MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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FIRST COAST SERVICE OPTIONS INC.

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

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
[ ] _____
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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:

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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

Point-of-origin for admission or visit codes update to the UB-04 (CMS-1450) manual code list

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

Provider types affected

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

Provider action needed

STOP – impact to you

This article is based on change request (CR) 6801, which updates the point-of-origin for admission or visit codes to the UB-04 (CMS-1450) manual code list.

CAUTION – what you need to know

The following point-of-origin for admission or visit (formerly source of admission) codes (discontinued by the National Uniform Billing Committee (NUBC)) will be discontinued for use by Medicare systems: '7' – discontinued effective July 1, 2010; 'B' – discontinued effective July 1, 2010; and 'C' – discontinued effective July 1, 2010. In addition, point of origin for admission or visit code '1' example and definition language has been updated, though the processing of code '1' is not being changed. Also, point of origin for admission or visit code '2' definition language has been updated, though the processing of code '2' is not being changed.

GO – what you need to do

Be sure billing staff are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) health insurance claim Form UB-04 and its electronic equivalence has a required field (form locator [FL] 15) on all institutional inpatient claims and outpatient registrations for diagnostic testing services. FL 15 indicates the point of patient origin for the admission or visit of the claim being billed.

The point of origin for admission or visit (formerly source of admission) codes '7', 'B', and 'C' (discontinued by the National Uniform Billing Committee (NUBC)) will be discontinued for use by the fiscal intermediary standard system (FISS) effective July, 1, 2010. In addition, Point of Origin for Admission or Visit code '1' example and definition language has been updated (the processing of code '1' is not being changed), and Point of Origin for Admission or Visit code '2' definition language has been updated (the processing of code '2' is not being changed). These revisions are shown in the following table:

Form locator (FL) 15 – point of origin for admission or visit

Required: The provider enters the code indicating the source of the referral for this admission or visit.

Code structure:		
1	**Non-health care facility point of origin** (physician referral) **Effective July 1, 2010:** **Non-health care facility point of origin** **Usage note:** Includes patients coming from home, a physician's office, or workplace. **Effective July 1, 2010** Examples: Includes patients coming from **home or workplace.**	**Inpatient:** The patient was admitted to this facility upon an order of a physician. **Effective July 1, 2010:** **Inpatient:** The patient was admitted to this facility. **Outpatient:** The patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). Includes non-emergent self-referrals. **Effective July 1, 2010:** **Outpatient:** The patient presented to this facility for outpatient services.

Point-of-origin for admission or visit codes update to the UB-04 (CMS-1450) manual code list (continued)

Code structure:		
2	Clinic	**Inpatient:** The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic. **Effective July 1, 2010:** **Inpatient:** The patient was admitted to this facility.
		Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services. **Effective July 1, 2010** **Outpatient:** The patient presented to this facility for outpatient services.
7	Emergency room (ER)	**Inpatient:** The patient was admitted to this facility after receiving services in this facility's emergency room department. **Discontinued July 1, 2010**
B	Transfer from another home health agency	The patient was admitted to this home health agency as a transfer from another home health agency. **Discontinued July 1, 2010. See condition code 47.**
C	Readmission to same home health agency	The patient was readmitted to this home health agency within the same home health episode period. **Discontinued July 1, 2010.**

Additional information

The official instruction, CR 6801, issued to your FI, A/B MAC, and RHHI regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1917CP.pdf*.

If you have any questions, please contact your FI, A/B MAC, or RHHI 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: MM6801
Related Change Request (CR) Number: 6801
Related CR Release Date: February 5, 2010
Related CR Transmittal Number: R1917CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1917, CR 6801

Correction to processing of noncovered revenue codes

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

Provider types affected

All providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FI], regional home health intermediaries [RHHI], and A/B Medicare administrative contractors [MAC]) for Medicare beneficiaries are affected.

Provider action needed

This article, based on CR 6774, explains that claims containing an institutional service line submitted with a revenue code that is not valid for Medicare billing will only be returned to the provider if the line is submitted with covered charges or the claim indicates that beneficiary liability may apply. Affected providers should ensure that their billing staffs are aware of these changes that are effective for claims processed on or after July 6, 2010.

Background

In October 2004, the Centers for Medicare & Medicaid Service (CMS) issued Transmittal 332, change request (CR) 3416, entitled "New Policy and Refinements on Billing Non-covered Charges to Fiscal Intermediaries (FIs)." This transmittal completed a series of instructions that established requirements for processing noncovered charges on institutional claims and for correctly assigning financial liability for noncovered charges. One underlying premise of those instructions was that any institutional provider should be able to submit a claim line with noncovered charges for any service that the provider delivered and that Medicare systems should process that noncovered line to completion without payment. This premise is consistent with the goals of administrative simplification and increasing automated coordination of benefits across various payers.

Correction to processing of noncovered revenue codes (continued)

Those instructions contained one significant omission in that they did not take into account the fact that Medicare systems currently determine whether a particular revenue code is valid for Medicare billing without regard to whether the revenue code line is submitted as noncovered. Each Medicare contractor that processes institutional claims maintains a revenue code file which lists the revenue codes that are valid for each type of bill. If a provider submits a claim with a revenue code that is not listed on the revenue code file as valid for the submitted type of bill, the claim is returned to the provider. This should happen when the revenue code line is submitted with covered charges, but the claim should not be returned if it is submitted entirely with noncovered charges.

Medicare systems will be changed so that a revenue code line submitted with entirely noncovered charges and no indication that beneficiary liability may apply will not be returned to the provider. Such claims should be processed to completion without payment, assigning liability to the provider. CR 6774 revises Medicare systems to ensure this outcome. CR 6774 also contains miscellaneous clarifications to Chapter 1, General Billing Requirements, in the *Medicare Claims Processing Manual* and those clarifications, which do not change any Medicare policies, are attached to CR 6774.

Additional information

The official instruction, (CR 6774), issued to your Medicare contractor regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1900CP.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: MM6774
Related Change Request (CR) Number: 6774
Related CR Release Date: January 29, 2010
Related CR Transmittal Number: R1900CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1900, CR 6774

Using condition code DR and modifier CR on Medicare fee-for-service claims

As part of its response to the 2005 Katrina hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed condition code "DR" and modifier "CR" to facilitate the processing of claims affected by that emergency. (See Transmittal 184, change request [CR] 4106, issued on October 15, 2005.)

Use of these indicators was also authorized for claims affected by subsequent emergencies. The discretionary use of these indicators by a provider or supplier was permitted and such use signified not only that the item or service was affected by an emergency or disaster, but also that the provider or supplier had met all of CMS' requirements related to the furnishing of such item or services during the emergency or disaster.

Subsequently, on July 31, 2009, CMS issued Transmittal 1784 (CR 6451) which, among other things, narrowed the scope of permitted uses of these indicators. In particular, it eliminated the discretionary use of both condition code "DR" and modifier "CR" by providers and suppliers.

For the H1N1 pandemic emergency, CMS has authorized the use of condition code "DR" and modifier "CR" only by providers that have been granted a formal waiver under section 1135 of the Social Security Act and then only for services affected by the emergency and while the waiver remains in effect. No other provider or supplier may use either indicator at this time.

Providers and suppliers who have been annotating their claims with one or both indictors should cease doing so (unless they are operating under a formal 1135 waiver). Processing of claims annotated with these indicators, that are submitted by providers and suppliers that have not been granted an 1135 waiver, may be delayed.

If you have questions or need more information, contact your local CMS regional office. You may also visit the H1N1 Web page at *http://www.cms.hhs.gov/H1N1*. ❖

Source: CMS PERL 201001-30

Providers randomly selected to participate in the MCPSS urged to respond

The Centers for Medicare & Medicaid Services (CMS) has released a special *edition Medicare Learning Network (MLN) Matters* article that reminds providers and suppliers that CMS has launched the fifth annual national administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS). Providers and suppliers that have received a letter indicating that they were randomly selected to participate in the 2010 MCPSS are urged to take a few minutes to go online and complete this important survey via a secure Internet Web site.

The article, SE1005 – Providers Randomly Selected to Participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS) Urged to Respond, is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf*. ❖

Source: CMS PERL 201001-23

April 2010 quarterly average sales price update and revision to prior files

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 who submit claims to Medicare contractors (Medicare administrative contractors [MACs], fiscal intermediaries [FIs], carriers, durable medical equipment Medicare administrative contractors [DME MACs] or regional home health intermediaries [RHHIs]) are affected by this issue.

What you need to know

This article is based on change request (CR) 6804 which instructs Medicare contractors to download and implement the April 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised January 2010, October 2009, July 2009, and April 2009 files. Medicare will use the April 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 5, 2010, with dates of service April 1, 2009, through June 30, 2010.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions.

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

Files	Effective Dates of Service
April 2010 ASP and NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and NOC files	April 1, 2009, through June 30, 2009

Additional information

The official instruction (CR 6804) 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/R1899CP.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: MM6804
Related Change Request (CR) Number: 6804
Related CR Release Date: January 29, 2010
Related CR Transmittal Number: R1899CP
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Source: CMS Pub. 100-04, Transmittal 1899, CR 6804

Feedback page

One of the trends identified in the 2009 Medicare Contractor Provider Satisfaction Survey (MCPSS) was our providers' preference to have more ways to communicate with us. Our feedback page offers our customers the convenience of a central "hub" for communication and includes three interactive feedback, available at *http://medicare.fcso.com/feedback/*.

Processing negative CARC adjustment amounts on Medicare secondary payer claims

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

Provider types affected

This article applies to all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6736, which provides Medicare contractors with processing instructions for claim adjustment reason code (CARC) adjustment amounts that are negative when certain CARCs appear on incoming Medicare secondary payer (MSP) claims.

You should know that Medicare contractors will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive claim adjustment segment (CAS) CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as a negative adjustment. Please be sure your billing staffs are aware of these changes.

Background

CRs 6426 and 6427 instruct Medicare contractors to take into consideration the CARCs and the applicable adjustment amounts when processing MSP claims. Business requirements (BRs) 6426.6 and 6427.6 instruct shared systems to add certain CARC adjustment amounts to the paid amounts when these CARCs are received on a claim. There have been rare circumstances where the CARCs found in BR 6426.6 and 6427.6 on incoming MSP claims include a negative adjustment amount and the shared systems mistakenly added the same adjustment amount to the claim based on instructions found in CR 6426 and 6427.

CR 6736 instructs Medicare contractors not to add the CARCs when the adjustment amounts on incoming MSP claims are negative. Medicare systems will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive CAS CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as negative adjustment.

Additional information

CR 6426 is available at *http://www.cms.hhs.gov/transmittals/downloads/R70MSP.pdf*.

CR 6427 is available at *http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf*.

The official instruction, CR 6736, issued to your Medicare contractor regarding this change, may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R73MSP.pdf*.

CR 6736 includes the revisions that will be made to the *Medicare Secondary Payer (MSP) Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.5, Effect of Failure to File Proper Claim, as an attachment to that CR.

