MEDICARE A Bulletin

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## 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:

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

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

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# 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

## Medicare contractor annual update of the ICD-9-CM

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

### Provider types affected

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

### Provider action needed

This article is based on change request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You may see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage*, or at the National Center for Health Statistics (NCHS) website at *http://www.cdc.gov/nchs/icd9.htm* in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

### Background

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

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

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

### Additional information

For complete details regarding this CR, please see the official instruction (CR 7006) issued to your Medicare contractor, which may be found on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2017CP.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: MM7006
Related Change Request (CR) Number: 7006
Related CR Release Date: August 4, 2010
Related CR Transmittal Number: R2017CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2017, CR 7006



## Written and audio transcripts of the June 15 ICD-10 teleconference now available

The written and audio transcripts of the June 15 national provider conference call, "ICD-10 Implementation in a 5010 Environment," hosted by Centers for Medicare & Medicaid Services (CMS) is now available. To access the transcripts, go to the CMS website *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*.

In the Downloads section select the "June 15, 2010 ICD-10 Conference Call" zip file. This zip file contains the written and audio transcripts, as well as the slide presentation used during the teleconference.

The length of the audio transcript is 1 hour and 51 minutes.

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

Source: CMS PERL 201007-24

# ICD-10 implementation information

*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, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

## What you need to know

This *MLN Matters*® special edition article provides information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The first ICD-10-related compliance date is less than two years away. On January 1, 2012, standards for electronic health transactions change from version 4010/4010A1 to version 5010. Unlike version 4010, version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

On October 1, 2013, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

## Background

### ICD-10 implementation compliance date

On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
  - There will be **no** delays.
  - There will be **no** grace period for implementation.

**Important, please be aware:**

- **ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.**
- **ICD-10 codes will not be accepted for services prior to October 1, 2013.**

You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2013, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2013.

Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2013.

**Note:** Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on *Current Procedural Terminology* **(***CPT***)** and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report *CPT* and HCPCS codes.

### What are the differences between the ICD-10-CM/ICD-10-PCS and ICD-9-CM code sets?

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

### What are benefits of the ICD-10 coding system?

The new up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition
- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

***ICD-10 implementation information (continued)***

## ICD-10-CM code use and structure

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is three to seven characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters three-seven are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

A78 – Q fever

A69.21 – Meningitis due to Lyme disease

O9A.311 – Physical abuse complicating pregnancy, first trimester

S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

1) Laterality (left, right, bilateral)
For example:

   C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast

   H16.013 – Central corneal ulcer, bilateral

   L89.022 – Pressure ulcer of left elbow, stage II

2) Combination codes for certain conditions and common associated symptoms and manifestations

   For example:

   K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding

   E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema

   I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

3) Combination codes for poisonings and their associated external cause
For example:

   T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequel

4) Obstetric codes identify trimester instead of episode of care
For example:

   O26.02 – Excessive weight gain in pregnancy, second trimester

5) Character "x" is used as a fifth character placeholder in certain six character codes to allow for future expansion and to fill in other empty characters (e.g., character five and/or six) when a code that is less than six characters in length requires a seventh character
For example:

   T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter

   T15.02xD – Foreign body in cornea, left eye, subsequent encounter

6) Two types of excludes notes
**Excludes 1** – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).
For example:

   Q03 – Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

   **Excludes 2** – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).
For example:

   L27.2 – Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

7) Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)
For example:

   T45.526D – Underdosing of antithrombotic drugs, subsequent encounter

   Z67.40 – Type O blood, Rh positive

   Y90.6 – Blood alcohol level of 120–199 mg/100 ml

8) A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)
For example:

   E10.610 – Type 1 diabetes mellitus with diabetic neuropathic arthropathy

   F10.182 – Alcohol abuse with alcohol-induced sleep disorder

   T82.02xA – Displacement of heart valve prosthesis, initial encounter

9) Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders
For example:

   D78.01 – Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen

   D78.21 – Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM

***ICD-10 implementation information (continued)***

- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now four weeks rather than eight weeks)
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review "Basic Introduction to ICD-10-CM" audio or written transcripts from the March 23, 2010 provider outreach conference call. Go to *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage*. Scroll to the bottom of the Web page to the *Downloads* section and select the 2010 ICD-10 Conference Calls zip file and locate the March 23rd written or audio transcript.

### ICD-10-PCS code use and structure

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have seven characters that can be either alpha (non-case sensitive) or numeric. The numbers zero-nine are used (letters O and I are not used to avoid confusion with numbers zero and one), and they do not contain decimals.

For example:

- 0FB03ZX – Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ – Repair, upper esophagus, open approach

### Help with converting codes

The general equivalence mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers
- All providers
- Medical researchers
- Informatics professionals
- Coding professionals—to convert large data sets
- Software vendors—to use within their own products
- Organizations—to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use may be found at *http://www.cms.gov/ICD10* (select from the left side of the Web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings". Go to *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*, scroll to the bottom of the page, under Downloads select – 2009 ICD-10 Conference Calls to locate the audio and written transcripts.

### What to do now in preparation for ICD-10 implementation?

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types
- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims
- Learn about system impact and 5010
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation
- Review and refresh knowledge of medical terminology as needed based on the assessment results
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology)
- Plan to provide intensive coder training approximately six-nine months prior to implementation
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much

### Additional information

To find additional information about ICD-10, visit *http://www.cms.gov/ICD10*. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page:** This site links Medicare fee-for-service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this

***ICD-10 implementation information (continued)***

Web page. Bookmark *http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp* and check back regularly for access to ICD-10 implementation information of importance to you.

**Note:** Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

- **CMS Sponsored National Provider Conference Calls:** During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit on the CMS website *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage*.
- **Frequently Asked Questions (FAQs)**: To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at *http://www.cms.gov/ICD10/*, select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- Workgroup for Electronic Data Interchange (WEDI) *http://www.wedi.org*
- Health Information and Management Systems Society (HIMSS) *http://www.himss.org/icd10*.

*MLN Matters*® Number: SE1019
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE1019



## PPACA requirements for ICD-10 crosswalk revisions – public forum meeting

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Coordination and Maintenance (C&M) Committee will convene on Wednesday and Thursday, September 15-16, 2010, at the Centers for Medicare & Medicaid Services (CMS) headquarters, 7500 Security Blvd, Baltimore, MD. The C&M Committee meeting is a public forum for the presentation of proposed modifications to the ICD-9-CM.

Section 10109(c) of the Patient Protection and Affordable Care Act and the Reconciliation Act of 2010 (PPACA) requires that the C&M Committee convene a meeting before January 1, 2011, to receive stakeholder input regarding the crosswalk between the ninth and tenth revisions of the ICD-9 and ICD-10, respectively, posted to the CMS website at *http://www.cms.gov/ICD10/* for the purpose of making appropriate revisions to said crosswalk. Section 10109(c) further requires that any revised crosswalk be treated as a code set for which a standard has been adopted by the Secretary, and that revisions to this crosswalk be posted to the CMS website.

The C&M Committee will use the first half of the first day of the September C&M Committee meeting, 9:00 a.m. to 12:30 p.m., Wednesday, September 15, 2010, to fulfill the above-referenced PPACA requirements for this meeting to be held prior to January 1, 2011, and receive public input regarding the above-referenced crosswalk revisions. Interested parties and other stakeholders should be prepared to submit their written comments and other relevant documentation at the meeting, or no later than November 12, 2010.

For the complete *Federal Register* notice, please go to *http://edocket.access.gpo.gov/2010/pdf/2010-16610.pdf*.

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

Source: CMS PERL 201007-20

# October 2009 quarterly average sales price update and revision to prior files

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

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 7007 and instructs Medicare contractors to download and implement the October 2010 average sales price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised, July 2010, April 2010, January 2010, and October 2009 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

## Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

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

| Files | Effective dates of service |
|---|---|
| October 2010 ASP and ASP NOC files | October 1, 2010, through December 31, 2010 |
| July 2010 ASP and ASP NOC files | July 1, 2010, through September 30, 2010 |
| April 2010 ASP and ASP NOC files | April 1, 2010, through June 30, 2010 |
| January 2010 ASP and ASP NOC files | January 1, 2010, through March 31, 2010 |
| October 2009 ASP and ASP NOC files | October 1, 2009, through December 31, 2009 |

**Note:** The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

## Additional information

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

The official instruction (CR 7007) issued to your Medicare MAC, carrier, and/or FI may be found on CMS website at *http://www.cms.gov/Transmittals/downloads/R1990CP.pdf*.

*MLN Matters*® Number: MM7007
Related Change Request (CR) Number: 7007
Related CR Release Date: June 18, 2010
Related CR Transmittal Number: R1990CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1990, CR 7007

## Healthcare common procedure coding system quarterly update – other codes

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

Changes are effective on the date indicated on the update.

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

Source: CMS PERL 201007-03

## July update to the 2010 Medicare physician fee schedule database

*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 and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], 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).

### Provider action needed

This article is based on change request (CR) 6974, which amends payment files that were issued to Medicare contractors based on the 2010 MPFS final rule. Be sure your billing staff is aware of these changes.

### Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm* on the Internet) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2010 MPFS final rule. CR 6974 amends those payment files. CR 6974 provides corrections, effective for dates of service on or after January 1, 2010, to those files. These changes include the following:

| *CPT*/HCPCS code | Action |
|---|---|
| *36148* | Multiple procedure indicator = 0 |
| *74261* | Multiple procedure indicator = 4<br>Diagnostic family imaging indicator = 02 |
| *74261TC* | Multiple procedure indicator = 4<br>Diagnostic family imaging indicator = 02 |
| *74262* | Multiple procedure indicator = 4<br>Diagnostic family imaging indicator = 02 |
| *74262TC* | Multiple procedure indicator = 4<br>Diagnostic family imaging indicator = 02 |
| *97026* | Procedure status = R |

### Pharmacogenomic testing for warfarin response

HCPCS code G9143 was implemented with the 2010 HCPCS file with an effective date of August 3, 2009. Currently, Medicare contractors have a 2010 MPFSDB record but not a 2009 MPFSDB record. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after August 3, 2009.

### *CPT* code 90470

*CPT* code *90470* became effective on September 28, 2009. However, due to an off cycle effective date it was not included on the MPFSDB for 2009. Contractors were instructed to manually add this code to the procedure code file and the MPFSDB effective for dates of service on or after September 28, 2009.

### Screening for the human immunodeficiency virus (HIV) infection

On December 8, 2009, CMS issued a noncoverage decision (transmittal 118, CR 6786, dated March 23, 2010) on screening for HIV infection. Medicare contractors were instructed to manually add HCPCS codes G0432, G0433, and G0435 to the procedure code file and MPFSDB effective for dates of service on or after December 8, 2009.

### Outpatient intravenous insulin treatment (OIVIT)

On December 23, 2009, CMS issued a noncoverage decision (transmittal 114, CR 6775, dated February 22, 2010) on the use of OIVIT. Contractors were instructed to manually add HCPCS code G9147 to the procedure code file and MPFSDB effective for dates of service on or after December 23, 2009.

### Dermal injections for treatment of facial lipodystrophy syndrome (LDS)

In CR 6974, contractors are being instructed to manually adjust the effective date (for dates of service on or after March 23, 2010) for HCPCS codes G0429, Q2026, and Q2027 on the procedure code file and the MPFSDB:

G0429 Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)

Q2026 Injection, Radiesse®, 0.1ml)

Q2027 Injection, Sculptra®, 0.1ml)

### Collagen meniscus implant

In CR 6974, contractors are being instructed to manually adjust the effective date for HCPCS code G0428 (Collagen meniscus implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex™) on the procedure code file and the MPFSDB. HCPCS code G0428 is effective for dates of service on or after May 25, 2010.

***July update to the 2010 Medicare physician fee schedule database (continued)***

### Other changes

In addition to the above, attachment 1 of CR 6974 contains numerous adjustments of the MPFSDB for various *CPT*/HCPCS codes and associated indicators. This attachment to CR 6974 may be viewed at *http://www.cms.gov/Transmittals/downloads/R1992cp.pdf*.

### Additional information

Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that are affected by these changes. However, contractors will adjust such claims that you bring to their attention.

The official instruction, CR 6974, issued to your carrier, FI, RHHI, and A/B MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1992cp.pdf*.

If you have any questions, please contact your carrier, FI, RHHI, 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: MM6974
Related Change Request (CR) Number: 6974
Related CR Release Date: June25, 2010
Related CR Transmittal Number: R1992CP
Effective Date: January 1, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1992, CR 6974



## CMS to review provider enrollment, chain and ownership system process

### Medicare working with ordering and referring providers and suppliers to streamline enrollment process

The Centers for Medicare & Medicaid Services (CMS) is working with providers to address concerns about enrollment in the provider enrollment, chain and ownership system (PECOS) to ensure that Medicare beneficiaries continue to receive the health care services and items they need. PECOS is the electronic system used to enroll physicians and eligible professionals into the Medicare program.

As part of those efforts, CMS will, for the time being, not implement changes that would automatically reject claims based on orders, certifications, and referrals made by providers that have not yet had their applications approved by July 6. While more than 800,000 physicians and other health professionals have enrolled and have approved applications in the PECOS system, some providers have encountered problems. CMS is continuing to update and streamline the process, and more providers have been enrolled in the past few days.

CMS issued an interim final regulation on May 5 implementing provisions of the Affordable Care Act that permit only a Medicare enrolled physician or eligible professional to certify or order home health services, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) , and certain items and services under Medicare Part B. The new law applies to orders, referrals and certifications made on or after July 1. The comment period for the regulation closed on July 6, after which the comments will be reviewed and considered before a final regulation is issued.

The Affordable Care Act provisions and the regulation were designed as steps to prevent fraud in Medicare by ensuring that only eligible and identifiable providers and suppliers can order and refer covered items and services to Medicare beneficiaries.

Many physicians and other providers and suppliers have continued to make good faith efforts to comply with the requirements of the law and regulation. These efforts will be a significant factor in determining the procedures and processes that will be incorporated in the final rule.

Although the regulation will be effective July 6, CMS will not implement automatic rejections of claims submitted by providers that have attempted to enroll in PECOS. However, until the automatic rejections are operational, providers should not see any change in the processing of their submitted claims; they will continue to be reviewed and paid as they have in the past.

In addition, although CMS is taking a more deliberative approach to using PECOS, the agency will employ a contingency plan to meet the Affordable Care Act requirement that effective July 1, written orders and certifications are only to be issued by eligible professionals.

CMS will continue to send informational notices to providers reminding them of the need to submit or update their enrollment and will work with the provider community to provide guidance on enrollment and will process all applications expeditiously.

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

Source: CMS PERL 201006-57

## Impacts to Florida Part A payment schedule in August 2010

On August 13, 2010, First Coast Service Options (FCSO) will transition its Part A financial accounting system for Puerto Rico and U.S. Virgin Islands from the fiscal intermediary standard system (FISS) to the healthcare integrated general ledger accounting system (HIGLAS). This transition will result in minor impacts to the timing of Medicare payments to Florida Part A providers. Please share this notice with the financial representatives in your organization.

### Impacts to Florida providers – reduction to payment floor

Since all Part A payment activity in Jurisdiction 9 will be interrupted while the transition occurs, the Centers for Medicare & Medicaid Services has approved a temporary pay-floor reduction of Florida Part A payments for both paper and electronic data interchange (EDI) claims.

**On August 12** the payment floor for Florida will be reduced by three days for both EDI and paper claims. This means that all claims that are approved to pay and scheduled to be released during August 12-17 will have been paid on the August 12 payment cycle.

This payment may give the appearance that your cash revenues have increased when, in fact, payments for some of your claims have simply been made earlier than normal. Providers are encouraged to monitor their payments and make adjustments as necessary to prevent cash flow problems during the transition period. Payments will resume to providers on August 18, 2010.

### HIGLAS dark day

FCSO will impose a HIGLAS system dark day **on August 13, 2010.** Remittance advices and electronic remittance advices will not be available on this day.

Providers may continue to submit and adjust claims as usual. There will be no impacts on claim processing activities within FISS. ❖

## Impacts to Part A August payment schedule for Puerto Rico and U.S. Virgin Islands

On August 13, 2010, First Coast Service Options (FCSO) will transition its Part A financial accounting system for Puerto Rico and U.S. Virgin Islands from the fiscal intermediary standard system (FISS) to the healthcare integrated general ledger accounting system (HIGLAS). This transition will result in impacts to the timing of Medicare payments to Part A providers. Please share this notice with the financial representatives in your organization.

### Payment schedule impacts

Since all Part A payment activity in Jurisdiction 9 will be interrupted while the transition occurs, the Centers for Medicare & Medicaid Services has approved FCSO to release claims already approved for payment on the August 11 payment cycle for Part A providers in Puerto Rico and U.S. Virgin Islands. This action will result in one high payment, then lower payments over the next 10-14 days.

The payment generated on August 11 may give the appearance that your cash revenues have increased when, in fact, payments for some of your claims will have been made earlier than normal. Providers are encouraged to monitor their payments and make adjustments as necessary to prevent cash flow problems during the transition period.

The HIGLAS transition will be completed on Monday, August 16 and payment cycles will also resume.

### HIGLAS dark days

During the transition, FCSO will also impose HIGLAS dark days on August 12-13 for Puerto Rico and U.S. Virgin Islands. During these dark days, remittance advices and electronic remittance advices will not be available.

Providers may continue to submit and adjust claims as usual. There will be no impacts on claim processing activities within FISS. ❖

## Declare independence from paper enrollment – use Internet-based PECOS

The Internet-based provider enrollment, chain and ownership system (Internet-based PECOS) may be used in lieu of the Medicare enrollment application (i.e., Form CMS-855) to:

- Submit an initial Medicare enrollment application
- View or change your enrollment information
- Track your enrollment application through the Web submission process
- Add or change a reassignment of benefits
- Submit changes to existing Medicare enrollment information
- Reactivate an existing enrollment record
- Withdraw from the Medicare program

### Advantages of Internet-based PECOS

- Faster than paper-based enrollment (45 day processing time in most cases, versus. 60 days for paper)
- Tailored application process means you only supply information relevant to your application
- Gives you more control over your enrollment information, including reassignments
- Easy to check and update your information for accuracy
- Less staff time and administrative costs to complete and submit enrollment to Medicare

### Physicians and nonphysician practitioners

**Using Internet-based PECOS is easy**

Learn how to use the system by visiting the Medicare Physician and Non-Physician Practitioner

***Declare independence from paper enrollment – use Internet-based PECOS (continued)***

Getting Started Guide available at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf*

If you encounter problems or have questions as you navigate the system, there are several resources that may help.

**So, don't wait, set your practice free from paper -- start using Internet-based PECOS today.**

### Provider and supplier organizations

**Using Internet-based PECOS is easy**

Learn how to use the system by visiting the Getting Started Guide for Provider and Supplier Organization available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationGettingStarted.pdf*.

Remember, creating a record in Internet-based PECOS may take several weeks for an organization provider. It is recommended that you begin this process (if necessary) well in advance of any upcoming enrollment actions. For more information on this setup process, visit the Provider and Supplier Organization Overview at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrganizationOverview.pdf*.

