MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

The *Medicare A Bulletin* should be shared with all health care practitioners and managerial members of the provider/supplier staff. Publications issued after October 1, 1997, are available at no-cost from our provider Web site at *http://medicare.fcso.com/*.

Routing Suggestions:

[ ] Medicare Manager
[ ] Reimbursement Director
[ ] Chief Financial Officer
[ ] Compliance Officer
[ ] DRG Coordinator
[ ] _____
[ ] _____
[ ] _____

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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The *Medicare A Bulletin* is published monthly by First Coast Service Options Inc. Provider Outreach and Education division, to provide timely and useful information to Medicare Part A providers.

Questions concerning this publication or its contents may be faxed to:

Medicare Publications
1-904-361-0723

About the *Medicare A Bulletin*

The *Medicare A Bulletin* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Medicare Part A providers in Florida, Puerto Rico and U.S. Virgin Islands in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important notifications requiring communication in between publications are posted to the FCSO Medicare provider education Web site *http://medicare.fcso.com*.

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education Web site. Providers who cannot obtain the *Bulletin* from the Internet (because of a technical barrier) are required to register with us to receive a complimentary hardcopy. Registration forms must be submitted annually or when the provider's business practices have experienced a change in circumstances that impact electronic access.

Distribution of the *Medicare Part A Bulletin* in hardcopy format is limited to one copy per medical facility that has billed at least one Part A claim to the fiscal intermediary in Florida during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, *if a technical barrier exists that prevents them from obtaining it from the Internet and they have returned a completed hardcopy registration form to us*.

For additional copies, providers may purchase a separate annual subscription. A subscription order form may be found at the end of the *Educational Resources* section in each issue. Issues published since January 1997 may be downloaded from the Internet free of charge.

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

What is in the *Bulletin*?

The *Bulletin* is divided into sections addressing general and coverage guidelines, and facility-specific information:

- Sections comprise of administrative and general information, processing guidelines, billing issues, and Medicare coverage guidelines applicable to all Medicare Part A providers and facilities are included in the first part of the publication.
- Coverage guidelines and billing issues targeting specific facilities or Part A providers are usually included in individual sections named under the applicable facility type. These facility-specific sections are in the *Bulletin* only when an article in that category is published (for example, if no CORF/ORF information is in the issue, that section is omitted.)
- The *Local Coverage Determination* (LCD) section contains notification of new finalized medical LCDs and additions, revisions, and corrections to previously published LCDs. In addition, this section may contain information on widespread probe reviews conducted by the fiscal intermediary.
- As needed, the *Bulletin* contains *Electronic Data Interchange* and *Fraud and Abuse* sections.
- The *Educational Resources* section includes educational events and materials, such as seminar schedules, Medicare provider education Web site information, and reproducible forms.
- Important addresses and phone numbers are in the back of every issue.

The Medicare A Bulletin represents formal notice of coverage policies

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

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

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

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

Providers may access the QPU by going to the CMS Web site at *http://www.cms.hhs.gov/QuarterlyProviderUpdates/*.

Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU. ❖

GENERAL INFORMATION

Annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6520 and reminds the Medicare contractors and providers that the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* will be effective for dates of service on and after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009). You may see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage*, or at the National Center for Health Statistics (NCHS) Web site at *http://www.cdc.gov/nchs/icd9.htm* in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6520 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, nonphysician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims; but is not required for ambulance supplier claims.

Additional information

The official instruction (CR 6520) issued to your Medicare MAC and/or FI/carrier is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1770CP.pdf*.

If you have questions, please contact your Medicare MAC and/or FI/carrier at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6520
Related Change Request (CR) Number: 6520
Related CR Release Date: July 10, 2009
Related CR Transmittal Number: R1770CP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1770, CR 6520

New and revised educational resources on ICD-10-CM/PCS

The Centers for Medicare & Medicaid Services (CMS) has developed two educational resources to assist providers with the upcoming implementation the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) initiatives.

- *ICD-10-CM/PCS Myths & Facts* (June 2009). This fact sheet presents correct information in response to some myths regarding the ICD-10-clinical modification/procedure coding system, and it is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10-CM_PCS_Myths&Facts.pdf*.
- *Second in Series: General Equivalence Mappings – ICD-9-CM to and from ICD-10-CM and ICD-10-PCS* (May 2009). This fact sheet provides basic information about the general equivalence mappings (GEM) including possible users of the GEM, why the GEM are needed, and how the GEM files are formatted as well as reimbursement mappings information, and it is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfctsht.pdf*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200907-10

2009 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations

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

Provider types affected

This article has information for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs]) for influenza and pneumococcal vaccinations provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6539 to remind the Medicare physician community of the requirements to correctly enroll in order to conduct mass immunization roster billing and centralized billing for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for mass immunizer roster billers.

Providers take note:

A vaccine is being developed for the H1N1 virus and the development of the H1N1 vaccine could result in beneficiaries being eligible to receive more than one influenza vaccine during the upcoming influenza season. CMS will release more information regarding the development of the H1N1 vaccine and any coding updates in future CRs as necessary.

Background

CMS is issuing CR 6539 as a reminder for mass immunization roster billing and centralized billing for influenza and pneumococcal vaccinations. Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza and/or pneumococcal vaccinations to a large number of individuals, and they must be properly licensed in the states in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors or A/B MACs processing claims. Individuals and entities must be properly licensed in the states in which they plan to operate influenza (flu) and/or pneumococcal clinics.

All providers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, already enrolled in the Medicare program may render and bill for providing influenza and/or pneumococcal vaccinations. DMEPOS suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Providers/suppliers who will only render influenza and/or pneumococcal vaccination services must enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a centralized biller.

They must:

- Accept assignment on both the vaccine and its administration.
- Bill only for influenza and/or pneumococcal vaccinations.
- Submit claims using the roster billing process.

Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one Medicare specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Providers and suppliers must enroll using the appropriate CMS-855 provider enrollment form. Information on provider enrollment forms may be found on the CMS Web site at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp*.

Refer to the *Medicare Claims Processing Manual*, Chapter 18, Sections 10-10.5 for more information on billing requirements. This manual is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

CMS offers a number of free educational products on its *Medicare Learning Network (MLN)*. These products are available on the MLN Preventive Services Educational Products Web page located on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

Note: Medicare Part B pays 100 percent for pneumococcal vaccines, influenza virus vaccines, and their administration. The Part B deductible and coinsurance do not apply for influenza virus and pneumococcal vaccine.

Remember the following regarding the influenza vaccine:

- Medicare allows one influenza (flu) vaccination per year.
- Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the influenza vaccine and its administration.
- The beneficiary may receive the influenza vaccine upon request without a physician's order and without physician supervision.

2009 reminder for roster billing and centralized billing for influenza and pneumococcal vaccinations (continued)

Remember the following with regard to the pneumococcal vaccine, effective for services furnished on or after July 1, 2000:

- Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration.
- The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, the pneumococcal vaccine is administered once in a lifetime. Claims for pneumococcal vaccines are paid for beneficiaries who:

- Are at high risk of pneumococcal disease; and
- Have not received a pneumococcal vaccine within the last five years; or
- Are revaccinated because they are unsure of their vaccination status.

Additional information

CMS offers a number of free educational products on its *MLN*. These products are available on the MLN Preventive Services Educational Products Web page located on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*.

The official instruction, CR 6539, issued to your Medicare FI, carrier or A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R515OTN.pdf*.

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

MLN Matters® Number: MM6539
Related Change Request (CR) Number: 6539
Related CR Release Date: July 10, 2009
Related CR Transmittal Number: R515OTN
Effective Date: August 10, 2009
Implementation Date: August 10, 2009

Source: CMS Pub. 100-20, Transmittal 515, CR 6539

Health care costing: Data, methods, future directions report now available

The National Cancer Institute (NCI), the Agency for Healthcare Research and Quality (AHRQ), and the Department of Veterans Affairs (VA) are pleased to announce the publication of *Health Care Costing: Data, Methods, Future Directions*, published July 2009, Volume 47, Issue 7, Supplement 1 in Medical Care. Accurate measurement of health care costs is critical for developing health care budgets, setting priorities for allocating funds, and making health care policy decisions. Estimates of these costs are key inputs to cost-effectiveness analyses and other economic evaluations. The supplement takes a careful look at diverse methodological issues related to this timely and important topic.

Written by experts in health economics, epidemiology, health services research, and biostatistics, the papers discuss ways to improve and apply health care cost estimation methods and promote research in this area. The supplement was developed by scientists at the NCI, the AHRQ, the VA, and Emory University. It was based on a 2007 workshop sponsored by the NCI and the AHRQ. For more information about the supplement and the workshop, visit *http://healthservices.cancer.gov/publications/costing.html*.

Requests for one free copy of the supplement may be made to the AHRQ publications clearinghouse. Please order by specifying AHRQ publication number OM 09-0079: Medical Care supplement on health care costing. If more than one copy is needed, please describe the reason in your request.

In the United States, call the toll-free number 800-358-9295, 24 hours a day, 7 days a week.

Hearing impaired persons may call 888-586-6340 for the TDD service.

Callers from outside of the United States only should use the telephone number 703-437-2078.

Written requests may be sent to:

AHRQ Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907-8547

Electronic requests may be made to: mailto:*AHRQPubs@ahrq.hhs.gov*. ❖

Source: CMS PERL 200907-20

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Billing routine costs of clinical trials

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters* article MM6431 to reflect a revision to change request (CR) 6431, with a release date of June 26, 2009. The transmittal number, CR release date, and the Web address for accessing CR 6431 have changed. In addition, the implementation date was changed to September 28, 2009. All other information is the same. The previous revised *MLN Matters* article MM6431 was published in the May 2009 *Medicare A Bulletin* (page 11).

Provider types affected

Physicians and nonphysician practitioners submitting claims to Medicare administrative contractors (MACs) and carriers for clinical trials.

Provider action needed

This article is based on change request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. **It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.**

Background

CR 6431 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 69.6 (Requirements for Billing Routine Costs of Clinical Trails). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the **modifier QV or Q1** is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor **will not** consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims **processed after September 28, 2009 with dates of service on or after January 1, 2008,** claims submitted with either the **modifier QV or the modifier Q1** will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.
- Providers will see the following messages from their Medicare contractor with the returned claim:

  Claim adjustment reason code 16 – Claim/service lacks information which is needed for adjudication, **and**

  As least **one remark code,** which may be comprised of either:

  - The remittance advice code (M76, Missing/ incomplete/invalid diagnosis or condition) **or**
  - National council for prescription drug programs reject reason code.

Note: Healthcare Common Procedure Coding System (HCPCS) codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30
- Report a secondary diagnosis code of V70.7, and
- Identify all lines that contain an investigational item/ service with a HCPCS modifier of:
  - **QA/QR** for dates of service before January 1, 2008, or
  - **Q0** for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
  - **QV** for dates of service before January 1, 2008, or
  - **Q1** for dates of service on or after January 1, 2008.

