Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

May 2012

In this issue

CMS' improvements to Internet-based PECOS have made it easier to use

During the last 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 improvements to:

- Incorporate search capabilities on the My Enrollments page
- Increase access to information, and
- Allow electronic signature of the Certification Statement and Electronic Funds Transfer Agreement.

The following upgrades are now available:

Overall usability

Users will now have a search and filter feature that will allow the user to filter enrollments on the My Enrollments page. Users will be able to filter the enrollments shown on the My Enrollments page based on:

- Medicare ID
- National provider identifier (NPI)
- Enrollment type
- Enrollment status
- State

Additional data has been added to the enrollment data on the My Enrollments page (i.e., enrollment type, Medicare ID, and practice location).

Access to more information

Users will also be able to see if a request for revalidation has been sent by the Medicare administrative contractor (MAC). A "Revalidation Notice Sent" date will be displayed on the My Enrollments page. This will reflect the date in which the revalidation letter was mailed by the MAC to the provider/supplier. The date will be displayed on the My Enrollments page for 120 days.

In addition, users will be able to identify those enrollments that are accredited for advanced diagnostic imaging (ADI) services. An ADI services indicator will be visible on the My Enrollments page as either a "Yes" or "No."

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Register for free, hands-on Internet based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Select from the following session dates: June 19, July 17, August 21, or September 11, 2012.

Contents

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.

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.fcso.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/Regulations-and-Guidance/Guidance/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/Medicare/Medicare-General-Information/BNI/index.html*.

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 (wavier of liability statement on file).

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

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the Contact Information section of this publication for the address in which to send written appeals requests.

Handling misdirected claims for Part B items and services

Provider types affected

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

Provider action needed

Stop – impact to you

Your misdirected claims for Part B items and services (those that you send to the wrong Medicare contractor) will be returned as unprocessable.

Caution – what you need to know

Change request (CR) 7629, from which this article is taken, announces that effective July 20, 2012, your carrier or A/B MAC will return all misdirected claims as unprocessable; and your DME MAC will similarly return claims that should have been sent to a carrier or B MAC, as well as paper claims as that are sent to the wrong DME MAC.

Go – what you need to do

You should make sure that claims are submitted to the correct carrier, A/B MAC, or DME MAC. See the *Background* section for details.

Background

A "misdirected claim" is a claim that you submit to the wrong carrier, A/B MAC, or DME MAC. As each fee-for-service (FFS) claims administration contractor is assigned a specific geographic and subject matter jurisdiction for claims processing, you must submit your claims to the one having the appropriate jurisdiction.

Carriers and A/B MACs previously returned as unprocessible assigned claims for Part B items and services that were sent to the wrong carrier or A/B MAC, and denied such claims that were unassigned; and DME MACs denied paper claims if sent to the wrong DME MAC.

CR 7629, from which this article is taken, implements new instructions on handling misdirected claims.

With implementation of CR 7629, carriers and A/B MACs will return all misdirected claims as unprocessable, regardless of their unassigned/assigned status. This includes: durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims that are appropriately billable to a A/B MAC or carrier, but are billed to the wrong one; and misfiled claims for United Mine Workers of America (UMWA) and Railroad Beneficiaries (RRB) beneficiaries.

Misdirected carrier and A/B MAC claims

Specifically, when it receives a claim for Medicare payment for items/services that have been furnished outside of its payment jurisdiction (other than for RRB and UMWA beneficiaries), your Part A/B MAC or carrier will return it as unprocessable; using the following messages:

- Claim adjustment reason code (CARC) 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remittance advice remark code (RARC) N104 – This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at *www.cms.gov*.
- RARC MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note: These remittance and remark code messages remain the same, and Medicare summary notice messages have been removed.

Similarly, effective for claims received on and after July 20, 2012, when it receives a claim for Medicare payment for items or services that are in a DME MAC's payment jurisdiction (other than for RRB and UMWA beneficiaries), your A/B MAC or carrier will return it as unprocessable, using the same messages.

Additionally, while DME MACs will continue to follow existing procedures for misdirected beneficiary-submitted claims (form CMS-1490S) and electronic claims; effective with implementation of CR 7629, a paper claim (form CMS-1500), sent to the wrong DME MAC will be returned as unprocessable, using the same messages.

Effective July 20, 2012, when it receives a claim for an RRB beneficiary (and therefore should be processed by the RRB contractor), your carrier, A/B MAC, or DME MAC will return it as unprocessable using the following messages:

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Misdirected *(continued)*

Misdirected Railroad Beneficiaries (RRB) beneficiary claims

- RA – Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remark code N105 – This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claim processing.
- RARC MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Effective July 20, 2012, when it receives a claim for Medicare payment that should be processed by the UMWA, your carrier, A/B MAC, or DME MAC will return it as unprocessable using the following messages:

United Mine Workers of America (UMWA) beneficiary claims

- RA – Claim adjustment reason code 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remark code N127 – This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.
- RARC MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Please note that this new guidance does not apply to:

- Misdirected beneficiary-submitted claims (please refer to the *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 80.3.2 (Handling Incomplete or Invalid Claims) regarding the handling of such claims);
- Electronic claims for DMEPOS that are submitted to the incorrect DME MAC (misdirected DMEPOS claims are automatically routed to the appropriate DME MAC jurisdiction for processing), or
- A claim submitted to the wrong Part A MAC or fiscal intermediary (FI), including a regional home health intermediary (RHHI).

Additional information

You can find the official instruction, CR 7629, issued to your carrier, A/ B MAC, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2474CP.pdf*.

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

MLN Matters® Number: MM7629
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Related CR Transmittal #: R2474CP
Implementation Date: July 20, 2012

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Drugs and Biologicals

July 2012 HCPCS code update for drugs/biologicals

Provider types affected

This *MLN Matters*® article is intended for physicians, other 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 (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 7831 announces the quarterly updating of specific Healthcare Common Procedure Coding System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2012. You should make sure that your billing staffs are aware of these HCPCS code changes.

Background

The HCPCS code set is updated on a quarterly basis. CR 7831 describes the Centers for Medicare & Medicaid Services (CMS) process for updating specific HCPCS codes.

Key points

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will no longer be payable for Medicare:

HCPCS	Short description	Long description	MPFSDB* status indicator
J1680	Human fibrinogen conc inj	Injection, human fibrinogen concentrate, 100 mg	I
J9001	Doxorubicin hcl liposome inj	Injection, doxorubicin hydrochloride, all lipid formulations, 10 mg	I

* Medicare physician fee schedule database (MPFSDB)

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will be payable for Medicare:

HCPCS	Short description	Long description	Type of service code	MPFSDB status indicator
Q2034	Agriflu vaccine	Influenza virus vaccine, split virus, for intramuscular use (agriflu)	V	X
Q2045	Human fibrinogen conc inj	Injection, human fibrinogen concentrate, 1 mg	1,9	E
Q2046	Aflibercept injection	Injection, aflibercept, 1 mg	1,9	E
Q2047	Peginesatide injection	Injection, peginesatide, 0.1 mg (for ESRD on dialysis)	L	E
Q2048	Doxil injection	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 MG	1,9	E
Q2049	Imported Lipodox inj	Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg	1,9	E

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July *(continued)*

Additional information

The official instruction, CR 7831, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2450CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7831
Related Change Request (CR) #: CR 7831
Related CR Release Date: April 26, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R2450CP
Implementation Date: July 2, 2012

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New influenza virus vaccine code

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI), Medicare administrative contractors (A/B MAC) and regional home health intermediaries (RHHI) for providing influenza virus vaccines to Medicare beneficiaries.

Provider action needed

Effective for claims with dates of service on or after July 1, 2012, Medicare will pay for influenza virus vaccine code Q2034. Change request (CR) 7794, from which this article is taken, provides instructions for the payment of influenza virus vaccine code Q2034 for claims with dates of service on or after July 1, 2012, processed on or after October 1, 2012. Annual Part B deductible and coinsurance amounts do not apply. You should make sure that your billing staffs are aware of this new code for influenza virus vaccine.

Background

Effective July 1, 2012, your Medicare carrier, FI, A/B MAC, or RHHI will begin accepting influenza virus vaccine code Q2034 (for dates of service on or after that date). This code will also be added to existing influenza virus vaccine common working file (CWF) edits. For professional claims, for dates of service of July 1, 2012, through September 30, 2012, your contractor will use local pricing guidelines to determine payment rates for Q2034. After September 30, 2012, professional claims will be paid using the Medicare Part B payment limit for Q2034 according to the established payment rate in the October 2012 Part B drug pricing file.

Processing institutional claims

Your contractor will pay for influenza virus vaccine code Q2034 **based on reasonable cost** to:

- Hospitals using type of bill (TOB) 12x and 13x
- Skilled nursing facilities (SNF) using TOB 22x and 23x
- Home health agencies (HHA) using TOB 34x
- Hospital-based renal dialysis facilities (RDF) using TOB 72x, and
- Critical access hospitals (CAH) using TOB 85x.

Your contractor will pay for influenza virus vaccine code Q2034 **based on the lower of the actual charge or 95 percent of the average wholesale price (AWP)** to:

- Indian Health Service (IHS) hospitals using TOB 12x and 13x, and
- IHS CAHs using TOB 85x.
- Comprehensive outpatient rehabilitation facilities (CORF) using TOB 75x, and
- Independent RDFs using TOB 72x.

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Influenza *(continued)*

Until systems are implemented, your contractor will hold institutional claims, containing code Q2034, with dates of service on or after July 1, 2012; and that are received before October 1, 2012. Upon implementation of CR 7794 on October 1, contractors will begin to process the held claims.

Additional information

You can find more information about the new code for influenza virus vaccine (Q2034) by going to CR 7794, located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2446CP.pdf*.

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

MLN Matters® Number: MM7794
Related Change Request (CR) #: CR 7794
Related CR Release Date: April 26, 2012
Effective Date: July 1, 2012
Related CR Transmittal #: R2446CP
Implementation Date: October 1, 2012

Durable Medical Equipment

July update for 2012 DMEPOS fee schedule

Provider types affected

This *MLN Matters*® article is intended for physicians, other 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 [DME MACs]) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider action needed

This article is based on change request (CR) 7822 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Note: Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that were previously processed, will be adjusted to reflect the newly-established fees if you bring those claims to your contractor's attention.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Key points

Healthcare Common Procedure Coding System (HCPCS) codes L6715 and L6880 were added to the HCPCS file effective January 1, 2012. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2012. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that have already been processed may be adjusted to reflect the newly-established fees if you bring those claims to your contractor's attention.

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DMEPOS *(continued)*

Per CR 7679, the claims filling jurisdiction for the following HCPCS codes is changed from DME MAC to joint local carrier and DME MAC jurisdiction, effective January 1, 2012:

- L8511 Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only
- L8512 Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10
- L8513 Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush, or equal, replacement only, each
- L8514 Tracheoesophageal puncture dilator, replacement only, each
- L8515 Gelatin capsule, application device for use with tracheoesophageal voice prosthesis, each

Additional information

The official instruction, CR 7822 issued to your FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2467CP.pdf*. If you have any questions, please contact your FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

Current and past DMEPOS fee schedules can be viewed at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html*.

MLN Matters® Number: MM7822
Related Change Request (CR) #: CR 7822
Related CR Release Date: May 11, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R2467CP
Implementation Date: July 2, 2012

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Negative pressure wound therapy interpretive guidelines

Provider types affected

This *MLN Matters*® special edition article is intended for suppliers who submit claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for negative pressure wound therapy services provided to Medicare beneficiaries.

What you need to know

This article is intended to provide interpretive guidance to Centers for Medicare & Medicaid Services (CMS)-approved accrediting organizations to use in their accreditation of suppliers that provide negative pressure wound therapy (NPWT) equipment to Medicare beneficiaries. These guidelines also apply to suppliers that are furnishing NPWT equipment to Medicare beneficiaries. SE1222 is also intended to assist the supplier in understanding their responsibilities related to this equipment in order to be in compliance with CMS durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) quality standards.

Background

(NPWT is defined as the application of sub-atmospheric pressure to a wound to remove exudate and debris from the wound(s). NPWT is delivered to a qualified wound through an integrated system that includes:

- A suction pump
- A separate exudate collection chamber, and
- Dressing sets.

In these systems, the exudate is completely removed from the wound site to the collection chamber.

This special edition article, while assisting the supplier of NPWT to fulfill all Centers for Medicare & Medicaid Services (CMS) DMEPOS quality standards, does not contain a detailed discussion of all coverage and documentation requirements pertinent to this subject. Please consult the appropriate local coverage determination

(continued on next page)

Negative *(continued)*

(LCD) (or local coverage article) more complete information using the Medicare Coverage Database Quick Search at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Some of the more pertinent LCDs, per DME MAC jurisdiction, are as follows:

Jurisdiction A:

L11500 (Local coverage determination (LCD) for negative pressure wound therapy pumps)

See *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11500&ContrId=137&ver=35&ContrVer=1&Date=&DocID=L11500&bc=iAAAAAgAAAAA&*.

A35347 (Local coverage article for negative pressure wound therapy pumps – policy article – effective October 2011)

See *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35347&ver=17&ContrId=137&ContrVer=1&LCDId=11500&Date=&DocID=L11500&IsPopup=y&*.

Jurisdiction B:

L27025 (Local coverage determination (LCD) for negative pressure wound therapy pumps)

See *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=27025&ContrId=138&ver=12&ContrVer=1&Date=&DocID=L27025&bc=iAAAAAgAAAAA&*.

A47111 (Local coverage article for negative pressure wound therapy pumps – policy article – effective October 2011)

See *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=47111&ver=8&ContrId=138&ContrVer=1&CntrctrSelected=138*1&Date=&DocID=A47111&bc=hAAAAAgAAAAA&*.

Jurisdiction C:

L5008 (Local coverage determination (LCD) for negative pressure wound therapy pumps)

See *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=5008&ContrId=140&ver=46&ContrVer=2&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&LCntrctr=140*2&bc=AgACAAIAAAAA&*.

A35363 (Local coverage article for negative pressure wound therapy pumps – policy article – effective October 2011)

See *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35363&ver=19&ContrId=140&ContrVer=2&CntrctrSelected=140*2&Date=&DocID=A35363&bc=hAAAAAgAAAAA&*.

