MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

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THE 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

Revised instructions for reporting assessment dates under the IRF, SNF, SB-SNF prospective payment systems

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

Provider types affected

This article is for inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF), and swing bed (SB) providers paid under the respective prospective payment systems (PPSs) for these providers. Facilities submitting claims to Medicare contractors (fiscal intermediaries [FIs] and Medicare administrative contractors [MAC]) for services paid under these PPSs are affected.

Provider action needed

This article, based on change request (CR) 7019, informs you that the assessment date data element has been removed from the new version of the 837I electronic format. Therefore, the Centers for Medicare & Medicaid Services (CMS) has revised the billing instruction to now require an occurrence code 50, for reporting assessment dates for IRF, SNF, and SB PPS providers, effective for dates of service on or after January 1, 2011. Occurrence code 50: Assessment date is defined as "Code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. minimum data set (MDS) for skilled nursing). (For IRFs, this is the date assessment data was transmitted to the CMS national assessment collection database)." Please ensure that your billing staffs are aware of this change.

Background

Current Medicare instruction requires IRF and SNF PPS providers to report assessment dates in form locator 45, service date, of the UB-04 form or loop 2400, date and time period (DTP) assessment date field, in the current 4010A1 837I electronic version. The DTP assessment date is removed from the new 837I electronic version. Because of the removal of this field, you will no longer be able to report assessment dates in the service date fields.

For IRF PPS, IRFs will begin using occurrence code 50 to report the date on which assessment data was transmitted to the CMS national assessment collection database. Providers should no longer report this date in the service date field on the UB-04 and the 837I electronic version for dates of service on or after January 1, 2011. Occurrence code 50 must be reported on all IRF PPS 11x bill types for dates of service on or after January 1, 2011. Medicare will return such claims as unprocessed if you fail to include occurrence code 50.

Note: For IRFs, for a revenue code 0024 line containing case-mix GROUPER (CMG) A9999, instead of inputting the transmission date of the IRF-patient assessment instrument in the service date field (as is required on fee-for-service claims), input the discharge date as a default for these informational only claims. As of January 1, 2011, use occurrence code 50 to report this default discharge date, instead of using the service date field.

For service dates on or after January 1, 2011, SNF and SB PPS providers will append an occurrence code 50 with the assessment reference date (ARD) for each health insurance prospective payment system code (HIPPS) reported on the claim. Please note that health insurance prospective payment system (HIPPS) code AAAxx (where 'xx' is varying digits) does not need an accompanying occurrence code 50. SNF providers must ensure that each HIPPS code reported on the claim is billed in the order in which that level of care is received for the month.

SNF and SB PPS providers, therefore, must include occurrence code 50 for each revenue code 0022 on your 21x and 18x bill types, except where the HIPPS code reported with the 0022 revenue code is AAAxx. Medicare will return such claims as unprocessed if you do not include occurrence code 50.

Note: Only one occurrence code 50 needs to be reported for two HIPPS code lines that both end in the same two digits for the following HIPPS: xxx05, xxx06, xxx12, xxx13, xxx14, xxx15, xxx16, xxx17, xxx24, xxx25, xxx26, xxx34, xxx35, xxx36, xxx44, xxx45, xxx46, xxx54, xxx55, and xxx56, where "xxx" is varying digits.

Additional information

The official instruction issued to your Medicare carrier and/or MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2011CP.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: MM7019
Related Change Request (CR) Number: 7019
Related CR Release Date: July 30, 2010
Related CR Transmittal Number: R2011CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2011, CR 7019

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Timely claim filing – additional instructions

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

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7080 to expand the Medicare fee-for-service (FFS) reimbursement instructions outlined in change request (CR) 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. CR 7080 lists the standards for dates of service used to determine the timely filing of claims. Be sure your billing staffs are aware of these changes.

Background

CMS is addressing institutional claims and professional/supplier claims differently with respect to span date claims. Institutions often bill for extended length of stays that exceed a month's (or more) duration. Therefore, it is both less burdensome and more reasonable to use the date of the claim "through" rather than the "from" date as the date of service for determining claims filing timeliness.