Additional information

The official instruction (CR 6431) issued to your Medicare MAC, or carrier is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1761CP.pdf*.

If you have questions, please contact your Medicare MAC and/or carrier at their toll-free number, which may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6431 – Revised
Related Change Request (CR) Number: 6431
Related CR Release Date: June 26, 2009
Related CR Transmittal Number: R1761CP
Effective Date: For claims with dates of service on or after January 1, 2008, and processed after September 28, 2009
Implementation Date: September 28, 2009

Source: CMS Pub. 100-04, Transmittal 1761, CR 6431

Prompt payment interest rate revision

The Centers for Medicare & Medicaid Services (CMS) has revised Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 80.2.2 (Interest Payment on Clean Non-PIP Claims Not Paid Timely) to replace the Internet address (URL)with the latest URL for accessing the Department of the Treasury Web site current and past prompt payment interest rates payable when clean Medicare claims are not paid in a timely manner by Medicare contractors.

The prompt payment interest rate is determined by the Department of the Treasury on a six-month basis, effective every January and July 1. Providers may access the prompt payment interest rate history on the Financial Management Service Web page at *http://fms.treas.gov/prompt/rates.html*.

The new rate of 4.875 percent is in effect through December 31, 2009.

This revision is addressed under change request 6542.

Source: CMS Pub. 100-04, Transmittal 1771, CR 6542

Healthcare common procedure coding system quarterly update

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the healthcare common procedure coding system (HCPCS) code set. These changes have been posted to the HCPCS Web site at *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp*.

Changes are effective on the date indicated on the update. ❖

Source: CMS PERL 200907-06

CMS Web site on the American Recovery and Reinvestment Act and health information technology now available

A new Web site section is now available from the Centers for Medicare & Medicaid Services (CMS) concerning health information technology as provided for in the American Recovery and Reinvestment Act of 2009. On this Web site, you may find information pertaining to the Medicare and Medicaid incentives for electronic health records adoption and important links to related Web sites at the Department of Health & Human Services.

Posted now are:

- A CMS fact sheet and questions/answers pertaining to the incentive programs
- Link to press release pertaining to the process of defining meaningful use
- Resources on health information technology, and privacy and security (Health Insurance Portability and Accountability Act of 1996 [HIPAA])

Bookmark *http://www.cms.hhs.gov/Recovery/11_HealthIT.asp#TopOfPage* today to find the latest on health information technology. ❖

Source: CMS PERL 200906-33

Get ready for DMEPOS competitive bidding

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

Summer 2009

- CMS announces bidding schedule/schedule of education events
- CMS begins bidder education campaign
- Bidder registration period to obtain user ID and passwords begins

Fall 2009

- Bidding begins

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

Update your national supplier clearinghouse (NSC) files: DMEPOS supplier standard # 2 requires **all** suppliers to notify the NSC of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update:

- The list of products and services found in Section 2.D
- The authorized official(s) information in Sections 6A and 15
- The correspondence address in Section 2A2 of the CMS-855S.

This is especially important for suppliers who will be involved in the Medicare DMEPOS competitive bidding program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC Web site (*http://www.palmettogba.com/nsc*) by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Get ready for DMEPOS competitive bidding (continued)

Get licensed: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. As part of the bid evaluation we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

Get accredited: CMS would like to remind DMEPOS suppliers that time is running out to obtain accreditation by the September 30, 2009, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of six months to complete.

DMEPOS suppliers should contact a CMS-deemed accreditation organization to obtain information about the accreditation process and the application process. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at the CMS Web site *http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Get bonded: CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009, deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of sureties from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies;" the Web site is located at *http://www.fms.treas.gov/c570/c570_a-z.html*.

Visit the CMS Web site at *http://www.cms.hhs.gov/DMEPOSCompetitiveBid/* for the latest information on the DMEPOS competitive bidding program. ❖

Source: CMS PERL 200907-12

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DMEPOS accreditation and surety bond requirement deadlines coming in October

Suppliers may choose to voluntarily terminate enrollment if they do not plan to comply.

Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by October 1, 2009, and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntary terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page 4 of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the national supplier clearinghouse (NSC). By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to *http://www.cms.hhs.gov/MedicareProviderSupEnroll*.

Frequently asked questions (FAQs) on the surety bond requirement may be found on the NSC's FAQ page at *http://www.palmettogba.com/nsc*. ❖

Source: CMS PERL 200907-04

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Proposed DMEPOS regulatory updates

The Centers for Medicare & Medicaid Services (CMS) has announced limited proposed regulatory provisions for the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. These proposals include a proposed administrative process for contract suppliers whose contracts were terminated by the Medicare Improvements for Patients and Providers Act of 2008 to submit claims for any applicable damages and proposed grandfathering provision updates. These proposed provisions are found in Section O of the Physician Fee Schedule and Other Revisions to Part B regulation (CMS-1413-P), which is now on display at the Office of the Federal Register.
To view the rule and obtain additional information, visit the CMS Web site at *http://www.cms.hhs.gov/center/dme.asp*. ❖

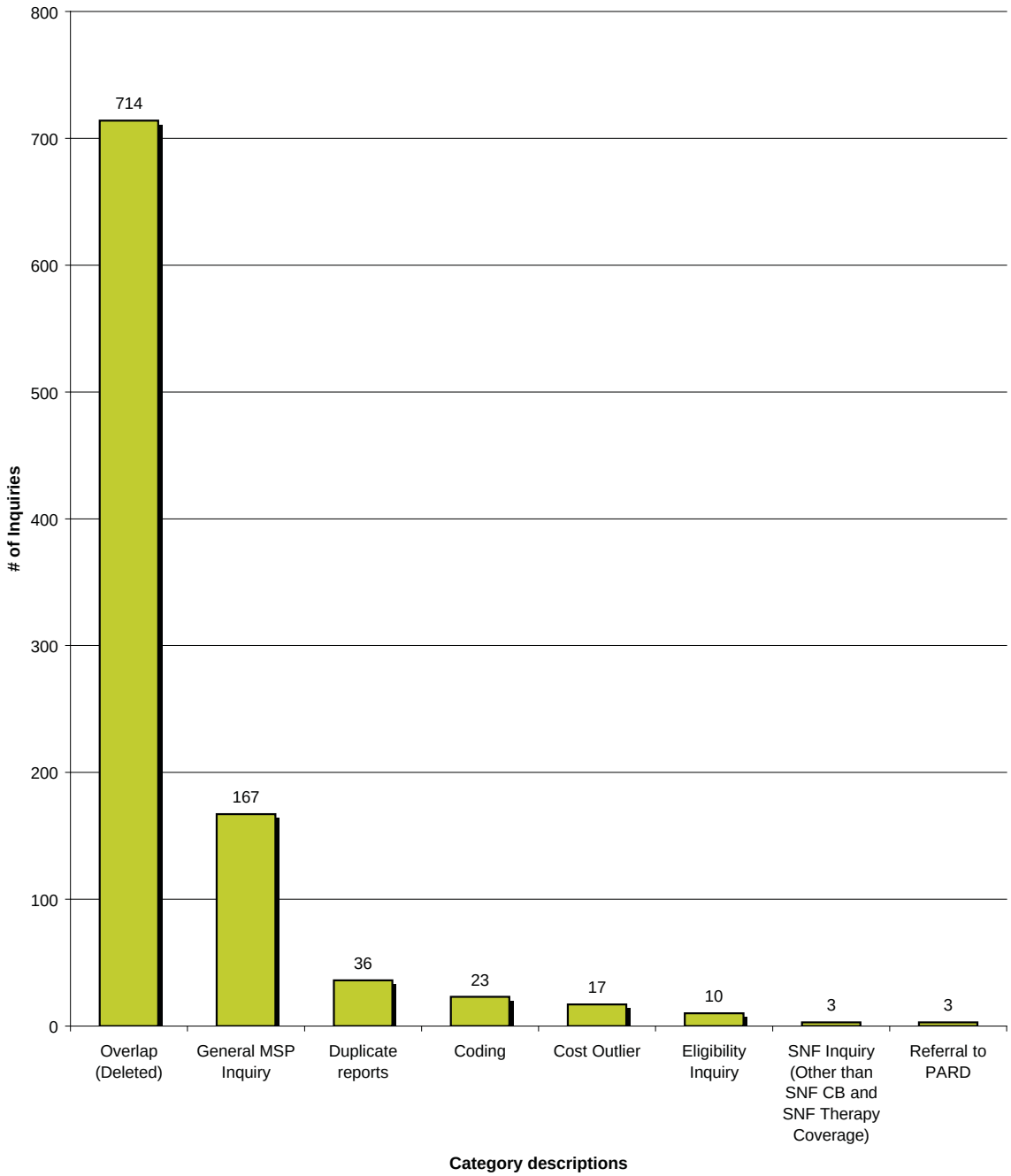
Source: CMS PERL 200907-02

Top inquiries, return to provider, and reject claims for June 2009

The following charts demonstrate the available top number of inquiries, the top reason codes for return to providers (RTPs), and reject claims submitted to First Coast Service Options Inc. (FCSO), by Florida, Puerto Rico and U.S. Virgin Island providers during June 2009.