Jurisdiction D:

L11489 (Local coverage determination (LCD) for negative pressure wound therapy pumps)

See *http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11489&ContrId=139&ver=39&ContrVer=1&Date=&DocID=L11489&bc=iAAAAAgAAAAA&*.

A35425 (Local coverage article for negative pressure wound therapy pumps – policy article)

See *http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35425&ver=17&ContrId=139&ContrVer=1&LCDId=11489&Date=&DocID=L11489&IsPopup=y&*.

Note: These interpretive guidelines do not address clinical aspects of NPWT, nor do they intend to assign clinical responsibilities to DMEPOS suppliers that provide the NPWT equipment to Medicare beneficiaries.

In addition to the LCDs and articles, following are some guidelines for the CMS DMEPOS quality standards that CMS uses to ascertain compliance with standards:

I. Supplier business services requirements

Consumer services

CMS DMEPOS quality standard: Suppliers shall provide information and telephone number(s) for customer service, regular business hours, after-hours access, equipment and/or item(s) repair, and emergency coverage.

Interpretive guidelines:

Suppliers shall demonstrate that they have provided the beneficiary/caregiver with the following information:

1. How to contact the supplier for equipment problems both during business hours and after hours through a 24/7 support function provided by the manufacturer or supplier
2. How to access supplier staff for 24/7 technical product consultation. and
3. That they shall call their physician or 911 if a medical emergency arises.

Product safety

CMS DMEPOS quality standards: Suppliers shall implement and maintain a plan for identifying, monitoring and reporting equipment and item(s) failure, repair and preventive maintenance provided to beneficiaries:

Suppliers shall implement a program that promotes the safe use of equipment and item(s) and minimizes safety risks, infections, and hazards both for its staff and for beneficiaries.

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Interpretive guideline:

- Suppliers shall demonstrate that they have ensured the equipment is cleaned between uses by different beneficiaries per the manufacturers' recommendations.

II. Supplier product-specific service requirements

Intake & assessment

CMS DMEPOS quality standard: The supplier shall consult with the prescribing physician as needed to confirm the order and to recommend any necessary changes, refinements, or additional evaluations to the prescribed equipment, item(s), and/or service(s).

Interpretive guidelines:

The supplier shall:

- Ensure the physician order contains all of the documentation requirements in the LCD, including the pump type and necessary supplies.
- If there is a home health agency involved in the patient's care, identify and document in the patient's record the home health care provider by contacting the physician.

CMS DMEPOS quality standard: The supplier shall review the beneficiary's record as appropriate and incorporate any pertinent information, related to the beneficiary's condition(s) which affect the provision of the DMEPOS and collaboration with the prescribing physician.

Interpretative guidelines:

The supplier shall:

1. Confirm that the wound type or risk factors in the patient record are not among those listed in the most recent public health notification of the U.S Food and Drug Administration. Refer to the FDA's link for all of the specific clinical information at *http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm190704.htm*.
2. Confirm that if the wound type or any of the risk factors included in the patient's record are also in the most recent guidance issued by the FDA, there is a written approval from the patient's physician that the NPWT equipment is appropriate for this patient.
3. Not supply the NPWT equipment to a beneficiary without the physician's written approval.

Delivery and set-up

CMS DMEPOS quality standard: Suppliers shall deliver and set-up, or coordinate set-up with another supplier, all equipment and item(s) in a timely manner as agreed upon by the beneficiary and/or caregiver, supplier, and prescribing physician.

Interpretive guidelines:

Suppliers shall:

1. Coordinate the delivery of the equipment with the home health care providers' home visit, if there is a home health agency (HHA) involved in the patient's care.
2. Deliver the NPWT pump, dressings, and supplies prior to a beneficiary's discharge from the hospital, if the patient is being discharged from an acute care facility.

CMS DMEPOS quality standard: Suppliers shall provide all equipment and item(s) that are necessary to operate the equipment or item(s) and perform any further adjustments as applicable.

Interpretive guidelines:

The supplier shall demonstrate that they have (prior to home delivery):

1. Performed quality checks on pumps, tubing, dressings, drapes, containers, and canisters per the manufacturer maintenance schedule, before delivery
2. Confirmed that each NPWT component is operational and that equipment and supplies are available and complete prior to setup or at the time of setup
3. Confirmed that all of the supplies are within expiration date
4. Confirmed that the number and sizes of dressings are correct and the packaging is sterile
5. Confirmed that the correct pump, containers/canisters, dressing, tubing is used for the specific brand of equipment according to manufacturer requirements
6. Confirmed that clamps are available if required
7. Confirmed that the exudate collection containers or canister are specific to the NPWT system being used
8. Confirmed that the beneficiary has sufficient number of exudate collection containers to meet his/her wound needs based on the patient's history of drainage amount
9. Confirmed that the alarms are setup and working properly, capable of sounding an audible alarm and/or visual alarm, dependent upon the pump type when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) or the wound drainage container/canister is full or the battery is low, and
10. Confirmed that the pump and the wound system (stationary or portable) are operational during use.

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CMS DMEPOS quality standard: Suppliers shall provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period except for orthotics and prosthetics.

Interpretive guidelines:

The supplier shall demonstrate that they have:

1. Performed or arranged maintenance and repairs or replacement of the pump and supplies, and
2. Given information to the beneficiary and/or caregiver(s) on how to obtain service for purchased equipment.

Training/instruction to beneficiary and/or caregiver(s)

CMS DMEPOS quality standards: Suppliers shall provide or coordinate the provision of, appropriate information related to the set-up, features, routine use, troubleshooting, cleaning, infection control practices and maintenance of all equipment and item(s) provided.

Suppliers shall provide relevant information and/or instructions about infection control issues related to the use of all equipment and item(s) provided.

Interpretive guidelines:

Suppliers shall demonstrate that they have provided training to the beneficiary/caregiver:

- That is specific to the system being used; and
- At a minimum it includes:
    1. Verification that new packages are not torn, damaged or opened prior to use
    2. Operation of the pump and its settings
    3. Written instructions that are left with the beneficiary/caregiver on the safety section of the manufacturer's manual after they have been reviewed by the supplier at a comprehension level applicable for the beneficiary/caregiver needs
    4. Instructions on not servicing any of the equipment without calling the supplier first
    5. What to do in case of equipment-related complications, including power failure, dislodged tube, accidental disconnection from pump and low battery
    6. Equipment troubleshooting in case of equipment-related complications, including situations where tube replacement may be required; or alarm will not turn off or other failure of the pump or its supplies
    7. How to contact the supplier if the physician changes settings, or the pump stops working or any review is necessary of the initial instruction
    8. Contacting the supplier if the system shuts off
    9. How to disconnect the system to take a shower or bath
    10. How to disconnect the system when toileting, if the system is not portable
    11. How to respond when the pump is turned off and the alarm sounds after a period of time
    12. Review of the physician's order for the length of time per day that the pump has to be used
    13. What to do if there is a sudden or rapid increase of blood under the drape, in the tubes or container
    14. When to immediately turn off the pump
    15. When to call the physician or other treating practitioner
    16. Contacting the supplier if the NPWT is being discontinued or if the beneficiary is being transferred to another setting
    17. How to arrange with the supplier for pickup or shipment of the system
    18. The function of the clamps on the tubing both open and closed
    19. How to attach, remove, and change the exudates collection container
    20. Importance of infection control procedures such as good hand washing techniques when working with the pump and its supplies
    21. How to keep the pump clean, the importance of not spilling liquids or food on the pump and wipe off spills immediately
    22. Instruction on the frequency of canister changes. No canisters are to be re-used
    23. Disposal procedure of the tubing, dressings and canister according to local waste policy requirements, and
    24. The beneficiary/caregiver is given written warranty information for purchased equipment.

Follow-up

CMS DMEPOS quality standard: Suppliers shall provide follow-up services to the beneficiary and/or caregiver(s), consistent with the type(s) of equipment, item(s) and service(s) provided, and recommendations from the prescribing physician or healthcare team member(s).

Interpretive guidelines:

The supplier shall have an on-going individualized service plan with a defined frequency that addresses, defines or confirms:

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Negative *(continued)*

1. The ongoing operation and maintenance of the equipment, operation and maintenance of the equipment
2. The frequency for scheduled/planned delivery or supply of additional supplies
3. That the beneficiary is using the equipment per the physicians order, and
4. The supplier picks up the equipment when it is no longer needed per the physicians orders.

Additional information

If you have any questions, please contact your DME MAC at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: SE1222
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

Prior authorization demonstration update

The Centers for Medicare & Medicaid Services (CMS) will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. This demonstration will begin summer 2012.

To read more about the demonstration, visit the *Prior Authorization of Power Mobility Devices (PMD) Demonstration Web page*. Stakeholders may submit questions to *PAdemo@cms.hhs.gov*.

Source: CMS PERL 201205-40

Evaluation & Management

Additional information on home health face-to-face encounter requirements

On May 7, the Centers for Medicare & Medicaid Services (CMS) released an *MLN article* designed to provide education on the contents of the home health certification, including homebound criteria and requirements for the face-to-face encounter and documentation. It included guidance that physicians, non-physician practitioners, physician support personnel, and home health agencies can use to ensure that all certification requirements are understood and met. In addition, on May 4, updated face-to-face encounter *questions and answers* were posted and are available through the *CMS Home Health Agency (HHA) Spotlight page*.

Source: CMS PERL 201205-19

Laboratory/Pathology

Coverage of the technical component of physician pathology services furnished to hospital patients

Under previous law, including, most recently, Section 3006 of the Middle Class Tax Relief and Job Creation Act of 2012, a statutory moratorium allowed certain practitioners and suppliers (such as pathologists and independent laboratories) meeting specific criteria to bill a carrier or an A/B Medicare administrative contractor (MAC) for the technical component (TC) of physician pathology services furnished to hospital patients. This moratorium expires on June 30, 2012. Therefore, pathologists and independent laboratories that provide the TC of physician pathology services furnished to hospital patients may no longer bill for and receive Medicare payment for these services, effective for claims with dates of service on and after July 1, 2012.

For background and policy information regarding payment to pathologists and independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to *MLN Matters® article MM5943* and *MLN Matters® article MM5347*.

Source: CMS PERL 201205-47

Mental Health

Additional instructions related to CR 7633: Screening and behavioral counseling interventions in primary care to reduce alcohol misuse

Provider types affected

This *MLN Matters®* article is intended for physicians, providers and suppliers submitting claims to fiscal intermediaries (FI), carriers and A/B Medicare administrative contractors (A/B MAC) for screening and behavioral counseling services provided to Medicare beneficiaries.

What you need to know

If a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in Medicare's claims history within a prior 12-month period, change request (CR) 7791 requires contractors to deny these claims. Be sure to inform your staff of these changes.

Background

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

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

In the Medicare population, Saitz (2005) defined risky use as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age, and >14 standard drinks per week or >4 drinks per occasion for men ≤65 years of age. Importantly, Saitz included the caveat that such thresholds do not apply to pregnant women for whom the healthiest choice is generally abstinence. The 2005 "Clinician's Guide" from the National

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Institutes of Health National Institute on Alcohol Abuse and Alcoholism also stated that clinicians recommend lower limits or abstinence for patients taking medication that interacts with alcohol, or who engage in activities that require attention, skill, or coordination (e.g., driving), or who have a medical condition exacerbated by alcohol (e.g., gastritis).

CR 7791 adds further instructions for contractors if a claim is submitted by a provider for G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes) when there are no claims for G0442 (Annual alcohol misuse screening, 15 minutes) in claims history within a prior 12-month period. It requires contractors to deny such claims with the following specific messages:

- Claim adjustment reason code (CARC) B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) M16 – Alert: Please see our website, mailings, or bulletins for more details concerning this policy/procedure/decision.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary, if a claim is received with a modifier indicating a signed advanced beneficiary notice (ABN) is on file.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received without a modifier indicating no signed ABN is on file.

Also, remember that Medicare will only pay for up to four G0443 services within a 12-month period. Claims for G0443 that exceed that four session limit in a 12-month period will be rejected.

Additional information

The official instruction, CR 7791, issued to your FI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2454CP.pdf*.

The *MLN Matters*® article MM7663, titled, "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse," may be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7633.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Related CR Transmittal #: R2454CP
Implementation Date: October 1, 2012

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Radiology

Coding changes to ultrasound diagnostic procedures for transesophageal Doppler monitoring

Provider types affected

This *MLN Matters*® article is intended for providers billing Medicare contractors (Medicare carriers and/or A/B Medicare administrative contractors [A/B MACs]) for transesophageal Doppler services used for cardiac monitoring of Medicare beneficiaries.

What you need to know

- This new code will be used, effective October 1, 2012, to bill for payment of esophageal Doppler monitoring:

  G9157 Transesophageal Doppler used for cardiac monitoring

- Effective October 1, 2012, you should no longer use Healthcare Common Procedure Coding System (HCPCS) code *76999* when billing for esophageal Doppler monitoring. Medicare contractors will deny claim lines containing HCPCS code *76999* when billing for esophageal Doppler monitoring.
- Medicare contractors will deny claims for these services on or after October 1, 2012, submitted with HCPCS *76999* using claim adjustment reason code (CARC) 189: "'Not otherwise classified' or 'unlisted' procedure code (*CPT*/HCPCS) was billed when there is a specific procedure code for this procedure/service." and remittance advice remarks code (RARC) M20: "Missing/incomplete/invalid HCPCS."
- However, Medicare will deny HCPCS G9157 when billed with modifier TC (technical services) when services are provided in place of service (POS 21) using CARC 125 (Submission/billing error[s]), RARC M2 (Not paid separately when the patient is an inpatient.), and a group code of CO (contractual obligation).
- Medicare will allow HCPCS G9157 to be billed with either modifier 26 (professional component) or TC (technical component) when services are provided in POS 24 for operative patients with a need for intra-operative fluid optimization.
- Medicare will deny HCPCS G9157 when billed in any POS other than 21 or 24 using 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.) and group code CO.

Please note that no changes are being made to the current policy for esophageal Doppler monitoring. For a discussion of that policy, see the *MLN Matters*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5608.pdf*.

Additional information

The official instruction, change request 7819, issued to your carrier and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2472CP.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7819
Related Change Request (CR) #: CR 7819
Related CR Release Date: May 18, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2472CP
Implementation Date: October 1, 2012

Surgery

CMS to cover new technology for Medicare patients with heart valve damage

The Centers for Medicare & Medicaid Services (CMS) will now cover transcatheter aortic valve replacement (TAVR) for Medicare patients under certain conditions. The coverage decision announced May 1 by CMS Acting Administrator Marilyn Tavenner offers important new technology to some of Medicare's sickest patients.

