Medicare B CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers July 2012

In this issue

Announcing ground-breaking public-private partnership to prevent health care fraud

On July 26, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and Attorney General Eric Holder announced the launch of a ground-breaking partnership among the federal government, state officials, several leading private health insurance organizations, and other health care anti-fraud groups to prevent health care fraud. This voluntary, collaborative arrangement uniting public and private organizations is the next step in the Obama administration's efforts to combat health care fraud and safeguard health care dollars to better protect taxpayers and consumers.

The new partnership is designed to share information and best practices in order to improve detection and prevent payment of fraudulent health care billings. Its goal is to reveal and halt scams that cut across a number of public and private payers. The partnership will enable those on the front lines of industry anti-fraud efforts to share their insights more easily with investigators, prosecutors, policymakers, and other stakeholders. It will help law enforcement officials to more effectively identify and prevent suspicious activities, better protect patients' confidential information and use the full range of tools and authorities provided by the Affordable Care Act and other essential statutes to combat and prosecute illegal actions.

One innovative objective of the partnership is to share information on specific schemes, utilized billing codes, and geographical fraud hotspots so that action can be taken to prevent losses to both government and private health plans before they occur. Another potential goal of the partnership is the ability to spot and stop payments billed to different insurers for care delivered to the same patient on the same day in two different cities. A potential long-range goal of the partnership is to use sophisticated technology and analytics on industry-wide health care data to predict and detect health care fraud schemes.

The Executive Board, the Data Analysis and Review Committee, and the Information Sharing Committee will hold their first meeting in September. Until then, several public-private working groups will continue to meet to finalize the operational structure of the partnership and develop its draft initial work plan.

(continued on Page 25)

Register for free, hands-on Internet-based PECOS class

Join First Coast Service Options, in Jacksonville on September 11, for the **last** free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment.

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.

The importance of correct place-of-service coding on Medicare Part B claims

Provider types affected

This *MLN Matters*® special edition article is intended for physicians and their billing agents who submit claims to Medicare carriers or Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to remind providers that accurate place of service (POS) coding on claims is essential to avoid improper payments. Make sure that your billing staffs are aware of this article and the need to correctly code the POS on your Medicare claims.

Background

The Medicare Part B Program pays for physician services provided to beneficiaries. Physicians may

perform these services in a facility setting, such as a hospital outpatient department or freestanding ambulatory surgical center (ASC), or in a non-facility setting such as a physician's office, urgent care center, or independent clinic. To account for the increased overhead expenses physicians incur by performing these services in non-facility locations, Medicare reimburses physicians based on a fee schedule that may pay a higher rate for individual services provided in these locations. When physicians perform these services in facility settings, such as hospital outpatient departments or ASCs, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate.

Physicians are required to identify the POS on the health insurance claim forms that they submit to Medicare contractors. The correct POS code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the payment if the service was performed in a facility setting.

The Office of Inspector General (OIG) conducted an audit in 2009 that followed up on a similar audit from a 2007 report. The 2009 audit covered 494,129 non-facility-coded physician services valued at $42,245,142. These services were provided in calendar year 2009 and matched hospital outpatient or ASC claims for the same type of service provided to the same beneficiary on the same day.

The OIG conducted the 2009 audit to determine whether physicians correctly coded non-facility POS on selected part B claims submitted to and paid by Medicare contractors. The audit report, titled *Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009* is available at *http://oig.hhs.gov/oas/reports/region10/11000516.pdf*.

Results of recent OIG audit

Physicians correctly coded the claims for 17 of the 100 services that the OIG sampled. However, physicians incorrectly coded the claims for 83 sampled services by using non-facility POS codes for services that were actually performed in hospital outpatient departments or ASCs.

Based on the sample results, OIG estimated that nationally, **Medicare contractors overpaid physicians $9.5 million** for incorrectly coded services provided during calendar year 2009. These overpayments may be due to internal control weaknesses at the physician billing level. They may also be attributed to insufficient post-payment reviews at the Medicare contractor level to identify potential POS coding errors.

As a result, Strategic Health Solutions, a CMS contractor, performed a specialty medical review study on POS coding for physician services. This study concluded that the most common finding was documentation submitted indicated that the service was incorrectly coded as a non-facility POS. In addition, a number of providers acknowledged that the claim was coded incorrectly upon receipt of the documentation, or had already initiated the adjustment process.

Additional information

For an overview of POS coding and a list of the appropriate codes, visit *https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html*.

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

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

New waived tests

Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare contractors (carriers and A/B Medicare administrative contractors [MACs]) for services to Medicare beneficiaries.

Provider action needed

Stop – Impact to you

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

Caution – what you need to know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the Centers for Medicare & Medicaid Services (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 7868, from which this article is taken, informs carriers and MACs about the latest new *CPT* codes that are subject to CLIA edits.

Go – what you need to do

Make sure that your billing staffs are aware of these CLIA-related changes for 2012 and that you remain current with certification requirements.

Background

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

CPT code	Effective date	Description
G0434QW	March 14, 2012	Wondfo oxycodone urine test (dip card format)
G0434QW	March 14, 2012	Wondfo oxycodone urine test (cup format)
87880QW	March 23, 2012	McKesson strep A test-dipstick
87880QW	March 23, 2012	McKesson strep A test-twist
86318QW	April 3, 2012	McKesson H. pylori test (whole blood)
87804QW	April 20, 2012	Sofia analyzer and influenza A+B FIA (for user with nasal swabs and nasopharyngeal swabs)
85610QW	May 8, 2012	AlereINRatio® 2 PT/INR home monitoring system (prescription home use)
83986QW	May 8, 2012	Dale Medical Products, Inc. RightLevel pH
83986QW	May 8, 2012	Dale Medical Products, Inc. RightSpot pH
G0434QW	May 22, 2012	Chemtron Biotech, Inc. Chemtrue single/multi-panel drug screen cassette tests
G0434QW	May 22, 2012	Chemtron Biotech, Inc. Chemtrue single/multi-panel drug screen dip card tests

Additional information

The official instruction, CR 7868, 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/R2496CP.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: MM7868
Related Change Request (CR) #: CR 7868
Related CR Release Date: July 20, 2012
Effective Date: October 1, 2012
Related CR Transmittal #: R2496CP
Implementation Date: October 1, 2012

Drugs and Biologicals

Billing and coverage for drug wastage

First Coast Service Options Inc. (FCSO) will consider payment for unused and discarded portion of a single-use drug/biological product after administration of the appropriate (reasonable and necessary) dosage for the patient's condition. This applies to drugs priced through the average sales price (ASP) drug/biological program. The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals and other providers to provide injectable drug therapy incident to a physician's services in a fashion that maximizes efficiency of therapy in a clinically appropriate manner. If a physician, hospital, or other provider must discard the unused portion of a single-use vial or other single-use package after administering a dose/quantity appropriate to the clinical context for a Medicare beneficiary, the program provides payment for the entire portion of drug or biological indicated on the vial or package label.

If less than a complete vial is administered at the time of service, and the unused portion is discarded, drug wastage must be documented in the patient's medical record with the date, time, and quantity wasted. Upon review, any discrepancy between amount administered to the patient and the billed amount will be denied, unless wastage is clearly documented. The amount billed as "wastage" must not be administered to another patient or billed again to Medicare. *All procedures for drug storage, reconstitution and administration should conform to applicable Federal Drug Administration (FDA) guidelines and provider scope of practice.*

J0490 Benlysta® (belimumab)

Benlysta® (belimumab) is indicated for the treatment of adult patients with active, autoantibody-positive, systemic lupus erythematosus (SLE) who are receiving standard therapy. Benlysta® was approved by the Food and Drug Administration (FDA) March 9, 2011.

Benlysta® is supplied as a sterile, preservative-free lyophilized powder for reconstitution, dilution, and intravenous infusion provided in single-use glass vials with a latex-free rubber stopper and a flip-off seal. Each 5-mL vial contains 120 mg of belimumab. Each 20-mL vial contains 400 mg of belimumab. As approved by the FDA, the recommended dosage regimen for belimumab is 10 mg/kg at 2-week intervals for the first 3 doses and at 4-week intervals thereafter.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document and support the diagnosis of systemic lupus erythematosus, using the appropriate ICD-9-CM code 710.0, as well as the FDA label related to the appropriate administration of this drug.

J9315 Istodax® (romidepsin)

Istodax® (romidepsin) is a histone deacetylase (HDAC) inhibitor indicated for treatment of cutaneous T-cell lymphoma (CTCL) in patients who have received at least one prior systemic therapy or treatment of peripheral T-cell lymphoma (PTCL) in patients who have received at least one prior therapy. Istodax® was approved by the Food and Drug Administration (FDA) for CTCL on November 05, 2009, and for PTCL on June 16, 2011.

Istodax® is supplied as a kit which includes a sterile, lyophilized powder in a single-use vial containing 10 mg of romidepsin and 20 mg of the bulking agent, povidone, USP. In addition, each kit includes 1 sterile vial containing 2 mL (deliverable volume) of the Diluent composed of 80% propylene glycol, USP, and 20% dehydrated alcohol, USP. As approved by the FDA, the recommended dose of romidepsin is 14 mg/m administered intravenously over a 4-hour period on days 1, 8, and 15 of a 28-day cycle. Cycles should be repeated every 28 days provided that the patient continues to benefit from and tolerates the drug.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician's service or in the hospital setting. The medical record must clearly document the patient's prior therapy and support the diagnosis of either cutaneous T-cell lymphoma or peripheral T-cell lymphoma, using the appropriate ICD-9-CM diagnosis code of 202.10--202.28 or 202.60-202.88 (Other malignant neoplasm's of lymphoid and histiocytic tissue) and FDA guidance for use as well as the administration.

J9999/C9399 Elelyso™ (taliglucerase alfa)

Elelyso™ (taliglucerase alfa) for injection is a hydrolytic lysosomal glucocerebroside-specific enzyme indicated for long-term enzyme replacement therapy (ERT) for adults with a confirmed diagnosis of Type 1 Gaucher disease. Elelyso™ was approved by the Food and Drug Administration (FDA) on May 1, 2012.

Elelyso™ (taliglucerase alfa) is available as a lyophilized powder 200 unit single- use vial. As approved by the FDA, the recommended dose is 60 Units/kg administered every other week as a 60-120 minute intravenous infusion.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient's history and physical, prior treatment regimen and Type 1 Gaucher-disease related progression. The patient's medical record must also support the diagnosis of Type 1 Gaucher disease using the appropriate ICD-9-CM code of 272.7 (Lipidoses) and FDA guidance for use as well as the administration.

J9999/C9399 Kyprolis™ (carfilzomib)

Kyprolis™ (carfilzomib) for injection, a proteasome inhibitor, is approved for the treatment of patients with multiple myeloma who have received at least two prior therapies, including bortezomib and an immunomodulatory agent, and have demonstrated disease progression on or within 60 days of completion of the last therapy. Kyprolis™ was approved by the Food and Drug Administration (FDA) on July 20, 2012.

Kyprolis™ (carfilzomib) for injection is supplied as an individually cartoned single-use vial containing a dose of 60mg of carfilzomib as a white to off-white lyophilized cake or powder. Kyprolis™ is administered intravenously over two to ten minutes, on two consecutive days, each week for three weeks (days 1, 2, 8, 9, 15, and 16), followed by a 12-day rest period (days 17 through 28). Each 28-day period is considered one treatment cycle. As approved by the FDA, the recommended Cycle 1 dose is 20 mg/m². If tolerated in Cycle 1, the dose should be escalated to 27 mg/m ² beginning in Cycle 2 and continued at 27 mg/m² in subsequent cycles.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient's prior chemotherapy regimens, disease progression and body surface area. The patient's medical record must also support the diagnosis of multiple myeloma, using the appropriate ICD-9-CM code(s) of 203.00 (Multiple myeloma, without mention of having achieved remission/failed remission) or 203.02 (Mutliple Myeloma, in relapse) and FDA guidance for use as well as the administration.

J9999/C9399 Perjeta™ (pertuzumab)

Perjeta™ (pertuzumab) is a HER2/neu receptor antagonist indicated in combination with trastuzumab and docetaxel for the treatment of patients with HER2-positive metastatic breast cancer who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease. Perjeta™ was approved by the Food and Drug Administration (FDA) on June 8, 2012.

