI providers and/or suppliers must be accredited for ADI services specific to each modality for which they will submit claims. Originally, CMS required the providers/suppliers to provide their accreditation information on their respective CMS-855 form, or through the internet-based PECOS.

CR 7681 establishes a new process that allows for ADI providers and/or suppliers to bypass ADI information collection on the appropriate CMS-855 form or in the Internet-based PECOS Web application. CR 7681 instructs that Medicare contractors will:

- Not require documentation from the ADI provider/supplier for proof of their accreditation; and

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- Not require providers/suppliers to complete the ADI section in the Internet-based PECOS application nor in the appropriate CMS-855 form.

Instead, Medicare and its contractors will receive this information directly from the accrediting organizations.

Additional information

The official instruction, CR 7681, issued to your carriers and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R407PI.pdf>.

If you have any questions, please contact your carriers 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: MM7681 *Revised*
Related Change Request (CR) #: CR 7681
Related CR Release Date: February 9, 2012
Effective Date: January 27, 2012
Related CR Transmittal #: R407PI
Implementation Date: January 27, 2012

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Incentive Programs

Physician Quality Reporting System program update – measure #235 claims error

The Centers for Medicare & Medicaid Services (CMS) has recently identified an error related to the submission of measure #235, “Hypertension: Plan of Care,” for the 2012 Physician Quality Reporting System. “Hypertension: Plan of Care” is a claims/registry measure with G-codes that are inactive due to an error found on the HCPCS tape. Consequently, this has resulted in claims containing the G-codes associated with the measure being rejected by the carrier/Medicare administrative contractors (MACs) or denied.

The codes G8675, G8676, G8677, G8678, G8679, G8680, and 4050F will be reactivated with the next update of the HCPCS tape in April 2012. For 2012 claims-based reporting, PQRS requires at least three measures to each be reported at a 50 percent reporting rate. In the interim, eligible professionals who had intended to report this measure via claims for the 2012 PQRS may want to consider taking the following steps:

- Eligible professionals may want to consider reporting additional measures to substitute for measure #235, “Hypertension: Plan of Care.”
- “Hypertension: Plan of Care” is a per-visit measure, which requires reporting for 50 percent of eligible patient visits. Therefore, eligible professionals could report the measure on more than 50 percent of eligible visits from April through December 2012 to increase the likelihood for successful reporting of the measure.



For additional information, visit the [Physician Quality Reporting System](#) Web page on the CMS website.

Source: CMS PERL 201202-63

2012 Physician Quality Reporting System claims-based coding and reporting principles

Provider types affected

This article is intended for physicians and other providers who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System reporting and incentive program.

What providers need to know

This article describes claims-based coding and reporting, and outlines steps that eligible professionals or practices should take prior to participating in 2012 Physician Quality Reporting.

For guidance on reporting the electronic prescribing (eRx) measure, please reference the *Claims-Based Reporting Principles for 2012 Electronic Prescribing Incentive Program* at <http://www.cms.gov/ERxIncentive.asp>, under the eRx “Downloads” section.

Background

The Physician Quality Reporting System (Physician Quality Reporting) is a voluntary reporting program. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual national provider identifier (NPI) and tax identification number (TIN) who satisfactorily report data on quality measures for covered Medicare physician fee schedule (MPFS) services furnished to Medicare Part B fee-for-service (FFS) beneficiaries (including Railroad Retirement Board and Medicare secondary payer).

Key points

How to get started

Step 1: Fill out claim(s) with codes for reimbursement

Step 2: Reference measure specifications

To ensure accurate application of Physician Quality Reporting denominator and numerator codes, reference the 2012 Physician Quality Reporting System Measure Specifications available as a download at http://www.cms.gov/PQRS/15_MeasuresCodes.asp.

Step 3: Do a double check

CMS encourages eligible professionals to review their claims for accuracy prior to submission for reimbursement and reporting purposes.

Step 4: Review your remittance advice (RA)/explanation of benefits (EOB)

Review your RA/EOB for denial code N365. This code indicates that the Physician Quality Reporting codes were received into the national claims history.

Coding and reporting principles—tips when reporting via claims

Claims-based reporting principles

Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim.

- Only one diagnosis can be linked to each line item.
- Physician Quality Reporting analyzes claims data using ALL diagnoses from the base claim (Item 21 of the CMS-1500 or electronic equivalent) and service codes for each individual eligible professional (identified by individual NPI).
- **Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL chosen measures applicable to that patient’s care.**

All diagnoses reported on the base claim will be included in Physician Quality Reporting analysis, as some measures require reporting more than one diagnosis on a claim.

- For line items containing a quality-data code (QDC), only one diagnosis from the base claim should be referenced in the diagnosis pointer field.
- To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure’s diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, all diagnoses on the claim(s) are considered in the Physician Quality Reporting analysis.

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(Quality continued)

If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny to one of the line items on that second claim for a total charge of one penny.

- Physician Quality Reporting analysis will subsequently join claims based on the same beneficiary for the same date-of-service, for the same taxpayer identification number/national provider identifier (TIN/NPI), and analyze as one claim.
- **Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses, QDCs, or nominal charge amounts are not dropped.**

A sample CMS-1500 form can be found in Appendix D of the 2012 Physician Quality Reporting System Implementation Guide at http://www.cms.gov/PQRS/15_MeasuresCodes.asp, under the “Downloads” section of Physician Quality Reporting on the CMS website.

Submitting quality-data codes (QDCs)

QDCs are specified *Current Procedural Terminology II (CPT-II)* codes (with or without modifiers) and G-codes used for submission of Physician Quality Reporting data. QDCs can be submitted to carriers or A/B Medicare administrative coordinators (MACs) either through:

1. **Electronic-based submission** (using the ASC X 12N Health Care Claim Transaction [version 5010]); **OR,**
2. **Paper-based submission** using the **CMS-1500 claim form (version 08-05).**

Principles for reporting QDCs

The following principles apply for claims-based reporting of Physician Quality Reporting measures:

1. QDCs must be reported:
 - On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B MPFS encounter
 - For the same beneficiary
 - For the same date of service (DOS), and
 - By the same eligible professional (individual NPI) who performed the covered service, applying the appropriate encounter codes (ICD-9-CM, *CPT* Category I or HCPCS codes). These codes are used to identify the measure’s denominator.
2. QDCs must be submitted with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed.
 - The submitted charge field cannot be blank.
 - The line item charge should be \$0.00.
 - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted – the beneficiary is not liable for this nominal amount.
 - Entire claims with a zero (\$0.00) charge will be rejected.
 - Whether a \$0.00 charge or a nominal amount is submitted to the carrier or A/B MAC, the Physician Quality Reporting code line will be denied but will be tracked in the National Claims History (NCH) for analysis.
3. When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician’s NPI must be placed on each line item, including all allowed charges and quality-data line items. Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field (#33a on the CMS-1500 form or the electronic equivalent).

Note: Claims may **not** be resubmitted for the sole purpose of adding or correcting QDCs.

Remittance advice/explanation of benefits

The RA/EOB denial code N365 is your indication that the Physician Quality Reporting codes were received into the national claims history.

- **N365** reads: “This procedure code is not payable. It is for reporting/information purposes only.”

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- The **N365** denial code is just an indicator that the QDC codes were received. It does not guarantee the QDC was correct or that incentive quotas were met. However, when a QDC is reported satisfactorily (by the individual eligible provider), the **N365** can indicate that the claim will be used for calculating incentive eligibility.
- Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the carrier or A/B MAC. Each QDC line-item will be listed with the N365 denial remark code.

Timeliness of quality data submission

Claims processed by the carrier or A/B MAC must reach the national Medicare claims system data warehouse (national claims history file) by **February 22, 2013**, to be included in analysis. Claims for services furnished toward the end of the reporting period should be filed promptly.

Additional information

For more information on reporting individual measures via claims, please see the following resources available as downloads on the Physician Quality Reporting website at http://www.cms.gov/PQRS/15_MeasuresCodes.asp:

- 2012 Physician Quality Reporting System Measure Specifications Manual and Release Notes
- 2012 Physician Quality Reporting System Measures List
- 2012 Physician Quality Reporting QDC Categories
- 2012 Physician Quality Reporting System Implementation Guide

For more information on reporting measures groups via claims, please see the following resources available as downloads on the Physician Quality Reporting website at http://www.cms.gov/PQRS/15_MeasuresCodes.asp.

- 2012 Physician Quality Reporting System Measures Groups Specifications Manual
- Getting Started with 2012 Physician Quality Reporting of Measures Groups
- 2012 Physician Quality Reporting System Fact Sheet: Physician Quality Reporting Made Simple – Reporting the Preventive Care Measures Group

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New educational resources for the Physician Quality Reporting System

The Centers for Medicare & Medicaid Services (CMS) has created a number of useful resources for eligible professionals participating in the Physician Quality Reporting System, including:

[2012 Physician Quality Reporting System: Registry Reporting Made Simple](#) – this document describes registry-based reporting and outlines steps that eligible professionals or practices should take in selecting a registry to work with for the 2012 program year.

[2012 Physician Quality Reporting System: Electronic Health Record \(EHR\) Reporting Made Simple](#) – this document describes EHR-based reporting and outlines steps that eligible professionals should take in selecting an EHR to work with for the 2012 program year.

[2012 Physician Quality Reporting System: Maintenance of Certification Program Incentive Made Simple](#) – this fact sheet provides steps for successful participation in the Maintenance of Certification Program Incentive. It also explains the role of the qualified Maintenance of Certification Program Incentive entity.

[2012 Physician Quality Reporting System: Claims-Based Coding and Reporting Principles](#) – this document describes claims-based coding and reporting and outlines steps that eligible professionals or practices should take prior to participating in 2012 Physician Quality Reporting.

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(Resources continued)

[2012 Physician Quality Reporting System: Made Simple for Reporting the Preventive Care Measures Group via Claims](#) – this fact sheet provides guidance on satisfactorily reporting the Preventive Care Measures Group via claims for 2012 Physician Quality Reporting.