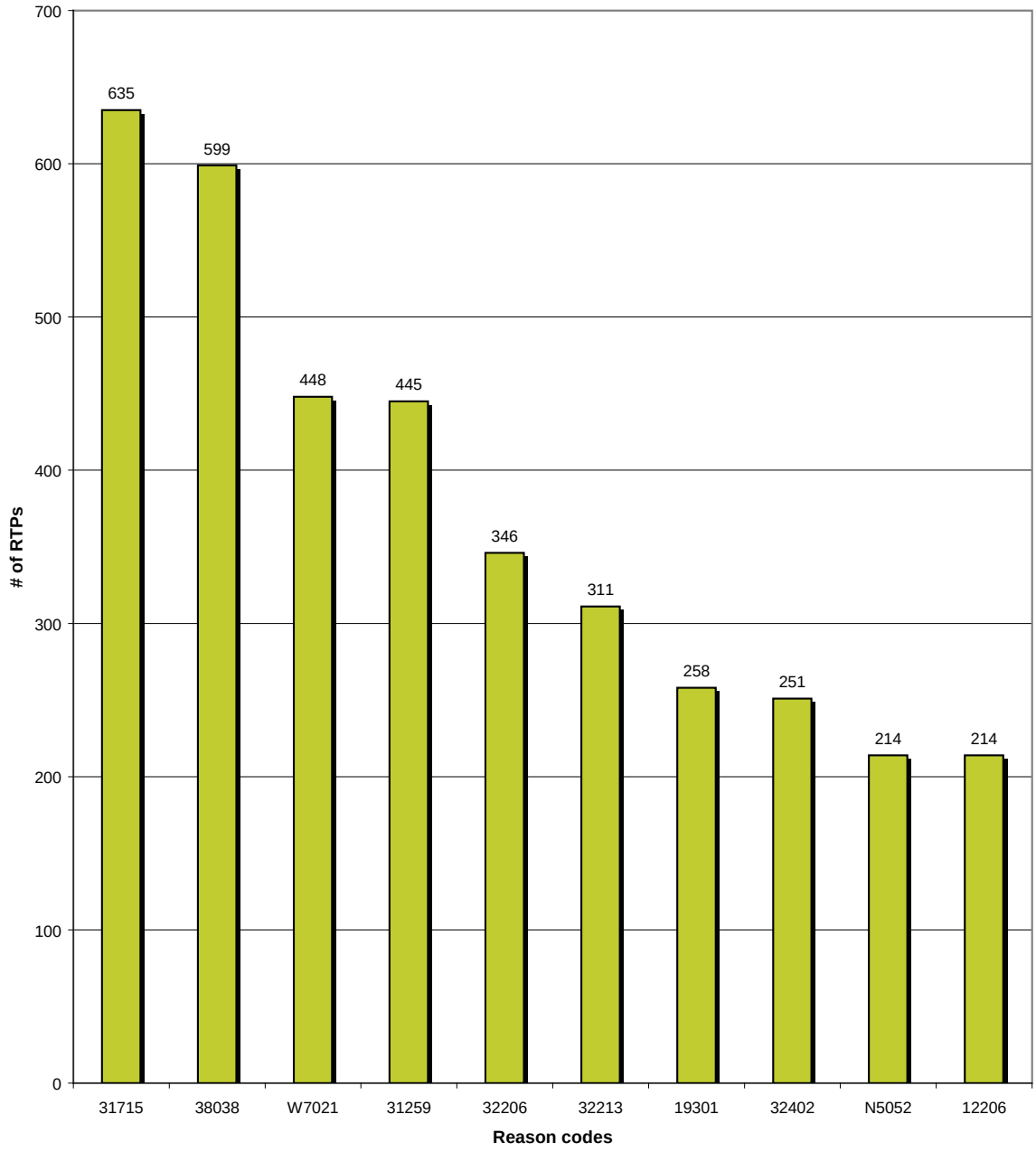
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for June 2009



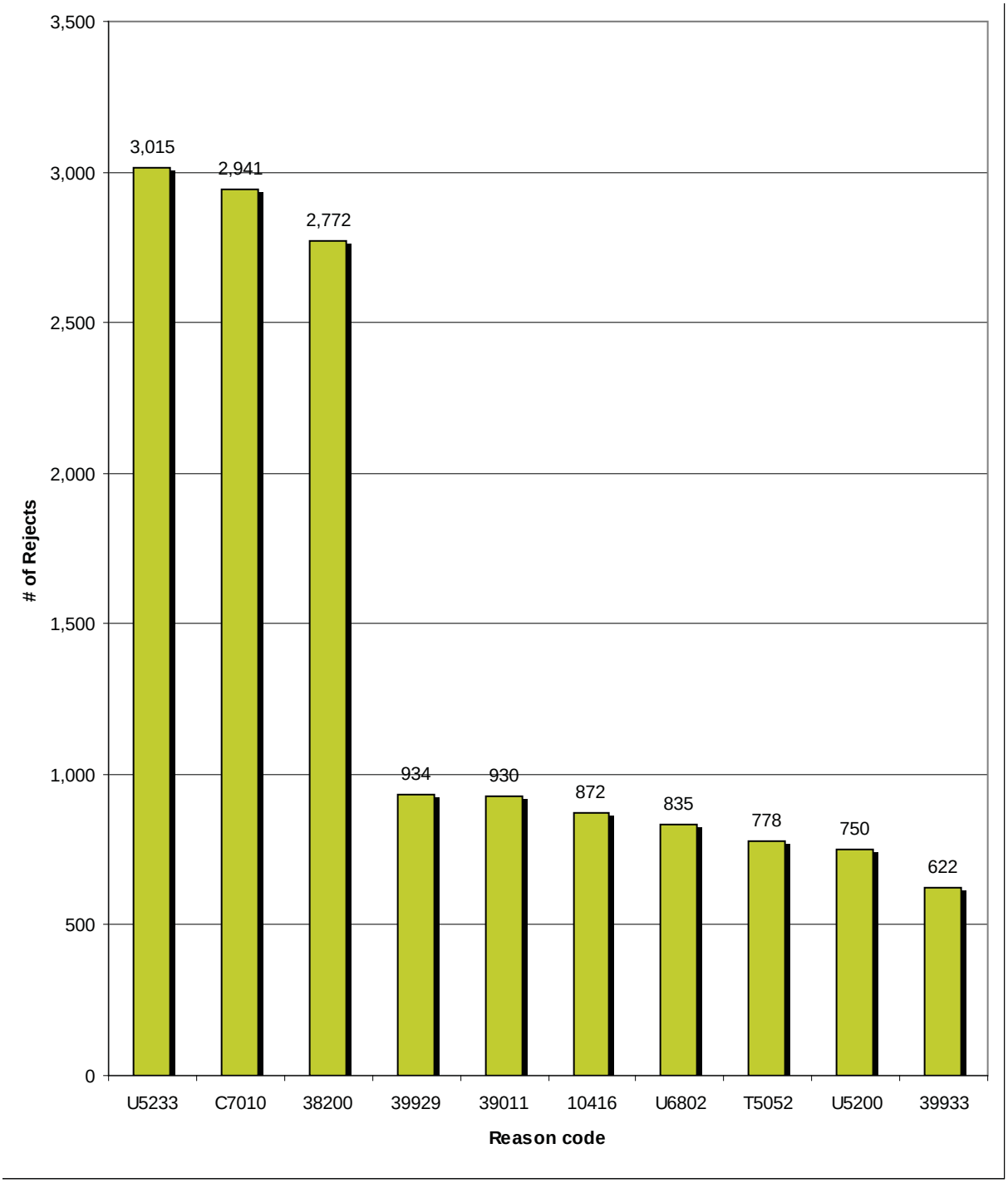
Top inquiries, return to provider, and reject claims for June 2009 (continued)

Florida Part A top RTPs for June 2009



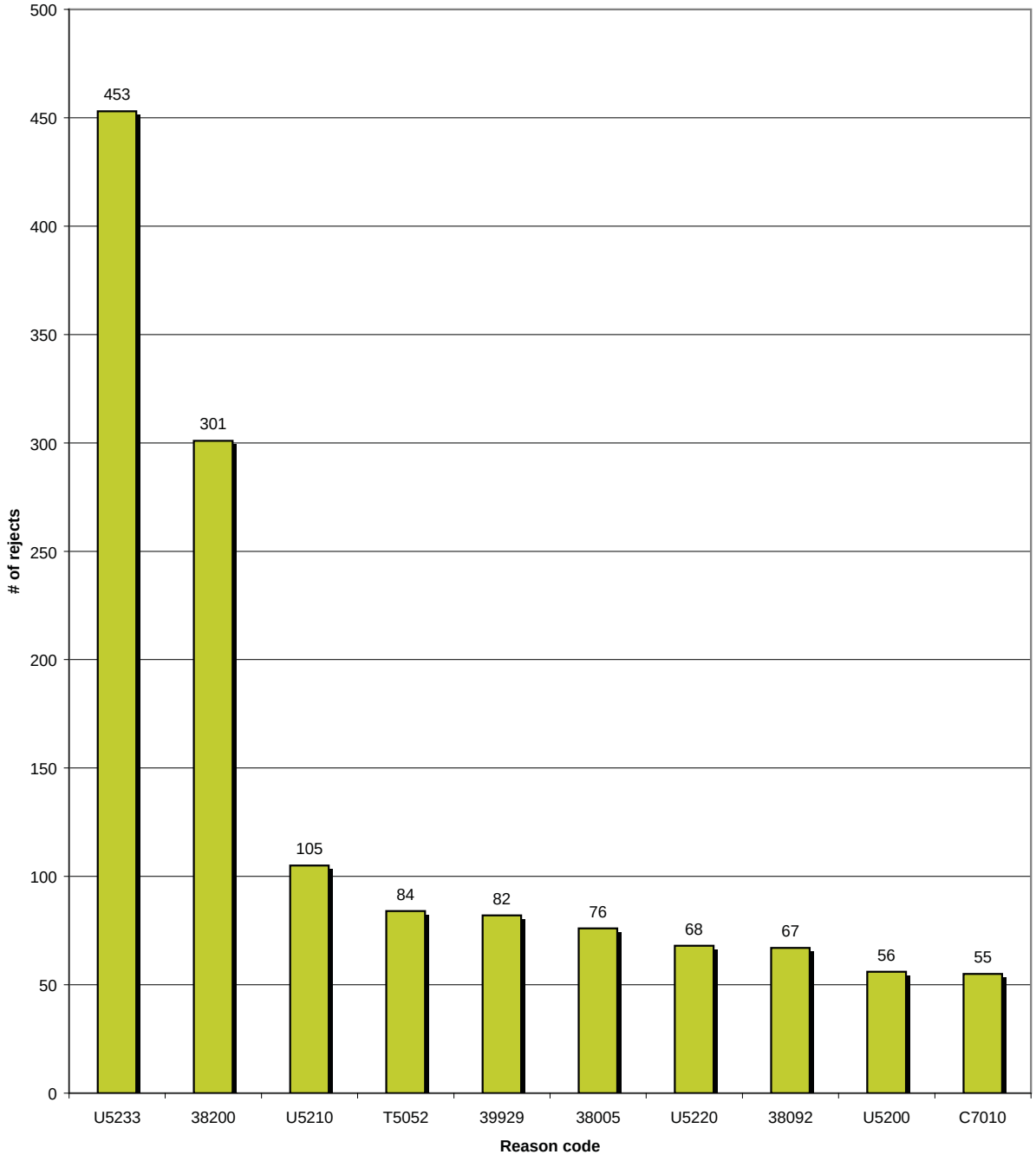
Top inquiries, return to provider, and reject claims for June 2009 (continued)

Florida Part A top rejects for June 2009



Top inquiries, return to provider, and reject claims for June 2009 (continued)

Puerto Rico/U.S. Virgin Islands Part A top rejects for June 2009



GENERAL COVERAGE

October 2009 changes to the laboratory national coverage determination edit software

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

Provider types affected

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

Provider Action Needed

This article is based on change request (CR) 6548, which announces the changes that will be included in the October 2009 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in July 2009. Be sure billing staff are aware of the changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001.

Nationally uniform software was developed and incorporated in Medicare systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2 (see on the Centers for Medicare & Medicaid Services (CMS) Web site *http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf*), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6548 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2009. These changes become effective for services furnished on or after October 1, 2009. The changes that are effective for dates of service on and after October 1, 2009 are as follows:

For the urine culture, bacterial

Add ICD-9-CM codes 670.10, 670.12, 670.14, 670.20, 670.22, 670.24, 670.30, 670.32, 670.34, 670.80, 670.82, 670.84, and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the urine culture, bacterial (190.12) NCD.