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

MLN Matters® Number: MM6736
Related Change Request (CR) Number: 6736
Related CR Release Date: February 5, 2010
Related CR Transmittal Number: R73MSP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-05, Transmittal 73, CR 6736

Compliance standards for consignment closets and stock and bill arrangements

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 rescinded change request (CR) 6528, Transmittal 300, dated September 1, 2009, to consider other implementation dates. The *MLN Matters* article MM6528 was also rescinded on February 5, 2010. The *MLN Matters* article MM6528 was published in the September 2009 *Medicare A Bulletin* (page 10).

MLN Matters® Number: MM6528 – Rescinded
Related Change Request (CR) Number: 6528
Related CR Release Date: September 1, 2009
Related CR Transmittal Number: R300PI
Effective Date: September 8, 2009
Implementation Date: March 1, 2010

Source: CMS Pub. 100-08, Transmittal 300, CR 6528

Billing and processing for healthy control group volunteers in a qualified clinical trial

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

Provider types affected

All providers submitting inpatient and outpatient claims for qualified clinical trials to fiscal intermediaries (FI) and Part A/B Medicare administrative contractors (A/B MAC) for healthy control group volunteers are affected.

Provider action needed

This article is based on change request (CR) 6776, which corrects institutional billing requirements for clinical trial claims. Institutional providers billing inpatient and outpatient clinical trial services must report International Classification of Diseases, Ninth Edition Clinical Modification (ICD-9-CM) diagnosis code of V70.7 (Examination of participant in clinical trial) in the secondary position (or in the primary position if the patient is a healthy, control group volunteer) and condition code 30 regardless of whether all services are related to the clinical trial or not.

Note: For claims with dates of service on or after September 19, 2000 through December 31, 2001, V70.5 should be used for the primary diagnosis. Please be sure that your billing staffs are aware of these changes.

Background

Healthy control group volunteers, by definition, do not have any underlying conditions. Therefore, providers need to report ICD-9-CM diagnosis code, V70.7 (V70.5 for dates of service on or after September 19, 2000 through December 31, 2001), as the primary diagnosis instead of the secondary diagnosis, as no primary diagnosis exists.

Note: For clinical trial billing requirements for patients enrolled in a managed care plan, please refer to the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Chapter 32, Section 69.9, available at *http://www.cms.hhs.gov/manuals/downloads/clm104c32.pdf*.

Additional information

The official instruction, CR 6776, issued to your FI or A/B MAC regarding this change, may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1901CP.pdf*.

If you have questions, please contact your Medicare A/B MAC 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: MM6776
Related Change Request (CR) Number: 6776
Related CR Release Date: January 29, 2010
Related CR Transmittal Number: R1901CP
Effective Date: September 19, 2000
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1901, CR 6776

Medicare Part A now issuing daily payments

Great news for providers, clearinghouses, and billing services in Puerto Rico and the U.S. Virgin Islands

First Coast Service Options (FCSO) implemented changes to the financial cycle that will improve timeliness of your payments and cash flow. Previously, Part A providers in Puerto Rico and U.S. Virgin Islands received eligible Medicare payments once a week. Effective Monday, March 1, 2010, providers now receive their eligible Medicare payments each business day, excluding federal holidays. Florida Part A providers currently receive their payments daily.

Providers may not notice the increased payment frequency until mid-March as this change applies to adjustments and claims approved to pay after March 1, 2010. The change to a daily financial payment cycle will not affect Medicare timeliness standards for processing claims.

Providers will:

- Receive eligible payments each business day
- Access electronic remittance advices (ERA) on a daily basis

Clearinghouse/billing services will:

- Provide remittance advice files to their customers on a daily basis

Providers using a third-party vendor, such as a clearinghouse or a billing agency, are encouraged to contact their vendors to ensure the ERAs are posted daily starting March 1, 2010. Most vendors already offer this daily service. If you use PC ACE-Pro 32® or other software to download ERAs, the process to access the remits will not change. The only change is the ability to download the ERA on a daily basis.

Providers may consider reviewing their internal process for retrieving remits and reconciling patients' accounts to determine if any modification to their process is necessary to accommodate this change to daily payments. Providers will continue to receive certain eligible payments, such as indirect medical education (IME) and bad debt payments, on a biweekly basis.

Note: FCSO's transition to a daily financial payment cycle does not change the current payment cycles for Medicare Advantage plans. ❖

Problem with Medicare claim crossover to supplemental payer

The Centers for Medicare & Medicaid Services (CMS) has identified a problem where claims were not automatically crossing over to supplemental payers even though the provider remittance advice indicated otherwise. This problem began January 5. Part A institutional claims and Part B professional claims, with the exception of supplier claims processed by durable medical equipment Medicare administrative contractors (DME MACs), were impacted by this problem. Claims processed by DME MACs were not impacted.

Part A institutional claims

No action is required by Part A institutional providers. As of February 2, CMS successfully implemented a systems fix to ensure that all Part A institutional claims are crossing over to supplemental payers as indicated on the remittance advice received by providers. As part of the fix, CMS' Medicare contractors were able to identify claims processed between January 5 and February 1 where the provider remittance advice indicated that the affected claims were crossed over to various supplemental payers but were not. On February 2, the affected Medicare contractors began to send the affected claims to the coordination of benefits contractor (COBC) to be crossed over to supplemental payers. This effort is now largely completed. Please allow until March 1 for supplemental payers to receive and process these claims before attempting to balance bill them for any remaining balances after Medicare.

Part B professional claims

Action is required on behalf of Part B professional providers where a remittance advice with an issue date between January 5 and February 12 has two or more service lines for a beneficiary and both of the following apply:

- One service line is 100 percent reimbursable (i.e., the approved amount and amount to be paid are equal)
- One service line where part of or the entire Medicare approved amount is applied to the Part B deductible and/or carries co-insurance amounts.

CMS is not able to forward these beneficiary claims to supplemental payers even though the remittance advice may indicate otherwise. Providers will need to identify these claims by reviewing their remittance advice with an issue date between January 5 and February 12 that contain the criteria noted above. Once identified, providers will need to take action to balance bill the beneficiary's supplemental payer. As of February 12, this system problem was fixed and all claims are crossing over to supplemental payers as indicated on the provider remittance advice.

CMS has already notified supplemental payers of these issues. CMS regrets any inconvenience you may experience related to this Medicare claim supplemental payer crossover problem. ❖

Source: CMS PERL 201002-25

There is still time to get the seasonal flu shot

Although influenza activity has declined recently, it still may continue for several months.[1] The Centers for Disease Control and Prevention continues to recommend that patients and health care providers and caregivers be vaccinated against seasonal influenza.

CMS encourages health care providers to use each office visit as an opportunity to talk with Medicare your patients about the importance of getting a seasonal flu shot. And remember, it is also important to immunize yourself and your staff.

Remember: Seasonal influenza vaccinations and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are not Part D covered drugs.

For information about Medicare coverage of the seasonal influenza virus vaccine and its administration, as well as related educational resources for health care professionals and their staff, please go to *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf*.

You will find a variety of resources that explain Medicare coverage and claims submission policies related to the seasonal influenza vaccine.

For information on Medicare policies related to H1N1 influenza, please go to the CMS Web site at *http://www.cms.hhs.gov/H1N1*.

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

Source: CMS PERL 201002-08

[1] Seasonal Influenza (Flu). [online]. Atlanta, GA: The Centers for Disease Control and Prevention, January 19, 2010 [cited 21 January 2010]. Available at *http://www.cdc.gov/flu*.

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

Organizations approved to accredit suppliers of advanced imaging services

The Centers for Medicare & Medicaid Services (CMS) is designating the following three national accreditation organizations to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging procedures:

- American College of Radiology (ACR)
- Intersocietal Accreditation Commission (IAC)
- Joint Commission (TJC)

The accreditation requirement will apply only to the suppliers furnishing the imaging services, and not to the physician's interpretation of the images.

As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), all suppliers of the TC of advanced imaging will have to become accredited by an accreditation organization designated by the Secretary of Health and Human Services by January 1, 2012. The accreditation requirement applies to physicians, nonphysician practitioners, and physician and nonphysician organizations that are paid for providing the technical component of advanced imaging services under the Medicare physician fee schedule.

MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). The details of the accreditation organization selection process went through notice and comment rulemaking in the calendar year 2010 physician fee schedule rule.

While advanced diagnostic imaging procedures can be useful in identifying health problems that might otherwise require surgery, the rapid growth in their use raises important questions of quality and safety," said Barry Straube, M.D., CMS chief medical officer and director of the CMS Office of Standards and Quality. "The three organizations that will be accrediting suppliers have the expertise and authority to set a standard of excellence industry-wide.

To be designated, the accrediting organizations had to demonstrate that they were experienced in the advanced diagnostic imaging area, and that their accreditation requirements met or exceeded the standards set out in MIPPA, including requirements for:

- Qualifications of nonphysician personnel performing the imaging
- Qualifications and responsibilities or medical directors and supervising physicians
- Procedures to ensure the safety of the individuals furnishing the imaging procedure and of the persons to whom the services are furnished
- Procedures to ensure the reliability, clarity, and accuracy of the technical quality of the diagnostic images produced by the supplier
- Procedures to assist the beneficiary in obtaining his/her imaging records on request
- Procedures to notify CMS of any changes to the imaging modalities subsequent to the accrediting organization's decision.

In addition, the accrediting organizations were required to develop a plan for reducing the burden and cost of accreditation to small and rural suppliers. The accrediting organizations are also required to provide CMS with detailed information about their survey processes.

MIPPA specifically excluded from the accreditation requirement certain imaging services such as x-rays, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography, which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

CMS will issue further guidance to suppliers about meeting the accreditation requirements. CMS plans to undertake a provider education outreach program to ensure that all affected suppliers understand the requirements and are able to comply with them prior to the January 1, 2012, accreditation deadline.

Additional information may be found at *http://www.cms.hhs.gov/medicareprovidersupenroll*. ❖

Source: CMS PERL 201002-01

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

Medicare system edit refinements related to hospice services

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

Provider types affected

Providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment Medicare administrative contractors [DME MACs] and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries that have elected the hospice benefit.

Provider action needed

This article is based on change request (CR) 6778 which:

1. Revises existing Medicare standard systems edits to allow Medicare fee for service (FFS) claims to process for beneficiaries in a Medicare Advantage plan on the date of a Medicare hospice election.
2. Adds new edits ensuring the appropriate place of service is reported for hospice general inpatient care (GIP), respite, and continuous home care (CHC).
3. Provides a technical correction to the *Medicare Benefit Policy Manual* regarding the requirement for nursing care related to hospice continuous home care.

Be certain your billing staffs are aware of these Medicare changes.