Aortic valve replacements are used in patients, whose aortic heart valves are damaged, causing the valve to narrow – a condition known as "aortic stenosis." Once patients experience symptoms of aortic stenosis, treatment is critical to improve their chances of survival. Until recently, aortic stenosis has been treatable only through invasive surgery. In contrast, TAVR allows doctors to replace a patient's aortic valve through a small opening in the leg. This less invasive procedure gives patients who cannot undergo open heart surgery a new way to repair their damaged heart valve.

This final national coverage decision is one of the first coverage decisions completed under a mutual memorandum of understanding between CMS and the Food and Drug Administration (FDA), a joint effort aimed at getting sometimes lifesaving, new technology to patients sooner. Because this technology is still relatively new, it is important that these procedures are performed by highly trained professionals in optimally equipped facilities. Therefore, this decision uses "coverage with evidence development," which, as a condition of coverage, will require certain provider, facility, and data collection criteria to be met. Such requirements are important to ensure beneficiaries receive the safest and most appropriate care.

The decision can be found on the *CMS website*.

Full text of this excerpted *CMS press release* (issued May 1).

Source: CMS PERL 201205-09

Therapy Services

Revisions of the financial limitation for outpatient therapy services

Provider types affected

This *MLN Matters*® article is intended for physicians, other suppliers and providers who submit claims to Medicare contractors (carriers, fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for therapy services provided to Medicare beneficiaries.

Provider action needed

Stop – Impact to you

This article is based on change request (CR) 7785, which extends the therapy cap exceptions process through December 31, 2012, adds therapy services provided in outpatient hospital settings other than critical access hospitals (CAHs) to the therapy cap effective October 1, 2012, requires the national provider identifier (NPI) of the physician certifying therapy plan of care on the claim, and addresses new thresholds for mandatory medical review.

Caution – What you need to know

The therapy cap amounts for 2012 are $1880 for occupational therapy services, and $1880 for the combined services for physical therapy and speech-language pathology. Suppliers and providers will continue to use the KX modifier to request an exception to the therapy caps on claims that are over these amounts. The use of the KX modifier indicates that the services are reasonable and necessary, and there is documentation of medical necessity in the patient's medical record. For services provided on or after October 1, 2012, and before January 1, 2013, there will be two new therapy services thresholds of $3700 per year: one annual threshold each for 1) occupational therapy (OT) services, and 2) physical therapy (PT) services, and speech-language pathology (SLP) services combined. Per-beneficiary services above these thresholds will require mandatory medical review.

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Therapy *(continued)*

Go – What you need to do

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

Background

The Balanced Budget Act of 1997 (see *http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf*) enacted financial limitations on outpatient PT, OT, and SLP services in all settings except outpatient hospital. Exceptions to the limits were enacted by the Deficit Reduction Act (see *http://www.gpo.gov/fdsys/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf*), and have been extended by legislation several times.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, Section 3005; see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf*) extended the therapy caps exceptions process through December 31, 2012, and made several changes affecting the processing of claims for therapy services.

The therapy cap amounts for 2012 are:

- $1880 for OT services, and
- $1880 for the combined services for PT and SLP.

CR 7785 instructs Medicare suppliers and providers to continue to use the KX modifier to request an exception to the therapy cap on claims that are over these amounts. Note that use of the KX modifier is an attestation from the provider or supplier that:

1. The services are reasonable and necessary, and
2. There is documentation of medical necessity in the patient's medical record.

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps. However, MCTRJCA requires original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between October 1, 2012, and December 31, 2012.

Although the therapy caps are only applicable to hospitals for services provided on or after October 1, 2012, in applying the caps after October 1, 2012, claims paid for outpatient therapy services since January 1, 2012, will be included in the caps accrual totals.

In addition, MCTRJCA contains two requirements that become effective on October 1, 2012.

- The first of these requires that suppliers and providers report on the beneficiary's claim for therapy services the national provider identifier (NPI) of the physician (or non-physician practitioner (NPP) where applicable) who is responsible for reviewing the therapy plan of care. For implementation purposes, the physician (or NPP as applicable) certifying the therapy plan of care is reported. NPPs who can certify the therapy plan of care include nurse practitioners, physician assistants and clinical nurse specialists.
- The second requires a manual medical review process for those exceptions where the beneficiary therapy services for the year reach a threshold of $3,700. The two separate thresholds triggering manual medical reviews build upon the separate therapy caps as follows:
  - One for OT services, and
  - One for PT and SLP services combined.

Although PT and SLP services are combined for triggering the threshold, medical review is conducted separately by discipline.

Claims with the KX modifier requesting exceptions for services above either threshold are subject to a manual medical review process. The count of services to which these thresholds apply begins on January 1, 2012. Absent Congressional action, manual medical review expires when the exceptions process expires on December 31, 2012.

Claims for services at or above the therapy caps or thresholds for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable. Although Medicare suppliers and providers are not required to issue an advance beneficiary notice (ABN) for these benefit category denials, they are encouraged to issue the voluntary ABN as a courtesy to their patients requiring services over the therapy cap amounts ($1,880 for each cap in CY 2012) to alert them of their possible financial liability.

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Therapy *(continued)*

Key billing points

Remember the caps will apply to outpatient hospitals as detected via:

- Types of bill (TOB) 12x (excluding CAHs with CMS certification numbers (CCNs) in the range of 1300-1399) or 13x
- A revenue code of 042x, 043x, or 044x
- Modifier GN, GO, or GP, and
- Date of service on or after October 1, 2012.

Other important points are as follows:

- The new thresholds will accrue for claims with dates of service from January 1, 2012, through December 31, 2012. Medicare will display the total amount applied toward the therapy caps and thresholds on all applicable inquiry screens and mechanisms.
- Providers should report the NPI of the physician/NPP certifying the therapy plan of care in the attending physician field on institutional claims for outpatient therapy services, for dates of service on or after October 1, 2012.
- In cases where different physicians/NPPs certify the OT, PT, or SLP plan of care, report the additional NPI in the referring physician field (loop 2310F) on institutional claims for outpatient therapy services for dates of service on or after October 1, 2012.
- On professional claims, providers are to report the physician/NPP certifying the therapy plan of care, including his/her NPI, for outpatient therapy services on or after October 1, 2012.
- For claim processing purposes, the certifying physician/NPP is considered a referring provider and such providers must follow the instructions in Chapter 15, Section 220.1.1 of the *Medicare Benefit Policy Manual* (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf*) for reporting the referring provider on a claim.
- On electronic professional claims, report the referring provider, including NPI, per the instructions in the appropriate ASC X12 837 technical report 3 (TR3).
- For paper claims, report the referring provider, including NPI, per the instructions in Chapter 26, Section 10 of the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf*.

Claims without at least one referring provider, including his/her NPI, will be returned as unprocessable with the following codes:

- Claim adjustment reason code 165 (Referral absent or exceeded).
- Remittance advice remark code of N285 (Missing/incomplete/invalid referring provider name) and/or N286 (Missing/incomplete/invalid referring provider number).

Additional information

The official instruction, CR 7785, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2457CP.pdf*.

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

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Related Change Request (CR) #: CR 7785
Related CR Release Date: April 27, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2457CP
Implementation Date: October 1, 2012

General Coverage

A physician's guide to Medicare's home health certification, including the face-to-face encounter

Provider types affected

This *MLN Matters*® special edition article is intended for physicians who refer patients to home health, order home health services, and/or certify patients' eligibility for the Medicare home health benefit, home health agencies, and non-physician practitioners (NPPs).

What you need to know

1. Requirements which must be met in order for a patient to qualify for Medicare's home health benefit.

The patient must:

- be confined to the home
- be under the care of a physician
- receive services under a plan of care established and periodically reviewed by a physician, and
- be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or have a continuing need for occupational therapy

2. Physician home health certification requirements

- Physician must be Medicare-enrolled:
  - When a resident is not Medicare-enrolled, the Medicare-enrolled teaching physician, who is supervising the resident, would sign the certification.
- The certifying physician must certify that the patient is receiving home health services under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and
- The certifying physician must not have a financial relationship with the home health agency, as defined in 42 CFR 411.354, unless exceptions to the referral prohibition defined in Section 1877 of the Social Security Act apply.

3. Timeframe for completion of the certification

- Must be obtained when the plan of treatment is established, or as soon as possible thereafter
- Must be signed and dated by the physician who established the plan, and
- Must be complete prior to the home health agency billing Medicare.

4. Certification content requirements

The physician must certify that:

- Home health services are or were needed because the patient is homebound.
- The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan), the physician must include a brief narrative describing the clinical justification of this need as part of the certification and recertification, or as a signed addendum to the certification and recertification.
- A plan of care has been established and is periodically reviewed by a physician.
- The services are or were furnished while the patient is or was under the care of a physician.

5. Face-to-face requirements

- For initial home health certifications, the certifying physician must document that the physician himself or herself, an allowed NPP, or a physician caring for the patient in an acute or post-acute facility who has privileges at the facility had a face-to-face encounter with the patient.
- The face-to-face encounter must occur within 90 days prior to the home health start of care date or within 30 days after the start of care.
- The face-to-face encounter can be performed via a telehealth service, in an approved originating site.
- Prior to billing, the home health agency should ensure that all certifications are complete, including that the face-to-face documentation that has been clearly titled, dated, and signed by the certifying physician.

6. Face-to-face documentation requirements

- Documentation must be clearly titled, dated, and signed by the certifying physician, whether as part of the certification form itself, or as an addendum. It must also include the date the face-to-face encounter was performed.

(continued on next page)

Certification *(continued)*

- Documentation includes a brief narrative which describes how the patient's clinical condition, as seen during that encounter, supports the patient's homebound status and need for skilled services.
- The face-to-face documentation must be that of the certifying physician, and cannot be altered/changed in any way by the home health agency.
- The face-to-face documentation is part of the certification, and the certification is required at the time the home health agency bills Medicare.
- The face-to-face documentation can include, or exist as, checkboxes so long as it comes from the certifying physician.
- If the physician who cared for the patient in the acute or post-acute facility chooses to use documentation that is compiled from the patient's medical record (e.g. a discharge summary) to inform the certifying physician of how the clinical findings of the face-to-face encounter support Medicare home health eligibility for that patient, the compiled documentation must be reflective of the clinical findings of that face-to-face encounter as observed by that physician caring for the patient in the acute or post-acute facility, thus serving as that physician's communication to the certifying physician. Further, if the certifying physician chooses to use the encounter documentation from the informing physician as his or her documentation of the face-to-face encounter, the certifying physician must sign and date the documentation, demonstrating that the certifying physician received that information from the physician who performed the face-to-face encounter, and that the certifying physician is using that discharge summary or documentation as his or her documentation of the face-to-face encounter.One physician signature, from the certifying physician, suffices if the face-to-face encounter documentation is co-located with the physician's certification of eligibility. Otherwise, if the face-to-face documentation is attached as an addendum to the certification (a separate document), the face-to-face documentation and certification each require a signature from the certifying physician.
- Electronic signatures are acceptable.

7. Who can perform the face-to-face encounter?

- Medicare-enrolled physicians who are also the certifying physician
- The following physicians are allowed to perform the face-to-face encounter and inform the certifying physician:
  - Physicians (Medicare-enrolled or otherwise) who cared for the patient in an acute or post-acute facility during a recent acute or post-acute stay and have privileges at the facility
  - Because residents (Medicare-enrolled or otherwise) do not have privileges at acute or post-acute facilities, if they are performing the encounter and informing the certifying physician, they must inform the certifying physician under the supervision of their teaching physician who must have such privileges.
- NPPs allowed to perform the face-to-face encounter include:
  - A nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician in accordance with state law
  - A certified nurse-midwife under the supervision of the certifying physician, as authorized by state law, and
  - A physician assistant under the supervision of the certifying physician.
- NPPs are subject to the same financial restrictions with the home health agency as the certifying physician.

8. Recertifications

- Face-to-face encounter documentation is only required for the initial certification
- At the end of the 60-day episode, a decision must be made whether or not to recertify the patient for a subsequent 60-day episode.

Additional information

A list of frequently asked questions is available at *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html*.

MLN Matters® article SE1038, which provides guidance for the original face-to-face implementation, is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1038.pdf*.

If you have any questions, please contact your carrier or Medicare administrative contractor at their toll-free number, which may be found at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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

New physician specialty code for sleep medicine and sports medicine

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners, and suppliers who bill Medicare carriers, Medicare administrative contractors (A/B MACs), or durable medical equipment (DME) MACs for sleep medicine service and/or sports medicine services provided to Medicare beneficiaries.

Provider action needed

Effective April 2, 2012, you will need to use physician specialty code (C0) for sleep medicine services. In addition, claims submitted to DME MACs for sports medicine service should use the sports medicine specialty code of 23.

You should make sure that your billing staffs are aware of this new specialty code for sleep medicine services.

Background

Medicare physician and non-physician practitioner specialty codes describe the specific or unique types of medical services that physicians and non-physician practitioners provide. While physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) when they enroll in the Medicare program, non-physician practitioners are assigned a Medicare specialty code when they enroll. The specialty code becomes associated with the claims submitted by physicians or non-physician practitioners. Medicare contractors also use specialty code data to develop claim processing edits.

New specialty code

CR 7600 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for sleep medicine. This new physician specialty code, which will be effective April 2, 2012, is C0. PECOS and your carrier or A/B MAC will recognize and use this new code as a valid primary and/or secondary specialty code for sleep medicine. Also, a new specialty code is established for sports medicine and that code is 23.

Additional information

You can find more information about the new sleep medicine specialty code by going to CR 7600, located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2462CP.pdf*. A related transmittal that updates the *Medicare Financial Management Manual* is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R209FM.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7600
Related Change Request (CR) #: 7600
Related CR Release Date: April 27, 2012
Effective Date: April 1, 2012
Related CR Transmittal #: R2462CP and R209FM
Implementation Date: October 1, 2012

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

Your Feedback Matters

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

Less than 30 days left before version 5010 enforcement discretion period ends

Version 5010 enforcement discretion period ends in less than 30 days

The deadline for all HIPAA-covered entities to upgrade to version 5010 electronic standards was January 1, 2012. However, the Centers for Medicare & Medicaid Services (CMS) initiated an enforcement discretion period until June 30, 2012, to give the industry additional time to complete testing. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades for this transition. If you have not yet finalized your version 5010 upgrade, you should be working to complete this step as soon as possible.