[Physician Quality Reporting System: Updates for 2012](#) – this fact sheet includes important information about changes to the Physician Quality Reporting System for 2012, as authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

[2012 Physician Quality Reporting System and Electronic Prescribing \(eRx\) Incentive Program Group Practice Reporting Option \(GPRO\): Participation for the Incentive Payment Made Simple](#) – this fact sheet provides guidance for group practices wishing to participate in the 2012 Physician Quality Reporting System and the 2012 eRx incentive program as a CMS selected group practice.

[2012 Physician Quality Reporting System Medicare EHR Incentive Pilot: Quick Reference Guide](#) – this quick-reference guide provides direction to eligible professionals participating in the Medicare EHR incentive program on reporting and satisfying the clinical quality measure (CQM) requirements through participation in the Physician Quality Reporting System-Medicare EHR incentive pilot.

[2012 Physician Quality Reporting System: Claims Reporting Made Simple](#) – this document describes claims-based reporting and outlines steps that eligible professionals or practices should take prior to participating. It also provides helpful reporting tips for eligible professionals and their billing staff.

To access these and other educational products on the Physician Quality Reporting System, visit the [“Educational Resources”](#) section of the [Physician Quality Reporting System](#) Web page.

Source: CMS PERL 201202-40

2012 Electronic Prescribing Incentive Program: Future payment adjustments

Provider types affected

This article is intended for physicians and other providers who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Electronic Prescribing (eRx) Incentive Program.

What providers need to know

This article provides guidance on avoiding future eRx incentive program payment adjustments for individual eligible professionals and selected group practices participating in the 2012 eRx group practice reporting option (GPRO).

Background

Under Section 1848(a)(5)(A) of the Social Security Act, for years 2012 through 2014, a Medicare physician fee schedule (MPFS) payment adjustment applies to eligible professionals who are not successful electronic prescribers at an increasing rate through 2014. Specifically, if the eligible professional is not a successful electronic prescriber for the respective reporting period for the appropriate program year, the MPFS amount for covered professional services during the year shall be a percentage less than the MPFS amount that would otherwise apply.

The applicable electronic prescribing percent for payment adjustments under the eRx incentive program are as follows:

- 1.0 percent adjustment in 2012 (eligible professional will receive 99% of their Medicare Part B PFS amount that would otherwise apply to such services)
- 1.5 percent adjustment in 2013 (eligible professional will receive 98.5% of their Medicare Part B PFS amount for covered professional services), and
- 2.0 percent adjustment in 2014 (eligible professional will receive 98% of their Medicare Part B PFS amount for covered professional services).

Key points

Exclusion criteria for individual eligible professionals is as follows:

- An individual eligible professional (regardless of participation in other CMS incentive programs) will not be included in analysis for the payment adjustment if one of the payment adjustment exclusion criteria (listed in Table 1) applies.

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(eRx ... continued)

- CMS will determine whether an individual eligible professional (defined by individual rendering national provider identifier, or NPI) is subject to future payment adjustments for each tax identification number (TIN).

Table 1: Payment adjustment exclusion criteria for individual eligible professionals

2013 payment adjustment exclusion criteria	2014 payment adjustment exclusion criteria
The eligible professional is a successful electronic prescriber during the 2011 eRx 12-month reporting period (January 1-December 31, 2011).	The eligible professional is a successful electronic prescriber during the 2012 eRx 12-month reporting period (January 1-December 31, 2011).
The eligible professional is not an MD, DO, podiatrist, nurse practitioner, or physician assistant by June 30, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).	The eligible professional is not an MD, DO, podiatrist, nurse practitioner, or physician assistant by June 30, 2013, based on primary taxonomy code in the NPPES.
The eligible professional does not have at least 100 MPFS cases containing an encounter code in the measure’s denominator for dates of service from January 1-June 30, 2012.	The eligible professional does not have at least 100 MPFS cases containing an encounter code in the measure’s denominator for dates of service from January 1-June 30, 2013.
The eligible professional does not have 10 percent or more of their MPFS allowable charges (per TIN) for encounter codes in the measure’s denominator for dates of service from January 1-June 30, 2012.	The eligible professional does not have 10 percent or more of their MPFS allowable charges (per TIN) for encounter codes in the measure’s denominator for dates of service from January 1-June 30, 2013.
The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim from January 1-June 30, 2012.	The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim from January 1-June 30, 2013.

Avoiding the 2013 eRx payment adjustment

Individual eligible professionals and group practices participating in the eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx incentive program payment adjustment by meeting the specified reporting requirements during the appropriate reporting period. Please refer to the tables in Appendix 1 for reporting options and criteria. (Appendices are part of the *Additional information* section of this article.)

Avoiding the 2014 eRx payment adjustment

Individual eligible professionals and group practices participating in the eRx GPRO can avoid the 2014 eRx payment adjustment by meeting the specified reporting requirements during the appropriate reporting period. Please refer to the tables in Appendix 2 for reporting options and criteria.

2013 hardship codes and hardship exemption requests

CMS may exempt individual eligible professionals and group practices participating in the eRx GPRO from the 2013 payment adjustment if it is determined that compliance with the requirement for being a successful electronic prescriber would result in a significant hardship.

Hardship exemption circumstances and codes

- Inability to electronically prescribe due to state, or federal law, or local law or regulation
- The eligible professional prescribes fewer than 100 prescriptions during a six-month payment adjustment reporting period
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642), and
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643).

Submitting a hardship request

- CMS established the Quality Reporting Communication Support Page at <http://www.qualitynet.org/pqrs> for eligible professionals to submit hardship requests, including those associated with a G-code. For more information detailing how to navigate the Quality Reporting Communication Support Page, please reference the following documents:

(eRx ... continued)

- “Quality Reporting Communication Support Page User Guide” posted on the QualityNet website at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234; and
- “Tips for Using the Quality Reporting Communication Support Page” at http://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp.
- A hardship G-code may also be submitted at least once on a claim during the six-month 2013 eRx payment adjustment reporting period, if applicable.
 - The hardship G-code must be submitted on a claim with a billable Medicare Part B service.
 - The hardship G-code does not need to be submitted on a claim that contains eRx measure denominator codes.

eRx participation feedback

Refer to the remittance advice (RA) to determine whether or not eRx quality-data codes submitted to the Medicare carrier or A/B Medicare administrative contractor (MAC) are processed into the national claims history database (NCH). CMS uses the NCH data for eRx program analysis. Take the following steps to ensure the eRx quality-data codes (QDCs) are processed into the NCH:

- The eRx line items will be denied for payment, but are passed through the claims processing system to the NCH used for eRx claims analysis.
- The RA will include a standard remark code (N365). N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.” The N365 remark code does NOT indicate whether the eRx G-code is accurate for that claim or for the reported measure. N365 only indicates that the eRx G-code passed into the NCH.
- If the entire claim is rejected, please review claim for errors before re-submitting, since eRx G-codes will **not** be processed or tracked if the claim is rejected.
- Claims may **not** be resubmitted for the sole purpose of adding or correcting QDCs.

Eligible professionals reporting eRx via claims can find additional information about claims submission and claims processing in the “2012 eRx Claims-Based Reporting Principles” document at <http://www.cms.gov/ERxIncentive>.

Additional information

For more information on the CMS eRx Incentive Program, go to <http://www.cms.gov/ERxIncentive>.

For more information on future payment adjustments, go to http://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp.

CMS has provided the following resource to answer inquiries regarding the Physician Quality Reporting System and eRx incentive program, incentive payments, feedback reports, and Individuals Authorized Access to CMS Computer Services (IACS) registration:

QualityNet Help Desk – 7:00 AM – 7:00 p.m. CST. This desk can help with:

- General CMS Physician Quality Reporting System and eRx Incentive Program information
- Portal password issues
- Feedback report availability and access
- Physician Quality Reporting-IACS registration questions, and
- Physician Quality Reporting-IACS login issues.

Phone: 1-866-288-8912 TTY: 1-877-715-6222 Email: Qnetsupport@sdps.org

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Appendix 1: Reporting options for avoiding the 2013 payment adjustment

**Individual eligible professionals – 12-month reporting period
(dates of service January 1-December 31, 2012)**

Reporting method	Data processing	Criteria
Claims	Data must be processed into the NCH no later than February 24, 2012.	Report G8553 for at least 25 unique denominator eligible eRx events
Registry	Submit data during the 2012 submission period.	
EHR eRx	Submit data during the 2012 submission period.	

Note: Successful submission of the required number of eRx events in the 12-month reporting period will allow for receipt of 2011 eRx incentive payment and allow the eligible professional to avoid the 2013 payment adjustment.

**Individual eligible professionals – six-month reporting period
(dates of service January 1-June 30, 2012)**

Reporting method	Data processing	Criteria
Claims	Data must be processed into the NCH no later than July 27, 2012.	Report G8553 for at least 10 MPFS encounters. The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, regardless of whether the claim contains coding in the eRx measure’s denominator.

**eRx GPRO – six-month reporting option
(dates of service January 1-June 30, 2012)**

Group size	Reporting period	Reporting mechanism	Criteria for avoiding the 2013 eRx payment adjustment
25-99 EPs	January 1–June 30, 2012	Claims	Report G8553 for at least 625 unique MPFS encounters. The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, regardless of whether the claim contains coding in the eRx measure’s denominator.
100+ EPs	January 1–June 30, 2012	Claims	Report G8553 for at least 2,500 unique MPFS encounters. The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, regardless of whether the claim contains coding in the eRx measure’s denominator.

Appendix 2: Reporting options for avoiding the 2014 payment adjustment

**Individual eligible professionals–12-month reporting period
(dates of service January 1-December 31, 2012)**

Note: Successful submission of the required number of eRx events in the 12-month reporting period will allow for receipt of 2012 eRx incentive payment and allow the eligible professional to avoid the 2014 payment adjustment.

