MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

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:

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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.

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THE FCSO MEDICARE A BULLETIN

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 website *http://medicare.fcso.com.*

Who receives the *Bulletin*?

Anyone may view, print or download the *Bulletin* from our provider education website. 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 website 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 website at *http://www.cms.gov/QuarterlyProviderUpdates/*.

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

GENERAL INFORMATION

Systems changes necessary to implement timely filing limit changes

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

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the timely filing limits for submitting claims for Medicare fee-for-service (FFS) reimbursement. As a result of the PPACA, claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare. Further details follow in this article. Make sure your billing staff is aware of these changes.

Background

Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act as well as the *Code of Federal Regulations* (CFR), 42 CFR Section 424.44 specify the timely filing limits for submitting claims for Medicare FFS reimbursement. Prior to PPACA, the regulations stated the service provider or supplier must submit claims for services furnished during the first nine months of the calendar year on or before December 31 of the following calendar year. For services rendered during the last quarter of the calendar year, the provider or supplier must submit the claim on or before December 31 of the second following year.

Section 6404 of PPACA amended the timely filing requirements to reduce the maximum-time period for submission of all Medicare FFS claims to one calendar year after the date of service. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010, must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.

What you need to know

Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009, will be subject to pre-PPACA timely filing rules and associated edits.
- Claims with dates of service October 1, 2009, through December 31, 2009, received after December 31, 2010, will be denied as being past the timely filing deadline.
- Claims with dates of service January 1, 2010, and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

Note: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "from" date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify exceptions to the one calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR Section 424.44(b)(1), for "error or misrepresentation" of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

Additional information

The official instruction (change request 6960) issued to your Medicare FI, carrier, DME MAC, A/B MAC and/or RHHI is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R697OTN.pdf*.

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

MLN Matters® Number: MM6960
Related Change Request (CR) Number: 6960
Related CR Release Date: May 7, 2010
Related CR Transmittal Number: R697OTN
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-20, Transmittal 697, CR 6960

Clinical review judgment

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

Provider types affected

This impacts all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FI], regional home health intermediaries [RHHI], Medicare administrative contractors [A/B MAC], or durable medical equipment Medicare administrative contractors [DME MAC]) for services provided to Medicare beneficiaries.

What you need to know

CR 6954, from which this article is taken:

- Adds Section 3.14 (Clinical Review Judgment) to the *Medicare Program Integrity Manual*, clarifying existing language regarding clinical review judgments, and
- Requires that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Background

Medicare claim review contractors (carriers, FIs [called affiliated contractors, or ACs], MACs, the comprehensive error rate testing (CERT) contractor, and recovery audit contractors [RACs]), along with program safeguard contractors (PSC) and zone program integrity contractors (ZPIC) are tasked with measuring, detecting and correcting improper payments in the Medicare fee-for-service (FFS) program.

Change request (CR) 6954, from which this article is taken, updates the *Medicare Program Integrity Manual* by adding a new section (3.14 – Clinical Review Judgment) which clarifies existing language regarding clinical review judgments; and also requires that Medicare claim review contractors instruct their clinical review staffs to use the clinical review judgment process when making complex review determinations about a claim.

This clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient.
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

Note: Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).

Additional information

You may find more information about clinical review judgment by going to CR 6954, located on the CMS website at *http://www.cms.gov/Transmittals/downloads/R338PI.pdf*.

You will find the updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section14 (Clinical Review Judgment) as an attachment to that CR.

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

MLN Matters® Number: MM6954
Related Change Request (CR) Number: 6954
Related CR Release Date: May 14, 2010
Related CR Transmittal Number: R338PI
Effective Date: April 23, 2010
Implementation Date: June 15, 2010

Source: CMS Pub. 100-08, Transmittal 338, CR 6954.

Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010

On March 23 President Obama signed into law the Patient Protection and Affordable Care Act. One week later, on March 30, the President also signed into law the Health Care and Education Reconciliation Act of 2010. These two new laws have a significant impact on the Medicare program and many of the provisions have effective dates prior to this point in time. Over the past several weeks, the Centers for Medicare & Medicaid Services (CMS) has begun implementing various provisions of the new laws, including those with past effective dates. In addition to implementing these legislative changes, the Medicare physician fee schedule is being updated to include certain corrections, retroactive to January 1, 2010, as prescribed in recently published notices in the *Federal Register*.

Once Medicare contractors have the new payment files in place, per the above, all claims going forward will be processed at the revised rates. However, CMS continues to work on the best way to address the many claims that are paid at the rates that were in place before the current corrections and updates are made.

Please be on the alert for further information about how CMS will address past claims. Until then, providers should not resubmit previously-processed claims affected by the payment changes, as it is likely that these resubmissions may be denied as duplicate claims. ❖

Source: CMS PERL 201005-24

Amount in controversy requirement for an administrative law judge hearings and federal district court appeals

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6894, which notifies Medicare contractors of the amount in controversy (AIC) required to sustain administrative law judge (ALJ) and federal district court appeal rights beginning January 1, 2010.

- The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2010, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2010, is $130.
- For federal district court review, the amount remaining in controversy goes from $1,220 for requests on or after January 1, 2009, to $1,260 for requests on or after January 1, 2010.

Please ensure that your staff knows of these changes.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6894 modifies the *Medicare Claims Processing Manual*, Chapter 29, Sections 220, 330.1, and 345.1 to update the AIC required for an ALJ hearing or judicial court review. CR 6894 also expands the background information in the Amount in Controversy General Requirements, Principles for Determining Amount in Controversy, and Aggregation of Claims to meet Amount in Controversy sections 250, 250.1, 250.2 and 250.3 in the *Claims Processing Manual*, Chapter 29. The revised portions of the manual are attached to CR 6894.

Additional information

The official instruction (CR 6894) issued to your Medicare carrier, A/B MAC, DME MAC, FI, and/or RHHI is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1965CP.pdf*.

A brochure entitled, *The Medicare Appeals Process: Five Levels To Protect Providers, Physicians And Other Suppliers*, provides an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process. The brochure is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf*.

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

MLN Matters® Number: MM6894
Related Change Request (CR) Number: 6894
Related CR Release Date: May 7, 2010
Related CR Transmittal Number: R1965CP
Effective Date: August 9, 2010
Implementation Date: August 9, 2010

Source: CMS Pub. 100-04, Transmittal 1965, CR 6894

Revised 2010 Medicare physician fee schedule database payment files and other retroactive provisions

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

Provider types affected

Physicians, nonphysician practitioners, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or Part A/B Medicare administrative contractors [A/B MACs] for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS) are affected by this article.

Provider action needed

This article is based on change request (CR) 6973, which amends payment files that were issued to contractors to take into account the 2010 MPFS final rule correction notice that went on display at the *Federal Register* on May 5, 2010, and retroactive provisions under the Affordable Care Act.

Background

Payment files were issued to contractors based on the calendar year (CY) 2010 MPFS final rule. Subsequent to the publication of the calendar year (CY) 2010 MPFS final rule:

- The Department of Defense Appropriations Act of 2010 provided a two month zero percent update to the 2010 MPFS, effective for dates of service January 1, 2010, through February 28, 2010.

Revised 2010 Medicare physician fee schedule database payment files and other retroactive provisions (continued)

- The Temporary Extension Act of 2010 extended the zero percent update to the 2010 MPFS for dates of service through March 31 2010.
- The Continuing Extension Act of 2010 extended the zero percent update to the 2010 MPFS for dates of service through May 31, 2010.

CR 6973 includes changes as a result practice expense (PE) and malpractice (MP) relative value unit (RVU) corrections and provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act), as modified by the Health Care and Education Reconciliation Act of 2010, which was signed into law on March 23, 2010, and March 30, 2010, respectively.

The PE and MP RVUs have been revised to align their values with the final CY 2010 MPFS policies for PE and MP RVUs. Although the zero percent (0%) update to the 2010 MPFS has been extended through legislation, the conversion factor (CF) has been revised as a result of the PE and MP RVU corrections. The revised CF used in calculating the payment amounts associated with this instruction is $36.0791.

The Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, also included the extension of several provisions, retroactive to January 1, 2010, that had previously been included in other legislation. The extended provisions include:

1) the extension of the work geographic practice cost index (GPCI) floor of 1.0 through December 31, 2010
2) the extension of the MPFS mental health add-on
3) the extension of the exceptions process for Medicare therapy caps
4) the extension of payment for the technical component (TC) of certain physician pathology services.

Also included is a revision to the PE GPCIs for CY 2010 and a new provision regarding payment for bone density tests in CY 2010.

Description of provisions

Revisions to CY 2010 work and PE GPCIs

Section 3102 of the Affordable Care Act extends the 1.0 work GPCI floor for services furnished through December 31, 2010. It also revises the PE GPCIs for CY 2010 so that the employee wage and rent portions of the PE GPCI reflect only one-half of the relative cost differences for each locality compared to the national average. Each PFS locality is held harmless under the PE GPCI changes.

These changes are reflected in the revised payment files and are retroactive to January 1, 2010.

Extension of physician fee schedule mental health add-on

Section 138 of the Medicare Improvements for Patients and Providers Act of 2008 increased the Medicare payment amount for specific "Psychiatry" services by five percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extends this provision retroactive to January 1, 2010, through December 31, 2010. The "Psychiatry" *CPT* codes that represent the "specified services" are as follows:

Office or other outpatient facility

- (Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy) *CPT* codes *90804, 90805, 90806, 90807, 90808, 90809*
- (Interactive Psychotherapy) *CPT* codes *90810, 90811, 90812, 90813, 90814, 90815*

Inpatient hospital, partial hospital or residential care facility

- (Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy) *CPT* codes *90816, 90817, 90818, 90819, 90821, 90822*
- (Interactive Psychotherapy) *CPT* codes *90823, 90824, 90826, 90827, 90828, 90829*

The increased payment amounts for these codes are included on the revised payment files and are retroactive to January 1, 2010.

Payment for bone density tests

Section 3111 of the Affordable Care Act adjusts the payment amounts for bone density tests. For dual-energy X-ray absorptiometry services furnished during CY 2010, the payment amount will be equal to 70 percent of the product of a) the relative value for the service for CY 2006; b) the conversion factor for CY 2006; and c) the CY 2010 geographic adjustment factor for the service for the fee schedule area (payment locality). In CY2011, part (c) of the formula will use the CY 2011 geographic adjustment factor.

These services were identified in 2006 by *CPT* codes *76075* and *76077*, but have since been renumbered to *77080* and *77082*. Based on this provision, the adjusted RVUs for these services are shown in the following table.

Revised 2010 Medicare physician fee schedule database payment files and other retroactive provisions (continued)

CPT	MOD	WRVU	Non-facility PE RVU	Facility PE RVU	Malpractice RVU	Non-facility total	Facility total
77080		0.22	2.35	NA	0.13	2.70	NA
	26	0.22	0.07	0.07	0.01	0.30	0.30
	TC	0.00	2.28	NA	0.12	2.40	NA
77082		0.12	0.59	NA	0.05	0.76	NA
	26	0.12	0.04	0.04	0.01	0.17	0.17
	TC	0.00	0.55	NA	0.04	0.59	NA

The adjusted payment amounts for these codes are included on the revised payment files and are retroactive to January 1, 2010.

Extension of exceptions process for Medicare therapy caps

Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continues the exceptions process through December 31, 2010.

Extension of payment for modifier TC of certain physician pathology services

Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a Medicare administrative contractor (MAC) for modifier TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extends the payment for modifier TC of certain physician pathology services retroactive to January 1, 2010, through December 31, 2010.

Additional information

The official instruction (CR 6973) issued to your carrier, FI, RHHI or A/B MAC, regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R700OTN.pdf*.

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

MLN Matters® Number: MM6973
Related Change Request (CR) Number: 6973
Related CR Release Date: May 10, 2010
Related CR Transmittal Number: R700OTN
Effective Date: January 1, 2010
Implementation Date: No later than June 1, 2010

Source: CMS Pub. 100-20, Transmittal 700, CR 6973

Update to guidance on standardized Medigap policy

The Centers for Medicare & Medicaid Services (CMS) recently issued guidance on a new standardized Medigap policy (Plan N) that will become effective June 1. Based on inquiries received from the provider community since the guidance was released, CMS has made several clarifying changes, which have resulted in the original guidance being replaced with the following.

Revised questions and answers regarding implementation of Medicare supplement Plan N co-payment, deductible, and coinsurance

Medicare supplement insurance plans and benefits have been updated in accordance with recent revisions to the Medicare Supplement Model Regulation and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 9.1E(11) of the model provides that new Medicare supplement Plan N will include a co-payment structure. As states and companies are working towards implementation of these new changes (which apply for policies with effective dates on or after June 1), a number of questions have surfaced regarding implementation of the new Plan N co-payment, deductible, and coinsurance requirements.

Update to guidance on standardized Medigap policy (continued)

Plan N requirements

Section 9.1E(11) of NAIC Model Regulation 651 (as published in the *Federal Register* on April 24, 2009 (see page 18823) states:

"(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with co-payment s in the following amounts:

(a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists), and

(b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense."

In order to ensure consistent implementation of this new standardized benefit Plan N, the Centers for Medicare and Medicaid Services (CMS) and the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC), have developed the following guidance. This information will also be provided to Medicare supplement carriers. References to *CPT* codes and Medicare procedures in this document have been reviewed by CMS, but are subject to change as Medicare rules and coding may change.

Deductible

Q1. Will payment of the Medicare Part B deductible by the beneficiary when the beneficiary has a Plan N policy operate the same way as fee-for-service Medicare, in that the beneficiary pays coinsurance or a co-payment for the Medicare-approved amount for services only after meeting the Part B deductible?

A1. Yes, the Plan N subscriber is responsible for meeting the deductible before any coinsurance or co-payment is collected. Once the deductible is met, the subscriber is responsible for up to $20 per office visit and up to $50 for an emergency room visit.

Office visit coinsurance or co-payment

Q2. Under Plan N, what constitutes an "office visit" for purposes of determining whether the subscriber is subject to the Part B coinsurance or co-payment of up to $20?

A2. Services coded as office visits or evaluation and management visits and billed on Part B professional claim forms (CMS-1500 or ASC X12N 837 professional) would be considered "office visits" for purposes of determining whether the subscriber is subject to the Plan N Part B coinsurance or co-payment of up to $20. These include *CPT*-4 codes *99201-99205* and *99211-99215*, as well as *92002*, *92004*, *92012*, and *92014* (ophthalmology), and *90805* (psychotherapy).

Note: Consultation *CPT-4* codes have been deleted from the 2010 Medicare physician fee schedule and are no longer payable by Medicare as of January 1, 2010.

Q3. When applying the Plan N physician office co-payment or coinsurance, should the amount be applied only to the office visit charge and not to other charges such as laboratory, X-ray or durable medical equipment (DME)?

A3. Yes, the coinsurance or co-payment should be applied only to *CPT*-4 codes *99201-99205* and 99211-*99215*, which are codes used to bill an office visit.

Q4. If the Plan N subscriber presents for multiple Medicare-covered office visits in one day, is the coinsurance or co-payment applicable to each office visit?

A4. Yes, the coinsurance or co-payment is applicable to each Medicare-covered office visit.

Q5. What are the *CPT*-4 codes applicable to physician specialty office visits for Plan N?

A5. There are no office visit codes used solely for visits to specialists, with the exception of the ophthalmology and psychotherapy codes listed above. *CPT*-4 codes *99201-99205* and *99211-99215*, which apply to nonspecialty office visits, also apply to the Plan N specialty office visit coinsurance or co-payment.

Q6. Would online, telephone, or telehealth services constitute "office visits" for purposes of determining whether a Plan N subscriber is subject to the Part B coinsurance or co-payment of up to $20?

A6. Providers do not code these services as office visits, office consultations or evaluation and management visits in their Part B billings. Therefore, these services would not be subject to the Plan N coinsurance or co-payment.

Q7. Does the Plan N office visit or emergency room co-pay apply to the foreign travel emergency benefit?

A7. No, the Plan N office visit and emergency room co-pays do not apply to the foreign travel emergency benefit. These services will not have a valid NPI attached. Therefore, the claims cannot be crossed over.

Emergency room coinsurance or co-payment

Q8. Does the Plan N emergency room (ER) coinsurance or co-payment apply to the physician professional fee charges, the ER facility fees, or both the ER and the physician office visit coinsurance or co-payment?

A8. The Plan N ER coinsurance or co-payment applies to the total Medicare Part B coinsurance or co-payment patient responsibility amount as shown in the remittance advice. The physician professional fee portion of the charges for ER visits are identified as *CPT*-4 codes *99281-99285*.

Q9. Is a Plan N subscriber subject to both the Plan N physician professional fee charge coinsurance or co-payment of up to $20 and the emergency room facility coinsurance or co-payment of up to $50 as a result of a covered emergency room visit that does not result in an inpatient hospital admission?

Update to guidance on standardized Medigap policy (continued)

A9. No, the beneficiary is subject to one Plan N emergency room coinsurance or co-payment of up to $50 based on the total Part B coinsurance liability.

Q10. When is the Part B emergency room coinsurance or co-payment of up to $50 waived for a Plan N subscriber?