Perjeta™ is supplied as a 420mg/mL (30mg/mL) single-use vial containing preservative free solutions. As approved by the FDA, the recommended initial dosage regimen for pertuzumab is 840mg administered as a 60-minute intravenous infusion, followed every three weeks thereafter by a dose of 420 mg administered as an intravenous infusion over 30 to 60 minutes.

When administered with Perjeta™, the recommended initial dose of trastuzumab is 8 mg/kg administered as a 90-minute intravenous infusion, followed every three weeks thereafter by a dose of 6 mg/kg administered as an intravenous infusion over 30 to 90 minutes.

When administered with Perjeta™, the recommended initial dose of docetaxel is 75 mg/ḿ administered as an intravenous infusion. The dose may be escalated to 100 mg/ḿ administered every three weeks if the initial dose is well tolerated.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly document the patient has HER2-positive metastatic breast cancer and which chemotherapy agent(s) is being used in combination with pertuzumab. The patient's medical record must also support the diagnosis of metastatic breast cancer, using the appropriate ICD-9-CM code(s) of 174.0-174.9 (Malignant neoplasm of female breast) or 175.0-175.9 (Malignant neoplasm of male breast) and FDA guidance for use as well as the administration.

Durable Medical Equipment

Get ready for DMEPOS competitive bidding

The Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program round 1 recompete is coming soon.

Summer 2012:

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

Fall 2012:

- Bidding begins

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

- Update your contact information: The following contact information in your enrollment file at the national supplier clearinghouse (NSC) must be up-to-date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. If you want to bid, you will need to register even if you registered for a previous round. DMEPOS suppliers should review and update:
  - The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and
  - The correspondence address.

DMEPOS suppliers can update their enrollment file via the Internet-based provider enrollment, chain and ownership system (PECOS) or by using the July 11, 2011, version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the *PECOS website* or reviewing the *PECOS fact sheet*. Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found in the *"Change of Information Guide"* on the NSC website.

- **Get licensed**: Contracts are only awarded to suppliers that have all required state licenses at the time of bidding. Therefore, if you are bidding for a product category in a competitive bidding area (CBA), you must ensure that all required state licenses for that product category are either on file with the NSC or received by the NSC by the close of bidding. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. Make sure that current versions of all required licenses are with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, your bid(s) may be rejected.
- **Get accredited**: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited for all items in the product category.

More information about the DMEPOS accreditation requirements may be found on the *CMS website*.

The competitive bidding implementation contractor (CBIC) is the official information source for bidders. Stay informed – visit the *CBIC website* to subscribe to email updates and for the latest information about the DMEPOS competitive bidding program.

Source: CMS PERL 201207-50

Medicare Physician Fee Schedule Database

Proposed rule would increase payment to family physicians

On July 6, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would increase payments to family physicians by approximately seven percent and other practitioners providing primary care services between three and five percent. The increase in payment to family practitioners is part of the proposed rule that would update payment policies and rates under the Medicare physician fee schedule (MPFS) for calendar year (CY) 2013. Under the MPFS, Medicare pays more than one million physicians and non-physician practitioners that provide vital health services to Medicare beneficiaries.

The seven percent increase for family physicians comes from a proposal that continues the administration's policies to promote high-quality, patient-centered care. For CY 2013, CMS is proposing for the first time to explicitly pay for the care required to help a patient transition back to the community following a discharge from a hospital or nursing facility. The proposals calls for CMS to make a separate payment to a patient's community physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. The proposed rule also asks for public comment on how Medicare can better recognize the range of services community physicians and practitioners provide as part of treating patients either through face-to-face services in the office or coordinating care outside the office when the patient does not see the physician.

As has been the case every year since CY 2002, CMS projects a significant reduction in MPFS payment rates under the sustainable growth rate (SGR) methodology due to the expiration of the adjustment made for CY 2012 in the statute. For CY 2013, CMS projects a reduction of 27 percent and is required by law to include this reduction in these calculations. However, Congress has acted to avert the cuts every year since 2003. The administration is committed to fixing the SGR formula in a fiscally-responsible way.

The proposed rule would also continue the careful implementation of the physician value-based payment modifier (value modifier) that was included in the Affordable Care Act by providing choices to physicians regarding how to participate. The value modifier adjusts payments to individual physicians or groups of physicians based on the quality of care furnished to Medicare beneficiaries compared to costs. The law allows CMS to phase in the value modifier over three years from CY 2015 to CY 2017. For the CY 2015 physician payment rates, the proposed rule would apply the value modifier to all groups of physician with 25 or more eligible professionals. The proposed rule also provides an option for these groups to choose how the value modifier would be calculated based on whether they participate in the Physician Quality Reporting System (PQRS). For groups of 25 or more that do not participate in the PQRS, CMS is proposing to set their value modifier at a 1.0 percent payment reduction. For groups that wish to have their payment adjusted according to their performance on the value modifier, the rule proposes a system whereby groups with higher quality and lower costs would be paid more, and groups with lower quality and higher costs would be paid less. The performance period for the CY 2015 value modifier was established as CY 2013 in the MPFS final rule for CY 2012.

The proposed rule continues efforts by CMS to align quality reporting across programs to reduce burden and complexity. The proposed rule proposes changes to two quality reporting programs that are associated with the MPFS – the PQRS and the Electronic Prescribing (eRx) Incentive Program – as well as the Medicare Electronic Health Records (EHR) Incentive Pilot Program which promotes the use of health information technology. The PQRS proposal includes simplified, lower burden options for reporting and the proposed rule aligns quality reporting across the various programs in support of the national quality strategy. The proposed rule also addresses the next phase in a plan to enhance the Physician Compare Website to foster transparency and public reporting of certain information to give beneficiaries more information for purposes of choosing a physician.

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Proposed *(continued)*

The proposed rule also includes proposals for the following:

- Include additional Medicare-covered preventive services on the list of services that can be provided via an interactive telecommunications system
- Implement a durable medical equipment (DME) face-to-face requirement as a condition of payment for certain high-cost Medicare DME items
- Apply a multiple procedure payment reduction (MPPR) policy to the technical component of the second and subsequent cardiovascular and ophthalmology diagnostic services furnished by the same doctor to the same patient on the same day
- Collect data on patient function to improve how Medicare pays for physical and occupational therapy, and speech language pathology services
- A request for public comments on payment for advanced diagnostic molecular pathology services
- Revise a regulation that only allows Medicare to pay for portable X-rays ordered by an MD or DO. The revised regulations would allow Medicare to pay for portable X-ray services ordered physicians and non-physician practitioners acting within the scope of their Medicare benefit and state law
- Clarify when Medicare will pay for interventional pain management services provided by certified Registered nurse anesthetists (CRNAs) when permitted by state law. This proposal will foster access to pain management services in areas where states have determined that CRNAs may provide these services.

The proposed rule will appear in the July 30, 2012, *Federal Register*. CMS will accept comments on the proposed rule until September 4, 2012, and will respond to them in a final rule with comment period to be issued by November 1, 2012.

For more information:

- *Proposed rule*
- *Fact sheet*

Full text of this excerpted *CMS press release* (issued July 6).

Source: CMS PERL 201207-12

FAQs from March 28 call on the initial preventive physical exam and annual wellness visit now available

The Centers for Medicare & Medicaid Services (CMS) has posted *frequently asked questions* (FAQs) from the March 28, 2012, Medicare preventive services national provider call on the initial preventive physical exam and the annual wellness visit.

Visit the *national provider calls and events March 28, 2012*, Web page for access to all of the related call materials including the YouTube video slideshow presentation, podcasts, call presentation, audio recording, and written transcripts.

Source: CMS PERL 201207-16

Pulmonary Services

Pulmonary rehabilitation services

Note: This article was revised July 10 and July 16, 2012, to add clarifying language, as contained in CR 6823, to show that the covered benefit for the comprehensive PR program is for patients with moderate to very severe COPD. All other information is the same. This information was previously published in the *June 2010 Medicare B Update!, Pages 22-24*.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs) and/or carriers) for pulmonary rehabilitation (PR) services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6823 which alerts providers that the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added payment and coverage improvements for patients with chronic obstructive pulmonary disease (COPD) and other conditions effective January 1, 2010. As a result, Medicare provides a covered benefit for a comprehensive PR program **for patients with moderate to very severe COPD** under Medicare Part B effective for services on or after January 1, 2010. Be certain your billing staffs are aware of these Medicare changes and of the claims processing system changes to handle claims for PR services that must be implemented no later than October 4, 2010.

Background

PR is a multi-disciplinary program of care for patients with chronic respiratory impairment who are symptomatic and often have decreased daily life activities. A PR program is individually tailored and designed to optimize physical and social performance and autonomy. The program must provide an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory impairment. In September 2007, the Centers for Medicare & Medicaid Services (CMS), in its final decision memorandum for PR Services, announced there was no basis for a national coverage determination at that time. Specifically, this decision was based on a determination by CMS that the Social Security Act did not expressly define a comprehensive PR program as a Part B benefit, and the evidence was not adequate to draw conclusions on the benefit of the individual components of PR. CMS did (and still does) cover medically reasonable and necessary respiratory treatment services in comprehensive outpatient rehabilitation facilities (CORFs), as well services to patients with respiratory impairments who are not eligible for PR but for whom local contractors determine respiratory treatment services are covered. MIPPA added payment and coverage improvements for patients with COPD and other conditions, and now provides a covered benefit for a comprehensive PR program for patients with moderate to very severe COPD under Medicare Part B effective January 1, 2010. This law authorizes a PR program, which was codified in the physician fee schedule calendar year 2010 final rule at 42 CFR 410.47.

Key points of CR 6823

Effective January 1, 2010, MIPPA provisions added a physician-supervised, comprehensive PR program for patients with **moderate to very severe COPD**. Medicare will pay for up to two (2) one-hour sessions per day, for up to 36 lifetime sessions (in some cases, up to 72 lifetime sessions) of PR. The PR program must include the following mandatory components:

(continued on next page)

Pulmonary *(continued)*

1. Physician-prescribed exercise
2. Education or training
3. Psychosocial assessment
4. Outcomes assessment
5. An individualized treatment plan

The following bullet points detail Medicare claim processing requirements for PR services furnished on or after January 1, 2010:

- Effective January 1, 2010, Medicare contractors will pay claims containing Healthcare Common procedure Coding System (HCPCS) code G0424 when billing for PR services, including exercise and monitoring, as described in the *Medicare Benefit Policy Manual*, Chapter 15, Section 231, as revised by CR 6823, and the *Medicare Claims Processing Manual*, Chapter 32, Section 140, as revised by CR 6823. These revised documents are attached to CR 6823, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R124BP.pdf* (*Benefit Policy Manual*) and *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1966CP.pdf* (*Claims Processing Manual*).
- Medicare contractors will pay claims for HCPCS code G0424 (PR) only when services are provided in the following places of service (POS): 11 (physician's office) or 22 (hospital outpatient). Medicare will deny claims for HCPCS code G0424 performed in other than, and billed without, POS 11 or 22, using the following:
  - Claim adjustment reason code (CARC) 58 – "treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - Remittance advice remark code (RARC) N428 – "Service/procedure not covered when performed in this place of service."
  - Group code PR (patient responsibility) assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed advance beneficiary notice (ABN) is on file or group code CO (contractual obligation) assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare contractors will pay claims for PR services containing HCPCS code G0424 and revenue code 0948 on types of bill (TOB) 13x and 85x under reasonable cost.
- Contractors will pay for PR services for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission on an outpatient basis, TOB 13x, in accordance with the terms of the Maryland waiver.
- Contractors will deny claims for PR services provided in other than TOB 13x and 85x using the following:
  - CARC 58 – "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

    Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
  - RARC N428 – "Service/procedure not covered when performed in this place of service."
  - Group code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Using the Medicare physician fee schedule, Medicare contractors will also pay for PR services billed with HCPCS code G0424 and revenue code 096x, 097x, or 098x on TOB 85x from method II critical access hospitals (CAHs).
- Medicare will deny PR services that exceed two units on the same date of service and, in doing so, will use the following:
  - CARC 119 – "Benefit maximum for this time period or occurrence has been reached."
  - RARC N362 – "The number of days or units of service exceeds our acceptable maximum."
  - Group code PR assigning financial liability to the patient if the claim was received with a GA modifier

(continued on next page)

Pulmonary *(continued)*

indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

- Medicare will normally pay for 36 sessions of PR, but may pay up to 72 sessions when the claim(s) for sessions 37-72 includes a KX modifier. Claims for HCPCS code G0424 which exceed 36 sessions without the KX modifier will be denied using the following:
  - CARC 151 – "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."
  - Group code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.
- Medicare contractors will deny claims for HCPCS code G0424 when submitted for more than 72 sessions even where the KX modifier is present. In the denials, contractors will use the following:
  - CARC B5 – "Coverage/program guidelines were not met or were exceeded."
  - Group code PR assigning financial liability to the patient if the claim was received with a GA modifier indicating a signed ABN is on file or group code CO assigning financial liability to the provider if the claim is received with the GZ modifier indicating no signed ABN on file.