**Individual eligible professionals – six-month reporting period
(dates of service January 1-June 30, 2013)**

Reporting method	Data processing	Criteria
Claims	Data must be processed into the NCH no later than July 26, 2013.	Report G8553 for at least 10 MPFS encounters. The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, regardless of whether the claim contains coding in the eRx measure’s denominator.

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Related Change Request (CR) #: N/A
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Effective Date: NA
Related CR Transmittal #: N/A
Implementation Date: NA

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New educational resources for the eRx incentive program

The Centers for Medicare & Medicaid Services (CMS) has created a number of useful resources for eligible professionals participating in the Medicare electronic prescribing (eRx) incentive program, including:

- [2012 eRx Incentive Program: Future Payment Adjustments](#) – this article provides guidance on avoiding future eRx incentive program payment adjustments for individual eligible professionals and selected group practices participating in the 2012 eRx group practice reporting option (GPRO).
- [2012 Physician Quality Reporting System and eRx Incentive Program Group Practice Reporting Option: Participation for the Incentive Payment Made Simple](#) – this fact sheet provides guidance for group practices wishing to participate in the 2012 physician quality reporting system and the 2012 eRx incentive program as a CMS selected group practice.
- [2012 eRx Incentive Program: Participation for the Incentive Payment Made Simple](#) – this fact sheet provides step-by-step advice for participating in the 2012 eRx incentive program.
- [2012 eRx Incentive Program Updates for 2012](#) – this fact sheet contains information about changes to the eRx incentive program for 2012 and future payment adjustments as authorized by MIPPA.

To access these and other educational products on the Medicare eRx incentive program, visit the [“Educational Resources”](#) section of the [electronic prescribing incentive program](#) Web page.

Source: CMS PERL 201202-39

New Web page on CQMs added to the EHR website

The Centers for Medicare & Medicaid Services (CMS) has created a new page http://www.cms.gov/EHRIncentivePrograms/29_ClinicalQualityMeasures.asp to the electronic health record (EHR) website <http://www.cms.gov/EHRIncentivePrograms/> dedicated to the clinical quality measures (CQMs) and their role in the Medicare and Medicaid EHR incentive programs. The page intends to help providers better understand the purpose of CQMs and how to report on the measures.

The new CQM page of the website includes information on the following topics:

- General program definitions, like “Reporting Period”
- Eligible professional (EP) CQM reporting requirements
- Eligible hospital and critical access hospital (CAH) CQM reporting requirements
- Information on the CQM pilot program
- Resources and additional information on CQMs

You can also find helpful CQM resources on the new page, including the [Guide to CQMs](#) and a [webinar video](#) that provides an overview of the measures. Also be sure to review the [CQM EP reporting table](#) and the [CQM eligible hospital and CAH reporting table](#). Each document lists the CQMs for the Medicare and Medicaid EHR incentive programs for 2011-2012.

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

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

Source: CMS PERL 201202-41

New information on the appeals process for Medicare and Medicaid EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) has added new information to the [Attestation section](#) of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs website about the appeals process.

On Thursday, December 1, CMS began accepting appeals for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs). To help EPs, eligible hospitals, and CAHs, the CMS Office of Clinical Standards and Quality (OCSQ) is providing guidance on how to file an appeal. Note that the filing deadline for an eligibility appeal for an eligible hospital ended Monday, January 30, 2012.

OCSQ's Division of Health Information Technology released the first informal review decision for the EHR incentive program on Monday, January 19. Beginning in February, this informal review decision and other appeal decisions will be posted on the [OCSQ appeals website](#). Starting in March, providers may find their decisions by visiting the [appeals portal](#).

For general questions and for information on how to file an appeal, EPs, eligible hospitals, CAHs, and Medicare advantage organizations may contact OCSQ's designated appeal support contractor, Provider Resources Inc. at:

Toll-free number: 855-796-1515 (Between 9:00 a.m. and 5:00 p.m. ET, Monday through Friday)

Email: OCSQappeals@provider-resources.com

Want more information about the EHR incentive programs? Visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201201-49

Electronic health record incentive program highlights and resources

One-year milestone for the Medicare and Medicaid EHR incentive programs marked January 3

Tuesday, January 3, was the one-year anniversary of the start of registration for the Medicare and Medicaid electronic health record (EHR) incentive programs. Over the past year, there has been a tremendous amount of interest in the incentive programs as providers across the country have implemented EHRs.

Year-one highlights include:

- 43 states have started their Medicaid EHR incentive programs
- More than 176,000 people have registered for the Medicare and/or Medicaid EHR incentive programs
- More \$2.5 billion has been paid in incentive payments to eligible professionals (EPs) and eligible hospitals and critical access hospitals (CAHs) across the country

The Centers for Medicare & Medicaid Services (CMS) has created useful resources for participants in the Medicare and Medicaid EHR Incentive Programs, including:

1. [An Introduction to the Medicare EHR Incentive Program for Eligible Professionals](#) – this interactive guide walks EPs through every aspect of the Medicare program, and provides helpful resources and tips along the way.
2. Updated user guides – CMS has updated the registration and attestation user guides, which direct EPs and eligible hospitals through the CMS registration and attestation system. There are five guides that can be downloaded from the [Educational Materials](#) page of the EHR website.
3. Provider testimonial videos – these videos, which can be found on the [CMS YouTube channel](#), highlight providers' experiences participating in the EHR incentive programs.

A look ahead

As we move into 2012 and the second participation year of the Medicare and Medicaid EHR incentive programs, CMS is hopeful that providers will begin or continue their participation in the programs, and take advantage of these incentives for meaningful use of EHRs.

If you are considering registering for the programs, but have not done so yet, take a look at the CMS EHR website and use the [eligibility tool](#) to find out if you can participate.

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(Important continued)

Remember that 2012 is the last year in which EPs can receive a full incentive payment in the Medicare EHR incentive program; beginning in 2013, EPs will receive a smaller overall total payment.

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

CMS has updated the EHR information center with enhanced functionality

CMS is proud to announce that after a review of collected feedback, enhancements and changes have recently been made to the EHR information center interactive voice response (IVR) system.

Among these caller-friendly revisions is a new feature to assist with hot topics, including registration and attestation, as well as updated password reset menus. These improvements will enable eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) to obtain information about the EHR incentive program more easily and efficiently.

Directions for calling the EHR information center:

To contact the IVR, dial 888-734-6433 or 888-734-6563 (TTY number).

Take advantage of the new options from the main menu:

- Press 1 for hot topics
 - For information on when registration begins, press 1.
 - For information on attestation, press 2.
 - For information on being a dually-eligible hospital, press 3.
 - For information on registration tips, press 4.
 - For information on payment time frames, press 5.
 - For information on important upcoming dates, press 6.
 - For information on the clinical quality measures (CQM) eReporting pilot, press 7.
 - For information on Health Professional Shortage Area (HPSA) payments, press 8.
- Press 2 for information on NPPES (national plan and provider enumeration system) and PECOS (provider enrollment, chain, and ownership system) password resets
 - For EPs needing NPPES/PECOS password resets, press 1.
 - For eligible hospitals needing PECOS password resets, press 2.
- Press 0 to speak with an information specialist.
 - For registration questions, press 1.
 - For all other questions, press 2.
 - Press # to repeat the menu.

EHR information center hours of operation: 7:30 a.m.-6:30 p.m. (CT), Monday through Friday, except federal holidays. (General information is available on the IVR anytime, except during planned system maintenance.)

Program information can also be found on the [FAQs section](#) of the EHR incentive programs website, where users can search for any questions they have about the Medicare or Medicaid EHR incentive programs.

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

Source: CMS PERL 201202-05

Electronic health record (EHR) new self-serve options

CMS has updated the EHR information center with new self-service options

Following months of review and collective input, the electronic health record (EHR) information center interactive voice response (IVR) system has been enhanced to provide users with an increased number of options and services to make accessing and reviewing data easier than ever before.

For eligible professionals (EPs), eligible hospitals, or critical access hospitals (CAHs), the revised functionality vastly improves the efficiency in obtaining desired information, while also offering a more varied amount of information and options for callers. The Centers for Medicare & Medicaid Services (CMS) is proud to announce that providers can now obtain information through an extensive IVR self-service option. Included in this option is a reinforced privacy protection module that requires your individual national provider identifier (NPI), the last five digits of your tax identification number (TIN), and your EHR registration ID. Once accepted, this newly enhanced self-service tool allows you to:

- Obtain registration status
- Acquire attestation status
- Review payment information
- Check progress towards meeting the \$24,000 threshold amount

Users may access these new options by dialing 888-734-6433, pressing 3 for self-service, and entering the authentication elements. These options will be available on the IVR effective Thursday, February 16.

EHR information center hours of operation: 7:30 a.m.-6:30 p.m. CT, Monday through Friday, except federal holidays. (Note that general information and self-service options may be reached via IVR 24 hours a day, except during periods of planned system maintenance or upgrades).

Supplementary information on the program may also be viewed by visiting the [FAQs section](#) of the EHR incentive programs website, where users can search for any questions they have about the Medicare or Medicaid EHR incentive programs.

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

Updated and new FAQs added to the CMS EHR website

CMS wants to help keep you updated with information on the Medicare and Medicaid electronic health record (EHR) incentive programs, and has recently updated previously-posted FAQs and added new FAQs on several incentive program topics, including reporting periods and incentive payments. Take a minute and review these FAQs:

- For the 2011 payment year, how and when will incentive payments for the Medicare EHR incentive programs be made? [Read the answer.](#)
- What are the EHR reporting periods for eligible hospitals participating in both the Medicare and the Medicaid EHR incentive programs, as well as the requirements for receiving an EHR incentive payment? [Read the answer.](#)
- For the Medicare and Medicaid EHR incentive programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR hospital calculations? [Read the answer.](#)
- In order to qualify for payment under the Medicaid EHR incentive program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their state Medicaid agency an official letter containing information about the clinic's electronic health record from IHS (which is an operating division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Health IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU? [Read the answer.](#)
- For the Medicaid EHR incentive program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits. [Read the answer.](#)

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Want more information about the EHR incentive programs? Make sure to visit the [CMS EHR incentive programs website](#) for the latest news and updates on the EHR incentive programs.