**So, don't wait, set your organization free from paper – start using Internet-based PECOS today**

Internet-based PECOS will be made available for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) later this year.

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

Source: CMS PERL 201007-14, PERL 201007-13

## Tips for using Internet-based PECOS

Internet-based PECOS may be used by providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies suppliers) to submit Medicare enrollment applications over the Internet.

As a reminder, providers and suppliers should report application navigation, printing, or access problems with Internet-based PECOS to the external user service (EUS) help desk at 1-866-484-8049 or send an e-mail to the EUS help desk to mailto: *EUSSupport@cgi.com*. In addition, providers and suppliers must have Internet Explorer version 5.5 or higher and have the most recent version of Adobe® Acrobat Reader before initiating an enrollment action using Internet-based PECOS.

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

Source: CMS PERL 201007-06

## CMS to expand Medicare preventive services and improve access to primary care in 2011

### Proposals would implement Affordable Care Act benefits

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would implement key provisions in the Affordable Care Act of 2010 that expand preventive services for Medicare beneficiaries, improve payments for primary care services, and promote access to health care services in rural areas. The proposed policies would apply to payments under the Medicare physician fee schedule (MPFS) for services furnished on or after January 1, 2011.

The proposed rule would implement provisions in the Affordable Care Act that will eliminate out-of-pocket costs for beneficiaries for most preventive services, including the new annual wellness visit. This visit augments the benefits of the initial preventive physical examination (IPPE or "Welcome to Medicare Visit") with an annual wellness visit that allows the physician and patient to develop a personalized prevention plan that includes not only the preventive services generally available to the Medicare population, but additional services that may be appropriate because of the patient's individual risk factors.

The proposed rule would improve access to primary care services by implementing an incentive payment for primary care services furnished by primary care practitioners that can include physicians, nurse practitioners, clinical nurse specialists, and physician assistants. The proposed rule would also implement a payment incentive program for general surgeons performing major surgery in areas designated by the Secretary of the Department of Health & Human Services (HHS) as health professional shortage areas (HPSAs), would allow physician assistants to order post-hospital extended care services in skilled nursing facilities, and would pay certified nurse midwives for their services under the MPFS at the same rates as physicians.

The entire CMS press release issued June 25 may be viewed at *http://www.cms.gov/apps/media/press_releases.asp*.

CMS issued fact sheets with additional details is available at *http://www.cms.gov/apps/media/fact_sheets.asp*.

The proposed rule is available at *http://www.federalregister.gov/OFRUpload/OFRData/2010-15900_PI.pdf* or *http://www.federalregister.gov/inspection.aspx#special*.

CMS will accept comments on the proposed rule until August 24 and will respond to them in a final rule to be issued on or about November 1. Unless otherwise specified, the payment policies and rates adopted in the final rule will be effective for services on or after January 1, 2011. ❖

Source: CMS PERL 201006-45

## Proposed rule expands patients' visitation rights

On April 15, President Barack Obama issued a presidential memorandum to the Department of Health & Human Services (HHS) calling for the initiation of rulemaking that would ensure that hospitals that participate in Medicare or Medicaid respect the rights of patients to designate visitors, regardless of whether the visitors are legally related to the patients. The President's directive clearly instructed HHS to propose that a participating hospital not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability.

At the direction of the President, Secretary Kathleen Sebelius and her team at the Centers for Medicare & Medicaid Services have been working on a proposed regulation that would ensure that patients' visitation rights are respected. The proposed rule "Medicare and Medicaid Programs: Changes to the Hospital and Critical Access Hospital Conditions of Participation to Ensure Visitation Rights for All Patients," was published in the *Federal Register* on June 28 and is currently available for review. The comment period closes on August 27.

Secretary Sebelius sent a letter to leaders of major hospital associations asking them to encourage their member hospitals not to wait for the formal rulemaking process to run its course before reviewing their current visitation policies to ensure they comply with the President's suggested patient-centered visitation rights.

The entire HHS release may be viewed at *http://www.hhs.gov/news/press/2010pres/06/20100622c.html*.

The public inspection website is available at *http://www.federalregister.gov/inspection.aspx#special*.

The document is available at the *Federal Register* at *http://www.access.gpo.gov/su_docs/fedreg/frcont10.html*. ❖

Source: CMS PERL 201006-46

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## One year anniversary of President Obama's "Year of Community Living" initiative

### Eleventh anniversary of Olmstead Supreme Court ruling also observed

In honor of the one year anniversary of the Obama Administration's "Year of Community Living," Health & Human Services Secretary Kathleen Sebelius announced new funds for states to build innovative systems to link persons with disabilities to affordable housing in their home communities.

This new $3.2 million, three-year contract is designed to create unprecedented collaboration between human services agencies and housing authorities at all levels of government to help persons living in institutions find homes and live more independently. The effort, "Housing Capacity Building Initiative for Community Living," will be led by New Additions Consulting Inc.

The announcement also aids the implementation of the U.S. Supreme Court's decision in Olmstead v. L.C., which was handed down 11 years ago today. In that decision, the court ruled that, under the Americans with Disabilities Act, unnecessarily institutionalizing a person with a disability who, with proper support, can live in the community is discrimination. In its ruling, the Supreme Court said that institutionalization severely limits the person's ability to interact with family and friends, to work, and to make a life for him or herself.

"The Department is continuing to build on the important efforts launched by the President's Year of Community Living initiative," said Secretary Sebelius "Our efforts are being strengthened with the support and efforts of our colleagues in the Department of Housing and Urban Development and at the Department of Justice."

Secretary Sebelius is promoting partnerships within HHS and with other departments, including the Department of Housing and Urban Development to create a productive collaboration in ensuring that people with disabilities, seniors, and individuals with chronic conditions have new opportunities to live as valued members of their communities.

Also, the Centers for Medicare & Medicaid Services is issuing a letter to state Medicaid directors describing the extension of the "Money Follows the Person" demonstration as a result of the Affordable Care Act. This program has been a very successful partnership with states and has resulted in many individuals moving from institutional to community-based settings.

"The implementation of the Affordable Care Act helps advance the civil rights of individuals with disabilities and community living arrangements, building on the important cornerstone in the Olmstead decision," said Henry Claypool, director of the Office on Disability. "Today's announcement is yet another step in HHS' 11-year effort to achieve that goal."

To read more on HHS accomplishments during the "Year of Community Living," please visit *http://www.hhs.gov/od/topics/community/keyadvances.html*.

More information about the "Money Follows the Person" program may be found at *http://www.cms.gov/CommunityServices/20_MFP.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 201006-39

## Enrollment guidance for physicians that infrequently receive reimbursement

Traditionally, most physicians have enrolled in the Medicare program to furnish covered services to Medicare beneficiaries. However, with the implementation of Section 6405 of the Affordable Care Act, some physicians will need to enroll in the Medicare program for the sole purpose of certifying or ordering services for Medicare beneficiaries. These physicians do not send claims to a Medicare contractor for the services they furnish.

In the process of implementing the provisions contained in the Affordable Care Act, the Centers for Medicare & Medicaid services (CMS) has become aware of several unique enrollment issues for certain types of physicians or practitioners. Specifically, CMS modified the process of enrollment to accommodate the special circumstances of the following individual physicians and practitioners:

- Physicians employed by the Department of Veterans Affairs
- Physicians employed by the Public Health Service
- Physicians employed by the Department of Defense Tricare program
- Physicians employed by federally qualified health centers (FQHCs), rural health clinics (RHCs) or critical access hospitals (CAHs)
- Physicians in a fellowship
- Dentists, including oral surgeons

For details on the modifications to the enrollment process for these special circumstances, visit on the CMS website the special enrollment fact sheet for Physicians with Infrequent Reimbursements at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SpecialEnrollmentFactsheetInfrequentPhysicianReimbursement.pdf.*

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

Source: CMS PERL 201007-25

## 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.*

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® article MM6945 to reflect changes made to change request (CR) 6945. Language under the key points section of CR 6945 (in bold) was corrected to state that claims for HCPCS codes A4336, E1036, L8031, L8032, L8629, and Q0506 will be adjusted if brought to the contractor's attention. In addition, the transmittal number, CR release date, and Web address for the CR has been changed. All other material remains the same. The article was published originally published in the May 2010 *Medicare A Bulletin* (pages 12-13).

### Provider types affected

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

### Provider action needed

This article is based on 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 A4336, E1036, L8031, L8032, L8629, and Q0506 with dates of service on or after January 1, 2010, that have already been processed may be adjusted to reflect the newly established fees if brought to the attention of your Medicare contractor.**

***July update to the 2010 DMEPOS fee schedule (continued)***

- 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.
- 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, the 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 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/R1993CP.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 – Revised
Related Change Request (CR) Number: 6945
Related CR Release Date: July 1, 2010
Related CR Transmittal Number: R1993CP
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 1993, CR 6945

# ELECTRONIC HEALTH RECORDS

## Electronic health record incentive program meaningful use final rule

On July 13, 2010, the Centers for Medicare& Medicaid Services (CMS) and the Office of the National Coordinator (ONC) for Health Information Technology jointly announce their final rules for both electronic health record standards for certification and the Medicare and Medicaid electronic health record (EHR) incentive programs, including the definition of meaningful use.

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health-care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives. One of the two regulations announced on July 13, 2010, defines the "meaningful use" objectives that providers must meet to qualify for the bonus payments, and the other regulation identifies the technical capabilities required for certified EHR technology.

Announcement of these regulations marks the completion of multiple steps laying the groundwork for the incentive payments program. With "meaningful use" definitions in place, EHR system vendors can ensure that their systems deliver the required capabilities, providers can be assured that the system they acquire will support achievement of "meaningful use" objectives, and a concentrated five-year national initiative to adopt and use electronic records in health care can begin.

To read the press release issued July 13, 2010, click here: *http://www.cms.gov/apps/media/press_releases.asp* or *http://www.hhs.gov/news/press/2010pres/2010.html*.

Also CMS issued fact sheets on July 13 with additional details at *http://www.cms.gov/apps/media/fact_sheets.asp*.

To learn more about the Medicare and Medicaid EHR incentive programs, visit the CMS-dedicated website to this program, *http://www.cms.gov/EHRIncentivePrograms/*.

Here you'll find information about eligibility, requirements, upcoming events and more. To learn more about electronic health records and certification standards, visit the HHS/ONC-website at *http://healthit.hhs.gov/portal/server.pt*.

This website is the premier place to learn about the benefits of using EHR technology in a meaningful way, local resources to assist in EHR adoption and more.

And, be sure to attend our upcoming joint CMS and ONC training on the EHR incentive programs and certification on July 22 at 2:00 p.m. ET. More information may be found on the CMS website at *http://www.cms.gov/EHRIncentivePrograms/*.

### Links to rules via the Federal Register

*http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf*

*http://www.ofr.gov/OFRUpload/OFRData/2010-17210_PI.pdf*

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Source: CMS PERL 201007-22

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## Final rule issued to establish a temporary electronic health record certification program

The Office of the National Coordinator (ONC) for Health Information Technology issued a final rule to establish a temporary certification program for electronic health record (EHR) technology. The press release is available at *http://www.hhs.gov/news/press/2010pres/06/20100618d.html*.

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

Source: CMS PERL 201006-26

## Fact sheets on electronic health record incentive programs now available

**Office of the National Coordinator (ONC) certification and Medicare and Medicaid electronic health record (EHR) incentive program final rules: How will they impact you?**

The Centers for Medicare & Medicaid Services (CMS) has issued the following two fact sheet regarding electronic health records incentive program EHR final rules:

- CMS finalizes definition of meaningful use of certified electronic health record technology

  For more information, see the fact sheet from July 16, 2010.

- CMS finalizes requirements for the Medicare electronic health record incentive program
  For more information, see the fact sheet from July 16, 2010.

Be sure to visit the CMS Web section on the Medicare & Medicaid EHR incentive programs at *http://www.cms.gov/EHRIncentivePrograms/*.

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

Source: CMS PERL 201007-39

# RECOVERY AUDIT CONTRACTOR

## Recovery audit contractor demonstration high-risk vulnerabilities – insufficient or no documentation submitted

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

This is the **first** in a series of articles that will disseminate information on recovery audit contractor (RAC) high dollar improper payment vulnerabilities. This article provides education regarding RAC demonstration-identified vulnerabilities in an effort to prevent the same problems from occurring in the future. With the expansion of the RAC program and the initiation of complex medical review (coding and medical necessity) in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

### Provider types affected

This article is for all inpatient hospital and skilled nursing facility providers that submit fee-for-service claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (MACs).

### Provider action needed

Review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

### Background

The Medicare Modernization Act of 2003 (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) establish the recovery audit contractor (RAC) program as a three-year demonstration. The demonstration began March 2005 in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008.

The success of the demonstration resulted in the passage of legislation in the Tax Relief and Healthcare Act of 2006, Section 302, which required CMS to establish a national RAC program by January 1, 2010.

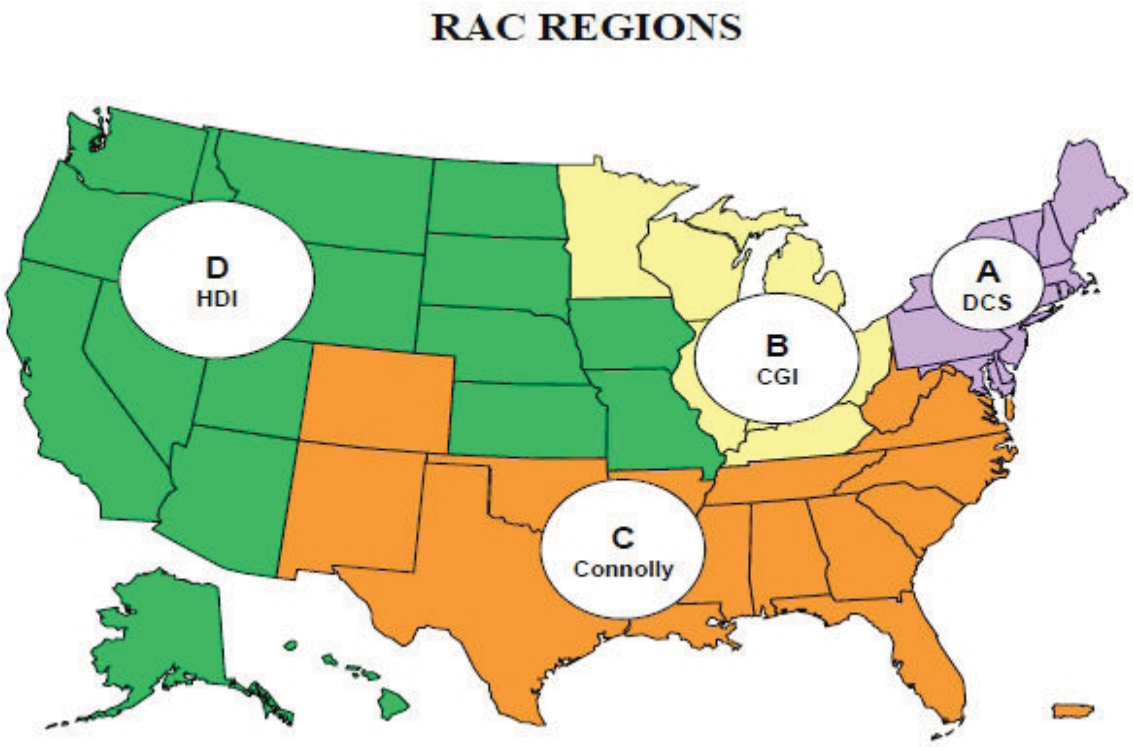
CMS uses four RACs to implement the national RAC program. Each RAC is responsible for identifying overpayments and underpayments in approximately one quarter of the country. Figure 1 displays each of the four RAC regions and identifies the RAC responsible for recovery activities in that region.

### Feedback page

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

***RAC demonstration high-risk vulnerabilities – no documentation or insufficient documentation submitted (continued)***

**Figure 1:**




The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. While the demonstration proved recovery auditing was successful identifying and correcting improper payments in Medicare, it also provided best practices for developing a national program and allowed CMS to identify high risk vulnerabilities. Two of the high risk vulnerabilities identified during the RAC demonstration include:

- Provider non-compliance with timely submission of requested medical documentation
- Insufficient documentation that did not justify that the services billed were covered, medically necessary, or correctly coded.

### Medical documentation reminders

CMS reminds providers that **medical documentation must be submitted within 45 days** of the date of the additional documentation request (ADR) letter. Medicare contractors, including RACs, have the legal authority to review any information, including medical records, pertaining to a Medicare claim. If a provider fails to submit documentation, there is no justification for the services or the level of care billed. Failure to submit medical records (unless an extension has been granted) results in denial of the claim.

Submission of incomplete or illegible medical records can also result in denial of payment for services billed. Claim payment decisions that result from a medical review of records are based on the documentation that Medicare contractors received. For a Medicare claim to be paid, there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment and the provider may be requested to repay the claim paid amount to Medicare.

### Actions to assist providers

The following requirements have been developed to assist providers in ensuring the timely submission of sufficient documentation to justify the services billed:

- RACs must clearly indicate deadlines for submission of medical records in ADR letters
- RACs must initiate one additional contact with the provider before issuing a denial for a failure to submit documentation
- RACs must accept and review extensions requests if providers are unable to submit documentation timely
- RACs must clearly indicate in ADR letters suggested documentation that will assist them in adjudicating the claim
- RACs must allow providers to submit medical records on CD/DVD or to fax the needed medical records
- RACs must implement the RAC look back date of three years with a maximum look back date of October 1, 2007
- RACs must limit the number of medical records requests every 45 days

***RAC demonstration high-risk vulnerabilities – no documentation or insufficient documentation submitted (continued)***

- RACs must indicate the status of a provider's additional documentation requests on their claim status websites
- RACs must establish a provider web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters
- RACs must post all approved issues under review on their websites.

### Preparing for RAC audits

CMS recommends providers implement a plan of action for responding to RAC ADR letters. This could involve developing a RAC team to coordinate all RAC activities that may include tracking audit and appeal findings, identifying patterns of error, implementing corrective actions, etc. Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters. Providers should tell the RAC the precise address and contact person to use when sending ADR letters. Providers may submit this information to the RAC. Additional information on how to identify a point of contact may be found on the individual RAC Web pages listed at the end of this article. Providers may also check the status of the submitted documentation by accessing the applicable RAC website. This allows providers to track whether the RAC received the documentation. Providers should consult the individual RAC Web pages to determine the proper method for accessing this information. Providers should also consider monitoring their RAC websites for updates on approved new issues. This will assist providers in better understanding what audits are taking place so they can prepare to respond to ADR letters.