Background

Claims for Medicare Advantage (MA) plan beneficiaries electing hospice

In an effort to alleviate the often timely process involved for providers to resolve claim disputes on payment responsibility between MA plans and Medicare fee-for-service (FFS), the Centers for Medicare & Medicaid Services (CMS) is revising the Medicare hospice and MA enrollment edit(s) for claims submitted on or after July 6, 2010, to allow claims to be processed by FFS Medicare for services occurring on the date of the hospice election. This will prevent services provided on the date of the election from rejecting as MA plan responsibility. Providers that have claims being disputed may resubmit their claims on or after July 6, 2010, to FFS Medicare for payment consideration. Contractors will not be required to provide automated adjustments.

Place of service for general inpatient care (GIP), respite, and continuous home care (CHC)

Medicare hospice patients are able to receive hospice care in a variety of settings. CMS began collecting additional data on hospice claims in January 2007 with CR 5245, available at *http://www.cms.hhs.gov/transmittals/Downloads/R1011CP.pdf*, which required reporting of a Healthcare Common Procedure Coding System (HCPCS) code on the claim to describe the location where services are provided. Coverage and payment regulations at 42 CFR 418.202 and 418.302 define the locations where certain levels of care may be provided. GIP is described in the regulations at 42 CFR 418.202(e) as "short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or skilled nursing facility (SNF)..." Additionally, the regulations at 42 CFR 418.202(e) require that respite care be furnished in an inpatient setting, as described in 418.108, which limits care settings to a participating Medicare or Medicaid hospital, SNF, hospice facility, or nursing facility (NF). Finally, payment regulations at 42 CFR 418.302(a)(2) define CHC as "a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home." Because CMS now has site-of-service data on hospice claims, they are able to use system edits to ensure more accurate billing of Medicare claims. CMS now edits claims to ensure that the level of care billed, for hospice, was provided at an appropriate site.

To facilitate more accurate billing of Medicare hospice claims, CMS is implementing several edits within the claim processing system to return to providers (RTP), claims submitted on types of bill 81x or 82x for which hospice days are billed for services provided in noncovered settings. Claims for days of GIP care (revenue code 0656) will be RTP'd if HCPCS site of service locations Q5001 (patient's home/residence), Q5002 (assisted living facility), or Q5003 (nursing long-term care facility of non-skilled nursing facility) are reported on the same line, as these are not appropriate settings for payment of GIP. GIP may only be provided at Medicare certified hospice facilities, hospitals, or SNFs.

Similarly, claims for respite days (revenue code 0655) will be RTP'd if HCPCS site of service HCPCS codes Q5001 (patient's home/residence) or Q5002 (assisted living facility) are reported on the same line, as these are not appropriate settings for payment of this level of care. Respite care may only be provided in a Medicare or Medicaid participating hospital, SNF, hospice facility, or NF.

Finally, claims for days of CHC care (revenue code 0652) will be RTP'd if HCPCS site of service locations Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5006 (inpatient hospice), Q5007 (long term care hospital), or Q5008 (inpatient psychiatric facility) are reported on the same line, as these locations are not appropriate settings to bill for payment of CHC. CHC may only be provided in the patient's home, and may not be provided in these types of facilities. We believe these edits will improve the accuracy of Medicare billing and payment for hospice services.

Technical correction

Regulations at 42 CFR 418.204 describe CHC as being provided during periods of crisis as necessary to maintain an individual at home. The regulation requires that care provided on days billed as CHC be "predominantly nursing care". This means that more than half of the time the nurse, aide, or homemaker spends providing care must be nursing hours.

Manual clarification regarding ambulance transport on the date of hospice election

CR 6778 also revises the *Medicare Benefit Policy Manual* to clarify policy regarding payment of ambulance transports on the effective date of hospice election. Hospices

Medicare system edit refinements related to hospice services (continued)

do not feel that they are responsible for an ambulance transport, which occurs on the effective date of hospice election, if the hospice has not yet conducted their initial assessment.

The deciding factor in determining whether a hospice is financially responsible for an ambulance transport on the effective day of hospice election is when the transport occurred, relative to when all the hospice coverage and eligibility criteria are met. If an ambulance transport occurs on the date of hospice election, but before all the criteria for hospice eligibility and coverage are met (i.e. the initial assessment has been conducted and the plan of care has been developed and includes the ambulance transport), the hospice is not responsible for the transport and the ambulance transport is covered through the ambulance benefit.

Additional Information

The official instruction, CR 6778, was issued to your MAC, carrier, RHHI or FI regarding this change via two transmittals. The first, contains revisions to the *Medicare Benefit Policy Manual*, located at *http://www.cms.hhs.gov/Transmittals/downloads/R121BP.pdf*.

The second transmittal contains revisions to the *Medicare Claims Processing Manual* at *http://www.cms.hhs.gov/Transmittals/downloads/R1907CP.pdf*.

MM5245, Instructions for Reporting Hospice Services in Greater Line Item Detail, is available on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf*.

For additional information regarding the hospice payment system, see the CMS Web site *http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf*.

If you have questions, please contact your MAC, carrier, RHHI 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: MM6778
Related Change Request (CR) Number: 6778
Related CR Release Date: February 5, 2010
Related CR Transmittal Number: R121BP and R1907CP
Effective Date: Claims submitted on or after July 6, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1907, CR 6778

Place and date of service instructions for interpretation of diagnostic tests

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 rescinded change request (CR) 6375, Transmittal 1873, dated December 11, 2009, and will be replaced with another CR in the future pending further policy clarification on date of service and place of service reporting for the interpretation of diagnostic tests that consistently addresses the full spectrum of clinical scenarios. The *MLN Matters* article MM6375 was also rescinded on February 5, 2010. The *MLN Matters* article MM6375 was published in the January 2010 *Medicare A Bulletin* (pages 12-13).

MLN Matters® Number: MM6375 – Rescinded
Related Change Request (CR) Number: 6375
Related CR Release Date: December 11, 2009
Related CR Transmittal Number: R1873CP
Effective Date: January 4, 2010
Implementation Date: January 4, 2010, except July 1, 2010, for DOS instruction in this article.

Source: CMS Pub. 100-04, Transmittal 1873, CR 6375

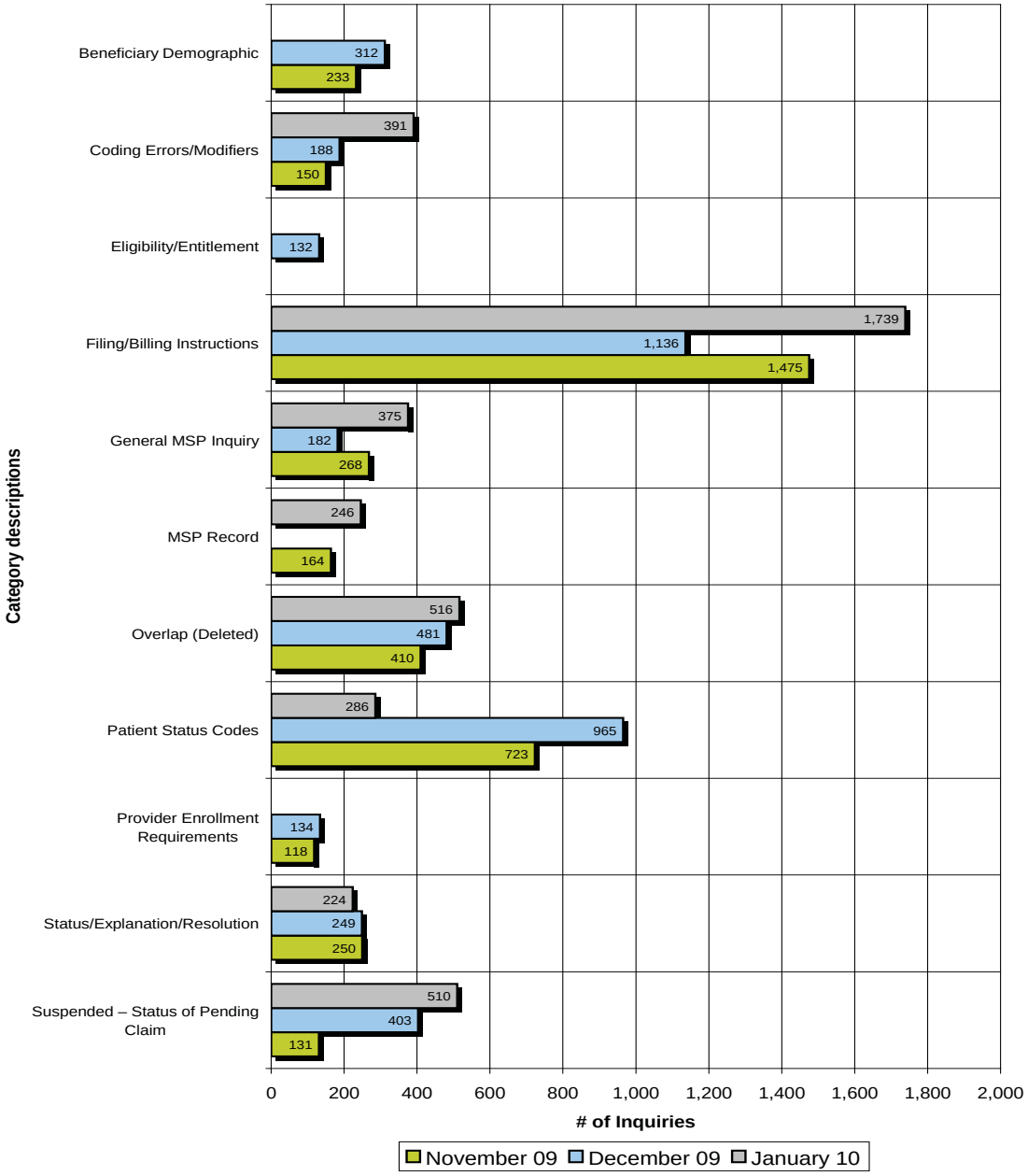
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for November 2009-January 2010

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, and U.S. Virgin Islands providers during November 2009-January 2010.