Stay informed via the CMS EHR incentive programs Listserv

CMS wants to invite you to join a free email service to receive the latest news on the EHR incentive programs. The [CMS EHR incentive program Listserv](#) provides timely information on program requirements and changes in the EHR incentive programs.

By subscribing to this Listserv, you will receive early notification of new program developments, the availability of new resources, and the addition of any [frequently asked questions](#) that are published on the CMS EHR incentive programs website. [Join](#) the Listserv and visit the [Listserv section](#) of the EHR incentive programs website to take a review some of the recent messages CMS has sent. CMS encourages you to let others know about the CMS EHR incentive program Listserv, and to share its messages.

Want more information about the EHR incentive programs? Make sure to visit the [EHR incentive programs website](#) for complete information about the CMS Medicare and Medicaid EHR incentive programs.

Source: CMS PERL 201202-23

General Information

Immediate recoupment for fee-for-service claims overpayments

Provider types affected

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

Provider action needed

Change request (CR) 7688 is policy that implements a standard “immediate recoupment” process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date. See the *Key points* section of this article for specifics.

Background

Currently, Medicare contractors begin recoupment of an overpayment on day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if not paid in full by day 30.

Key points

The “immediate recoupment” process implemented in CR 7688 allows providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to day 31.

Key to understanding this change is that providers who request an immediate recoupment must realize it is considered a voluntary repayment

1. Providers who choose immediate recoupment must do so in writing to the contractors. . Also, note the following:
2. The request may be for:
 - a) a one-time request for a specific demanded overpayment (the total amount of the demanded overpayment); or
 - b) a permanent request for the specific demanded overpayment and all future overpayments.
3. The request may be submitted via regular mail, facsimile, or e-mail and the request must include the provider’s name, contact phone number, Medicare number and/or national provider identifier (NPI), provider or chief financial officer’s signature, demand letter number and what option the provider is requesting.
4. By choosing immediate recoupment, providers must understand that they are waiving their rights to interest under Section 935 of the Medicare Modernization Act (MMA) should the overpayment be reversed at the administration law judge level (ALJ) or subsequent higher levels.

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(Recoupment continued)

5. Providers can terminate the immediate recoupment process at anytime. The request to terminate must be in writing.

Providers should note that Medicare contractors will not consider any recoupment after qualified independent contractor (QIC) proceedings (30 days after a QIC decision) as voluntary payments. Medicare contractors will follow the rules proscribed by Section 935 of the MMA for all recoupment activity after a QIC decision. These rules are explained in Chapter 3, Section 200 of the *Medicare Financial Management Manual* that is available at <http://www.cms.gov/manuals/downloads/fin106c03.pdf>.

You may further review all of the specifics of this change along with the applicable manual section changes by reading the official instruction for CR 7688 issued to your Medicare contractor. The Web address for CR 7688 is listed in the *Additional information* section of this article.

Note: If there is a remaining principal balance after the initial immediate recoupment contractors' shall continue recoupment and other collection activities. In addition, if you currently have an immediate recoupment arrangement, you must submit a new request to continue the immediate recoupment process.

Additional information

The official instruction, CR 7688, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R205FM.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: MM7688

Related Change Request (CR) #: 7688

Related CR Release Date: February 9, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R205FM

Implementation Date: July 2, 2012

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Proposed new steps to protect taxpayer dollars – Affordable Care Act gives new authority to recover overpayments more quickly

On Tuesday, February 14, the Centers for Medicare & Medicaid Services (CMS) proposed that providers and suppliers must report and return self-identified overpayments either within 60 days of the incorrect payment being identified or on the date when a corresponding cost report is due, whichever is later.

The new announcement is one in a series of steps Medicare is taking to protect taxpayer dollars, including efforts to prevent overpayments from occurring. These efforts include letting private auditors working on behalf of Medicare catch wasteful spending before it happens, by expanding the use of recovery audit contractors; testing changes to outdated hospital billing systems to help prevent over-billing; and changing processes for approving payments for medical equipment with high error rates.

A Medicare overpayment means any funds that a person receives or retains under Medicare to which the person is not entitled. Examples of overpayments in Medicare include:

- Duplicate submission of the same service or claim
- Payment to the incorrect payee
- Payment for excluded or medically-unnecessary services
- Payment for non-covered services

Before the Affordable Care Act, providers did not face an explicit deadline for returning taxpayers' money. Thanks to the Affordable Care Act, there will be a specific timeframe by which overpayments must be reported returned. Any failure to report and return the overpayment within the applicable time frame could be a violation of the False Claims Act. Providers also could be subject to civil monetary penalties or excluded from participating in federal health care programs for failure to report and return an overpayment.

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(Proposed continued)

To read the proposed rule that would require providers and suppliers receiving funds under the Medicare program to report and return overpayments within specific timeframes, visit the *Federal Register* at <http://s3.amazonaws.com/public-inspection.federalregister.gov/2012-03642.pdf> (or, after Thursday, February 16, visit <http://www.FederalRegister.gov/a/2012-03642>).

The full text of this excerpted CMS press release (issued Tuesday, February 14) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4266>.

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

Source: CMS PERL 201202-38

Physician feedback program and quality and resource use reports: New website updates

Website updates: The physician feedback program and quality and resource use reports (QRURs) section of *the CMS website* has been updated. A more detailed [Overview page](#), a new program [Background page](#), details from recent national provider calls and events, downloadable documents, and new program information and updates have been added.

Important information on QRURs for program year 2010 added: In September 2011, the Centers for Medicare & Medicaid Services (CMS) sent QRURs to 35 medical group practices which participated in the group practice option of the physician quality reporting system. A group report template, description of methodology, and additional information about these reports are available at http://www.cms.gov/PhysicianFeedbackProgram/Downloads/QRURs_for_Medical_Practice_Groups.pdf. In March 2012, CMS will distribute QRURs to more than 20,000 individual physicians practicing in Medicare administrative contractor jurisdiction 5, which includes Kansas, Iowa, Missouri and Nebraska; an individual physician report template, description of methodology, and additional information about these reports are also available at http://www.cms.gov/PhysicianFeedbackProgram/Downloads/QRURs_for_individual_physicians.pdf.

National provider call/event materials:

- **Materials from the Wednesday, December 21 national provider call now posted:** The complete audio recording and written transcript from the Wednesday, December 21 national provider call titled "Payment Standardization and Risk Adjustment" are now available. To view these materials, visit <http://www.CMS.gov/PhysicianFeedbackProgram/PFP/itemdetail.asp?itemID=CMS1254988>.
- **New educational presentation available:** This educational presentation, recorded on Monday, December 19, provides information on the physician feedback program and the QRURs for program year 2010, as well as links to additional information. To view all materials for this event -- including slide presentation, audio recording, written transcript, and YouTube video slideshow presentation -- visit <http://www.CMS.gov/PhysicianFeedbackProgram/PFP/itemdetail.asp?itemID=CMS1255707>.

Given the scope of the physician feedback program and the recent updates to content, CMS urges you to visit the program's website 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 201202-25

January 2012 updates to the physician compare website

On Thursday, January 26, the Centers for Medicare & Medicaid Services (CMS) released its quarterly enhancement to the Physician Compare website. Improvements were based on recommendations made during July 2011 testing as well as suggestions from users and stakeholders. This is part of the agency's ongoing effort to improve the Physician Compare website's data accuracy and ease of use.

What's new?

- **Page updates:** Home, results, and profile pages were updated and content reorganized to make it easier for providers and beneficiaries to find information. For example, a new menu option, "Provider Resources," is a direct link providers can use to find information about updating their Provider Enrollment, Chain, and Ownership System (PECOS) information.
- **Improved feedback tool:** The tool now allows providers and beneficiaries to contact Physician Compare administrators directly with questions or concerns.

For additional information on future new releases and updates visit the [Physician Compare website](#).

Source: CMS PERL 201202-64

Updating beneficiary information with the coordination of benefits contractor

Provider types affected

This *MLN Matters*[®] special edition article is intended for physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare.

Provider action needed

Stop – impact to you

A new Medicare secondary payer (MSP) initiative will affect how you may update beneficiary information to the coordination of benefits contractor (COBC).

Caution – what you need to know

This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the COBC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare's common working file (CWF).

Go – what you need to do

You should make sure that your appropriate staffs are aware of these options for updating a beneficiary's MSP information.

Background

There has been considerable discussion about the accuracy of beneficiary MSP information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the COBC by phone.

Therefore (as noted below), CMS and the COBC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

In compliance with Section 111 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which private insurers (both group health plans [GHP] and non-group health plans [NGHP]) submit coverage information to the COBC when they also provide coverage to a Medicare beneficiary. A private GHP insurer reporting under Section 111 is known as a responsible reporting entity (RRE), and the COBC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records.

CMS initiatives

This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

Occasionally, information submitted to the COBC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the COBC. To reduce such conflicts in the future, CMS has developed and implemented a data management "Reporting

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(Beneficiary continued)

Hierarchy” process, which the COBC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found at <http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf>.

The COBC works closely with GHP RREs and other reporters in order to reduce “hierarchy” conflicts in future reporting. The following steps are in place to help providers update MSP records:

COBC initiatives

- **Provider attempting update with the beneficiary in the office:**

The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4 2011, no update will be made on the call, but two options are available:

- 1) Proof of information can be faxed or mailed on the insurer or employer’s company letterhead, and the update will be made in 10-15 business days
- 2) You can contact the insurer or employer organization that last updated the record.

- **Provider attempting update when the beneficiary is not in the office:**

No update will be made from a telephone call. The provider has three options to have the record updated:

- 1) Have the beneficiary contact COBC
- 2) Contact the beneficiary’s insurer to resolve the issue
- 3) Fax or mail proof of information on the insurer or employer’s company letterhead and the update will be made in 10-15 business days.