### CMS RAC website information

The following list identifies information unique to each of the four RACs, the states they cover, their subcontractor(s), and includes website information to assist providers in preparing for RAC audits:

### RAC region A – Diversified Collection Services (DCS), Inc. of Livermore, California

- **States in region:** Maryland (MD), Washington, D.C., Delaware (DE), New Jersey (NJ), Pennsylvania (PA), New York (NY), Maine (ME), Vermont (VT), New Hampshire (NH), Massachusetts (MA), Connecticut (CT), and Rhode Island (RI).
- **Subcontractors:** PRGX (formerly PRG Schultz), Federal Review Services, and iHealth Technologies
- **E-mail:** Info@dcsrac.com
- **Website:** *http://www.dcsrac.com/portal.html*

### RAC region B – CGI Technologies and Solutions, Inc. of Fairfax, Virginia

- **States in region:** Michigan (MI), Minnesota (MN), Wisconsin (WI), Illinois (IL), Indiana (IN), Kentucky (KY), and Ohio (OH).
- **Subcontractor:** PRGX
- **E-mail:** racb@cgi.com
- Website*: http://racb.cgi.com/*

### RAC region C – Connolly, Inc. of Philadelphia, Pennsylvania

- **States in region:** Colorado (CO), New Mexico (NM), Texas (TX), Oklahoma (OK), Arkansas (AR), Louisiana (LA), Mississippi (MS), Tennessee (TN), Alabama (AL), Georgia (GA), North Carolina (NC), South Carolina (SC), West Virginia (WV), Virginia (VA), Florida (FL), US Virgin Islands (VI) and Puerto Rico (PR).
- **Subcontractor:** Viant
- **E-mail:** racinfo@connollyhealthcare.com
- Website: *http://www.connollyhealthcare.com/RAC/*

### RAC Region D – HealthDataInsights (HDI), Inc. of Las Vegas, Nevada

- States in region: Washington (WA), Oregon (OR), California (CA), Alaska (AK), Hawaii (HI), Nevada (NV), Idaho (ID), Montana (MT), Utah (UT), Arizona (AZ), Wyoming (WY), North Dakota (ND), South Dakota (SD), Nebraska (NE), Kansas (KS), Iowa (IA), and Missouri (MO).
- Subcontractor: PRGX
- Email: racinfo@emailhdi.com
- Website: *https://racinfo.healthdatainsights.com/*

### Additional information

Providers are also encouraged to visit the CMS RAC website for updates on the national RAC program at *http://www.cms.gov/RAC*.

On that website, you can register to receive e-mail updates and view current RAC activities nationwide.

*MLN Matters*® Number: SE1024
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
Related CR Transmittal Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE1024

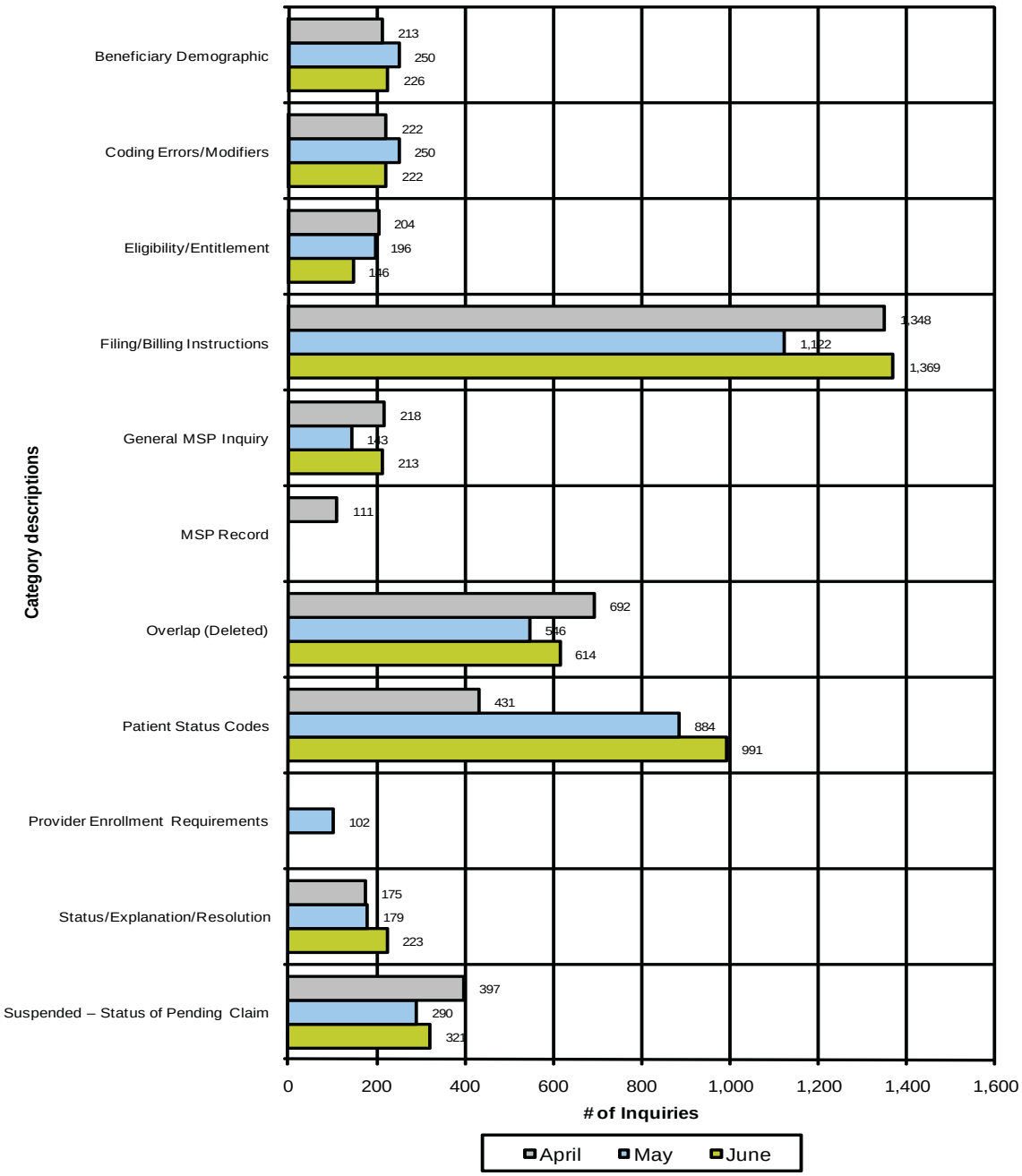
# CLAIM AND INQUIRY SUMMARY DATA

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

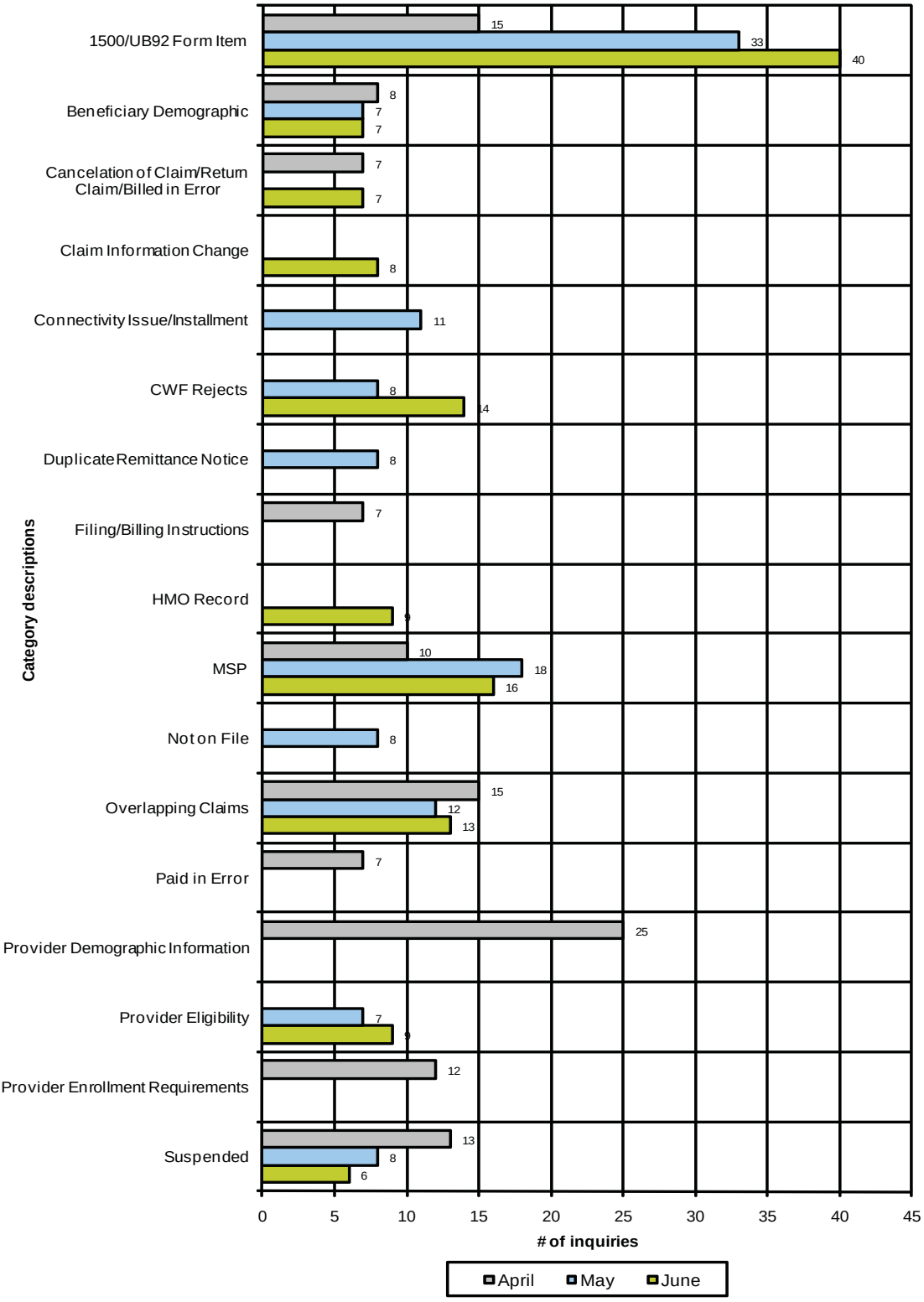
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

### Florida Part A top inquiries for April-June 2010



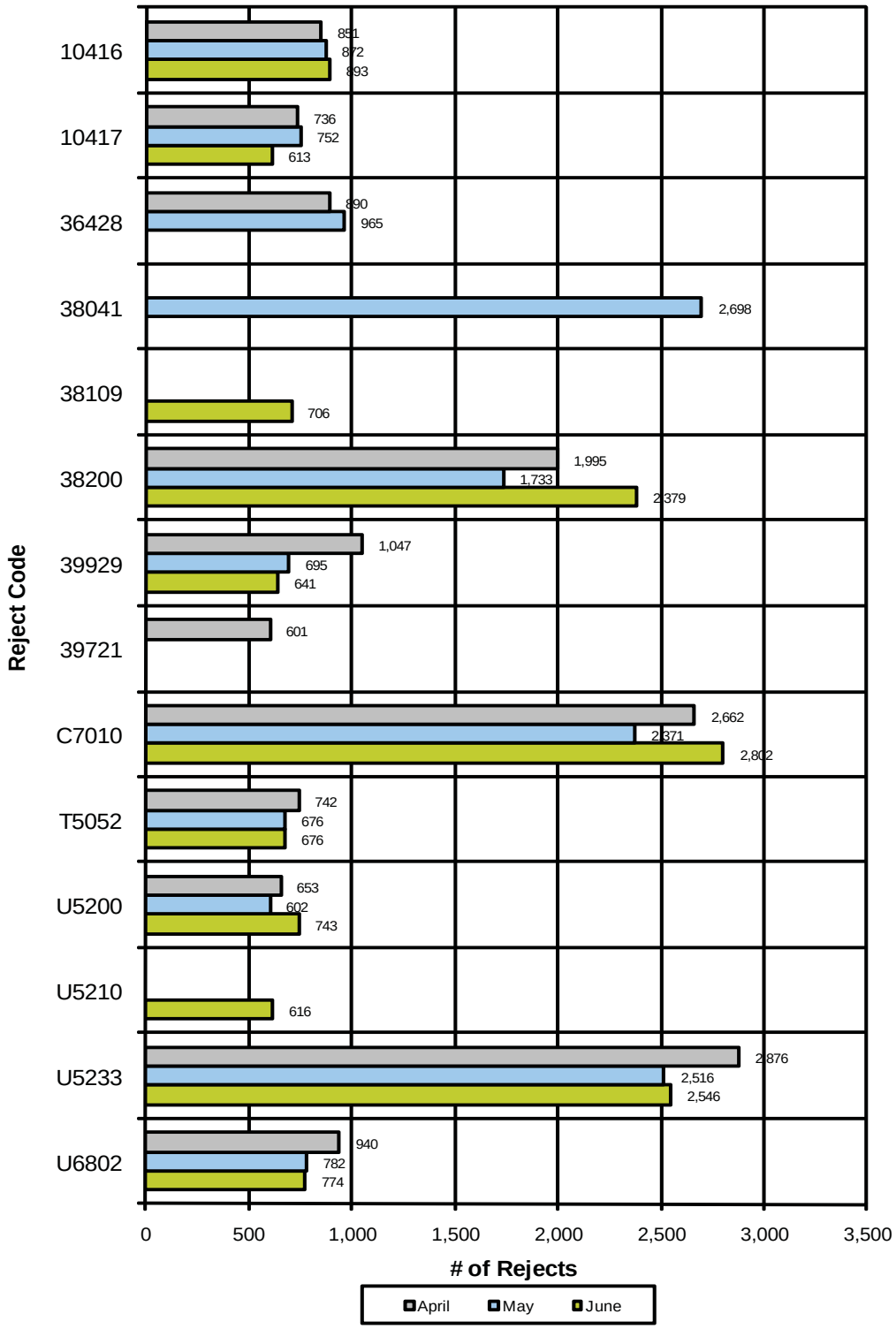
*Top inquiries, return to provider, and reject claims for April-June 2010 (continued)*

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



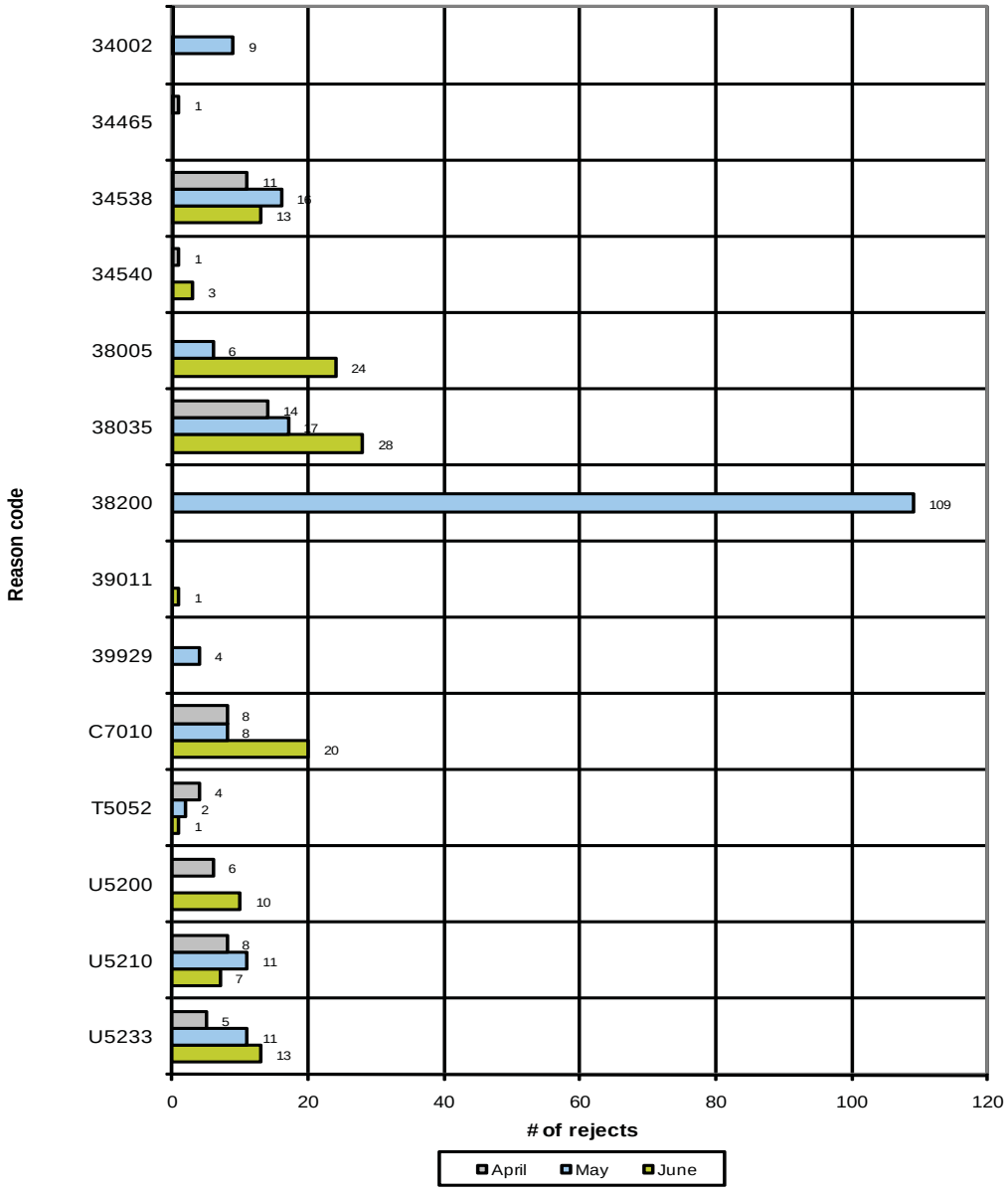
*Top inquiries, return to provider, and reject claims for April-June 2010 (continued)*