Additional information

If you have questions, please contact your Medicare MAC, FI, or carrier 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*.

CR 6823 was issued to your Medicare MAC, FI, or carrier in two transmittals. One transmittal modifies the *Medicare Benefit Policy Manual* and that transmittal is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R124BP.pdf*. The second transmittal modifies the *Medicare Claims Processing Manual* and that transmittal is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1966CP.pdf*.

For related detailed policy and claims processing instructions issued December 11, 2009, you may review MM6751 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6751.pdf*.

MLN Matters® Number: MM6823 *Revised*
Related Change Request (CR) #: 6823
Related CR Release Date: May 7, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R124BP and R1966CP
Implementation Date: October 4, 2010

FAQs related to the three-day payment window policy

The Centers for Medicare & Medicaid Services (CMS) has posted *43 new frequently asked questions* (FAQs) related to *MLN Matters*® article *MM7502*, "Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatient: 3-Day payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Offices."

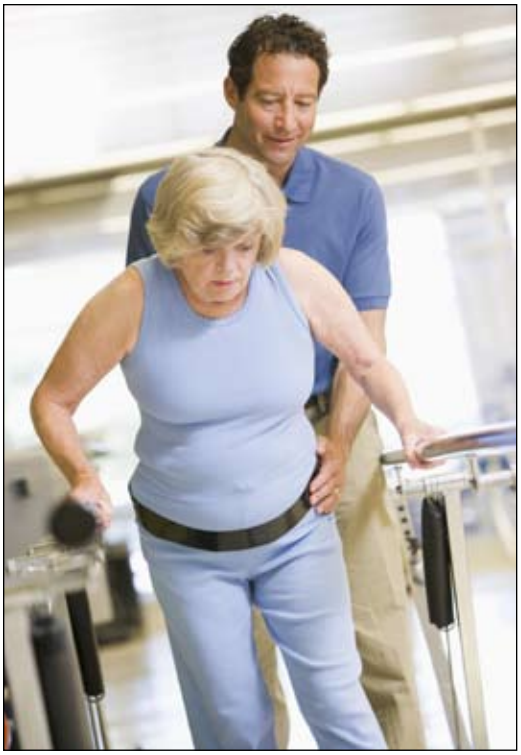
The new FAQs for the three-day (or one-day) payment window policy as it pertains to physician practices are located in the "Downloads" section of the CMS *physician fee schedule* Web page and the *Hospital PPS* Web page.

Source: CMS PERL 201207-19

Therapy Services

Proposed rule issued for claims-based data collection strategy for therapy services

The Centers for Medicare & Medicaid Services (CMS) issued proposed rule CMS-1590-P July 6 that includes a proposal to collect data on patient function related to physical and occupational therapy, and speech language pathology services. Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) requires CMS to implement, beginning January 1, 2013, ". . . a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of Section 1833(g) of the Act. Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes."



The proposed rule will appear in the July 30, 2012, *Federal Register*. **CMS will accept comments on the proposed rule until September 4, 2012**, and will respond to them in a final rule with comment period to be issued by November 1, 2012.

Source: CMS PERL 201207-29

CMS releases CBR on outpatient physical therapy services with the KX modifier

Released July 20

On July 20, the Centers for Medicare & Medicaid Services (CMS) released a national provider comparative billing report (CBR) addressing outpatient physical therapy services with the KX modifier.

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 outpatient physical therapy services with the KX modifier 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 201207-18

Surgery

Appropriate use of assistant at surgery modifiers and payment indicators – clarification

First Coast Service Options Inc. (FCSO) published a detailed article titled *"Appropriate use of assistant as surgery modifiers and payment indicators" on page 19 of the Medicare B Connection*, which clearly articulated Medicare's coverage requirements related to assistant at surgery services billed under the Medicare physician fee schedule.

FCSO is the Medicare administrative contractor (MAC) for jurisdiction 9 (J9). Some providers in J9 are billing "assistant at surgery" services to Medicare Part B, but the services do not meet Medicare's coverage requirements.

It appears that some providers are billing the services of surgical assistants (e.g., certified first assistants, registered nurse surgical assistants, surgical technologists) under the performing provider number of the surgeon performing the surgical procedure as if "incident to" provisions applied to the service. These services are being billed with an 80 modifier, which indicates the assistant at surgery services were rendered by an assistant surgeon.

As noted in *Current Procedural Terminology*® (*CPT*®) and as outlined in the aforementioned article, modifiers 80, 81, and 82 may only be appended to the claim if assistant at surgery services were performed by a physician (surgeon). Modifier AS must be used if assistant at surgery services were rendered by a Medicare covered non-physician provider type, which includes physician assistants (PA), nurse practitioners (NP), nurse midwife, or clinical nurse specialists (CNS). Assistant at surgery services rendered by "covered" non-physician practitioners (NPP) billed with the AS modifier receive the appropriate non-physician payment reduction. These services must be billed under the NPP's Medicare performing provider number, as physician "incident to" provisions do not apply in the facility setting.

In summary, Medicare Part B reimbursement for an assistant at surgery is only appropriate when the procedure is covered for an assistant at surgery and one of the following situations exists:

- The person performing the assistant at surgery service is a physician, or
- The person performing the assistant at surgery service is enrolled in Medicare as a physician assistant (PA), nurse practitioner (NP), nurse midwife, or clinical nurse specialist (CNS).

Assistant at surgery services rendered by a surgical technician, a first surgical assistant, scrub nurse, or any person bearing a title other than physician, PA, NP, CNS, or nurse midwife are not payable by Medicare Part B and is not billable to the patient. Billing the services of a non-covered assistant at surgery under the surgeon's performing provider number is an inappropriate application of the "incident to" guidelines, and any services billed in this manner represents an overpayment to the provider and must be refunded to the Medicare program.

References:
Social Security Act
Code of Federal Regulations
Internet-only (IOM) Manuals:
Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, Sections 10-20; Chapter 15, Section 60
Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 12, Sections *20.4.3*, *110.1*, *110.3* and *120.1*
NHIC's statement on assistant at surgery services: *Modifier billing guide October 2010*
Trailblazer's statement on assistant at surgery services: *Non-physician practitioners*

Extracorporeal photopheresis

Note: This article was revised on July 11, 2012, to reflect the revised change request (CR) 7806 issued on July 10. The CR release date, transmittal number, and the Web address for accessing CR 7806 were revised. All other information is the same. This information was previously published in the June 2012 *Medicare B Connection*, Pages 20-22.

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for providing extracorporeal photopheresis procedures for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation.

Provider action needed

Effective for claims with dates of service on and after April 30, 2012, Medicare will cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation, but only when provided under an approved clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. You should make sure that your billing staffs are aware of the expanded coverage provided in this NCD.

Background

Extracorporeal photopheresis is a second-line treatment for a variety of oncological and autoimmune disorders that is performed in the hospital inpatient, hospital outpatient, and critical access hospital (CAH) settings. In the procedure, some of a patient's removed white blood cells are exposed first to the drug 8-methoxypsoralen (8-MOP) and then to ultraviolet A (UVA) light. After UVA light exposure, the treated white blood cells are re-infused into the patient, stimulating their immune system in a series of cascading reactions. This activation of the immune system then impacts the illness being treated.

Currently, Medicare covers extracorporeal photopheresis for the following indications:

- Palliative treatment of skin manifestations of CTCL that has not responded to other therapy;
- Patients with acute cardiac allograft rejection whose disease is refractory to standard immunosuppressive drug treatment; and
- Patients with chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

On August 4, 2011, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request for a reconsideration to add coverage for extracorporeal photopheresis treatment for patients who have received lung allografts and then developed progressive BOS refractory to immunosuppressive drug treatment.

As a result of the reconsideration, effective for claims with dates of service on and after April 30, 2012, Medicare will begin to cover extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation; but only when provided under a clinical research study that meets specific requirements to assess its effect in the treatment of BOS following lung allograft transplantation.

NCD clinical research study requirements

This is a national coverage determination (NCD). In keeping with this NCD, any clinical research study that includes Medicare coverage of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation must be approved by meeting the requirements listed below. Additionally, consistent with section 1142 of the Social Security Act, AHRQ supports clinical research studies that CMS determines meet these standards and address the research questions.

An approved clinical research study:

1. Must address one or more aspects of the following question:

Prospectively, do Medicare beneficiaries who have received lung allografts, developed BOS refractory to standard immunosuppressive therapy, and received extracorporeal photopheresis, experience improved patient-centered health outcomes as indicated by:

a) Improved forced expiratory volume in one second (FEV1);

b) Improved survival after transplant; and/or

(continued on next page)

Photopheresis *(continued)*

c) Improved quality of life?

2. Must adhere to the following standards of scientific integrity and relevance to the Medicare population:

a) Its principal purpose is to test whether extracorporeal photopheresis potentially improves the participants' health outcomes;

b) It is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

c) It does not unjustifiably duplicate existing studies;

d) Its design is appropriate to answer the research question being asked in the study;

e) It is sponsored by an organization or individual capable of successfully executing the proposed study;

f) It is in compliance with all applicable federal regulations concerning the protection of human subjects found at 45 *Code of Federal Regulations* CFR Part 46. If a study is regulated by the Food and Drug Administration (FDA), it must also be in compliance with 21 CFR parts 50 and 56;

g) All of its aspects are conducted according to appropriate standards of scientific integrity (see *http://www.icmje.org*);

h) It has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for coverage with evidence development (CED) coverage;

i) It is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR Section 312.81(a) and the patient has no other viable treatment options;

j) It is registered on the ClinicalTrials.gov website (*http://clinicaltrials.gov*) by the principal sponsor/investigator prior to the enrollment of the first study subject;

k) Its protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (*http://www.icmje.org*).

l) It explicitly discusses subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations on the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary

m) Its study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability or Medicaid eligibility.

Note: Any clinical study in which there is coverage of extracorporeal photopheresis for this indication under this NCD must be approved by April 30, 2014 (two years from the effective date of this NCD). If there are no approved clinical studies by this date, this NCD will expire and coverage of extracorporeal photopheresis for BOS will revert to the coverage policy in effect prior to the issuance of its Final Decision Memorandum (DM) on April 30, 2012.

Billing requirements

Effective for claims with dates of service on and after April 30, 2012, your carrier, FI, or A/B MAC will accept and pay for hospital outpatient and physician claims containing Healthcare Common Procedure Coding System (HCPCS) procedure code *36522* along with one of the International Classification of Diseases (ICD-9-CM or ICD-10) diagnosis codes displayed in the following table.

ICD 9 CM	ICD 9 CM Description	ICD-10	ICD-10 Description
491.20	Obstructive chronic bronchitis without exacerbation	J44.9	Chronic obstructive pulmonary disease, unspecified

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Photopheresis *(continued)*

ICD 9 CM	ICD 9 CM Description	ICD-10	ICD-10 Description
491.21	Obstructive chronic bronchitis with (acute) exacerbation	J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
491.9	Unspecified chronic bronchitis	J42	Unspecified chronic bronchitis
496	Chronic airway obstruction, not elsewhere classified	J44.9	Chronic obstructive pulmonary disease, unspecified
996.84	Complications of transplanted lung	T86.810	Lung transplant rejection
996.84	Complications of transplanted lung	T86.811	Lung transplant failure
996.84	Complications of transplanted lung	T86.812	Lung transplant infection (not recommended for ECP coverage)
996.84	Complications of transplanted lung	T86.818	Other complications of lung transplant
996.84	Complications of transplanted lung	T86.819	Unspecified complication of lung transplant
V70.7	Examination of participant in clinical trial	Z00.6	Encounter for examination for normal comparison and control in clinical research program (needed for CED)

Please note that your claims will only be paid when they also contain all of the following:

- Diagnosis code V70.7 (as secondary diagnosis);
- Condition code 30 (institutional claims only);
- Clinical trial modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved research study); and
- Value code D4 with an 8-digit clinical trial number (optional)(FIs only).