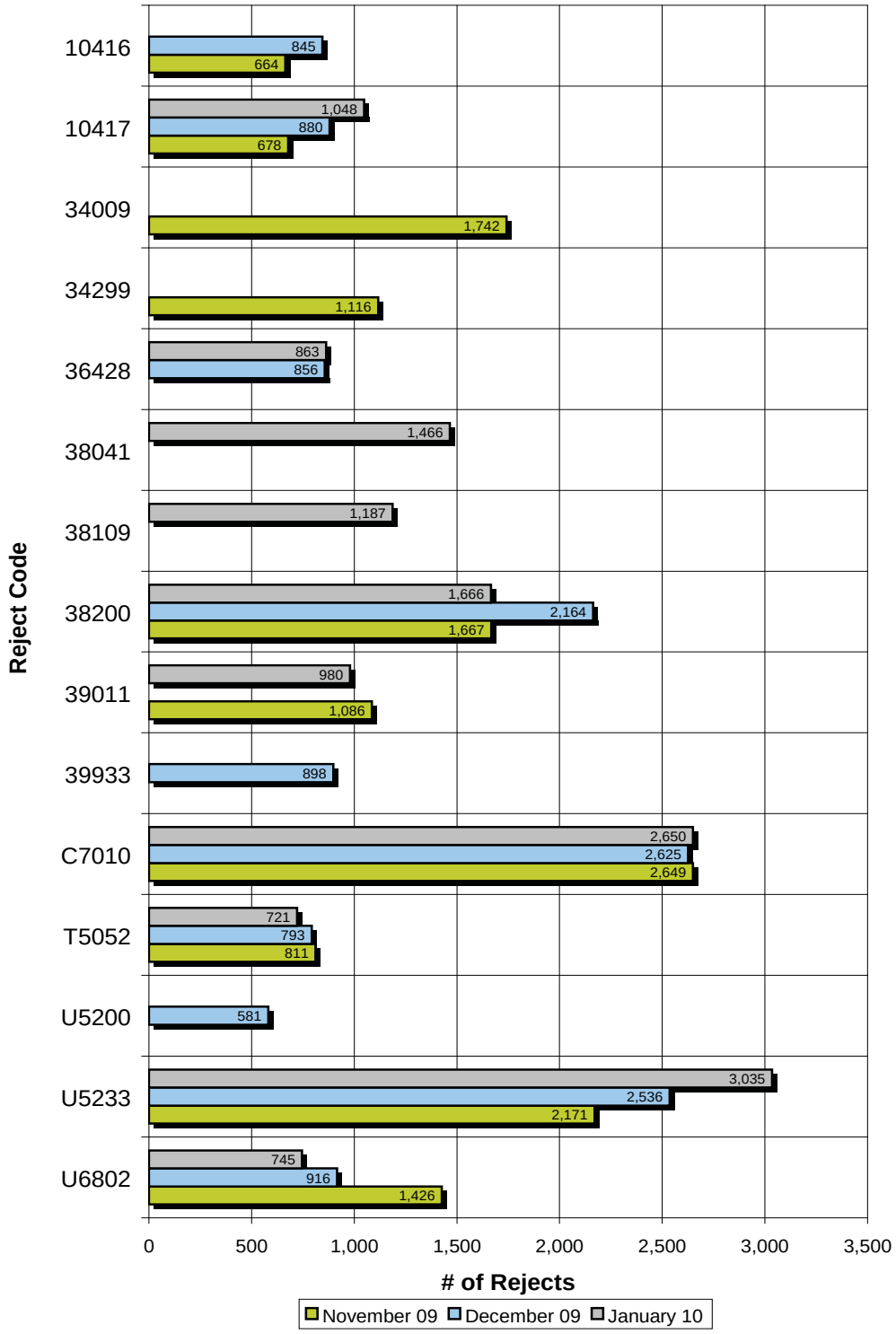
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our Web site at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for November 2009-January 2010



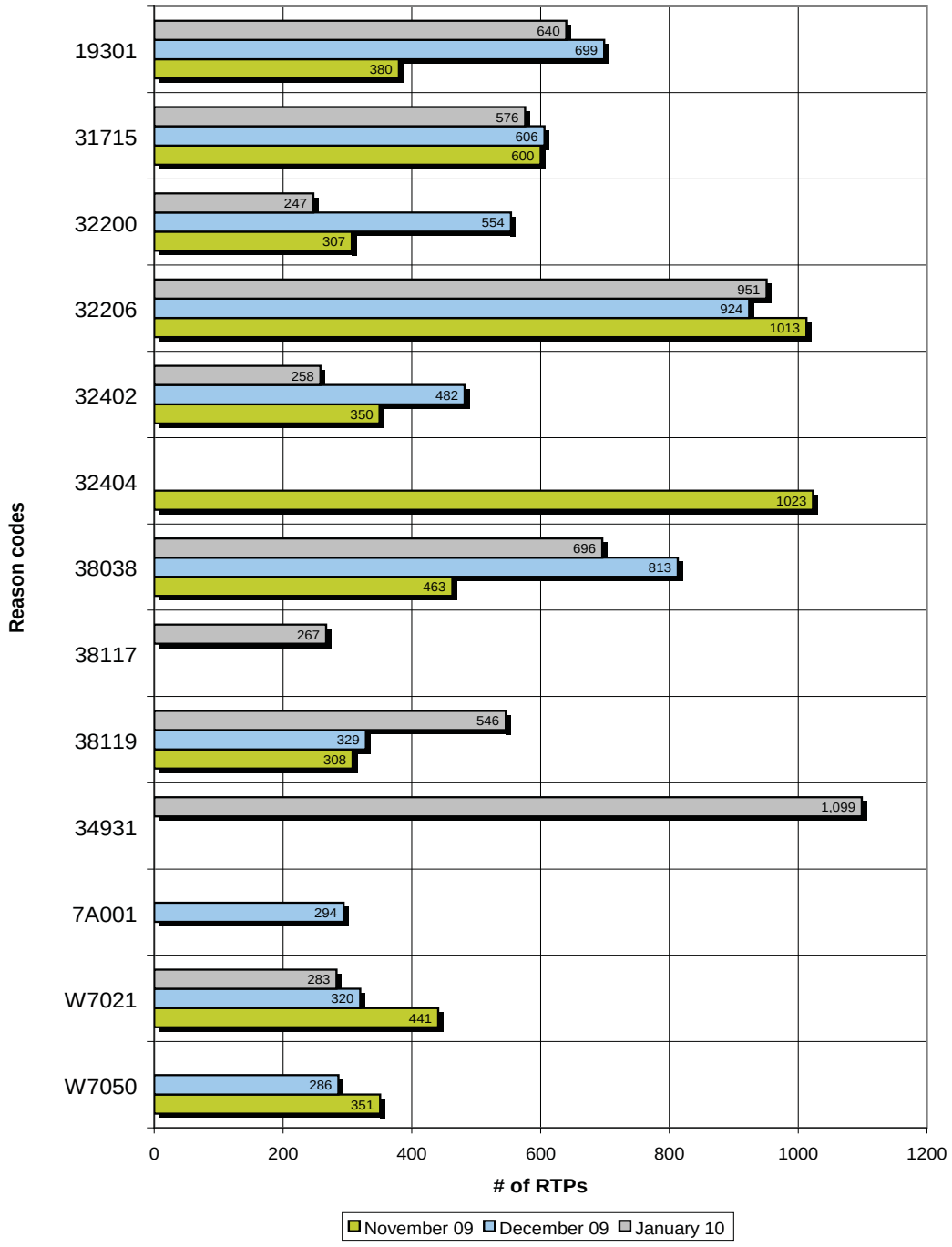
Top inquiries, return to provider, and reject claims for November 2009-January 2010 (continued)

Florida Part A top rejects for November 2009-January 2010



Top inquiries, return to provider, and reject claims for November 2009-January 2010 (continued)

Florida Part A top return to providers (RTPs) for November 2009-January 2010

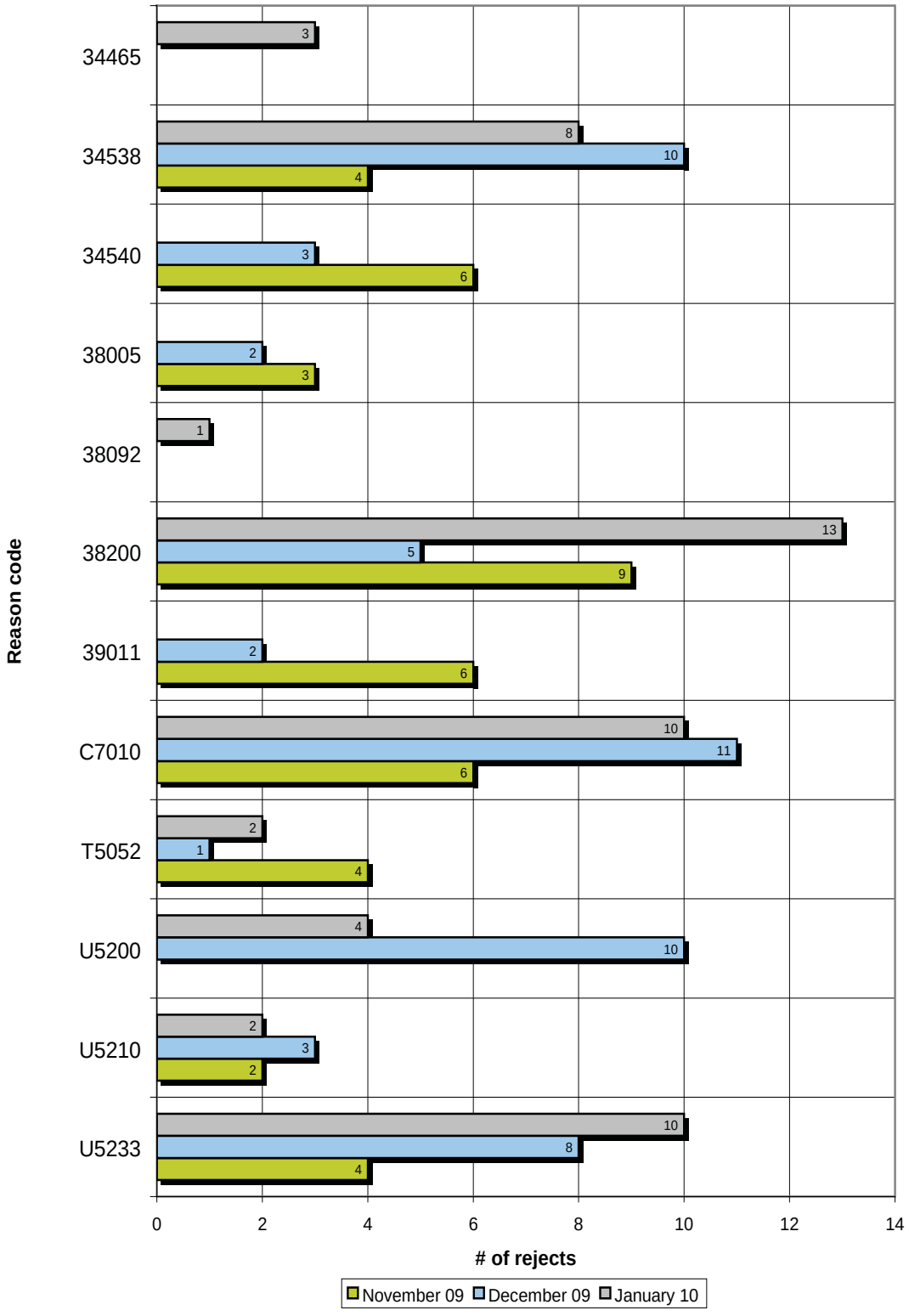


Keep Informed

Join *e-News*, FCSO e-mailing list to receive the most current revisions and updates. Check our upcoming provider events calendar and learn how to register for free teleconferences and webcasts that will help you increase your knowledge of the Medicare program and find ways to improve Medicare billing and payment efficiency.