Conversely, for physicians and other suppliers that bill claims with span dates, these span date services cannot exceed one month. Thus, there is no compelling need to create an extended filing period. CMS also notes that, if the "from" date of these span date services is timely, then those services billed within the span are timely as well, and this will generally ease the administrative burden of the claim-processing contractors in their determination of timely filed claims. Therefore, the "from" date standard will be used for determining claims filing timeliness for physicians and other suppliers that bill claims with span date services. With respect to supplies and rental items, they are physically furnished at or near the beginning of the span dates on the claim. Therefore, the "from" date standard reflects more precisely when the supply or item was delivered to the beneficiary, and will be used as the date for determining claims filing timeliness.

Key points of change request 7080

- For institutional claims that include span dates of service (i.e., a "from" and "through" date span on the claim), the "through" date on the claim will be used to determine the date of service for claims filing timeliness.
- For professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item "from" date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).
- Be aware: If a line item "from" date is not timely, but the "to" date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.
- Claims having a date of service of February 29 must be filed by February 28 of the following year to be considered as timely filed. If the date of service is February 29 of any year and is received on or after March 1 of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional information

Remember CR 6960 established that Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

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

You may find the official instruction, CR 7080, issued to your carrier, FI, A/B MAC, or RHHI on the CMS website at *http://www.cms.gov/Transmittals/downloads/R734OTN.pdf*.

To review MM6960, Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 – Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months, you may go to the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf*.

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

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Related CR Transmittal Number: R734OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-20, Transmittal 734, CR 7080

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Processing additional ICD-9-CM diagnosis and procedure codes in the PRICERs, GROUPER, and Medicare code editor

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

Provider types affected

This article is for providers, hospitals and skilled nursing facilities (SNFs) who submit claims to Part A/B Medicare administrative contractors (A/B MACs) and/or fiscal intermediaries (FIs) for services to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7004 to alert providers that with the implementation of HIPAA version 5010 837I in January of 2011 providers can report up to 25 ICD-9-CM diagnosis codes and up to 25 ICD-9-CM procedure codes. Be sure you are ready for the new standards.

Key points

Changes are being made to the inpatient prospective payment system (IPPS), inpatient psychiatric facility (IPF) PPS and the skilled nursing facility (SNF) PRICERs, and to the fiscal intermediary standard system (FISS) to allow these additional codes to be processed. In addition, the FISS interface to the GROUPER and Medicare code editor (MCE) will be changed. The GROUPER and MCE will be able to process more ICD-9-CM codes to determine the Medicare severity-diagnosis related group (MS-DRG).

Background

The Administrative Simplification provisions of Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the Secretary of Health & Human Services to adopt standard electronic transactions and code sets for administrative health-care transactions. The purpose of CR 7004 is to make the necessary base FISS changes related to various PRICERs, GROUPER, and the MCE to accommodate the changes in data content for the next version of HIPAA.

Additional information

The official instruction associated with this CR 7004, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2028CP.pdf*.

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

MLN Matters® Number: MM7004
Related Change Request (CR) Number: 7004
Related CR Release Date: August 13, 2010
Related CR Transmittal Number: R2028CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2028, CR 7004

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Handling misdirected mailings from Medicare

As a health-care provider subject to the privacy and security requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or under state law, you must safeguard patients' personally identifiable health information. If you receive a remittance advice on a Medicare beneficiary who's not your patient, you should 1) destroy it and 2) report it to your fiscal intermediary, carrier, or Medicare administrative contractor, as appropriate. ❖

Source: CMS PERL 201007-48

Revised tip sheet regarding national provider identifier

The revised *National Provider Identifier Tip Sheet: Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees (June 2010)* is now available on the Centers for Medicare & Medicaid Services (CMS) website. This resource details the steps an organization that is a health-care provider should take when applying for an employee's national provider identifier (NPI), on an individual record-by-record basis. Available in PDF format, the fact sheet may be downloaded or printed from the "Education Resources" section of the NPI Web page at *http://www.cms.gov/NationalProvIdentStand/04_education.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 201008-14

Reopening certain claims denied when MSP data deleted or terminated

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

Provider types affected

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

What you need to know

Change request (CR) 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen group health plan (GHP) Medicare secondary payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the Background section, below, for more details.

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

1. Reopen certain MSP claims when certain MSP records are deleted, or
2. Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare secondary payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional information

You may find the official instruction, CR 6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting the Centers for Medicare & Medicaid Services (CMS) website *http://www.cms.gov/Transmittals/downloads/R2014CP.pdf*.