Additionally, should your Medicare contractor return your claims as unprocessable because they are missing: 1) Diagnosis code V70.7 (as secondary diagnosis), 2) Condition code 30 (Institutional claims only), 3) Clinical trial modifier Q0 (Institutional claims only), and 4) Value code D4 with an 8-digit clinical trial number (optional) (FIs only); they will use the following messages:

- CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC MA 130 – 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.
- RARC M16 – Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

Please keep in mind that your contractor will not retroactively adjust claims from April 30, 2012, processed prior to implementation of CR 7806. However, they may adjust claims that you bring to their attention.

Additional information

The official instruction, CR 7806, was issued in two transmittals. The first updates to the *Medicare National Coverage Determinations Manual* are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R143NCD.pdf*. The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2494CP.pdf*.

MLN Matters® Number: MM7806 *Revised*
Related Change Request (CR) #: CR 7806
Related CR Release Date: July 10, 2012
Effective Date: April 30, 2012
Related CR Transmittal #: R143NCD and R2494CP
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.

General Coverage

How to prepare for documentation changes and improvements with ICD-10

Although the final rule on the proposed ICD-10 deadline change has not been published yet, it is important to continue planning for the transition. ICD-10 will require an increased granularity and specificity in documentation of patient encounters. This change will mean that providers and payers need to adjust how they document patient visits but will create more detailed data that can be used to improve patient care. More specific code sets can also assist providers avoid delays in reimbursement payments by identifying why certain claims are being rejected or denied by payers.

You will need to prepare for these changes in clinical documentation by taking certain steps:

1. **Inventory systems and identify discrepancies**: You should review your systems that currently use ICD-9 in order to identify areas in your revenue cycle, reimbursement rates, health information management, electronic medical records, and clinical systems that will eventually use ICD-10. These systems will be affected by the increased specificity of documentation, as well as the increase in number of codes used in ICD-10. Your systems inventory will need to evaluate any potential gaps in clinical conditions or work flow processes that could be affected by increased documentation. Once you have identified any discrepancies, you can update and modify your systems and processes prior to transitioning to the new code sets. This will save your organization time by finding incomplete or non-specific data and ensuring that they do not cause a delay with coding and billing when you finalize implementing ICD-10.

> Providers and payers need to adjust how they document patient visits.

2. **Evaluate current software systems**: As you conduct your systems inventory, you may realize that some of your systems have become out-of-date or are redundant. You will need to determine if it is more cost-effective and efficient to upgrade these systems or centralize and replace them before ICD-10 implementation.
3. **Train and educate staff**: Your organization should identify staff members, from providers to coders, who currently use ICD-9 codes. Staff who will now be using ICD-10 will need training to become familiar with the increased documentation standards necessary with the new code sets. Training will help staff members become comfortable with both the heightened specificity and increased number of code sets that they will be using frequently.
4. **Test the documentation process**: Finally, your organization will need to test each stage of the new documentation process in a trial setting. Staff members should simulate a typical patient encounter in its entirety to ensure that data is being documented thoroughly and consistently. This will also help identify any areas that still require improvement in the coding process.

Keep up to date on ICD-10:

Please visit the *ICD-10* website for the latest news and resources to help you prepare.

Source: CMS PERL 201207-62

Steps to assess how the ICD-10 transition will affect your organization

Although the final rule on the proposed ICD-10 deadline change has yet to be published, it is important to continue planning for the transition to ICD-10. The switch to the new code set will affect every aspect of how your organization provides care, from registration and referrals, to software/hardware upgrades and clinical documentation.

A critical step in planning for the transition is to conduct an impact assessment of how the new code sets will affect your organization. Your impact assessment should include the following:

- **Documentation changes**
  - You will need to consider the increased specificity of ICD-10 codes compared to ICD-9 codes, and ensure that patient encounters are documented with appropriately comprehensive clinical descriptions. You should:

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Assess *(continued)*

- Train staff to accommodate the substantial increase and specificity in code sets
- Consider physician workflow and patient volume changes
- Revise forms, documents, and encounter forms to reflect ICD-10 codes
- Evaluate processes for ordering and reporting lab/diagnostic services to health plans

- **Reimbursement structures**
  - You should coordinate with payers on contract negotiations and new policies that reflect the expanded code sets, since they can affect reimbursement schedules.
- **Systems and vendor contracts**
  - Ensure your vendors can accommodate your ICD-10 needs. Find out how and when your vendor plans to update your existing systems. You will need to review existing and new vendor contracts and to evaluate vendor offerings and capabilities against your organization's expectations. Work with your vendors to draft a schedule for needed tasks.
- **Business practices**
  - Once you have implemented ICD-10, you will need to determine how the new codes affect your processes for referrals, authorizations/pre-certifications, patient intake, physician orders, and patient encounters.
- **Testing**
  - Work with your vendors to determine the amount of time needed for testing and schedule accordingly.
  - ICD-10 will affect nearly all areas of your practice, but with a thorough impact assessment, you can keep your day-to-day activities running smoothly while you transition to ICD-10.

Keep up to date on ICD-10

Please visit the *ICD-10 website* for the latest news and resources to help you prepare.

Source: CMS PERL 201207-45

2013 ICD-10-CM codes and mapping files are now available

The 2013 ICD-10-CM codes and mapping files are now posted on the *2013 ICD-10-CM and GEMs* Web page. The files contain information on the new diagnosis coding system, ICD-10-CM, that is being developed as a replacement for ICD-9-CM, volumes 1 and 2. This posting includes the following 2013 files:

- Tabular and index of ICD-10-CM
- Addenda (changes since the 2012 version)
- Complete list of ICD-10-CM code titles – long and abbreviated
- General equivalence mappings
- Reimbursement mappings
- Duplicate ICD-9-CM and ICD-10-CM codes

As a reminder, the Centers for Medicare & Medicaid Services (CMS) recently posted the 2013 ICD-10-PCS files to the *2013 ICD-10-PCS and GEMs* Web page. CMS also posted the ICD-10 Medicare code editor v 29 (MCE v29 to be used with v29 definitions manual) on the *ICD-10 MS-DRG conversion project* Web page, along with additional files for the ICD-10 MS-DRG conversion project.

Source: CMS PERL 201207-63

Medicare automatically converting format 4010A1 ERA (835) to X12 version 5010

Effective August 1, if you have not yet converted from the 4010A1 format of the electronic remittance advice, the Medicare fee-for-service program is automatically converting your electronic remittance advice to the X12 version 5010 format. If the computer software you use to open/translate the electronic remittance advice X12 version 5010 format is not ready for this conversion, you may not be able to open and read the electronic remittance advice to review payments, adjustments, and denials, as well as post payments to patient accounts.

If you use a vendor, clearinghouse, or billing service for receipt of your electronic remittance advice and your computer software is unable to open/translate the electronic remittance advice X12 version 5010 format, please contact your vendor, clearinghouse, or billing service before contacting your Medicare contractor.

Providers should be advised that any billing staff or representatives that make inquiries related to Medicare payment on his/her behalf will need a copy of the remittance advice.

Before contacting your Medicare contractor

Any issue with opening/translating the electronic remittance advice X12 version 5010 format should be addressed with your vendor, clearinghouse, or billing service (if you use one of these entities for receipt of the electronic remittance advice).

Source: CMS PERL 201207-73

Transition to version 5010 for the remittance advice (835)

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare fee-for-service (FFS) released the following updates for the week of July 23, 2012:

Transition to version 5010 for the remittance advice (835)

Providers were encouraged to test with Medicare and transition to version 5010 for remittance advice. The new version 5010 introduced some significant improvements over the current version ASC X12 version 4010; e.g., in version 5010, the Health Policy Segment reports the national coverage determinations (NCDs) and local coverage determinations (LCDs). In addition, the 835 also have the website where the specific LCD/NCD code is explained. Providers have access to the code as well as the code description. The 5010 version of the 835 also contains technical contact information not currently in version 4010. Version 5010 contains new segments such as coverage expiration date and claim received date which helps provider's access important information without manual intervention.

Remittance advice closeout activities (835)

Beginning August 1, the Medicare FFS program produced only the 835 remittance advice transaction in the ASC X12 version 5010. Medicare FFS stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last Accredited Standards Committee (ASC) X12 version 4010A1 835 data on July 31. Remittance advice files from the last processing cycle became available for retrieval upon conclusion of the July 31 batch cycle.

More information

For more information on ASCX12 version 5010 and NCPDP version D.0, please visit the *versions 5010 and D.0 website*.

Source: CMS PERL 201207-59

Latest version of MREP for Medicare fee-for-service professional providers and suppliers

The latest claim adjustment reason codes and remittance advice remark codes are available in the Codes.ini file for the Medicare Remit Easy Print (MREP) software. You can access this file in the zipped folder for "Medicare Remit Easy Print - Version 3.2.4" on the *MREP* Web page of the CMS website.

Source: CMS PERL 201207-48

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

Note: This article was revised July 25, 2012, to reflect a revised change request (CR) 7499 issued on July 19, 2012. The article was also revised July 2, 2012, to reflect a revised CR 7499 issued on June 28, 2012. The article was revised to show a financial control number in PLB 03-2 of the remittance advice. The article was revised to show a revised transmittal number, CR release date, and Web address for accessing CR 7499. All other information is the same. This information was previously published in the May 2012 *Medicare B Connection*, Page 26.

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], durable medical equipment 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 claim processing system 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 health insurance claim (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. (DME ERAs (835's) will show a financial control number in positions 1-14 of PLB 03-2 and the adjustment claim control number in positions 15-29 of PLB 03-2.)

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/R1101OTN.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: July 19, 2012
Effective Date: January 1, 2012
Related CR Transmittal #: R1101OTN
Implementation Date: January 3, 2012 for professional claims billed to carriers or B MACs; April 2, 2012 for institutional claims billed to Fiscal intermediaries or A MACs; October 1, 2012 for supplier claims submitted to DME MACs

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

Medicare FFS version 5010 implementation update for the week of July 16

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare fee-for-service (FFS) has the following updates for the week of July 16:

- Why transition to Accredited Standards Committee (ASC) X12 version 5010 (5010) remittance advice (835)?
- Remittance advice (835) closeout activities

Why transition to version 5010 for the remittance advice (835)?

Providers are encouraged to test with Medicare and transition to version 5010 for remittance advice now. The new version 5010 introduces some significant improvements over the current version ASC X12 version 4010; e.g., in version 5010, the health policy segment will report the national coverage determinations (NCDs) and local coverage determinations (LCDs). In addition, the 835 also will have the website where the specific LCD/NCD code is explained. Providers will have access to the code as well as the code description. The 5010 version of the 835 also will contain technical contact information not currently in version 4010. Version 5010 contains new segments such as coverage expiration date and claim received date which will help provider's access important information without manual intervention.

If you haven't already finished testing, please contact your Medicare contractor and begin testing so that you are ready on or before August 1, 2012. If you have already finished testing, contact your Medicare contractor and start receiving the version 5010 835s now.

Remittance advice closeout activities (835)

Beginning August 1, 2012, the Medicare FFS program shall produce only the 835 remittance advice transaction in the ASC X12 version 5010. Medicare FFS has stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last ASC X12 version 4010A1 835 data on July 31, 2012. Remittance advice files from the last processing cycle will be available for retrieval upon conclusion of the July 31, 2012, batch cycle.

More information

For more information on ASCX12 version 5010 and NCPDP version D.0, please visit the *versions 5010 and D.0* website.

Source: CMS PERL 201207-38

Implementation of the paperwork segment rescheduled to October 1

The Centers for Medicare & Medicaid Services (CMS) is rescheduling the implementation date of the paperwork (PWK) segment within the 5010 837 professional and institutional electronic transactions to October 1, 2012. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. The PWK was originally due to be implemented on April 1, 2012, but was delayed in order to address system concerns. For additional information, please refer to *MLN Matters*® articles *MM7041* and *MM7306*.

Source: CMS PERL 201207-10

Medicare FFS version 5010 implementation update for the week of July 9

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare fee-for-service (FFS) has the following updates for the week of July 9, 2012:

- Business partner confirmation for version 5010
- Claims (837) rejection error messages
- Remittance advice (835) closeout activities

Business partner confirmation for version 5010

Have you confirmed your business partner has converted to version 5010 on your behalf? By now all providers should have contacted their clearinghouses, billing services, or vendors that they use to electronically submit Medicare FFS claims to ensure that as of July 1, 2012, all of your claims will be submitted in version 5010. Please contact your clearinghouse, billing service or vendor before calling your MAC's EDI helpdesk to search for your claims and confirm your transition to version 5010.