A10. If a Plan N subscriber is admitted to an inpatient facility subsequent to the ER visit, and the care is paid under a Medicare Part A hospital inpatient stay, then the Plan N ER coinsurance or co-payment must be waived. If the emergency room visit, including physician and facility outpatient charges are paid under Part B, as they will be when the subscriber is not admitted to an inpatient facility, then the Plan N Part B coinsurance or co-payment of up to $50 will apply.

Q11. If the Plan N subscriber presents for multiple Medicare-covered ER visits in one day and is not admitted, is the ER coinsurance or co-payment applicable to each visit?

A11. Yes, the Plan N ER coinsurance or co-payment of up to $50 is applicable to each Medicare-covered visit.

Q12. Is the Plan N ER or office visit coinsurance or co-payment applicable to urgent care facilities?

A12. No. Since a visit to an urgent care facility is not coded as either an office visit or an ER visit and has a unique code, the Plan N co-payment or coinsurance for either the office visit or ER visit does not apply to visits to an urgent care facility.

Q13. Under Plan N, why is there a greater coinsurance or co-payment for emergency room visits than for office visits?

A13. The intent of having a greater coinsurance or co-payment for emergency room visits is to encourage office visits where they are appropriate and discourage unnecessary emergency room visits.

Additional questions?

If you have any questions, you may contact Jane Sung at the NAIC for matters relating to the NAIC model regulation or related issues at 1-202-471-3979 or mailto:*jsung@naic.org*, or Jay Dobbs at CMS for matters relating to Medicare procedures and coding at 1-410-786-1182 or mailto:*jay.dobbs2@cms.hhs.gov*.

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

Source: CMS PERL 201005-02

Re-Assignment of certain providers to Jurisdiction 1 and Jurisdiction 4 Medicare administrative contractors

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

Provider types affected

Certain hospitals, skilled nursing facilities, and other institutional providers who:

a. Currently submit claims to Wisconsin Physicians Service (WPS) in its capacity as a Medicare fiscal intermediary

b. Were serviced by Mutual of Omaha prior to 2007 when WPS assumed the Medicare fiscal intermediary contract

c. Will be transferred to the Jurisdiction 1 A/B MAC (currently Palmetto GBA) or the Jurisdiction 4 A/B MAC (currently TrailBlazer Health Enterprises) pursuant to the Centers for Medicare & Medicaid Services (CMS) geographic rule for assigning providers to MACs.

Impact on providers

Change requests (CRs) 5979, 6569, and 6902 describe in more detail the CMS approach for assigning providers to MACs and discuss the process of moving providers to MACs. Pursuant to these policies and procedures, approximately 2,000 providers will be moved from WPS to the Jurisdiction 1 A/B MAC and the Jurisdiction 4 A/B MAC in year 2010.

Background

Mutual of Omaha ("Mutual") served the Medicare program as a fiscal intermediary for several decades. Medicare Part A providers located in 49 states were serviced in that workload. Mutual's Medicare functions were assumed by WPS in 2007. This fiscal intermediary workload was, and still is, identified in Medicare data systems as "workload number 52280." This set of providers has been serviced under a distinct contract and maintained in a WPS workload separate from the Jurisdiction 5 A/B MAC workload (Iowa, Kansas, Missouri, and Nebraska), which is also serviced by WPS.

Under CMS' policy framework for assigning providers to A/B MACs, each provider currently serviced by WPS in workload 52280 is slated for transition to the A/B MAC that covers the state where the provider is located. A few providers will be exempt from the geographic assignment rule. Please see Section IV below.

I. What is taking place, and when?

In keeping with CMS policy for assigning providers to A/B MACs, CMS will be reassigning two sets of providers from the WPS legacy FI contract (workload 52280) to their destination A/B MACs during calendar 2010.
The first transition affected about 1,000 providers that were transferred to the Jurisdiction 1 A/B MAC, which is Palmetto GBA. The Jurisdiction 1 transition took place on April 19, 2010. The second transition will affect another 1,000 providers transferring to the Jurisdiction 4 A/B MAC, which is TrailBlazer Health Enterprises. The Jurisdiction 4 transition is currently scheduled to take place in October of 2010.

Re-Assignment of certain providers to Jurisdiction 1 and Jurisdiction 4 Medicare administrative contractors (continued)

II. When will the Jurisdiction 4 transferees be notified?

Non-chain providers will receive an initial letter during June. Providers in chains should receive their initial notice in August. This will allow the maximum amount of time for chain providers to be classified as qualified chain providers (QCPs)(see IV below) and for QCPs to make a decision as to whether they wish to centralize (or not) their Medicare billing relationship with the A/B MAC that services the state in which the QCP's home office is located.

III. What will happen to my Medicare payments during the period around cutover weekend?

CMS, WPS, and the Jurisdiction 4 A/B MAC will coordinate activities to ensure that Medicare claims payment operations continue uninterrupted for affected providers. These transition processes were successful in the recent transfer of providers to the Jurisdiction 1 A/B MAC.

IV. How did CMS decide which providers are moving?

For several years providers have no longer been allowed to choose their FI or MAC. With certain exceptions, CMS assigns providers to A/B MACs based on the geographic location of the provider. The geographic assignment rule requires that each provider will be assigned to the MAC that covers the state where the provider is located. A discussion of the geographic assignment rule can be found in MLN Matters® article number MM5979, which is available on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM5979.pdf*.

Providers located in the states of Hawaii, California, and Nevada, and the territories of American Samoa, Guam, and the Mariana Islands were moved to the Jurisdiction 1 A/B MAC. Providers located in the states of Texas, New Mexico, Colorado, and Oklahoma will be moved to the Jurisdiction 4 A/B MAC.

There are a few exceptions to the geographic assignment rule. One of the pertinent exceptions is for a limited subset of Medicare chains called "qualified chain providers" (QCPs). These provider chains are comprised of ten or more hospitals, and/or skilled nursing facilities (SNFs) collectively operating 500 or more certified Medicare beds. See the regulation at 42 CFR 421.404 for the detailed requirements. If a hospital or a SNF is part of a QCP, then CMS considers the location of the QCP's "home office."

If the QCP home office is located in a state or territory covered by Jurisdiction 1 (California, Hawaii, Nevada, American Samoa, Guam, or the Mariana Islands), then all the hospitals and SNFs in that QCP were transferred to the Jurisdiction 1 A/B MAC – even if the provider is located elsewhere.

If the QCP home office is located in a state covered by the Jurisdiction 4 (Texas, New Mexico, Colorado, or Oklahoma), then all hospitals and SNFs in the QCP will be transferred to the Jurisdiction 4 A/B MAC – even if the provider is located elsewhere.

If the QCP home office is located in a state not covered by either Jurisdiction 1 or Jurisdiction 4, then all the providers in the subject QCP will remain in the WPS fiscal intermediary workload until CMS schedules future provider transfers to A/B MACs.

The second pertinent exception is for providers that are provider-based pursuant to 42 CFR 413.65. These providers will be moved (or not moved) based on CMS' assignment of the "main provider" to the appropriate A/B MAC under CR 5979.

The third exception is for hospital subunits pursuant to 42 CFR 483.5(b). These providers will also be moved (or not moved) together with the connected hospital.

Additional Information

For complete details regarding the Jurisdiction 1 A/B MAC CR please see the official instruction (CR 6569) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to the CMS website at *http://www.cms.gov/Transmittals/downloads/R583OTN.pdf*.

For complete details regarding the Jurisdiction 4 A/B MAC CR please see the official instruction (CR6902) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to the CMS website at *http://www.cms.gov/transmittals/downloads/R691OTN.pdf*.

To view any of the federal regulations cited in this article or in CR 5979, visit *http://www.gpoaccess.gov/cfr/index.html*.

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

MLN Matters® Number: SE1016
Related Change Requests (CRs) Number: 6569 & 6902
Related CR Release Date: N/A
Related CR Transmittal Number: R583OTN and R691OTN
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters®* Article SE1016

Time is running out – have you responded?

Your opportunity to participate in the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) is quickly coming to an end and the Centers for Medicare & Medicaid Services (CMS) still needs your feedback. If you or your office received notification from CMS that you were randomly selected to participate in the 2010 MCPSS – this is your last chance to respond before the survey closes. Your feedback is very important. The MCPSS is your opportunity to tell us about your satisfaction with the services you receive from the Medicare contractor that processes and pays your fee-for-service Medicare claims.

Completion of the survey is quick and easy. It only takes a few minutes of your time. To respond to the survey or to designate a proxy respondent to complete it on your behalf, please call the MCPSS Provider Helpline today, at 1-800-835-7012, or send an e-mail to *mcpss@scimetrika.com*. A representative from the MCPSS team will be happy to assist you.

We assure you we will not provide information that identifies you or your practice or facility to anyone outside the study team, except as required by law.

If you have already responded to the 2010 MCPSS, thank you. If you have not, don't pass up this golden opportunity to let your voice be heard. Time is running out… please respond today!

Please note: Only providers and suppliers who have been randomly selected and notified can participate in the 2010 MCPSS. A new random sample of providers and suppliers is selected annually to participate in the MCPSS study.

For more information about the MCPSS, please visit the CMS MCPSS website at *http://www.cms.gov/mcpss*, or read the CMS *MLN Matters* special edition article, SE1005, at *http://www.cms.gov/MLNMattersArticles/downloads/SE1005.pdf* featuring the survey.

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

Source: CMS PERL 201005-15

July update to the 2010 durable medical equipment, prosthetic and, orthotic devices, and surgical supply fee schedule

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

Provider types affected

This article is for providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for durable medical equipment, prosthetic and, orthotic devices, and surgical supply (DMEPOS) provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6945 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for DMEPOS by Sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

Key points of change request 6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes with A4336, E1036, L8031, L8032, L8629, and Q0506 with dates of service on or after January 1, 2010, that have already been processed will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.
- CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code – A4221 Supplies for maintenance of drug infusion catheter, per week. To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.

July update to the 2010 DMEPOS fee schedule (continued)

- CR 6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items.

Additionally, the descriptors for modifiers RA and RB are being revised, effective April 1, 2010, to read as follows:

RA Replacement of a DME, orthotic or prosthetic item
RB Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair

Suppliers should continue to use the modifier RA on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item, which has been lost, stolen or irreparably damaged. Likewise, modifier RB should continue to be used on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).

- Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is five years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than five years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than five years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR 6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to three months.
- HCPCS code Q0506 Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than lithium ion – HCPCS codes Q0496 and Q0503 – remains at six months as described in CR 3931, Transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA (Replacement of a DME, orthotic or prosthetic item) to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR 3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

Additional information

The official instruction (CR 6945) issued to your Medicare DME MAC may be found on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1967CP.pdf*.

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

MLN Matters® Number: MM6945
Related Change Request (CR) Number: 6945
Related CR Release Date: May 7, 2010
Related CR Transmittal Number: R1967CP
Effective Date: January 1, 2010, for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010, for the revisions to modifier descriptors of RA and RB, which became effective April 1, 2010; July 1, 2010, for all other changes
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1967, CR 6945

Implementation of home health agency program safeguard provisions

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 6750 and the related *MLN Matters* article MM6750 on May 5, 2010. The *MLN Matters* article MM6750 was published in the March 2010 *Medicare A Bulletin* (pages 12).

MLN Matters® Number: MM6750 – Rescinded
Related Change Request (CR) Number: 6750
Related CR Release Date: December 18, 2009
Related CR Transmittal Number: R318PI
Effective Date: January 1, 2010
Implementation Date: January 1, 2010

Source: CMS Pub. 100-08, Transmittal 318, CR 6750

Temporary three percent rural add-on for home health prospective payment system

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

Provider types affected

Home health agencies (HHA) who bill regional home health intermediaries (RHHI) or Medicare administrative contractors (MAC) are impacted by this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 6955 in order to update the national episode rates and the national per-visit amounts under the home health protective payment system (HH PPS) for calendar year (CY) 2010 for episodes and visits ending on or after April 1, 2010, and before January 1, 2011 by adding three percent for home health services furnished in a rural area. This rural add-on payment is specified in Section 3131 of the Patient Protection and Affordable Care Act of 2010 (PPACA). The three percent add-on will be implemented via the HH PRICER used to process your claims.

Background

Section 3131 of the PPACA institutes, for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Social Security Act (or Act) with respect to episodes and visits ending on or after April 1, 2010 and before January 1, 2016 that the Secretary of Health & Human Services increase by three percent the payment amount otherwise made under section 1895 of the Act. The statute waives budget neutrality related to this provision as it specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute. The three percent rural add-on is applied to the national standardized 60-day episode rate, the national per-visit rates, the low utilization payment adjustment (LUPA) add-on payment amount, and the non-routine supply (NRS) conversion factor when home health services are provided in rural (non-CBSA) areas. The applicable case-mix and wage index adjustments are subsequently applied. All other provisions of the HH PPS final rule published on November 10, 2009 are still valid. The payment amounts are different based on whether or not an HHA reports the required quality data.

The following five tables show the rates for HHAs that DO report the required quality data:

Refer to Table 1 for the calculations that yield the calendar year (CY) 2010 updated national standardized 60-day episode payment rate for beneficiaries who reside in rural areas. These payments will be further adjusted by the individual episode's case-mix weight and wage index.

Table 1 – CY 2010 Total national standardized 60-day episode payment amount for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do submit required quality data

National standardized 60-day episode payment amount for CY 2010	Multiplied by three percent rural increase	CY 2010 Total national standardized 60-day episode payment amount for a beneficiary who resides in a rural, non-CBSA area
$2,312.94	X 1.03	$2,382.33

The national standardized per-visit amounts are used to calculate low utilization payment adjustments (LUPAs) and outlier payments. The national per-visit amounts for beneficiaries who reside in rural areas are as follows:

Table 2 – CY 2010 total per-visit rates for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do submit required quality data.

Home health discipline	CY 2010 Per-Visit Rate	Multiplied by three percent rural increase	CY 2010 total per-visit rates for a beneficiary who resides in a rural, non-CBSA area
Home health aide	$51.18	X 1.03	$52.72
Medical social services	$181.16	X 1.03	$186.59
Occupational therapy	$124.40	X 1.03	$128.13
Physical therapy	$123.57	X 1.03	$127.28
Skilled nursing	$113.01	X 1.03	$116.40
Speech-language pathology	$134.27	X 1.03	$138.30

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. The CY 2010 LUPA add-on payment for beneficiaries who reside in rural areas is updated in Table 3.

Temporary three percent rural add-on for home health prospective payment system (continued)

Table 3 – CY 2010 LUPA add-on payment for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do submit required quality data.		
CY 2010 LUPA add-on payment	Multiplied by three percent rural increase	CY 2010 LUPA add-on payment for a beneficiary who resides in a rural, non-CBSA area
$94.72	X 1.03	$97.56

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The NRS conversion factor for CY 2010 payments for beneficiaries who reside in rural areas is updated in Table 4a.

Table 4a – CY 2010 NRS conversion actor for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do submit required quality data		
CY 2010 NRS conversion factor	Multiplied by three percent rural increase	CY 2010 NRS conversion factor for a beneficiary who resides in a rural, non-CBSA area
$53.34	X 1.03	$54.94

The payment amounts for beneficiaries who reside in rural areas for the various severity levels based on the updated conversion factor are shown in Table 4b.

Table 4b – NRS Payment Amount for HHAs that Do submit required quality data.			
Relative Weights for the six-severity NRS system			
Severity level	Points (scoring)	Relative weight	NRS payment amount
1	0	0.2698	$14.82
2	1 to 14	0.9742	$53.52
3	15 to 27	2.6712	$146.76
4	28 to 48	3.9686	$218.03
5	49 to 98	6.1198	$336.22
6	99+	10.5254	$578.27

The following five tables show the rates for HHAs that DO NOT report the required quality data:

The CY 2010 national standardized 60-day episode payment rate for beneficiaries who reside in rural areas for HHAs who do not submit the required quality data is shown in Table 5 below.

Table 5		
National standardized 60-day episode payment amount for CY 2010 for HHAs that Do Not submit required quality data	Multiplied by three percent rural increase	CY 2010 Total national standardized 60-day episode payment amount for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do Not submit required quality data
$2,267.59	X 1.03	$2,335.62

The national standardized per-visit amounts are used to calculate low utilization payment adjustments (LUPAs) and outlier payments. The national per-visit amounts for beneficiaries who reside in rural areas for HHAs that do not submit the required quality data are as follows:

Table 6			
Home health discipline	CY 2010 per-visit rate	Multiplied by three percent rural increase	CY 2010 Per-visit rate for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do Not submit required quality data
Home health aide	$50.18	X 1.03	$51.69
Medical social services	$177.60	X 1.03	$182.93
Occupational therapy	$121.96	X 1.03	$125.62

Temporary three percent rural add-on for home health prospective payment system (continued)

Table 6			
Physical therapy	$121.15	X 1.03	$124.78
Skilled nursing	$110.79	X 1.03	$114.11
Speech-language pathology	$131.64	X 1.03	$135.59

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. This additional LUPA add-on amount for beneficiaries who reside in rural areas for HHAs that do not submit the required quality data is updated in Table 7.

Table 7		
CY 2010 LUPA add-on payment	Multiplied by three percent rural increase	CY 2010 LUPA add-on payment for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do Not submit required quality data
$92.86	X 1.03	$95.65

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2010 payments for beneficiaries who reside in rural areas to HHAs that do not submit the required quality data, the NRS conversion factor is shown in Table 8a.