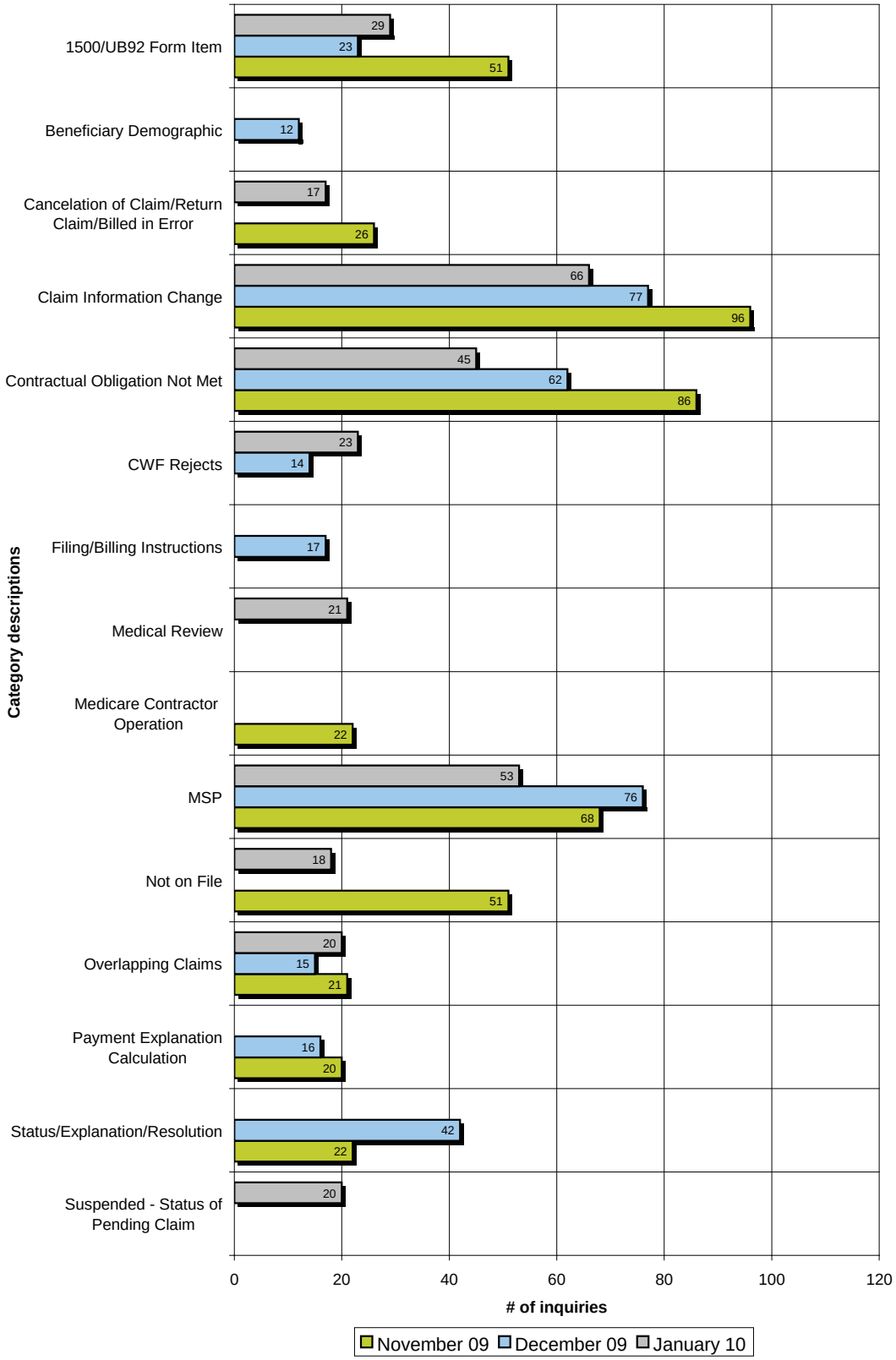
Top inquiries, return to provider, and reject claims for November 2009-January 2010 (continued)

U.S. Virgin Islands Part A top rejects for November 2009-January 2010



Top inquiries, return to provider, and reject claims for November 2009-January 2010 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for November 2009-January 2010



GENERAL COVERAGE

Revision of Medicare Benefit Policy Manual regarding the definition of compendia

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

Provider types affected

This article is for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FI], Part A/B Medicare administrative contractors [A/B MAC], or DME Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR 6806), from which this article is taken, announces that effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen). This revision requires a publicly transparent process for evaluating therapies and for identifying potential conflicts of interest. Please see the *Background* section for details.

Background

A compendium is defined "as a comprehensive listing of the Food and Drugs Administration (FDA)-approved drugs and biologicals (or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment)."

Section 1861(t)(2)(B)(ii)(I) of the Social Security Act (the Act), as amended by section 6001(f)(1) of the Deficit Reduction Act of 2005, Pub. Law 109-171, recognizes three compendia: 1) American Medical Association Drug Evaluations (AMA-DE); 2) United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and 3) American Hospital Formulary Service-Drug Information (AHFS-DI). To date, AHFS-DI, plus other authoritative compendia (found at *http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp#TopOfPage*) that the Secretary of Health & Human Services identifies, serve as sources for you to use in determining the "medically-accepted indication" of drugs and biologicals that are used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia).

In the Medicare physician fee schedule final rule for calendar year 2008, CMS established a process for revising the list of compendia, and also increased the transparency of the process by incorporating a list of desirable compendium characteristics outlined by the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) on March 30, 2006, as criteria for decision-making.

Although the MEDCAC desirable characteristics for compendia included reference to conflict of interest and transparency, section 182(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended Section 1861(t)(2)(B) of the Act by adding the following new sentence: "On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests."

CR 6806, from which this article is taken, announces that effective January 1, 2010, CMS is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.5 to include this public transparency requirement.

In this revised definition, a compendium:

1. Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases
2. Is indexed by drug or biological, and
3. **Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.**

Additional information

You may find more information about the revised definition of "compendium" by going to CR 6806, located on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R120BP.pdf*.

For more detailed information about the revised definition of "compendium" and the incorporation of MIPPA section 182 (b) into the compendia review process for current and future statutorily recognized compendia based on this provision, see Issues Related to MIPPA Number 13. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen released in the November 25, 2009 *Federal Register*, which you may find at *http://www.gpo.gov/fdsys/pkg/FR-2009-11-25/pdf/E9-26502.pdf*.

You will find this revised compendium definition in the updated *Medicare Benefit Policy Manual*, Chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen) as an attachment to that CR.

Revision of Medicare Benefit Policy Manual regarding the definition of compendia (continued)

You might also want to read the *MLN Matters*® article titled Compendia as Authoritative Sources for Use in the Determination of a "Medically Accepted Indication" of Drugs and Biologicals Used Off-Label in an Anti-Cancer Chemotherapeutic Regimen, released on October 24, 2008, which you may find on the CMS Web site at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6191.pdf*.

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

MLN Matters® Number: MM6806
Related Change Request (CR) Number: 6806
Related CR Release Date: January 29, 2010
Related CR Transmittal Number: R120BP
Effective Date: January 1, 2010
Implementation Date: March 1, 2010

Source: CMS Pub. 100-02, Transmittal 120, CR 6806

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

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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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

AJ9305: Pemetrexed – revision to the LCD

LCD ID Number: L28947 (Florida)
LCD ID Number: L28968 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pemetrexed was most recently revised on April 2, 2009. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to update the Food and Drug Administration (FDA) approved indication for pemetrexed. Additionally, the off-label indication for thymic malignances when used as a second-line chemotherapy regimen has been included for coverage. The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been updated with the addition of ICD-9-CM codes 164.0 and 212.6. Dosage and frequency of administration has been removed from the "Utilization Guidelines" section of the LCD, and the "Sources of Information and Basis for Decision" section of the LCD has been updated.

Effective date

This LCD revision is effective for services provided **on or after February 18, 2010.** 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 updated on October 1, 2009. Since that time, a revision was made to delete/add verbiage under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

The following sentence regarding noncoverage in the last paragraph of the above mentioned section of the LCD was deleted:

> "All other such products, unless they are specifically FDA labeled as "Skin substitutes" and for use in the types of ulcers considered in this LCD will be denied coverage under this LCD."

In addition, the word "other" was added to "All such products" in the next sentence of this section of the LCD to read "All other such products."

Effective date

This LCD revision is effective for services provided **on or after February 4, 2010.** 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. ❖

RETIRED LCDS

A93798: Cardiac rehabilitation programs – retired LCD

LCD ID Number: L28794 (Florida)
LCD ID Number: L28799 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cardiac rehabilitation programs was effective for services rendered on or after February 16, 2009, for Florida, and March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, based on the Centers for Medicare & Medicaid Services (CMS) Joint Signature Memorandum (JSM/TDL) 10087, dated December 17, 2009, the decision was made to retire the LCD.

JSM/TDL 10087 refers to the Amendment to the *Code of Federal Regulations (CFR)*, published on November 25, 2009, Section 410.49, which outlines the Medicare coverage of the cardiac rehabilitation program and the intensive cardiac rehabilitation program.

Effective January 1, 2010, Section 20.10, the national coverage determination (NCD) for cardiac rehabilitation programs, was repealed from the *Medicare National Coverage Determination (NCD) Manual* (Pub. 100-03).

Effective date

This LCD retirement is effective for services provided **on or after January 1, 2010.** 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. ❖

PROCESSING ISSUES

Q0139 (type of bill 72x) claims processing issue

First Coast Service Options Inc. (FCSO) has identified a Medicare claims processing issue where claims for type of bill (TOB) 72x billed with dates of service on or after January 1, 2010, with HCPCS code Q0139 (Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis)) were returned to the provider, indicating that this drug was part of the ESRD composite rate.

This issue has been addressed and corrected and providers may begin to refile their claims after February 9, 2010.

We apologize for any inconvenience you may experience related to this issue. ❖

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Looking for an LCD? Try the new integrated-search features on our redesigned medical coverage page. You may now search for local coverage determinations (LCDs) by procedure name or code as well as by L number. With its new features and user-friendly layout, you'll also find the medical coverage news and resources you need more quickly and easily than ever before – try it today. *http://medicare.fcso.com/Landing/139800.asp*.

HOSPITAL SERVICES

Fiscal year 2009 inpatient prospective payment system PC PRICER updated

The fiscal year (FY) 2009 inpatient prospective payment system (IPPS) personal computer (PC) PRICER has been updated for FY 2009 claims with corrected provider data from January 2010. If you use the FY 2009 IPPS PC PRICER, go to the IPPS PC PRICER page, *http://www.cms.hhs.gov/PCPricer/03_inpatient.asp*, and download the latest version of the FY 2009 PC PRICER. ❖

Source: CMS PERL 201002-32

Inpatient psychiatric facility prospective payment system PC PRICERs updated

The inpatient psychiatric facility prospective payment system (IPF PPS) personal computer (PC) PRICERs have been updated with the latest January 2010 provider data for rate year (RY) 2010 and RY 2009.