Claim (837 I and P) rejection error message

Since June 29, all Medicare FFS claims must be sent as ASC X12 version 5010 or NCPDP D.0. Any Medicare FFS claims received in version 4010 format after normal close of business on June 29 are being rejected back to the submitter. The specific message received if a claim is rejected depends on your specific MAC. A detailed list of 4010 rejection error messages by Medicare administrative contractor (MAC) may be found on *the Important 4010 - 5.1 Rejection Information* Web page.

Remittance advice (835)

Medicare FFS has stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last Accredited Standards Committee (ASC) X12 version 4010A1 835 data July 31, 2012. Remittance advice files from the last processing cycle will be available for retrieval upon conclusion of the July 31, 2012 batch cycle. Beginning August 1, 2012, the Medicare FFS program shall only produce the 835 remittance advice transaction in the ASC X12 version 5010.

More information

For more information on ASCX12 version 5010 and NCPDP version D.0, please visit the *versions 5010 and D.0* website.

Source: CMS PERL 201207-26

Medicare FFS version 5010 implementation update for the week of July 2

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare fee-for-service (FFS) has the following updates for the week of July 2:

- Business partner confirmation for version 5010
- Claims (837) rejection error messages
- Remittance advice (835) closeout activities

Business partner confirmation for version 5010

Have you confirmed that your business partner has converted to version 5010 on your behalf? By now all providers should have contacted their clearinghouses, billing services, or vendors that they use to electronically submit Medicare FFS claims to ensure that as of July 1 all of your claims will be submitted in version 5010. Please contact your clearinghouse, billing service, or vendor before calling your MAC's EDI help desk to search for your claims and confirm your transition to version 5010.

Claims (837) rejection error messages

Since June 29, all Medicare FFS claims must be sent as Accredited Standards Committee (ASC) X12 version 5010 or NCPDP D.0. Any Medicare FFS claims received in version 4010 format after normal close of business June 29 are being rejected back to the submitter. The specific message received if a claim is rejected depends on

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Action *(continued)*

your specific MAC. A detailed list of 4010 rejection error messages by MAC may be found on the *Important 4010 - 5.1 Rejection Information* Web page.

Remittance advice (835)

Medicare FFS has stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last ASC X12 version 4010A1 835 data July 31. Remittance advice files from the last processing cycle will be available for retrieval upon conclusion of the July 31 batch cycle. Beginning August 1, the Medicare FFS program shall only produce the 835 remittance advice transaction in the ASC X12 version 5010.

More information

For more information on ASCX12 version 5010 and NCPDP version D.0, please visit the *Versions 5010 and D.0* Web page.

Source: CMS PERL 201207-05

Learn the secrets to billing Medicare correctly

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

Fraud

Portable X-ray suppliers billing for transportation and set-up fees

Recently, Safeguard Services LLC, the Zone Program Integrity Contractor (ZPIC) for Florida has found that a large volume of Florida portable X-ray suppliers have submitted claims for HCPCS codes Q0092 (set up portable X-ray equipment), R0070 (transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen) and R0075 (transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility of location, more than one patient seen) that may be billed inappropriately. Analysis of claims data reveals that most suppliers are paid more for equipment set-up and transportation than for the actual X-ray service to be provided.

The Medicare guidelines for portable X-ray suppliers from the *Medicare Program Integrity Manual*, Chapter 10, state the following:

- As stated in Publication 100-07, Chapter 2, Section 2422, the "residence used as the patient's' home" can include a SNF or hospital that does not provide X-ray services for its patients and arranges for these services though a PXRS, such as a mobile unit. However the mobile unit can neither be fixed at any one location nor permanently located in a SNF or hospital.

The supplier must actually "transport" the equipment to be paid for the transportation service. In addition to the above noted policy, the *Medicare Claims Processing Manual*, Chapter 13, states the following:

- **90.3 – Transportation Component (HCPS Codes R0070-R0076) (Rev.343, issued: 10-29-04, Effective: 04-01-05, implementation: 04-04-05)**

  Carriers shall allow only a single transportation payment for each trip the portable X-ray supplier makes to a particular location. When more than one Medicare patient is X-rayed at the same location, e.g., a nursing home, prorate the single fee schedule transportation payment among all patients receiving the services. For example, if two patients at the same location receive X-rays, make one-half of the transportation payment for each. R0075 must be billed in conjunction with the CPT radiology codes (70000 series) and only when the X-ray equipment used was actually transported to the location where the X-ray was taken. R0075 should not apply to the X-ray equipment stored in the location where the X-ray was done (e.g., a nursing home) for use as needed. Note: No transportation charge is payable unless the portable X-ray equipment used was actually transported to the location where the X-ray was taken. For example, carriers do not allow a transportation charge when the X-ray equipment is stored in a nursing home for use as needed. However, a set- up payment (see 90.4) is payable in such situations. Further, for services furnished on or after January 1, 1997, carriers may not make separate payments under HCPCS code R0076 for the transportation of EKG equipment by portable X-ray suppliers or any other entity.

- **90.4 – Setup Component (HCPSC Code Q0092 (Rev.1,10-01-03)**

  Carriers must pay a set-up component for each radiological procedure (other than retakes of the same procedure) during both single patient and multiple patient trips under Level II HCPCS code Q0092. Carriers do not make the set-up equipment payment for EKG services furnished by the portable X-ray supplier.

Provider types affected

The article is for suppliers who submit claims to Medicare carriers, fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC) for the provisions of portable X-ray services.

Additional information

Please refer to the *Medicare Claims Processing Manual, Chapter 13 - Radiology Services and other Diagnostic Procedures* for further guidance.

Partnership *(continued)*

The partnership builds on existing tools provided by the Affordable Care Act, resulting in:

- Tougher sentences for people convicted of health care fraud. Criminals will receive 20 to 50 percent longer sentences for crimes that involve more than $1 million in losses;
- Enhanced screenings of Medicare and Medicaid providers and suppliers to keep fraudsters out of the program.
- Suspended payments to providers and suppliers engaged in suspected fraudulent activity.

The administration's efforts to date have already resulted in a record-breaking $10.7 billion in recoveries of health care fraud over the last three years. For more information on this partnership and the Obama administration's work to combat health care fraud, please visit the *Stop Medicare Fraud* Web page.

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

Source: CMS PERL 201207-75

Provider Enrollment

Act now to avoid claim denials for ordered/referred services

The Centers for Medicare & Medicaid Services (CMS) will soon begin denying Part B, durable medical equipment (DME), and Part A home health agency (HHA) claims that fail the ordering/referring provider edits. These edits ensure that physicians and others who order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60-day advanced notice prior to turning on the ordering/referring edits. CMS does not have a date at this time.

If you order or refer items or services for Medicare beneficiaries, or bill for these services, please read these CMS resources to be sure you are following Medicare requirements.

***MLN Matters*® articles:**

- *SE1221 Phase 2 of Ordering and Referring Requirement*
- *SE1011 Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims*

MLN® fact sheets:

- *"Medicare Enrollment Guidelines for Ordering/Referring Providers"*
- *"The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement"*

All providers may also confirm whether or not an eligible ordering or referring provider is enrolled in Medicare by reviewing the *ordering and referring file* on the CMS website.

Source: CMS PERL 201207-68

Home health agencies must use individual practitioner NPI to bill ordered and referred services

Regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (MACs) with home health workloads will be contacting home health agencies (HHAs) that submitted claims using both a group name and national provider identifier (NPI) as the attending NPI for ordered or referred services. The physician's name and NPI, not a group name and NPI, must be used as the attending name and NPI on the claim. Claims containing a group NPI will be denied after the Centers for Medicare & Medicaid Services (CMS) turns on the editing for ordering/referring services.

Please note: CMS recently sent a message to remind physicians to provide their individual NPI to HHAs upon request. Physicians may verify their individual NPI using the *NPI Registry*.

Source: CMS PERL 201207-53

Attention physicians who order/refer services for Medicare beneficiaries residing in home health agencies

When billing Medicare, home health agencies (HHAs) must use the individual national provider identifier (NPI) of the physician who orders/refers services, not the NPI of the physician's group practice. If an HHA asks for your NPI, be sure to provide your individual NPI.

Don't know your individual NPI? You may verify your NPI on the *NPI Registry*.

Source: CMS PERL 201207-20

Additional major improvements to the Internet-based PECOS system

Over the last year, the Centers for Medicare & Medicaid Services (CMS) has listened to your feedback about the *Internet-based Provider Enrollment Chain & Ownership System (PECOS)* and made improvements to increase access to more information. CMS is pleased to announce that the following upgrades are now available:

Access to more information

The layout of the Internet-based PECOS homepage and log-in screen has been redesigned. The homepage updates provide an easier way for users to register for a PECOS account and update personal information. It also features additional helpful links to allow access to multiple tools and reference information. The helpful links include PECOS enrollment tutorials, the ordering and referring list, and the revalidation notice sent list.

- Users will also now be able to see if their revalidation application has been received and processed by the Medicare administrative contractor (MAC). In addition to a "Revalidation Notice Sent" date, a "Revalidation Received" date and a "Revalidation Complete" date will be displayed on the My Enrollments page. The "Revalidation Notice Sent" date and the "revalidation received" date will display on the My Enrollment page for 120 days. The "Revalidation Complete" date will display on the My Enrollments page indefinitely. (At this time, the quickest way to see if a revalidation letter was mailed to you is to check the revalidation notice sent list link on the PECOS homepage. Later this year, a faster process will be used to update this information on the My Enrollments page.) **Note: Find out now** whether you have been sent a revalidation request by using First Coast Service Options' popular *enrollment status lookup*.
- A reassignment report is now available for all organizations and individuals that are accepting reassignments. The option to view this report is only available if the enrollment has current reassignments. The reassignment report is accessible via the application questionnaire page and displays the following columns:
  - Provider Name
  - National Provider Identifier (NPI)
  - Current Enrollment Status
  - Enrollment State
  - Revalidation Notice Sent Date
  - Revalidation Status

The report displays up to 50 records on the report screen. For reassignment reports containing more than 50 records, the authorized user will be prompted to download the report into an excel spreadsheet by clicking the "Generate Report" button at the bottom of the screen.

Source: CMS PERL 201207-06

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 201207-65

Revised fact sheet providing basic Part B enrollment information

The fact sheet titled *"The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers"* (ICN 903768) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on basic Medicare enrollment information and how to ensure physicians and other Part B suppliers are qualified and eligible to enroll in the Medicare program. It includes information on how to enroll in the Medicare program, how to report changes, and a list of resources.

Source: CMS PERL 201207-51

Medicare Learning Network® (MLN) educational products update

"The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" *MLN* fact sheet revised

The *"Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement"* fact sheet (ICN 006881) was revised and is now available in downloadable format. This fact sheet is designed to provide education on general Medicare enrollment information for those physicians who are required to enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries. It includes information on frequently asked questions and resources.

"Medicare Enrollment Guidelines for Ordering/Referring Providers" *MLN* fact sheet revised

The *"Medicare Enrollment Guidelines for Ordering/Referring Providers"* fact sheet (ICN 906223) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A home health agency, Part B, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) beneficiary services.

Source: CMS PERL 201206-59

Revised fact sheet for PECOS technical assistance

The *"Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information"* fact sheet (ICN 903766) has been revised and is now available in downloadable format. This fact sheet is designed to provide contact information for technical assistance with Internet-based Provider Enrollment, Chain and Ownership System (PECOS). It includes a list of contacts and other resources.

Source: CMS PERL 201207-32

'How to Protect Your Identify Using the Provider Enrollment, Chain and Ownership System (PECOS)' fact sheet – revised

The *"How to Protect Your Identify Using the Provider Enrollment, Chain and Ownership System (PECOS)"* fact sheet (ICN 905103) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on identity protection when using Internet-based PECOS. It includes step-by-step instructions on how providers can protect their identity while using Internet-based PECOS.

Source: CMS PERL 201207-51

Revised fact sheet designed to help protect your enrollment information

The *"Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record"* fact sheet (ICN905183) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how to ensure Medicare enrollment records are up-to-date and secure. It includes information on the actions physicians and non-physician practitioners should take to protect their Medicare enrollment information.