## Florida Part A top rejects for April-June 2010



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

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

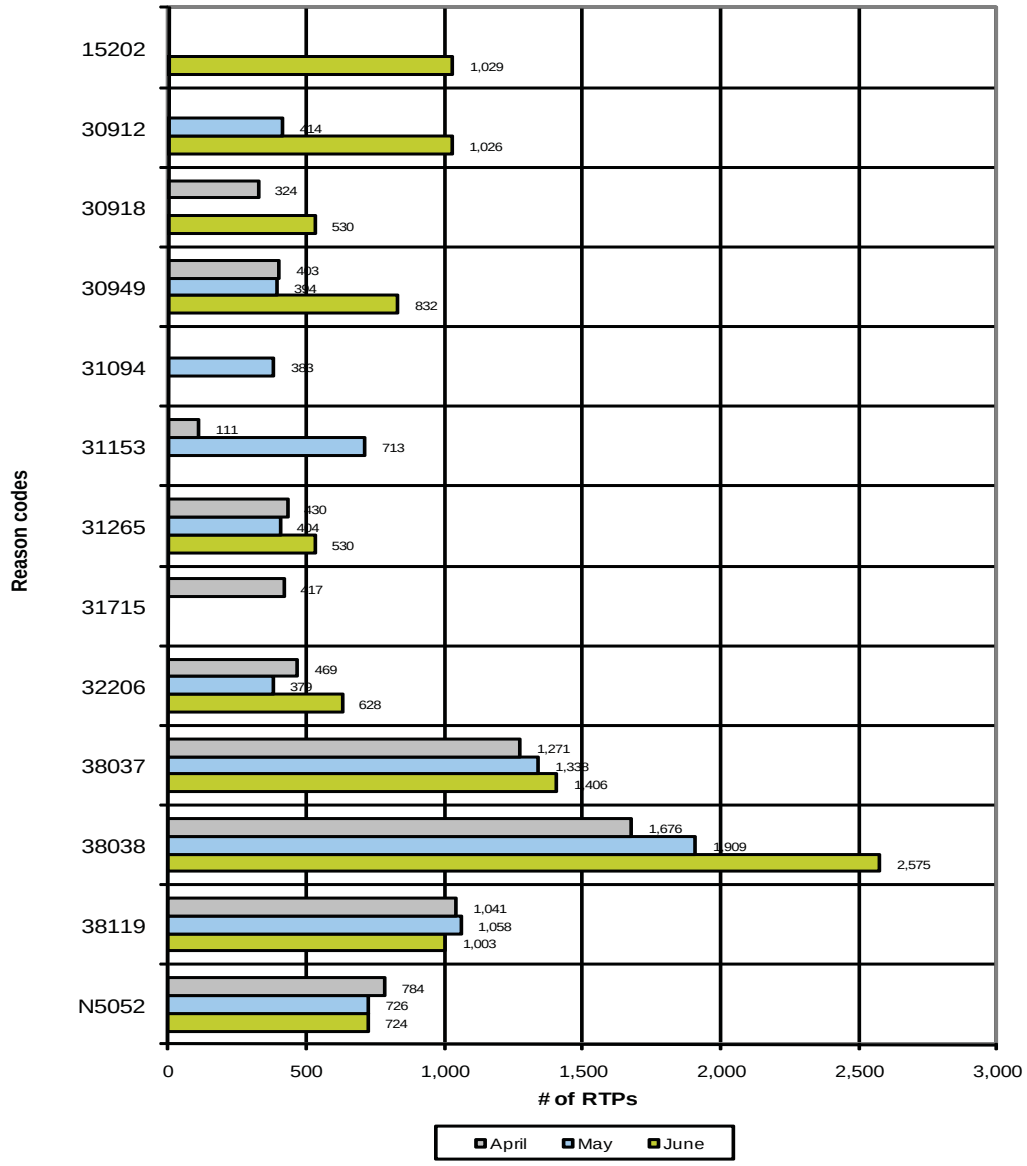



### Keep Informed

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 April-June 2010 (continued)*

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

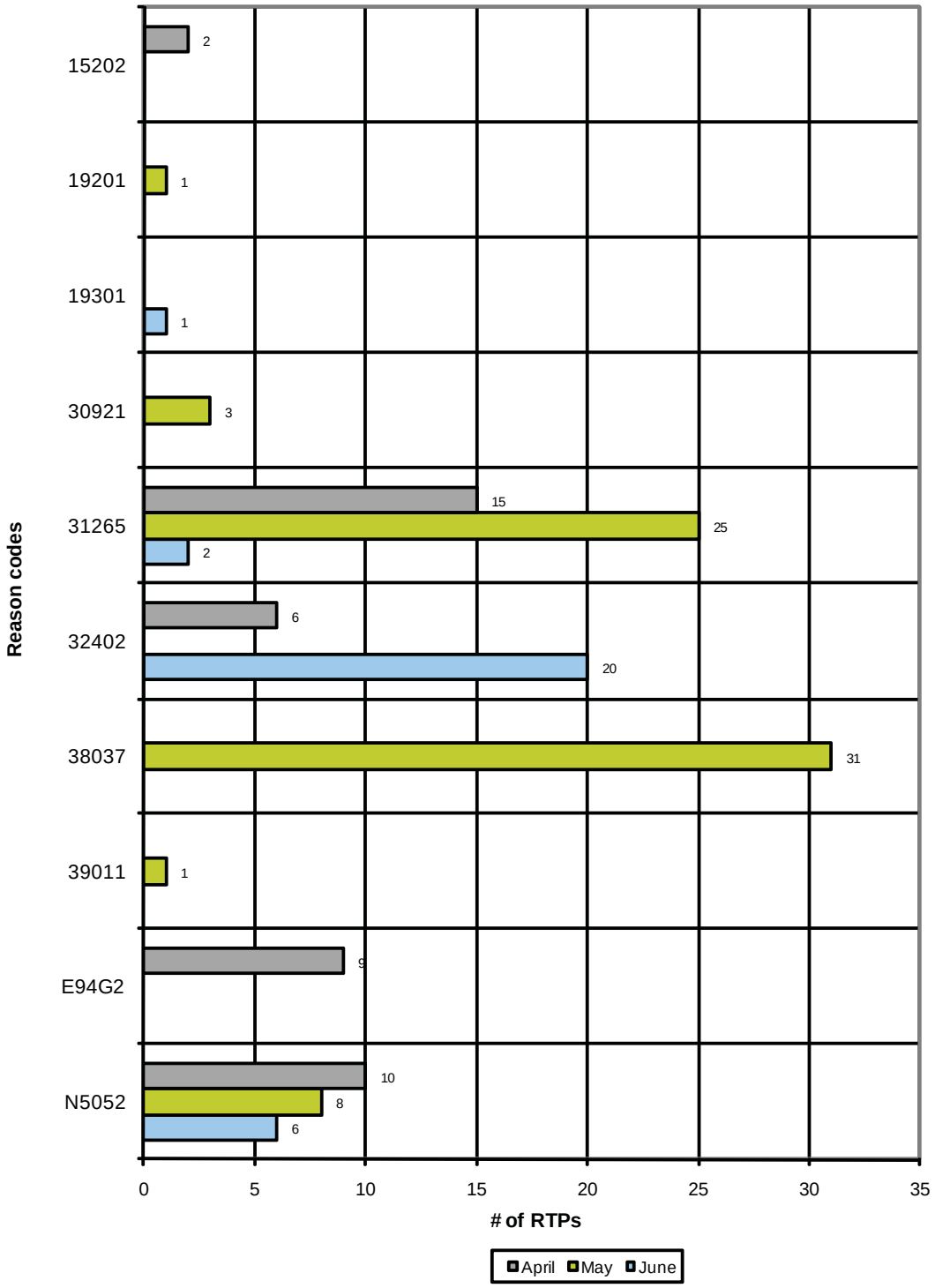



### Educational Resources

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.

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

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



# GENERAL COVERAGE

## Changes to the laboratory national coverage determination edit software for October 2010

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

### Provider action needed

This article is based on change request (CR) 7057, which announces the changes that will be included in the October 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 July 2010. Please ensure that your billing staffs are aware of these changes.

### Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare'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* on the Centers for Medicare & Medicaid Services (CMS) website, 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 7057 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2010. These changes become effective for services furnished on or after October 1, 2010. The changes that are effective for dates of service on and after October 1, 2010 are as follows:

#### For bacterial urine cultures

- **Add** ICD-9-CM code 780.66 to the list of ICD-9-CM codes that are covered by Medicare for the urine culture, bacterial (190.12) NCD.

#### For human immunodeficiency virus (HIV) testing (diagnosis)

- **Add** ICD-9-CM codes 780.66, 786.30, 786.31, and 786.39 to the list of ICD-9-CM codes that are covered by Medicare for the human immunodeficiency virus (HIV) testing (diagnosis) (190.14) NCD.
- **Delete** ICD-9-CM code 786.3 from the list of covered ICD-9-CM codes for the human immunodeficiency virus (HIV) testing (diagnosis) (190.14) NCD.

#### For blood counts

- **Add** ICD-9-CM codes 832.2, V11.4, V25.11, V25.12, V25.13, V49.86, and V62.85 to the list of "Do Not Support Medical Necessity" ICD-9-CM codes that are covered by Medicare for the blood counts (190.15) NCD.
- **Delete** ICD-9-CM code V25.1 from the list of covered "Do Not Support Medical Necessity" ICD-9-CM codes for the blood counts (190.15) NCD.

#### For partial thromboplastin time (PTT)

- **Add** ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 786.30, 786.31, and 786.39 to the list of ICD-9-CM codes covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- **Delete** ICD-9-CM codes 275.0, 287.4, and 786.3 from the list of covered ICD-9-CM codes for the PTT (190.16) NCD.

#### For prothrombin time

- **Add** ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 786.30, 786.31, 786.39, 999.80, 999.83, 999.84, and 999.85 to the list of ICD-9-CM codes covered by Medicare for the prothrombin time (190.17) NCD.
- **Delete** ICD-9-CM codes 275.0, 287.4, and 786.3 from the list of covered ICD-9-CM codes covered for the prothrombin time (190.17) NCD.
- **Correct** a typographical error by replacing ICD-9-CM code 531.21 with ICD-9-CM code 534.21 within the code range 534.20-531.21 for the prothrombin time (190.17) NCD.

#### For serum iron studies

- **Add** ICD-9-CM codes 237.73, 237.79, 275.01, 275.02, 275.03, 275.09, 287.41, 287.49, 999.80, 999.83, 999.84, and 999.85 to the list of ICD-9-CM codes covered by Medicare for the serum iron studies (190.18) NCD.
- **Delete** ICD-9-CM codes 275.0 and 287.4 from the list of covered ICD-9-CM codes for the serum iron studies (190.18) NCD.

#### For blood glucose testing

- **Add** ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 276.61, 276.69, 780.33, 787.60, 787.61, 787.62, and 787.63 to the list of ICD-9-CM codes covered by Medicare for the blood glucose testing (190.20) NCD.
- **Delete** ICD-9-CM codes 275.0, 276.6, and 787.6 from the list of covered ICD-9-CM codes for the blood glucose testing (190.20) NCD.

***Changes to the laboratory national coverage determination edit software for October 2010 (continued)***

### For glycated hemoglobin/glycated protein

- **Add** ICD-9-CM codes 275.01, 275.02, 275.03, and 275.09 to the list of ICD-9-CM codes covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- **Delete** ICD-9-CM code 275.0 from the list of covered ICD-9-CM codes for the glycated hemoglobin/glycated protein (190.21) NCD.

### For lipids testing

- **Add** ICD-9-CM code 278.03 to the list of ICD-9-CM codes covered by Medicare for the lipids testing (190.23) NCD.

### For digoxin therapeutic drug assay

- **Add** ICD-9-CM codes 276.61 and 276.69 to the list of ICD-9-CM codes covered by Medicare for the digoxin therapeutic drug assay(190.24) NCD.
- **Delete** ICD-9-CM code 276.6 from the list of covered ICD-9-CM codes for the digoxin therapeutic drug assay (190.24) NCD.

### For alpha-fetoprotein

- **Add** ICD-9-CM codes 275.01, 275.02, 275.03, and 275.09 to the list of ICD-9-CM codes covered by Medicare for the alpha-fetoprotein (190.25) NCD.
- **Delete** ICD-9-CM code 275.0 from the list of covered ICD-9-CM codes for the alpha-fetoprotein (190.25) NCD.

### For gamma glutamyl transferase

- **Add** ICD-9-CM codes 273.73, 237.79, 275.01, 275.02, 275.03, 275.09, 560.32, 780.66, 970.81, and 970.89 to the list of ICD-9-CM codes covered by Medicare for the gamma glutamyl transferase (190.32) NCD.
- **Delete** ICD-9-CM codes 275.0 and 970.8 from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD.

### For hepatitis panel/acute hepatitis panel

- **Add** ICD-9-CM code 780.33 to the list of ICD-9-CM codes covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

### For fecal occult blood test

- **Add** ICD-9-CM codes 287.41, 287.49, and 560.32 to the list of ICD-9-CM codes covered by Medicare for the fecal occult blood test (190.34) NCD.
- **Delete** ICD-9-CM code 287.4 from the list of covered ICD-9-CM codes for the fecal occult blood test (190.34) NCD.

### Additional information

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

The official instruction, CR 7057, issued to your Medicare carrier, FI, or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2001CP.pdf*.

*MLN Matters*® Number: MM7057
Related Change Request (CR) Number: 7057
Related CR Release Date: July 16, 2010
Related CR Transmittal Number: R2001CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-4, Transmittal 2001, CR 7057



## Dermal injections for treatment of facial lipodystrophy syndrome

*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, hospitals, and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for facial lipodystrophy services provided to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 6953, which informs Medicare contractors that effective for claims with dates of service on and after March 23, 2010, dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration (FDA) for this purpose, and then only in human immunodeficiency virus (HIV)-infected Medicare beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

### Background

The Centers for Medicare & Medicaid Services (CMS) received a request for national coverage of treatments for facial LDS for human immunodeficiency virus (HIV)-infected Medicare beneficiaries. LDS is often characterized by a loss of fat that results in a facial abnormality such as severely sunken cheeks. This fat loss can arise as a complication of HIV and/or highly active antiretroviral therapy (HAART). Due to their appearance, patients with LDS may become depressed, socially isolated, and in some cases may stop their HIV treatments in an attempt to halt or reverse this complication.

### Nationally covered indications

Effective for claims with dates of service on and after March 23, 2010, dermal injections for LDS are only reasonable and necessary using dermal fillers approved by

***Dermal injections for treatment of facial lipodystrophy syndrome (continued)***

the Food and Drug Administration (FDA) for this purpose, and then only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment.

### Nationally noncovered indications

- Dermal fillers that are not approved by the FDA for the treatment of LDS
- Dermal fillers that are used for any indication other than LDS in HIV-infected individuals who manifest depression as a result of their antiretroviral HIV treatments.

### Claims coding/pricing information

Effective with the July 2010 Healthcare Common Procedure Coding System (HCPCS) update, the July Medicare physician fee schedule (MPFS), and the July integrated outpatient code editor (IOCE):

- HCPCS codes Q2026, Q2027, and G0429 will be designated for dermal fillers Sculptra® and Radiesse®
- HCPCS codes Q2026, Q2027, and G0429 are effective for dates of service on or after March 23, 2010
- HCPCS codes Q2026 and Q2027 are contractor-priced under the July MPFS
- HCPCS code G0429 is payable under the July MPFS.

**However, because HCPCS Q2026, Q2027 and G0429 are not considered valid HCPCS until implementation of the July 2010 HCPCS update, providers will not be able to bill and receive payment for these HCPCS codes prior to July 6, 2010.**

Therefore, included in the July 2010 HCPCS update and in the July IOCE is a temporary HCPCS code C9800, which was created to describe both the injection procedure and the dermal filler product. This code provides a payment mechanism to hospital outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) providers until average sales price (ASP) or wholesale acquisition cost (WAC) pricing information becomes available. When ASP or WAC pricing information becomes available, the temporary HCPCS code will be deleted and separate payment will be made under the OPPS and ASC payment systems for HCPCS Q2026, Q2027, and G0429.

For hospital institutional non-OPPS claims, Medicare contractors will use current payment methodologies for claims for dermal injections for treatment of LDS.

### Hospital and ASC billing instructions

For hospital outpatient claims, hospital institutional non-OPPS claims, and ASCs, covered dermal injections for treatment of LDS must be billed by having all the required elements on the claim:

- A line with HCPCS codes Q2026 or Q2027 with a line item date of service (LIDOS) on or after March 23, 2010
- A line with HCPCS code G0249 with a LIDOS on or after March 23, 2010
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (lipodystrophy)

Medicare will line item deny institutional claims where the LIDOS is prior to March 23, 2010.

**Note to OPPS hospitals or ASCs**: For line item dates of service on or after March 23, 2010, and until pricing information is made available to price OPPS claims, LDS claims will contain the temporary HCPCS code C9800, instead of HCPCS G0429 and HCPCS Q2026/Q2027, as shown above.

**Note on all hospital claims:** An ICD-9-CM diagnosis code for a depression-comorbidity may also be required for coverage on an outpatient and/or inpatient basis as determined by the individual Medicare contractor's policy.

### Practitioner billing instructions

Practitioners must bill covered claims for dermal injections for treatment of LDS by having all the required elements on the claim:

- A date of service (LIDOS) on or after March 23, 2010
- HCPCS codes Q2026 0r Q2027
- A line with HCPCS code G0249
- ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (Lipodystrophy).

**Note:** An ICD-9-CM diagnosis code for a depression comorbidity may also be required for coverage based on the individual Medicare contractor's policy.

### Billing for services prior to Medicare coverage

ASCs and practitioners billing for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following messages upon their Medicare denial:

- **Remittance advice remark code (RARC) N386**: This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/mcd/search.asp*.

  If you do not have web access, you may contact your local contractor to request a copy of the NCD.

- **Group code**: contractual obligation (CO)

Medicare beneficiaries whose provider bills Medicare for dermal injections for treatment of LDS prior to the coverage date of March 23, 2010, will receive the following Medicare summary notice (MSN) message upon the Medicare denial:

- **21.11**: This service was not covered by Medicare at the time you received it.

### Billing for services not meeting comorbidity coverage requirements

Hospitals and practitioners billing for dermal injections for treatment of LDS on patients that do not have on the claim both ICD-9-CM diagnosis codes of 042 and 272.6, indicating HIV and lipodystrophy will receive the following messages upon their Medicare claims denial:

***Dermal injections for treatment of facial lipodystrophy syndrome (continued)***

- **CARC 50**: These are noncovered services because this is not deemed a "medical necessity" by the payer. **Note**: Refer to the 835 health care policy identification segment (loop 2110 Service Payment Information REF), if present.
- **RARC M386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact your local contractor to request a copy of the NCD.
- **Group code:** contractual obligation (CO)

Medicare beneficiaries who do not meet Medicare comorbidity requirements of HIV and lipodystrophy (or even depression if deemed required by the Medicare contractor) and whose provider bills Medicare for dermal injections for treatment of LDS will receive the following MSN message upon the Medicare denial:

- **15.4:** The information provided does not support the need for this service or item.

### Additional information

The official instruction, CR 6953, issued to your carrier, FI, and A/B MAC regarding this change via two transmittals. The first transmittal revised the *Medicare NCD Manual* and it may be viewed on the CMS website at *http://www.cms.gov/transmittals/downloads/R122NCD.pdf*.

The second transmittal revises the *Medicare Claims Processing Manual* and it is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1978CP.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: MM6953
Related Change Request (CR) Number: 6953
Related CR Release Date: June 4, 2010
Related CR Transmittal Number: R122NCD and R1978CP
Effective Date: March 23, 2010
Implementation Date: July 6, 2010

Source: CMS Pub. 100-04, Transmittal 1978, CR 6953



## Provisions in the Affordable Care Act of 2010

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

### Provider types affected

All providers that bill Medicare for services provided to Medicare beneficiaries.

### Provider action needed

Providers should be aware of these provisions and frequently visit the Centers for Medicare & Medicaid Services (CMS) website for updates on their implementation.