- **Provider with new information:**

The COBC will take new information for a beneficiary, but if the new information requires changes to an existing record, two options are available:

- 1) The beneficiary will need to call to close out the record
- 2) Fax or mail proof of information on the insurer or employer’s company letterhead and the update will be made in 10-15 business days.

- **Provider update for deceased beneficiary:**

A **single** update can be made by **one** provider for a deceased beneficiary, once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

Additional information

An explanation of the GHP RRE Hierarchy rules can be found at <http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf>.

General information about mandatory insurer reporting is available at <http://www.cms.gov/mandatoryinsrep>.

The COBC’s contact information is:

Telephone: 1-800-999-1118 (8:00 a.m. to 8:00 p.m. ET)

Fax: 1-734-957-9598 (address the fax to Medicare coordination of benefits)

Mailing address:

Medicare – Coordination of Benefits
P.O. Box 33847
Detroit, MI 48232

MLN Matters® Number: SE1205
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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

Affordable Care Act announcements

Care Innovation Summit builds on Affordable Care Act; highlights private and public innovations to improve health care quality and lower costs

Obama Administration officials and a breadth of representatives from across the health care system met in Washington Thursday, January 26, 2012, for a day-long meeting to explore how they can collaborate and improve the quality of health care while at the same time lowering costs.

The Obama Administration also released a new report highlighting the success of the Center for Medicare & Medicaid Innovation. Created by the Affordable Care Act, the Innovation Center has already worked to test and support innovative new health care models that can reduce costs and strengthen the quality of health care. The CMS Innovation Center year-in-review report is available at http://www.Innovation.CMS.gov/documents/pdf/CMMIreport_508.pdf.

The summit showcased nearly half a dozen announcements of major new initiatives by leading health care organizations, including new “challenges” to reverse the trend of diabetes, advance the field of Alzheimer’s prevention and treatment, and bolster the battle against HIV/AIDS. For more information on the Care Innovation Summit, visit <http://www.Innovation.CMS.gov/summit>.

The full text of this excerpted Department of Health and Human Services (HHS) press release (issued Thursday, January 26) can be found at <http://www.HHS.gov/news/press/2012pres/01/20120126a.html>.

Affordable Care Act will save states and taxpayers \$17.7 billion on prescription drugs; proposed rule cuts costs and increases transparency in Medicaid prescription drug pricing

Provisions in the health care reform law, the Affordable Care Act, will save taxpayers and states an estimated \$17.7 billion over five years on prescription drugs bought through Medicaid, according to estimates in a proposed rule issued Friday, January 27.

The announcement, implementing the Medicaid prescription drug provisions of the Affordable Care Act, will increase transparency in drug pricing, and ensure taxpayers and states are not overpaying for prescription drugs.

The Medicaid pharmacy regulation notice of proposed rulemaking can be found in the *Federal Register* at <http://www.gpo.gov/fdsys/pkg/FR-2012-02-02/pdf/2012-2014.pdf>. The comment period on the proposed rule will be open until Monday, April 2. The Centers for Medicare & Medicaid Services (CMS) plans to issue a final rule in 2013.

The full text of this excerpted press release can be found on the CMS website at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4251>.

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

Source: CMS PERL 201202-06

Physician self-referral prohibition: Additional information on exception process for physician-owned hospitals

As a reminder, the outpatient prospective payment system (OPPS) final rule that was released Wednesday, November 30, 2011, stated that in order for a physician-owned hospital to receive an exception to the prohibition on facility expansion, it must satisfy eligibility criteria to qualify as an “applicable hospital” or “high Medicaid facility.”

The Centers for Medicare & Medicaid Services has published additional guidance at http://www.CMS.gov/PhysicianSelfReferral/85_Physician_Owned_Hospitals.asp that will address the process for accessing data, as well as provide sample computations for determining whether a hospital satisfies the respective criteria. Questions regarding this issue can be emailed to POHexceptions@cms.hhs.gov.

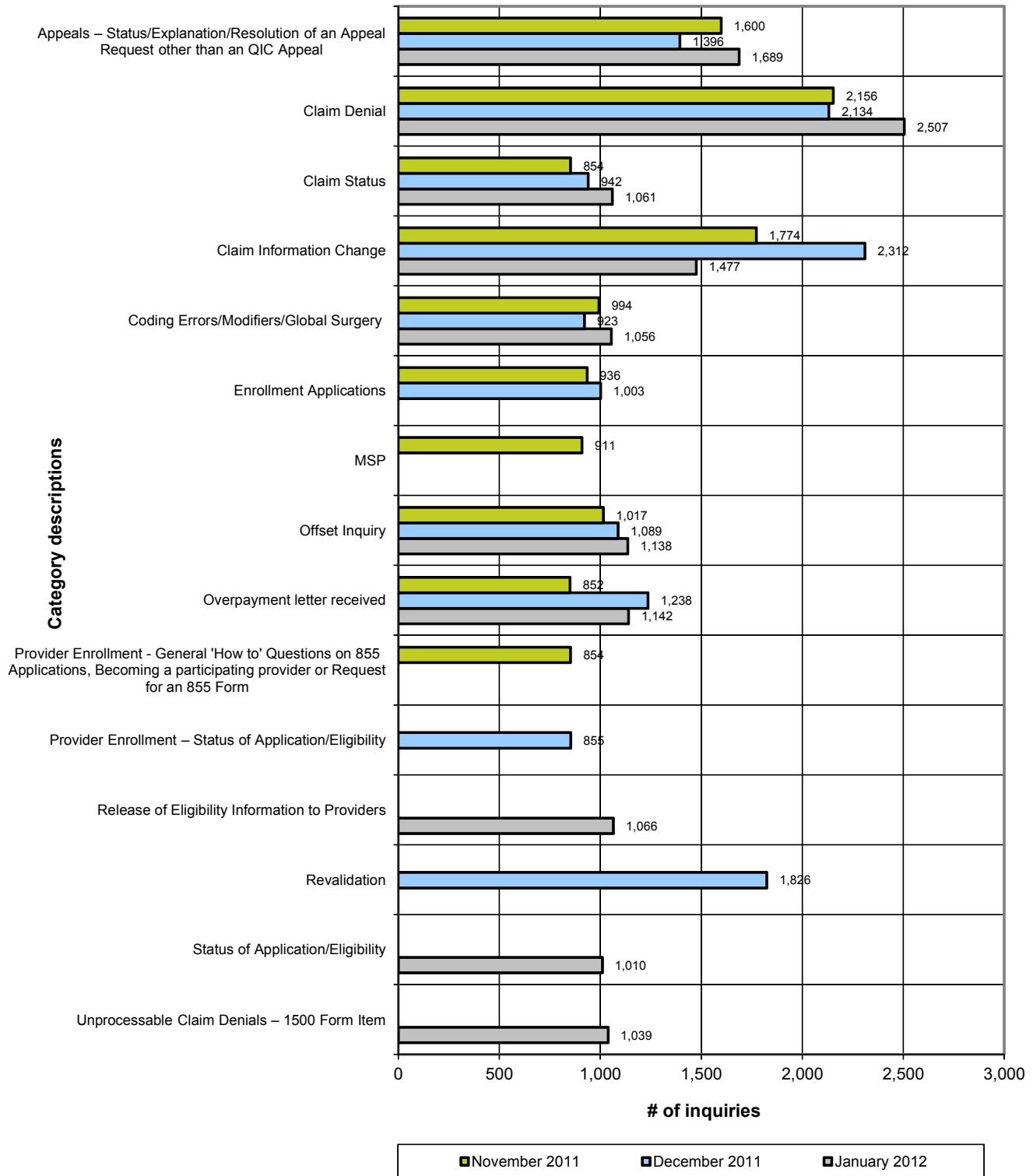
Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201202-02

Top inquiries, denials, and return unprocessable claims

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 November 2011-January 2012. 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.

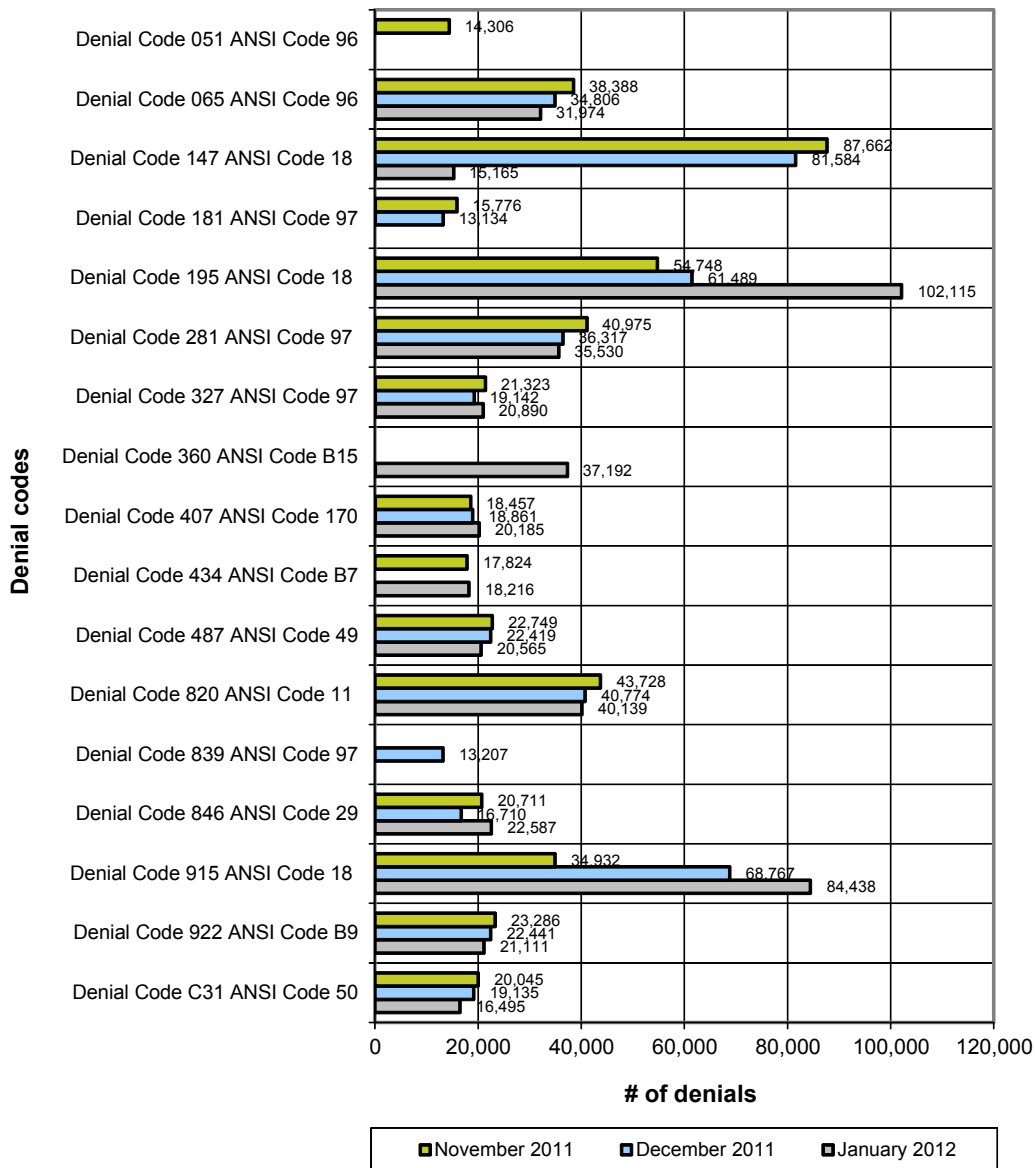
Florida Part B top inquiries for November 2011-January 2012