Source: CMS PERL 201207-32

Provider Enrollment, Chain and Ownership System fact sheet revised

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" fact sheet (ICN 903764) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how physician and non-physician practitioners should enroll in the Medicare Program and maintain their enrollment information using Internet-based PECOS. It includes information on how to complete an enrollment application using Internet-based PECOS and a list of frequently asked questions and resources.

Source: CMS PERL 201207-74

Incentive Programs

2012 Physician Quality Reporting System Program reminder

It is not too late to start participating in the 2012 Physician Quality Reporting System (PQRS) and potentially qualify to receive an incentive payment equal to 0.5 percent of an eligible professional's total Medicare Part B allowed charges for services furnished during the reporting period. A new six-month reporting period using the registry submission option began July 1. In addition, there are still ways to participate in the 12-month reporting period using claims, registry, or electronic health record (EHR) submission.

The 2012 PQRS has two reporting periods:

- 12-month (January 1-December 31, 2012)
- Six-month (July 1-December 31, 2012)

To report PQRS data for services furnished January 1–December 31, 2012:

- EHR-based reporting (direct EHR or data-submission vendor) of at least three PQRS measures for 80 percent or more of the applicable Medicare Part B fee-for-service (FFS) patients
- EHR-based reporting (alignment with Medicare EHR incentive program) of all three Medicare EHR incentive program core measures or up to three Medicare EHR incentive program alternate core measures and three additional measures for the Medicare EHR incentive program
- Registry-based reporting of at least three PQRS measures for 80 percent or more of the applicable Medicare Part B FFS patients
- Registry-based reporting of at least one measures group for 30 or more applicable Medicare Part B FFS patients
- Registry-based reporting of at least one measures group for 80 percent or more of applicable Medicare Part B FFS patients (with a minimum of 15 patients)
- Claims-based reporting of at least one measures group for 30 or more applicable Medicare Part B FFS patients

To report PQRS data for services furnished July 1-December 31, 2012, use the following option:

- Registry-based reporting of one measures group for 80 percent or more of applicable Medicare Part B FFS patients (with a minimum of eight patients)

Eligible professionals **do not need to sign up or pre-register** to participate in the 2012 PQRS. Submission of the appropriate quality-data codes (QDCs) for individual PQRS measures or for a measures group to the Centers for Medicare & Medicaid Services (CMS) on Part B claims will indicate intent to participate. Eligible professionals who intend to participate via registry or EHR mechanisms should work with their registry or EHR vendor on transmitting their 2012 PQRS measure data to CMS in early 2013.

Although there is no requirement to register prior to submitting the data, **there are some preparatory steps** that eligible professionals should take prior to undertaking PQRS reporting. CMS has created many educational products that provide information about how to get started with PQRS reporting. To access all available educational resources on PQRS please visit the *PQRS Web page*. Eligible professionals are encouraged to visit the *PQRS Web page* often for the latest information and downloads on PQRS.

Eligible professionals also should note that **2012 is the last reporting year tied exclusively to an incentive payment. Beginning in 2015, CMS will apply a negative payment adjustment** to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. Reporting during the 2013 PQRS program year will be used to determine whether a PQRS payment adjustment applies in 2015. The proposed criteria for satisfactorily reporting data on quality measures to avoid the 2015 PQRS payment adjustment is detailed in the *2013 Medicare physician fee schedule proposed rule*, which went on public display July 6, 2012.

(continued on next page)

Physician Quality Reporting System and eRx educational video presentations available

Need to have a basic understanding of the Physician Quality Reporting System and the electronic prescribing (eRx) incentive program or want to learn more in-depth information about PQRS and eRx? The following video slideshow presentations on Physician Quality Reporting System and the eRx incentive program are available to view on the CMS YouTube channel. Click on the title to view.

Welcome to the Physician Quality Reporting System

This presentation provides 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. Target audience: Medicare fee-for-service providers. **Run time**: 15 minutes.

Welcome to the electronic prescribing (eRx) incentive program

This presentation provides 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**: 17 minutes.

November 8, 2011, Physician Quality Reporting System & eRx national provider call

The Centers for Medicare & Medicaid Services (CMS) subject matter experts provide an overview of the Medicare physician fee schedule to address the 2012 Physician Quality Reporting System & eRx incentive program followed by a question and answer session. **Run time**: 84 minutes.

December 20, 2011, PQRS & eRx national provider call

CMS subject matter experts provide a brief overview on electronic health record (EHR) and registry-based reporting options that are available for eligible professionals participating or looking to participate in the Physician Quality Reporting System and/or eRx incentive program. A question and answer session follows the presentations. **Run time**: 80 minutes.

January 17, 2012, PQRS & eRx national provider call

CMS subject matter experts provide a brief overview on how the 2012 eRx payment adjustment will appear on the remittance advice, as well as an overview of the self-nomination process. A question and answer session follows the presentations. **Run time**: 88 minutes.

February 21, 2012, PQRS and eRx national provider call

CMS subject matter experts provide a brief overview on claims-based reporting for both the Physician Quality Reporting System and eRx incentive program. **Run time**: 30 minutes.

Please visit the *CMS National Provider Calls Video Presentations* Web page for a list of other video slideshow presentations currently available on a variety of Medicare topics.

Source: CMS PERL 201207-44

Reminder *(continued)*

Resources

- *2012 PQRS Implementation Guide and Measures List*
- *Phase I Qualified Registries for 2012 PQRS Reporting* (final list of 2012 qualified registries will be posted at the end of July 2012)
- *Phase I Qualified EHR Direct Vendors for 2012 PQRS Reporting* (final list of 2012 qualified EHR direct vendors and data submission vendors to be posted later this summer)
- *2013 Medicare Physician Fee Schedule Proposed Rule*

Source: CMS PERL 201207-64

Submit your CQM data for the Medicare EHR incentive program electronically

The Physician Quality Reporting System (PQRS) Medicare electronic health record (EHR) incentive pilot allows eligible professionals to meet the *clinical quality measure* (CQM) reporting objective of *meaningful use requirements* for the *EHR incentive program* through electronic submission while also reporting for the *PQRS program*.

A provider who wishes to participate in the electronic reporting pilot must submit 12 months of clinical quality measures data. Eligible professionals must submit the data between January 1, 2013, and February 28, 2013.

CQM data for the electronic reporting pilot must be derived from certified EHR technology. If you decide to submit the data directly from your EHR, your EHR also needs to be PQRS "qualified." You can also have a PQRS-qualified data submission vendor submit quality measures data for the electronic reporting pilot on your behalf.

A list of the 2012 PQRS-qualified EHR and data-submission vendors is posted on the *PQRS* website.

You can register for the electronic reporting pilot program while attesting for the EHR incentive program on the *online registration* page. Simply check "Yes" on the eReporting page as you go through the attestation process.

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 201207-61

CMS has added a new FAQ for EPs on using hospital EHR modules for meaningful use

The Centers for Medicare & Medicaid Services (CMS) wants to help keep you updated with information on the Medicare and Medicaid electronic health record (EHR) incentive programs. CMS has recently added a new frequently asked question (FAQ) that discusses the ability for eligible professionals (EPs) in the EHR incentive programs to use hospital EHR modules to achieve meaningful use. Take a minute and review the new FAQ below.

Question: Can an EP use EHR technology certified for an inpatient setting to meet a meaningful use objective and measure?

Answer: Yes. For objectives and measures where the capabilities and standards of EHR technology designed and certified for an inpatient setting are equivalent to or require more information than EHR technology designed and certified for an ambulatory setting, an EP can use the EHR technology designed and certified for an inpatient setting to meet an objective and measure. There are some EP objectives, however, that have no corollary on the inpatient side. As a result, an EP must possess certified EHR technology designed for an ambulatory setting for such objectives. Please reference ONC FAQ 12-10-021-1 and 9-10-017-2 and CMS FAQ 10162 for discussions on what it means to possess certified EHR technology, ONC FAQ 6-12-025-1 for a list of affected capabilities and standards, and how that relates to the exclusion and deferral options of meaningful use.

You can find this FAQ in the *CMS FAQ system* by searching for it by FAQ number. Type in 6421 in the "FAQ # Search" box found at the top, left side of the FAQ page. Choose the "FAQ #" option by clicking the circle and highlighting it in blue.

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 201207-01

Available EHR resources for EPs – register now for EHR incentive programs

The Centers for Medicare & Medicaid Services (CMS) has created a new comprehensive guide, *An Introduction to the Medicaid EHR Incentive Program for Eligible Professionals*, to help walk eligible professionals (EPs) through all of the phases of the Medicaid program. This guide includes chapters on:

- An overview of the Medicaid electronic health record (EHR) incentive program
- Eligibility determination
- Registration through CMS and eligibility verification at the state level
- Meaningful use and picking appropriate measures
- Attestation
- Helpful resources on the Medicaid EHR incentive programs

EPs can use this guide as their source for any information they need on the Medicaid EHR incentive program. The guide can be found on the *"Educational Materials"* section of the EHR website along with several other helpful tools and resources for participants in the Medicare and Medicaid EHR incentive programs, including the guide, *An Introduction to the Medicare EHR Incentive Program for Eligible Professionals*, that CMS previously created.

Register today to receive maximum incentives

CMS recommends that all EPs *register* as early as possible for the Medicare and Medicaid EHR incentive programs.

By registering early you can verify that your information is up to date in all of the CMS systems and resolve any issues so that you can participate in the EHR incentive programs. If you do not resolve registration problems in time, you will not be able to attest and could potentially miss out on a payment year. Registering does not mean you are required to participate – so register today.

This is the last year for Medicare EPs to start participating in the EHR incentive programs in order to receive their full Medicare incentive payments. For more information on registration in the EHR incentive programs, visit the *"Registration"* 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.

Source: CMS PERL 201207-47

Audio recording and written transcript from June 27 EHR call now available

The audio recording and written transcript from the June 27 Medicare & Medicaid Electronic Health Record (EHR) incentive programs and certified EHR technology national provider call are now available on the *June 27* call page in the "Presentation" section.

Source: CMS PERL 201207-41

General Information

HHS announces 89 new accountable care organizations

2.4 million People with Medicare to receive better and more coordinated care

On July 9, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, announced that as of July 1, 89 new accountable care organizations (ACOs) began serving 1.2 million People with Medicare in 40 states and Washington, D.C. ACOs are organizations formed by groups of doctors and other health care providers that have agreed to work together to coordinate care for people with Medicare.

These 89 new ACOs have entered into agreements with the Centers for Medicare & Medicaid Services (CMS), taking responsibility for the quality of care they provide to People with Medicare in return for the opportunity to share in savings realized through high-quality, well-coordinated care.

Participation in an ACO is purely voluntary for providers. The Medicare shared savings program (MSSP), and other initiatives related to ACOs, is made possible by the 2010 Affordable Care Act. Federal savings from this initiative could be up to $940 million over four years.

The 89 ACOs announced on July 9 bring the total number of organizations participating in Medicare shared savings initiatives to 154, including the 32 ACOs participating in the testing of the pioneer ACO model by CMS's Center for Medicare and Medicaid Innovation (Innovation Center) announced last December, and six physician group practice transition demonstration organizations that started in January 2011. In all, as of July 1, more than 2.4 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

The selected ACOs operate in a wide range of areas of the country and almost half are physician-driven organizations serving fewer than 10,000 beneficiaries, demonstrating that smaller organizations are interested in operating as ACOs. Their models for coordinating care and improving quality vary in response to the needs of the beneficiaries in the areas they are serving.

To ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe, and timely, an ACO must meet quality standards. For 2012, CMS has established 33 quality measures relating to care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care.

Beginning this year, new ACO applications will be accepted annually. The application period for organizations that wish to participate in the MSSP beginning in January 2013 is from August 1 through September 6, 2012. More information, including application requirements, is available on the *shared savings program application* Web page.

To learn more about the ACOs announced, see the fact sheet.

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

Source: CMS PERL 201207-31

New shared saving program FAQs posted to the CMS website

The Centers for Medicare & Medicaid Services (CMS) has posted new *Medicare Shared Savings Program Frequently Asked Questions (FAQs)* to the CMS shared savings program website. In response to questions from industry stakeholders, the FAQs have been updated to provide additional guidance to all Medicare shared savings program applicants and future applicants about the requirements under 42 CFR part 425 related to mergers and acquisitions. The new FAQs cover the following topic categories: general, Accountable Care Organization (ACO) participant list, form CMS-588 electronic funds transfer, and governing body. To learn more about the shared saving program, please visit the *CMS Shared Savings Program* website.