### Background

The Affordable Care Act (ACA), signed into law on March 23, 2010, includes a number of provisions designed to help physicians. Some of those changes are reflected in the notice of proposed rulemaking (NPRM), CMS-1503-P. (CMS is accepting comments on the proposed rule until August 24, 2010, and will respond to them in a final rule to be issued on or about November 1, 2010, that sets forth the policies and payment rates effective for services furnished to Medicare beneficiaries on or after January 1, 2011.)

### Provisions in the Affordable Care Act

#### Coverage of annual wellness visit providing a personalized prevention plan

The ACA extends the preventive focus of Medicare coverage, which currently pays for a one-time only initial preventive physical examination (also known as the "Welcome to Medicare Visit"). Medicare will cover annual wellness visits where beneficiaries receive personalized prevention plan services.

#### Elimination of deductible and coinsurance for most preventive services

Effective January 1, 2011, the ACA waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services, specifically for Medicare covered preventive services that have been recommended with a grade of A ("strongly recommends") or B ("recommends") from the U.S. Preventive Services Task Force, as well as the initial preventive physician examination and the annual wellness visit. The ACA also waives the Part B deductible for colorectal cancer screening tests that become diagnostic.

#### Incentive payments to primary care practitioners for primary care services

The ACA authorizes CMS to make incentive payments equal to 10 percent of the provider's allowed charges for primary care services furnished by certain physician and nonphysician specialties that are designated as primary care practitioners. This provision begins with calendar year

***Provisions in the Affordable Care Act of 2010 (continued)***

2011. Primary care practitioners are physicians (1) who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's allowed charges under Part B for a prior period as determined by the Secretary of Health & Human Services.

### Incentive payments for general surgery services in rural areas

The ACA calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the Medicare physician fee schedule – in health professional shortage areas (HPSAs) between January 1, 2011, and December 31, 2016. To be eligible for the incentive payment, you must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the payment for the surgical services furnished by the general surgeon occurring in a ZIP code that is located in an area designated as a primary care HPSA.

### Revisions to the practice expense geographic adjustment to assist rural providers

The ACA limits recognition of local differences in employee wages and office rents in the practice expense geographic adjustments (PE GPCI's) for calendar year 2010 and 2011 as compared to the national average. Localities are held harmless to any decrease in 2010 and 2011 in their PE GPCIs that would result from this alternative methodology. The new law also establishes a permanent 1.0 floor for the PE GPCI for frontier states (Montana, Wyoming, Nevada, North Dakota, and South Dakota), raising the rural area payment for physicians' services to be no less than the national average.

### Physician self-referral for certain imaging services

The ACA amends the in-office ancillary services exception to the self-referral law as applied to advanced imaging services, such as magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that there are other suppliers of these imaging services, along with a list of other suppliers in the area in which the patient resides.

### Misvalued codes under the physician fee schedule

The ACA requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. Building on this authority, the new rule identifies additional categories of services that may be misvalued, including codes with low work relative value units (RVUs) commonly billed in multiple units per single encounter and codes with high volume and low work RVUs.

### Modification of equipment utilization factor for advanced imaging services

The ACA adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment to more consistently reflect the typical actual use of the equipment and, thereby, reduces payment rates for the associated procedures. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the ACA increases the established multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

### Maximum period for submission of Medicare claims reduced to not more than 12 months

The ACA changes the time frame during which claims may be submitted for physicians' services to one year from the date of service, beginning with services furnished on or after January 1, 2010. This reflects a reduction in the maximum prior timely filing deadline of 15 to 27 months and aims to improve prompt payment and improve program integrity.

## Additional information

You may find information (as of June 11, 2010) on CMS published regulations, CMS policy instructions, key implementation dates, and other accomplishments that relate to ACA on the CMS website at *https://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf*.

Many of the new provisions outlined in the ACA are reflected in the proposed Medicare physician fee schedule regulation, which may be found on the Internet at *http://www.federalregister.gov/inspection.aspx*.

You may also find a beneficiary brochure that provides information about the services and benefits of the new health care law (Medicare and the New Health Care Law – What it Means for You) at *http://www.medicare.gov/Publications/Search/Results.asp?PubID=11467&Type=PubID*.

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

*MLN Matters*® Number: SE1023
Related Change Request (CR) Number: N/A
Related CR Release Date: N/A
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Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE1023

# Magnetic resonance angiography

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

## Provider types affected

All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FI], carriers, and A/B Medicare administrative contractors [MAC]) for magnetic resonance angiography (MRA) services provided to Medicare beneficiaries are affected.

## Provider action needed

This article is based on change request (CR) 7040. You need to know that, effective for claims with dates of services on or after June 3, 2010, Medicare contractors will have the discretion to cover or not cover all indications of MRA (and magnetic resonance imaging [MRI]) that are not specifically nationally covered or nationally noncovered. Existing national coverage for both MRI and MRA will be maintained. Please ensure that your billing staffs are aware of these changes.

## Background

The Centers for Medicare & Medicaid Services (CMS) in October, 1995, set forth the original conditions under which MRA would be covered. Revisions to the national coverage determination (NCD) policy took place in 1997, 1999, and 2003 to expand coverage for additional indications. Currently covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest. All other uses of MRA are nationally noncovered unless coverage is specifically indicated.

In addition, CMS recently reconsidered the NCD for MRI at section 220.2 of the *NCD Manual* and removed national noncoverage for MRI for blood flow determination, thereby permitting local Medicare contractors to make local coverage determinations within their respective jurisdictions effective for claims with dates of service on or after June 3, 2010. Such local determinations would apply to all indications of MRA/MRI that are not specifically covered nationally or noncovered nationally.

While reviewing published scientific evidence for the MRI reconsideration, CMS became aware of evidence that may speak to currently noncovered indications for MRA. As a result, CMS initiated this reconsideration to evaluate the current evidence for the noncovered indications for the MRA NCD at Section 220.3.C of the *National Coverage Determination (NCD) Manual*.

MRA is a specific application of MRI. CMS believes that the continued existence of separate NCDs is unnecessary, and that the provisions of the MRA NCD at Section 220.3 should be merged under the NCD for MRI at Section 220.2. Thus, Section 220.3, MRA, of the *National Coverage Determination (NCD) Manual*, will no longer appear as a separate NCD.

The effect of this change will maintain existing national coverage for both MRI and MRA, and will eliminate the noncoverage language that currently exists for MRA at section 220.3.C of the *National Coverage Determination (NCD) Manual*, thereby permitting local Medicare contractors to cover (or not cover) all indications of MRA (and MRI) that are not specifically nationally covered or nationally noncovered.

## Additional information

The official instruction, CR 7040, was issued to your Medicare contractor via two transmittals. The first transmittal modifies the *National Coverage Determination (NCD) Manual* as discussed above and that transmittal is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R123NCD.pdf*.

The second transmittal updates the *Medicare Claims Processing Manual* and that is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1998CP.pdf*.

If you have questions, please contact your Medicare carrier 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: MM7040
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Related CR Release Date: July 9, 2010
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Effective Date: June 3, 2010
Implementation Date: August 9, 2010

Source: CMS Pub. 100-04, Transmittal 1998, CR 7040

## Solicitation for proposal to participate in the Medicare imaging demonstration

The Centers for Medicare & Medicaid Services (CMS) has announced that it is soliciting proposals for participation in the Medicare Imaging Demonstration (MID). The MID was authorized by Section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008 and will test whether the use of decision support systems (DSSs) can improve quality of care and reduce unnecessary radiation exposure and utilization by promoting appropriate ordering of advanced imaging services.

The two-year demonstration will assess the impact that DSSs used by physician practices have on the appropriateness and utilization of advanced medical imaging services ordered for the Medicare fee-for-service population. A DSS provides immediate feedback based on current medical specialty guidelines to the physician on the appropriateness of the test ordered for the patient. In addition, the demonstration will focus on magnetic resonance imaging, computed tomography, and nuclear medicine advanced imaging diagnostic services.

All current Medicare coverage and payment policies are unaffected under this demonstration. Prior authorization processes, which may be used to deny coverage for tests, are not part of the demonstration.

CMS will use "conveners" to reach eligible physicians interested in participating in the demonstration. Conveners will be responsible for recruiting physician practices, deploying a DSS that incorporates medical specialty society guidelines for the selected procedures, ensuring the DSS remains current with those guidelines, collecting and transmitting data, and distributing payments to practices for reporting data. Conveners and physician practices will be paid for reporting complete data necessary to determine the appropriateness of the test.

A wide variety of interested parties may be eligible to apply as conveners or in collaboration with other organizations to perform the responsibilities specified in the demonstration. Examples of conveners include, but are not limited to, physician groups, integrated health care delivery systems, independent practice associations, radiology benefit managers, health plans, information technology vendors, medical specialty societies, and collaborations among the above parties.

CMS is particularly interested in proposals from conveners that involve a diverse mix of physician practice sizes and types, medical specialties, and geographic areas. CMS will consider the characteristics of the physician practices and the ability of the convener to perform the functions identified in the solicitation when selecting demonstration areas. Award is contingent on the acceptance of CMS demonstration terms and conditions prior to the start of the demonstration.

Eleven advanced imaging procedures – SPECT myocardial perfusion imaging (MPI), magnetic resonance imaging (MRI) lumbar spine, computerized tomography (CT) lumbar spine, MRI brain, CT brain, CT sinus, CT thorax, CT abdomen, CT pelvis, MRI knee, and MRI shoulder – will be included in the demonstration. The 11 tests were selected based on high expenditures and utilization in the Medicare fee-for-service population and the availability of relevant medical specialty appropriateness guidelines. The law requires that the appropriateness criteria used in the demonstration be based on those developed or endorsed by medical specialty societies. CMS worked with medical specialty societies and other stakeholders, including the AQA Alliance, to solicit their input and information on available appropriateness criteria.

Applications are due to CMS by September 21, 2010.

Additional information about this demonstration including how to apply may be found at *http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1222075*.

Questions on this demonstration may be submitted to CMS at *ImagingDemo135b@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 201007-44

### Use the PDS report to improve your Medicare billing operations

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

# Medicare reporting and payment of services for alcohol and/or substance abuse other than tobacco

*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, nonphysician practitioners, and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for certain mental health services provided to Medicare beneficiaries.

## Impact on providers

This article is informational only and does not alter existing Medicare policy nor does it introduce new policy.

## Background

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS), working with the Substance Abuse and Mental Health Services Administration (SAMHSA), to inform Medicare providers about reporting and payment for the appropriate delivery of alcohol and/or substance (other than tobacco) abuse structured assessment and brief intervention (SBIRT) services.

SBIRT is an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach is in contrast with the primary focus of specialized treatment of individuals with more severe substance use, or those who have met the criteria for diagnosis of a substance use disorder.

In the 2008 Medicare physician fee schedule (MPFS), Medicare created two Healthcare Common Procedure Coding System (HCPCS) G-codes to allow for the appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services. See MM5895 (related to CR 5895, Transmittal R1423CP, February 1, 2008 (Summary of Policies in the 2008 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount) on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM5895.pdf*.

Additionally, these services are paid under the hospital outpatient prospective payment system (OPPS). See the January 2008 Update of the OPPS – Manualization, which includes a summary of the OPPS policies regarding these codes on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM5946.pdf*.

These two HCPCS G-codes are:
G0396 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes

G0397 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes

**These HCPCS G-codes (G0396 and G0397) allow for appropriate Medicare reporting and payment for alcohol and substance abuse assessment and intervention services, but only those services that are performed for the diagnosis or treatment of illness or injury.**

Medicare contractors will consider payment for HCPCS codes G0396 and G0397 only when medically reasonable, and necessary (i.e., when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) as per the Social Security Act (Section 1862(a)(1)(A)). It is important to remember that Medicare only covers SBIRT services that are reasonable and necessary and meet the requirements of diagnosis or treatment of illness or injury.

### Structured assessment and brief intervention (SBIRT) services

Medicare pays for medically reasonable and necessary SBIRT services when they are delivered in the following settings: physicians' offices and outpatient hospitals. Providers assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment.

## General principles of medical record documentation for individual mental health services

It is important to remember that all claims for Medicare services must be supported by information in the patient's medical record, and the general principles of medical record documentation for the reporting of SBIRT services for Medicare payments include the following as applicable to the specific setting/encounter (See CR 2520 [Transmittal AB-03-037] on the CMS website at *http://www.cms.gov/Transmittals/downloads/AB03037.pdf*):

- Medical records should be complete and legible
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history
  - Physical examination findings and prior diagnostic test results
  - Assessment, clinical impression, and diagnosis
  - Plan for care
  - Date and legible identity of observer
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Documentation must denote start/stop time or total face-to-face time with the patient, because the SBIRT G-codes are time-based codes
- Past and present diagnoses should be accessible for the treating and/or consulting physician
- Appropriate health risk factors should be identified
- The patient's progress, response to changes in treatment, and revision of diagnosis should be documented

***Medicare reporting and payment of services for alcohol and/or substance abuse other than tobacco (continued)***

- The *CPT* and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim should be supported by documentation in the medical record.

Like all providers of services billed to Medicare, it is essential that providers of mental health services document their services fully in the medical record, because if the records are incomplete, the provider is at risk of losing Medicare payments in the event of a claims audit.

## Qualifications of practitioners providing mental health services that are covered under Medicare

In order to bill Medicare, providers of mental health services must be qualified to perform the specific mental health services rendered. In order for these services to be covered, mental health professionals must be working within their state scope of practice act, and licensed (or certified) to perform mental health services by the state in which the services are performed. See CR 2520 (Transmittal AB-03-037, March 28, 2003) at *http://www.cms.gov/Transmittals/downloads/AB03037.pdf*.

### Physician

A qualified physician must be legally authorized to practice medicine by the state in which he/she performs his/her services, and perform his/her services within the scope of his/her license as defined by state law.

### Clinical psychologist

A clinical psychologist (CP) must hold a doctoral degree in psychology; and be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

In general, CP services are covered in the same manner as physician's services. CPs must be legally authorized to perform the services under applicable licensure laws of the state in which they are furnished.

See 42 CFR 410.71 at *http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.71.htm* and the *Medicare Benefits Policy Manual* (Chapter 15, Section 160) at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf* for the covered services of a CP.

### Clinical social workers

A clinical social worker (CSW) must possess a master's or doctor's degree in social work; have performed at least two years of supervised clinical social work; and be licensed or certified as a clinical social worker by the state in which the services are performed.

In the case of an individual in a state that does not provide for licensure or certification, the individual must be licensed or certified at the highest level of practice provided by the laws of the state in which the services are performed. As well, the CSW must have completed at least two years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, skilled nursing facility (SNF), or clinic.

See 42 CFR 410.73 at *http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.73.htm* and the *Medicare Benefits Policy Manual* (Chapter 15, Section 170) for the covered services of a CSW.

### Nurse practitioner

A nurse practitioner (NP) must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. They must also be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner by December 31, 2000.

NPs who applied to be a Medicare billing supplier for the first time on or after January 1, 2001, and prior to January 1, 2003, must be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law. As well, they must be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners. The following organizations are recognized national certifying bodies for NPs at the advanced practice level:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses)
- Oncology Nurses Certification Corporation
- AACN Certification Corporation
- National Board on Certification of Hospice and Palliative Nurses.

NPs applying to be a Medicare billing provider for the first time on or after January 1, 2003, must possess a master's degree in nursing or a DNP degree from an accredited institution, be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a nurse practitioner in accordance with state law, and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.

See 42 CFR 410.75 at *http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.75.htm* and the *Medicare Benefits Policy Manual* (Chapter 15, Section 200) for the covered services of an NP.

### Clinical nurse specialist

A clinical nurse specialist (CNS) must be a registered nurse who is currently licensed to practice in the state where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with state law, have a master's degree in a defined clinical area of nursing from an accredited educational institution, and be certified as a clinical nurse specialist by a recognized

***Medicare reporting and payment of services for alcohol and/or substance abuse other than tobacco (continued)***

national certifying body that has established standards for a CNS. The following organizations are recognized national certifying bodies for CNSs at the advanced practice level:

- American Academy of Nurse Practitioners
- American Nurses Credentialing Center
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses)
- Oncology Nurses Certification Corporation
- AACN Certification Corporation
- National Board on Certification of Hospice and Palliative Nurses.

See 42 CFR 410.76 at *http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.76.htm* and the *Medicare Benefits Policy Manual* (Chapter 15, Section 210) for the covered services of a CNS.

### Physician assistant

A physician assistant (PA) must have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs and the Committee on Allied Health Education and Accreditation), or have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and be licensed by the state to practice as a PA.

See 42 CFR 410.74 at *http://edocket.access.gpo.gov/cfr_2009/octqtr/42cfr410.74.htm* and the *Medicare Benefits Policy Manual* (Chapter 15, Section 190) for the covered services of a PA.

## Medicare's outpatient mental health treatment limitation

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program. This limitation does not apply to payment made to facilities under the OPPS.

Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amends Section 1833(c) of the Social Security Act to phase out the outpatient mental health treatment limitation over a five-year period, from 2010-2014. MM6686 (related to CR 6686 – see *http://www.cms.gov/MLNMattersArticles/Downloads/MM6686.pdf* on the CMS website) alerts providers that CMS is phasing out the outpatient mental health treatment limitation over this five-year period.

The 62.5 percent limitation will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 – December 31, 2011, the limitation percentage is 68.75 percent.
  (Medicare pays 55 percent and the patient pays 45 percent).
- January 1, 2012 – December 31, 2012, the limitation percentage is 75 percent.
  (Medicare pays 60 percent and the patient pays 40 percent).
- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25 percent.
  (Medicare pays 65 percent and the patient pays 35 percent).
- January 1, 2014 – onward, the limitation percentage is 100 percent.
  (Medicare pays 80 percent and the patient pays 20 percent).

**Note:** There is no national policy that establishes whether the outpatient mental health treatment limitation (the limitation) applies to these SBIRT services. Therefore, the application of the limitation to the SBIRT services would be made by the local Medicare contractor.

## Additional information

For additional details about the outpatient mental health treatment limitation, please see the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 5, Section 100.4; Chapter 9, Section 60; and Chapter 12, Section 210 & Section 210.1E) at *http://www.cms.gov/Manuals/IOM/list.asp*.

For more information on SBIRT, please visit SAMHSA's website at *http://sbirt.samhsa.gov*.

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

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Source: CMS Special Edition *MLN Matters*® Article SE1013

# 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

## Table of contents

### Additions/revisions to existing LCDs



### Advance beneficiary notice

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

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

# ADDITIONS/REVISIONS TO EXISTING LCDS

## A70544: Magnetic resonance angiography (MRA) – revision to the LCD

**LCD ID Number: L28903 (Florida)**
**LCD ID Number: L28925 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for magnetic resonance angiography (MRA) was most recently revised on October 5, 2009. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS), transmittals 123 and 1998, change request 7040, dated July 9, 2010. In this regard, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to remove the following statement: All other uses of MRA for which CMS has not specifically indicated coverage continue to be noncovered.