Version 5010 resources

CMS is committed to helping you successfully upgrade to version 5010 and ICD-10 by providing resources on the CMS ICD-10 website to help you understand and manage your upgrade. CMS regularly updates the CMS ICD-10 website, including a *Web page* dedicated to version 5010 information and resources. CMS has also posted a *fact sheet*, which discusses steps providers should be taking now to be compliant with the upgrade to version 5010 by June 30.

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.

Source: CMS PERL 201205-51

Healthcare provider taxonomy code updates effective July 1, 2012

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

Source: Change request 7742

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

Existing regulations at 42 *Code of Federal Regulations* (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 201205-50

Go green to get your green faster

Save time, money, and the environment all at the same time by signing up for electronic funds transfer (EFT). With EFT, funds are transferred directly to your financial institution, which means quicker reimbursement for you. To start receiving EFT, simply complete and return the EFT Authorization Agreement form at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS588.pdf*.

CMS answers the industry's top questions about the version 5010 upgrade

Upgrading to *version 5010* involves significant planning and preparation. The version 5010/4010A electronic standards upgrade deadline was January 1, 2012. However, the Centers for Medicare & Medicaid Services (CMS) enacted an enforcement discretion period through June 30, 2012, for all HIPAA-covered entities. It you haven't upgraded to version 5010, it is important to begin testing now.

Denise Buenning, MsM, Acting Deputy Director, Office of E-health Standards & Services (OESS), recently took time to answer some of the industry's top questions on the version 5010 upgrade.

1. Is the industry up to date with the version 5010 upgrade and taking steps to prepare for the ICD-10 transition?

   Yes, CMS is hearing that the industry is progressing with version 5010 implementation. CMS also continues to see from the Medicare fee-for-service (FFS) group consistent increases across the board for 5010 transaction volumes and number of 5010 submitters. CMS is also hearing that the industry is continuing to take steps to prepare for ICD-10. ICD-10 is a major undertaking for providers, payers, and vendors. It will drive business and systems changes throughout the health care industry, from large national health plans to smaller provider offices, laboratories, hospitals, and more. The updates will go much more smoothly for organizations that plan ahead and prepare now. A successful upgrade to version 5010 now and transition to ICD-10 later will be vital to transforming our nation's health care system.

2. What steps should I take if I am behind in the upgrade to version 5010?

   There are a number of things that HIPAA-covered entities should do now. Communication among plans, providers, clearinghouses, and vendors, as well as other trading partners, is critical. Below outlines three steps providers can take now:

   - Reach out to clearinghouses for assistance and/or take advantage of any free or low cost software that may be available from payers.
   - Check with payers now to see what plans they will have in place to handle incoming claims, and what interim alternatives are available.
   - Consider contacting financial institutions to establish lines of credit to get through any possible temporary interruptions in claims reimbursement as a result of not being version 5010 compliant.

CMS has developed a *fact sheet* for health care providers, which discusses the risk mitigation steps in more detail.

3. How is CMS helping the industry prepare?

   - The Workgroup for Electronic Data Interchange (WEDI) and CMS held a webinar on ASCX12 5010 implementation and problem solving on May 23 from 1-2:30 p.m. ET. These online presentations are designed to gather feedback, track challenges and provide guidance to correcting ASC X12 5010 implementation-related issues.
   - WEDI and CMS previously held a webinar on ASCX12 5010 implementation, and a *replay* of the webinar with the slides presented is located online.
   - Additionally, the *CMS website* has official resources to help the industry prepare for version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition. Sign up for *ICD-10 email updates* and follow @CMSgov on *Twitter* for the latest news and resources.

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.

Source: CMS PERL 201205-41

Reporting of recoupment for overpayment on the remittance advice with patient control number

Note: This article was revised on May 14, 2012, to reflect a revised change request (CR) issued on May 10. The article was revised to show (above) the correct implementation date of October 1, 2012, for claims submitted to durable medical equipment Medicare administrative contractors (DME MACs). In addition, the transmittal number, release date, and the Web address for accessing CR 7499 were revised. All other information is the same. This information was previously published in the November 2011 *Medicare B Connection*, Pages 34-35.

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7499 which instructs Medicare's claims processing systems maintainers to replace the health insurance claim (HIC) number being sent on the ASC X12 Transaction 835 with the patient control number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR 6870 and CR 7068. The *MLN Matters*® article corresponding to CR 6870 can be reviewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6870.pdf* and CR 7068 can be reviewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R812OTN.pdf*.

It has been brought to the attention of CMS that providing the patient control number as received on the original claim rather than the HIC number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR 7499 instructs the shared systems to replace the HIC number being sent on the ERA with the patient control number, received on the original claim. The ERA will continue to report the HIC number if the patient control number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the accounts receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: Instructions in CR 7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the standard paper remit or the 004010A1 version of ASC X12 Transaction 835.

Additional information

The official instruction, CR 7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI, regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1088OTN.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7499 *Revised*
Related Change Request (CR) #: CR 7499
Related CR Release Date: May 10, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1088OTN
Implementation Date: January 3, 2012 for professional claims billed to carriers or B MACs; April 2, 2012, for institutional claims billed to FIs or A MACs; October 1, 2012, for supplier claims submitted to DME MACs

Fraud

Health care law protects against fraud – saves nearly $1.6 billion

Law requires stronger standards for ordering and certifying medical services, equipment, and supplies

On April 24, the Centers for Medicare & Medicaid Services (CMS) announced a final rule that prevents fraud in Medicare and is estimated to save taxpayers nearly $1.6 billion over 10 years.

This rule ensures that only qualified, identifiable providers and suppliers can order or certify certain medical services, equipment and supplies for people with Medicare. The rule also helps ensure beneficiaries receive quality care because CMS will verify the credentials of a provider who is ordering or certifying equipment and supplies.

In addition, the final rule continues to require that all providers and suppliers who qualify for a unique identification number – the national provider identifier (NPI) – include their NPI on applications to enroll in Medicare and Medicaid and on all reimbursement claims submitted. This gives CMS and states the ability to tie specific claims to the ordering or certifying physician or eligible professional and to check for suspicious ordering activity.

This rule builds on the work CMS is also doing in Medicare Part D by requiring that all prescriptions include an NPI for prescribing physicians. In conjunction with Part D, these efforts will help better safeguard the Medicare trust funds by giving CMS the ability to know which providers are ordering, certifying, and prescribing items and services to Medicare beneficiaries.

To see the final rule, visit the *Office of the Federal Register website*.

Full text of this excerpted *CMS press release* (issued April 24).

Source: CMS PERL 201204-45

New 'Medicare Fraud & Abuse: Prevention, Detection, and Reporting' Web-based training

This Web-based training (WBT) course is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against and detect fraud and abuse, as well as how you can help prevent and report it. Continuing education credit is available for this course. To access a new or revised WBT course, visit the *MLN Products Web page* and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the page.

Source: CMS PERL 201205-46

Provider Enrollment

Improvements *(continued from Page 1)*

Electronic submission and signature of electronic funds transfer (EFT) agreement

Users may now complete and submit EFT agreements electronically and have the option to e-sign the document. If the provider/supplier submits the EFT agreement electronically but chooses not to e-sign, he or she must include a hardcopy form of the completed and signed EFT agreement with its supporting documentation to the contractor. Providers/suppliers are still required to physically mail confirmation of account information on bank letterhead or a voided check regardless of whether the EFT is submitted electronically or via the paper version. Along with the documentation, it is also important that the provider/supplier print and mail the enrollment submission confirmation page containing the Web tracking ID. This will ensure that the provider/supplier's supporting documents mailed to the MAC will be associated with his or her electronic application submission.

Did you know?

All fee-for-service (FFS) providers, including federally qualified health centers (FQHCs), end-stage renal disease (ESRD) facilities, and rural health clinics (RHCs) can take advantage of Internet-based PECOS to check and update Medicare enrollment information.

To access Internet-based PECOS, go to the *PECOS website*.

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

Source: CMS PERL 201204-56

Complete signing your Medicare enrollment application electronically

Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) now allows providers to sign Medicare enrollment applications electronically. You can save time and expedite review of your application by utilizing the electronic signature process. **This feature does not change who is required to sign the application**.

Authorized officials of the organization will receive an email providing the steps they need to take to electronically sign the enrollment application. This email will be automatically sent when the enrollment application is submitted. Make sure to add *customerservice-donotreply@cms.hhs.gov* to your safe sender list and check your spam or junk mail folders to ensure you receive the electronic signature email notifications.

An example of the beginning of the email to the authorized official is shown below:

From: *customerservice-donotreply@cms.hhs.gov*

Subject: Pending Medicare e-Signature request (Tracking ID: XXXXXX0047)

An application on behalf of Lexa Hospital was recently submitted by:

Submitter's name: Lexa Smith

Submitter's phone: 5555555555

Submitter's email: *lexa.smith@lexahospital.com*

For more information about signing your Medicare enrollment electronically, see "Sign Your Medicare Enrollment Application Electronically" in the *March 29 edition of the e-News*.

Source: CMS PERL 201204-48

Register for free, hands-on Internet based PECOS class

Join First Coast Service Options, in Jacksonville, for a free, *interactive sessions* on using Internet-based PECOS to electronically create or update your Medicare enrollment . Select from the following session dates: June 19, July 17, August 21, or September 11, 2012.

Were you sent a request to revalidate your Medicare enrollment?

At this time, the quickest way to see if a revalidation letter was mailed to you is to check the "Downloads" on the *Revalidation page* on the cms.gov website. You can now view:

- *Medicare Part A/B revalidation letters mailed February-March 2012*
- *Medicare Part A/B revalidation letters mailed January 2012*
- *Medicare Part A/B revalidation letters mailed November-December 2011*
- *Medicare Part A/B revalidation letters mailed September-October 2011*
- *NSC revalidation letters mailed*

Later this year, the Centers for Medicare & Medicaid Services (CMS) plans to implement a faster process for allowing users to see the date the revalidation notice was sent directly on the "My Enrollments" page within Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

You can also use the search option featured on First Coast Service Options' popular enrollment status lookup; simply enter your NPI or your PTAN.

Source: CMS PERL 201205-29

Confirm the request

Find out whether you have been sent a revalidation request by using this search option featured on First Coast Service Options' *popular enrollment status lookup*.

Medicare enrollment/revalidation: Requests for the IRS Form CP 575

The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter you receive from the IRS granting your employer identification number (EIN). A copy of your CP 575 may be required by the Medicare contractor to verify the provider or supplier's legal business name and EIN.

When is the CP 575 required to be submitted to the Medicare contractor?

- If the applicant is enrolling as a professional corporation, professional association, or limited liability corporation
- If the applicant is enrolling as a sole proprietor using an EIN
- If the Medicare contractor determines a discrepancy between the provider or supplier's legal business name and EIN provided in Section 2 of the CMS-855 form

The CP 575 may be requested by the Centers for Medicare & Medicaid Services (CMS) external user services (EUS) help desk, for verification, when the authorized official (AO) of the provider or supplier organization registers for Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) access.

If you do not have a form CP 575: contact the IRS at 800-829-4933 from 7:00 a.m. to 7:00 p.m.

Source: CMS PERL 201205-28

Submit your Medicare enrollment application up to 60 days before the effective date

Providers and suppliers can now submit their enrollment applications 30 days sooner. The Centers for Medicare & Medicaid Services (CMS)-855 enrollment applications and Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) applications may now be submitted 60 days prior to the effective date.

Note: This does not apply to providers and suppliers submitting a Form CMS-855A application, ambulatory surgical centers (ASCs), or portable X-ray suppliers (PXRSs).

Source: CMS PERL 201205-30

Examining the difference between a national provider identifier and a provider transaction access number

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What you need to know

This article explains the difference between a national provider identifier (NPI) and a provider transaction access number (PTAN). There are no policy changes in this article.

Background

New enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare contractor, the provider or supplier will also be issued a provider transaction access number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.

Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National provider identifier (NPI)

The NPI is a national standard under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the unique physician identification number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (entity type 1 individual). Incorporated individuals should obtain one NPI for themselves (entity type 1 individual) if they are health care providers and an additional NPI(s) for their corporation(s) (entity type 2 organization). Organizations that render health care or furnish health care supplies may obtain NPIs (entity type 2 organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

Provider transaction access number (PTAN)

A PTAN is a Medicare-only number issued to providers by Medicare contractors upon enrollment to Medicare. When a Medicare contractor approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using Medicare contractor self-help tools such as the interactive voice response (IVR) phone system, Internet portal, on-line application status, etc.

(continued on next page)

Difference *(continued)*

- The PTAN's use should generally be limited to the provider's contacts with Medicare contractors.

Relationship of the NPI to the PTAN

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

Protect your information in PECOS

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use Internet-based PECOS: Log on to Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do*.
- Use the paper CMS-855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).

Note: The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The *MLN* fact sheet titled *How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)*, provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf*.

Additional information

MLN Matters® special edition article SE1126 titled *Further Details on the Revalidation of Provider Enrollment Information*, is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf*.

"Medicare Provider–Supplier Enrollment National Educational Products," contains a list of products designed to educate Medicare fee-for-service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare program and maintain their enrollment information. This resource is available at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Implementation Date: N/A

Incentive Programs

Suggestions being accepted for potential Physician Quality Reporting System measures

The Center for Medicare & Medicaid Services (CMS) will be accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System for future rule-making years. To learn more about the Physician Quality Reporting System Call for Measures, visit the *CMS Measures Management System Web page*.

For measures to be considered into the Physician Quality Reporting System, **provide the required documentation for each measure submitted for consideration no later than 5:00 p.m. (ET), August 1, 2012**.

Required documentation includes the "Measure Submitted for Consideration Form," measure specifications (measure title, description, numerator, and denominator, including exclusions, exceptions, and inclusions), and electronic specification and data tables for Electronic Health Record (EHR)-specified candidate measures.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee that the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the Physician Quality Reporting System. CMS will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the Physician Quality Reporting System.