Table 8a		
CY 2010 NRS conversion factor	Multiplied by trhee percent rural increase	CY 2010 NRS conversion factor for a beneficiary who resides in a rural, non-CBSA area for HHAs that Do Not submit required quality data
$52.29	X 1.03	$53.86

The payment amounts for beneficiaries who reside in rural areas for the various severity levels based on the updated conversion factor are calculated in Table 8b.

Table 8b			
For HHAs that Do Not Submit the required quality data – relative weights for the six-severity NRS system			
Severity level	Points (scoring)	Relative weight	NRS Payment Amount for HHAs that Do Not submit required quality data
1	0	0.2698	$14.53
2	1 to 14	0.9742	$52.47
3	15 to 27	2.6712	$143.87
4	28 to 48	3.9686	$213.75
5	49 to 98	6.1198	$329.61
6	99+	10.5254	$566.90

Additional Information

The official instruction associated with this CR6955, issued to your Medicare MAC and/or RHHI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R674OTN.pdf*.

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

MLN Matters® Number: MM6955
Related Change Request (CR) Number: 6955
Related CR Release Date: April 23, 2010
Related CR Transmittal Number: R674OTN
Effective Date: April 1, 2010
Implementation Date: May 24, 2010

Source: CMS Pub. 100-20, Transmittal 674, CR 6955

Enhancements to home health consolidated billing enforcement

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

Provider types affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries during an episode of home health care.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the home health prospective payment system (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

What you need to know

Consolidated billing edit modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, Chapter 10, Section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both "from" and "to" dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item "from" or "to" date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the "from" date and the date by which the supplies will be used in the "to" date. When this causes the "to" date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the "from" date on the supply line item falls within a HH episode.

A new file of HH certification information

Chapter 10, Section 20.1 of the *Medicare Claims Processing Manual* describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file, which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

G0179	Physician re-certification for Medicare-covered home health services under a plan of care
G0180	Physician certification for Medicare-covered home health services under a plan of care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their request for anticipated payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60 percent or 50 percent payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's common working file (CWF) query screens, Medicare systems will display all certification code dates within nine months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within 9 months before the current date as the default response.

Note: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particular true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40 percent of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Enhancements to home health consolidated billing enforcement (continued)

Additional information

The official instruction (CR 6911) issued to your Medicare RHHI/MAC is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1952CP.pdf*.

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

MLN Matters® Number: MM6911
Related Change Request (CR) Number: 6911
Related CR Release Date: April 28, 2010
Related CR Transmittal Number: R1952CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 19521, CR 6911

Updates to the home health prospective payment system PC PRICER

The calendar year (CY) 2008 and CY 2009 home health prospective payment system (HH PPS) personal computer (PC) PRICERs have been updated with revised logic. The PC PRICERs are on the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPRICER/05_HH.asp*, under the Downloads section.

If you use the CY 2008 or CY 2009 HH PPS PC PRICERS, please go to the page above and download the latest version of the PC PRICER posted on April 30, 2010.

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

Source: CMS PERL 201005-01

AMBULANCE SERVICES

Medicare Benefit Policy Manual updated to include ambulance transports with joint responses

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6949 which updates the *Medicare Benefit Policy Manual* (Chapter 10, Section 10.5 [Joint Response]) to incorporate information that has been re-organized to include ambulance transports with joint responses. No new policy is presented as this just updates the relevant manual section to reflect current policy.

Background

The Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport.

Basic life support/advanced life support joint responses

In situations where a basic life support (BLS) entity provides the transport of the beneficiary and an advanced life support (ALS) entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, paramedic intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists.

Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their Medicare contractor upon request.

Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

Medicare Benefit Policy Manual updated to include ambulance transports with joint responses (continued)

Ground to air ambulance transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided and mileage from the point of pickup to the point of transfer to the air ambulance.

Note: There is no new policy being developed by CR 6949. CR 6949 re-instates language to the *Medicare Benefit Manual* (Publication 100-02, Chapter 10) to incorporate information that has been re-organized to include ambulance transports with joint responses.

Additional information

The official instruction, CR 6949, issued to your carrier, FI, and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R125BP.pdf*.

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

MLN Matters® Number: MM6949
Related Change Request (CR) Number: 6949
Related CR Release Date: May 14, 2010
Related CR Transmittal Number: R125BP
Effective Date: January 4, 2010
Implementation Date: June 15, 2010

Source: CMS Pub. 100-02, Transmittal 125, CR 6949

ELECTRONIC HEALTH RECORDS

Four states and Puerto Rico to receive matching funds for electronic health record incentive program

In another key step to further states' role in developing a robust U.S. health information technology (HIT) infrastructure, the Centers for Medicare & Medicaid Services (CMS) announced additional federal matching funds for certain state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009 (Recovery Act).

EHRs will improve the quality of health care for the citizens of the recipient states and Puerto Rico and make their care more efficient.

The records make it easier for the many providers who may be treating a Medicaid patient to coordinate care. Additionally, EHRs make it easier for patients to access the information they need to make decisions about their health care.

This batch is part of a rolling announcement CMS began in November 2009. To date, including these latest matching funds, CMS has awarded a total of $58.38 million to 35 states, Puerto Rico, and the U.S. Virgin Islands.

Recipient	Award amount
Missouri	$1.53 million
New Mexico	$405,000
Oregon	$3.53 million
Puerto Rico	$1.80 million
Washington	$967,000
Subtotal	$8.23 million
Total awards to date	$58.38 million

Additional information on implementation of the Medicaid-related provisions of the Recovery Act's EHR incentive payment program may be found at *http://www.cms.gov/Recovery/11_HealthIT.asp*.

The press releases, which were issued on April 26, are available at *https://www.cms.gov/apps/media/press_releases.asp*.

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

Source: CMS PERL 201005-08

Beacon communities lead the charge to improve health outcomes

The following is a message from Dr. David Blumenthal, national coordinator for Health Information Technology.

Establishing beacons for nationwide advances in health information technology

Health-care professionals appreciate opportunities to learn from innovative colleagues and communities – to see what really works, to get "boots-on-the-ground" perspectives, to learn best practices, and to use the experience of other leaders to inform how to improve performance more broadly.

The Beacon Community Cooperative Agreement Program (*http://healthit.hhs.gov/portal/server.pt?open=512&objID=1805&parentname=CommunityPage&parentid=2&mode=2&cached=true*), by its very design, was intended to shine a spotlight on health information technology (health IT) innovators, so that we all might learn from them. On May 4, Secretary Sebelius awarded $220 million to establish 15 Beacon communities throughout America. Read the press release at *http://www.hhs.gov/news/press/2010pres/05/20100504a.htm*). These community consortia – selected from 130 applicants – have demonstrated leadership in developing advanced health IT solutions to help improve specific health outcomes. They also share a strong conviction in the benefits of health IT as a critical pillar to advance broad and sustainable health system improvement. The average award amount is $15 million over 36 months.

The Beacon community awards recognize collaborative community efforts operating at the cutting edge of health IT and health care delivery system innovation. Beacon communities will implement a range of care delivery innovations building on existing infrastructure of interoperable health IT and standards-based information exchange, in coordination with the Regional Extension Center Program and State Health Information Exchange Program.

In addition, the program will help Beacon communities plan and develop new initiatives that can ensure the longer-term sustainability of health IT-enabled improvements in health care quality, safety, efficiency, and population health. This includes preparing for future policy changes resulting from enactment of health care reform legislation that will permit providers, states, and regional health care organizations to test new payment methods emphasizing improvements in quality and value.

Like so many other providers who effectively implement health IT, Beacon communities will leverage other existing federal programs and resources to promote health information exchange at the community level. These resources include:

- Department of Defense and the Department of Veterans Affairs Virtual Lifetime Electronic Record (VLER) program, which aims to develop a longitudinal electronic health record for all active duty, Guard and Reserve, retired military personnel, and eligible separated Veterans
- Health Resources and Services Administration (HRSA) programs at federally qualified health centers (FQHCs) and Health Center Controlled Networks (HCCNs) to advance the adoption of certified electronic health records and exchange of health information
- Department of Agriculture and Department of Commerce efforts to extend broadband infrastructure

The partnership with applicable VLER, FQHC, and HCCN sites is particularly important to ensure we realize measurable and tangible results in federally funded, military, and private sector health care settings alike.

I would like to acknowledge and praise the many applicants who were not funded today, but whose experience and commitment suggests our nation has an encouraging foundation of health information exchange to build on. An additional $30.3 million is currently available to fund additional Beacon community cooperative agreement awards. An announcement to apply will be made in the near future.

Especially, I am particularly pleased by the diversity among Beacon awardees (*http://healthit.hhs.gov/blog/onc/index.php/2010/05/05/beacon-communities-lead-the-charge-to-improve-health-outcomes/*): geographically, they span the continental United States and reach as far as Hawaii; both urban and rural communities are well represented; and targeted program outcomes span some of America's most pressing health concerns, from reducing medication errors and improving the care of individuals with cardiovascular disease to reducing disparities in access and outcomes for patients with diabetes. Additionally, the programs bring health IT innovation to a variety of underserved populations to address health disparities and improve patient care. The Beacon communities demonstrate that health IT can bring meaningful change to health care for all Americans – not just the healthiest, wealthiest, or best insured.

I extend my sincere congratulations to our 15 Beacon communities. Your work inspires me, and I believe that in the coming months, it will inspire and inform America's medical and health IT communities.

Sincerely,

David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health & Human Services

The Office of the National Coordinator for Health Information Technology (ONC) encourages you to share this information as we work together to enhance the quality, safety and value of care and the health of all Americans through the use of electronic health records and health information technology.

Source: CMS PERL 201005-21

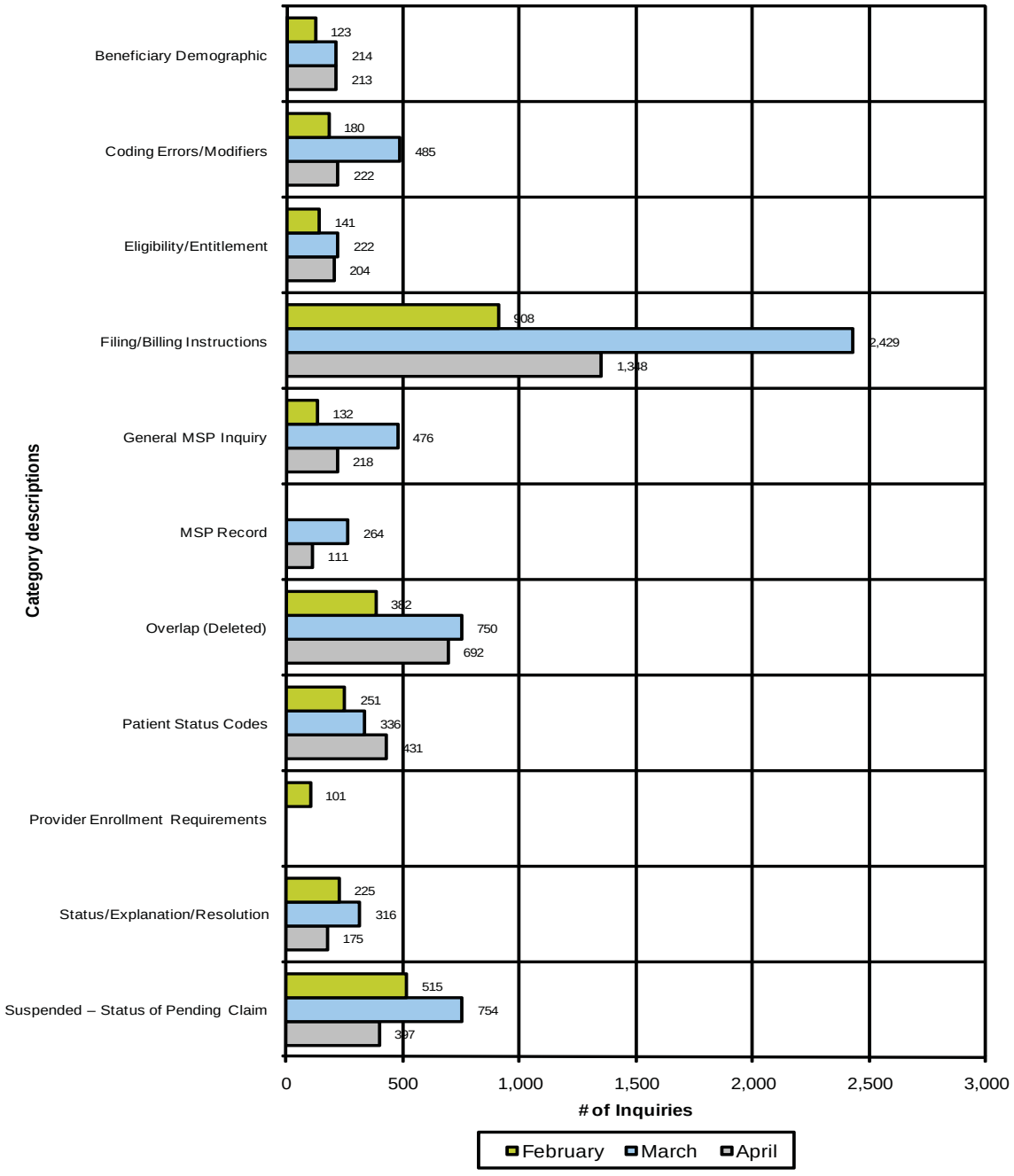
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims for February-April 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 February-April 2010.

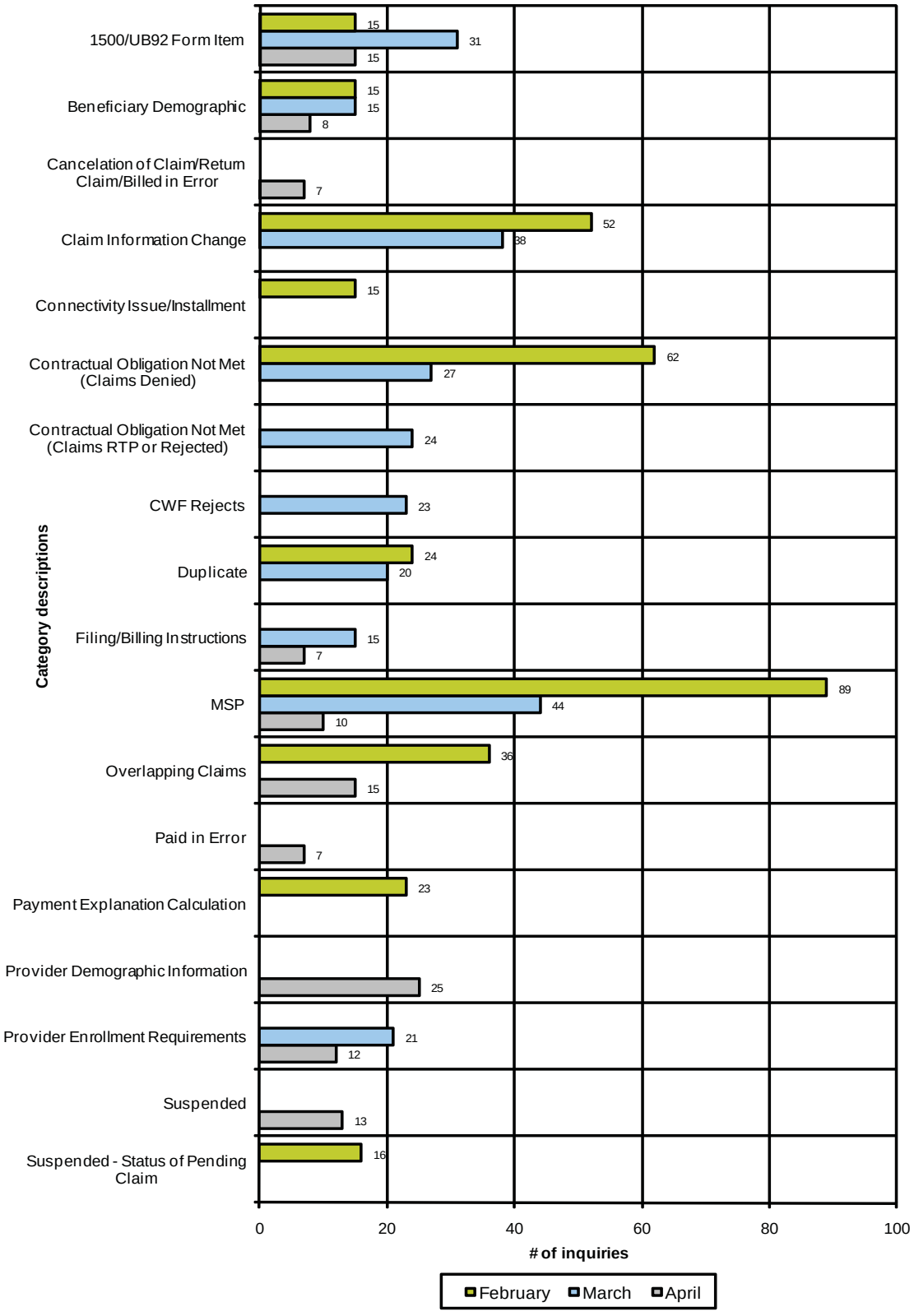
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for February-April 2010