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

MLN Matters® Number: MM6625
Related Change Request (CR) Number: 6625
Related CR Release Date: July 30, 2010
Related CR Transmittal Number: R2014CP
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Source: CMS Pub. 100-04, Transmittal 2014, CR 6625

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Update to banking transition date

The Centers for Medicare & Medicaid Services awarded new banking contracts to U.S. Bank and JPMorgan Chase. Medicare providers do not have to take any action. However, providers should be aware that the Medicare payments may be made by a different bank than in the past because of these new banking contractors.

Due to issues identified in testing, providers that submit claims to CIGNA Government Services, Highmark Medicare Services, National Government Services, NHIC, and Noridian Administrative Services may experience a delay in the transition to U.S. Bank. The transition now occurred on August 30 instead of August 2. ❖

Source: CMS PERL 201007-61

Medical record retention and media formats for medical records

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

Provider types affected

This is an informational article for physicians, nonphysician practitioners, suppliers, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and Medicare administrative contractors[MAC]) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is informational in nature. There are no additions or changes to current policies and procedures.

Caution – what you need to know

This article provides guidance for physicians, suppliers, and providers on record retention timeframes.

Go – what you need to do

Review the information in this article and ensure that you are in compliance. Be sure to inform your staff.

Retention periods

State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt state laws if they require shorter periods. Your state may require a longer retention period. The HIPAA requirements are available on the Internet at 45 CFR 164.316(b)(2) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl*).

While the HIPAA privacy rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. The privacy rule is available on the Internet at 45 CFR 164.530(c) (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl*).

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least five years after the closure of the cost report. This requirement is available on the Internet at 42 CFR 482.24[b][1] (*http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr482_05.html*).

CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available on the Internet at 42 CFR 422.504 [d][2][iii] (*http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=ab240bf0e5f6388a75cbe07cc5cf1d21;rgn=div5;view=text;node=42%3A3.0.1.1.9;idno=42;cc=ecfr*).

Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient. Remember that medical records must be accurately written, promptly completed, accessible, properly filed and retained. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.

The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Providers may want to obtain legal advice concerning record retention after these time periods and medical document format.

Additional information

CMS is currently engaged in a multi-year project to offer incentives to eligible providers that meaningfully use certified electronic health records (EHRs). In close coordination with this incentive program, the Office of the National Coordinator for Health IT (ONC) has developed the initial set of standards and certification requirements for EHRs in order to promote health information exchange and interoperability. You may be eligible to receive incentive payments to assist in implementing certified EHR technology systems.

Use of "certified EHR technology" is a core requirement for physicians and other providers who seek to qualify to receive incentive payments under the Medicare and Medicaid Electronic Health Record Incentive Programs provisions authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Additional information may be found at *http://www.cms.gov/EHRIncentivePrograms/*.

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: SE1022
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 SE1022

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October update to the 2010 DMEPOS fee schedule

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

Provider types affected

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, orthotic devises, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider action needed

This article is based on change request (CR) 7070, which provides the required quarterly update of the 2010 DMEPOS fee schedule. Be sure billing staffs are aware of the update.

Background

The DMEPOS fee schedule is updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at *https://www.cms.gov/manuals/downloads/clm104c23.pdf*.

Key points of change request 7070

- Per transmittal 686 (CR 6743), the claims filing jurisdiction for HCPCS code L8509 (Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type) is changing from the DME MACs to the A/B MACs/Part B carriers, effective October 1, 2010. To reflect this change, the claims jurisdiction for HCPCS code L8509 will change in the DMEPOS fee schedule file to local carrier as part of this update.
- As part of this update, the Alaska and Hawaii fee schedule amounts for HCPCS code E0973 (Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each) are being revised in order to correct errors made in the calculation of the fee schedule amounts. Medicare contractors will adjust previously processed claims for code E0973 with dates of service on or after January 1, 2010, if they are resubmitted as adjustments.

Additional information

The official instruction, CR 7070, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2006CP.pdf*.

An earlier *MLN Matters*® article, MM6743 on the change in claims filing jurisdiction for tracheo-esophageal voice prostheses Healthcare Common Procedure Coding System (HCPCS) code may be reviewed on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6743.pdf*.