If you use the IPF PPS PC PRICERS for RY 2009 or RY 2010, the latest versions (posted February 4, 2010) are available at *http://www.cms.hhs.gov/PCPricer/09_inppsy.asp*, under the Downloads section. ❖

Source: CMS PERL 201002-17

INPATIENT REHABILITATION SERVICES

Inpatient rehabilitation facility prospective payment system PC PRICER updates

The fiscal year 2010 and 2009 inpatient rehabilitation facility prospective payment system (PPS) personal computer (PC) PRICERs have been updated with January 2010 provider specific data and are ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.hhs.gov/PCPricer/06_IRF.asp*.

If you use the IRF PPS PC PRICER, please go to the page above and download the latest versions of the PRICERs, posted on February 5, 2010, in the Downloads section. ❖

Source: CMS PERL 201002-22

Coverage of inpatient rehabilitation services

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 MM6699 to reflect revisions to change request (CR) 6699. The CR release date, transmittal number, and the Web address for accessing CR 6699 were revised. All other information remains the same. The *MLN Matters* article MM6699 was published in the October 2009 *Medicare A Bulletin* (pages 34-39).

Provider types affected

Inpatient rehabilitation facilities (IRFs) billing Medicare contractors (fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for inpatient rehabilitation services provided to Medicare beneficiaries are affected by change request (CR) 6699.

Provider action needed STOP – impact to you

This article is based on CR 6699, which implements new instructions for coverage of inpatient rehabilitation services provided to Medicare beneficiaries.

CAUTION – what you need to know

CR 6699 issues new instructions to replace the existing instructions found in Section 110 of the *Medicare Benefit Policy Manual*. These new instructions are consistent with the new IRF coverage requirements adopted by the Centers for Medicare & Medicaid Services (CMS) in the fiscal year (FY) 2010 final rule.

These new policies apply to discharges from IRFs occurring on or after January 1, 2010.

GO – what you need to do

IRFs need to be aware of these policies and also need to know that existing Medicare contractor local coverage determination policies for inpatient rehabilitation facility admissions are no longer effective with discharges occurring on or after January 1, 2010.

Coverage of inpatient rehabilitation services (continued)

Background

CMS adopted new IRF coverage requirements to reflect changes that have occurred in the practice of medicine during the past 25 years and the implementation of the IRF prospective payment system (PPS). See the FY 2010 final rule (74 FR 39762 (August 7, 2009) on the Internet at *http://edocket.access.gpo.gov/2009/pdf/E9-18616.pdf*.

In light of adopting the new coverage requirements (effective for IRF discharges occurring on or after January 1, 2010), a notice has been issued to rescind Health Care Financing Administration ruling 85-2 (HCFAR 85-2) when the new coverage requirements take effect.

Section 110 of *the Medicare Benefit Policy Manual* (MBPM) was originally based upon the provisions found in HCFAR 85-2. Therefore, the purpose of CR 6699 is to issue new instructions that are consistent with the new IRF coverage requirements adopted in the FY 2010 final rule.

The manual revision attached to CR 6699 replaces Section 110 of the MBPM with new instructions that describe coverage for inpatient rehabilitation services provided in IRFs. These new instructions are based on recent regulatory changes, which may be found on the Internet at *http://edocket.access.gpo.gov/2009/pdf/E9-18616.pdf*.

Under the new coverage policies, the decision to admit the beneficiary to the IRF is the key to determining whether the admission is reasonable and necessary. Therefore, the new instructions (which are provided as an attachment to CR 6699) are detailed below and cover the following subjects:

- Documentation Requirements
- Required Preadmission Screening
- Required Post-Admission Physician Evaluation
- Required Individualized Overall Plan of Care
- Required Admission Orders
- Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
- Inpatient Rehabilitation Facility Medical Necessity Criteria
- Multiple Therapy Disciplines
- Intensive Level of Rehabilitation Services
- Ability to Actively Participate in Intensive Rehabilitation Program
- Physician Supervision
- Interdisciplinary Team Approach to the Delivery of Care
- Definition of Measurable Improvement.

Inpatient rehabilitation facility (IRF) services

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who, therefore, are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) if the patient meets all of the requirements outlined in 42 CFR 412.622(a)(3), (4), and (5), as interpreted in Chapter 1, Section 110 of the *Medicare Benefit Policy Manual*, which is attached to CR 6699. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.23(b)(2)(iii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, please see Chapter 15, Sections 220 and 230 of the *Medicare Benefit Policy Manual*. That manual is on the CMS Web site at *http://www.cms.hhs.gov/Manuals/IOM/list.asp*.

Documentation requirements

Medicare contractors must consider the documentation contained in a patient's IRF medical record when determining whether an IRF admission was reasonable and necessary, specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.

Required preadmission screening

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the

Coverage of inpatient rehabilitation services (continued)

patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's prior level of function, expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

If the patient is being transferred from a referring hospital, the preadmission screening may be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, a preadmission screening conducted entirely by telephone will not be accepted without transmission of the patient's medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff in the IRF.

The IRF is responsible for developing a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which is expected to include all of the required elements described in section 110.1.1 of the MBPM, as attached to CR 6699. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed or certified (to the extent possible under state licensure laws and requirements) and qualified to perform the evaluation within their scopes of practice and training. Although clinical personnel are required to evaluate the preadmission screening information, each IRF may determine its own processes for collecting and compiling the preadmission screening information.

The "rehabilitation physician" need not be a salaried employee of the IRF but must be a licensed physician with specialized training and experience in rehabilitation.

All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening.

All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in the patient's medical record at the IRF.

"Trial" IRF admissions, during which patients were sometimes admitted to IRFs for three to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings, are no longer considered reasonable and necessary.

Required post-admission physician evaluation

A post-admission physician evaluation of the patient must be performed by a rehabilitation physician. The purpose of the post-admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care. The post-admission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and must include a documented history and physical examination, as well as a review of the patient's prior and current medical and functional conditions and comorbidities.

In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the first 24 hours of admission to the IRF and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient's medical record at the IRF.

In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. This could occur, for example, if the patient's condition changes after the preadmission screening is completed. In these cases, it is important for a rehabilitation physician to note the discrepancy and to document any deviations from the preadmission screening as a result. For example, if the patient's preadmission screening indicated an expectation that the patient would actively participate in an intensive rehabilitation therapy program on admission to the IRF, but the patient is only able to tolerate a less intensive therapy program on the first day due to an increase in pain secondary to a long ambulance trip to the IRF, the IRF does not have to discharge the patient.

Instead, the reason for the temporary change must be noted in the patient's medical record at the IRF.

In addition, the preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either (for example, due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability

Coverage of inpatient rehabilitation services (continued)

to meet the demands of the IRF rehabilitation program). If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. Medicare contractors will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the third day following the patient's admission to the IRF are not considered reasonable and necessary. In these particular cases, instead of denying the entire IRF claim, Medicare authorizes its contractors to permit the IRF claim to be paid at the appropriate case-mix group (CMG) for IRF patient stays of three days or less.

Required individualized overall plan of care

Information from the preadmission screening and the post-admission physician evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care must include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient's course of treatment must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient's medical record at the IRF.

In the unlikely event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record at the IRF.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first four days of the IRF admission; it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient's medical record at the IRF. IRFs may develop this required documentation using whatever internal processes they believe are most appropriate.

Required admission orders

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a rehabilitation physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF.

Required inpatient rehabilitation facility patient assessment instrument (IRF-PAI)

Medicare now requires that the IRF patient assessment instrument (IRF-PAI) forms be included in the patient's medical record at the IRF (either in electronic or paper format). The information in the IRF-PAIs must correspond with all of the information provided in the patient's IRF medical record.

Inpatient rehabilitation facility medical necessity criteria

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.
2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2 of the MBPM. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three hours of therapy per day at least five days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven consecutive day period, beginning with the date of admission to the IRF.
3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment and if such improvement can be expected to be made within a prescribed period of time.
4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision

Coverage of inpatient rehabilitation services (continued)

means that the rehabilitation physician must conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

Multiple therapy disciplines

A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care.

Intensive level of rehabilitation services

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Although the intensity of rehabilitation services can be reflected in various ways, the generally accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least three hours per day at least five days per week.

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a seven-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of four hours of therapy three days per week and 1 ½ hours of therapy on two (or more) other days per week in order to accommodate his or her chemotherapy schedule. Therefore, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a seven-consecutve day period starting from the date of admission), as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services. As such, they are included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

Brief exceptions policy

While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be true for a limited number of days during a patient's IRF stay because patients' needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in the intensive therapy program for a brief period not to exceed three consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient's IRF medical record. If these reasons are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

Ability to actively participate in intensive rehabilitation therapy program

The information in the patient's IRF medical record (especially the required documentation described in Section 110.1 of the MBPM) must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program.

Physician supervision

A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient's care is generally demonstrated by documented face-to-face visits from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least three days per week

Coverage of inpatient rehabilitation services (continued)

throughout the patient's IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than three days per week. However, the requirement for IRF physician supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress, in light of their medical conditions, by a rehabilitation physician with the necessary training and experience to make these assessments at least three times per week. The required rehabilitation physician visits should be documented in the patient's medical record at the IRF.

Interdisciplinary team approach to the delivery of care

An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. The complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be achieved through periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals.

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

- A rehabilitation physician with specialized training and experience in rehabilitation services
- A registered nurse with specialized training or experience in rehabilitation
- A social worker or a case manager (or both)
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions, regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic team conferences—held a minimum of once per week—must focus on:

- Assessing the individual's progress towards the rehabilitation goals
- Considering possible resolutions to any problems that could impede progress towards the goals
- Reassessing the validity of the rehabilitation goals previously established
- Monitoring and revising the treatment plan, as needed.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF.

Definition of measurable improvement

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient's admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services and an inter-disciplinary team approach to care. Further, the IRF medical record must also demonstrate that the patient is making functional

Coverage of inpatient rehabilitation services (continued)

improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment.

Additional information

The official instruction, CR 6699, issued to your FI or MAC regarding this change may be viewed on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R119BP.pdf*.

Attached to that CR are the complete sections of Chapter 1 that have been added to the *Medicare Benefit Policy Manual*.

If you have any questions, please contact your FI or 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: MM6699 – Revised
Related Change Request (CR) Number: 6699
Related CR Release Date: January 15, 2010
Related CR Transmittal Number: R119BP
Effective Date: IRF Discharges on or after January 1, 2010
Implementation Date: January 4, 2010

Source: CMS Pub. 100-02, Transmittal 119, CR 6699

ESRD Services

Dialysis adequacy, infection and vascular access reporting

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

Provider types affected

Renal dialysis facilities (RDFs) submitting claims to fiscal intermediaries (FIs) and A/B Medicare administrative contractors (A/B MACs) for services to Medicare beneficiaries are impacted by this issue.