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Florida Part B top denials for November 2011-January 2012



What to do when your claim is denied

Before contacting customer service, check claim status through the IVR. The IVR will release necessary details around claim denials.

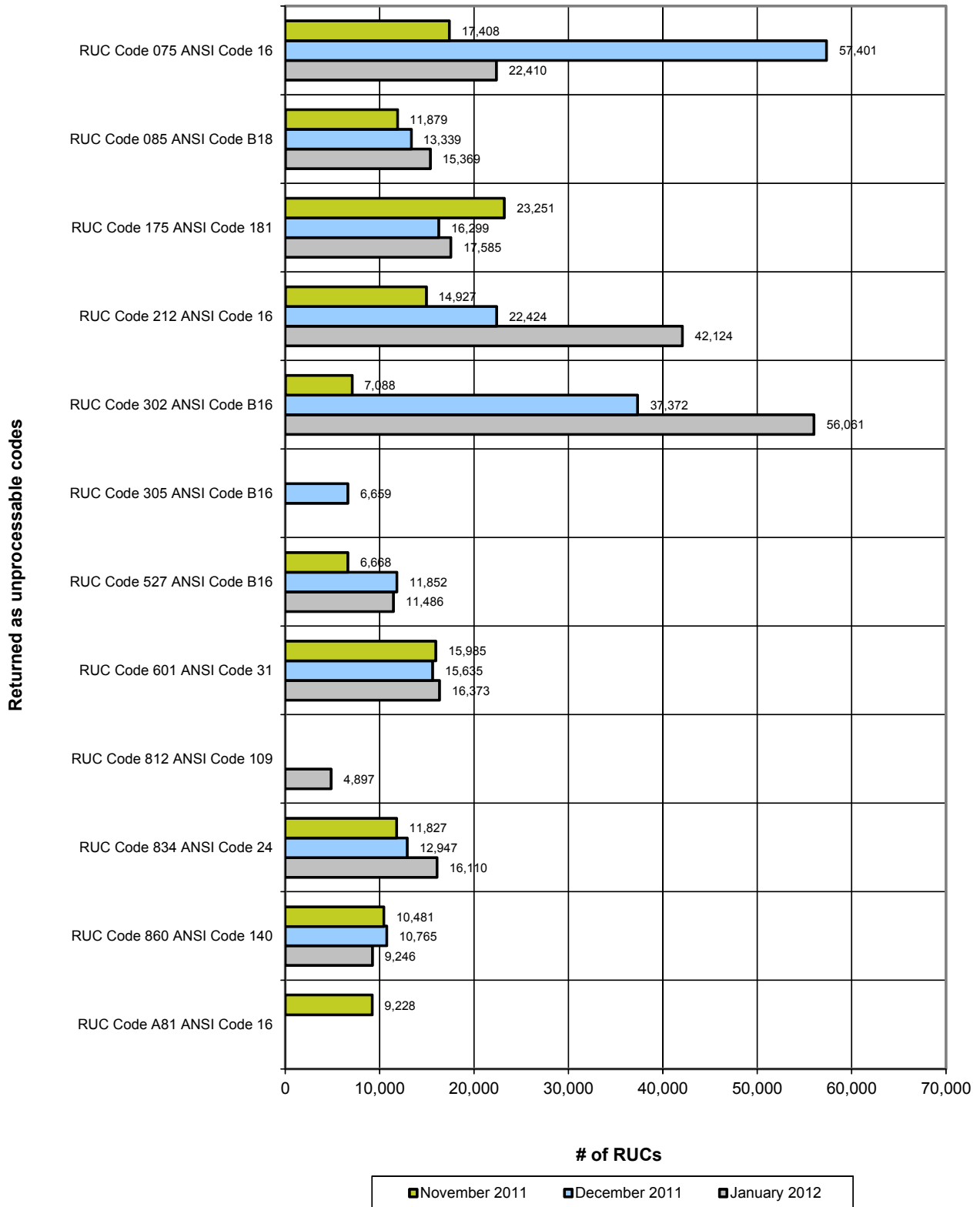
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

Refer to the [Claim completion FAQs](#), [Billing issues FAQs](#), and [Unprocessable FAQs](#) on the FCSO Medicare provider website for additional information on why claims may deny and how to correct this.

You may also refer to the [Top Part B claim denials](#) and [RUCs](#) tip sheets for tips and resources on correcting and avoiding certain claim denials.

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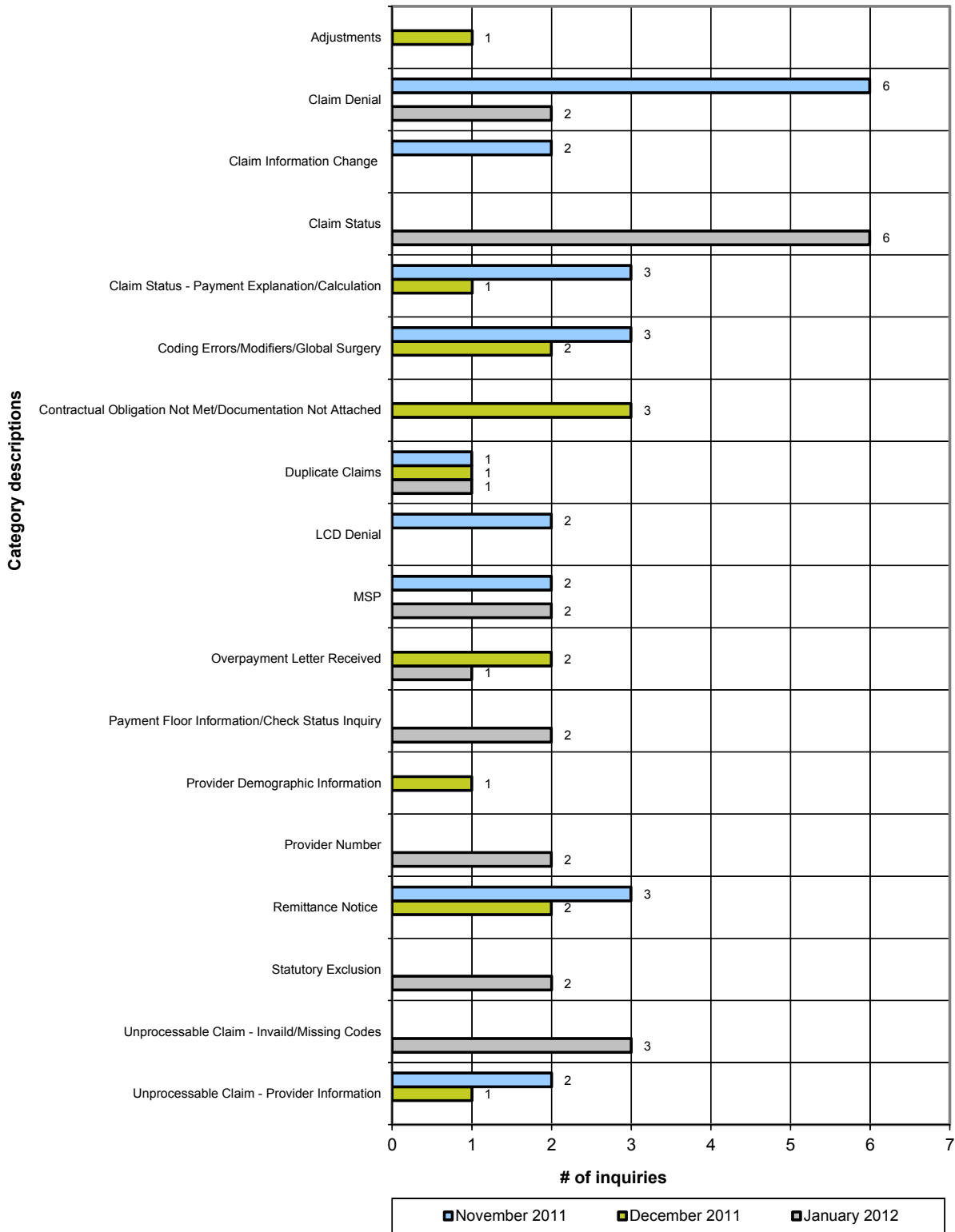
Florida Part B top return as unprocessable claims for November 2011-January 2012