Source: CMS PERL 201205-36

Medicare eRx prescribing payment adjustment hardship exemption

In 2009, the Centers for Medicare & Medicaid Services (CMS) implemented the electronic prescribing (eRx) incentive program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B physician fee schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0 percent in 2012, 1.5 percent in 2013, and 2.0 percent in 2014 will result in an eligible professional or group practice participating in the eRx group practice reporting option (eRx GPRO) receiving 99.0 percent, 98.5 percent, and 98.0 percent respectively of their Medicare Part B PFS amount for covered professional services.

Exclusion criteria

The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will automatically exclude those individual eligible professionals who meet the following 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 not a physician, doctor of osteopathic medicine, 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 does not have at least 100 Medicare physician fee schedule (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1-June 30, 2012.

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eRx *(continued)*

- The eligible professional does not have 10 percent or more of their MPFS allowable charges (per tax identification number) for encounter codes in the measure's denominator for dates of service 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 between January 1 and June 30, 2012.

Avoiding the 2013 eRx payment adjustment

Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2012.

Six-month reporting requirements to avoid the 2013 payment adjustment:

- Individual eligible professionals – 10 eRx events via claims
- Small eRx GPRO – 625 eRx events via claims
- Large eRx GPRO – 2,500 eRx events via claims

For more information on individual and eRx GPRO reporting requirements, please see the *MLN Matters*® special edition article *SE1206 - 2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments*.

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

Significant hardships

The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions during a six-month reporting period (January 1-June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

Submitting a significant hardship code or request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the *Quality Reporting Communication Support Page* (Communication Support Page) on or between March 1 and June 30, 2012. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page or on at least one claim during the 2013 eRx payment adjustment reporting period (January 1-June 30, 2012). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page.

For more information on how to navigate the *communication support*, please reference the following documents:

- *Quality Reporting Communication Support Page User Guide*
- *Tips for Using the Quality Reporting Communication Support Page*

For additional information and resources, please visit the *eRx incentive program Web page*.

If you have questions regarding the eRx incentive program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet help desk at 866-288-8912 (TTY 877-715-6222) or via *qnetsupport@sdps.org*. They are available Monday through Friday from 7:00 a.m.-7:00 p.m. CT.

Source: CMS PERL 201205-10

Updated FAQ on attesting with multiple certified EHRs

Question: For the Medicare and Medicaid electronic health record (EHR) incentive programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures?

Answer: EPs, eligible hospitals, and CAHs should look at the measure of each meaningful use objective to determine the appropriate calculation method for individual numerators and denominators. The calculation of the numerator and denominator for each measure is explained in the *July 28, 2010, final rule (75 FR 44314)*.

For objectives that require a simple count of actions (e.g., number of permissible prescriptions written, for the objective of "Generate and transmit permissible prescriptions electronically (eRx)," number of patient requests for an electronic copy of their health information, for the objective of "Provide patients with an electronic copy of their health information;" etc.), EPs, eligible hospitals, and CAHs can add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "Record demographics," "Record vital signs," etc.), EPs, eligible hospitals, and CAHs may also add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. Previously the Centers for Medicare & Medicaid Services (CMS) had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, we now permit simple addition for all meaningful use objectives.

Please keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators whenever applicable in order to provide accurate numbers.

To report clinical quality measures, EPs who practice in multiple locations that are equipped with certified EHR technology should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).

Website update

Please also note that the EHR incentive programs' frequently asked questions (FAQs) were reorganized during the CMS.gov website upgrade. The EHR incentive programs' FAQs are now incorporated in the same page as other CMS program FAQs. To navigate the EHR incentive program FAQs you must go to the *FAQ page*, and click "Electronic Health Records Incentive Programs" on the blue navigation pane on the left-hand side. CMS appreciates your understanding and apologize for any inconvenience.

Want more information about the EHR incentive programs?

Make sure to visit the *EHR incentive programs website* for the latest news and updates.

Source: CMS PERL 201204-44

Nebraska launches its Medicaid EHR incentive program

Nebraska launched its Medicaid electronic health record (EHR) incentive program on May 7. This means that eligible professionals (EPs) and eligible hospitals in Nebraska can now complete their EHR incentive program registration. More information about the Medicaid EHR incentive program can be found on the *Medicare and Medicaid EHR Incentive Program Basics* page of the CMS EHR website.

If you are a resident of Nebraska and are eligible to participate in the Medicaid EHR incentive program, visit your *state Medicaid Agency website* for more information on your state's participation in the Medicaid EHR incentive program.

As of May 7, 44 states have launched Medicaid EHR incentive program. For a complete list of states that have already begun participation in the Medicaid EHR incentive program, see the *Medicaid State Information page* on the CMS EHR website. CMS looks forward to announcing the launches of additional states' programs in the coming months.

Want more information about the EHR incentive program?

Make sure to visit the *EHR incentive program website* for the latest news and updates on the EHR incentive program.

Source: CMS PERL 201205-53

New data provides information on EPs who participated in the Medicare EHR incentive program in 2011

The Centers for Medicare & Medicaid Services (CMS) has posted the *2011 Medicare electronic health record (EHR) incentive program eligible professionals public use file (PUF)* to the EHR website. This new file contains data on eligible professionals (EPs) who participated in the Medicare EHR incentive program in 2011.

The CMS 2011 Medicare EHR incentive program eligible professionals PUF provides detailed information about EPs who attested as of December 22, 2011, including each provider's type, specialty, and his/her responses to the meaningful use core and menu measures. The PUF excludes data from hospitals in the Medicare EHR incentive program, which will be posted at a later date. There is no 2011 data available for participants in the Medicaid EHR incentive program, who received incentive payments in 2011 only for adopting, implementing, or upgrading to certified EHR technology.

Additional information on the PUF can be found on the *Data and Reports page* of the EHR website.

Want more information about the EHR incentive programs?

Make sure to visit the *EHR Incentive Programs website* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201205-27

Information on recipients of Medicare EHR incentive program payments

In compliance with the HITECH Act's requirement, the Centers for Medicare & Medicaid Services (CMS) has posted the names, business phone numbers, and business addresses of Medicare eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that have successfully demonstrated meaningful use and received a payment as of March 2012. Medicare EPs, eligible hospitals, and CAHs were able to verify and edit their business phone numbers and addresses during the registration process. CMS has not posted information on group practices, as incentive payments are not provided at the group practice level.

Beginning this month, CMS is posting two file formats of Medicare electronic health records (HER) incentive program payment recipients. One format is a searchable portable document format (PDF), and the other is a tabular downloadable (comma-separated values) (CSV) file that can be opened in many common spreadsheet programs. This CSV file can also be used to sort information about recipients, for example, by medical specialty or the state in which they practice. Use the links below to access the PDF and CSV files.

CSV format

EP recipients of Medicare EHR incentive program payments

Hospital recipients of Medicare EHR incentive program payments

PDF format

EP recipients of Medicare EHR incentive program payments

Hospital recipients of Medicare EHR incentive program payments

Please note: These lists will be updated on a quarterly basis. Not all providers are eligible for the Medicare EHR incentive program. Only those professionals, hospitals, and CAHs that are eligible based on the regulation's *eligibility requirements*, attested to meaningfully using an EHR, and have received a Medicare incentive payment will be displayed online. Finally, the Act does not require CMS to post the names of eligible professionals, eligible hospitals, and CAHs that have received Medicaid EHR incentive program payments.

Want more information about the EHR incentive programs?

Make sure to visit the *EHR incentive program website* for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201205-43

General Information

Medicare stable, but requires strengthening

The Medicare Trustees Report released on April 23 shows that the hospital insurance (HI) trust fund is expected to remain solvent until 2024, the same as last year's estimate, but action is needed to secure its long-term future. In 2011, the HI trust fund expenditures were lower than expected.

Without the Affordable Care Act, the HI trust fund would expire eight years earlier, in 2016. The law provides important tools to control costs over the long run such as changing the way Medicare pays providers to reward efficient, quality care. These efforts to reform the health care delivery system are not factored into the trustees' projections as many of the initiatives are just launching.

The report projects that the supplementary medical insurance (SMI) trust fund is financially balanced because beneficiary premiums and general revenue financing are set to cover expected program costs. Spending from the Part B account of the SMI trust fund grew at an average rate of 5.9 percent over the last five years.

SMI Part D, the Medicare prescription drug program, had an average growth rate of 7.2 percent over the last five years. Cost projections for Part D are lower than in the 2011 trustees' report, due to lower spending in 2011 and greater expected use of generic drugs.

HI expenditures have exceeded income annually since 2008 and are projected to continue doing so under current law in all future years. Trust fund interest earnings and asset redemptions are required to cover the difference. HI assets are projected to cover annual deficits through 2023, with asset depletion in 2024. After asset depletion, if Congress were to take no further action, projected HI trust fund revenue would be adequate to cover 87 percent of estimated expenditures in 2024 and 67 percent of projected costs in 2050. In practice, Congress has never allowed a Medicare trust fund to exhaust its assets.

The financial projections for Medicare reflect substantial cost savings resulting from the Affordable Care Act, but also show that further action is needed to address the program's continuing cost growth.

The *report* is now available.

Full text of this excerpted *CMS press release* (issued April 23).

Source: CMS PERL 201204-46

Providers who receive error codes H20203 and H45255 need to balance bill

Providers who receive rejection codes H20203 and/or H45255 will need to balance bill their patients' supplemental payers for any balances left after Medicare. The Centers for Medicare & Medicaid Services (CMS) deeply regrets that these error conditions have arisen.

On February 29, 2012, CMS alerted Medicare physicians/practitioners, providers, and suppliers to three edits that they may be seeing reflected on special provider notification letters that they receive from their local fiscal intermediary (FI), carrier, A/B Medicare administrative contractor (MAC), or durable medical equipment MAC (DME MAC). These edits had resulted, or are still resulting, from defects within our coordination of benefits (COB) HIPAA 837 compliance editing. The defects associated with the firing of edits H51108 and H20203 at the coordination of benefits contractor (COBC) were resolved on January 16 and February 27, respectively. CMS has the following additional information updates to offer regarding edits H20203 and H45255:

- H20203: Element CLM16 is present though marked "Not Used"
  - **Update**: Medicare was able to repair all affected 837 professional claims right after February 27, 2012. Unfortunately, due to more highly critical HIPAA 5010 fixes that were needed to the version 5010 837 institutional COB/crossover claims process, the fiscal intermediary shared system (FISS) was unable to resend 837 institutional claims that incorrectly rejected with error code H20203. Fortunately, the overall volume of affected claims was determined to be very low. Providers that received rejection code H20203 on their provider notification letters issued from their FI or A/B MAC will need to balance bill their patients' supplemental payers for any balances left after Medicare.
- H45255: The other subscriber primary identifier (2330A NM109) cannot be the same as the group or policy number (2320 SBR03)

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H20203 *(continued)*

- **Resolution**: COBC's translation routine will scrub the duplicate identifier that is present in 2320 SBR03.
- **Updated confirmed fix date**: May 18, 2012
- **Scope of impact**: The current problem seems to only be impacting HIPAA 5010A1 837 professional claims billed to Medicare by physicians/practitioners and DMEPOS suppliers. The error is principally impacting crossover claims that would have been transferred to North Dakota Medicaid. (**Note**: This is due to its reporting of the Medicare health insurance claim number (HICN) as the policy number for crossover claim purposes).
- **Update**: Because certain carriers, A/B MACs, and DME MACs have been holding generation of their provider notification letters tied to rejection code H45255 since February 2012, CMS has determined that a future claim repair action after May 18, 2012, would not be viable. Therefore, physicians/practitioners and suppliers may be seeing error H45255 on their provider notification letters. If physicians/practitioner and supplier offices see this rejection code, they will need to balance bill their patients' supplemental payer for any balances remaining after Medicare.

Source: CMS PERL 201205-08

HHS announces first 26 health care innovation awards

Programs will save estimated $254 million and improve health care

On May 8, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, announced the first batch of organizations for health care innovation awards. Made possible by the health care law – the Affordable Care Act – the awards will support 26 innovative projects nationwide that will save money, deliver high quality medical care, and enhance the health care workforce. The preliminary awardees announced expect to reduce health spending by $254 million over the next three years.

The new projects include collaborations of leading hospitals, doctors, nurses, pharmacists, technology innovators, community-based organizations, and patients' advocacy groups, among others, located in urban and rural areas that will begin work this year to address health care issues in local communities. This initiative allows applicants to come up with their best ideas to test how we can quickly and efficiently improve the quality and affordability of health care.

Preliminary awardees were chosen for their innovative solutions to the health care challenges facing their communities and for their focus on creating a well-trained health care workforce that is equipped to meet the need for new jobs in the 21st century health system. The Bureau of Labor Statistics projects the health care and social assistance sector will gain the most jobs between now and 2020.

The awards total $122.6 million. The Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) at HHS administers the awards through cooperative agreements over three years.

For more information on the awards announced today, go to the *Healthcare Innovation Awards Web page*. Learn more about other innovative models being tested on the *CMS Innovation Center Web page*.

Full text of this excerpted *CMS press release* (issued May 8).

Source: CMS PERL 201205-32

HHS finalizes new rules to cut regulations for hospitals and health care providers – savings more than $5 billion

Changes will reduce costs and allow more focus on medical care

On May 9, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced significant steps to reduce unnecessary, obsolete, or burdensome regulations on American hospitals and health care providers. These steps will help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and save nearly $1.1 billion across the health care system in the first year and more than $5 billion over five years.

The new rules were issued on May 9 by the Centers for Medicare & Medicaid Services (CMS). The first rule revises the Medicare conditions of participation (CoPs) for hospitals and critical access hospitals (CAHs). CMS estimates that annual savings to hospitals and CAHs will be approximately $940 million per year.

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Cuts *(continued)*

The second, the Medicare Regulatory Reform rule, will produce savings of $200 million in the first year by promoting efficiency. This rule eliminates duplicative, overlapping, and outdated regulatory requirements for health care providers.

Among other changes, the final rules will:

- Increase flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system;
- Let CAHs partner with other providers so they can be more efficient and ensure the safe and timely delivery of care to their patients;
- Require that all eligible candidates, including advanced practice registered nurses and physician assistants, be reviewed by medical staff for potential appointment to the hospital medical staff and then be granted all of the privileges, rights, and responsibilities accorded to appointed medical staff members; and
- Eliminate obsolete regulations, including outmoded infection control instructions for ambulatory surgical centers; outdated Medicaid qualification standards for physical and occupational therapists; and duplicative requirements for governing bodies of organ procurement organizations.