Provider action needed

STOP – impact to you

RDFs need to know that CR 6782 requires new quality data reporting for dialysis adequacy, infection and vascular access on all end-stage renal disease (ESRD) claims and all ESRD hemodialysis claims with dates of service on or after July 1, 2010.

CAUTION – what you need to know

The new data reporting will allow the Centers for Medicare & Medicaid Services (CMS) to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153c.

GO – What you need to do

Make sure that your billing staffs are aware of these new reporting and claim requirements described below.

Background

This article is based on CR 6782, which explains that section 153c of the MIPPA requires CMS to implement a quality based payment program for dialysis services effective January 1, 2012. CMS currently collects two monthly measurements of quality of care via the ESRD claims submitted by dialysis providers: hemoglobin or hematocrit as a measure of anemia management and urea reduction ratio (URR) as a measure of hemodialysis adequacy.

The source data for the two current quality measures are collected on dialysis provider claims. The anemia management quality measure uses the most recent hemoglobin or hematocrit lab value, collected using value codes 48 or 49 on type of bill 72x. The hemodialysis adequacy measure uses the current month's urea reduction ratio (URR) lab value, collected using Healthcare Common Procedure Coding Systems (HCPCS) modifiers G1 through G6 on hemodialysis line items (revenue center 082x and *CPT* code *90999*).

These two quality measures meet the minimum requirements as mandated in MIPPA section 153c. However, the URR measure of dialysis adequacy does not provide data for the entire ESRD dialysis population. Not having dialysis adequacy data for a segment of the dialysis population (peritoneal dialysis patients) is problematic in the development of a quality based payment program that will decrease provider payment by up to two percent based on quality outcome data because, with the missing data, CMS will not be able to assess all ESRD dialysis providers based on the same criteria.

MIPPA section 153c also requires the use of quality measures endorsed by a consensus organization. CMS recently reexamined and received National Quality Forum (NQF) endorsement for the ESRD quality measures. Both CMS and NQF found that dialysis adequacy is best measured by Kt/V (K-dialyzer clearance of urea; t-dialysis time; V-patient's total body water) for both hemodialysis and peritoneal dialysis patients. The NQF granted time-limited endorsement of URR for hemodialysis patients and recommended that CMS drop it in favor of Kt/V as soon as possible. While dialysis adequacy is measured monthly for in-center hemodialysis patients, dialysis adequacy is measured less frequently for peritoneal dialysis patients (at least every four months). Therefore, it is necessary to track both the date of the most recent measurement and the result of the most recent measurement.

Finally, MIPPA section 153c provides for the use of additional quality measures for the quality based payment program as determined by the Secretary of Health & Human Services. Two additional quality measures could easily be collected using HCPCS modifiers for hemodialysis patients to record vascular access. The first measure is use of an arteriovenous fistula with two needles, which is recognized as the best vascular access because it is associated with the least infections. The second measure is the use of any vascular catheter, which is recognized as the worst vascular access because it is associated with the most infections. Collecting vascular access data will allow CMS to develop a more robust quality based payment program in order to implement national policy without additional data collection burden on dialysis providers, who are already required to collect these data under the fistula first initiative.

Consequently, CMS will require the reporting of the Kt/V reading and date of the reading, vascular access and infection data on ESRD claims with dates of service on or after July 1, 2010. This new data reporting requirement will allow CMS to implement an accurate quality incentive payment for dialysis providers by January 1, 2012, as required by MIPPA, section 153c. The July 2010 implementation date is needed because the quality incentive payment must be in part based on provider improvement over time; thus, CMS requires an accurate measurement of baseline provider performance. CMS will require that providers continue to report the existing modifiers G1 through G6 for URR at this time.

Dialysis adequacy, infection and vascular access reporting (continued)

New quality data required on all ESRD claims with dates of service on or after July 1, 2010

Claim level codes

- **Value code D5:** Result of last Kt/V reading. For in-center hemodialysis patients, this is the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this may be before the current billing period but should be within four months of the claim date of service.
- **Occurrence code 51:** Date of last Kt/V reading. For in-center hemodialysis patients, this is the date of the last reading taken during the billing period. For peritoneal dialysis patients (and home hemodialysis patients), this date may be before the current billing period but should be within 4 months of the claim date of service.

In the event that the provider has not performed the Kt/V test for the patient, the provider must attest that no test was performed by reporting the value code D5 with a 9.99 value. The occurrence code date should not be reported on the claim in the case of no Kt/V reading being reported. For dates of service on or after July 1, 2010, failure to report the D5 value code on the type of bill 72x will result in the claim being returned to the provider. Also, Medicare will return type of bill 72x with dates of service on or after July 1, 2010, to the provider if the claim does not contain occurrence code 51, except where there is a D5 value code with 9.99.

Line level codes to be reported on dialysis revenue code lines

- **Modifier V8:** Infection present
- **Modifier V9:** No infection present

Note: Medicare systems will return to the provider type of bill 72x with dates of service on or after July 1, 2010, when either the modifier V8 or V9 is not present on each dialysis revenue code line (0821, 0831, 0841, or 0851).

New quality data required on All ESRD Hemodialysis claims with dates of service on or after July 1, 2010

Line level codes to be reported on hemodialysis revenue code lines:

Vascular access for ESRD hemodialysis patients – an indicator of the type of vascular access used for the delivery of hemodialysis at the last hemodialysis session of the month. The code is required to be reported on the latest line item date of service billing for hemodialysis revenue code 0821. It may be reported on all revenue code 0821 lines at the discretion of the provider.

- **Modifier V5:** Any vascular catheter (alone or with any other vascular access)
- **Modifier V6:** Arteriovenous graft (or other vascular access not including a vascular catheter)
- **Modifier V7:** Arteriovenous fistula only (in use with two needles)

Note: Medicare systems will return to the provider type of bill 72x with dates of service on or after July 1, 2010 billing for hemodialysis when the latest line item date of service billing for revenue code 0821 does not contain one of the following modifiers: V5, V6, or V7.

The modifiers V5-V9 are effective January 1, 2010, and the Medicare integrated code editor has been updated to allow the reporting of these codes for claims with dates of service on or after January 1, 2010. Therefore, providers may voluntarily report these modifiers for claims with dates of service January 1, 2010, through July 1, 2010.

Additional information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI or A/B MAC, which is available on the CMS Web site at *http://www.cms.hhs.gov/Transmittals/downloads/R1898CP.pdf*.

If you have questions, please contact your Medicare 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*.

The *Medicare Learning Network* catalog of products contains a fact sheet Outpatient Maintenance Dialysis – End-Stage Renal Disease fact sheet, which provides general information about Outpatient Maintenance Dialysis for ESRD, the composite payment rate system, and separately billable items and services. The fact sheet is available on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymtfctsht08-508.pdf*.

MLN Matters® Number: MM6782
Related Change Request (CR) Number: 6782
Related CR Release Date: January 29, 2010
Related CR Transmittal Number: R1898CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1898, CR 6782

Revised outpatient maintenance dialysis – end-stage renal disease fact sheet

The revised *Outpatient Maintenance Dialysis – End-Stage Renal Disease* fact sheet (January 2010), is available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/ESRDpaymtfctsht2010.pdf*.

This fact sheet provides information about the bundled ESRD prospective payment system for Medicare outpatient ESRD facilities that will replace the current basic case-mix adjusted composite payment system beginning January 1, 2011, the basic case-mix adjusted composite payment rate system, and separately billable items and services ❖

Source: CMS PERL 201002-04

Web site survey

We would like to hear your comments and suggestions on the Web site through our survey. If you see our customer satisfaction survey pop up while you are browsing the Medicare site, please take a few minutes and fill it out. We want to know how well the entire site and specific site elements address your needs. As our site is constantly changing, we would appreciate your input every two months or so. It is your feedback that makes changes possible.

SKILLED NURSING FACILITY SERVICES

January minimum data set 3.0 information update

The Centers for Medicare & Medicaid Services has updated the Web site page for nursing home quality initiatives with the minimum data set (MDS) 3.0 latest information.

- Long-term care facility Resident Assessment Instrument User's Manual: Chapters 2 and 4 along with Appendix C have been published on the minimum data set (MDS) 3.0 homepage *http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*.
- The MDS 3.0 Item Subsets V1.00.1 January 2010: Includes a file called *MDS3.0_Item_Changes_v1.00.1.pdf* that lists the changes that have made since the previously posted version to each of the individual item subsets. The previously posted MDS 3.0 Item Matrix has been moved to Appendix F of the RAI manual. A more detailed version of the item matrix that is intended for software developers is available as part of the MDS 3.0 data submission specifications.
- Information about the upcoming MDS 3.0 training in March and April has also been added to the MDS 3.0 Training Conference Information Web page (*http://www.cms.hhs.gov/NursingHomeQualityInits/40_NHQIMDS30TrainingConferenceInformation.asp*). All details regarding the training and registration process is contained within this Web page. Individuals will not be able to get any additional information by contacting CMS staff or submitting questions to *MDS30Comments@cms.hhs.gov*.

  A listserv note will be sent out when additional information becomes available. Any questions about the MDS 3.0 RAI manual may be directed to *mds30comments@cms.hhs.gov*.

  Any technical questions pertaining to software development should be directed to *Michael.Stoltz@cms.hhs.gov*.

Responses to questions will be provided during regularly scheduled Centers for Medicare & Medicaid Services public teleconferences. ❖

Source: CMS PERL 201002-11

Skilled nursing facility prospective payment system PRICER updated

Due to receiving updated quarterly provider data, the fiscal year (FY) 2010 skilled nursing facility prospective payment system (SNF PPS) personal computer (PC) PRICER has been updated. Go to the SNF PPS PC PRICER page, *http://www.cms.hhs.gov/PCPricer/04_SNF.asp*, under the Downloads section.

The FY 2009 SNF PPS PC PRICER and the FY 2010 SNF PPS PC PRICER have been updated with the most recent provider data from January 2010.

If you use the FY 2010 SNF PPS PC PRICER or the FY 2009 SNF PPS PC PRICER, please go to the page above and download the latest versions of the 2009 and 2010 PC PRICER. ❖

Source: CMS PERL 201002-13

Five-star quality rating system – February news

The five-star provider preview reports was available now for viewing. 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.

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 reports (CASPER) reporting link located at the bottom of the login page.
- Once in the CASPER system:
  - Click on the "folders" button and access the five-star report in your "st LTC facid" folder
  - Where st is the two-digit postal code of the state in which your facility is located
  - "Facid" is the state assigned "facid" of your facility.

  BetterCare@cms.hhs.gov is available to address any five-start rating questions and concerns.

  Nursing Home Compare was update with February five-star data on Thursday, February 25, 2010.

  For the latest five-star quality rating system information, please visit *http://www.cms.hhs.gov/CertificationandComplianc/13_FSQRS.asp*. ❖

Source: CMS PERL 201002-27

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Integrated outpatient code editor PC (interactive and batch) re-write

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 MM6709 to reflect revisions to change request (CR) 6709. The effective date, implementation date, CR release date, transmittal number, and the Web address for accessing CR 6709 were revised. All other information remains the same. The *MLN Matters* article MM6709 was published in the December 2009 *Medicare A Bulletin* (page 34).