For blood counts

Add ICD-9-CM codes V26.42, V26.82, V53.50-V53.51, V53.59, V61.07-V61.08, V61.23-V61.25, V61.42, V72.60-V72.63, and V72.69 to the list of ICD-9-CM codes that do not support medical necessity for the blood counts (190.15) NCD.

Delete ICD-9-CM codes V53.5 and V72.6 from that list.

For partial thromboplastin time (PTT)

Add ICD-9-CM codes 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PTT (190.16) NCD.

Delete ICD-9-CM code 453.8 from that list.

For prothrombin time (PT):

Add ICD-9-CM codes 209.70-209.75, 209.79, 453.50-453.52, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 789.7, and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the PT (190.17) NCD.

Delete ICD-9-CM code 453.8 from that list.

Replace the duplicate ICD-9-CM code 868.19 with 868.09 within that list.

For serum iron studies

Add ICD-9-CM codes 209.31-209.36, 209.70-209.75, 209.79, 239.81, 239.89, 285.3, 453.50-453.52 and 569.87 to the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

Delete ICD-9-CM code 239.8 from the list of ICD-9-CM codes that are covered by Medicare for the serum iron studies (190.18) NCD.

For thyroid testing

Add ICD-9-CM codes 279.41, 279.49, 784.42-784.44, 784.51, 784.59, 799.21-799.25, 799.29, and V10.91 to the list of ICD-9-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.

Delete ICD-9-CM codes 279.4, 784.5, and 799.2 from that list.

For lipids testing

Add ICD-9-CM codes 438.13-438.14 to the list of ICD-9-CM codes that are covered by Medicare for the lipids testing (190.23) NCD.

For digoxin therapeutic drug assay

Add ICD-9-CM codes 787.04, 799.21-799.25, 799.29 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the digoxin therapeutic drug assay (190.24) NCD.

Delete ICD-9-CM code 799.2 from that list.

For alphafetoprotein

Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the alpha-fetoprotein (190.25) NCD.

October 2009 changes to the laboratory national coverage determination edit software (continued)

For carcinoembryonic antigen

Add ICD-9-CM codes 209.70-209.75 and 209.79 to the list of ICD-9-CM codes that are covered by Medicare for the carcinoembryonic antigen (190.26) NCD.

For gamma glutamyl transferase

Add ICD-9-CM codes 209.70-209.75, 209.79, 453.6, 453.71-453.77, 453.79, 453.81-453.87, 453.89, 569.87, 969.00-969.05, 969.09, 969.70-969.73 and 969.79 to the list of ICD-9-CM codes that are covered by Medicare for the gamma glutamyl transferase (190.32) NCD.

Delete ICD-9-CM codes 453.8, 969.0 and 969.7 from that list.

For the hepatitis panel/acute hepatitis panel

Add ICD-9-CM codes 787.04 and 789.7 to the list of ICD-9-CM codes that are covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

For fecal occult blood test

Add ICD-9-CM codes 209.70-209.75, 209.79, 285.3, 569.87, 787.04, 789.7 and 995.24 to the list of ICD-9-CM codes that are covered by Medicare for the fecal occult blood test (190.34) NCD.

Delete HCPCS code G0394 from the list of *CPT* codes covered by Medicare for the fecal occult blood test (190.34) NCD.

For all 23 Lab NCDs

ICD-9-CM codes V20.31-V20.32, V60.81. V60.89, V80.01, and V80.09 will be denied for all 23 NCDs.

ICD-9-CM codes V60.8 and V80.0 will be deleted from the noncovered by Medicare lists for all 23 NCDs.

Additional information

The official instruction (CR 6548) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1766CP.pdf*.

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

MLN Matters® Number: MM6548
Related Change Request (CR) Number: 6548
Related CR Release Date: July 10, 2009
Related CR Transmittal Number: R1766
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-04, Transmittal 1766, CR 6548

Sleep testing for obstructive sleep apnea

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6534, which announces that Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of OSA as contained in section 240.4.1 of the *National Coverage Determination (NCD) Manual*. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has addressed the coverage of continuous positive airway pressure (CPAP) in three separate decisions in October 2001, April 2005, and March 2008. In each of those decisions, CMS limited coverage of CPAP in patients with OSA to those patients whose diagnosis was based on specific testing modalities. Initially, it limited coverage to OSA diagnosed with polysomnography (PSG). In the latest decision, it expanded coverage to OSA diagnosed with several types of home sleep tests. However, CMS has not, at a national level, specifically addressed coverage of the tests themselves. In other words, CPAP is nationally covered for beneficiaries with OSA if diagnosed with these specific tests; yet, coverage of the specific tests has previously been left to local contractor discretion.

After careful consideration, Medicare will allow for coverage of specified sleep tests for adult beneficiaries based upon clinical evaluation and a suspicion of OSA as contained in section 240.4.1 of the NCD manual.

Effective for claims with dates of service on and after March 3, 2009, Medicare will allow for coverage of the following:

1. Type I PSG when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
2. Type II or Type III sleep testing device when used to aid the diagnosis of OSA in beneficiaries who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
3. Type IV sleep testing device measuring three or more channels, one of which is airflow, when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

Sleep testing for obstructive sleep apnea (continued)

4. Sleep testing device measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone when used to aid the diagnosis of OSA in beneficiaries who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

Nationally noncovered indications

Effective for claims with dates of services on and after March 3, 2009, other diagnostic sleep tests for the diagnosis of OSA, other than those noted above for prescribing CPAP, are not sufficient for the coverage of CPAP and are not covered.

Note: All current claims processing and associated coding remain unchanged. Consult CR 6048, dated October 15, 2008, for detailed claims processing information. The MLN Matters® article related to CR 6048 is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6048.pdf*.

Additional information

Note that Medicare contractors will not search their files to adjust claims processed prior to the implementation date of CR 6534. However, they will adjust such claims that you bring to their attention.

The official instruction (CR 6534) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R103NCD.pdf*.

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

MLN Matters® Number: MM6534
Related Change Request (CR) Number: 6534
Related CR Release Date: July 10, 2009
Related CR Transmittal Number: R103NCD
Effective Date: March 3, 2009
Implementation Date: August 10, 2009

Source: CMS Pub. 100-03, Transmittal 103, CR 6534

Smoking and tobacco use cessation counseling billing code update to Medicare

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised this *MLN Matters* article MM5878, to add a reference to change request (CR) 6163 (*http://www.cms.hhs.gov/Transmittals/downloads/R1593CP.pdf*), which removes the outpatient physical therapy provider (OPT) type of bill 74x and comprehensive outpatient rehabilitation facility (CORF) type of bill 75x from the list of applicable bill types for smoking and tobacco cessation counseling (effective July 1, 2008). The related *MLN Matters*® article may be found on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6163.pdf*. All other information is unchanged. The *MLN Matters* article MM5878 was published in the March 2008 *Medicare A Bulletin* (page 18).

Provider types affected

Physicians and providers who bill Medicare contractors (fiscal intermediaries [FI], carriers, or Medicare administrative contractors [A/BMAC]) for smoking and tobacco use cessation counseling.

Provider action needed

Stop – Impact to you

Effective for services on or after January 1, 2008, you must bill for smoking and tobacco use cessation counseling services with new *CPT* codes *99406* or *99407*. If you bill using the former HCPCS codes G0375 and G0376 for services provided after December 31, 2007, your claims will not be paid.

CAUTION – What you need to know

CR 5878, from which this article is taken, announces that the 2008 Medicare physician fee schedule database (MPFSDB) includes two new *CPT* codes for smoking and tobacco use cessation counseling services; replacing the temporary HCPCS G-codes G0375 and G0376 currently in use for billing these services. These new codes (effective on and after January 1, 2008) are:

99406 *Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*

99407 *Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.*

GO – What you need to do

Make sure that your billing staffs are aware of these newly required CPT codes for smoking and tobacco use cessation counseling services.

Background

CR 5878, from which this article is taken announces that the temporary HCPCS G-codes G0375 and G0376, which are currently used to bill for smoking and tobacco-use cessation counseling services, are effective only through December 31, 2007.

They are being replaced by two new *CPT* codes (*99406 – Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes;* and *99407 – Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes*). These new *CPT* codes, which are included in the 2008 MPFSDB, become effective for claims with dates of service January 1, 2008 and later.

Smoking and tobacco use cessation counseling billing code update to Medicare (continued)

FIs, carriers, and A/B MACs will pay for counseling services billed with HCPCS codes G0375 and G0376 for dates of service performed on and after March 22, 2005, through Dec. 31, 2007 and with *CPT* codes *99406* and *99407* for dates of service on or after January 1, 2008.

Additional Information

You may find CR 5878 on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1433CP.pdf*.

You will find the updated *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 12.1(HCPCS and Diagnosis Coding), 12.2 (Carrier Billing Requirements), and 12.3 (FI Billing Requirements) as an attachment to that CR.

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

MLN Matters® Number: MM5878 – Revised
Related Change Request (CR) Number: 5878
Related CR Release Date: February 1, 2008
Related CR Transmittal Number: R1433CP
Effective Date: January 1, 2008
Implementation Date: July 7, 2008

Source: CMS Pub. 100-04, Transmittal 1433, CR 5878

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LOCAL COVERAGE DETERMINATIONS

In accordance with publications specified by CMS, Medicare contractors no longer distribute full-text local coverage determinations (LCDs) to providers in hardcopy format. Providers may obtain full-text LCDs from our provider education Web site *http://medicare.fcso.com* through the CMS Medicare Coverage Database.

Final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries may be printed from the Part A section under the Part A Medical Coverage section.

This section of the *Medicare A Bulletin* features summaries of new and revised LCDs developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the fiscal intermediary's LCDs and review guidelines are consistent with accepted standards of medical practice.

Effective and notice dates

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

Electronic notification

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

More information

If you do not have Internet access, contact the Medical Policy and Procedures department at:

Medical Policy and Procedures – 19T
First Coast Service Options, Inc.
P.O. Box 2078
Jacksonville, FL 32231-0048

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Additions/revisions to existing LCDs

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our provider education Web site at *http://medicare.fcso.com*.

ADDITIONS/REVISIONS TO EXISTING LCDS

A93000: Electrocardiography – revision to the LCD

LCD ID Number: L28833 (Florida)
LCD ID Number: L28866 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for electrocardiography was effective for services provided on or after February 16, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, the LCD has been revised. The "Documentation Requirements" section of the LCD has been revised to clarify that the physician must document that he/she has reviewed, interpreted and agrees with the results of the test and document how the findings are being used to manage the patient's condition. First Coast Service Options Inc. (FCSO) expects that this information will be documented in the medical record and be made available upon request for medical review.