View the *Medicare CoPs final rule* and the *Medicare Regulatory Reform final rule*. For additional information on the hospital and other CoPs, visit the *Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) website*.

Full text of this excerpted *CMS press release* (issued May 9).

Source: CMS PERL 201205-44

HHS announces new Affordable Care Act options for community-based care

Medicaid and Medicare introduce greater flexibility for beneficiaries to receive care at home or in settings of their choice

New opportunities in Medicaid and Medicare that will allow people to more easily receive care and services in their communities rather than being admitted to a hospital or nursing home were announced on April 26 by Department of Health and Human Services (HHS) Secretary Kathleen Sebelius.

HHS finalized the Community First Choice rule, which is a new state plan option under Medicaid, and announced the participants in the Independence At Home Demonstration program. The demonstration encourages primary care practices to provide home-based care to chronically-ill Medicare patients.

Both are made possible by the Affordable Care Act. Studies have shown that home – and community-based care can lead to better health outcomes.

The final rule released today on the Community First Choice option provides states choosing to participate in this option a six percentage point increase in federal Medicaid matching funds for providing community-based attendant services and supports to beneficiaries who would otherwise be confined to a nursing home or other institution.

Also today, the first 16 organizations that will participate in the new Independence at Home Demonstration were announced. They will test whether delivering primary care services in the home can improve the quality of care and reduce costs for patients living with chronic illnesses. These 16 organizations were selected from a competitive pool of more than 130 applications representing hundreds of health care providers interested in delivering this new model of care.

The Independence at Home demonstration, which is voluntary for Medicare beneficiaries, provides chronically ill Medicare beneficiaries with a complete range of in-home primary care services. Under the demonstration, the Centers for Medicare & Medicaid Services (CMS) will partner with primary care practices led by physicians or nurse practitioners. They will evaluate the extent to which delivering primary care services in a home setting is effective in improving care for Medicare beneficiaries with multiple chronic conditions and reducing costs. Up to 10,000 Medicare patients with chronic conditions will be able to get most of the care they need at home.

The demonstration is scheduled to begin June 1, 2012, and conclude May 31, 2015.

HHS is also seeking comment on a proposed rule that describes a separate Home and Community-Based Services state plan option, which was originally authorized in 2005 then enhanced by the Affordable Care Act. Like the Community First Choice option, this benefit will make it easier for states to provide Medicaid coverage for home and community-based services.

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Affordable *(continued)*

The announcements made today are one part of the Obama administration's efforts to help people with disabilities and those living with chronic illness stay in their own homes when they wish to do so.

For more information:

- *Administration for Community Living website*
- *"Community First Choice Option" fact sheet*

For more information on the Independence at Home demonstration and the organizations selected to participate visit the *Center for Medicare & Medicaid Innovation website*.

The rules may be viewed at the *Office of the Federal Register website*.

Full text of this excerpted *CMS press release* (issued April 26).

Source: CMS PERL 201205-11

Physician Compare April 2012 release

On April 19, 2012, the Centers for Medicare & Medicaid Services (CMS) released an enhancement of the Physician Compare website. Improvements were based on recommendations made during testing as well as suggestions from users and stakeholders. This release is part of ongoing effort to improve Physician Compare.

New group practice option

Physician Compare has a new group practice option, including *Search*, *Compare*, and *Profile* pages. The new features allow users to search by group practice name, get maps and directions, and do side-by-side comparisons of group practices.

The group practice pages are ready for you to preview now. Please take a few moments to evaluate the overall look and feel of the pages as well as the way the group practice search operates, as this will be the platform for sharing quality of care data when they become available. Once you review the pages, please let us know what you think by sending an email to *PhysicianCompare@Westat.com*.

CMS will continue to inform you about future releases and updates to the Physician Compare website, and looks forward to reviewing your feedback.

Source: CMS PERL 201205-34

CMS to release comparative billing report on evaluation and management services

On or around June 4, the Centers for Medicare & Medicaid Services (CMS) will release a national provider comparative billing report (CBR) addressing evaluation and management services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers located in the 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 evaluation and management services CBR, please visit the *CBR Services website* or call the SafeGuard Services' provider help desk, CBR support team at 530-896-7080.

Source: CMS PERL 201205-39

Return of claims when there is a name and HICN mismatch

Provider types affected

This *MLN Matters*® article is intended 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.

Provider action needed

If Medicare systems reject a claim when the beneficiary name does not match the health insurance claim number (HICN), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use reason code 140 (Patient/ Insured health identification number and name do not match).

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on change request (CR) 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

All providers should ensure that their billing staffs are aware of these changes.

Additional information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2449CP.pdf*.

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

MLN Matters® Number: MM7260
Related Change Request (CR) #: CR 7260
Related CR Release Date: April 26, 2012
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Related CR Transmittal #: R2449CP
Implementation Date: October 1, 2012

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Clarification of Medicare conditional payment policy and billing procedures for liability, no-fault and workers' compensation MSP claims

Provider types affected

This *MLN Matters*® article is intended for physicians, hospitals, home health agencies, and other providers who bill Medicare carriers, fiscal intermediaries (FIs) or Medicare administrative contractors (A/B/MACs); and suppliers who bill durable medical equipment MACs (DME MACs) for Medicare beneficiary liability insurance (including self-insurance), no-fault insurance, and WC Medicare secondary payer (MSP) claims.

Provider action needed

This article provides clarifications in the procedures for processing liability insurance (including self-insurance), no-fault insurance and WC Medicare secondary payer (MSP) claims. Not following the procedures identified in this article may impact your reimbursement. Change request (CR) 7355, from which this article is taken, clarifies the procedures you are to follow when billing Medicare for liability insurance (including self-insurance), no-fault insurance, or WC claims, when the liability insurance (including self-insurance), no-fault insurance, or WC carrier does not make prompt payment. It also includes definitions of the promptly payment rules and how contractors will identify conditional payment requests on MSP claims received from you. You should make sure that your billing staffs are aware of these Medicare instructions.

Background

CR 7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting Medicare conditional payments on these types of MSP claims.

The term group health plan (GHP) as related to this *MLN* article means health insurance coverage that is provided by an employer to a Medicare beneficiary based on a beneficiary's own, or family member's, current employment status. The term Non-GHP means coverage provided by a liability insurer (including self-insurance), no-fault insurer and WC carrier where the insurer covers for services related to the applicable accident or injury.

Key points

Conditional Medicare payment procedures

Medicare may not make payment on a MSP claim where payment has been made or can reasonably be expected to be made by GHPs, a WC law or plan, liability insurance (including self-insurance), or no-fault insurance.

Medicare can make conditional payments for both Part A and Part B WC, or no-fault, or liability insurance (including self-insurance) claims if payment has not been made or cannot be reasonably expected to be made by the WC, or no-fault, or liability insurance claims (including self-insurance) and the promptly period has expired.

Note: If there is a primary GHP, Medicare may not pay conditionally on the liability, no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed first and the primary payer payment information must appear on the claim submitted to Medicare.

These payments are made "on condition" that the trust fund will be reimbursed if it is demonstrated that WC, no-fault, or liability insurance is (or was) responsible for making primary payment (as demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver, or release [whether or not there is a determination or admission of liability for payment for items or services included in a claim against the primary payer or the primary payer's insured]; or by other means).

"Promptly" definition

No-fault insurance and WC "promptly" definition

For no-fault insurance and WC, promptly means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the promptly period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the promptly period.

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MSP *(continued)*

Liability insurance "promptly" definition

For liability insurance (including self-insurance), promptly means payment within 120 days after the earlier of the following:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; or
- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

The *Medicare Secondary Payer (MSP) Manual*, Chapter 1 (*Background* and *Overview*), Section 20 (Definitions), provides the definition of promptly (with respect to liability, no-fault, and WC) which all Medicare contractors must follow.

Note: For the liability situation, the MSP auxiliary record is usually posted to the Medicare's common working file (CWF) after the beneficiary files a claim against the alleged tortfeasor (the one who committed the tort [civil wrong]) and the associated liability insurance (including self-insurance). In the absence of evidence to the contrary, the date the general liability claim is filed against the liability insurance (including self-insurance) is no later than the date that the record was posted on Medicare's CWF. Therefore, for the purposes of determining the promptly period, Medicare contractors consider the date the liability record was created on Medicare's CWF to be the date the general liability claim was filed.

How to request a conditional payment

The following summarizes the technical procedures that Part A and Part B and supplier contractors will use to identify providers' conditional payment requests on MSP claims.

Part A conditional payment requests

Providers of Part A services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 institutional electronic claims, using the appropriate insurance value code (i.e., value code 14, 15, or 47) and zero as the value amount. Again, you must bill the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

For hardcopy (CMS-1450) claims, providers must identify the other payer's identity on line A of form locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65, and the address of the insured is shown in FL38 or remarks (FL 80). All primary payer amounts and appropriate codes must appear on your claim submitted to Medicare.

For 837 institutional claims, providers must provide the primary payer's zero value code paid amount and occurrence code in the 2300 HI. (The appropriate occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), must be used in billing situations where you attempted to bill a primary payer in non-GHP (i.e., liability, no-fault, and workers' compensation) situations, but the primary payer did not make a payment in the promptly period). **Note**: Beginning July 1, 2012, Medicare contractors will no longer be accepting 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 1 displays the required information of the electronic claim in which a Part A provider is requesting conditional payments.

Table 1

Data requirements for conditional payment for Part A electronic claims

Type of insurance	CAS	Part A value code (2300 HI)	Value amount (2300 HI)	Occurrence code (2300 HI)	Condition code (2300 HI)
No-fault/ liability	2320 - valid information why NGHP or GHP did not make payment	14 or 47	$0	01-Auto accident & date 02-No-fault insurance involved & date 24 – Date insurance denied	

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MSP *(continued)*

Type of insurance	CAS	Part A value code (2300 HI)	Value amount (2300 HI)	Occurrence code (2300 HI)	Condition code (2300 HI)
WC	2320 - valid information why NGHP or GHP did not make payment	15	$0	04-Accident/tort liability & date 24 – Date insurance denied	02-Condition is employment related

Part B conditional payment requests (Table 2)

Since the electronic Part B claim (837 4010 professional claim) does not contain value codes or condition codes, the physician or supplier must complete the: 1) 2320AMT02 = $0 if the entire claim is a non-GHP claim and conditional payment is being requested for the entire claim; or 2) 2430 SVD02 for line level conditional payment requests if the claim also contains other service line activity not related to the accident or injury, so that the contractor can determine if conditional payment should be granted for Part B services related to the accident or injury.

For version 4010, physicians and other suppliers may include CP - Medicare conditionally primary, AP - auto insurance policy, or OT - other in the 2320 SBR05 field. The 2320 SBR09 may contain the claim filing indicator code of AM - automobile medical, LI - liability, LM - liability medical or WC - workers' compensation health claim. Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types.

The 2300 DTP identifies the date of the accident with appropriate value. The "accident related causes code" is found in 2300 CLM 11-1 through CLM 11-3. **Note**: Beginning July 1, 2012, Medicare contractors will no longer accept 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 2 displays the required information for a MSP 4010 professional in which a physician/supplier is requesting conditional payments.

Table 2

Data requirements for conditional payments for MSP 4010 professional claims

Type of insurance	CAS	Insurance type code (2320 SBR05)	Claim filing indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Insurance type code (2000B SBR05)	Date of accident
No-fault/ liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI, or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AP or OA
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Please note that for 837 5010 professional claims, the insurance codes changed and the acceptable information for Medicare conditional payment request is modified as displayed in Table 3.

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MSP *(continued)*

Table 3

Data requirements for conditional payment for 837 5010 professional claims

Type of insurance	CAS	Insurance type code 2320 SBR05 from previous payer(s)	Claim filing indicator (2320 SBR09)	Paid amount (2320 AMT or 2430 SVD02)	Condition code (2300 HI)	Date of accident
No-fault/ liability	2320 or 2430 – valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00		2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA
WC	2320 or 2430 – valid information why NGHP or GHP did not make payment	15	WC	$0.00	02-Condition is employment related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Note: Medicare beneficiaries are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim, but they are required to cooperate in the filing of no-fault claims. If the beneficiary refuses to cooperate in filing of no-fault claims Medicare does not pay.

Situations where a conditional payment can be made for no-fault and WC claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates the no-fault insurance or WC is involved for that specific item or service
- There is/was no open GHP record on the Medicare CWF MSP file as of the date of service
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the no-fault insurer or WC entity first, and
- There is information on the claim that indicates the no-fault insurer or WC entity did not pay the claim during the promptly period.

Note: When a conditional payment is made to you, Medicare contractors will use remittance advice remark code M32 to indicate a conditional payment is being made.

Situations where a conditional payment can be made for liability (including self-insurance) claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates liability insurance (including self-insurance) is involved for that specific item or service
- There is/was no open GHP record on the Medicare's CWF MSP file as of the date of service
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and
- There is information on the claim that indicates the liability insurer (including the self-insurer) did not make payment on the claim during the promptly period.

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MSP *(continued)*

Conditional primary Medicare benefits paid when a GHP is a primary payer to Medicare

Conditional primary Medicare benefits may be paid if the beneficiary has GHP coverage primary to Medicare and the following conditions are **not** present:

- It is alleged that the GHP is secondary to Medicare
- The GHP limits its payment when the individual is entitled to Medicare
- The services are covered by the GHP for younger employees and spouses but not for employees and spouses age 65 or over
- If the GHP asserts it is secondary to the liability (including self-insurance), no-fault or workers' compensation insurer

Situations where conditional payment is denied

Liability, no-fault, or WC claims denied

1. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - You did not send the claim to the employer GHP first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, or WC entity, but the insurer entity did not pay the claim.
2. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare, and
   - The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first, and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, insurer or WC entity, but the insurer entity did not pay the claim.

Denial codes

To indicate that claims were denied by Medicare because the claim was not submitted to the appropriate primary GHP for payment, Medicare contractors will use the following codes on the remittance advice sent to you:

- Claim adjustment reason code 22 – "This care may be covered by another payer per coordination of benefits," and
- Remittance advice remark code MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

Additional information

You can find official instruction, CR 7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R86MSP.pdf*.