Provider types affected

This article is for all providers who submit institutional outpatient claims (including non-outpatient prospective payment system (non-OPPS) hospitals) to Medicare administrative contractors (MACs), fiscal intermediaries (FIs), or regional home health intermediaries (RHHIs) for outpatient services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6709, which notifies providers of the intended re-write of the integrated outpatient code editor (IOCE) personal computer (PC) software (interactive and batch) to the Java programming language with InstallAnywhere for installation software. Be sure billing staffs using the PC-based IOCE are aware of these changes. Once the rewrite is complete, such staff will need to obtain the new version.

Background

Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) as amended by the Workforce Investment Act of 1998 (P.L. 105-220), specifically, subsection 508(a)(1), requires that when the federal government procures electronic and information technology (EIT), the EIT must allow federal employees and individuals of the public with disabilities comparable access to and use of information and data that is provided to federal employees and individuals of the public without disabilities.

Therefore, per 36 CFR 1194 (508 Standards), regardless of format, all Web content or communications materials produced, including text, audio or video, must conform to applicable Section 508 standards. All contractors (including subcontractors) or consultants responsible for preparing or posting content must comply with applicable Section 508 accessibility standards, and where applicable, those set forth in the referenced policy or standards documents.

The new PC-based IOCE software will:

- Make the interactive product fully comply to current Section 508 accessibility standards for electronic and information technology
- Standardize current Java-based development platform technology to streamline future development and increase re-usability.

Note: This re-write does not affect the mainframe version of the IOCE installed and run by Medicare's fiscal intermediary shared system (FISS) on a quarterly basis. The inputs/outputs to the IOCE batch PC program will not change. It also does not affect the content of the IOCE.

Additional information

The official instruction (CR 6709) issued to your Medicare MAC and/or FI is available on the Centers for Medicare & Medicaid Services (CMS) at *http://www.cms.hhs.gov/Transmittals/downloads/R628OTN.pdf*.

CMS also has a Web-based training module on the OCE. The module is available on the Internet at *http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1*.

If you have questions, please contact your Medicare MAC 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: MM6709 – Revised
Related Change Request (CR) Number: 6709
Related CR Release Date: January 29, 2009
Related CR Transmittal Number: R628OTN
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-20, Transmittal 628, CR 6709

Use the PDS report to improve your Medicare billing operations

Did you know that the Provider Data Summary (PDS) report can help you improve the accuracy and efficiency of your Medicare billing? Just access the PDS report through our convenient online portal, establish your account, and compare your billing patterns with those of similar providers during a specified billing period. This invaluable resource will help you proactively reduce billing errors by learning to avoid them before they occur. Would you like to find out more? Just visit our dedicated PDS page, where you'll find helpful simulations, a quick-start guide, and a helpful guide to teach you how to apply PDS results to your business needs.

ELECTRONIC DATA INTERCHANGE

Healthcare provider taxonomy code updates effective April 1, 2010

Effective April 1, 2010, the healthcare provider taxonomy codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of HPTC is available from the *Washington Publishing Company* Web site at *http://www.wpc-edi.com/codes/taxonomy*.

If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level deletion (rejection) may occur. To ensure you do not receive a claim or file level rejection, it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system, please contact your software support vendor. ❖

Source: CMS Pub. 100-04, Transmittal 1896, CR 6840

Find out first: Subscribe to FCSO eNews

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

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
March 2010 – July 2010

Topic – Hot Topics

When: Tuesday, March 9, 2010
Time: 10:30 a.m. – 12:00 noon ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Hot Topics

When: Tuesday, May 11, 2010
Time: 11:30 a.m. – 1:00 p.m., ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Medifest educational event – Orlando, Florida

When: Tuesday and Wednesday, June 8 and 9, 2010
Time: 8:00 a.m. – 5:00 p.m. ET **Delivery language:** English (selected seminars also in Spanish)
Type of Event: In person seminar/symposium **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Hot Topics

When: Tuesday, July 13, 2010
Time: 11:30 a.m. – 1:00 p.m., ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

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.

Please Note:

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

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

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

PREVENTIVE SERVICES

February is American Heart Month

Heart disease is the leading cause of death in the United States for both men and women.[1] Medicare provides coverage for cardiovascular screening blood tests, ultrasound screening for abdominal aortic aneurysms (AAA), and smoking and tobacco-use cessation counseling for qualified beneficiaries.

What you can do

As a health care professional who provides care to seniors and others with Medicare, you can help protect the health of your Medicare patients by educating them about their risk factors and reminding them of the importance of Medicare-covered preventive services that are appropriate for them, including services related to cardiovascular health.

For more information

The Centers for Medicare & Medicaid Services (CMS) has developed several educational products related to Medicare-covered preventive services:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals – this newly revised comprehensive resource provides coverage and coding information on the array of preventive services and screenings that Medicare covers, including cardiovascular screening blood tests, AAA screenings, and smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

The MLN Preventive Services Educational Products Web Page – provides descriptions and ordering information for *Medicare Learning Network* (MLN) preventive services educational products and resources for health care professionals and their staff.

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Quick Reference Information: Medicare Preventive Services – this double-sided chart provides coverage and coding information on Medicare-covered preventive services, including smoking and tobacco-use cessation counseling, and AAA and cardiovascular screenings.

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

Expanded Benefits brochure – this brochure provides information on coverage for Medicare-covered cardiovascular blood test and AAA screenings.

http://www.cms.hhs.gov/MLNProducts/downloads/expanded_benefits.pdf

Smoking and Tobacco-Use Cessation Counseling brochure – this brochure provides information on coverage for Medicare-covered smoking and tobacco-use cessation counseling.

http://www.cms.hhs.gov/MLNProducts/downloads/smoking.pdf

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

For more information on American Heart Month, please visit the American Heart Month Web site at *http://www.americanheart.org/presenter.jhtml?identifier=4441*.

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries about the importance of taking advantage of preventive services covered by Medicare. ❖

Source: CMS PERL 201002-06

[1] Heart Disease, Heart Disease Facts. [online]. Atlanta, GA: The Centers for Disease Control and Prevention, December 21, 2009 [cited 21 January 2010]. Available at *http://www.cdc.gov/heartdisease/facts.htm*.

OTHER EDUCATIONAL RESOURCES

Redesigned indexes for 2007-2009 MLN Matters articles

The indexes for 2007 through 2009 *MLN Matters* articles have been redesigned. These redesigned indexes are much more user friendly and are available in the Downloads section at *http://www.cms.hhs.gov/MLNMattersArticles/*.

Use the new indexes to find relevant articles needed to explain and support transmittals from the Centers for Medicare & Medicaid Services (CMS) – zero in on the article needed to get the information you want now. ❖

Source: CMS PERL 201002-02

Free educational products and free shipping from the Medicare Learning Network

The high quality *Medicare Learning Network* products you depend on are always free. Did you know that shipment to your office or home is also free?

Go to the MLN Product Ordering page for a listing of products available in hard copy, and then add the products to your shopping cart. Your order will be processed for delivery and shipped right to your door.

Need multiple copies? When you checkout, just increase the quantity and follow the system prompts. Make sure to include your e-mail address in case we need to contact you to process your order.

Visit the MLN Products page at *http://www.cms.hhs.gov/mlnproducts/*, and select MLN Products Ordering Page to start learning today. ❖

Source: CMS PERL 201002-12

Medicare Learning Network – quality you can trust

There is information – and then there is quality information you can trust from the *Medicare Learning Network*. All *Medicare Learning Network* products are thoroughly researched and cleared by the experts at CMS.

What this mean to you

It means there is official Medicare fee-for-service (FFS) program information that is always available for your immediate use to assist with your business needs. The *Medicare Learning Network* knows how to translate complex language into easier to understand language and in various formats, e.g., guides, booklets, Web-based training courses, brochures, national articles, and fact sheets.

Test the quality of our products for yourself and begin obtaining information regarding billing and Medicare coverage & payment – or even basic information such as office management. Visit the MLN Publications page on the CMS Web site to view downloadable publications or click on the Product Ordering Page to see what is available in hard copy.

Remember: There's never a charge for *Medicare Learning Network* products. ❖

Source: CMS PERL 201002-33

New fact sheet for speech-language pathologist in private practice

The new *Medicare Billing for Speech-Language Pathologists in Private Practice* fact sheet (January 2010), which provides general information and guidance to speech-language pathologists (SLPs) on enrollment and billing procedures, is now available in downloadable format from the Centers for Medicare & Medicaid Services' *Medicare Learning Network* on the CMS Web site at *http://www.cms.hhs.gov/MLNProducts/downloads/SpeechLangPathfctsht.pdf*. ❖

Source: CMS PERL 201002-02

Revised fact sheet for the Medicare physician fee schedule

The *Medicare Physician Fee Schedule* fact sheet (February 2010) has been revised to include information about the two month zero percent (0 percent) update to the 2010 Medicare physician fee schedule (MPFS), effective only for dates of service January 1, 2010, through February 28, 2010. This fact sheet, which also provides information about MPFS payment rates and the MPFS payment rates formula, is available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network* at *http://www.cms.hhs.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*. ❖

Source: CMS PERL 201002-05

New national provider identifier booklet available

The National Provider Identifier (NPI): What You Need to Know booklet is available for download. The administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of a standard, unique health identifier for each health care provider. The NPI final rule, published on January 23, 2004, established the NPI as this standard. Covered entities under HIPAA are required by regulation to use NPIs to identify health-care providers in HIPAA standard transactions. This booklet contains information previously available in NPI fact sheet and tip sheets and is available at *http://www.cms.hhs.gov/MLNProducts/downloads/NPIBooklet.pdf*.

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

Source: CMS PERL 201002-24

Educational Resources

First Coast Service Options (FCSO) provides the training and information you need when it best fits into your busy schedule. If you or your colleagues were unable to attend one of FCSO's past Medicare educational webcasts, or if you would like to review the topics discussed, you may download a recording and listen to the webcast whenever it is *most convenient for you*. It's the next best thing to being there.

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 2009 through September 2010.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				

Please write legibly	Subtotal	**$**
	Tax (***add % for your area***)	**$**
	Total	**$**

Mail this form with payment to:

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

Contact Name:
_____

Provider/Office Name:
_____

Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
_____

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ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Addresses

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

General MSP Information
Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
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

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

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY
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
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

PROVIDERS
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

Option 1
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
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

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

Addresses

CLAIMS/CORRESPONDENCE
Claim Status
Additional Development
General Correspondence
Coverage Guidelines
Billing Issues Regarding
Outpatient Services, CORF, ORF, PHP
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

REDETERMINATION and REDETERMINATION OVERPAYMENTS
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

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

General MSP Information
Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
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

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

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY
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
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