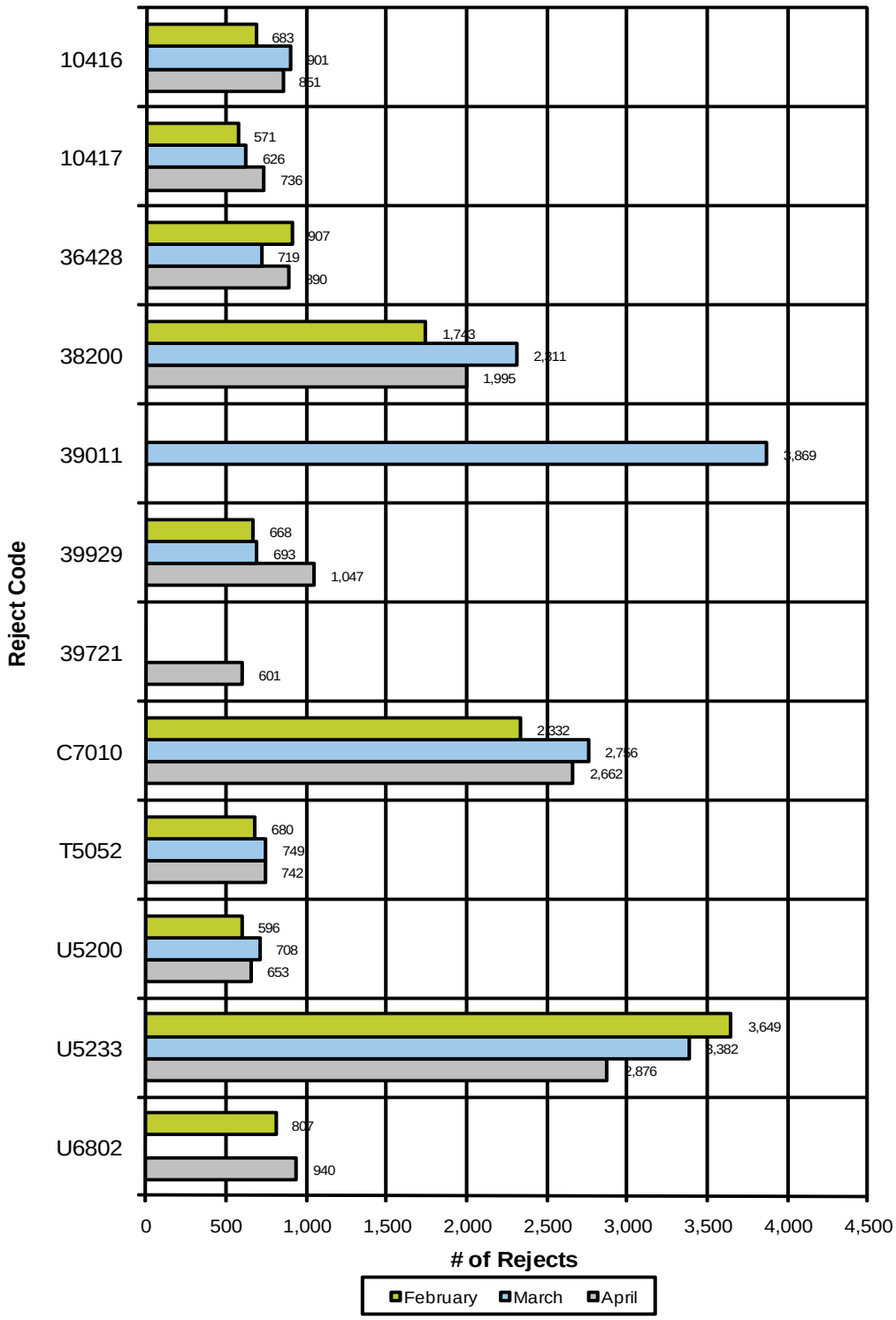
Top inquiries, return to provider, and reject claims for February-April 2010 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for February-April 2010



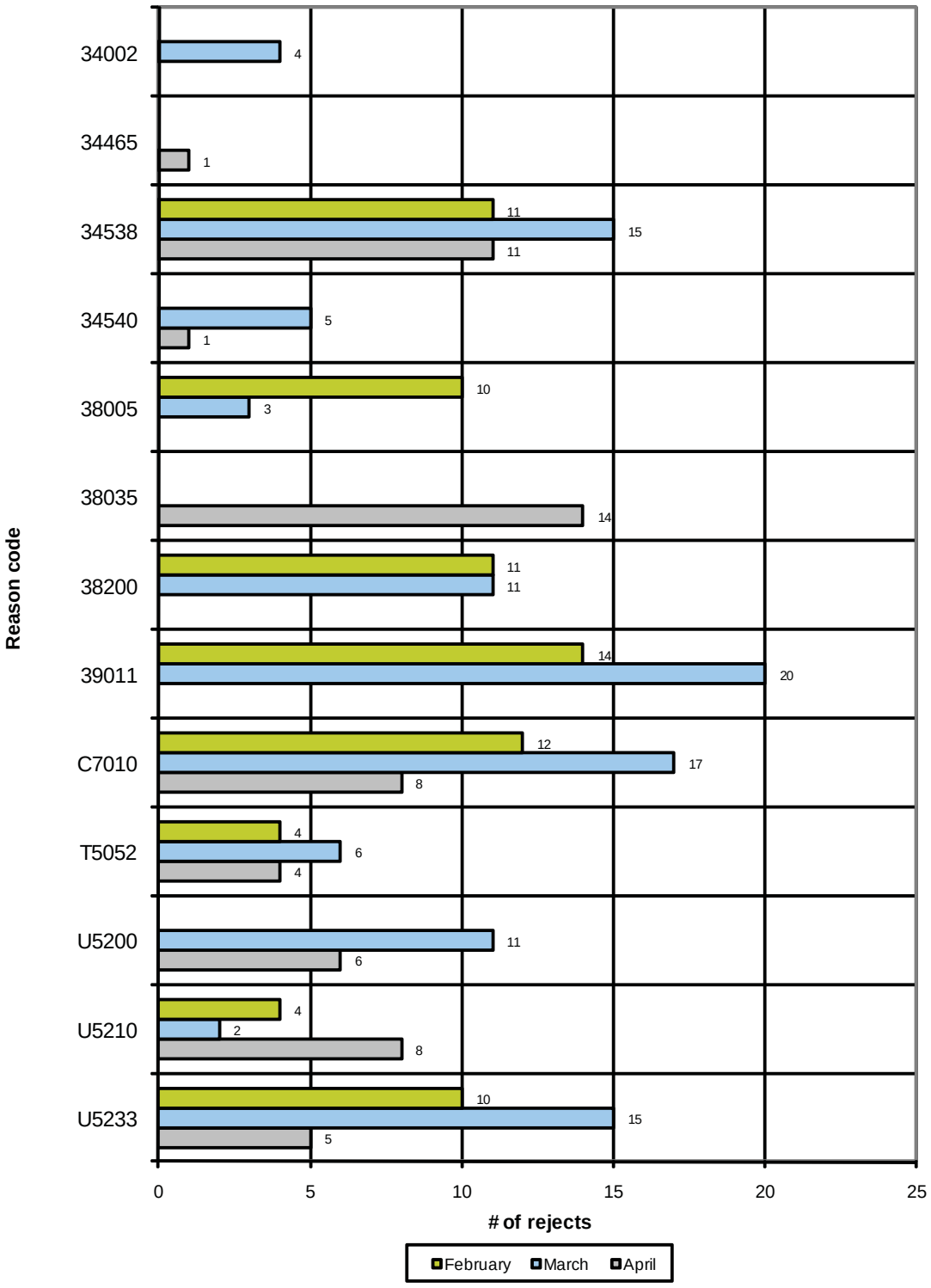
Top inquiries, return to provider, and reject claims for February-April 2010 (continued)

Florida Part A top rejects for February-April 2010



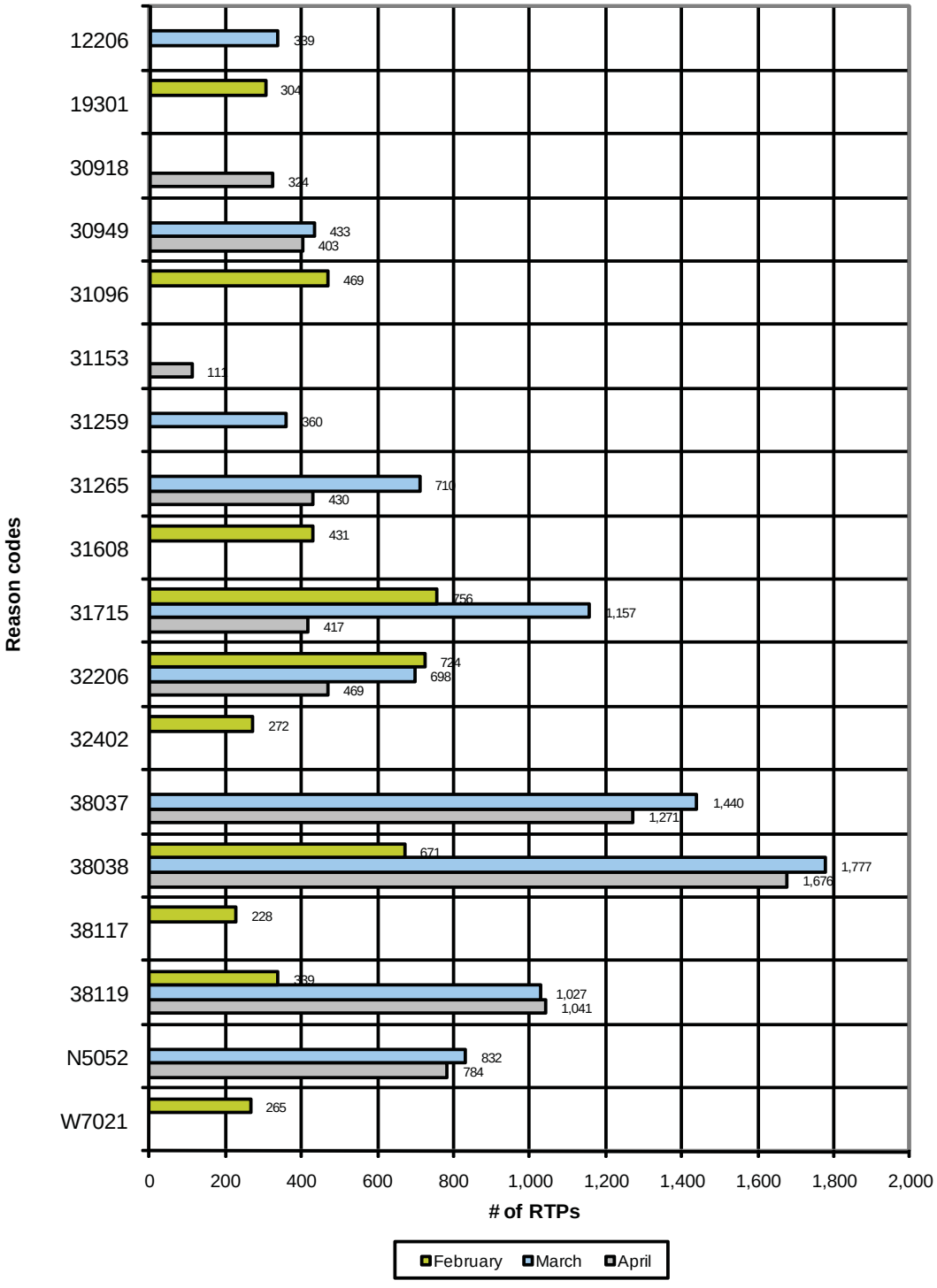
Top inquiries, return to provider, and reject claims for February-April 2010 (continued)

U.S. Virgin Islands Part A top rejects for February-April 2010



Top inquiries, return to provider, and reject claims for February-April 2010 (continued)

Florida Part A top return to providers (RTPs) for February-April 2010

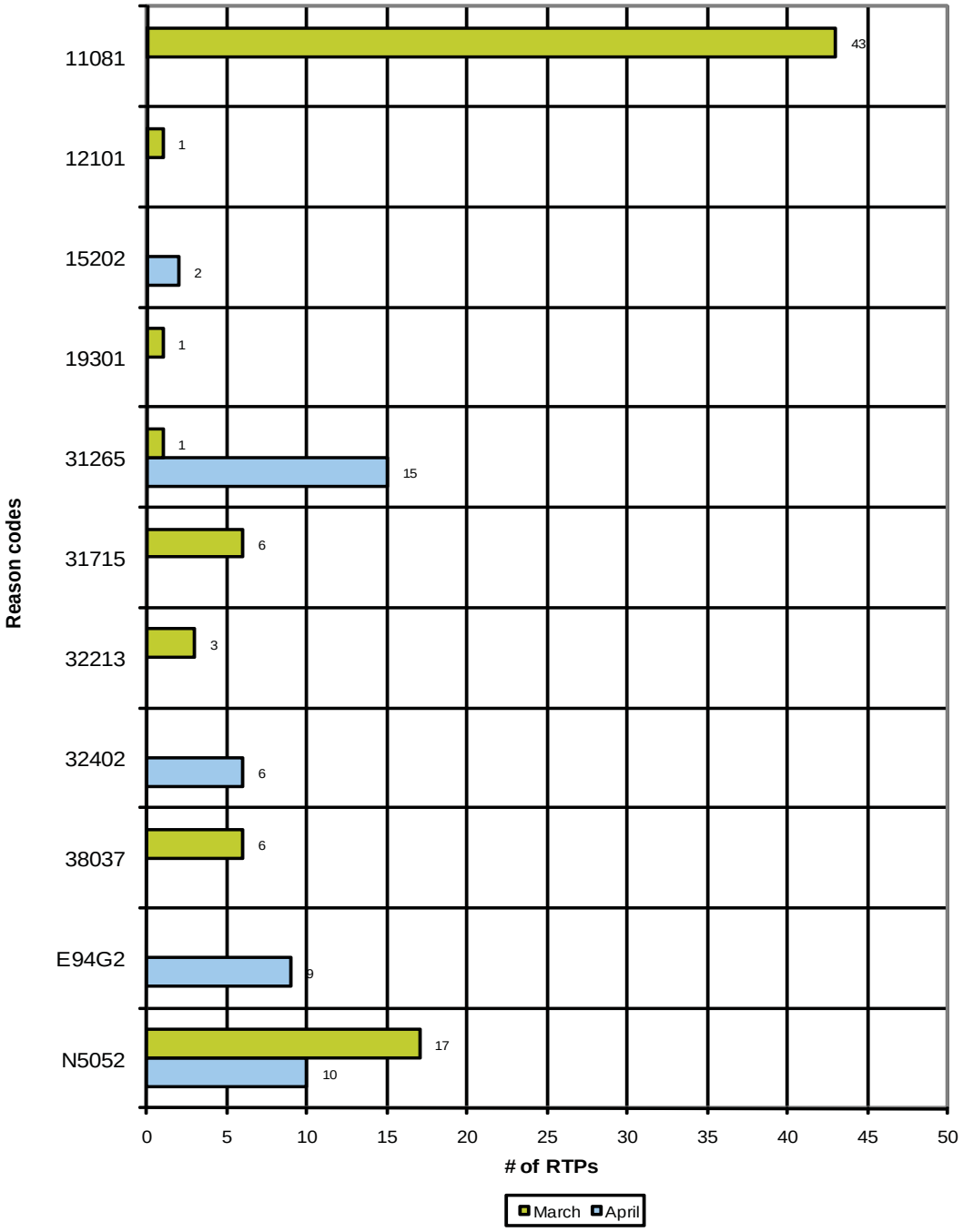


Keep Informed

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 February-April 2010 (continued)

U.S. Virgin Islands Part A top return to providers (RTPs) for March-April 2010



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.

GENERAL COVERAGE

Screening for the human immunodeficiency virus infection

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

Provider types affected

This article is for all physicians, providers, and clinical diagnostic laboratories submitting claims to Medicare contractors (fiscal intermediaries [FI], carriers, and Parts A/B Medicare administrative contractors [A/B MAC]) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has issued a new national coverage determination (NCD) that the evidence is adequate to conclude that screening for human immunodeficiency virus (HIV) infection is reasonable and necessary for prevention or early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Caution – what you need to know

Effective for claims with dates of service on and after December 8, 2009, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries, subject to the criteria in the *National Coverage Determination (NCD) Manual*, Sections 190.14 and 210.7, and the *Medicare Claims Processing Manual (CPM)*, Chapter 18, Section 130. These manual sections are attached to the transmittals, which comprise CR 6786. This article is based on CR 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.

Go – what you need to do

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

Background

Effective January 1, 2009, CMS is authorized to add coverage of "additional preventive services" through the NCD process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act (MIPPA). One of those requirements is that the services be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

Consequently, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786.

  Note: Eleven full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.

- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

  Note: Three tests will be covered for each term of pregnancy beginning with the date of the first test.

The USPSTF guideline upon which this policy is based contains eight increased-risk criteria. The first seven require the presence of both diagnosis codes V73.89 (Special screening for other specified viral disease) and V69.8 (Other problems related to lifestyle) for the claim to be paid. The last criterion, which covers persons reporting no increased risk factors, only requires diagnosis code V73.89 for the claim to be paid.