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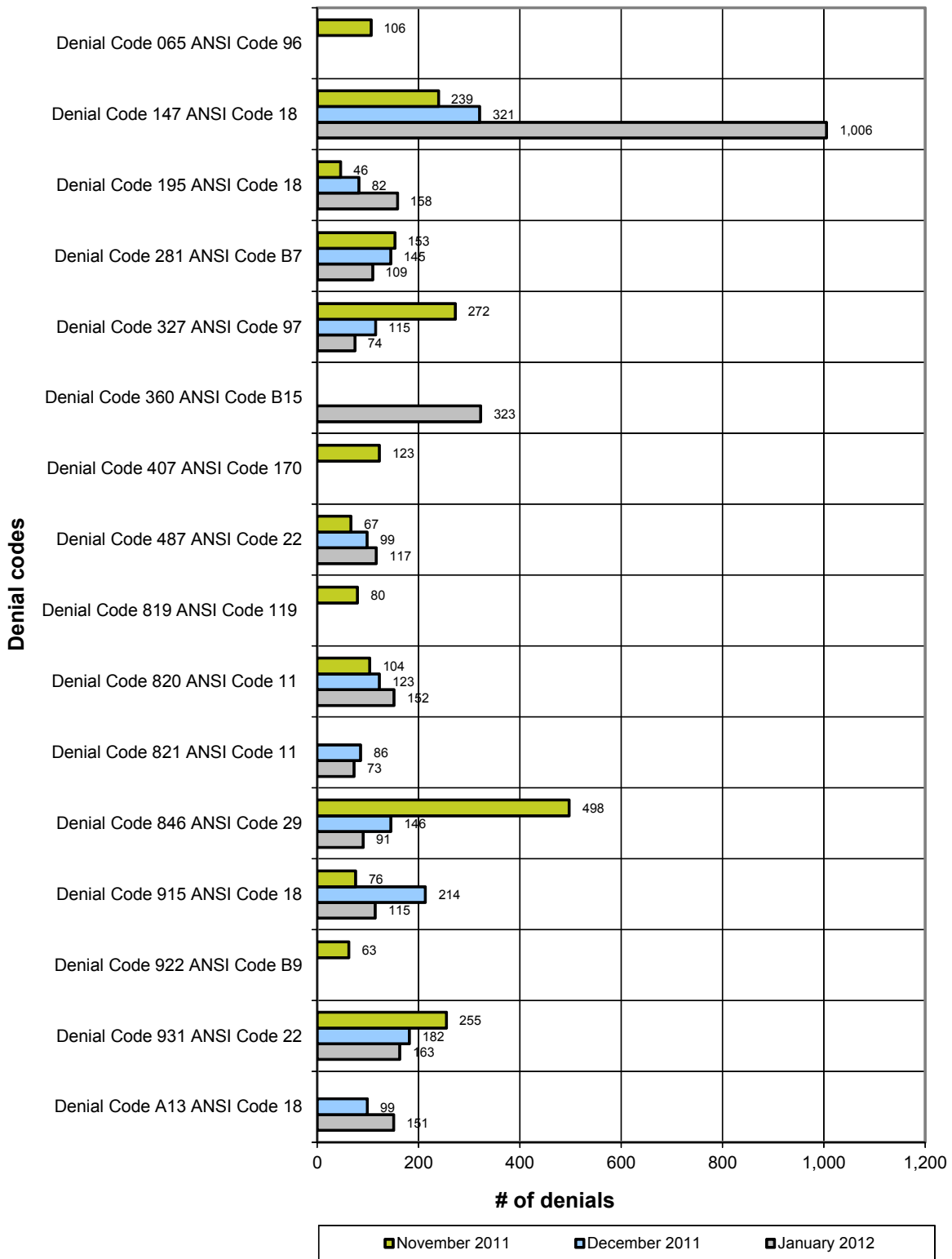
U.S. Virgin Islands Part B top inquiries for November 2011-January 2012



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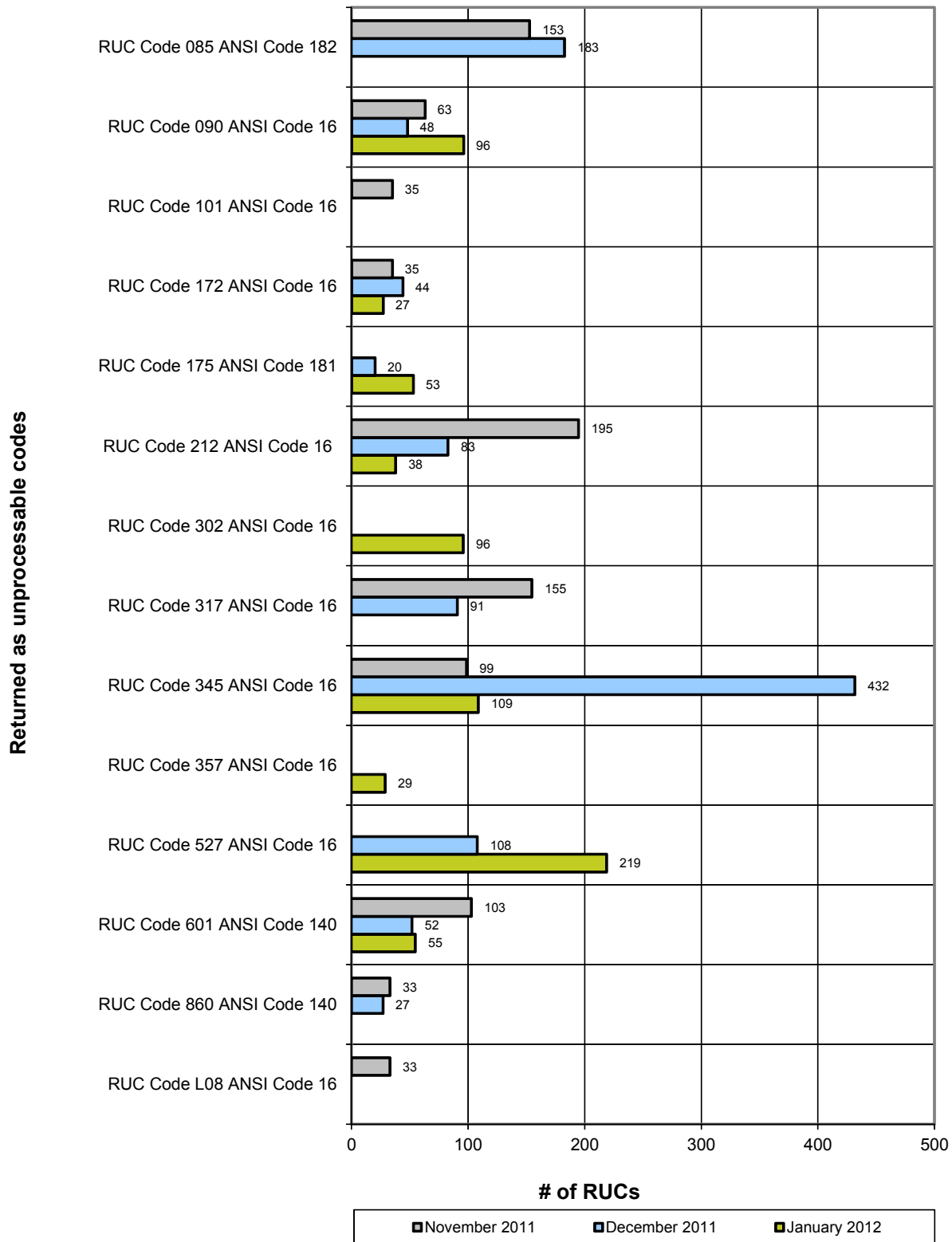
U.S. Virgin Islands Part B top denials for November 2011-January 2012



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(Top continued)

U.S. Virgin Islands Part B top return as unprocessable claims for November 2011-January 2012



This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

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

Effective and notice dates

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

Electronic notification

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

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

Contents
Advance beneficiary notice 67
Additional Information
Administration of vaccines/toxoids 68
Claims for CPT® code 36415 or HCPCS codes P9612/P9615 denied in error 68

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.

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

Modifier GA must be used when 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, keyword, 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.

Additional Information

Administration of vaccines/toxoids

To report the administration of a vaccine/toxoid, the vaccine/toxoid product codes 90476-90749* and Q2035-Q2039 must be used in addition to an immunization administration code(s) 90460-90474 and G0008-G0010 as appropriate. CPT codes 90476-90749 and HCPCS codes Q2035-Q2039 identify the vaccine product only.

Effective for claims processed **on or after March 16, 2012**, First Coast Service Options Inc. (FCSO) will be implementing editing to deny** administration codes (90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009, and G0010) when vaccine/toxoid codes (90476-90749 or Q2035-Q2039), as appropriate, are not billed or are denied on the same date of service.

* 90749 unlisted vaccine/toxoid

** The administration code will be denied with message B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated).

Claims for CPT® code 36415 or HCPCS codes P9612/P9615 denied in error

Claims submitted for CPT® code 36415 (*Collection of venous blood by venipuncture*), HCPCS code P9612 (Catheterization for collection of specimen, single patient, all places of service), or HCPCS code P9615 (Catheterization for collection of specimen[s] [multiple patients]) for claims processed **on or after January 2, 2012**, may have been denied incorrectly with the following denial message: "This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated."

This error was corrected on January 26, 2012. Claims processed on or after January 27, 2012, were adjudicated correctly.

Providers whose claims were denied incorrectly due to this error do not need to take any action. First Coast Service Options Inc. (FCSO) will perform adjustments to correct the error on all the affected claims. We apologize for any inconvenience this issue may have caused.



Find out first: Subscribe to FCSO eNews

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

Educational Events

Upcoming provider outreach and educational events

March 2012

Place of service coding (POS) for physician services webcast

When: Wednesday, March 28

Time: 11:00 a.m.-noon

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.fcsouniversity.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: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the FCSO Medicare training 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 offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

Preventive Services

Release of reports on improved access to preventive services under the Affordable Care Act

Affordable Care Act extended free preventive services to 54 million Americans with private health insurance in 2011; free preventive care also provided to 32.5 million in Medicare.