Effective date

This LCD revision is effective for services provided **on or after July 9, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

A95805: Polysomnography and sleep testing – revision to the LCD

LCD ID Number: L29905 (Florida)
LCD ID Number: L29907 (Puerto Rico/U.S. Virgin Islands)

The new local coverage determination (LCD) for polysomnography and sleep testing that includes home sleep testing (HST) was effective for services provided on or after June 30, 2009, for Florida, Puerto Rico, and the U.S. Virgin Islands. Since that time, a revision to the LCD was made to update CMS language for Type I devices, and to add verbiage for clarification of accreditation and physician training/certification requirements, including the extended date for accreditation of sleep testing facilities.

The following sections of the LCD were updated:

- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for Type I devices, added the following CMS language: "*Type I PSG is covered when used to aid the diagnosis of obstructive sleep apnea (OSA) in beneficiaries who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.*" This revision is effective for claims processed **on or after August 10, 2009,** for services provided **on or after March 3, 2009,** based on CMS change request 6534.
- Under the "Indication of Coverage" portion of the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, added language for clarification for "Accreditation" and "Physician Training/Certification."
- Under the "Type of Bill Code" section of the LCD, added type of bill 23x.
- Under the "Documentation/Credentialing Requirements" section of the LCD, added language for clarification of accreditation requirements including the extended date of accreditation for sleep testing facilities, and sub-headings of Accreditation, Physician Training/Certification, and Technician Credentials/Training. In addition, added sub-heading and information on "Home Sleep Testing" under this section.
- Updated the "Sources of Information and Basis for Decision" section of the LCD.

Effective date

The revisions to the LCD for bullets 2, 3, 4 and 5 above are effective for services provided **on or after July 23, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

ASKINSUB: Skin substitutes – revision to the LCD

LCD ID Number: L28985 (Florida)
LCD ID Number: L29327 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was last revised on June 30, 2009. Since that time, a revision was made to the LCD based on change request 6492 (July 2009 Update of the Hospital Outpatient Prospective Payment System [OPPS]) issued by the Centers for Medicare & Medicaid Services (CMS).

A review of HCPCS code C9363 determined that this skin substitute code should be added to the Non-Covered Products section of the "CPT/HCPCS Codes" section of the LCD.

- C9363 – Skin substitute, Integra meshed bilayer wound matrix, per square centimeter

In addition, under the "Type of Bill Code" section of the LCD, type of bill 22x was added, and references under the "Sources of Information and Basis for Decision" section of the LCD were updated.

Effective date

This LCD revision is effective for claims processed **on or after July 6, 2009**, for services provided **on or after July 1, 2009.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

AVISCO: Viscosupplementation therapy for knee – revision to the LCD

LCD ID Number: L29005 (Florida)
LCD ID Number: L29037 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was last revised May 15, 2009. Since that time, it has been brought to the attention of First Coast Service Options Inc. (FCSO) that the LCD contains the incorrect HCPCS code for synvisc-one. Therefore, the LCD has been revised to replace HCPCS code J3490 with HCPCS code C9399 for use when billing synvisc-one.

Effective date

This LCD revision is effective for claims processed **on or after July 16, 2009**, for services provided **on or after February 26, 2009.** FCSO LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.hhs.gov/mcd/overview.asp*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. ❖

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HOSPITAL SERVICES

Wrong surgical/other invasive procedure performed on a patient and/or body part

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

Provider types affected

Physicians, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries [FIs] or Medicare administrative contractors [MACs]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, sections 10 and [120] and Chapter 16, section [180]. This is pursuant to the national coverage determinations (NCDs) made as part of CR 6405.

Caution – what you need to know

For inpatient claims, hospitals are required to bill two claims when the erroneous surgery related to the NCD is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the noncovered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

GO – what you need to do

Make sure that your billing staff are aware of these new billing and claim requirements.

Background

In 2002, the National Quality Forum (NQF) published "Serious Reportable Events in Healthcare: A Consensus Report," which listed 27 adverse events that were "serious, largely preventable and of concern to both the public and health care providers." (That report is available on the Internet at *http://www.qualityforum.org/pdf/reports/sre.pdf*.)

These events and subsequent revisions to the list became known as "never events." This concept and need for the proposed reporting led to NQF's "Consensus Standards Maintenance Committee on Serious Reportable Events," which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally non cover the three surgical errors and sets billing policy to implement appropriate claim processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs:

1) a different procedure altogether;
2) the correct procedure but on the wrong body part; or
3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these noncovered procedures as defined in the *Medicare Benefit Policy Manual* (BPM) Chapter 1, sections 10 and [120], and Chapter 16, section [180]. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

Note: Related services do not include performance of the correct procedure.

Definitions

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the *Current Procedural Terminology (CPT)* and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.
- A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.
- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

Note: Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

Beneficiary Liability

Generally, a beneficiary liability notice such as an advance beneficiary notice of noncoverage (ABN) or a hospital issued notice of noncoverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the *Medicare Claims Processing Manual*, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the noncovered item/service. (The *Medicare Claims Processing Manual* is available on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the *Medicare Claims Processing Manual*, Chapter 30, Section 200.

Thus, a provider cannot shift financial liability for the noncovered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the *Medicare Claims Processing Manual*.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the noncovered surgical error that would not be considered a related service to the noncovered surgical error (see Chapter 1, Sections 10 and [120], and Chapter 16, Section [180], of the *Benefit Policy Manual*).

Implementation

Inpatient claims

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to bill two claims when the erroneous surgery(s) related to the NCD is reported:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a type of bill (TOB) 11x (with the exception of 110), and,
- The other claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
- Both the covered and noncovered claim must have a matching "Statement Covers Period."

The noncovered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in form locator (FL) 80 (Remarks), or the 837I (electronic) claim form, loop 2300, one of the applicable two-digit surgical error codes as follows:

- MX – for a wrong surgery on patient;
- MY – for surgery on the wrong body part; or
- MZ – for surgery on the wrong patient.

The claim for the noncovered services will be denied using:

- **Claim adjustment reason code (CARC) 50** – These are noncovered services because this is not deemed a 'medical necessity' by the payer.
- **Group code CO** – contractual obligation.

Outpatient, ambulatory surgical centers (ASCs), other appropriate bill types and practitioner claims

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery wrong body part
- PB: Surgery wrong patient
- PC: Wrong surgery on patient

Contractors shall suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Contractors shall create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence shall be added to the list, and an MPP event or a system control facility (SCF) rule shall be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors shall then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

- **CARC 50** – These are noncovered services because this is not deemed a "medical necessity" by the payer.
- **Group code – CO** – contractual obligation

Related claims

Within **five** days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors shall review any claims applied to SCF rules and MPP events to identify incoming claims that have the potential to be related. When Medicare identifies such claims, it will take

Wrong surgical/other invasive procedure performed on a patient and/or body part (continued)

appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors shall continue to review beneficiary history for related claims and take appropriate action as necessary.

Additional information

For complete details regarding this change request (CR) please see the official instruction (CR 6405) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction was issued in two transmittals. The first transmittal presents the national coverage determination related to this issue and that transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf*.

The other transmittal presents the Medicare Claims Processing Manual revision and instructions. That transmittal is on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1778CP.pdf*.

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

MLN Matters® Number: MM6405
Related Change Request (CR) Number: 6405
Related CR Release Date: July 24, 2009
Related CR Transmittal Number: R1778CP and R102NCD
Effective Date: January 15, 2009
Implementation Date: July 6, 2009, for those billing carriers and Part B MACs; October 5, 2009, for FIs and Part A MACs

Source: CMS Pub. 100-04, Transmittal 1778, CR 6405

Supplemental security income Medicare beneficiary data for fiscal year 2007

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

Provider Types Affected

Inpatient prospective payment system (IPPS) hospitals, inpatient rehabilitation facilities (IRFs), and long term care hospitals (LTCHs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 6530, which 1) provides updated supplemental security income (SSI)/Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low income patients and 2) furnishes links to the electronic files containing the data used for interim payments and for cost settlement purposes.

Background

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA; Section 9105) provides additional payment amounts for IPPS hospitals with a disproportionate share of low-income patients. This is done by making adjustments to the prospective payment rate. See on the Centers for Medicare & Medicaid Services (CMS) Web site *http://www.cms.hhs.gov/acuteinpatientpps/05_dsh.asp* and *http://www.cms.hhs.gov/COBRAContinuationofCov/01_Overview.asp*.

Under the IRF PPS, IRFs receive additional payment amounts to account for the cost of furnishing care to low-income patients. See 42 CFR Section 412.624(e) (2) on the Internet at *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr412.624.pdf*.

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases is based on the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (i.e., the "IPPS comparable amount."). See 42 CFR Section 412.529 on the Internet at *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr412.529.pdf*.

The calculation of the "IPPS comparable amount" in the LTCH PPS SSO payment adjustment includes an IPPS comparable adjustment for the costs of serving a disproportionate share of low-income patients, where applicable, which utilizes SSI data (see 42 CFR Section 412.529(d)(4)).

Change request (CR) 6530 provides links to the electronic files containing updated SSI Medicare beneficiary data for determining additional payment amounts for hospitals with a disproportionate share of low-income patients. The SSI/Medicare beneficiary data for hospitals contains the name of the hospital, provider number, SSI days, total Medicare days, and the ratio of Medicare Part

Supplemental security income Medicare beneficiary data for Fiscal year 2007 (continued)

A patient days attributable to SSI recipients. The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during fiscal year 2007 (cost reporting periods beginning **on or after October 1, 2006, and before October 1, 2007**).

The files are located at the following addresses:

- The IPPS data is available on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopofPage*
- The IRF PPS data is on the CMS Web site at *http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopofPage*
- The LTCH PPS data is on the CMS Web site at *http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopofPage*.

Additional information

The official instruction, CR 6530, issued to your Medicare FI and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1774CP.pdf*.

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

MLN Matters® Number: MM6530
Related Change Request (CR) Number: 6530
Related CR Release Date: July 24, 2009
Related CR Transmittal umber: R1774CP
Effective Date: August 7, 2009
Implementation Date: August 7, 2009

Source: CMS Pub. 100-04, Transmittal 1774, CR 6530

2010 proposed policy and payment rate changes for services in hospital outpatient departments and ambulatory surgical centers

Hospitals would be able to bill Medicare for pulmonary and intensive cardiac rehabilitation services furnished in outpatient departments beginning January 1, 2010, under a proposed rule issued today by the Centers for Medicare & Medicaid Services (CMS). The proposed rule would also provide for payments to rural hospitals for kidney disease education services furnished in their outpatient departments for Medicare beneficiaries with stage IV chronic kidney disease.