If you have any 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: MM7070
Related Change Request (CR) Number: 7070
Related CR Release Date: July 23, 2010
Related CR Transmittal Number: R2006CP
Effective Date: January 1, 2010 for codes in effect then, October 1, 2010 for other changes
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2006, CR 7070,

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Update to hospice payment rates, cap, wage index, and PRICER for fiscal year 2011

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

Provider types affected

Hospice providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs] for services provided to Medicare beneficiaries need to be aware of this article.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7077 which provides the annual update to the hospice payment rates for fiscal year (FY) 2011, the hospice aggregate cap amount for the cap period ending October 31, 2010, and the hospice-wage index and PRICER for FY 2011. Be sure your billing staffs are aware of these changes, which are described in the *Background* section, below.

Background

CMS updates the payment for hospice care, the hospice aggregate cap amount, and the hospice-wage index annually. The Social Security Act (the Act) (Section 1814(i)(1)(C)(ii)) stipulates that the payments for hospice care for fiscal years after 2002 will increase by the market-basket percentage increase for that fiscal year (FY), and this payment methodology is codified in the *Code of Federal Regulations* (refer to Title 42, Section 418.306 (a)&(b)).

Update to hospice payment rates, cap, wage index, and PRICER for fiscal year 2011 (continued)

FY 2011 hospice payment rates

The FY 2011 payment rates will be the FY 2010 payment rates, increased by 2.6 percentage points, which is the total hospital market-basket percentage increase forecasted for FY 2011. The FY 2011 hospice-payment rates are shown in the following table and are effective for care and services furnished on or after October 1, 2010 through September 30, 2011.

Code	Description	Rate	Wage component subject to index	Non-weighted amount
651	Routine home care	$146.63	$100.75	$ 45.88
652	Continuous home care full rate = 24 hours of care $35.66= hourly rate	$855.79	$588.01	$267.78
655	Inpatient respite care	$151.67	$ 82.10	$ 69.57
656	General inpatient care	$652.27	$417.52	$234.75

Reference to the hospice payment rate is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 30.2 (Payment Rates); see the CMS website *http://www.cms.gov/manuals/downloads/clm104c11.pdf*.

Hospice cap

The latest hospice cap amount for the cap year ending October 31, 2010 is $23,874.98. In computing the cap, CMS used the medical care expenditure category of the March 2010 consumer price index for all urban consumers, published by the Bureau of Labor Statistics, (see *http://www.bls.gov/cpi/home.htm* on the Internet), which was 387.142. The hospice cap is discussed further in the *Medicare Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 80.2 (Cap on Overall Hospice Reimbursement); see the CMS website *http://www.cms.gov/manuals/downloads/clm104c11.pdf*).

Hospice-wage index

The hospice-wage index notice with comment period will be effective October 1, 2010 and published in the *Federal Register* before that date. The revised wage index and payment rates will be incorporated in the hospice PRICER and forwarded to the intermediaries following publication of the wage index final rule.

Additional information

You may find the official instruction, CR 7077, issued to your FI, A/B MAC, or RHHI by visiting the CMS website at *http://www.cms.gov/Transmittals/downloads/R2004CP.pdf*.

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

MLN Matters® Number: MM7077
Related Change Request (CR) Number: 7077
Related CR Release Date: July 23, 2010
Related CR Transmittal Number: R2004CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2004, CR 7077

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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/*.

Easy use of Internet-based provider enrollment chain and ownership system

The Internet-based provider enrollment chain and ownership system (PECOS) is easy to use and offers a host of advantages over the paper-based enrollment process.

Did you know that you can submit an initial Medicare enrollment application, along with other enrollment actions, using the Internet-based PECOS instead of the traditional paper application?

And, did you know that Internet-based PECOS can be faster than the paper application process by up to 50-percent (with a 30 to 45-day processing window, versus 60 days for the paper-based process)?

Learn how to use the system by selecting the appropriate instructions below based on the type of provider:

Physicians and nonphysician practitioners

Using Internet-based PECOS is easy

Learn how to use the system by using the *Medicare Physician and Non-Physician Practitioner Getting Started Guide*, available at *http://www.cms.gov/MedicareProviderSupEnroll/downloads/GettingStarted.pdf*. And if you encounter problems or have questions as you navigate the system, there are several resources that can help.