Note: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following three new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 outpatient code editor and the January 2011 clinical laboratory fee schedule (CLFS) updates:

G0432 Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening

G0433 Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening

G0435 Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening

Claims for the annual HIV screening must contain one of the new HCPCS along with a primary diagnosis code of V73.89, and when increased risk factors are reported, a secondary diagnosis code of V69.8. For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030x for claims for HIV screening.

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason

Screening for the human immunodeficiency virus infection (continued)

code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered.). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached.) will be used.

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (types of bills 12x, 13x, or 14x) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.

Contractors shall pay for HIV screening tests with HCPCS codes G0432, G0433, or G0435 on TOBs 12x, 13x, 14x, 22x, and 23x, under the clinical laboratory fee schedule as of January 1, 2011. Deductible and coinsurance do not apply.

Prior to inclusion of the new G codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted *CPT* procedure code *87999* may be used when paying for these services.

Note that for HIV screening claims with dates of service on or after December 8, 2009, through July 6, 2010, and processed before CR 6785 is implemented, Medicare will not adjust such claims automatically. However, your Medicare contractor will adjust such claims that you bring to their attention.

Additional information

CR 6786 was issued in two transmittals, one that modifies the *Medicare Claims Processing Manual*, which is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1935CP.pdf*.

The second transmittal revises the *Medicare NCD Manual* and that transmittal is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R113NCD.pdf*.

If you have questions, please contact your Medicare contractor at their toll free number, which is listed on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6786
Related Change Request (CR) Number: 6786
Related CR Release Date: March 23, 2010
Related CR Transmittal Number: R1935CP and R113NCD
Effective Date: December 8, 2009
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1935, CR 6786

Signature guidelines – 20-day timeframe for additional documentation requests

Medicare claim review contractors, including the comprehensive error rate testing (CERT) contractors and recovery audit contractors, are tasked with measuring, detecting, and correcting improper payments in the Medicare fee-for-service (FFS) program. These contractors review claims and medical documentation submitted by providers.

The previous language in the Program Integrity Manual (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. Change request (CR) 6698 updates these requirements and adds e-Prescribing language.

In situations where the guidelines in the PIM indicate for a medical reviewer to contact the billing provider requesting to submit an attestation statement or signature log to authenticate a medical record, the provider must submit the attestation statement or signature log within 20-calendar days.

The 20-day timeframe begins when:

- The reviewer makes actual phone contact with the provider, or
- The reviewer's request letter is received by the U.S. Postal Service

Signature log

A signature log lists the typed or printed name of the author associated with initials or an illegible signature. The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document. Medical reviewers will encourage the listing of credentials in the log; however, CMS has instructed reviewers not to deny a claim for a signature log that is missing credentials.

Signature attestation statement

The author of the medical record entry must sign and date the attestation statement in order to be considered valid for Medicare medical review purposes. The attestation statement must contain the appropriate information to identify the beneficiary in question.

Provider assistance

First Coast Service Options (FCSO) has implemented faxination accounts to assist providers with meeting these requirements and expedite this process. FCSO will provide you with these important numbers upon the request for the signature log or attestation statement.

Additional information

For detailed information regarding signature requirements, click here.

Source: CR 6698, Transmittal 327, March 16, 2010

July 2010 updates to the laboratory national coverage determination edit software

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 6964, which announces the changes that will be included in the July 2010 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in January 2010.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003.

In accordance with the Medicare Claims Processing Manual, Chapter 16, Section 120.2, available at *http://www.cms.gov/manuals/downloads/clm104c16.pdf*, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6964 announces changes to the laboratory edit module for changes in laboratory NCD code lists for July 2010. These changes become effective for services furnished on or after July 1, 2010. The changes that are effective for dates of service on and after July 1, 2010, are as follows:

- ICD-9-CM codes V17.4 and V18.1 have been deleted from the list of noncovered ICD-9-CM codes for all 23 NCDs.
- ICD-9-CM codes V17.41, V17.49, V18.11 and V18.19 have been added to the list of noncovered ICD-9-CM codes for all 23 NCDs.

Additional information

The official instruction (CR 6964) issued to your Medicare MAC, carrier, and/or FI may be found on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1963CP.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 website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6964
Related Change Request (CR) Number: 6964
Related CR Release Date: April 30, 2010
Related CR Transmittal Number: R1963CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1963, CR 6964

Medicare coverage of blood glucose monitors and testing supplies

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

Provider types affected

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

What you need to know

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to remind providers what blood glucose self-testing equipment and supplies are covered for Medicare beneficiaries. In addition, prescription/order requirements, quantities and frequency limits of supplies, and documentation requirements for the beneficiary's medical record are detailed. This article reinforces information supplied in *MLN Matters*® article SE0738, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE0738.pdf*.

This article is informational only and represents no Medicare policy changes.

Background

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. These supplies include:

- Blood glucose monitors
- Blood glucose test strips
- Lancet devices and lancets
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies. Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent diabetics based on medical necessity. For more information regarding

Medicare coverage of blood glucose monitors and testing supplies (continued)

medical necessity, see the section below titled "Providing Evidence of Medical Necessity."

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions
- A two hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions, or
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

For more information, see the *Medicare Benefit Policy Manual*, Chapter 15, on the CMS website at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit, and the Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

Prescribing/ordering a blood glucose monitor and associated accessories

Provider requirements

For Medicare coverage of a blood glucose monitor and associated accessories, the provider must provide a valid prescription (order) which must state to the supplier:

1. The item(s) to be dispensed
2. The frequency of testing ("as needed" is not acceptable)
3. The physician's signature
4. The signature date, and
5. The start date of the order – only required if the start date is different than the signature date.

For beneficiaries who are insulin-dependent, Medicare provides coverage for up to 100 test strips and lancets every month, and one lancet device every six months.

For beneficiaries who are non-insulin dependent, Medicare provides coverage for up to 100 test strips and lancets every three months, and one lancet device every six months.

Note: Medicare allows additional test strips and lancets if deemed medically necessary. See the section below titled "Providing Evidence of Medical Necessity." Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers, even if the beneficiary has "authorized" this in advance. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the item(s) no sooner than approximately five (5) days prior to the end of usage for the current product(s). This includes lancets, test strips, and blood glucose monitors.

CR 2363 (Transmittal B-03-004) states that glucose test strips and supplies may be billed for up to three months of supplies at a time. Beginning April 1, 2002, claims for test strips and supplies must be submitted with the appropriate "start" and "end" dates. The "start" and "end" dates for each claim can span across three months. You may find CR 2363 at *http://www.cms.gov/Transmittals/Downloads/B03004.pdf*.

Suppliers may dispense most items of durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) based on a verbal order or preliminary written order from the treating physician. This dispensing order must include: a description of the item, the beneficiary's name, the physician's name and the start date of the order. Suppliers must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available to Medicare contractors upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is non-covered. See the *Medicare Program Integrity Manual*, Chapter 5, on the CMS website at *http://www.cms.gov/manuals/downloads/pim83c05.pdf*.

For verbal orders, the physician must sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation must be reviewed, signed, and dated by the physician. Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing or a change in supplier. Renewal orders must contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC. For more information regarding evidence of medical necessity, see the section below titled "Providing Evidence of Medical Necessity."

Note: CR 5971 (Transmittal 248) was issued to prohibit the use of stamped signatures. In addition, Medicare requires a legible identifier for services provided/ordered as outlined in CR 6698 (Transmittal R327PI). The method used should be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. You may review *MLN Matters*® articles related to CR 5971 and CR 6698 at *http://www.cms.gov/MLNMattersArticles/downloads/MM5971.pdf* and *http://www.cms.gov/mlnmattersarticles/downloads/mm6698.pdf*.

Medicare coverage of blood glucose monitors and testing supplies (continued)

Home blood glucose monitors

There are several different types of blood glucose monitors that use reflectance meters to determine blood glucose levels. Medicare coverage of these devices varies, with respect to both the type of device and the medical condition of the patient for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as DME for use in the home because their need for frequent professional re-calibration makes them unsuitable for home use.

However, some types of blood glucose monitors which use a reflectance meter specifically designed for home use by diabetic patients may be covered as DME, subject to the conditions and limitations described below.

Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and (following instructions which may vary with the device used), inserts it into the device to obtain a reading.

Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated.

Home blood glucose monitors enable certain patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment. Studies indicate that the patient's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to patients who must make frequent checks of their blood glucose levels.

Accordingly, coverage of home blood glucose monitors is limited to patients meeting the following conditions:

1. The patient has been diagnosed as having diabetes.
2. The patient's physician states that the patient is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician.
3. The device is designed for home use rather than clinical use.

There are also blood glucose monitoring systems designed especially for use by those with visual or manual dexterity impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable patients with visual or manual dexterity impairment to use the equipment without assistance.

These special blood glucose monitoring systems are covered under Medicare if the following conditions are met:

- The patient and device meet the three conditions listed above for coverage of standard home blood glucose monitors.
- The patient's physician certifies that the beneficiary has a visual or manual dexterity impairment severe enough to require use of this special monitoring system. Note: Section 1833(e) of the Social Security Act precludes payment to any provider of services "unless there has been furnished such information as may be necessary in order to determine the amounts due such provider…" See *http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm*.

For more information on home blood glucose monitors, including additional requirements for monitors with special features, see the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1 (Coverage Determinations), Section 40.2 (Home Blood Glucose Monitors) on the CMS website at *http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf* and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at *http://www.cms.gov/mcd/search.asp?from2=search.asp&* (search "Glucose Monitors").

The Health Care Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are shown in the following table:

HCPCS codes for blood glucose self-testing equipment and supplies

HCPCS code	HCPCS code descriptor
A4233	Alkaline battery for glucose monitor
A4234	J-cell battery for glucose monitor
A4235	Lithium battery for glucose monitor
A4236	Silver oxide battery glucose monitor
A4253	Test or reagent strips for home blood glucose monitor, per 50 strips
A4256	Calibration solutions
A4258	Spring-powered lancing device
A4259	Lancets for home blood glucose monitor, box of 100
E0607	Home blood glucose monitor
E2100	Home blood glucose monitor w voice capability (for visual impairment)
E2101	Home blood glucose monitor w integrated lancing/blood collection (for manual dexterity impairment)

Providing evidence of medical necessity

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

Medicare coverage of blood glucose monitors and testing supplies (continued)

- Basic coverage criteria for the glucose monitor and any related supplies, and
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
  - Justification for testing frequency, and
  - Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
  - Names, dosages, and timing of administration of medications used to treat the diabetes.
  - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia.
  - Review of beneficiary-maintained log of glucose testing values.
  - Changes in the patient's treatment regimen as a result of glucose testing results review.
  - Dosage adjustments that the patient should make on their own based on self-testing results.
  - Laboratory tests indicating level of glycemic control (e.g., Hemoglobin A1C).
  - Other therapeutic interventions and results.
- Documentation by the beneficiary of the actual frequency of testing.
  - Logs of self-testing values including the date, time, and results.
  - Information about medication dosage adjustments related to the results is also helpful.

Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

For more information regarding evidence of medical necessity, see the *Medicare Program Integrity Manual*, Chapter 5 (Items and Services Having Special DME Review Considerations) at *http://www.cms.gov/manuals/downloads/pim83c05.pdf* and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at *http://www.cms.gov/mcd/search.asp?from2=search.asp&* (search "Glucose Monitors").

Additional information

You may find SE0738, An Overview of Medicare Covered Diabetes Supplies and Services on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/SE0738.pdf*.

You may also find *The Guide to Medicare Preventive Services* on the CMS website at *http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_Web-061305.pdf* and the *Medicare Preventive Services Brochure* on the CMS website at *http://www.cms.gov/MLNProducts/downloads/DiabetesSvcs.pdf*.

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

MLN Matters® Number: SE1008
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Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters®* Article SE1008

FDG positron emission tomography for solid tumors and myeloma

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 MM6632 to reflect changes made to change request (CR) 6632. The CR transmittal number for the national coverage determination (NCD) transmittal and the Web address for accessing that transmittal were updated. All other information remains the same. The article was published in the October 2009 *Medicare A Bulletin* (pages 21-25).

Provider types affected

This article is for physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) when providing F-18 flouro-D-glucose (FDG) positron emission tomography (PET) scans to Medicare beneficiaries. Note that the term FDG PET includes FDG PET/CT (computed tomography).

What you need to know

Change request (CR) 6632, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is revising the *Medicare National Coverage Determinations Manual*, Section 220.6: Positron Emission Tomography (PET) Scans. Specifically, in CR 6632, CMS announces (effective April 3, 2009) a national coverage determination (NCD) that adopts a two-part framework which differentiates the use of F-18 flouro-D-glucose (FDG) PET imaging in the initial antitumor treatment strategy, from its other uses related to guiding subsequent antitumor treatment strategies after the completion of initial treatment. This framework replaces the previous, four-part framework that contained the diagnosis, staging, restaging, and monitoring response to treatment.

Background

The NCD that CR 6632 announces requires the replacement of the four-part framework (mentioned in the previous paragraph) with a two-part one that differentiates FDG PET imaging used for initial antitumor treatment strategy from subsequent antitumor treatment strategies after the completion of initial treatment. In so doing, it provides that (effective for services provided on or after April 3, 2009) the terms "diagnosis" and "staging" are to be replaced with "Initial Treatment Strategy," and the terms "restaging" and "monitoring" are to be replaced with "Subsequent Treatment Strategy."

National coverage determination requirements

Initial antitumor treatment strategy

CMS will cover one FDG PET study for beneficiaries who have solid tumors that are biopsy proven or strongly suspected based on other diagnostic testing when the beneficiary's treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to the initial treatment strategy:

- Whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; or
- The optimal anatomic location for an invasive procedure; or
- The anatomic extent of tumor when the recommended antitumor treatment reasonably depends on the extent of the tumor.

There are some exceptions to this initial treatment strategy:

- CMS will nationally non-cover the use of FDG PET imaging to determine initial treatment strategy in patients with adenocarcinoma of the prostate.
- CMS will continue to cover FDG PET imaging for the initial treatment strategy for male and female breast cancer when used in staging distant metastasis. FDG PET imaging for diagnosis and initial staging of axillary nodes will remain noncovered.
- CMS will continue non-coverage of FDG PET for the evaluation of regional lymph nodes in melanoma. Other uses to determine initial treatment strategy remain covered.
- CMS will continue to cover FDG PET imaging as an adjunct test for the detection of pre-treatment metastasis (i.e., staging) in newly diagnosed cervical cancers following conventional imaging that is negative for extra-pelvic metastasis. All other uses of FDG PET for the initial treatment strategy for beneficiaries diagnosed with cervical cancer will only continue to be covered through coverage with evidence development (CED).

Specifically, CMS will cover one initial FDG PET study for patients with newly diagnosed cervical cancer (when not used as an adjunct test to detect pre-treatment metastases following conventional imaging that is negative for extra-pelvic metastasis) only when the beneficiary's treating physician determines that the FDG PET study is needed to inform the initial antitumor treatment strategy, and the beneficiary is enrolled in, and the FDG PET provider is participating in, an FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Clinical studies for which CMS will provide coverage must answer one or more of the following three questions:

Prospectively, in Medicare beneficiaries with newly diagnosed cervical cancer who have not been found following conventional imaging to be negative for extra-pelvic metastases and whose treating physician determines that the FDG PET study is needed to inform the initial antitumor treatment strategy, does the addition of FDG PET imaging lead to:

- A change in the likelihood of appropriate referrals for palliative care,
- Improved quality of life, or
- Improved survival?

The study must adhere to the standards of scientific integrity and relevance to the Medicare population as described in the following section on subsequent antitumor strategy (items a through m, below).

FDG positron emission tomography for solid tumors and myeloma (continued)

Subsequent antitumor treatment strategy

For tumor types other than breast, colorectal, esophagus, head and neck (non-CNS/thyroid), non-small cell lung, and thyroid cancers, lymphoma, and melanoma, CMS has determined that FDG PET imaging for subsequent antitumor treatment strategy may be covered as research through CED.

However, CMS will cover a subsequent FDG PET study for tumor types other than breast, colorectal, esophagus, head and neck (non-CNS/thyroid), non-small cell lung, and thyroid cancers, lymphoma, and melanoma, when the beneficiary's treating physician determines that the FDG PET study is needed to inform the subsequent antitumor treatment strategy and the beneficiary is enrolled in, and the FDG PET provider is participating in, the following types of prospective clinical study:

- A FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management. Qualifying clinical studies must ensure that specific hypotheses are addressed; appropriate data elements are collected; hospitals and providers are qualified to provide the PET scan and interpret the results; participating hospitals and providers accurately report data on all enrolled patients not included in other qualifying trials through adequate auditing mechanisms; and all patient confidentiality, privacy, and other federal laws must be followed.

The clinical studies for which CMS will provide coverage must answer one or more of the following three questions:

Prospectively, in Medicare beneficiaries whose treating physician determines that the FDG PET study is needed to inform the subsequent antitumor treatment strategy, does the addition of FDG PET imaging lead to:

- A change in the likelihood of appropriate referrals for palliative care,
- Improved quality of life, or
- Improved survival?