The proposals, which would implement provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), were contained in a notice of proposed rulemaking (NPRM) that would revise payment policies and update the payment rates for services furnished to beneficiaries during calendar year (CY) 2010 in hospital outpatient departments under the outpatient prospective payment system (OPPS). Additional proposals to incorporate an adjustment for hospital pharmacy costs that would result in OPPS payment at the average sale price (ASP) plus four percent for most separately payable drugs and biologicals and to adapt current requirements for physician supervision of hospital outpatient services to the changing health care environment would help ensure beneficiary access to safe, cost-effective health care at all hospital outpatient sites.

The NPRM also includes proposals for policy changes and payment rates for services in ambulatory surgical centers (ASCs), which would continue the expansion of surgical procedures Medicare would cover when performed in ASCs. The proposed rule seeks to ensure that beneficiaries have access to outpatient services in all appropriate settings, while improving the quality and efficiency of service delivery.

"In this proposed rule, CMS is continuing to strengthen the connection between Medicare payment and efficient, high quality care," said CMS acting administrator Charlene Frizzera. "The payment proposals are also designed to ensure that when services can be performed in a variety of settings, such as a physician's office, a hospital outpatient department, or an ambulatory surgical center, the choice of setting is based on the patient's needs, rather than payment incentives."

Medicare currently pays more than 4,000 hospitals – including general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals – for outpatient services under the OPPS, which also sets payment policies and payment rates for partial hospitalization services furnished by community mental health centers. CMS is projecting a market basket update for CY 2010 of 2.1 percent for outpatient departments and estimates total payments of $31.5 billion under the OPPS in CY 2010.

There are approximately 5,000 Medicare-participating ASCs. Since January 1, 2008, ASCs have been paid under a revised payment system that not only aligns ASC payment rates with the rates paid for similar services when furnished in hospital outpatient departments but also greatly expands

2010 proposed policy and payment rate changes for services in hospital outpatient departments and ASCs (continued)

the number and types of surgical services that are covered by Medicare when performed in ASCs. CY 2010 is the third year of a four-year phase-in of the ASC payment rates calculated under the standard rate-setting methodology and the first year for which CMS is authorized to apply an update to the conversion factor. CMS is projecting the percentage increase in the consumer price index for all urban consumers that would update the ASC conversion factor to be 0.6 percent. Total CY 2010 payments to ASCs are estimated to be $3.4 billion.

The proposed rule affects Medicare payments to hospitals and ASCs for the resources – such as equipment, supplies, and hospital or ASC staff – they use to furnish ambulatory health care services to beneficiaries. CMS pays separately for the services of physicians and nonphysician practitioners under the Medicare physician fee schedule (MPFS).

Under the hospital outpatient department quality reporting program (HOP QDRP), hospitals that did not participate in the program or did not successfully report the quality measures will receive an update in CY 2010 equal to the annual payment update factor minus 2.0 percentage points, or 0.1 percent. Hospitals that are exempt from the inpatient prospective payment system – such as long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, cancer hospitals, and children's hospitals – as well as hospitals in Puerto Rico are not subject to the HOP QDRP payment reduction.

CMS is proposing to continue to require HOP QDRP participating hospitals to report the existing seven emergency department and perioperative care measures, as well as the four existing claims-based imaging efficiency measures for the CY 2011 payment determination. Although it is not proposing to adopt any new measures for the CY 2011 update, CMS is seeking public comment on potential additional quality measures for consideration for future OPPS updates. The potential measures relate to a number of areas including cancer care, emergency department throughput, diabetes, stroke and rehabilitation, osteoporosis, medication reconciliation, respiratory, immunization, health information technology, cataract surgery, overuse/appropriate use, imaging efficiency, and surgical care.

CMS is also proposing to phase in a new HOP QDRP validation requirement to ensure that hospitals are accurately reporting measures for chart-abstracted data, but the validation results will not have any impact on outpatient department payments in CY 2011. In addition, CMS is proposing to establish procedures to make quality data collected under the HOP QDRP for quarters beginning with the third quarter of CY 2008 publicly available.

CMS will accept comments on the proposed rule until August 31, 2009, and will respond to comments in a final rule to be issued by November 1, 2009.

The proposed rule is available at *http://edocket.access.gpo.gov/2009/pdf/E9-15882.pdf*.

The supporting information on the CY 2010 proposals for the OPPS and ASC payment system will be posted on the CMS Web site at:

OPPS: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*
ASC payment system:
http://www.cms.hhs.gov/ASCPayment/. ❖

Source: CMS PERL 200907-03

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New ratings for America's hospitals now available on Hospital Compare Web site

Individual rates provided on more than 4,000 hospitals nationwide, new mortality and readmission data included.

Important new information has been added to the Centers for Medicare & Medicaid Services' (CMS) *Hospital Compare* Web site that reports how frequently patients return to a hospital after being discharged, a possible indicator of how well the facility did the first time around. The site is *http://www.hospitalcompare.hhs.gov*.

On average, one in five Medicare beneficiaries who are discharged from a hospital today will re-enter the hospital within a month. Reducing the rate of hospital readmissions to improve quality and achieve savings is a key component of President Obama's health care reform agenda.

"The President and Congress have both identified the reduction of readmissions as a target area for health reform," said Health & Human Services Secretary Kathleen Sebelius. "When we reduce readmissions, we improve the quality of care patients receive and cut health care costs."

With the update announced today, *Hospital Compare* will provide better data on the previously posted mortality rates for individual hospitals, as well as the new data on 30-day readmissions for heart attack, heart failure, and pneumonia. Previously, *Hospital Compare* had provided only mortality rates for these three conditions.

Research has shown that hospital readmissions are reducing the quality of health care while increasing hospital costs. *Hospital Compare* data show that for patients admitted to a hospital for heart attack treatment, 19.9 percent of them will return to the hospital within 30 days; 24.5 percent of patients admitted for heart failure will return to the hospital within 30 days; and 18.2 percent of patients admitted for pneumonia will return to the hospital within 30 days.

Both the mortality and the readmissions measures have been endorsed by the National Quality Forum (NQF) and are supported by the Hospital Quality Alliance (HQA). These measure endorsement processes are instrumental in facilitating CMS's communication with hospitals and helping to motivate those hospitals to continually analyze and improve the

New ratings for America's hospitals now available on Hospital Compare Web site (continued)

quality of their care. Collaboration achieved through the CMS measure development process, the NQF, and HQA continues to ensure that public reporting efforts for hospitals are supported by a broad cross section of the health care community.

Both sets of measures are risk-adjusted and take into account previous health problems to "level the playing field" among hospitals and to help ensure accuracy in performance reporting.

The *Hospital Compare* Web site will show a hospital's mortality or readmissions rate is "Better than," "No different from," or "Worse than" the U.S. national rate. This data information includes each hospital's risk-standardized mortality rate (RSMR), an estimate of the rate's certainty (also known as the interval estimate), and the number of eligible cases for each hospital. By posting hospital RSMRs, interval estimates, and the number of eligible cases, CMS is giving consumers and communities additional insight into the performance of their local hospitals in hopes that this will prompt all hospitals to work toward achieving the level of the top-performing hospitals in the country.

Hospital Compare also includes 10 measures that capture patient satisfaction with hospital care, 25 process of care measures, and two children's asthma care measures. The site also features information about the number of selected elective hospital procedures provided to patients and what Medicare pays for those services.

Public reporting of these and other measures is intended to empower patients and their families with information they need to engage their local hospitals and physicians in active discussions about quality of care.

"CMS believes that all hospitals, regardless of their readmission and mortality rates, should use the data available in these free, detailed reports to find ways to continually improve the care they deliver," said Frizzera.

CMS urges consumers not to view any one process or outcome measure on *Hospital Compare* as a tool to "shop" for a hospital. The information contained on *Hospital Compare* is available for consumers to use in making health care decisions; although, consumers should gather information from multiple sources when choosing a hospital. For example, patients and caregivers could use the Web site to help them discuss plans of care with their trusted health care providers. In an emergency situation, patients should always go to the nearest, most easily accessible facility.

Consumers have relied on *Hospital Compare* since 2005 to provide information about the quality of care provided in over 4,700 of America's acute-care hospitals. In 2008 alone, *Hospital Compare* had over 18 million page views, and has received about 1 million page views each month of 2009 thus far.

CMS expands information for consumers about outcomes of care in America's hospitals

Overview

The Centers for Medicare & Medicaid Services (CMS) has expanded the amount of information available on its *Hospital Compare* Web site at *http://www.hospitalcompare.hhs.gov*.

As of July 2009, the Web site will now include updated information on 30-day mortality rates for patients admitted to many inpatient hospitals for heart failure, acute myocardial infarction (heart attack), and pneumonia. The Web site also includes the debut of new 30-day readmissions measures for patients who were originally admitted to these hospitals for one of these three conditions.

This information is shared with consumers and providers to improve the quality and transparency of care by giving the American public and healthcare professionals better access to important hospital data. The new readmissions measures complement the mortality measures and the clinical process and patient satisfaction measures already reported on *Hospital Compare* to promote increased scrutiny by hospitals of patient outcomes in the service of providing the right care for every patient, every time.

Background: Data about hospital care

CMS has been reporting information about the quality of care available at America's hospitals for several years. Before 2007, this information was limited to "process of care measures," the rates of which demonstrate how well hospitals follow generally recognized protocols believed to result in the best patient outcomes.

However, these "process of care measures" failed to capture how well patients fared as a result of these care protocols.

In 2007, CMS began reporting 30-day mortality rates for inpatient hospital stays related to heart attack and heart failure. CMS added 30-day mortality rates for pneumonia-related stays in 2008. Mortality rate measures are "outcome" measures because they give an indication of how the patient fared after the inpatient hospital stay. The rates themselves are actually predictions of how many patients will die within 30 days of discharge from the hospital (after having been admitted for heart attack, heart failure, and pneumonia), and are "risk adjusted" to account for extraneous influences, such as the difference among hospitals in the degree of their patients' illnesses. CMS placed each hospital into one of three categories, based on their mortality rates: "Better than U.S. National Rate," "No Different than U.S. National Rate," or "Worse than U.S. National Rate."

Updates to *Hospital Compare*: Adding readmissions data

Similar to the mortality measures, the readmissions measures are also outcome measures. In July 2009, CMS debuted a new set of measures on *Hospital Compare* that show 30-day all-cause readmissions for patients who had been admitted to the hospital for heart attack, heart failure, and pneumonia. About one in five patients who leave the hospital will be readmitted within 30 days of discharge. Researchers have noted that readmissions are too common and costly, and that they are often preventable.

These measures complement the mortality data already available on the *Hospital Compare* Web site to provide a complete picture of the outcomes of care in many of America's hospitals. Measuring and reporting readmissions information places a spotlight on the entire spectrum of care that hospitals provide, as well as the care that patients receive from other providers after being released from the

New ratings for America's hospitals now available on Hospital Compare Web site (continued)

hospital. Some readmissions are inevitable; however, learning more about how well patients are doing after they leave the hospital is paramount to CMS's goals to combat poor quality and to positively impact the lives of Medicare beneficiaries and the health of the American public overall.