### Effective date

This LCD revision is effective for claims processed **on or after August 9, 2010,** for services provided **on or after June 3, 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. ❖

## A77078: Bone mineral density studies – revision to the LCD

**LCD ID Number: L28766 (Florida)**
**LCD ID Number: L28767 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for bone mineral density studies was most recently revised on March 19, 2009. Since that time, the "Frequency Standards" under the "Indications and Limitations of Coverage and/or Medical Necessity" and "Utilization Guidelines" sections of the LCD have been revised to add denosumab (prolia) to the list of agents approved by the Food and Drug Administration (FDA) for osteoporosis prevention and/or treatment.

### Effective date

This LCD revision is effective for claims processed **on or after July 13, 2010,** for services provided **on or after June 1, 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. ❖

## A93965: Non-invasive evaluation of extremity veins – revision to the LCD

**LCD ID Number: L28936 (Florida)**
**LCD ID Number: L28957 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for noninvasive evaluation of extremity veins was most recently revised on October 1, 2009. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to include descriptors for physiologic studies and plethysmography procedures. The "Training Requirements" section of the LCD has also been revised to add language regarding the definition of a physician.

In addition, the LCD "Coding Guidelines" attachment has been revised and updated. Revisions include the addition of the following statements:

- Noninvasive physiologic studies are performed using equipment separate and distinct from the duplex scanner. *CPT* code *93965* describes the evaluation of non-imaging physiologic recordings of pressures, Doppler analysis of bi-directional blood flow, plethysmography, and/or oxygen tension measurements appropriate for the anatomic area studied (2009 *CPT*).
- Performance of both physiological tests (*CPT* code *93965*) and duplex scanning (*CPT* code *93970* or *93971*) of extremity veins during the same encounter would not generally be expected.
- Since the signs and symptoms of arterial occlusive disease and venous disease are so divergent, the performance of simultaneous arterial and venous studies during the same encounter should be rare.
- When an uninterpretable study results in performing another type of study, only the successful study should be billed.

***A93965: Non-invasive evaluation of extremity veins (continued)***

### Effective date

This LCD revision is effective for services provided **on or after July 8, 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. ❖



## ABOTULINUM TOXINS: Botulinum toxins – revision to the LCD

**LCD ID Number: L28788 (Florida)**
**LCD ID Number: L28790 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for botulinum toxins was most recently revised on January 1, 2010. Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to update the language and to add language regarding the differences in preparations for botulinum toxins. A bullet was also added under the "FDA Indications for Botox®" section for "upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and finger flexors (flexor digitorum profundus and flexor digitorum sublimis)".

The "ICD-9-CM Codes that Support Medical Necessity" section of the LCD has been revised for procedure code J0585, to add ICD-9-CM code 705.22 and to delete ICD-9-CM codes 343.0, 728.85 and 780.8. This notification serves as a 45-day notice that these deleted ICD-9-CM codes will no longer be allowed for procedure code J0585.

The "ICD-9-CM Codes that Support Medical Necessity" section of the LCD has also been revised for procedure code J0586, to add ICD-9-CM codes 333.81, 333.82, 342.11, 342.12 and 705.21.

The LCD "Coding Guidelines" attachment has been revised to add coding information and an associated table for the administration of botulinum toxins that correspond to the covered conditions addressed in the LCD.

### Effective date

This LCD revision is effective for services provided **on or after September 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. ❖

## ANCSVCS: The list of Medicare noncovered services – revision to the LCD

**LCD ID Number: L28991 (Florida)**
**LCD ID Number: L29023 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for the list of Medicare noncovered services was most recently revised on June 7, 2010. Since that time, based on guidance from the Centers for Medicare & Medicaid Services (CMS), the LCD for the list of Medicare noncovered services is being revised to remove *CPT* code *90662 (Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use*) from the "*CPT*/HCPCS Codes, Local Noncoverage Decisions, Drugs and Biologicals" section of the LCD.

### Effective date

This LCD revision is effective for services provided **on or after July 1, 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. ❖

## ASKINSUB: Skin substitutes – revision to the LCD

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

The local coverage determination (LCD) for skin substitutes was most recently revised on February 4, 2010. Since that time, a revision was made to the LCD based on change request 6996 (July 2010 Update of the Hospital Outpatient Prospective Payment System [OPPS]) issued by the Centers for Medicare & Medicaid Services (CMS).
A review of HCPCS code C9367 (Skin substitute, Endoform Dermal Template, per square centimeter) determined that this skin substitute code should be added to the "Non-Covered Products" section of the "*CPT*/HCPCS Codes" section of the LCD.

### Effective date

This LCD revision is effective for claims processed **on or after July 6, 2010,** for services provided **on or after July 1, 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*.

# HOSPITAL SERVICES

## Updates to the inpatient and outpatient hospital, long-term care hospital, and inpatient rehabilitation facility prospective payment system changes due to the Affordable Care Act

*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, long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and other providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services paid under one of the subject prospective payment systems.

### Provider action needed

#### STOP – impact to you

This article is based on change request (CR) 7029 which outlines changes for inpatient prospective payment system (IPPS) hospitals for federal fiscal year (FY) 2010, LTCHs for rate year (RY) 2010, IRFs for FY 2010, and outpatient prospective payment system (OPPS) for calendar year (CY) 2010 as a result of the Affordable Care Act (ACA).

#### CAUTION – what you need to know

The policy changes reflected in CR 7029 will appear in upcoming *Federal Register* notices for the IPPS/LTCH PPS, OPPS and IRF PPS. The changes in CR 7029 have various retroactive effective dates, and Medicare contractors will be instructed in a change request (CR) on how to handle past claims paid under pre-ACA requirements. Once that CR is released, a related article will be available on the Centers for Medicare & Medicaid Services (CMS) website.

#### GO – what you need to do

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

### Background

Several of the provisions of the Affordable Care Act (ACA) affect the FY2010 IPPS, the rate year (RY) 2010 LTCH PPS, and the CY 2011 OPPS. In particular, certain provisions require changes to the wage index and market basket update and, as a result, changes to area wage indices (including the statewide rural floor budget neutrality adjustments under the IPPS and OPPS, rates, and outlier thresholds for these provider payment systems.
CR 7029 outlines changes (as a result of the ACA) as follows:

### Inpatient prospective payment system updates

#### Extension of section 508 reclassifications and special exceptions wage indices and changes to the FY 2010 IPPS wage index

Sections 3137(a) and 10317 of the Affordable Care Act retroactively extend Section 508 reclassifications and special exceptions wage indices through September 30, 2010 (that is, for discharges occurring on or after October 1, 2009, through discharges on or before September 30, 2010). Effective April 1, 2010, Section 10317 also requires removing Section 508 and special exceptions hospitals' wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. As a result of these changes to the wage index (and the changes to the market basket update as discussed below), many of the originally published FY 2010 IPPS wage indices (including the statewide rural floor budget neutrality adjustment factors) have changed for either all of FY 2010 (for Section 508 and special exceptions hospitals) or for only the second half of FY 2010 (for all other IPPS hospitals).

All Section 508 and special exceptions hospitals affected by sections 3137(a) and 10317 will be assigned an individual special wage index effective October 1, 2009. A Section 508 or special exceptions hospital shall be assigned, for the entire FY 2010, the higher of its wage-index value from the FY 2010 IPPS final rule (74 FR 44032-44078, August 27, 2009), and correction notice (74 FR 51496-51507, October 7, 2009), or its wage index value under the revised FY 2010 wage-index values effective April 1, 2010. Attachment A of CR 7029 (the CR is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R728OTN.pdf*) shows the wage indices for the Section 508 or special exceptions hospitals paid under the IPPS for discharges on or after October 1, 2009, through discharges on or before September 30, 2010.

For all other IPPS providers not listed in Attachment A of CR 7029, the revised FY 2010 wage indices (including the revised statewide rural floor budget neutrality adjustment factors) resulting from the implementation of Sections 3137 and 10317 of the ACA (and the change in the market basket update as discussed below) are effective only for discharges occurring on or after April 1, 2010, and on or before September 30, 2010.

The revised FY 2010 IPPS wage indices discussed above for Section 508/special exceptions hospitals and all other IPPS hospitals are included in the latest version of PRICER. Updated IPPS wage-index tables reflecting the revised wage indices that are effective April 1, 2010, through September 30, 2010, (Table 2 – providers' case mix indices, wage indices, and average hourly wages; Tables 4A, 4B, and 4C – urban, rural, and reclassified area wage indices; and Table 4D-1 – statewide rural floor budget neutrality factors) may be downloaded from the CMS website at *http://www.cms.gov/AcuteInpatientPPS/WIFN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1234175&intNumPerPage=10*.

***Updates to the inpatient and outpatient hospital, LTCH, and IRF PPS changes due to the Affordable Care Act (continued)***

The following lists the IPPS providers with Medicare Geographic Classification Review Board (MGCRB) reclassifications and their revised wage index values for the second half of FY 2010 (April 1, 2010 – September 30, 2010):

| Provider number | special wage index effective 4/1/10-9/30/10 |
|---|---|
| 070015 | 1.2695 |
| 070033 | 1.2695 |
| 310002 | 1.2769 |
| 310009 | 1.2769 |
| 310015 | 1.2769 |
| 310017 | 1.2769 |
| 310018 | 1.2769 |
| 310038 | 1.2769 |
| 310039 | 1.2769 |
| 310054 | 1.2769 |
| 310070 | 1.2769 |
| 310076 | 1.2769 |
| 310083 | 1.2769 |
| 310093 | 1.2769 |

| Provider number | special wage index effective 4/1/10-9/30/10 |
|---|---|
| 310096 | 1.2769 |
| 310108 | 1.2769 |
| 310119 | 1.2769 |
| 330027 | 1.2930 |
| 330167 | 1.2930 |
| 330181 | 1.2930 |
| 330182 | 1.2930 |
| 330198 | 1.2930 |
| 330225 | 1.2930 |
| 330259 | 1.2930 |
| 330331 | 1.2930 |
| 330332 | 1.2930 |
| 330372 | 1.2930 |

All of the hospitals listed within this section are reclassified under Section 508 of the MMA or reclassified through the MGCRB.

### Market basket-update reduction for IPPS

Section 3401(a) of the ACA imposes a 0.25 percentage point reduction to the IPPS market basket update for FY 2010 that is applied to the operating standardized amounts and hospital-specific rates for sole community hospitals and Medicare dependant hospitals. This law also specified that the revised FY 2010 rates only apply to payments made for discharges occurring on or after April 1, 2010. As a result of this provision, CMS updated the IPPS standardized amounts, budget neutrality factors and outlier threshold to be applied in making payments for discharges on or after April 1, 2010, through discharges occurring on or before September 30, 2010, the second half of FY 2010. CMS notes that as a result of implementing these provisions of the ACA, for sole community hospitals and Medicare dependant hospitals, for discharges on or after April 1, 2010, through discharges on or before September 30, 2010, the PRICER will apply the revised diagnostic related group (DRG) reclassification and recalibration budget neutrality factor of 0.997935 to the hospital specific rate (see the "FY 2010 IPPS Rates" table below). (For sole community hospitals and Medicare dependant hospitals, for discharges on or after October 1, 2009, through discharges on or before March 30, 2010, the DRG reclassification and recalibration budget neutrality factor of 0. 997941 is applied to the hospital specific rate.) The updated FY 2010 IPPS rates, budget neutrality factors and outlier thresholds are listed in the tables below.

### FY 2010 IPPS rates (effective for discharges on or after April 1, 2010, through discharges on or before September 30, 2010)

| | |
|---|---|
| National standardized amounts update factor | 1.0185<br>0.9985 (for hospitals that do not submit quality data) |
| Puerto Rico specific standardized amounts update factor | 1.021<br>1.021 (for hospitals that do not submit quality data) |
| MDH/SCH hospital specific update factor | 1.0185<br>0.9985 (for hospitals that do not submit quality data) |
| Outlier fixed loss cost threshold | $23,135.00 |
| Federal capital rate | $429.56 |
| Puerto Rico capital rate | $203.57 |
| Outlier offset-operating national | 0.948998 |
| Outlier offset-operating Puerto Rico | 0.957417 |

*Updates to the inpatient and outpatient hospital, LTCH, and IRF PPS changes due to the Affordable Care Act (continued)*

**FY 2010 IPPS rates (effective for discharges on or after April 1, 2010, through discharges on or before September 30, 2010) (continued)**

| | |
|---|---|
| IME formula (no change for FY10) | 1.35 x [(1 + resident to bed ratio).405 – 1] |
| DRG reclassification and recalibration budget neutrality factor (applied to the hospital specific rate) | 0.997935 |

**Operating rates with FULL market basket**

| | Wage Index > 1 | | Wage Index ≤ 1 | |
|---|---|---|---|---|
| | Labor Share | Non-Labor Share | Labor Share | Non-Labor Share |
| National | $3,587.24 | $1,626.78 | $3,232.69 | $1,981.33 |
| PR national | $3,587.24 | $1,626.78 | $3,232.69 | $1,981.33 |
| PR specific | $1,543.61 | $942.07 | $1,541.12 | $944.56 |

**Operating rates with REDUCED market basket**

| | Wage Index > 1 | | Wage Index ≤ 1 | |
|---|---|---|---|---|
| | Labor Share | Non-Labor Share | Labor Share | Non-Labor Share |
| National | $3,516.80 | $1,594.84 | $3,169.22 | $1,942.42 |
| PR national | $3,587.24 | $1,626.78 | $3,232.69 | $1,981.33 |
| PR specific | $1,543.61 | $942.07 | $1,541.12 | $944.56 |

## Long-term care hospital prospective payment system updates

Section 3401(c) of the ACA imposes a 0.25 percentage point reduction to the LTCH market basket update for RY 2010. This law also specified that the revised RY 2010 rates only apply to payments made for discharges on or after April 1, 2010. Therefore, CMS has updated the LTCH standard federal rate and outlier threshold (shown in the following table) to be applied in making payments for discharges on or after April 1, 2010, through discharges on or before September 30, 2010, the second half of RY 2010.

| | |
|---|---|
| Federal rate | $39,794.95 |
| High cost outlier fixed-loss amount | $18,615.00 |

In addition, for making payments for the second half of RY 2010, the FY 2010 IPPS rates used to compute the "IPPS comparable amount" in the short-stay outlier (SSO) payment formula have also been updated to reflect the changes to those rates required by the ACA.

## Outpatient prospective payment system updates

Section 3401(i) of the Affordable Care Act, as amended by Section 10319 Pub. L. 111-148, imposes a 0.25 percentage point reduction to the OPPS hospital's market basket for CY 2010, effective for services furnished on or after January 1, 2010. Section 3137 of the Affordable Care Act as amended by Section 10317 extends wage index reclassifications under Section 508 and special exception reclassifications. Hospitals located in a CBSA that includes Section 508 reclassification or special exception reclassification will be paid using a revised wage index beginning April 1 under the IPPS and July 1 under the OPPS.

Further, Section 3137 as amended by Section 10317 specifies that if the Section 508 or special exception hospital's wage index applicable for the period beginning on October 1, 2009, and ending on March 31, 2010, is lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, the hospital shall be paid an additional amount that reflects the difference between the wage indices. The provision applies to both IPPS and OPPS hospital payments.

Instructions about how to handle past claims under pre-ACA requirements are forthcoming.

The new post-reclassification wage index values and changes to the hospital operating market basket affect the calculation of the CY 2010 OPPS conversion factor. For the CY 2010 OPPS final rule, CMS calculated a final conversion factor of $67.406 (74 FR 60419). CMS now calculates a revised CY 2010 OPPS conversion factor of $67.241 by applying the revised wage-index adjustment and the updated market basket. For a detailed discussion of the calculation of the conversion factor and the OPPS payment rates, please see the CY 2010 OPPS final rule claims accounting available online on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/Downloads/CMS_1414_FC_OPPS_2010_FR_Claims_Accounting_narrative.pdf* and the November 20, 2009, CY 2010 OPPS/ambulatory surgical center (ASC) final rule with comment period (74 FR 60419).

Due to the revised CY 2010 OPPS conversion factor, the CY 2010 OPPS payment rates for certain services based on the new conversion factor, effective January 1, 2010, will change. Consequently, any calculations based

***Updates to the inpatient and outpatient hospital, LTCH, and IRF PPS changes due to the Affordable Care Act (continued)***

on these revised OPPS payment rates would also change, including the OPPS copayment rates. Offset calculations that are based on payment rates have also changed, including the drug and device offsets available online at *http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage* and the device FB/FC modifier offsets available online on the CMS website at *http://www.cms.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage*.

Finally, Section 3121 of the ACA extends the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole community hospitals (SCHs) and essential access community hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010, through December 31, 2010 and these providers will receive transitional outpatient payments (TOPs) at 85 percent of the hold harmless amount until December 31, 2010. Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments in CY 2010.

### Changes to payments for certain drugs and biologicals

In addition to these changes created by the affordable care act, the copayment for diagnostic radiopharmaceuticals, implantable biologicals and contrast agents with pass-through status was incorrect in the April OPPS PRICER, version 2.0. The copayment amount is now correct in the updated OPPS PRICER, version 2.2.

### Changes to outpatient prospective system PRICER logic

- The OPPS PRICER is revised to reflect the CY 2010 OPPS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by Sections 3401 and 3137 of the ACA, respectively, effective for services furnished on and after January 1, 2010. New OPPS payment rates and copayment amounts will be effective for services furnished on and after January 1, 2010.
- Update unrelated to ACA – The OPPS PRICER is revised to reflect zero copayments for the diagnostic radiopharmaceuticals, implantable biologicals and contrast agents with pass-through status beginning January 1, 2010, as the OPPS PRICER, version 2.0, incorrectly included a copayment for those items.
- Update unrelated to ACA – The OPPS PRICER is revised to reflect correct payment amounts for three Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biological, effective April 1, 2010. The corrected payment rates are listed below and in CR 6996.

| HCPCS code | Status indicator | APC | Short descriptor | Corrected payment rate | Corrected minimum unadjusted copayment |
|---|---|---|---|---|---|
| C9258 | G | 9258 | Telavancin injection | $2.12 | $0.42 |
| C9262 | G | 9262 | Fludarabine phosphate, oral, 1 mg | $8.18 | $1.61 |
| J1540 | K | 0923 | Gamma globulin 9 CC inj | $141.64 | $28.33 |

- Effective for services furnished on and after January 1, 2010, all SCHs and EACHs will be eligible for TOPs without regard to the bed size of the facility. Effective for services furnished on and after January 1, 2010, small rural hospitals with 100 or fewer beds will be eligible for TOPs. Rural SCH/EACHs will continue to receive a 7.1 percent payment increase for most services in CY 2010. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173.
- Although copayment amounts will change as a result of the recalculation of the CY 2010 OPPS payment rates, all coinsurance rates remain limited to a maximum of 40 percent of the ambulatory payment classification (APC) payment rate. Copayment amounts for each service continue to be limited to the inpatient deductible of $1,100.
- Effective January 1, 2010, CMS is adopting the final FY 2010 IPPS post-reclassification wage-index values as revised by section 3137(a) as amended by 10317 of Pub. L. 111-148 for the calendar year, including extension of Section 508 reclassification wage-index values through September 30, 2010. Special exception wage values apply for CY 2010. Revised post-reclassification wage index values implemented in the IPPS PRICER in April will be implemented in the OPPS in July and issued with the July PRICER. (See CR 6996 on the CMS website at *http://www.cms.gov/Transmittals/downloads/R1980CP.pdf*.)
- Effective January 1, 2010 there will be two contrast agents receiving pass-through payments in the OPPS PRICER logic. For a specific set of APCs identified elsewhere in this update, PRICER will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the "policy-packaged" portions of the CY 2010 APC payments for procedures using contrast agents and may be found on the CMS website. These offset amounts have been updated to reflect CY 2010 OPPS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by Sections 3401 and 3137 of the ACA.