The study must adhere to the following standards of scientific integrity and relevance to the Medicare population:

a. The principal purpose of the research study is to test whether a particular intervention improves the participant's health outcomes.

b. The research study is well-supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

c. The research study does not unjustifiably duplicate existing studies.

d. The research study design is appropriate to answer the research question being asked in the study.

e. The research study is sponsored by an organization or individual capable of executing the proposed study successfully.

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

g. All aspects of the research study are conducted according to the appropriate standards of scientific integrity.

h. The research study has a written protocol that clearly addresses, or incorporates by reference, the Medicare standards.

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

j. The clinical research study is registered on the *http://www.clinicaltrials.gov* website by the principal sponsor/investigator prior to the enrollment of the first study subject.

k. The research study protocol specifies the method and timing of public release of all pre-specified outcomes to be measured including release of outcomes if such are negative or the study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer-reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors. However, a full report of the outcomes must be made no later than three years after the end of data collection.

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

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

Consistent with Section 1142 of the Social Security Act, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

FDG positron emission tomography for solid tumors and myeloma (continued)

As exceptions to the subsequent treatment strategy section above:

- CMS has determined that FDG PET for subsequent treatment strategy in Medicare beneficiaries with ovarian cancer is nationally covered.
- CMS has determined that FDG PET for subsequent treatment strategy in Medicare beneficiaries with cervical cancer is nationally covered.

Myeloma

CMS has determined that FDG PET for initial treatment strategy and subsequent treatment strategy in Medicare beneficiaries with myeloma is nationally covered.

Further exceptions

CMS will continue to cover FDG PET for subsequent treatment strategy for specific indications in the following nine tumor types:

- Breast
- Cervix
- Colorectal
- Esophagus
- Head and neck (non-CNS/thyroid)
- Lymphoma
- Melanoma
- Non-small cell lung
- Thyroid

The CMS has transitioned the prior framework—diagnosis, staging, restaging, and monitoring response to treatment—into the initial treatment strategy and subsequent treatment strategy framework while maintaining current coverage.

The chart below summarizes Section 220.6.1:

FDG PET coverage for solid tumors and myeloma

Tumor type	Initial treatment strategy (formerly "diagnosis" & "staging")	Subsequent treatment strategy (formerly "restaging" & "monitoring response to treatment")
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	CED
Cervix	See note (1) below or CED	Cover
Small cell lung	Cover	CED
Soft tissue sarcoma	Cover	CED
Pancreas	Cover	CED
Testes	Cover	CED
Breast (female and male)	See note (2)	Cover
Melanoma	See note (3)	Cover
Prostate	Noncover	CED
Thyroid	Cover	See note (4) or CED
All other solid tumor	Cover	CED

FDG positron emission tomography for solid tumors and myeloma (continued)

Tumor type	Initial treatment strategy (formerly "diagnosis" & "staging")	Subsequent treatment strategy (formerly "restaging" & "monitoring response to treatment")
Myeloma	Cover	Cover
All other cancers not listed herein	CED	CED

Notes:

(1) Cervix: Covered for the detection of pre-treatment metastases (i.e., staging) in newly diagnosed cervical cancer subsequent to conventional imaging that is negative for extra-pelvic metastasis. All other uses are CED.

(2) Breast: Noncovered for initial diagnosis and/or staging of axillary lymph nodes. Covered for initial staging of metastatic disease.

(3) Melanoma: Noncovered for initial staging of regional lymph nodes. All other uses for initial staging are covered.

(4) Thyroid: Covered for subsequent treatment strategy of recurrent or residual thyroid cancer of follicular cell origin previously treated by thyroidectomy and radioiodine ablation and have a serum thyroglobulin >10ng/ml and have a negative I-131 whole body scan. All other uses for subsequent treatment strategy are CED.

Coding and billing requirements

CR 6632 also announces new modifiers for PET imaging, effective for services provided on or after April 3, 2009.

PI – Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing.
Short descriptor: PET tumor init tx strat

PS – Positron emission tomography (PET) or PET/computed tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent antitumor strategy.
Short descriptor: PET tumor subsq tx strategy

Note: The two new FDG PET oncologic modifiers are included in the July quarterly update of the integrated outpatient code editor (IOCE) with an effective date of April 1, 2009. As of October 30, 2009, all FDG PET oncologic-related claims for dates of service on or after April 3, 2009, must include one of these two new modifiers in order for the claim to be processed correctly.

Medicare claims processing requirements in CR 6632 are as follows:

- For claims with dates of service on or after April 3, 2009, Medicare will accept and pay for FDG PET claims as specified in the CR 6632 NCD to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors.

Claims that your carrier, FI, or A/B MAC receive after October 30, 2009 (for dates of service on or after April 3, 2009), will return as unprocessable (professional claims) or as return to provider (institutional claims) if they do not include **modifier PI** with one of the following PET or PET/CT *CPT* codes when billing to inform the initial treatment strategy for solid tumors:

78608 78811 78812 78813 78814 78815 or *78816*.

- Your carrier or A/B MAC will return as unprocessable those professional claims for the subsequent treatment strategy without **modifier PS and** a *CPT* code of *78608, 78811, 78812, 78813, 78814, 78815*, or *78816*, **and** an ICD-9-CM cancer diagnosis code.

Should your carrier, FI, or A/B MAC return your claim that does not contain **modifier PI or PS**, they will use the following messages:

Claim adjustment reason code 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

Remittance advice remark code MA-130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remittance advice remark code M16 – Alert: Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

FDG positron emission tomography for solid tumors and myeloma (continued)

For claims with dates of service on or after April 3, 2009, Medicare will accept and pay for FDG PET oncologic claims billed for initial or subsequent treatment strategy when performed under CED only when billed with the following:

- PET/PET/CT *CPT* code *78608, 78811, 78812, 78813, 78814, 78815, or 78816* **and**
- Modifier PI, **or**
- Modifier PS, **and** an ICD-9-CM cancer code diagnosis code, **and**
- Modifier Q0.

For claims with dates of service on or after April 3, 2009, Medicare will return as unprocessable, return to provider, FDG PET oncologic claims for initial or subsequent treatment strategy when performed under CED billed without:

- PET/PET/CT *CPT* code *78608, 78811, 78812, 78813, 78814, 78815*, or *78816*, **and**
- Modifier PI, **or**
- Modifier PS, **and** an ICD-9-CM cancer code diagnosis code, **and**
- Modifier Q0.

You should also be aware that your carrier, FI, or A/B MAC will not search their files for FDG PET oncologic-related claims with dates of service April 3, 2009, through October 29, 2009, processed prior to October 30, 2009. However, they may adjust claims that you bring to their attention.

Additional Information

CR6632 was issued in two transmittals. One transmittal conveys the revisions to the *Medicare National Coverage Determinations Manual*, and the other conveys the changes to the *Medicare Claims Processing Manual*. These transmittals are on the CMS website respectively at *http://www.cms.gov/Transmittals/downloads/R120NCD.pdf* and *http://www.cms.gov/Transmittals/downloads/R1833CP.pdf*.

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

MLN Matters® Number: MM6632 – Revised
Related Change Request (CR) Number: 6632
Related CR Release Date: October 16, 2009
Related CR Transmittal Number: R1833CP and R120NCD
Effective Date: April 3, 2009
Implementation Date: October 30, 2009

Source: CMS Pub. 100-04, Transmittal 1833, CR 6632

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.

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 website *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 website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the FCSO *eNews* mailing list. It is very easy to do. Simply go to our educational website *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 website at *http://medicare.fcso.com*.

ADDITIONS/REVISIONS TO EXISTING LCDS

A51784: Anorectal manometry and EMG of the urinary and anal sphincters – revision to the LCD

LCD ID Number: L28762 (Florida)
LCD ID Number: L28763 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for anorectal manometry and EMG of the urinary and anal sphincters was most recently revised on August 10, 2009. Since that time, a request was received asking that the list of ICD-9-CM codes for *CPT* code *91122* (Anorectal manometry) be revised to include ICD-9-CM code 787.6 (Incontinence of feces). A review of the supporting literature submitted with the request supports the request for the revision.

Therefore, the list of diagnosis codes for *CPT* code *91122* has been revised to now include ICD-9-CM code 787.6.

Effective date

This LCD revision is effective for services provided **on or after May 6, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

A95805: Polysomnography and sleep testing – revision to the LCD

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

The local coverage determination (LCD) for polysomnography and sleep testing was most recently revised on July 23, 2009. Since that time, a request was received asking that a diplomate of the American Board of Family Medicine (ABFM) with a certificate of added qualifications (CAQ) in sleep medicine be added to the list of physician training/certification requirements. A review of available literature supported this request. Therefore the "Indications and Limitations" and "Documentation Requirements" sections of the LCD have been revised to now list a diplomate of the ABFM with a CAQ in sleep medicine as acceptable.

Effective date

This revision is effective for services provided **on or after May 13, 2010**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.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. ❖

Find LCDs faster on our new medical coverage page

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*.

ADDITIONAL MEDICAL INFORMATION

Improper billing of blood platelet grafts

Providers have been improperly associating blood platelet grafts with *CPT* code *20926* (*Tissue grafts, other [eg, paratenon, fat, dermis]*). The Centers for Medicare & Medicaid Services (CMS) currently has a national coverage determination (NCD) (Publication 100-03, NCD 270.3) supporting noncoverage of this service.

Autologous blood derived products for chronic, non-healing wounds include both: **(1)** platelet derived growth factor (PDGF) products (such as Procuren) and **(2)** platelet-rich plasma (PRP). These services are nationally noncovered under NCD 270.3 for the treatment of chronic non-healing, cutaneous wounds (cutaneous is further defined in the national coverage analysis to include superficial and deeper wounds).

Effective March 19, 2008, this service is nationally noncovered for the treatment of acute surgical wounds when the autologous PRP is applied directly to the closed incision, or for dehiscent wounds. Additionally, any services directly related are also noncovered.

Providers are encouraged to audit their records to determine if services were incorrectly billed to the Medicare program. In situations where providers may have inappropriately billed and were incorrectly paid for *CPT* code *20926* for grafting techniques using platelet-rich plasma, it would be expected that a voluntary reimbursement of the overpayment be sent to the First Coast Service Options Inc. (FCSO) Medicare program in order to proactively take action and/or address the identified error. The appropriate form along with instructions and mailing address for submitting a voluntary refund may be found at *http://medicare.fcso.com/Forms/138379.pdf*.

Medicare coverage of Qutenza® (capsaicin) 8% patch for treatment of postherpetic neuralgia

Shingles or herpes zoster rash is a painful viral infection caused by a reactivation of the varicella-zoster virus (human herpesvirus, type 3) that causes chickenpox. Approximately one million people in the United States develop shingles each year. It is estimated that up to one in five people with shingles will experience prolonged pain after shingles, known as postherpetic neuralgia (PHN). The pain can persist long after the shingles rash clears up and can disrupt sleep, mood, work, and the person's activities of daily living.

Qutenza® is a high concentration capsaicin patch that was approved by the Food and Drug Administration (FDA) in November 2009 for the management of neuropathic pain associated with PHN. Based on the FDA label, administration, warnings and precautions for this drug include the following:

- Qutenza® should only be administered by physicians or health care professionals under the close supervision of a physician.
- A topical anesthetic is applied prior to the application of Qutenza®.
- Qutenza® is applied for 60 minutes.
- Qutenza® should not be used near eyes or mucous membranes. Qutenza® should not be applied to the face or scalp to avoid risk of exposure to the eyes or mucous membranes.
- The patient's blood pressure should be monitored during and following the treatment procedure.
- Patients with unstable or poorly controlled hypertension, a recent history of cardiovascular or cerebrovascular events may be at an increased risk of adverse cardiovascular effects.

First Coast Service Options Inc. (FCSO) Medicare will cover Qutenza® (capsaicin) eight percent patch for the FDA-approved indications and administration. See the FDA drug label for full prescribing information regarding this drug.

Since there is currently no HCPCS code for Qutenza® (capsaicin) eight percent patch, providers should bill the unlisted HCPCS code C9399 (Unclassified drugs or biologicals) or J3490 (unclassified drugs) for this drug. In addition, *CPT* code *64999 (Unlisted procedure, nervous system)* should be billed for the application/preparation of this drug. An evaluation and management (E/M) service may be billed if there was a significant, separately identifiable evaluation and management service performed by the same physician on the same day of this procedure. If the patient is seen for an E/M visit and it is decided to administer the patch at that visit, the E/M visit is allowed. However, if the patient returns to the office on another date for the only purpose of having the patch applied, an E/M visit would not be allowed on the same date of the patch application.

Note: Providers must bill HCPCS codes C9399 or J3490 and *CPT* code *64999* on the same claim. ❖

Authentication requests for missing or illegible signatures

The Centers for Medicare & Medicaid Services' (CMS) change request (CR) 6698 (Signature Guidelines for Medical Review Purposes) clarifies Medicare signature requirements for all medical record documentation subject to medical review. This CR also requires contractors to implement a process for contacting the provider of services when previously submitted documentation does not contain the required appropriate signature(s).

Effective for all medical review decisions made on or after April 16, 2010, contractors are required to authenticate medical records when the signatures are missing or illegible. The signature for each entry must be legible and should include the practitioner's first and last name. For clarification purposes, First Coast Service Options Inc. (FCSO) also encourages the inclusion of the practitioner's credentials (e.g., Dr. John Smith, M.D. or Mary Jones, A.R.N.P.).

ADR letters for missing or illegible signatures: 20-day timeframe

If it is determined, upon review of medical record documentation, that CMS' signature requirements have not been met, FCSO will send an additional development request (ADR) letter to the provider. This second development request letter will require the provider to submit either a signed attestation statement for a missing signature or a signature log for an illegible signature. Unlike the standard process for requesting medical records (which allows providers 30 days to respond), the second development request will allow providers only 20 days to respond.

Note: For this process only, providers will be permitted to fax their response to the second development request. The appropriate fax numbers will be provided in the ADR request letter. In order for the response to be applied appropriately, the ADR request letter must be attached to the response.

Electronic or digital signatures

In addition to hand-written signatures, electronic or digital signatures may also be used to satisfy the signature requirements outlined in CR 6698. An electronic or digital signature is typically generated by specially encrypted software that allows use only by the intended user. The responsibility and authorship related to the signature should be clearly defined in the medical record.

Note: FCSO will consider electronic or digital signatures as acceptable only when accompanied by one of the following:

- Electronically-signed or e-signed signature
- Computerized signature
- Digitally signed or digital signature
- Confirmed by, released by, signed by, or reviewed by
- Authorized by, authenticated by, or verified by

FCSO encourages all facilities, physicians, and other providers who bill services to Medicare to review and implement the changes necessary to be compliant with signature requirements. Providers should conduct internal review of all medical record documentation prior to submission to Medicare to ensure documents are complete and appropriately signed. This will not only reduce the necessity for a second ADR for signature attestation/signature log, it will also reduce the number of other billing/coding inconsistencies and omissions.

Additional information

Additional information regarding signature requirements was previously published on pages 21-22 of the March 2010 *Medicare B Update!*

The official instruction regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R327PI.pdf*.

The *MLN Matters* article related to this change may be viewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf*. ❖

Source: Publication 100-08, Transmittal 327, Change Request 6698

HOSPITAL SERVICES

Use of type of bill 12x for billing colorectal screening services

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

Provider types affected

Hospitals that bill Medicare fiscal intermediaries (FI) or Medicare administrative contractors (A/B MAC) for colorectal screening services provided for hospital inpatients should be aware of this issue.

What you need to know

Change request (CR) 6760, from which this article is taken, requires you to use (effective October 1, 2010) 12x type of bill (TOB), in place of TOB 13x, to bill for colorectal screening services that you provide to hospital inpatients under Medicare Part B, or when Part A benefits have been exhausted. You should make sure that your billing staffs are aware of this new requirement.

Background

Currently, you use TOB 13x to bill for colorectal screening services that you provide to hospital inpatients under Part B. CR 6760, from which this article is taken, announces that such services may be covered under Part B (TOB 12x), even though the patient has Part A coverage for the hospital stay, if applicable conditions of coverage are met and he/she has not exceeded applicable frequency limitations.

Specifically (effective for claims with dates of service of October 1, 2010 and later), you must use TOB 12x in place of TOB 13x to bill for colorectal screening services that you provide to hospital inpatients under Part B, or when Part A benefits have been exhausted. This applies for services that you bill using *CPT* codes *82270 (Fecal occult blood test)*, G0104 (Flexible Sigmoidoscopy), G0105 (Colonoscopy (high risk)), G0106 (Barium Enema (alternative to G0104)), HPCPS codes G0120 (Barium enema [alternative to G0105]), G0121 (Colonoscopy [not high risk]), G0122 (Barium enema (noncovered), or G0328 (Fecal occult blood test [alternative]).

Please note that when billing for services to other than hospital inpatients, you should continue reporting appropriate TOBs: 13x, 14x, 22x, 23x, 83x, and 85x.

Additional information

You may find CR 6760 on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/Transmittals/downloads/R1953CP.pdf*.

You will find the updated *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 60.6 (Billing Requirements for Claims Submitted to FIs) as an attachment to that CR.