Methods for calculating outcomes measures

The CMS readmissions and mortality measures are risk-adjusted measures and were developed by a team of clinical and statistical experts from Yale and Harvard Universities under the direction of CMS. The National Quality Forum (NQF) endorsed the measures following a rigorous review process involving providers, consumers, purchasers, and researchers.

The model CMS uses to assess hospital readmissions and mortality rates is based on claims data and has been validated by models based on clinical data. It takes into account medical care received during the year prior to each patient's hospital admission, as well as the number of admissions at each hospital. The model uses this information to adjust for differences in each hospital's patient mix, so that hospitals that care for older, sicker patients are on a "level playing field" with those whose patients would be expected to be at less risk of dying within 30 days of admission.

In 2007 and 2008, CMS reported this mortality data based on one year of hospital claims. Starting in June 2009, CMS expanded its calculations to include three years of hospital claims for its mortality measures. The measures on *Hospital Compare* now include data on discharges that occurred from July 1, 2005, through June 30, 2008. These additional two years of data provide a clearer picture of hospital outcomes and will help consumers make better distinctions among the performance levels of hospitals in their communities. Readmissions measures also reflect three years of data.

Certain exclusions from measures

Certain admissions are excluded from the calculation of the mortality and readmissions measures. For example, CMS excludes claims from its mortality calculation when a patient was enrolled in the Medicare hospice program on the first day of admission or for the 12 months prior to hospital admission because the agency recognizes that this could potentially skew the hospital's mortality or readmissions rates. Likewise, CMS excludes from its calculation of the heart attack readmission measure patients who have been readmitted to the hospital within 30 days of a discharge after heart attack when the readmission is for the purpose of a planned cardiac treatment, such as a heart bypass or a coronary angioplasty. Lastly, CMS excludes from the mortality and readmissions measure calculations admissions of patients who left the hospital against medical advice, because those hospitals may not have been able to provide the best care possible for these patients.

In addition, CMS does not report mortality or readmissions data for hospitals that have treated fewer than 25 cases during the relevant reporting period in any of the mortality or readmission measure categories. Without at least 25 cases, CMS cannot make an accurate estimate of the hospital's performance for a particular measure. For those hospitals with fewer cases, the *Hospital Compare* Web site reads, "the number of cases is too small to reliably tell how the hospital is performing."

CMS updates most of its *Hospital Compare* measures quarterly. To learn more about the quality of care available at your local hospital, visit *Hospital Compare* at *http://www.hospitalcompare.hhs.gov*.

Outcome measure results for July 2009 reporting

Performance categories from July 2005-June2008 discharges

Mortality Measure	U.S. National Rate	Better than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate	… Number of Cases Too Small*
AMI 30-Day Mortality	16.6%	131	2,184	54	1,610
HF 30-Day Mortality	11.1%	213	3,812	163	585
PN 30-Day Mortality	11.5%	253	3,934	284	343
Mortality Readmission					
AMI 30-Day Readmission	19.9%	36	2,488	52	1,944
HF 30-Day Readmission	24.5%	180	3,854	233	520
PN 30-Day Readmission	18.2%	88	4,199	198	349

* Number of cases too small (fewer than 25) to reliably tell how the hospital is performing.

New ratings for America's hospitals now available on Hospital Compare Web site (continued)

Note: Maryland hospital information is being recalculated for *Hospital Compare* and is not available at *http://www.hospitalcompare.hhs.gov*. Because of the way hospitals are paid under Medicare in Maryland, the claims data contains patients admitted to hospital owned rehabilitation facilities, unlike hospitals in other states. This could adversely impact the 30 day readmission rates for Maryland hospitals by counting transfers to the hospital's rehabilitation facilities as readmissions.

In preparation for the public reporting of *Hospital Compare* measures, all hospitals were provided an opportunity to review their data. For this release of *Hospital Compare*, the preview period was in April and May, 2009. On the evening before the release of the *Hospital Compare* measures, one Maryland hospital brought the data issue to CMS's attention.

CMS is uncertain of the impact on the readmission rates for any particular Maryland hospital, and believes that it is likely to be small. Nevertheless, CMS is suppressing the measures results for Maryland hospitals due to these coding issues, unique to Maryland. CMS will correct for this coding issue for the next round of reporting. ❖

Source: CMS PERL 200907-12

Fact sheet for inpatient psychiatric facilities now available

The revised *Inpatient Psychiatric Facility Prospective Payment System* fact sheet (May 2009), which provides general information about the inpatient psychiatric facility prospective payment system (IPF PPS), how payment rates are set, and the rate year 2010 update to the IPF PPS, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo/*, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page." ❖

Source: CMS PERL 200907-09

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Medicare dependent hospital fact sheet

The *Medicare Dependent Hospital* fact sheet (April 2009) provides the criteria that rural hospitals must meet to be classified as a Medicare dependent hospital and is available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*® at *http://www.cms.hhs.gov/MLNProducts/downloads/MedDependHospfctsht508.pdf*.

If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser. ❖

Source: CMS PERL 200906-32

Clarification on use of national drug codes in 837I billing

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

Note: CMS has revised *MLN Matters* article MM6330 to provide a Web address in the *Additional information* section for accessing electronic billing information, including flat file formats. All other information remains the same. The *MLN Matters* article MM6330 was published in the May 2009 *Medicare A Bulletin* (page 29).

Provider types affected

Hospitals, home health agencies, and other providers who bill Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], or Medicare administrative contractors [MAC]) for drugs, especially new drugs provided under the outpatient prospective payment system (OPPS).

What you need to know

Change request (CR) 6330, from which this article is taken, specifies how quantities of drugs are to be reported and then processed by Medicare when the national drug codes (NDC) is used for institutional billing. Specifically, it also requires Medicare contractors to accept decimal values for NDC quantities. CR 6330 also adds to prior instructions regarding the reporting of drugs that have not yet been approved by the Food and Drug Administration (FDA). Be sure your billing staff is aware of these changes.

Background

As provided by CR 3287 issued May 28, 2004, (MMA-Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Specific Drug/Biological HCPCS Code); Medicare hospitals, subject to the OPPS, may use Healthcare Common Procedure Coding System (HCPCS) code C9399 to report drugs that have been approved by the FDA, but that do not yet have a product-specific drug/biological HCPCS code.

CR 6330, from which this article is taken, builds on those instructions and adds some additional requirements for providers. Effective for claims with dates of service on or after July 1, 2009, hospitals billing for drugs/biologicals that have received FDA-approval but which have not yet received product-specific drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the **quantity** of that drug/biological using the CTP segment in the ANSI X-12 837 I (in loop 2410 LIN 03).

Clarification on use of national drug codes in 837I billing (continued)

In addition, CR 6330 provides that the use of the 'units field,' while adequate to define quantities when HCPCS codes are used to describe drugs and biologicals, is not adequate to describe the quantities of a drug or biological identified only by an NDC. Thus, CR 6330 requires Medicare contractors to accept decimals to specify the quantity in this new quantity field, and requires Medicare's systems to retain this information in the repository and forward it to a subsequent payer (although the decimals may be rounded to whole numbers for actual claim processing).

Additional information

For further information, see the instruction issued to your FI, RHHI, or MAC regarding this issue, which may be found by going to the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R446OTN.pdf*.

Information on electronic claim formats, including the flat file formats, is available on the CMS Web site at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp*.

You might also want to review the *MLN Matters* article related to CR 3287, which you may find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.pdf*.

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

MLN Matters® Number: MM6330 – Revised
Related Change Request (CR) Number: 6330
Related CR Release Date: February 13, 2009
Related CR Transmittal Number: R446OTN
Effective Date: July1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-20, Transmittal 446, CR 6330

ESRD Services

List of ESRD-related diagnostic tests added to the Medicare Claims Processing Manual

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

Provider types affected

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

Provider action needed

This article is informational in nature and conveys that the purpose of change request (CR) 6515 is to place a listing of diagnostic tests that are considered end-stage renal disease (ESRD)-related as Exhibit 1 (new) at the end of Chapter 16 of the *Medicare Claims Processing Manual*.

Background

CR 6515 places the listing of diagnostic tests that are considered ESRD-related as Exhibit 1 (formerly Attachment 1 in CR 2906) at the end of Chapter 16 of the *Medicare Claims Processing Manual*. This listing was inadvertently omitted from the manual during the implementation of CR 2906 (Transmittal 69, January 25, 2004; see on the Centers for Medicare & Medicaid Services [CMS] Web site *http://www.cms.hhs.gov/transmittals/downloads/R69CP.pdf*).

The purpose of CR 2906 was to address specific areas of concerns regarding Medicare system edits for skilled nursing facilities (SNF) consolidated billing (CB) to permit payment for certain diagnostic services furnished to beneficiaries receiving treatment for ESRD at an independent provider-based dialysis facility. One of the areas of concern was that providers and suppliers needed a listing of diagnostic tests that are considered ESRD-related that would require modifier CB. Consequently, a list defining specific diagnostic tests as ESRD-related was included in CR 2906. This list applies only to SNF CB. According to CR 2906, any diagnostic services related to the beneficiary's ESRD treatment/care must be submitted using modifier CB, however, if these services are not on the list labeled as Attachment 1 in CR 2906 or the list being added to the *Medicare Claims Processing Manual* by CR 6515, your Medicare contractor may require supporting medical documentation.

To view the list being added to the end of Chapter 16 of the *Medicare Claims Processing Manual*, see CR 6515, which is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1769CP.pdf*.

Additional information

The official instruction, CR 6515, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1769CP.pdf*.

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

MLN Matters® Number: MM6515
Related Change Request (CR) Number: 6515
Related CR Release Date: July 10, 2009
Related CR Transmittal Number: R1769CP
Effective Date: July 31, 2009
Implementation Date: July 31, 2009

Source: CMS Pub. 100-04, Transmittal 1769, CR 6515

End-stage renal disease split-claim billing for dialysis services

First Coast Service Options Inc. (FCSO) is seeing a significant increase in the number of split-claim from facilities billing for end-stage renal disease (ESRD) services. Split-billed claims are multiple claims submitted for services provided in a single month to the same patient. This billing pattern is considered to be out of compliance and inconsistent with the Centers for Medicare & Medicaid Services (CMS) billing guidelines. According to the CMS Internet-only manual (Pub 100-04, Chapter 1, Section 50.2.2), repetitive services furnished to a single individual are to be billed monthly. This means that **a single claim**, which includes all services provided to the patient during that specific month, should be submitted. We will continue to monitor this situation on a provider specific basis to determine if further contractor actions are indicated.