***Updates to the inpatient and outpatient hospital, LTCH, and IRF PPS changes due to the Affordable Care Act (continued)***

- Effective January 1, 2010 there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS PRICER logic. For APCs containing nuclear medicine procedures, PRICER will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2010 APC payments for nuclear medicine procedures and may be found on the CMS website. These offset amounts have been updated to reflect CY 2010 OPPS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by sections 3401 and 3137 of the ACA.
- APC offset amounts equal to the device portion of the APC for devices received without cost or at a reduced cost, and indicated by **modifier FB and FC** respectively, are updated to reflect CY 2010 OPPS payment rates that are recalculated to reflect the changes to the hospital market basket and wage index that are required by Sections 3401 and 3137 of the ACA.

### Inpatient rehabilitation facility updates

Sections 1886(j)(3)(C) and (D) of the Act require the increase factor to be reduced by 0.25 percentage point for FY 2010 and FY 2011. In accordance with paragraph (p) of Section 3401 of the ACA, the adjusted FY 2010 market basket increase factor is only applied to discharges on or after April 1, 2010. Thus, CMS revised the FY 2010 IRF federal prospective payment rates for all IRF discharges occurring on or after April 1, 2010 to reflect an adjusted market basket increase factor of 2.25 percent, instead of the 2.5 percent market basket increase factor for FY 2010 that was published in the FY 2010 IRF PPS final rule (74 FR 39778). Revising the market basket increase factor for FY 2010 from 2.5 percent to 2.25 percent changes the FY 2010 standard payment conversion factor from the $13,661 that was published in the FY 2010 IRF PPS final rule (74 FR 39780) to $13,627.

In order to maintain estimated outlier payments in FY 2010 at the percentage adopted in the CMS FY 2010 final rule, CMS revises the IRF outlier threshold amount for FY 2010 from $10,652 that was published in the FY 2010 IRF PPS final rule (74 FR 39788) to $10,721 for FY 2010 IRF discharges occurring on or after April 1, 2010. The outlier threshold amount of $10,652 continues to apply for IRF discharges occurring on or after October 1, 2009, through March 31, 2010.

### Additional Information

The official instruction, CR 7029, 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/R728OTN.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: MM7029
Related Change Request (CR) Number: 7029
Related CR Release Date: July 15, 2010
Related CR Transmittal Number: R728OTN
Effective Date: Various as indicated in article.
Implementation Date: August 9, 2010

Source: CMS Pub. 100-20, Transmittal 728, CR 7029



## Proposed rule on policy and payment changes for services in hospital outpatient departments and ambulatory surgical centers

Medicare beneficiaries would see a decline in their out-of-pocket costs for services they receive in hospital outpatient departments (HOPDs) in calendar year (CY) 2011 under provisions in a proposed rule issued by the Centers for Medicare & Medicaid Services (CMS). The proposed rule implements changes required by the Affordable Care Act of 2010.

The Affordable Care Act, which was enacted as the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, waives beneficiary cost-sharing for most Medicare-covered preventive services, including the initial preventive physical examination (IPPE or "Welcome to Medicare Visit"). This waiver applies not only to the 20 percent coinsurance for the physician's service, but also to any cost-sharing relating to the separate payment to the facility when the service is furnished in an HOPD, as well as those preventive services, such as colonoscopies, that may be furnished in an ambulatory surgical center (ASC).

For more information on the CY 2011 proposals for the outpatient prospective payment system (OPPS) and ASC payment system, please see *http://www.ofr.gov/inspection.aspx#special*.

Additional information may be found on the CMS website at:

**OPPS:** *http://www.cms.gov/HospitalOutpatientPPS/*

**ASC payment system:** *http://www.cms.gov/ASCPayment/*

The news release and fact sheet were available on Tuesday, July 6 at *http://www.cms.gov/*. ❖

Source: CMS PERL 201007-05

## Statutory provision on three-day payment window

On June 25 President Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010." Among other provisions, this law clarifies Medicare's policy for payment of services provided in hospital outpatient departments on either the day of or during the three days prior to an inpatient admission (known as the three-day payment window).

The new law clarifies Medicare's policy to be consistent with how hospitals have largely been billing the program as far back as 1991. Under this policy, a hospital (or an entity wholly owned or operated by the hospital) includes, in its charges for the inpatient hospital stay, charges for all diagnostic services and non-diagnostic services "related" to the inpatient stay that are provided during the three-day payment window.

The new statute clarifies that the term "other services related to the admission" includes "all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made by" Medicare that are provided by a hospital to a patient: (1) on the date of the patient's inpatient admission, or (2) during the three days (or in the case of a hospital that is not a subsection (d) hospital, during the one day) immediately preceding the date of admission unless "the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related to such admission." The statute makes no changes to the billing of diagnostic services.

The provision is effective for services furnished on or after June 25, which is the date of enactment of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. The provision also prohibits Medicare from reopening, adjusting, or making payments when hospitals submit new claims or adjustment claims for services that were provided prior to the date of enactment in order to separately bill outpatient non-diagnostic services.

In the very near future, CMS expects to provide instructions to the hospital community through its contractors advising them how to bill for related therapeutic services provided during the three-day or one-day payment window. Until the instruction is issued, hospitals should include charges for all diagnostic services and all non-diagnostic services that it believes meet the requirements of this provision. If a hospital believes that a non-diagnostic service is truly distinct from an unrelated to the inpatient stay, the hospital may separately bill for the service provided that it has documentation to support that the service is unrelated to the admission, consistent with the new provision. Such separately billed service may be subject to subsequent review.

Hospitals may continue to bill Medicare separately for services provided prior to June 25 that are unrelated to an inpatient stay provided that such a claim meets all applicable filing deadlines and the hospital has supporting documentation that the service is truly unrelated to an inpatient stay. ❖

Source: CMS PERL 201006-44

## July 2010 quarterly provider specific file update

The July 2010 quarterly provider specific files (PSF) **statistical analysis software** (SAS) data files and text data files are now available on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp* in the Downloads section and the text data files are available on the CMS website at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp* also in the Downloads section.

If you use the provider specific text or SAS file data, please go to the respective page above and download the latest versions of the PSF files.

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

Source: CMS PERL 201007-27

## July 2010 update to fiscal year inpatient prospective payment system PC PRICER

The fiscal year (FY) 2010 inpatient prospective payment system (PPS) personal computer (PC) PRICERs has been updated with the July 2010 provider data. If you use the FY 2010 inpatient PPS PC PRICER, please go to the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPricer/03_inpatient.asp#TopOfPage*, and download the latest versions of the PC PRICERs.

Note there are now two PRICER versions for FY 2010. One is for claims dated from October 1, 2009, to March 31, 2010, and the other is for claims dated from April 1, 2010, to September 30, 2010. Both download modules changed. The update is dated July 16, 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 201007-30

## Fiscal year 2011 inpatient rehabilitation facility prospective payment system

The Centers for Medicare & Medicaid Services (CMS) issued a notice on July 16 to update the fiscal year (FY) 2011 payment rates for inpatient rehabilitation facilities (IRFs).

The IRF notice implements routine updates to the IRF prospective payment system (PPS) for discharges occurring on and after October 1, 2010. In this notice, CMS use the methods described in the FY 2010 IRF PPS final rule (74 FR 39762) to update the federal prospective payment rates for FY 2011 using updated FY 2009 IRF claims and FY 2008 IRF cost report data. No policy changes are being proposed in this notice.

The notice incorporates a 0.25 percentage point reduction in the market-basket increase for FY 2011 required by the Affordable Care Act. The changes will result in an estimated increase in IRF payments of $135 million for FY 2011. This reflects a $140 million increase from the update to the payment rates and a $5 million decrease to the proposed update to the outlier threshold amount to reduce estimated outlier payments from 3.1 percent in FY 2010 to three percent in FY 2011.

This rule will publish in the *Federal Register* on July 22, 2010. A copy of the update notice is available on the CMS website at *http://www.cms.gov/InpatientRehabFacPPS/LIRFF/list.asp#TopOfPage*.

The CMS website is a primary information resource for the IRF PPS. The website URL is *http://www.cms.gov/InpatientRehabFacPPS/*.

More information is available at *http://www.healthcare.gov/*, a new Web portal made available by the U.S. Department of Health & Human 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 201007-36

## Inpatient psychiatric facility prospective payment system fact sheet update

The revised fact sheet titled "Inpatient Psychiatric Facility Prospective Payment System" (May 2010), which provides inpatient psychiatric facility prospective payment system (IPF PPS) general information, explains how IPF PPS rates are set, and provides the rate year 2011 update to the IPF PPS, is now available in downloadable format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/InpatientPsychFac.pdf*.

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

Source: CMS PERL 201006-33

## New outpatient prospective payment system PRICER payment file

The outpatient prospective payment system (OPPS) PRICER Web page has been updated with new payment files for the 2010 update to the OPPS, as specified in change request (CR) 6996. The files are ready for download from the "Third Quarter 2010 Files" section of the OPPS PRICER Web page at *http://www.cms.gov/PCPricer/OutPPS/list.asp*.

If you use OPPS PRICER files, please go to this page and download the above files.

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Source: CMS PERL 201006-59

### Find your favorites fast – use Quick Find

Looking for the fastest way to find your favorite sections of our website? It's easy – just use the Quick Find navigational tool. Located on the left-hand side of every page, this convenient drop-down menu allows you to jump to the most popular pages on the site – with just one click. You'll find links to the Part A and Part B homepages as well as quick links to the procedure-diagnosis lookup tool, local coverage determinations (LCDs), fee schedules, publications, and more. Find out how easy is to find what you need fast – use Quick Find.

# SKILLED NURSING FACILITY SERVICES

## CMS announces increase in payment rates for Medicare skilled nursing facility for fiscal year 2011

The Centers for Medicare & Medicaid Services (CMS) announced that nursing home payment rates for fiscal year 2011 will increase 1.7 percent. This increase will result in an estimated $542 million increase in Medicare payments to nursing homes across the country during FY 2011.

CMS updates the payment rates annually, using a market-basket index reflecting changes in the prices of goods and services used to furnish covered care in nursing homes. In addition, CMS makes a forecast error adjustment whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold for the most recently available fiscal year for which there is final data. In initially establishing the forecast error adjustment, CMS noted that it would reflect both upward and downward adjustments, as appropriate.

For FY 2009 (the most recently available fiscal year for which there is final data), the estimated increase in the market-basket index was 3.4 percentage points, while the actual increase was 2.8 percentage points. This resulted in the actual increase being 0.6 percentage point lower than the estimated increase. Accordingly, as the difference between the estimated and actual amount of change exceeds the 0.5 percentage point threshold, the payment rates for FY 2011 include a negative 0.6 percentage point forecast error adjustment. This adjustment, when combined with the FY 2011 market-basket increase factor of 2.3 percent, yields a net update of positive 1.7 percent for FY 2011.

> "CMS is committed to ensuring that beneficiaries in skilled nursing facilities continue to receive high quality care while paying those facilities appropriately for that care," said Jonathan Blum CMS Deputy Administrator and Director of the Center for Medicare. "The payment rates for the coming year that we are announcing today reflect that goal."

In the notice, CMS discusses a self-implementing provision contained in Section 10325 of the Patient Protection and Affordable Care Act. This provision modifies the FY 2011 implementation schedule for the resource utilization groups, version IV (RUG-IV) case-mix classification system that CMS announced last year. CMS plans to delay implementation of the provision until system modifications are completed.

This rule will publish in the *Federal Register* on July 22, 2010. A copy of the update notice is available on the CMS website at *http://www.cms.gov/SNFPPS/LSNFF/list.asp#TopOfPage*.

**The comment period closes on September 14, 2010.**

More information is available at *http://www.healthcare.gov/*, a new Web portal made available by the U.S. Department of Health & Human 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 201007-37

## October quarterly update to 2010 annual update of HCPCS codes used for skilled nursing facility 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 is for physicians, skilled nursing facilities, suppliers, and other providers submitting claims to Medicare contractors (fiscal intermediaries [FI], or Part A/B Medicare administrative contractors [A/B MAC]) for services provided to Medicare beneficiaries.

### What you need to know

Change request (CR) 7002, from which this article is taken, provides the October quarterly update to the 2010 Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing facility (SNF) consolidated billing (CB). You should make sure your billing staffs are aware of the HCPCS code changes (effective October 1, 2010) that are provided in the *Background* section, below.

### Background

Section 1888 of the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm* on the Internet) codifies the SNF prospective payment system (PPS) and CB; and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS.

The SNF CB file reflects new codes that have been developed, and those that have been discontinued, for 2010, and any additions and deletions to categories of services excluded from CB. Please note that these new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined; nor will any additional services be added by these routine updates. Other regulatory changes beyond code list updates will be noted when, and if, they occur.

Medicare will pay SNF claims submitted to Medicare contractors for HCPCS codes only when they are included in SNF CB (in other words, do not appear on the exclusion list) Conversely, services excluded from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when in a SNF stay. Regardless, in order to assure proper payment in all settings, Medicare systems must edit

***October quarterly update to 2010 annual update of HCPCS codes used for SNF CB enforcement (continued)***

for services provided to SNF beneficiaries both included and excluded from SNF CB. Further, SNF CB applies to non-therapy services, only when they are furnished to a SNF resident during a covered Part A stay; however, it applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

The *Current Procedural Terminology* (*CPT*) codes in the following table will be terminated from the annotated major categories in the FI/A/B MAC file effective December 31, 2009:

**Table 1 – *CPT* codes terminated in the FI/A/B MAC file, effective December 31, 2009***

| Major category I.C – magnetic resonance imaging | |
|---|---|
| ***CPT* code** | **Long Description** |
| *75558* | *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification* |
| *75560* | *Cardiac magnetic resonance imaging for morphology and function without contrast material; with flow/velocity quantification and stress* |
| *75562* | *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification* |
| *75564* | *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with flow/velocity quantification and stress* |

| Major category I.E – angiography, lymphatic, venous and related procedures | |
|---|---|
| ***CPT* code** | **Long description** |
| *75790* | *Angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation* |

The *CPT* codes in the following table will be added to the annotated major categories in the FI/A/B MAC file effective December 31, 2009:

**Table 2 – CPT codes added to the FI/A/B MAC file, effective January 1, 2010***

| Major category I.C – magnetic resonance imaging (MRI) | |
|---|---|
| **CPT code** | **Long description** |
| *75565* | *Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)* |
| *75571* | *Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium* |
| *75572* | *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)* |
| *75573* | *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)* |
| *75574* | *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)* |

| Major category I.E – angiography, lymphatic, venous and related procedures | |
|---|---|
| **CPT code** | **Long description** |
| *75791* | *Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis).* |

*Codes added or terminated with this update are available on the CMS website at *http://www.cms.gov/SNFConsolidatedBilling/72_2010Update.asp#TopOfPage*.

***October quarterly update to 2010 annual update of HCPCS codes used for SNF CB enforcement (continued)***

Finally, for Indian Health Service (IHS) providers, your FI or MAC will bypass type of bill 13x bill types containing emergency care evaluation & management (E&M) *CPT* codes *99281, 99282, 99283, 99284, 99285* (effective January 1, 2010) using the same bypass logic as currently done when a revenue code 045x is present on an outpatient hospital claim (this includes the usage of **modifier ET** for emergency services that span multiple service dates).

### Additional information

You may find the official instruction, CR 7002, issued to your FI, carrier, or A/B MAC by visiting the CMS website *http://www.cms.gov/Transmittals/downloads/R1989CP.pdf*.

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

*MLN Matters*® Number: MM7002
Related Change Request (CR) Number: 7002
Related CR Release Date: June 18, 2010
Related CR Transmittal Number: R1989CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 1989, CR 7002



## Minimum data set 3.0 training material – June 15 updates

The following revised training materials are now available under the Downloads section on the MDS 3.0 Training Materials page (*http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*):

- **MDS 3.0 RAI Manual V1.02 June 15, 2010** – this update includes the following revised Chapter 3 sections of the Resident Assessment Instrument (RAI) manual: G and Q. This file now contains revised versions of the following sections of the RAI manual: Chapter 3, Sections: B, D, E, F, G, H, I, J, K, L, N, P, Q, X, and Z.
- **MDS 3.0 Training Slides V1.00 June 15, 2010** – this update includes the following revised Chapter 3 sections of the MDS 3.0 training slides: G and J. This file now contains revised versions of the following sections of the MDS 3.0 training slides: Chapter 3, Sections: B, D, E, F, G, H, I, J, K, L, N, P, X, and Z.
- **MDS 3.0 Instructor Guides V1.00 June 15, 2010** – this update includes the following revised Chapter 3 sections of the MDS 3.0 instructor guides: G and J. This file now contains MDS 3.0 instructor guides to facilitate MDS 3.0 training. Chapter 3, Sections: B, D, E, F, G, H, I, J, K, L, N, P, and X.
- **VIVE – Video on Interviewing Vulnerable Elders June 14, 2010** – this video on interviewing vulnerable elders (VIVE) was funded by the Picker Institute and produced by the JH Borun Center at the University of California, Los Angeles. DVD copies may be ordered from the Pioneer Network. The content in this video is the same as the information presented during the April national train the trainer conference and will help teach your staff how to use effective interviewing techniques. Note: The Pioneer Network has posted information for ordering the DVD on this website *http://www.pioneernetwork.net/*.
- **MDS 3.0 ADL Flowchart V1.02 June 14, 2010** – an updated version of the activities of daily living decision (ADL) flowchart to assist with the completion of the ADL assessment with MDS 3.0.

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Source: CMS PERL 201006-32

## Minimum data set 3.0 training material – June 29 updates

The following revised training materials are now available under the Downloads section on the MDS 3.0 Training Materials page (*http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*):

- **Minimum data set (MDS) 3.0 resident assessment instrument (RAI) Manual V1.02 June 29, 2010** – this update includes the following revisions of the RAI manual: Chapter 2.This file now contains revised versions of the following sections of the RAI manual: Chapter 1, Chapter 2, Chapter 3 (Introduction, Sections: A, B, C, D, E, F, G, H, I, J, K, L, N, P, Q, S, V, X and Z), Appendices B, C, D, E, and G) Chapter 4, and Chapter 5.
- **MDS 3.0 Training Slides V1.00 June 29, 2010** – this update includes the following: Chapter 3, Section C (BIMs). Chapter 3, Section C (Staff) was published earlier. The MDS 3.0 training slides for Section E have been updated (file dated June 28, 2010) to correct inaccurate graphics for some scenarios and practice questions. Specific changes are as follows:
  - Graphics have been corrected on slides 36, 39, 58, 82, 85, 104, 106, 117, and 121.
  - No changes have been made to the content of the lesson itself.