You will find the following revised chapters of the *Medicare Secondary Payer Manual*, as an attachment to that CR:

Chapter 1 (*Background* and *Overview*):

- Section 10.7 (Conditional Primary Medicare Benefits),
- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements):

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and
- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements):

- Section 40.6 (Conditional Primary Medicare Benefits),
- Section 40.6.1 (Conditional Medicare Payment), and
- Section 40.6.2 (When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable).

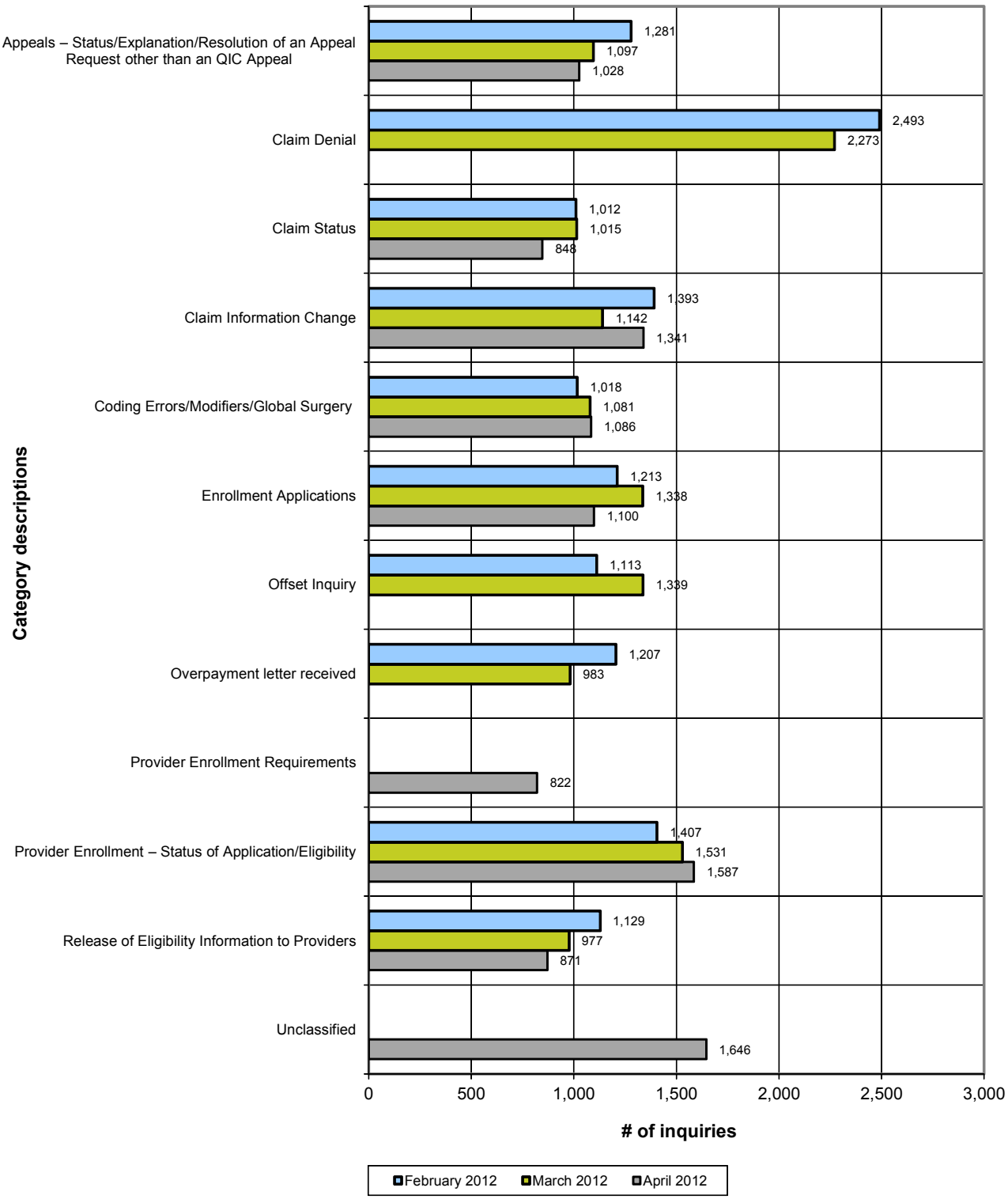
MLN Matters® Number: MM7355
Related Change Request (CR) #: 7355
Related CR Release Date: May 25, 2012
Effective Date: October 1, 2012, for professional claims and DME supplier claims; January 1, 2013, for institutional claims
Related CR Transmittal #: R86MSP
Implementation Date: January 7, 2013, for professional claims and DME supplier claims; January 7, 2013, for institutional claims

Top inquiries, denials, and return unprocessable claims

The following charts provide the most frequent inquiries, denials, and return unprocessable claims (RUC) submitted to First Coast Service Options Inc. (FCSO), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during February-April 2012.

For tips and resources to help providers 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*.

Part B top inquiries for February-April 2012



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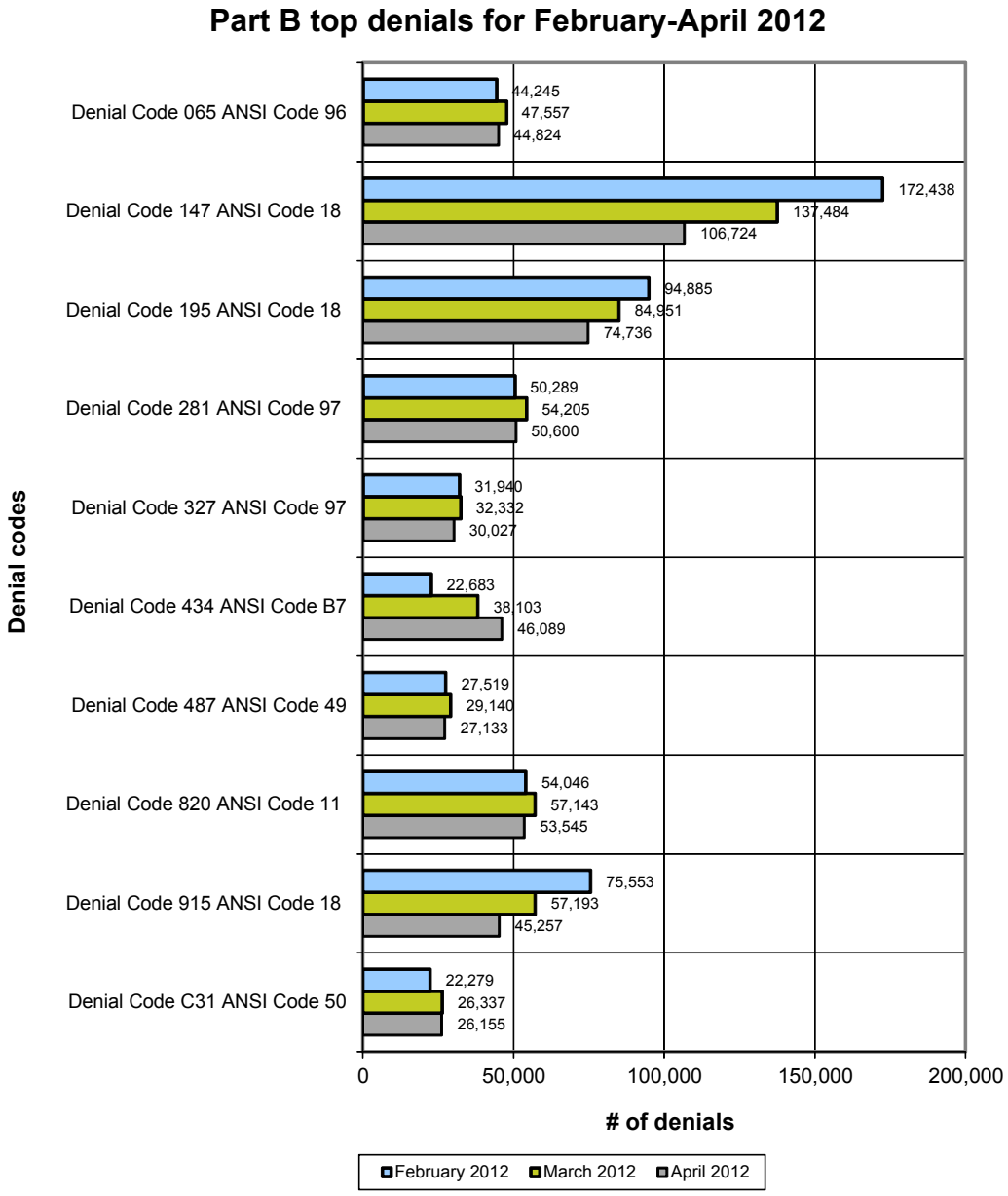
Top *(continued)*



What to do when your claim is denied

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

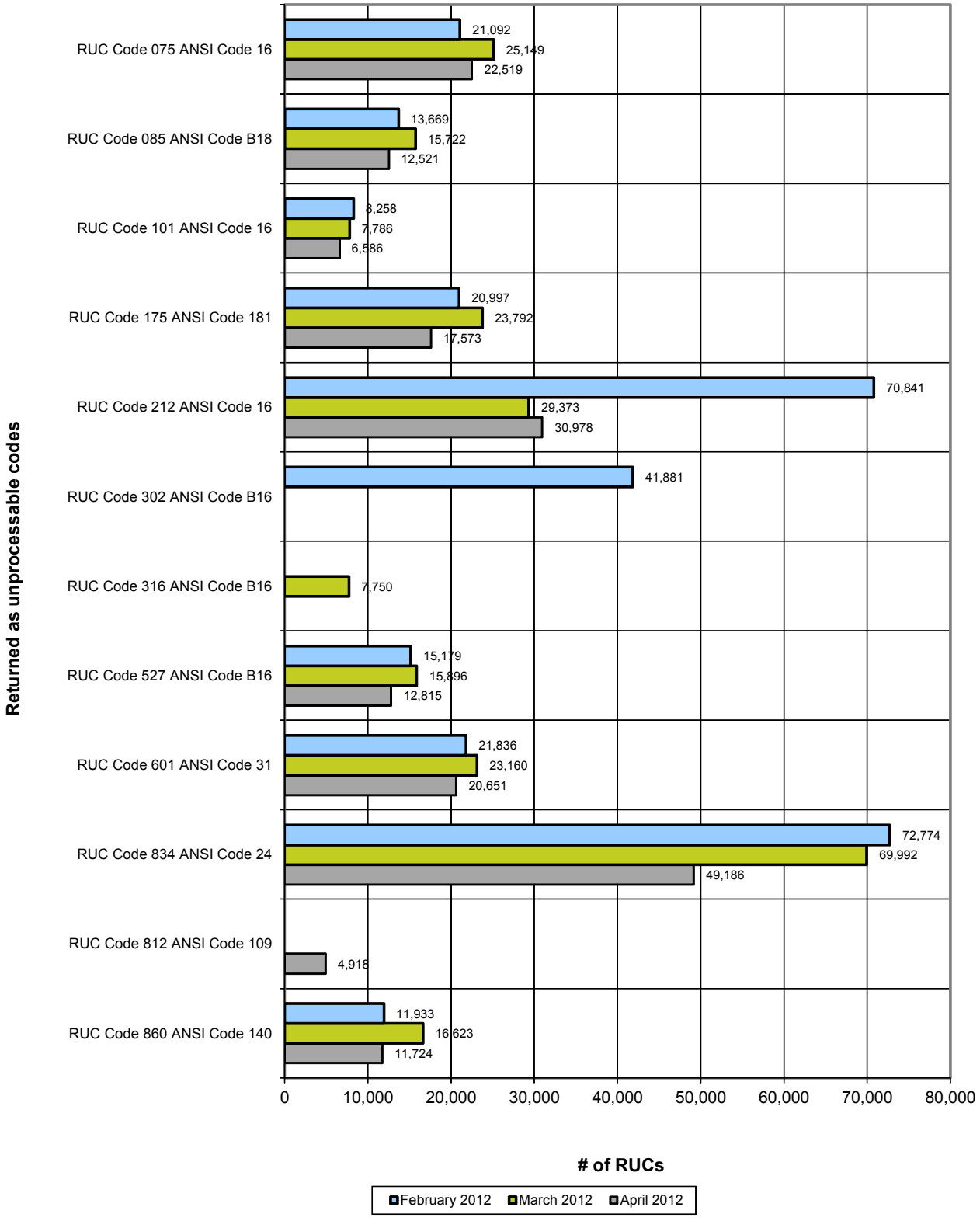
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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.

Top *(continued)*

Part B top return as unprocessable claims for February-April 2012



Educational Events

Upcoming provider outreach and educational events
June 2012

Internet-based PECOS class

When: Tuesday, June 19
Time: 8:00 a.m.-12:00 p.m.
Tyoe of event: Face-to-face

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

Preventive Services

Women's Health Week and Women's Checkup Day

Spotlight women's health in May

Mother's Day Sunday, May 13 through Saturday, May 19 is National Women's Health Week – and Monday, May 14 is National Women's Checkup Day. National Women's Health Week brings together communities, businesses, government, health organizations, and other groups in an effort to promote women's health. This year's observance advises women that *"It's Your Time"* to make health a top priority. Please join the Centers for Medicare & Medicaid Services (CMS) in honoring women during the month of May by supporting efforts to promote and protect the health, safety, and quality of life of women.

Did you know?