Don't wait, set your practice free from paper – start using Internet-based PECOS today at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*.

Provider and supplier organizations

Using Internet-based PECOS is easy

Learn how to use the system by using 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 section at *http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

Don't wait, set your organization free from paper – start using Internet-based PECOS today at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*. ❖

Source: CMS PERL 201007-53 and PERL 201007-54

PECOS creates custom applications tailored to your enrollment scenario

Have you tried Internet-based PECOS for your Medicare enrollment actions? Try it today.

Use the convenient Internet-based PECOS (provider enrollment chain and ownership system) to view and change enrollment information, and to track the processing of your enrollment application. And, because Internet-based PECOS creates a custom application tailored to your enrollment scenario, you only supply the information relevant to your application. Learn how to use the system by selecting the appropriate instructions below based on the type of provider:

Physicians and nonphysician practitioners

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Don't wait, set your practice free from paper – start today by using Internet-based PECOS at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*.

Provider and supplier organizations

Using Internet-based PECOS is easy

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Don't wait, set your practice free from paper – start today by using Internet-based PECOS at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp*.

Note: Internet-based PECOS is not yet available for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The system will be available for use by DMEPOS suppliers later this year. ❖

Source: CMS PERL 201008-23 and PERL 201008-24

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

Ambulance Services

Definition of ambulance services

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

Provider types affected

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

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7058 which updates the *Medicare Benefit Policy Manual* (Chapter 10, Section 30.1.1) to incorporate the application of basic life support (BLS) – emergency; advanced life support level 1 (ALS1) and emergency and advanced life support level 2 (ALS2) information. No new policy is presented but the CR 7058 updates the relevant manual section to reflect current policy. The updated manual section is attached to CR 7058.

Background

CMS issued MM7058 to update the relevant manual sections and provides the following application-based examples to accompany the definitions of BLS, ALS1 and ALS2 as follows:

Basic life support (BLS) emergency

Application: The determination to respond emergently with a BLS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advanced life support, level 1 (ALS1) – emergency

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Advance life support, level 2 (ALS2)

Application: Crystalloid fluids include fluids such as five percent dextrose in water, saline and lactated Ringer's. medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

In other words, the administration of 1/3rd of a qualifying dose three times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given three times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal three times X. Thus, if three administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of intravenous (IV) epinephrine in the treatment of pulseless ventricular tachycardia/ventricular fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25 mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to the American Heart Association (AHA), advanced cardiac life support (ACLS) protocol, calls for epinephrine to be administered in 1 mg increments every three to five minutes. Therefore, in order to receive payment for an ALS2 level of service based in part on the administration of epinephrine, three separate administrations of epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT.

A second example that would not qualify for the ALS2 payment level is the use of adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with paroxysmal supraventricular tachycardia (PSVT). According to ACLS guidelines, 6 mg of adenosine should be given by rapid intravenous push (IVP) over one to two seconds. If the first dose does not result in the

Definition of ambulance services (continued)

elimination of the supraventricular tachycardia within one to two minutes, 12 mg of adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of adenosine may be administered for a total of 30 mg of adenosine. Three separate administrations of the drug adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether the ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to transport also qualifies as an ALS2 procedure.

Additional information

The official instruction associated with this CR 7058, issued to your Medicare A/B MAC, carrier and/or FI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R130BP.pdf*.

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

MLN Matters® Number: MM7058
Related Change Request (CR) Number: 7058
Related CR Release Date: July 30, 2010
Related CR Transmittal Number: R130BP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-02, Transmittal 130, CR 7058

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Electronic Health Records

Get the facts on electronic health record incentives

There's a lot of talk right now about electronic health records (EHRs), and how health care professionals and hospitals are going to pay for them.

So you probably have a lot of questions about them as well: Am I eligible to receive incentive payments under the Medicare & Medicaid EHR Incentive Programs? When do the programs begin? How much are the incentive payments? What do I need to participate?

It's important that you have a reliable resource to turn to for accurate information. The Centers for Medicare & Medicaid Services (CMS) is the federal agency establishing these incentive programs. The CMS website is the official federal source for facts about the Medicare & Medicaid EHR Incentive Programs. The site contains up-to-date resources that will give you the insight you need to make educated decisions.