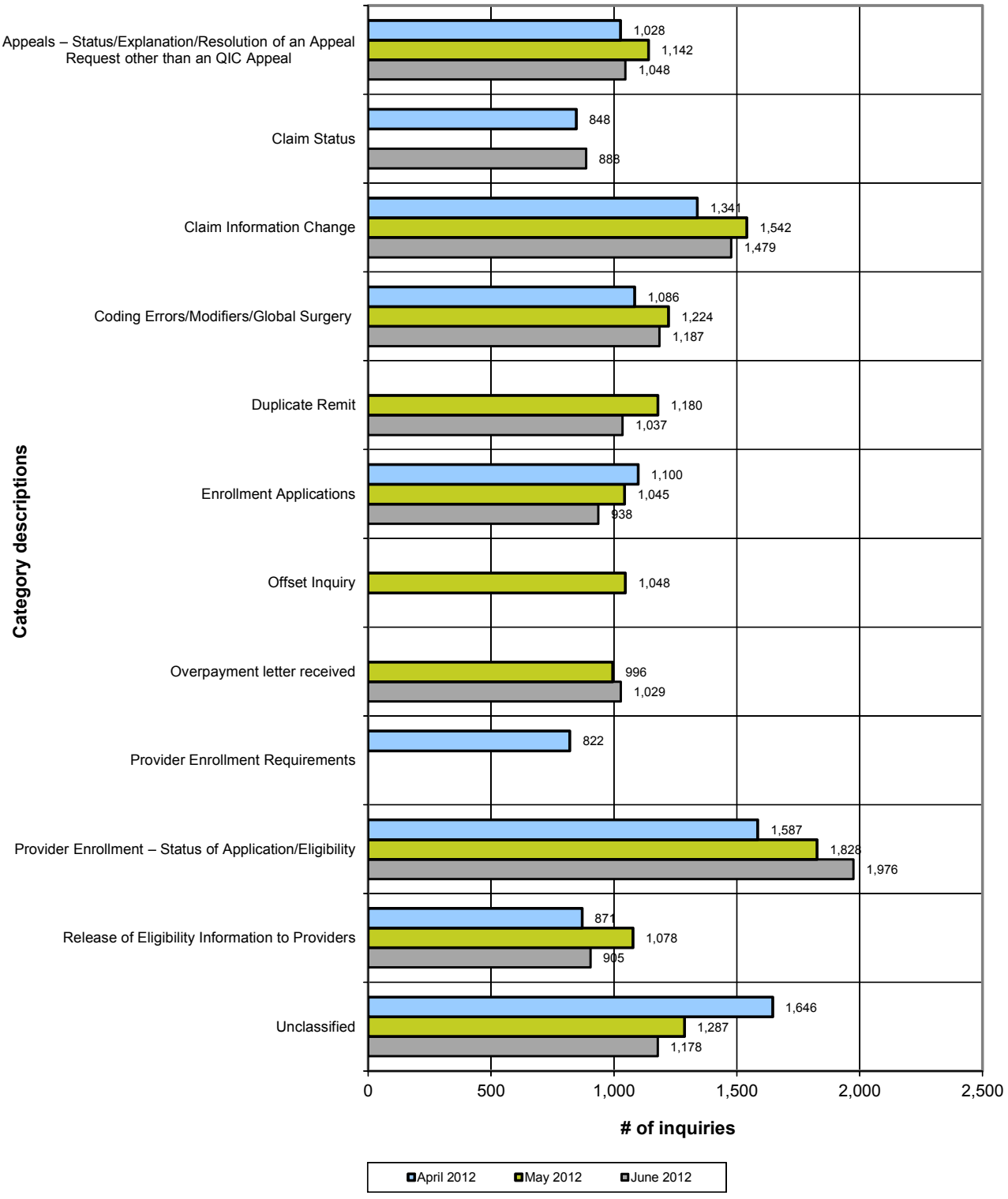
Source: CMS PERL 201207-70

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 April-June 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 April-June 2012



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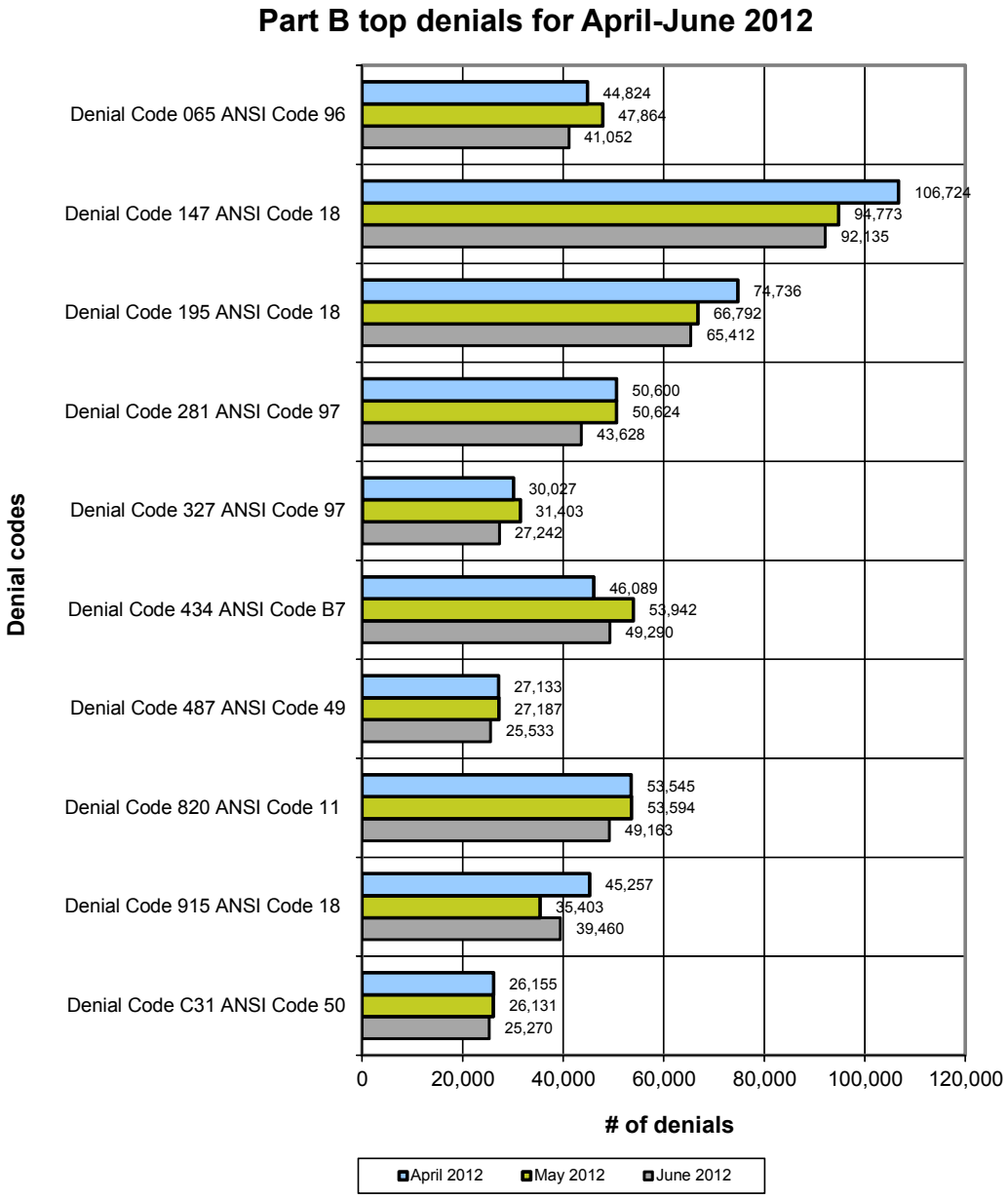
Top *(continued)*



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.

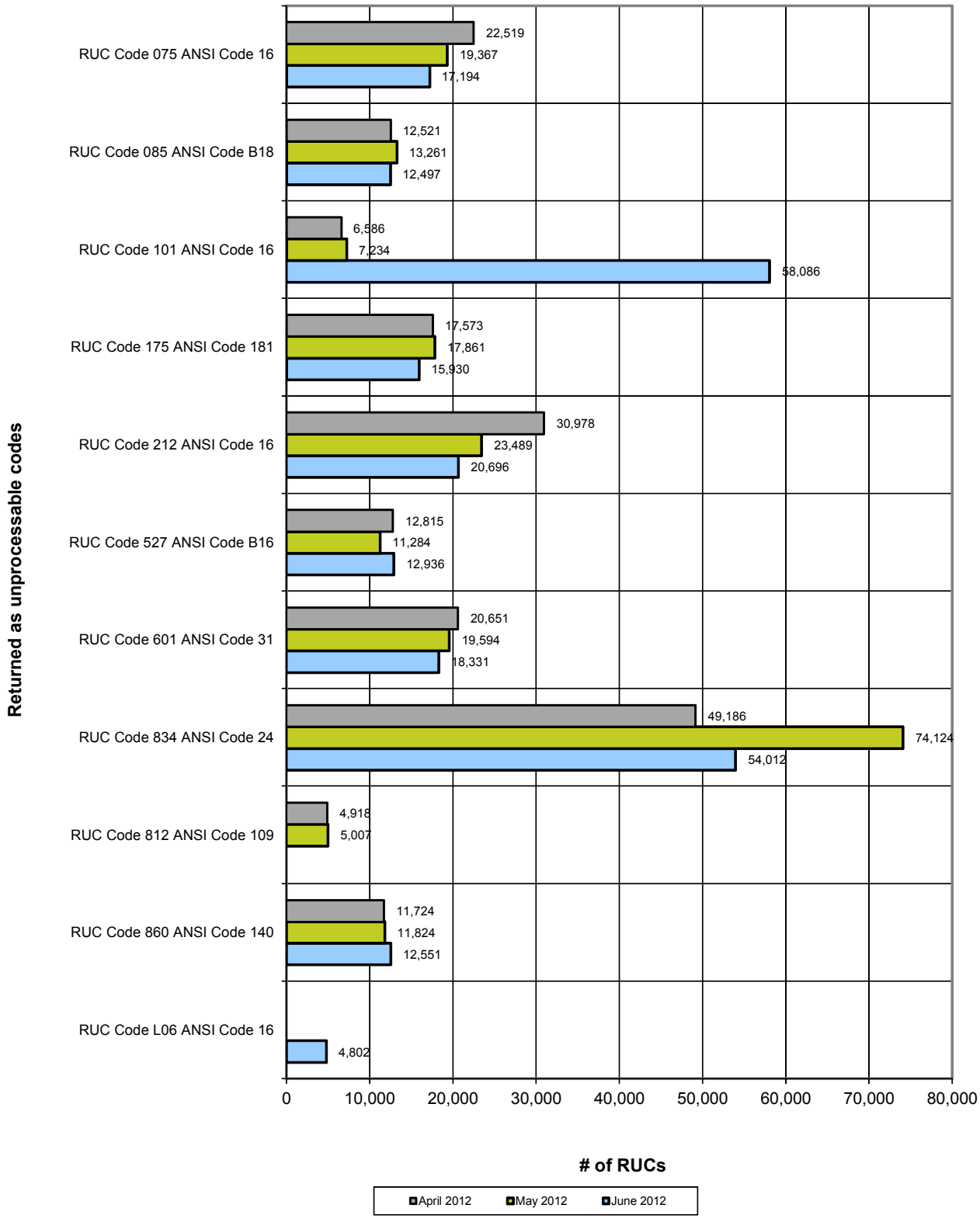
Ensure all information on a claim is correct before submitting to Medicare. Example: The date(s) of service (DOS) on the claim should correspond to the number of units/days being billed.

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 April-June 2012



Educational Events

Upcoming provider outreach and educational events August–September 2012

Evaluation and management: Find the code that fits the service

When: Wednesday, August 29
Time: 11:00 a.m.-1:00 p.m.
Type of event: Face-to-face

Medifest 2012 Jacksonville

When: Wednesday, September 12–Thursday, September 13
Time: 8:00 a.m.-5:00 p.m.
Type 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

Life-threatening outbreaks due to injection practices

On July 13, the Centers for Disease Control (CDC) released a *report* detailing two life-threatening outbreaks that occurred when healthcare providers used medication from single-dose/single-use vials for multiple patients undergoing treatment for pain. At least 10 patients contracted severe staph or methicillin-resistant Staphylococcus aureus (MRSA) infections and had to be hospitalized. An additional patient died, and although MRSA was not listed as the cause of death, it could not be ruled out.