The leading causes of death in all females at all ages* in the United States are:

1. Heart disease – 25.1 percent
2. Cancer – 22.1 percent
3. Stroke – 6.7 percent
4. Chronic lower respiratory diseases – 5.5 percent
5. Alzheimer's disease – 4.3 percent
6. Unintentional injuries – 3.6 percent
7. Diabetes – 2.9 percent
8. Influenza and Pneumonia – 2.3 percent
9. Kidney disease – 2.0 percent
10. Septicemia – 1.6 percent

***Based on 2007 data**

Source – *Centers for Disease Control and Prevention Office of Women's Health website*

Medicare provides coverage for a range of preventive services that can help women prevent disease, manage their health conditions, and detect disease early. As a result of the Affordable Care Act, women and others with Medicare can now receive many preventive services at no additional cost. Below is a list of some of the preventive services covered by Medicare, subject to certain requirements:

- Annual wellness visit
- Welcome to Medicare preventive visit
- Bone mass measurements
- Cancer screenings such as mammograms, Pap tests, pelvic exams (includes a clinical breast exam), and colorectal cancer screenings
- Cardiovascular disease screening
- Intensive behavioral therapy for cardiovascular disease
- Diabetes screening
- Glaucoma screening
- HIV screening
- Immunizations (seasonal influenza, pneumococcal, and hepatitis B)

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Women's *(continued)*

- Screening for sexually-transmitted infections (STIs) and high-intensity behavioral counseling (HIBC) to prevent STIs
- Tobacco-use cessation counseling
- Screening for depression in adults
- Intensive behavioral therapy for obesity

As a provider of healthcare services to people with Medicare and women in particular, this month presents a wonderful opportunity to help women to *"Take the Pledge!"* to get healthier by recommending steps to improve their physical and mental health, as well as lower their risks for certain diseases by:

- Regular exercise/increased activity
- Healthy food choices
- Attention to mental health, including getting enough sleep and managing stress
- Avoidance of unhealthy behaviors, such as smoking and not wearing a seatbelt or bicycle helmet and
- Taking advantage of appropriate preventive services and screenings

Women are our mothers, sisters, daughters, aunts, wives, friends, neighbors, co-workers, colleagues, and caregivers – Your encouragement can help promote and improve the health, safety, and quality of life for women and just might save their lives.

More information for health care professionals

- *The Guide to Medicare Preventive Services for Healthcare Professionals*
- *CMS Prevention General Information Website*
- *CMS MLN Preventive Services Products Website*
- *Quick Reference Information: The ABCs of Providing the Annual Wellness Visit*
- *MLN Quick Reference Information: Medicare Preventive Services*
- *National Women's Health Week Website*
- *National Women's Checkup Day Website*
- *The Centers for Disease Control and Prevention Women's Health Website*

Source: CMS PERL 201205-13

May is National Osteoporosis Month

Osteoporosis is common, serious, and costly – and it can lead to an increased risk of bone fractures, typically in the wrist, hip, and spine. Often called a silent disease because bone loss occurs without symptoms, people may not know that they have osteoporosis until their bones become so weak that a sudden bump or fall causes a fracture.

Did you know?

- About 10 million Americans have osteoporosis, and about 34 million more are at risk.
- One out of every two women and one in four men aged 50 and older will have an osteoporosis-related fracture in their lifetime.
- Twenty-four percent of hip-fractured patients age 50 and older die in the year following their fracture.

While men and women of all ages and ethnicities can develop osteoporosis, certain risk factors are linked to the development of osteoporosis and contribute to an individual's likelihood of developing the disease.

- **Gender** – women have a greater chance of developing osteoporosis due to less bone tissue and changes that occur due to menopause.
- **Ethnicity** – Caucasian and Asian women are at highest risk. African American and Hispanic women have lower but significant risk.

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Osteoporosis *(continued)*

- **Age** – older adults have greater risk of osteoporosis because bones become thinner and weaker with age.
- **Body size** – small, thin-boned women are at greater risk.
- **Diet** – an inadequate intake of calcium and vitamin D over a lifetime makes an individual more prone to bone loss and contributes to the development of osteoporosis.
- **Lifestyle** – an inactive lifestyle or extended bed rest tends to weaken bones.
- **Family history** – fracture risk may be due, in part, to heredity.
- **Smoking** – women who smoke have lower levels of estrogen compared with nonsmokers, often go through menopause earlier, and may also absorb less calcium from their diets.
- **Medication use** – long-term use of certain medications can lead to loss of bone density and fractures.
- **Alcohol** – those who drink heavily are more prone to bone loss and fracture, because of poor nutrition and increased risk of falling.

People with osteoporosis may have several risk factors, while others who develop the disease may have no known risk factors at all.

Osteoporosis is a preventable and treatable disease. Early diagnosis and treatment can reduce or prevent fractures. Medicare provides coverage of bone mass measurement for certain eligible beneficiaries. This important benefit can aid in the early detection of osteoporosis before fractures happen, provide a precursor to future fractures, and determine the rate of bone loss. Please help ensure that eligible Medicare patients utilize this benefit as it can help make a difference in the quality of their life.

For more information:

- *Medicare Learning Network® "Guide to Medicare Preventive Services"* (see Chapter 14)
- *CMS "Bone Mass Measurements" brochure*
- *National Institutes of Health (NHI) Osteoporosis and Related Bone Diseases National Resource Center*
- *National Osteoporosis Foundation website*

Source: CMS PERL 201205-31

'Quick Reference Information: Preventive Services' and 'Quick Reference Information: Medicare Immunization Billing' revised

The *Medicare Learning Network®* (MLN) has revised the *"Quick Reference Information: Preventive Services"* (ICN 006559) and *"Quick Reference Information: Medicare Immunization Billing"* (ICN 006799) educational tools. These charts were updated to include the recently released flu code Q2034. All other information remains the same.

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

Source: CMS PERL 201205-46

Honor our nation's seniors in May during Older Americans Month

Please join the Centers for Medicare & Medicaid Services (CMS) in recognizing *Older Americans Month* – a time to honor the many contributions of our nation's seniors, celebrate their successes, and recommit to supporting them as they shape America's next great generation. Older Americans are living longer and are more active than ever before, yet they are some of our most vulnerable citizens.

This year's theme, "Never Too Old to Play", encourages older Americans to stay active in their own lives and in their communities. We know that preventing disease before it starts helps people live longer, healthier lives. As a result of the Affordable Care Act, more seniors are taking advantage of preventive services covered by Medicare, without cost-sharing. Each office visit is an opportunity to ensure that your Medicare patients are aware of the preventive services covered by Medicare that are appropriate for them. Together we can help our older Americans live longer, and age healthy in their homes and communities.

More information for healthcare professionals

- *HHS Secretary News Release on Older Americans Month*
- *CMS Prevention General Information website*
- *Medicare Coverage Database*
- *MLN Preventive Services Educational Products*
- *Medicare.gov Preventive Services website*

Thank you for supporting Older Americans Month – it's "Never Too Old to Play."

Source: CMS PERL 201205-55

May is Hepatitis Awareness Month and May 19 is National Hepatitis Testing Day

The month of May has been designated *Hepatitis Awareness Month* and May 19 is the first ever *National Hepatitis Testing Day*. Every year, approximately 15,000 Americans die from liver cancer or chronic liver disease associated with viral hepatitis. Despite this, viral hepatitis is not well known. In fact, as many as 75 percent of the millions of Americans with chronic viral hepatitis don't know they're infected. Please join CMS in support of the Centers for Disease Control and Prevention's "Know More Hepatitis" national education initiative aimed to decrease the burden of chronic viral hepatitis by increasing awareness about this hidden epidemic and encouraging people who may be chronically infected to get tested.

Medicare provides coverage of the hepatitis B vaccine and its administration for certain individuals at high or intermediate risk.

Increased provider knowledge has been shown to improve delivery of preventive services, including those for viral hepatitis. By educating yourself on this hidden epidemic, you can help save lives and decrease this epidemic's burden. As a health care provider for people with Medicare, discuss with eligible patients who may be at high or intermediate risk, whether the hepatitis B vaccine is appropriate.

CMS *Medicare Learning Network*® (*MLN*®) Resources for Health Care Professionals:

- *The Guide to Medicare Preventive Services, Fourth Edition, Chapter 5*
- *The Preventive Immunizations Brochure*
- *Quick Reference Information: Medicare Immunizations Billing Chart*
- *Preventive Services Educational Products*

Source: CMS PERL 201205-45

Update to the MLN® Provider Compliance Web page

A new fast fact is now available on the *MLN® Provider Compliance* Web page. This Web page provides the latest *Medicare Learning Network*® products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities. Previous fast facts can now be viewed on the *MLN Provider Compliance Fast Fact Archive* page. Please bookmark this page and check back often as a new fast fact is added each month.

Source: CMS PERL 201205-46

Other Educational Resources

Provider education video presentations available on the CMS YouTube channel

The Centers for Medicare & Medicaid Services (CMS) has posted a selection of provider education presentations on a variety of Medicare topics to the *CMS YouTube channel*, including the following presentations listed below. Click on the title to view the presentation.

Medicare Shared Savings Program

- *Medicare Shared Savings Program and Advance Payment Model Application Process* – this presentation was presented on March 1, 2012. CMS subject matter experts provide an overview and updates to the Medicare Shared Savings Program application and Advance Payment Model application processes, followed by a question and answer session. **Run time**: 59 minutes.
- *Medicare Shared Savings Program Overview* – This presentation was presented on December 7, 2011. John Pilotte, Director of the Performance-Based Payment Policy Group at CMS presents an overview of the Medicare Shared Savings Program, followed by a question and answer session. **Run time**: 50 minutes.

Hospital value-based purchasing

- *Hospital Value-based Purchasing: Dry Run of the FY 2013 Hospital VBP Program* – This presentation was presented on February 28, 2012. CMS subject matter experts provide an overview and updates on the hospital value-based purchasing program for fiscal year 2013 and how hospitals will be evaluated. A question and answer session follows the presentations. **Run time**: 90 minutes.
- *Medicare Spending Per Beneficiary Measure* – This presentation was presented on February 9, 2012. CMS subject matter experts provide an overview on the background of the Medicare spending per beneficiary measure, as well as an explanation of how the measure is calculated, including the approach to risk adjustment and payment standardization. **Run time**: 84 minutes.

Physician Quality Reporting System and Electronic Prescribing Incentive Program

- *Welcome to the Electronic Prescribing eRx Incentive Program* – This presentation was recorded on March 28, 2012. CMS subject matter experts provide an overview of the Medicare Electronic Prescribing (eRx) Incentive Program. Highlights include a brief program background, a look at the program website and documentation, high-level steps on how to get started; available resources and who to contact for help. **Run time**: 16 minutes.
- *Welcome to the Physician Quality Reporting System* – This presentation was recorded on February 1, 2012. CMS subject matter experts provide an overview of the Medicare Physician Quality Reporting System. Highlights include a brief background of the program, a look at the program website and documentation, high-level steps to get you started, available resources and who to contact for help. **Run time**: 15 minutes.

Medicare physician feedback program

- *Medicare Physician Feedback Program: Payment Standardization and Risk Adjustment* – This presentation was presented on December 21, 2011. CMS subject matter experts discuss how and why per capita cost measures are adjusted under the Physician Feedback Program and in the Quality and Resource Use Reports. This call provided an opportunity to: (1) have a public dialogue about our methodology, (2) obtain stakeholder input, and (3) discuss ways to further improve these cost adjustment processes. **Run time**: 118 minutes.

Skilled Nursing Facility Prospective Payment System

- *Skilled Nursing Facility Prospective Payment System Minimum Data Set 3.0 and Resource Utilization Group-Version 4 Policies and Clarifications* – This presentation was presented on November 11, 2011. CMS subject matter experts provide a brief overview of the policies, along with clarifications on the SNF PPS FY2012 policies related to the MDS 3.0. A question and answer session follows the presentations. **Run time**: 83 minutes.

For a full list of available video presentations, please visit the *CMS National Provider Calls website*.

Source: CMS PERL 201205-54

Slides and comments from the WEDI-CMS industry collaboration and problem solving webinar have been posted

The workgroup for electronic data interchange (WEDI) and the Centers for Medicare & Medicaid Services (CMS) recently hosted a webinar on industry collaboration and problem solving for version 5010. Officials from CMS, WEDI, and other industry partners discussed and highlighted efforts to resolve ASC X12 5010 implementation issues. If you were unable to attend the webinar, you can watch a *replay* of the webinar with the slides presented online.

WEDI is also pleased to present the new ASC X12 implementation reporting system, which is available at *WEDI online*. This resource can help covered entities with their compliance efforts.

CMS, WEDI, and other industry partners are planning future webinars and will post the dates once they have been confirmed. You can post your issues and concerns related to *ASC X12 5010 implementation online*, and these may be used to inform an upcoming webinar.

Keep up to date on version 5010 and ICD-10

Please visit *CMS' ICD-10 page* to learn about the latest news and resources that will help you prepare. You may also download and share the *ICD-10 implementation widget*.

Source: CMS PERL 201205-03

Video and podcasts from March 1 provider call on the Medicare shared savings program and advance payment model application process

The Centers for Medicare & Medicaid Services (CMS) has released a YouTube video slideshow presentation and podcasts from the March 1, 2012, Medicare shared savings program and advance payment model application process national provider call.

YouTube video slideshow presentation

The call presentation is now available on the *CMS YouTube Channel* as a video slideshow that includes the call audio.

Podcasts

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are now available on the *National Provider Calls and Events March 1, 2012* detail page.

- **Podcast 1 of 3**: Medicare shared savings program application process
- **Podcast 2 of 3**: Advance payment model application process
- **Podcast 3 of 3**: Question and answer session

Select the links above to view the video slideshow presentation and listen to the podcasts, or visit the *National Provider Calls and Events March 1, 2012* detail page for access to all of the related call materials, including the slide presentation, full audio recording, and written transcripts.

Source: CMS PERL 201205-26

Audio recording and written transcript from March 28 national provider call on the IPPE/AWV now available

The audio recording and written transcript from the March 28 Medicare preventive services national provider call on the initial preventive physical exam (IPPE) and the annual wellness visit (AWV) are now available on the *March 28 national provider calls and events detail page* in the "Presentation Materials" section.

Source: CMS PERL 201204-49

Mail directory

Claims submissions

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

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

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

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

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

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

Communication

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

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

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

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

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

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

Durable medical equipment (DME)

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

Electronic media claims (EMC)

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

Additional development

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

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

Miscellaneous

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

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

Provider education

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

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

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

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

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

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

Phone numbers

Providers

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

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

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

U.S. Virgin Islands Contact Information

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

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

Medicare claims for railroad retirees

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

Fraud and abuse

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

Local coverage determinations

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

Post pay medical review

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

Overnight mail and/or other special courier services

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

Medicare websites

Provider

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

Centers for Medicare & Medicaid Services

www.cms.gov

Beneficiaries

Centers for Medicare & Medicaid Services
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Phone numbers

Provider customer service

1-866-454-9007

Interactive voice response (IVR)

1-877-847-4992

Email address:
AskFloridaB@fcso.com

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Beneficiary customer service

1-800-MEDICARE
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Education event registration

1-904-791-8103

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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.

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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		
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Medicare B Connection

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

Attention Billing Manager