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

MLN Matters® Number: MM6760
Related Change Request (CR) Number: 6760
Related CR Release Date: April 28, 2010
Related CR Transmittal Number: R1953CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1953, CR 6760

CMS ruling regarding three Medicare disproportionate share hospital issues

The Centers for Medicare & Medicaid Services (CMS) recently published CMS ruling "CMS-1498-R" pertaining to three Medicare disproportionate share hospital (DSH) issues. Specifically, the ruling addresses jurisdictionally proper pending appeals and open cost reports on the issues of Medicare noncovered days (such as exhausted benefit days and Medicare secondary payer days), the data matching process for supplemental security income "SSI" fractions, and "labor and delivery" days. The ruling became effective on April 28. You may view the ruling at *http://www.cms.gov/Rulings/downloads/CMS1498R.pdf*.

The main CMS rulings page is available at *http://www.cms.gov/Rulings/CMSR/list.asp*.

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

Source: CMS PERL 201005-05

Manual update regarding billing for discarded drugs or biologicals

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

Provider types affected

Physicians, hospitals, suppliers and other providers who bill Medicare contractors (carriers, fiscal intermediaries [FI], Part A/B Medicare administrative contractors [MACs], and durable medical equipment Medicare administrative contractors [DME MACs]) for administering or supplying drugs and biologicals should review this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued Change request (CR) 6711 to include in the *Medicare Claims Processing Manual* the updated policy, which describes when to use **modifier JW** for discarded drugs.

Background

As a reminder, your Medicare contractor may require its providers to use **modifier JW**. If required, when billing Medicare for all drugs except those provided under the Competitive Acquisition Program for Part B drugs and biologicals, use **modifier JW** to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the discarded drug or biological.

For example, a single use vial labeled to contain 100 units of a drug, where 95 units are used and billed and paid on one line, the remaining five units will be billed and paid on another line using modifier JW. Modifier JW is applied only to units not used.

Note Multi-use vials are not subject to payment for discarded amounts of drug or biological**.**

Additional information

The official instruction, CR 6711, issued to your Medicare FI, carrier, A/B MAC, or DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1962CP.pdf*.

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

MLN Matters® Number: MM6711
Related Change Request (CR) Number: 6711
Related CR Release Date: April 30, 2010
Effective Date: July 30, 2010
Related CR Transmittal Number: R1962CP
Implementation Date: July 30, 2010

Source: CMS Pub. 100-04, Transmittal 1962, CR 6711

Modifier JW not required – MLN Matters article MM6711 does not apply to FCSO

This article serves as both a reminder and a clarification of the guidelines in the *Medicare Claims Processing Manual* that describes how to use the modifier JW for discarded drugs.

Change request (CR) 5923 provided contractors the option to require or not to require the modifier JW. During implementation of CR 5923, First Coast Service Options Inc. (FCSO) made the decision not to require the modifier JW. CR 6711 does not modify this decision. **Therefore, the new instructions regarding the use of modifier JW, specified in CR 6711, do not apply to claims submitted to FCSO. The instructions in CR 6711 are only applicable to those contractors that require the use of the JW modifier.**

Additional information

Here is the link to the *MLN Matters* article MM5923 *http://www.cms.gov/MLNMattersArticles/downloads/MM5923.pdf*.

Here is the link to the official instruction issued to your Medicare carrier, DME/MAC, FI and/or A/B MAC for CR 5923 *http://www.cms.gov/Transmittals/downloads/R1478CP.pdf*.

Source: CMS Pub. 100-04, Transmittal 1962, CR 6711

Manual update related to determining self-administration of drugs or biologicals

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

Provider types affected

Physicians, nonphysician practitioners and hospitals submitting claims to Medicare contractors (fiscal intermediaries [FIs], carriers, and A/B Medicare administrative contractors [MAC]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6950, which furnishes Medicare contractors with updates to the *Medicare Benefit Policy Manual* relating to determining self-administration of drug or biological. This update allows for other routes of administration besides injections to be considered as not usually self-administered. Be sure your billing staff is aware of this manual change.

Background

The Medicare program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. FIs, carriers and MACs are instructed to follow the *Benefits Policy Manual* when applying the exclusion for drugs that are usually self-administered by the patient. The term "administered" is discussed in the *Benefits Policy Manual*. Due to recent drugs approved for marketing by the Food and Drug Administration, Chapter 15, Section 50.2, of this manual is being updated to allow for other routes of administration besides injections to be considered as not-usually self-administered.

The term "administered" refers only to the physical process by which the drug enters the patient's body. It does not refer to whether the process is supervised by a medical professional (for example, to observe proper technique or side-effects of the drug). Injectable drugs, including intravenously administered drugs, are typically eligible for inclusion under the "incident to" benefit. With limited exceptions, other routes of administration (including, but not limited to, oral drugs, suppositories, and topical medications) are considered to be usually self-administered by the patient.

Additional information

The official instruction issued to your Medicare FI, carrier, and/or MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R123BP.pdf*.

If you have questions, please contact your Medicare contractor at their toll free number, which is listed on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6950
Related Change Request (CR) Number: 6950
Related CR Release Date: April 30, 2010
Related CR Transmittal Number: R123BP
Effective Date: July 30, 2010
Implementation Date: July 30, 2010

Source: CMS Pub. 100-02, Transmittal 123, CR 6950

June 18 deadline for withdrawals and terminations of reclassifications

The Centers for Medicare & Medicaid Services (CMS) has identified hospitals that have reclassifications effective in fiscal year (FY) 2011 in Table 9A in the Addendum to the FY 2011 inpatient prospective payment system (IPPS) proposed rule (*http://www.cms.gov/AcuteInpatientPPS/downloads/FY_2011_NPRM_WI_TABLES.zip*).

Under 42 CFR 412.273, hospitals that have been reclassified by the Medicare Geographic Classification Review Board (MGCRB) are permitted to withdraw their applications for reclassification, or terminate an existing three-year reclassification that would be effective in FY 2011, within 45 days of the publication of CMS's annual notice of proposed rulemaking. The proposed rule was published on May 4. Therefore, the regulations require that the request for withdrawal or termination must be received by the MGCRB, by June 18 (see proposed rule for process for submitting requests).

CMS will be publishing in the *Federal Register* a supplemental FY 2011 IPPS proposed rule for implementing the provisions of the Affordable Care Act (ACA, Pub. L. 111-148). Wage-index values may change somewhat in the supplemental proposed rule due to CMS' application of Sections 3137(c), 3141, and 10324(a) of ACA. In addition, as a result of section 3137(c) of ACA, there may be additional hospitals listed as reclassified in Table 9A.

At this time, CMS expects hospitals will have sufficient time between the display or publication of the supplemental FY 2011 IPPS proposed rule in the *Federal Register* and the June 18 deadline for withdrawals and terminations to evaluate and make determinations regarding their reclassification for the FY 2011 wage index. However, CMS may reevaluate the deadline for submitting withdrawals and terminations in the supplemental proposed rule if it does not become available early enough to provide sufficient time for hospitals to make these decisions.

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

Source: CMS PERL 201005-11

Instructions regarding the processing of inpatient claims for gender/ procedure conflict

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

Provider types affected

This article is for hospitals submitting inpatient claims to Medicare contractors (fiscal intermediaries (FIs) and Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries.

Provider action needed

Claims for some services for beneficiaries who are transgender or hermaphrodite may be inadvertently denied due to sex related edits unless the se services are billed properly. The National Uniform Billing Committee (NUBC) approved condition code 45 (ambiguous gender category) to identify these unique claims and to allow the sex related edits to be processed correctly.

This article reminds institutional providers to report condition code 45 (ambiguous gender category) on inpatient claims related to transgender or hermaphrodite beneficiaries where the service performed is gender specific (i.e., services that are considered female or male only). Providers should use this claim-level condition code to identify these unique claims allowing the claims to bypass Medicare's sex related edits and to process correctly.

Please ensure that your billing staffs are aware of this change.

Additional information

The official instruction issued to your Medicare carrier and/or MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/Transmittals/downloads/R693OTN.pdf*.

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number, which is available on the CMS website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6917
Related Change Request (CR) Number: 6917
Related CR Release Date: April 29, 2010
Related CR Transmittal Number: R693OTN
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-20, Transmittal 693, CR 6917

Fiscal year 2010 inpatient prospective payment system PC PRICER updated

The fiscal year (FY) 2010 inpatient prospective payment system (PPS) personal computer (PC) PRICER has been updated on the Web for FY 2010 claims with corrected provider data from April 2010. If you use the FY 2010 inpatient PPS PC PRICER, go to the inpatient PPS PC PRICER page at *http://www.cms.gov/PCPricer/03_inpatient.asp*, under the Downloads section, and download the latest version of the PC PRICER.

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

Source: CMS PERL 201004-38

Inpatient rehabilitation facility prospective payment system personal computer PRICER updates

The fiscal year (FY) 2010 inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC PRICER has been updated with April provider data and calculation logic for the Health Care Reform Act. The PC PRICER is ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPricer/06_IRF.asp*.

If you use the IRF PPS PC PRICER, please go to the page above and download the latest version of the 2010 PRICER, posted April 28, 2010, in the Downloads section.

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

Source: CMS PERL 201004-40

Hospital attestation and billing of fiscal year 2007 and 2008 informational only inpatient claims for Medicare Advantage beneficiaries

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

Provider types affected

Hospitals submitting claims to Medicare contractors (fiscal intermediaries [](FIs] and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare Advantage beneficiaries are impacted by this issue.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is requiring certain non-teaching hospitals subject to the inpatient prospective payment system (IPPS), as well as facilities subject to the inpatient rehabilitation facility prospective payment system (IRF PPS) and the long-term care hospital prospective payment system (LTCH PPS) to submit informational only bills for the Medicare Advantage beneficiaries they treat by August 31, 2010. In addition, hospitals will be required to submit an attestation to their Medicare contractor that they have either submitted all of their Medicare Advantage claims for FY 2007 and/or FY 2008, or they have no Medicare Advantage claims for FY 2007 and/or FY 2008. Failure to furnish this information could result in the CMS issuance of a zero-percent supplemental security income (SSI) ratio to calculate disproportionate share hospital (DSH) payments or other action that may affect payments. See the *Background* and *Additional Information* sections of this article for further details regarding these requirements.

Background

For all hospitals subject to the IPPS, IRF PPS, and LTCH PPS, change request (CR) 5647 (Transmittal 1311 dated July 20, 2007; see the related *MLN Matters*® article on the CMS website at *http://www.cms.gov/MLNMattersArticles/Downloads/MM5647.pdf*) required the submission of informational only Medicare Advantage claims. The inpatient days are needed for the supplemental security income (SSI) ratio for fiscal years 2007 and beyond to accurately determine Medicare disproportionate share (DSH) payments for IPPS hospitals and low income patient (LIP) payments for IRF PPS hospitals.

CMS published the FY 2007 SSI ratios on the CMS website on June 24, 2009. These ratios are currently being used in the claims processing system for interim IPPS DSH payments, interim IRF PPS low income patient (LIP) payments, and LTCH PPS short-stay outlier (SSO) payments. In addition, this data is used for other purposes such as evaluating the greater than 25-day average length-of-stay requirement of Medicare patients for LTC hospitals.

In reviewing the data used to compute the FY 2007 SSI ratios, CMS determined that many hospitals have not reported any Medicare Advantage days. Therefore, effective with CR 6821, all applicable IPPS, IRF PPS and LTC hospitals will be given one final opportunity to submit FY 2007 informational only claims. In addition, each applicable hospital must attest to their Medicare contractor that:

- It has submitted all of its Medicare Advantage claims for FY 2007, or
- It has no Medicare Advantage claims for FY 2007.

CMS will recalculate and repost the FY 2007 SSI ratios once the informational-only claims have been processed.

Although the FY 2008 SSI ratios have not yet been published, CMS believes that a significant number of hospitals have not submitted informational only Medicare Advantage claims to be included in their FY 2008 SSI ratios. Therefore, effective with CR 6821, applicable IPPS, IRF PPS and LTC PPS hospitals will be given a final opportunity to submit FY 2008 Medicare Advantage informational only claims. In addition, each applicable hospital shall attest to its Medicare contractors that:

- It has submitted all of its Medicare Advantage claims for FY 2008 or
- It has no Medicare Advantage claims for FY 2008.

CMS will calculate and post the FY 2008 SSI ratios once the informational-only claims are processed.

Medicare contractors have been instructed to override timely filing for claims submitted in accordance with CR 6821. Providers shall not submit remarks for justification for timely filing.

Medicare providers

If a Medicare provider believes that it has already submitted all of its Medicare Advantage claims or it does not have any Medicare Advantage claims for FY 2007 based on the currently posted FY 2007 SSI ratios, the provider must submit an attestation that states:

- That it has submitted all of its Medicare Advantage claims for FY 2007, or
- That it does not have any Medicare Advantage claims for FY 2007.

A Medicare provider will be in non-compliance with the instructions in CR 6821, if it does not submit all of its:

- Informational only Medicare Advantage claims for FY 2007 and FY 2008, and
- Attestations that all of its Medicare Advantage claims for FY 2007 and FY 2008 have been submitted or that it does not have any Medicare Advantage claims for these years.

The Medicare Advantage claims must be submitted on or before August 31, 2010 and the attestations must be received by the Medicare contractor on or before September 15, 2010.

Applicable IPPS hospitals

CR 6821 applies to "non-teaching" IPPS hospitals that include an operating and/or capital DSH payment amount on their 2007 or 2008 Medicare hospital cost report. For purposes of CR 6821 only, "non-teaching IPPS hospitals" are defined as hospitals that do not train residents in approved medical residency training programs or that do not operate nursing and allied health (N&AH) education programs, and therefore, do not qualify to receive indirect medical education (IME) payments, direct graduate medical education (DGME) payments, or N&AH payments.

Hospital attestation and billing... claims for Medicare Advantage beneficiaries (continued)

Non-teaching hospitals that do not include an operating and/or capital DSH payment amount on their Medicare hospital cost report are exempt from the instructions in CR 6821 unless such hospital believes it would qualify for such a payment by submitting Medicare Advantage claims. A non-teaching hospital that has not previously included an operating and/or capital DSH payment amount on its cost report should notify its Medicare contractor if it believes it would qualify for such payment amount for FY 2007 and/or FY 2008 and should submit all of its Medicare Advantage claims and an attestation that it has submitted all of its Medicare Advantage claims.

Applicable IRFs

CR 6821 applies to IRFs that have not submitted any Medicare Advantage claims in accordance with CR 2476 for the purpose of receiving DGME or N&AH payments. IRFs that do not claim LIP on their Medicare cost report are exempt from the instructions in CR 6821 unless the provider believes it would qualify for such a payment by submitting Medicare Advantage claims. An IRF that has not previously included a LIP payment amount on its cost report should notify its Medicare contractor if it believes it would qualify for such a payment amount for FY 2007 and/or FY 2008 and should submit all of its Medicare Advantage claims and an attestation that it has submitted all of its Medicare Advantage claims.

Applicable LTC hospitals

CR 6821 applies to LTC hospitals that have not submitted any Medicare Advantage claims in accordance with CR 2476 for the purpose of receiving DGME or N&AH payments.

FY 2007 SSI ratios

The FY 2007 SSI ratios are currently posted on the CMS website.

The IPPS SSI ratios are located on the CMS website at *http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage*.

The IRF SSI ratios are located on the CMS website at *http://www.cms.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage*.

The LTCH SSI ratios are located on the CMS website at *http://www.cms.gov/LongTermCareHospitalPPS/08_download.asp#TopOfPage*.

Billing

Applicable non-teaching IPPS hospitals, IRFs and LTC hospitals have until August 31, 2010 to submit FY 2007 and FY 2008 Medicare Advantage informational only claims (111 Bill Type with Condition Code 04). Medicare Contractors have been instructed to override timely filing for claims submitted in accordance with CR 6821.

Hospitals are reminded that this requirement applies to claims for discharges during FY 2007 and FY2008 and that condition code 04 should be used on claims for beneficiaries they treat who are in Risk Medicare Advantage plans. (The HMO option code indicator can be seen on the HIQA or ELGA screen as A, B, or C.)

Attestation

Applicable non-teaching IPPS hospitals, IRFs and LTC hospitals should submit an attestation to their Medicare contractor attesting that they have submitted all of their Medicare Advantage claims for FYs 2007 and 2008. The attestation is included as an attachment to CR 6821 and should be:

- Printed on hospital letterhead and signed by a senior hospital officer or administrator
- Received by the Medicare contractor no later than September 15, 2010.

Additional information

The official instruction, CR 6821, issued to your FI and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R696OTN.pdf*.

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

MLN Matters® Number: MM6821
Related Change Request (CR) Number: 6821
Related CR Release Date: May 5, 2010
Related CR Transmittal Number: R696OTN
Effective Date: June 7, 2010
Implementation Date: June 7, 2010

Source: CMS Pub. 100-20, Transmittal 696, CR 6821

Rate year 2010 inpatient psychiatric facility prospective payment system personal computer PRICER update

The inpatient psychiatric facility (IPF) prospective payment system (PPS) personal computer (PC) PRICER for rate year (RY) 2010 has been updated with April 2010 provider data. The version for RY 2010 has been made available on the Centers for Medicare & Medicaid Services website.