  This file now contains revised versions of the following sections of the MDS 3.0 training slides: Chapter 3, Sections: B, C (Staff), C (BIMs), D, E, F, G, H, I, J, K, L, N, O, P, Q, V, X and Z.
- **MDS 3.0 Instructor Guides V1.00 June 29, 2010** – this update includes the following: Chapter 3, Section C (BIMs). Chapter 3, Section C (Staff) was published earlier. The MDS 3.0 Instructor Guide for Section E has been updated (file dated June, 28, 2010) to correct inaccurate graphics for some scenarios and practice questions. Specifically as follows:
  - The instructor guide has been revised with corrected slide reductions including the updated graphics.
  - No changes have been made to the content of the lesson itself.

  This file now contains MDS 3.0 instructor guides to facilitate MDS 3.0 training. Chapter 3, Sections: B, C, (Staff), C (BIMs), D, E, F, G, H, I, J, K, L, N, O, P, Q, V X, and Z.

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Source: CMS PERL 201007-12

## Minimum data set 3.0 training material – July 12 updates

Minimum data set (MDS) 3.0 training information for the October 1, 2010, implementation. The following revised training materials are now available under the Downloads section on the MDS 3.0 Training Materials page (*http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*):

- **Minimum data set (MDS) 3.0 resident assessment instrument (RAI) manual V1.02 July 12, 2010** – this update includes the following revisions of the RAI manual: Chapter 3, Section M. This file now contains revised versions of the following sections of the RAI manual: Title page, Chapter 1, Chapter 2, Chapter 3 (Introduction, Sections: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, S, V, X and Z), Appendices B, C, D, E, and G) Chapter 4, and Chapter 5, and Chapter 6.
- **MDS 3.0 Training Slides V1.00 July 12, 2010** – this update includes the following: Chapter 3, Section A and M. Chapter 3, Sections A C (Staff) was published earlier. This file now contains revised versions of the following sections of the MDS 3.0 training slides: Chapter 3, Sections: B, C (Staff), C (BIMs), D, E, F, G, H, I, J, K, L, N, O, P, Q, V, X and Z.
- **MDS 3.0 Instructor Guides V1.00 July 12, 2010** – this update includes the following: Chapter 3, Section A. This file now contains MDS 3.0 instructor guides to facilitate MDS 3.0 training. Chapter 3, Sections: A, B, C, (Staff), C (BIMs), D, E, F, G, H, I, J, K, L, N, O, P, Q, V X, and Z.

  For more information, please see the following URL *http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*.

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Source: CMS PERL 201007-23

## Minimum data set 3.0 training update – July 15 updates

The following revised training materials are now available under the Downloads section on the MDS 3.0 Training Materials page (*http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*):

- Minimum data set (MDS) 3.0 resident assessment instrument (RAI) manual V1.02 July 15, 2010 – this update includes the following revisions of the RAI manual: Appendix A and H (the item sets in Appendix H have not changed since they were last published in November 2009). The revised manual is now complete with the exception of Appendix F which is forthcoming.

  This file now contains revised versions of the following sections of the RAI manual: Title Page, Chapter 1, Chapter 2, Chapter 3 (Introduction, Sections: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, S, V, X and Z), Chapter 4, Chapter 5, Chapter 6 and Appendices (A, B, C, D, E, G, and H).

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

Source: CMS PERL 201007-41

## Skilled nursing facility consolidated billing as it relates to certain types of exceptionally intensive outpatient hospital services

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

**Note:** The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® special edition article SE0432 to include "ambulatory surgical centers" 'to the exclusion of services furnished in other non-hospital settings such as freestanding clinics. All other information remains the same. The article was published in the Third Quarter 2005 *Medicare A Bulletin* (pages 104-105).

### Provider types affected

Skilled nursing facilities (SNFs), physicians, suppliers, providers, and imaging centers

**Clarification:** The SNF consolidated billing (CB) requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier (DMERC).

### Provider action needed

This special edition describes SNF CB as it relates to certain types of exceptionally intensive outpatient hospital services, such as magnetic resonance imaging (MRI) services, computerized axial tomography (CT) scans, and radiation therapy.

### Background

When the SNF prospective payment system (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB, see *MLN Matters* special edition article SE0431 on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/se0431.pdf*.

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P. L. 105-33 (BBA 1997)) specified a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

Moreover, these services were excluded categorically, without regard to the specific setting in which they were furnished. This legislation did not authorize the Department of Health & Human Services (DHHS) to create additional categorical exclusions from CB administratively, thereby reserving this authority for the Congress itself. In fact, the Congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and non-hospital settings, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L. 106-113, Appendix F).

While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did define the SNF CB provision in terms of services furnished to a resident of a SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be a SNF "resident" for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identified several types of exceptionally intensive outpatient hospital services that were well beyond the general scope of SNF care plans. These services include:

***SNF consolidated billing as it relates to certain types of exceptionally intensive outpatient hospital services (continued)***

- Emergency services
- Cardiac catheterizations
- Computerized axial tomography (CT) scans
- Magnetic resonance imaging (MRI) services
- Ambulatory surgery
- Radiation therapy
- Angiography
- Lymphatic and venous procedures.

CMS established that a beneficiary's receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as a SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the *Code of Federal Regulations* (42 CFR), Section 411.15(p)(3)(iii).) The underlying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is specifically limited to "…certain outpatient services from a Medicare participating hospital or critical access hospital…" (emphasis added). (See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641)). **This means that the exclusion does not encompass services that are furnished in other, non-hospital settings (such as freestanding clinics or ambulatory surgical centers).**

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act. Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus freestanding) in which they are furnished.

For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(II) of the Social Security Act excludes certain types of intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.

Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS Code. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is **not** subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, the physician bills his/her service directly to the Medicare Part B carrier for reimbursement.

## Additional information

See *MLN Matters* special edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and may be found on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/se0431.pdf*.

The Centers for Medicare & Medicaid Services (CMS) MLN consolidated billing website may be found on the CMS website at *http://www.cms.gov/SNFConsolidatedBilling/*.

It includes the following relevant information:

- General SNF CB information
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB)
- Therapy codes that must be consolidated in a noncovered stay
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing Website may be found on the CMS website at *http://www.cms.gov/SNFPPS/*.

It includes the following relevant information:

- Background
- Historical questions and answers
- Links to related articles
- Links to publications (including transmittals and *Federal Register* notices).

*MLN Matters*® Number: SE0432 – Revised
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE0432

## Five-star quality rating system – July news

The five-star provider preview reports became available on Friday, July 16. Providers, in order to access your five-star preview report, go to the minimum data set (MDS) state welcome page available on the state servers where you submit the MDS information and select the CASPER (certification and survey provider enhanced reporting) link located at the bottom of the page. Once in the CASPER system,

- Click on the "Folders" button.
- Then click on "My Inbox" on the left hand side of the screen 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 and "facid" is the state assigned facid of your facility.

The five-star helpline will be available the week of July 19-23 for questions and concerns about the July data. The five-star data from July was available on the Nursing Home Compare website effective Thursday, July 22.

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

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

Source: CMS PERL 201007-32

### Use the PDS report to improve your Medicare billing operations

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

# ELECTRONIC DATA INTERCHANGE

## Claim status category and claim status code update

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

### Provider types affected

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

### Provider action needed

This article, based on change request (CR) 7052, explains that the claim status codes and claim status category codes for use by Medicare contractors with the health claim status request and response ASC X12N 276/277 along with the 277 health care claim acknowledgement were updated during the June 2010 meeting of the National Code Maintenance Committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on or about July 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on October 4, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

### Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the X12 276/277 health care claim status request and response format adopted as the standard for national use (004010X093A1 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 health care claim acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (institutional or professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

### Additional information

The official instruction, (CR 7052), issued to your Medicare contractor regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2002CP.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: MM7052
Related Change Request (CR) Number: 7052
Related CR Release Date: July 16, 2010
Related CR Transmittal Number: R2002CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2002, CR 7052



## Version 5010 and ICD-10 are coming – will you be ready?

Will you be ready for…

- The updated version 5010 standards for Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transactions on January 1, 2012?
- The International Classification of Diseases, 10th Edition (ICD-10) medical code set transition on October 1, 2013?

The Centers for Medicare & Medicaid Services (CMS) has new resources to help you prepare. Visit *http://www.cms.gov/ICD10* and click on:

- Provider resources – to find out about basic steps medical practices can take to prepare for ICD-10 and for a fact sheet on talking with your vendors about the version 5010 and ICD-10 transitions
- Vendor resources – for tips for software vendors about talking with customers about the transitions

Software vendors, third-party billers, and clearinghouses may view materials from our recent conference at *http://www.cmsvendorconference.com*. Here you can also request information about working with CMS to help raise awareness about the version 5010 and ICD-10 transitions.

Keep up to date on version 5010 and ICD-10. Please visit *http://www.cms.gov/icd10* for the latest news and coming soon. Coming soon you will be able to sign up for version 5010 and ICD-10 e-mail updates.

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

Source: CMS PERL 201006-34

## Vendors and providers start the conversation on version 5010 and ICD-10

**Providers:** The first recommended deadline for a successful transition to version 5010 is only five months away. By December 31, 2010, providers should complete their internal testing, and be ready to test with external partners beginning in January 2011.

Now is a great time for providers to check in with your vendors about their transition preparations. Not only is it important for you to make sure that you can count on them during the transition, but they are a great resource to provide you with details about what you need to do to comply with version 5010 standards and ICD-10.

**Vendors:** You play a vital role in the version 5010 and ICD-10 transition. Your customers will be looking to you for guidance to navigate them through the changes. Your products and services will be obsolete if steps are not taken now to get ready. Start talking with your customers about preparing for the version 5010 and ICD-10 transitions.

The Centers for Medicare & Medicaid Services (CMS) is here to help you both talk to each other – even help you get the conversation started if you haven't already. Go to the CMS website at *http://www.cms.gov/icd10/*, for provider and vendor resource pages that includes fact sheets with tips on asking each other the right questions.
Keep up-to-date on version 5010 and ICD-10.

Please visit *http://www.cms.gov/icd10/* for the latest news. Coming soon sign up for version 5010 and ICD-10 e-mail updates.

**Version 5010 and ICD-10 are coming. Will you be ready?**

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

Source: CMS PERL 201007-09

## Proposed rulemaking to implement Health Information Technology for Economic and Clinical Health Act modifications to the HIPAA rules

The Department of Health & Human Services (HHS) issued a notice of proposed rulemaking on July 8, 2010, to modify the privacy, security, and enforcement rules issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, is designed to promote the widespread adoption and standardization of health information technology, and requires HHS to modify the HIPAA privacy, security, and enforcement rules to strengthen the privacy and security protections for health information and to improve the workability and effectiveness of the HIPAA rules.

The proposed modifications to the HIPAA rules issued on July 8, 2010, include provisions extending the applicability of certain of the requirement of privacy and security rules to the business associates of covered entities, establishing new limitations on the use and disclosure of protected health information for marketing and fundraising purposes, prohibiting the sale of protected health information, and expanding individuals' rights to access their information and to obtain restrictions on certain disclosures of protected health information to health plans. In addition, the proposed rule adopts provisions designed to strengthen and expand the enforcement provisions from HIPAA.

"This proposed rule strengthens the privacy and security of health information, and is an integral piece of the Administration's efforts to broaden the use of health information technology in health care today," said Georgina Verdugo, director of the HHS Office for Civil Rights (OCR). These HIPAA rules are administered and enforced by OCR.

Once it is published in the *Federal Register*, the notice of proposed rulemaking may be viewed and commented on for 60 days at *http://www.regulations.gov/search/Regs/home.html#home*.

In addition to issuing the notice of proposed rulemaking, OCR also updated its breach notification Web page.

Breaches of unsecured protected health information affecting 500 or more individuals that are reported to the HHS Secretary are now posted in a new, more accessible format that allows users to search and sort the reported breaches. Additionally, this new format includes brief summaries of the breach cases that OCR has investigated and closed, as well as the names of private practice providers who have reported breaches of unsecured protected health information to the Secretary.

Visit the OCR website for more information about this proposed rule and the updated breach notification Web page at *http://www.hhs.gov/ocr/privacy/*.

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

Source: CMS PERL 201007-21

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

# EDUCATIONAL EVENTS

## Upcoming provider outreach and educational events
### August 2010 – September 2010

**Topic – Limitation on Recoupment (935)/Remittance Advice**

When: Tuesday, August 10, 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 – 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 Web site, *www.medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

### Never miss a training opportunity

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

### Take advantage of 24-hour access to free online training

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

# PREVENTIVE SERVICES

## Preventive services to help keep your Medicare patients healthy this summer

The Centers for Medicare & Medicaid Services (CMS) asks providers to help keep their Medicare patients healthy this summer by encouraging them to take advantage of Medicare-covered preventive services. Medicare covers a wide variety of preventive services, including screening mammographies, seasonal influenza vaccinations, and screening for certain types of cancer, among other services.

### What can you do?

Your patients rely upon you as their trusted health-care provider for advice and information to help them live longer, fuller, healthier lives. You can help protect the health of your patients by discussing their risk factors for preventable diseases, and by encouraging them to take advantage of Medicare-covered preventive services for which they qualify.

### For more information

CMS has developed several products to educate providers about Medicare coverage, coding, and claims submission policies related to Medicare-covered preventive services, including:

- **The Medicare Learning Network 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*

- **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 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, and pelvic exams. 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 preventive services educational products – this PDF document contains links to downloadable versions of the many products the MLN has available related to Medicare-covered preventive services, including brochures, quick reference guides, and more.

  *http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf*

- The preventive services resources – this CD-ROM contains the guide to Medicare preventive services, three-quick reference charts, and seven brochures on one easy to use CD-ROM. To order the CD, and other products that are available in hardcopy, 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."

Thank you for helping CMS improve the health of patients with Medicare by joining in the effort to educate beneficiaries about the importance of early detection of various diseases by taking advantage of the screenings and other preventive services covered by Medicare.

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

Source: CMS PERL 201007-08

## Medicare preventive services quick reference information charts

Need a quick and easy-to-use source of information to help you with Medicare-covered preventive services billing? The Medicare preventive service quick reference information charts contain coverage, coding, and billing information in an easy-to-use format and includes the following charts:

- **Quick Reference Information: Medicare Preventive Services**: This two-sided reference chart provides health-care providers with coverage, coding, and payment information on the many preventive services covered by Medicare.
- **Quick Reference Information: Medicare Immunization Billing**: This two-sided reference chart provides coverage, coding and payment information on seasonal influenza, pneumococcal, and Hepatitis B vaccinations covered by Medicare.
- **Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (IPPE)**: This two-sided reference chart provides a checklist of the elements of an IPPE as well as coding information and frequently asked questions.

All three charts are available, free-of-charge, from the *Medicare Learning Network®*, in both downloadable PDF (portable document format) and hardcopy format.

To view the PDF charts, please visit the "Preventive Services Educational Products" page at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp* and select the "Educational Products" link in the "Downloads" section.

To order hardcopies, please select the "MLN Product Ordering" link on the same Web page.

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

Source: CMS PERL 201007-40

# OTHER EDUCATIONAL RESOURCES

## New suite of MLN products now available for billing and coding professionals

It is important to the Centers for Medicare & Medicaid Services (CMS) that the billing and coding professionals who work with fee-for-service providers have the timely and accurate information they need to properly bill the Medicare program. That is why CMS developed the *Medicare Learning Network® Suite of Products and Resources for Billing and Coding Professionals* – to help billers, coders, and other reimbursement specialists submit claims correctly the first time.

Like all *MLN* products, the suite has nationally consistent, up-to-date Medicare information prepared by subject-specific experts – and it is available at no cost. The suite consists of the following four components that offer an uncomplicated way to understand more about the Medicare program:

- The business of Medicare
- Medicare benefits and services
- Special Medicare initiatives
- General Medicare program information and resources

CMS recommends that you forward the following message to your members and any staff who may have the responsibility for developing and submitting claims (e.g., billers, coders, reimbursement specialists, and office practice managers).

**E-mail subject line**

Something new from the *Medicare Learning Network (MLN)* for billing and coding professionals"

**Suggested message content**

There is information. And then there is information from the Centers for Medicare & Medicaid Services' (CMS) *Medicare Learning Network® (MLN)*.

As a billing and coding professional, you need Medicare information at your fingertips. That is why CMS experts developed a solution just for you — the "*Medicare Learning Network® Suite of Products and Resources for Billing and Coding Professionals*." The suite contains easy-to-understand, accessible and free Medicare program information developed especially for Medicare fee-for-service (FFS) providers.

Please start here *http://www.cms.gov/MLNProducts/downloads/Billers_and_Coders_flyer.pdf* to access current information you need to submit claims correctly the first time.

Equip yourself today with critical reimbursement solutions from the official source for Medicare FFS information.

For more details, please visit the *Medicare Learning Network*: *http://www.cms.gov/MLNGenInfo/*. ❖

Source: CMS PERL 201006-43

## CMS fact sheet on how to protect your Medicare enrollment record now available

If you are a physician or nonphysician practitioner who is enrolled in Medicare, or who is planning to enroll in Medicare, it is important that you protect your Medicare enrollment information from getting into the hands of dishonest and unscrupulous people. The Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network (MLN)* has released *Medicare Fee-for-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record* as the first in a series of fact sheets designed to educate FFS providers about important Medicare enrollment information. This particular fact sheet advises FFS physicians and nonphysician practitioners on how to ensure that their enrollment records are up-to-date and secure. The fact sheet is available in downloadable format on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnrollPrivcy_FactSheet_ICN903765.pdf*.

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

Source: CMS PERL 201007-42

## Revised Medicare physician fee schedule fact sheet now available

The downloadable version of the *Medicare Physician Fee Schedule* fact sheet (July 2010) has been revised to include information about the 2.2 percent update to the 2010 Medicare physician fee schedule (MPFS) effective for dates of service from June 1, 2010, through November 30, 2010. This publication also provides MPFS payment rate information, the MPFS payment rates formula, and MPFS resources. To access this *Medicare Learning Network* fact sheet, visit *http://www.cms.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf*.

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

Source: CMS PERL 201007-40

### 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:<br>**English [ ] Español [ ]** | | | | |

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

**Mail this form with payment to:**

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

Contact Name:
_____

Provider/Office Name:
_____

Telephone Number (include area code):
_____

Mailing Address:
_____

City:
_____

State, ZIP Code:
_____

***(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***

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***REDETERMINATION and REDETERMINATION OVERPAYMENTS***
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P. O. Box 45097
Jacksonville, FL 32232-5097

***MEDICARE SECONDARY PAYER***
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***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***
**U.S. V I Medicare Contractor**
***medicare.fcso.com***
**Centers for Medicare & Medicaid Services**
***www.cms.gov***

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

# MEDICARE A BULLETIN

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## ♦ ATTENTION BILLING MANAGER ♦