A previous ESRD article titled "End-stage renal disease frequency of dialysis" published in the May 2009 *Medicare A Bulletin* (page 33) indicated that treatments exceeding 14 dialysis sessions a month (three weekly) must include medical justification on the claim. As clarification to that article, justification must include a brief narrative with signs and symptoms that establish the medical necessity for the additional treatments. A diagnosis code alone will not suffice. ❖

SKILLED NURSING FACILITY SERVICES

Five-star quality rating system – July news

1. The five-star provider preview reports are available on Wednesday, July 15, 2009. Providers may access the report from the minimum data set (MDS) state welcome pages available at the state servers for submission of minimum data set information.

Provider preview access information

- Visit the MDS state welcome page available on the state servers where you submit MDS data to review your results.
- To access these reports, select the certification and survey provider enhanced reporting (CASPER) system link located at the bottom of the login page.
- Once in the CASPER system,
  - i. Click on the 'Folders' button and access the five-star report in your 'st LTC facid' folder,
  - ii. Where st is the two-digit postal code of the state in which your facility is located, and
  - iii. Facid is the state assigned facid of your facility.

2. The five star helpline reopened on July 15, 2009, from 9 a.m. to 5 p.m., EST through July 30, 2009, for questions and concerns about the July data. Alternatively, providers may write to *BetterCare@cms.hhs.gov*.
3. Nursing Home Compare will be updated with July's five-star data on Thursday, July 23, 2009.
4. Please visit *http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp* for the latest five-star quality rating system information. ❖

Source: CMS PERL 200907-15

Sign up to our *eNews* electronic mailing list

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

ELECTRONIC DATA INTERCHANGE

Claim status category code and claim status code update

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

Provider types affected

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

Provider action needed

This article, based on change request (CR) 6525, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 were updated during the January 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on the Internet on March 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the January 2009 committee meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on March 1, 2009. Medicare implemented those changes on July 6, 2009, as a result of CR 6525.

Additional information

The official instruction issued to your Medicare contractor regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1756CP.pdf*.

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

MLN Matters® Number: MM6525
Related Change Request (CR) Number: 6525
Related CR Release Date: June 12, 2009
Related CR Transmittal Number: R1756CP
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Source: CMS Pub. 100-04, Transmittal 1756, CR 6525

CMS dedicated section for information on versions 5010, D.0, and 3.0 available

This section of the Centers for Medicare & Medicaid Services (CMS) Web site contains information and educational resources pertaining to:

- Version 5010 – the new version of the X12 standards for Health Insurance Portability and Accountability Act (HIPAA) transactions
- Version D.0 – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation

This section includes background information on the new standards, regulatory information, the latest outreach messages from CMS, educational resources, resources specific to D.0 and 3.0, as well as implementation information for the Medicare fee-for-service systems. CMS plans to add additional information as it becomes available, so bookmark the section today. You may access this section at *http://www.cms.hhs.gov/Versions5010andD0*.

You may also view the presentation, transcript and listen to the audio file from the June 9 national provider conference call regarding versions 5010 and D.0, available on the Educational Resources page or on the CMS Web site at *http://www.cms.hhs.gov/Versions5010andD0/Downloads/6-9-2009_National_Provider_Call.pdf*. ❖

Source: CMS PERL 200907-26

Instructions on using ANSI X12 837 institutional segments for Medicare secondary payer Part A claims

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

Note: CMS has revised *MLN Matters* article MM6426 to reflect a revision to change request (CR) 6426, which was re-issued on June 26, 2009. The CR was revised to change the effective and implementation dates to October 1, 2009, and October 5, 2009, respectively. The CR release date, transmittal number and CR Web address were also changed. All other information remains the same. The *MLN Matters* article MM6426 was published in the April 2009 *Medicare A Bulletin* (page 35).

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

What you need to know

CR 6426, from which this article is taken, alerts your Medicare Part A contractors (FIs, MACs, and RHHIs) and their associated systems to the changes they will need to follow when calculating MSP payment amounts from incoming American National Standards Institute (ANSI) ASC X12N 837 4010-A1 claims transactions. It specifically addresses their use of data reported in ANSI ASC X12N 837 institutional claim adjustment segments (CAS) for MSP Part A claims.

CR 6426 only affects providers submitting Part A claims. It is important for such providers to code the CAS segments of their claims accurately so that Medicare will make the correct MSP payments. See the *Background* and *Additional Information* sections of this article for further details regarding these changes.

Background

The Medicare Secondary Payer (MSP) provisions apply to situations where Medicare is not the beneficiary's primary insurance. Medicare's secondary payment for Part A MSP claims is based on:

- Medicare-covered charges, or the amount the physician (or other supplier) is obligated to accept as payment in full (OTAF), whichever is lower;
- What Medicare would have paid as the primary payer; and
- The primary payer(s) payment.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health & Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions and the implementation guides for each transaction are available on the Internet at *http://www.wpc-edi.com*.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6426 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements.
- Providers code for the CAS segments claims to reflect any adjustments made by primary payers.
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 institutional claim.

Adjustments made by the payer are reported in the CAS segment on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer (a.k.a. your contractual obligation), you must identify this amount as value code 44 in the 2300 HI value information. This amount is also known as the obligated to accept as payment in full amount (OTAF). Details of the MSP payment provisions may be found in the *CMS Medicare Secondary Payer Manual* and in the federal regulations at 42 CFR 411.32 and 411.33.

Additional Information

You may find the official instruction (CR 6426) issued to your FI, RHHI, or MAC by visiting the Centers for Medicare & Medicaid Services (CMS) Web site at *http://www.cms.hhs.gov/transmittals/downloads/R70MSP.pdf*.

Instructions on using ANSI X12 837 institutional segments for Medicare secondary payer Part A claims (continued)

You will find the updated *Medicare Secondary Payer (MSP) Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.3.2 (Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format) as an attachment to that CR.

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

MLN Matters® Number: MM6426 – Revised
Related Change Request (CR) Number: 6426
Related CR Release Date: June 26, 2009
Related CR Transmittal Number: R70MSP
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Source: CMS Pub. 100-05, Transmittal 70, CR 6426

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events

September 2009

Topic – Medifest educational event – Orlando, Florida

Registration for this popular educational event is closed – All classes are full

When: Tuesday and Wednesday, September 1 and 2, 2009

Time: 8:00 a.m. – 5:30 p.m. ET **Delivery language:** English

Type of Event: In person seminar/symposium **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Hot Topic Series – Medicare 2009 updates and changes

When: Wednesday, September 16, 2009

Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** Florida and U.S. Virgin Islands

Hot Topic Series – Medicare 2009 updates and changes

When: Tuesday, September 22, 2009

Time: 2:00 p.m. – 3:30 p.m. ET **Delivery language:** Spanish

Type of Event: Webcast **Focus:** Puerto Rico

Two easy ways to register

Online – Visit our provider training Web site at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time User?** Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

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

Tips for using the FCSO provider training Web site

To search and register for events on *www.fcsomedicaretraining.com* click on the following links:

- "Course Catalog" from the top navigation bar
- "Catalog" in the middle of the page
- "Browse Catalog" on the right of the search box
- "FL – Part A or FL – Part B" from list in the middle of the page.

Select **Register** in the Options column located next to the specific course listed on the Instructor-Led Training (ILT) schedule page. For further assistance, contact FCSO Medicare training help desk at 1-866-756-9160 or send an e-mail to *fcsohelp@geolearning.com*.

Please Note:

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

Registrant's Name: _____
Registrant's Title: _____
Provider's Name: _____
Telephone Number: _____ Fax Number: _____
E-mail Address: _____
Provider Address: _____
City, State, ZIP Code: _____

Keep checking our Web site, *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. ❖

OTHER EDUCATIONAL RESOURCES

Revised Clinical Laboratory Improvement Amendments brochure

The Clinical Laboratory Improvement Amendment (CLIA) established quality standards for laboratories to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. The CLIA brochure contains information and links to a variety of CLIA resources including: CLIA regulations, CLIA enrollment, CLIA certificates, CLIA fee schedules, CLIA-approved accrediting organizations, and CLIA state and regional offices. To view the brochure, go to: *http://www.cms.hhs.gov/MLNProducts/downloads/CLIABrochure.pdf*." ❖

Source: CMS PERL 200907-11

Order form for Medicare Part A 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)

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (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 2008 through September 2009.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				

Please write legibly	Subtotal	**$**
	Tax (***add % for your area***)	**$**
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Mail this form with payment to:

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

Contact Name:
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Provider/Office Name:
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Telephone Number (include area code):
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State, ZIP Code:
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(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

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CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding Outpatient Services, CORF, ORF, PHP
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

PART A REDETERMINATION
Medicare Part A Redetermination and Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

MEDICARE SECONDARY PAYER
Information on Hospital Protocols
Admission Questionnaires, Audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

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Medicare Secondary Payer
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Jacksonville, FL 32231-0021

MSPRC DPP Debt Recovery
Automobile Accident Cases
Settlements/Lawsuits
Other Liabilities
Auto/Liability Department – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

ELECTRONIC CLAIM FILING
Direct Data Entry (DDE) Startup
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

FRAUD AND ABUSE
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

POST-PAY MEDICAL REVIEW
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

OVERPAYMENT COLLECTIONS
Repayment Plans for Part A Participating Providers
Cost Reports (original and amended)
Receipts and Acceptances
Tentative Settlement Determinations
Provider Statistical and Reimbursement (PS&R) Reports
Cost Report Settlement (payments due to provider or program)
Interim Rate Determinations
TEFRA Target Limit and SNF Routine Cost Limit Exceptions
Provider Audit and Reimbursement Department (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

Freedom of Information Act Requests (relative to cost reports and audits)
Provider Audit and Reimbursement Department (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268
1-904-791-8430

PROVIDER ENROLLMENT
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

PROVIDER ENROLLMENT
American Diabetes Association Certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

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Overnight Mail and/or other Special Courier Services
First Coast Service Options Inc.
532 Riverside Av.
Jacksonville, FL 32202-4914

Other Important Addresses

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Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

RAILROAD MEDICARE
Railroad Retiree Medical Claims
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
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CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

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Customer Service Center Toll-Free
1-888-664-4112

Interactive voice response (IVR)
1-888-664-4112

Speech and Hearing Impaired
1-877-660-1759

BENEFICIARY
Customer Service Center Toll-Free
1-800-MEDICARE
1-800-633-4227
Speech and Hearing Impaired
1-800-754-7820

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

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Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
(check return assistance only)

Option 6
Automated Response Line

PROVIDER EDUCATION & OUTREACH
Seminar Registration Hotline
1-904-791-8103

Seminar Registration Fax Number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

CREDIT BALANCE REPORT
Debt Recovery
1-904-791-6281
Fax
1-9043610359

Medicare Web sites

PROVIDERS
Florida Medicare Contractor
medicare.fcso.com
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www.cms.hhs.gov

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www.cms.hhs.gov

BENEFICIARIES
Centers for Medicare & Medicaid Services
www.medicare.gov

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