If you use the IPF PPS PC PRICER for RY 2010, please go to the page *http://www.cms.gov/PCPricer/09_inppsy.asp*, and download the latest versions of the IPF PPS 2010 PC PRICER, posted April 28, 2010.

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

Source: CMS PERL 201004-41

Inpatient psychiatric facility prospective payment system – update for rate year 2011

CMS-1424-N published at the *Office of the Federal Register* on April 30, 2010. Update for rate year beginning July 1, 2010 (RY 2011)

This notice updates the payment rates for the Medicare prospective payment system (PPS) for inpatient psychiatric hospital services provided by inpatient psychiatric facilities (IPFs). These changes are applicable to IPF discharges occurring during the rate year beginning July 1, 2010, through June 30, 2011. CMS is also responding to comments on the IPF PPS teaching adjustment and the market basket, which CMS received in response to May 2009 IPF PPS notice with request for comments.

You may view this notice at
http://www.cms.gov/InpatientPsychFacilPPS/IPFPPSRN/itemdetail.asp?itemID=CMS1235018.

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

Source: CMS PERL 201004-43

Affordable Care Act – impacts to outpatient prospective payment system hospitals

On March 23, President Obama signed into law the Affordable Care Act (ACA). Section 3401(i) of the Affordable Care Act of 2010 (ACA) imposes a 0.25 percentage point reduction to the outpatient prospective payment system (OPPS) market basket for calendar year (CY) 2010, effective for services furnished on or after January 1, 2010.

The Centers for Medicare & Medicaid Services is working to implement Section 3401(i) of ACA expeditiously. Providers will begin seeing payments under this provision in the late May/early June time frame. Be on the alert for more information about this provision and its impact on past and future claims. ❖

Source: CMS PERL 201005-14

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ESRD Services

Dialysis adequacy, infection and vascular access reporting

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 153c requires the Centers for Medicare and Medicaid Services (CMS) to implement an accurate **quality incentive payment for dialysis providers** by January 1, 2012. To implement this quality incentive payment, CMS requires all renal dialysis facilities (RDFs) to report **the Kt/V reading and date of the reading, vascular access, and infection data on all end-stage renal disease (ESRD) claims with dates of service on or after July 1, 2010.**

Action required by providers

Providers billing on a type of bill (TOB) 72x with dates of service **on or after July 1, 2010**, must report the following value and occurrence codes and modifiers:

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 four months of the claim date of service.

Line level codes to be reported on dialysis revenue code lines

- **Modifier V8:** Dialysis access-related infection present (documented and treated) during the billing month.
- **Modifier V9:** No dialysis-access related infection, as defined for modifier V8, present during the billing month.

Note: Medicare will return to the provider TOB 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). Providers may report HCPCS 90999 in all dialysis revenue code lines in order to report the required infection modifiers.

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 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.

For complete details regarding the quality incentive payment for dialysis providers, please refer to the *MLN Matters* article MM6782. This article was published in the April 2010 *Medicare A Bulletin* (pages 48-50). The *MLN Matters* article MM6782 is also available on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6782.pdf*.

Source: CMS Pub. 100-04, Transmittal 1932, CR 6782

Website survey

We would like to hear your comments and suggestions on the website 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

Skilled nursing facility health insurance prospective payment system coding updates

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

Provider types affected

This article is for skilled nursing facilities (SNFs) billing Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services paid under the SNF health insurance prospective payment system (HIPPS).

What you need to know

Note: Recent legislation postponed implementation of the resource utilization group (RUG-IV) system until October 1, 2011; however, the Centers for Medicare & Medicaid Services (CMS) is including new HIPPS codes that are included in the RUG-IV system into the standard system effective October 1, 2010. Further direction on HIPPS usage for October 1, 2010 is forthcoming.

This article is based on change request (CR) 6916, which describes major changes to the SNF HIPPS case-mix system. CR6916 contains an addendum with new HIPPS codes resulting from the conversion to the new RUG-IV coding system. (CR 6916 and its addendum are available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1958CP.pdf*.)

The five-digit HIPPS codes include two components: the three-digit classification code assigned to each RUG, and newly defined two-digit assessment indicators (AIs) that specify the type of assessment used to support billing. Be sure your billing staff is aware of these changes.

Background

CMS has announced that effective October 1, 2010, they are revising the SNF HIPPS case-mix system. The revised system will include 66 RUGs. This revised system is called the RUG-IV coding system.

Annual updates to the prospective payment system (PPS) rates for SNFs are required by Section 1888(e) of the Social Security Act (the Act), as added by Section 4432 of the Balanced Budget Act of 1997 (Pub. L. 105–33, enacted on August 5, 1997), and amended by the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Pub. L. 106–113, enacted on November 29, 1999), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554, enacted on December 21, 2000), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003). CMS's most recent annual update occurred in a final rule (74 FR 40289, August 11, 2009) that set forth updates to the SNF PPS payment rates for FY 2010. Under the BBA, each update of the SNF PPS payment rates must include the case-mix classification methodology applicable for the coming federal fiscal year (FY). The FY 2011 payment rates reflect the use of the RUG-IV system that was discussed in detail in the proposed and final rules for FY 2010.

Additional information

Providers may access HIPPS code information on the CMS website at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp*.

This link contains documents with the complete list of RUG Codes and AIs billed for SNF Part A stays. Definitions and usages of each code are included. In addition, the site contains a master file of all valid/termed HIPPS codes. The official instruction (CR6916) issued to your Medicare A/B MAC and/or FI is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1958CP.pdf*.

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

MLN Matters® Number: MM6916
Related Change Request (CR) Number: 6916
Related CR Release Date: April 28, 2010
Related CR Transmittal Number: R1958CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1958, CR 6916

Update to the 2010 skilled nursing facility prospective payment system PRICER

Due to receiving corrected quarterly provider data for April 2010, the fiscal year (FY) 2010 skilled nursing facility prospective payment system (SNF PPS) personal computer (PC) PRICER has been updated on the page *http://www.cms.gov/PCPricer/04_SNF.asp*, under the Skilled Nursing Facilities (SNF PPS) PC PRICER. Please go to the page above and download the latest version of the PC PRICER with the revised provider data.

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

Source: CMS PERL 201004-39

Five-star quality rating system – May news

The five-star provider preview report is 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 updated with May five-star data on Thursday, May 27, 2010.

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

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

Source: CMS PERL 201005-25

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.

CORF/ORF SERVICES

Removal of the provider-reporting requirement for total number of therapy visits using value codes 50-53

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

Provider types affected

Hospitals, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs), and other providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MACs) and regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 6899, which advises you that the requirement for providers to report the total number of therapy visits using value codes 50 – physical therapy, 51 – occupational therapy, 52 – speech therapy, and 53 – cardiac rehabilitation has been removed.

Effective October 1, 2010, providers are no longer required to submit any of the aforementioned value codes when billing for therapy services. The *Medicare Claims Processing Manual* has been updated to remove this requirement. Please ensure that your billing staffs are aware of this change.

Additional information

The official instruction issued to your Medicare contractor regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/Transmittals/downloads/R1951CP.pdf*.

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

MLN Matters® Number: MM6899
Related Change Request (CR) Number: 6899
Related CR Release Date: April 27, 2010
Related CR Transmittal Number: R1951CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1951, CR 6899

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.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

New Medicare summary notice message for higher than expected payments

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

Provider types affected

This article is for 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.

What you need to know

This article is based on change request (CR) 6910, which creates a new Medicare summary notice (MSN) message to explain to beneficiaries that payment greater than charges are acceptable under prospective payment systems. When Medicare sets payment prospectively, a payment unit is worked out in advance for a whole group of services that are delivered together as part of a single Medicare benefit. This type of payment is made instead of paying each service alone on the basis of its individual cost. Sometimes payments may be less than expected based on charges for individual services, but also, sometimes greater than expected. Consequently, CR 6910 institutes a new MSN message to briefly explain the higher-than-expected amounts under each PPS as outlined above.

Background

The Social Security Act (Section 1806; see *http://www.ssa.gov/OP_Home/ssact/title18/1806.htm* on the Internet) requires that Medicare send its beneficiaries a statement which lists the items and services where Medicare made payment on their behalf. Some Medicare beneficiaries have been surprised by MSNs showing higher than expected payment which are less than or equal to the amounts billed for services they received. These beneficiaries receive MSNs from Medicare as a record of what the Medicare program paid on their behalf. This also makes them aware of any related remaining financial liability, and informs them of existing appeal rights subsequent to the Medicare program's payment decisions.

The Centers for Medicare & Medicaid Services (CMS) recognizes that these concerns are conscientious and expressed by beneficiaries who are concerned about improper Medicare expenditures. Therefore, CR 6910 creates a new MSN message to briefly explain the higher-than-expected amounts outlines above. This new MSN message will reduce related administrative costs of individual explanations as questions arise with use of an appropriate MSN message for a reminder. The definition for this new message is shown in the following table in English and Spanish:

MSN Message #30.41

English	What Medicare pays for a service or item may be higher than the billed amount. The Medicare payment amount is correct. Medicare pays this provider less than the billed amount on other claims since payment rates are set in advance for certain services and averaged out over an entire year.
Spanish	La cantidad que Medicare paga por un servicio o suministro puede ser mayor a la cantidad facturada. El pago de Medicare es correcto. Medicare le paga a este proveedor menos de la cantidad facturada para otras reclamaciones, debido a que los índices de pago se establecen por anticipado para ciertos servicios y se promedian para el año.

Additional information

The official instruction, CR 6910, issued to your FI, A/B MAC, and RHHI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R684OTN.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 website at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM6910
Related Change Request (CR) Number: 6910
Related CR Release Date: April 28, 2010
Related CR Transmittal Number: R684OTN
Effective Date: October 1, 2009
Implementation Date: October 4, 2010

Source: CMS Pub. 100-20, Transmittal 684, CR 6910

ELECTRONIC DATA INTERCHANGE

Update of remittance advice remark codes and claim adjustment reason codes including Medicare Remit Easy

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, providers, and suppliers who submit 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.

Provider action needed

Change request (CR) 6901, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective July 1, 2010. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC and CARC lists are updated three times a year – in March, July, and November. Both code lists are posted at *http://www.wpc-edi.com/Codes*.

The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6901.
CR 6901 conveys the following updates:

New codes – CARC

Code	Current narrative	Effective date per WPC posting
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1/24/2010
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1/24/2010

Modified codes – CARC

None

Deactivated codes – CARC

None

New codes – RARC

Code	Current narrative	Medicare initiated
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.	Yes
N524	Based on policy this payment constitutes payment in full.	No
N525	These services are not covered when performed within the global period of another service.	No
N526	Not qualified for recovery based on employer size.	Yes
N527	We processed this claim as the primary payer prior to receiving the recovery demand.	Yes
N528	Patient is entitled to benefits for Institutional Services.	Yes
N529	Patient is entitled to benefits for Professional Services.	Yes

Update of RARC and CARC including Medicare Remit Easy Print (continued)

Code	Current narrative	Medicare initiated
N530	Our records indicate a mismatch in enrollment information for this patient.	Yes
N531	Not qualified for recovery based on direct payment of premium.	Yes
N532	Not qualified for recovery based on disability and working status.	Yes

Modified codes – RARC

Code	Modified narrative	Medicare initiated
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package	No
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	No

Deactivated codes - RARC

None

Additional information

To see the official instruction (CR 6901) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC, refer to on the CMS website *http://www.cms.gov/Transmittals/downloads/R1950CP.pdf*.

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

MLN Matters® Number: MM6901
Related Change Request (CR) Number: 6901
Related CR Release Date: April 23, 2010
Related CR Transmittal Number: R1950CP
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1950, CR 6901

ICD-10/5010 national provider call scheduled for June 15

The Centers for Medicare & Medicaid Services (CMS) will host a national provider conference call on June 15 titled "ICD-10 Implementation in a 5010 Environment." This toll-free teleconference call will include a question and answer session that will give call participants an opportunity to ask questions of CMS subject matter experts.

Target audience

Medical coders, physician office staff, provider billing staff, health records staff, vendors, educators, system maintainers and all Medicare fee-for-service (FFS) providers.

Conference call details

When: Tuesday, June 15, 2010

Time: Noon-2:00 p.m. ET

The presentation will include the following topics:

ICD-10

- ICD-10 implementation for services provider on or after October 1, 2013
- Benefits of ICD-10
- Differences between ICD-10 and ICD-9-CM codes
- Tools for converting codes – general equivalence mappings (GEMs)
- Proposal to freeze ICD-9-CM and ICD-10 code updates except for new technologies and diseases

HIPAA version 5010

- General overview HIPAA version 5010 and D.0 and who is impacted
- Compliance dates
- Benefits
- Version 5010 scope versus ICD-10 scope
- What you need to do to prepare
- Timelines
- Medicare FFS implementation of HIPAA version 5010 and D.0
- Impact on paper claim forms

Registration information

To register for this informative conference call, please go to the CMS website at *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*.

Registration for this call will close at noon ET on June 14, 2010, or when available space has been filled. No exceptions will be made. **Please register as early as possible.**

Additional information

Additional information about ICD-10/5010 may be found at *http://www.cms.gov/ICD10*.

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

Source: CMS PERL 201005-41

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events
July 2010 – September 2010

Topic – HIGLAS Transition

When: Wednesday, July 7, 2010

Time: 11:00 a.m. – 12:00 p.m. ET **Delivery language:** English

Type of Event: Webcast **Focus:** 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

Topic – HIGLAS Transition

When: Thursday, July 15, 2010

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

Type of Event: Webcast **Focus:** Puerto Rico, and U.S. Virgin Islands

Topic – Hot Topics

When: Tuesday, September 14, 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 website, *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 website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

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

PREVENTIVE SERVICES

May 9-15 is National Women's Health Week

In the spirit of National Women's Health week, the Centers for Medicare & Medicaid Services asks providers to help keep women with Medicare healthy by encouraging them to take advantage of Medicare-covered preventive services.

Medicare covers a wide range of preventive services that can help women with Medicare live longer, healthier lives. The preventive services Medicare covers for eligible beneficiaries include the following:

- Screening mammograms
- Bone mass measurements
- Screening Pap tests
- Screening pelvic exams.

For more information

CMS has developed a variety of educational products and resources to help health care professionals and their staff become familiar with coverage, coding, billing, and reimbursement for Medicare-covered preventive services.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers and Other Health Care Professionals – this comprehensive resource contains coverage, coding, and payment information for the many preventive services covered by Medicare.
http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Quick Reference Information: Medicare Preventive Services – this chart contains coverage, coding, and payment information for the many preventive services covered by Medicare in an easy-to-use quick-reference format.
http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

The Bone Mass Measurements Brochure – this brochure provides coverage, coding, and billing information on Medicare-covered bone mass measurements.
http://www.cms.gov/MLNProducts/downloads/bone_mass.pdf

The Bone Cancer Screenings Brochure – this brochure provides coverage, coding, and billing information on Medicare-covered cancer screenings, including screening mammographies, pap tests, and pelvic exams.
http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf

The Medicare Preventive Services Series: Part 3 Web-Based Training Course (WBT) – this WBT includes lessons on coverage, coding, and billing for several Medicare-covered preventive services, including screening mammography, pap tests, pelvic exams, and bone mass measurements. To access the WBT, please visit the MLN homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "WBT Modules."

The Medicare Learning Network (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.gov/MLNProducts/35_PreventiveServices.asp

To order hard copies of certain MLN products, including brochures and the Quick Reference Information chart, please visit the MLN homepage at *http://www.cms.gov/mlngeninfo*. Scroll down to "Related Links Inside CMS" and click on "MLN Product Ordering Page."

For more information about National Women's Health Week, please visit the Office on Women's Health website at *http://www.womenshealth.gov/whw*.

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

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

Source: CMS PERL 201005-18

OTHER EDUCATIONAL RESOURCES

New resources from the Medicare Learning Network

The April 2010 edition of the *Medicare Learning Network (MLN) Catalog of Products* is now available and may be accessed on the CMS website at *http://www.cms.gov/MLNproducts*. The MLN Catalog of Products is an interactive downloadable document that lists all *Medicare Learning Network* products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All product titles and the word "download" when selected, will link you to the online version of the product. The words "hard copy" when selected, will automatically link you to the MLN Product Ordering page. To access the catalog, click on the link called MLN Product Catalog.

The revised *Rehabilitation Therapy Information Resource for Medicare* fact sheet (April 2010) is now available in downloadable format from the Centers for Medicare & Medicaid Services' *Medicare Learning Network* at *http://www.cms.gov/MLNProducts/downloads/Rehab_Therapy_Fact_Sheet.pdf*. This fact sheet provides guidance and resources related to rehabilitation therapy services, coverage requirements, and payment systems.

The revised *Clinical Laboratory Fee Schedule* fact sheet (January 2010) is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit *http://www.cms.gov/MLNGenInfo*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." This fact sheet provides general information about the clinical laboratory fee schedule, coverage of clinical laboratory services, and how payment rates are set.

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

Source: CMS PERL 201005-03

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:
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Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
_____

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
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
1-904-361-0359

Medicare Websites

PROVIDERS
Florida Medicare Contractor
medicare.fcso.com
Centers for Medicare & Medicaid Services
www.cms.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

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www.cms.gov

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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 ♦