These breaches of basic infection control practices are a stark reminder that CDC recommendations for injection safety must be followed closely with every patient, even during times of medication shortages. In circumstances when individually packaged and appropriately sized single-dose/single-use vials are unavailable (e.g., during national shortage) contents from unopened vials can be packaged into multiple single-use vehicles, provided that the repackaging is performed in accordance with all standards in United States Pharmacopeia General Chapter <797 >.

The CDC encourages clinicians to *double check their practices against CDC's Injection Safety Recommendations*. In addition, CDC offers healthcare providers a *toolkit* featuring a narrated PowerPoint presentation that is ideal for staff meetings, seminars, and other education opportunities.

Source: CMS PERL 201207-37

Raise blood pressure control and cardiovascular disease awareness – 'Million Hearts™' campaign

More than 68 million Americans are living with high blood pressure, and many of them don't know it. High blood pressure increases the risk for heart disease and stroke, leading causes of death in the U.S. The good news is that you can help fight against cardiovascular disease and the "silent killer," high blood pressure.

On September 13, 2011, the Department of Health and Human Services, with several key partners, launched the *"Million Hearts™"* initiative. The goal of this campaign is to prevent 1 million heart attacks and strokes over the next five years. "Million Hearts™" focuses on empowering Americans to make healthy choices and on improving care by addressing the major risk factors for cardiovascular disease. As a health care professional, you can help save thousands of lives over the next five years by participating in this critical campaign.

Medicare provides coverage for a variety of preventive services that can help your Medicare patients prevent and detect certain health conditions that can contribute to cardiovascular disease. These include, but are not limited to:

- Cardiovascular disease screening (total cholesterol, high-density lipoproteins, and triglycerides tests)
- Intensive behavioral therapy for cardiovascular disease
- Tobacco-use cessation counseling services
- Initial preventive physical exam (also commonly referred to as the "Welcome to Medicare" preventive visit)
- Annual wellness visit, providing a personalized prevention plan service
- Intensive behavioral therapy for obesity
- Diabetes screening

As you talk with your Medicare patients about their risk factors for cardiovascular disease, and the steps they can take to help lower and control their blood pressure and cholesterol, please discuss these important services with them and encourage utilization as appropriate.

Many people's lives are endangered by heart disease – utilization of these Medicare covered services can help save those lives.

Resources from the *Medicare Learning Network*® (*MLN*):

- *"Expanded Benefits" brochure*

(continued on next page)

Campaign *(continued)*

- *"Tobacco-Use Cessation Counseling Services" brochure*
- *"The ABCs of Providing the Initial Preventive Physical Examination (IPPE)," or "Welcome to Medicare Preventive Visit" quick reference chart*
- *"The ABCs of Providing the Annual Wellness Visit (AWV)" quick reference chart*

More information for health care professionals:

National Coverage Determination (NCD) for Intensive Behavioral Therapy for Cardiovascular Disease

Source: CMS PERL 201207-30

Resources on immunization billing and care related to alcohol misuse available

Revised "Quick Reference Information: Medicare Immunization Billing" educational tool

The *"Quick Reference Information: Medicare Immunization Billing"* educational tool was revised and is available in downloadable and hard copy format. This educational tool is designed to provide education on Medicare-covered preventive immunizations. It includes coverage, coding, and billing information on the influenza, pneumococcal and Hepatitis B vaccines and their administration.

New "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" booklet

The *"Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse"* booklet (ICN 907798) is available in downloadable format. This brochure is designed to provide education on screening and behavioral counseling interventions in primary care to reduce alcohol abuse. It includes information about risky/hazardous and harmful drinking.

To access a new or revised product available for order in hard copy format, go to *MLN Products* and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the Web page.

Source: CMS PERL 201207-32

Over 16 Million people with Medicare get free preventive services in 2012

Affordable Care Act made many preventive services no cost to beneficiaries

The Affordable Care Act – the new health care law – helped over 16 million people with original Medicare get at least one preventive service at no cost to them during the first six months of 2012, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, announced on July 10. This includes 1.35 million who have taken advantage of the annual wellness visit provided by the Affordable Care Act. In 2011, 32.5 million people in Medicare received one or more preventive benefits free of charge.

Prior to 2011, people with Medicare faced cost-sharing for many preventive benefits such as cancer screenings. Through the Affordable Care Act, preventive benefits are offered free of charge to beneficiaries, with no deductible or copay, so that cost is no longer a barrier for seniors who want to stay healthy and treat problems early.

The law also added an important new service for people with Medicare – an annual wellness visit with the doctor of their choice – at no cost to beneficiaries.

For more information on Medicare-covered preventive services, please visit *Healthcare.gov*.

To learn what screenings, vaccinations and other preventive services doctors recommend for you and those you care about, please visit the *myhealthfinder tool* at *healthfinder.gov*.

Full text of this excerpted *CMS press release* (issued July 10).

Source: CMS PERL 201207-28

Slideshow and podcasts from March 28 call on the initial preventive physical exam and annual wellness visit now available

The Centers for Medicare & Medicaid Services (CMS) has released a YouTube video slideshow presentation and podcasts from the March 28, 2012, Medicare preventive services national provider call on the initial preventive physical exam and the annual wellness visit.

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 28, 2012*, Web page.

- **Podcast 1 of 3**: The initial preventive physical exam
- **Podcast 2 of 3**: The annual wellness visit
- **Podcast 3 of 3**: Question and answer session

Visit the *national provider calls and events March 28, 2012*, Web page for access to all of the related call materials including the slide presentation, audio recording, and written transcripts.

Source: CMS PERL 201206-56

New intensive behavioral therapy for obesity and depression booklets available

New "Intensive Behavioral Therapy (IBT) for Obesity" booklet

The *"Intensive Behavioral Therapy (IBT) for Obesity"* booklet (ICN 907800) has been released and is available in downloadable format. This booklet is designed to provide education on intensive behavioral therapy for obesity. It includes information about obesity rates, approaches on treating obesity, and other resources on obesity.

New "Screening for Depression" booklet

The *"Screening for Depression"* booklet (ICN 907799) has been released and is available in downloadable format. This booklet is designed to provide education on screening for depression. It includes coverage, coding, billing, and payment information.

Source: CMS PERL 201207-51

Substance abuse fact sheet reminder

The *"Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)"* fact sheet, ICN (904084) is available in downloadable and hard copy format. This fact sheet includes an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

Source: CMS PERL 201207-74

Other Educational Resources

Medicare Learning Network® tips and services

MLN Matters® search tips

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

- ***MLN Matters*® index**: A list of common keywords and phrases contained within *MLN Matters*® articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit the *MLN Matters® articles Web page* and scroll down to the "Downloads" section.
- ***MLN Matters*® dynamic lists**: An archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the *MLN Matters® articles Web page*.
- ***MLN Matters*® electronic mailing list**: This free electronic notification service sends an email message when new and revised *MLN Matters*® articles are released. For more information, including how to subscribe to the service, view the *"How to Sign Up for MLN Matters®"* document. You can also view and search an archive of previous messages *here*.

Submit feedback on *MLN* products and services

The *Medicare Learning Network*® (*MLN*) is interested in what you have to say. Visit the *MLN® opinion Web page* to submit an anonymous evaluation about specific *MLN*® products and resources. Your feedback is important in developing and improving future *MLN*® products and services.

Get connected with the *Medicare Learning Network*®

Want to stay informed about the latest new and revised *Medicare Learning Network*® (*MLN*) products and services? Subscribe to the *MLN*® educational products electronic mailing list. For more information about the *MLN*® and how to register for this service, view the *"The Medicare Learning Network® – Get Connected!"* document to learn how to start receiving updates immediately.

Source: CMS PERL 201207-74

'MLN® Guided Pathways to Medicare Resources' revised

The *"MLN® Guided Pathways to Medicare Resources"* have been revised and are now available in downloadable format. The "MLN® Guided Pathways" curricula contain brief descriptions and links to many of the Centers for Medicare & Medicaid Services (CMS) resources. These products are designed to allow users to quickly and easily scan or search the resources and click on topics of interest. They are also designed so you can move directly to a specific section by using bookmarks or the table of contents.

Source: CMS PERL 201207-32

Compliance newsletter and fast fact available from *Medicare Learning Network®*

"Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 4]" educational tool

The *"Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 4]"* educational tool (ICN 908064) is available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program. It highlights the top issues of the particular quarter. Visit the *Medicare Quarterly Provider Compliance Newsletter Archive* to download, print, and search an index of previously-issued newsletters.

New *MLN* provider compliance fast fact

A new fast fact is now available on the *MLN® provider compliance* page. This Web page provides the latest *Medicare Learning Network®* (*MLN*) products designed to help Medicare fee-for-service providers understand – and avoid – common billing errors and other improper activities. A list of previous fast facts is available 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 201207-51

New continuing education associations now accepting *Medicare Learning Network®* courses

The *Medicare Learning Network®* (*MLN*) is happy to announce that the latest continuing education associations to accept MLN courses are the National Academy of Ambulance Coders (NAAC) and the American Association of Medical Assistants (AAMA). NAAC and AAMA join the American Association of Professional Coders (AAPC), the American Medical Billing Association (AMBA), and the Medical Association of Billers (MAB).

For more information about continuing education associations that accept MLN courses, visit the *MLN educational Web guides* website.

If the association you belong to accepts outside credit sources and is not on the list, you should contact them to see if they are interested in working with the *MLN*. If they are interested, the association should email *CE_Issues@cms.hhs.gov*.

Source: CMS PERL 201207-09

Medscape ICD-10 video lectures have launched

In June, three continuing medical education (CME) modules regarding ICD-10 implementation were posted to Medscape:

- *"ICD-10: A Guide for Small and Medium Practices"*
- *"ICD-10: A Guide for Large Practices"*
- *"Transition to ICD-10: Getting Started"*

Medscape Healthcare Advisory on preventive services distributed

The Medscape Healthcare Advisory *"Helping You and Your Patients Take Advantage of Recent Healthcare Provisions"* was distributed on June 26.

Source: CMS PERL 201207-08

Medscape CME/CE module on HIV launched

On July 20, a continuing medical education (CME)/continuing education (CE) clinical anthology titled *"Obtaining and Paying for Care for HIV-infected Patients"* was made available. This anthology includes three parts:

- *Part 1 – Getting Started: Basics of HIV Therapy Initiation and Disease Monitoring*
- *Part 2 – Getting HIV-Infected Patients Into Care: What Are the Barriers?*
- *Part 3 – Obtaining Payment for HIV Care: Payment Options and Impact of the Affordable Care Act*

Please note: You must login to Medscape in order to view the items linked above.

Source: CMS PERL 201207-71

'Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff' fact sheet revised

The *"Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff"* fact sheet, (ICN 006903) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare secondary payer (MSP) provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the coordination of benefits contractor.

Source: CMS PERL 201207-51

'Publications for Medicare Beneficiaries' fact sheet revised

The *"Publications for Medicare Beneficiaries"* fact sheet (ICN905183) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on the variety of beneficiary-related publications available to assist providers in answering patients' questions. It includes a list of products with information you can print out and provide to your Medicare beneficiaries.

Source: CMS PERL 201207-32

Advance beneficiary notice of noncoverage booklet revised

The *"Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B"* booklet has been revised and is now available in downloadable format. This booklet is designed to provide education on the advanced beneficiary notice (ABN). It includes information on when an ABN should be used and how it should be completed.

Source: CMS PERL 201207-74

'Medicare Podiatry Services' fact sheet revised

This *fact sheet* is designed to provide education on Medicare-covered podiatry services. It includes a list of services that are not covered by Medicare, billing guidelines, and a list of resources.

Source: CMS PERL 201207-74

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

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

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
www.medicare.gov

Phone numbers

Provider customer service
1-866-454-9007

Interactive voice response (IVR)
1-877-847-4992

Email address:
AskFloridaB@fcso.com

FAX: 1-904-361-0696

Beneficiary customer service

1-800-MEDICARE
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

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

Order form for Medicare Part B materials

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

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

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications_B/index.asp* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2011 through September 2012.	40300260	$33		
2012 Fee Schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2012, are available free of charge online at *http://medicare.fcso.com/Data_files/* (English) or *http://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
Language preference: **English** [ ] **Español** [ ]				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

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

Medicare B Connection

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

Attention Billing Manager