The Department of Health & Human Services (HHS) secretary, Kathleen Sebelius, announced on Wednesday, February 15 that the Affordable Care Act provided approximately 54 million Americans with at least one new free preventive service in 2011 through their private health insurance plans, and that an estimated 32.5 million people with Medicare received at least one free preventive benefit, including the new annual wellness visit.

Together, this means an estimated 86 million Americans were helped by health reform's prevention coverage improvements. The new data was released in two new reports from HHS.

The Affordable Care Act requires many insurance plans to provide coverage without cost-sharing to enrollees for a variety of preventive health services, such as colonoscopy screening for colon cancer, Pap smears and mammograms for women, well-child visits, and flu shots for all children and adults. The law also makes proven preventive services free for most people on Medicare.

The report on private health insurance coverage also examined the expansion of free preventive services in minority populations. The results showed that an estimated 6.1 million Latinos, 5.5 million blacks, 2.7 million Asian Americans, and 300,000 Native Americans with private insurance received expanded preventive benefits coverage in 2011 as a result of the new health care law.

The report discussing Medicare preventive services found that more than 25.7 million Americans in traditional Medicare received free preventive services in 2011. The report also looked at Medicare Advantage plans and found that 9.3 million Americans – 97 percent of those in individual Medicare Advantage plans – were enrolled in a plan that offered free preventive services. Assuming that people in Medicare Advantage plans utilized preventive services at the same rate as those with traditional Medicare, an estimated 32.5 million people benefited from Medicare's coverage of prevention with no cost-sharing.

The full report on expanded preventive benefits in private health insurance is available at <http://aspe.HHS.gov/health/reports/2012/PreventiveServices/ib.shtml>. The report on expanded preventive benefits in Medicare and other ways that the Affordable Care Act strengthens Medicare is available at <http://www.CMS.gov/newsroom>.

The full text of this excerpted HHS press release (issued Wednesday, February 15) can be found at <http://www.HHS.gov/news/press/2012pres/02/20120215a.html>.

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

Source: CMS PERL 201202-49



'The Guide to Medicare Preventive Services: Errata Sheet to the Fourth Edition' fact sheet released

"The Guide to Medicare Preventive Services: Errata Sheet to the Fourth Edition" fact sheet (ICN 907802) has been released and is available in downloadable format. This errata sheet reflects the changes to *The Guide to Medicare Preventive Services*, and includes updates such as information on newly-covered benefits, updated codes, and resources.

Source: CMS PERL 201201-55

Tobacco-Use Cessation Counseling Services brochure revised

The *“Tobacco-Use Cessation Counseling Services”* brochure (ICN 006767) has been revised and is now available for download. This brochure is designed to provide education on tobacco-use cessation counseling services, and includes coverage information for both symptomatic and asymptomatic beneficiaries as well as information on tobacco-use cessation counseling.

Source: CMS PERL 201202-65

February is American Heart Month

Cardiovascular disease – including heart disease and stroke – is the leading cause of death in the United States. Every day, 2,200 people die from cardiovascular disease – that’s 815,000 Americans each year, or 1 in every 3 deaths. The good news is that many risk factors for cardiovascular disease such as hypertension, high cholesterol, and smoking can be prevented and controlled. To help, Medicare provides payment for the following benefits:

- Initial preventive physical exam (also known as the “Welcome to Medicare” visit)
- Annual wellness visit, including personalized prevention plan service
- Cardiovascular screening (total cholesterol, high-density lipoproteins, and triglycerides tests)
- Intensive behavioral therapy for cardiovascular disease
- Tobacco-use cessation counseling services

What can you do?

- Help seniors and others with Medicare better understand and identify their risk factors for heart disease and stroke
- Talk with your patients about what they can do to reduce, eliminate, or control their cardiovascular disease risk factors and encourage appropriate use of the Medicare preventive benefits that can help them reach these goals
- Learn more about and take advantage of information provided by campaigns like American Heart Month and *Million Hearts*, a national initiative to prevent 1 million heart attacks and strokes over five years



For more information

- [MLN Guide to Medicare Preventive Services for Healthcare Professionals](#)
- [MLN Expanded Benefits brochure](#)
- [MLN Annual Wellness Visit brochure](#)
- [MLN Tobacco-Use Cessation Counseling Services brochure](#)
- [National Coverage Determination \(NCD\) for Intensive Behavioral Therapy for Cardiovascular Disease](#)
- [MLN Preventive Services Educational Products Web page](#)
- [MLN Quick Reference Information: Medicare Preventive Services chart for providers](#)
- [CDC American Heart Month and CDC Heart Disease Guidelines and Recommendations](#) Web pages
- [HHS Million Hearts™ campaign](#)
- [CDC Report – Million Hearts: Strategies to Reduce the Prevalence of Leading Cardiovascular Disease Risk Factors](#)

Thank you for joining with CMS in promoting the increased awareness of cardiovascular disease, its risk factors, and related preventive benefits covered by Medicare.

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

Source: CMS PERL 201202-27

Other Educational Resources

MLN Matters® articles search tips

Looking for the latest new and revised *MLN Matters®* articles? The *Medicare Learning Network®* offers several ways to search and quickly find articles of interest to you:

- *MLN Matters®* search engine – an advanced search feature that allows you to search *MLN Matters®* articles from 2004 to the current year. For more information and introductions on how to use the search engine, visit the *MLN Matters* Search Tips Web page at http://www.CMS.gov/MLNMattersArticles/02_Search.asp.
- *MLN Matters®* index – a list of common keywords and phrases contained within *MLN Matters®* articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit http://www.CMS.gov/MLNMattersArticles/01_Overview.asp and scroll to the “Downloads” section of the page.
- *MLN Matters®* dynamic lists – an archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the *MLN Matters®* Article Web page at <http://www.CMS.gov/MLNMattersArticles>.
- *MLN Matters®* electronic mailing list – A free notification of new and revised *MLN Matters®* articles as they are released. For more information, including how to subscribe to the service, visit http://www.CMS.gov/MLNMattersArticles/downloads/What_Is_MLNMatters.pdf. You can also view and search an archive of previous messages at <http://list.nih.gov/cgi-bin/wa.exe?A0=MLNMATTERS-L>.

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

Source: CMS PERL 201202-65

New MLN® ‘fast fact’ highlights the importance of medical documentation

A new “fast fact” is now available on the *Medicare Learning Network®* (*MLN®*) *Provider Compliance* Web page. This Web page provides the latest *MLN®* products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities. A new “fast fact” is added each month, so please bookmark the Provider Compliance Web page and check it often.

Source: CMS PERL 201202-42

‘Guidelines for Teaching Physicians, Interns, and Residents’ fact sheet revised

The “*Guidelines for Teaching Physicians, Interns, and Residents*” fact sheet (*ICN 006347*) has been revised and is now available in downloadable format. It includes information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines.

Source: CMS PERL 201201-55

Physician volunteers needed to pilot test continuing education activities

The *Medicare Learning Network®* (*MLN®*) offers official information from the Centers for Medicare & Medicaid Services (CMS) for Medicare fee-for-service providers, designed to help increase understanding of the Medicare program and stay current on *program* policy changes, and to provide the information needed to bill correctly. *MLN®* pilot testers are unpaid volunteers whose feedback and comments help to evaluate activities and determine the average learning time for credit calculations.

CMS appreciates the help of its volunteers, as it helps them improve the educational materials created to make Medicare easier to navigate for the provider community. To volunteer, email CE_Issues@cms.hhs.gov with “Pilot Test” in the subject line.

Source: CMS PERL 201201-55

Comparative billing report on advanced diagnostic imaging

On Thursday, February 16, the Centers for Medicare & Medicaid Services (CMS) will release a national provider comparative billing report (CBR) addressing advanced diagnostic imaging.

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

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

For more information and to review a sample of the advanced diagnostic imaging CBR, please visit the CBR services website at www.CBRservices.com or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

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

Source: CMS PERL 201201-48

Medicare Learning Network® provider exhibit program schedule

Mark your calendars

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

- *American Medical Group Association: 2012 Annual Conference*
Wednesday, March 7 through Saturday, March 10
Manchester Grand Hyatt; San Diego, California
Booth #802
- *American Medical Student Association*
Thursday, March 8 through Sunday, March 11
Hyatt Regency Houston; Houston, Texas
Booth #12
- *National Association of Rural Health Clinics*
Monday, March 19 through Tuesday, March 20
Hyatt Regency; San Antonio, Texas
- *The American College of Cardiology's 61st Annual Scientific Session & Expo*
Saturday, March 24 through Monday, March 26
Chicago, Illinois
Booth #19076
- *National Hospice & Palliative Care Organization*
Thursday, March 29 through Saturday March 31
National Harbor, Md.
Booth #625

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

Source: CMS PERL 201202-42

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the “Improve your billing” section at <http://medicare.fcso.com/Landing/200831.asp>, where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find FCSO's most popular self-help resources, including the E/M interactive worksheet, Provider Data Summary (PDS) report, and the Comparative billing report (CBR).

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/prevaling 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

Email 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 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:
1-888-664-4112

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 Murphy
P. O. Box 2078
Jacksonville, FL 32231-0048

Provider education

Educational purposes and review of customary/prevaling 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

Email address:

AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE

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1-800-754-7820

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Education event registration

1-904-791-8103

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1-888-670-0940

Option 1 -Transaction support

Option 2 - PC-ACE support

Option 4 - Enrollment support

Option 5 - 5010 testing

Option 6 - Automated response line

DME, orthotic or prosthetic claims

Cigna Government Services
1-866-270-4909

Medicare Part A

Toll-Free:

1-888-664-4112

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/index.asp (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 2011 through September 2012.	40300260	\$33		
2012 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2012, 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 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 publication.	40300270	\$12		
Language preference: English [] Español []				
<i>Please write legibly</i>				
			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)



Medicare B Connection

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

Attention Billing Manager