Avoid reading false or misleading information. Get the facts from the federal source – the CMS Medicare & Medicaid EHR Incentive Programs website. Visit *http://www.cms.gov/EHRIncentivePrograms* today.

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

Source: CMS PERL 201008-31

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.

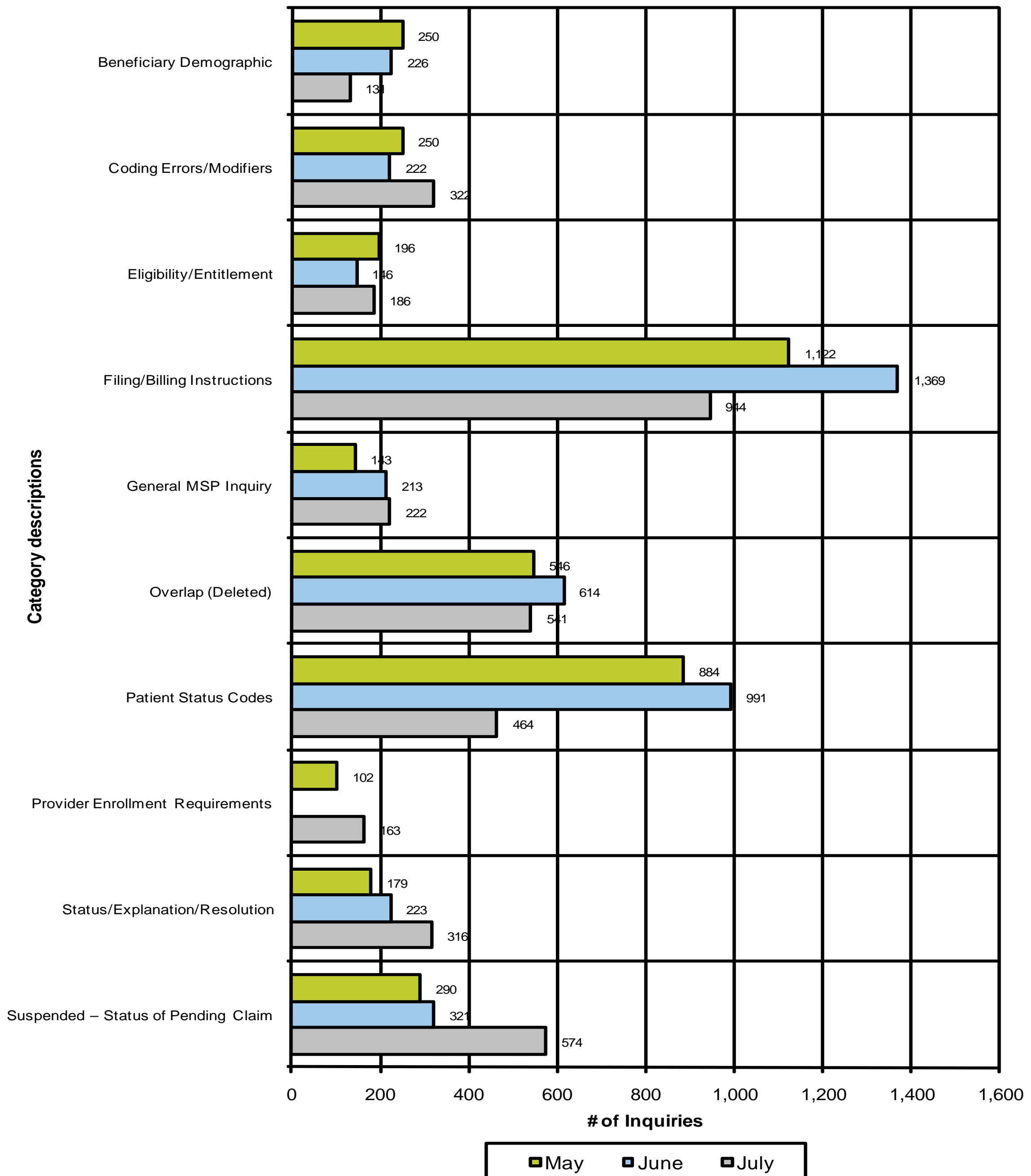
Claim and Inquiry Summary Data

Top inquiries, return to provider, and reject claims for May-July 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 May-July 2010.

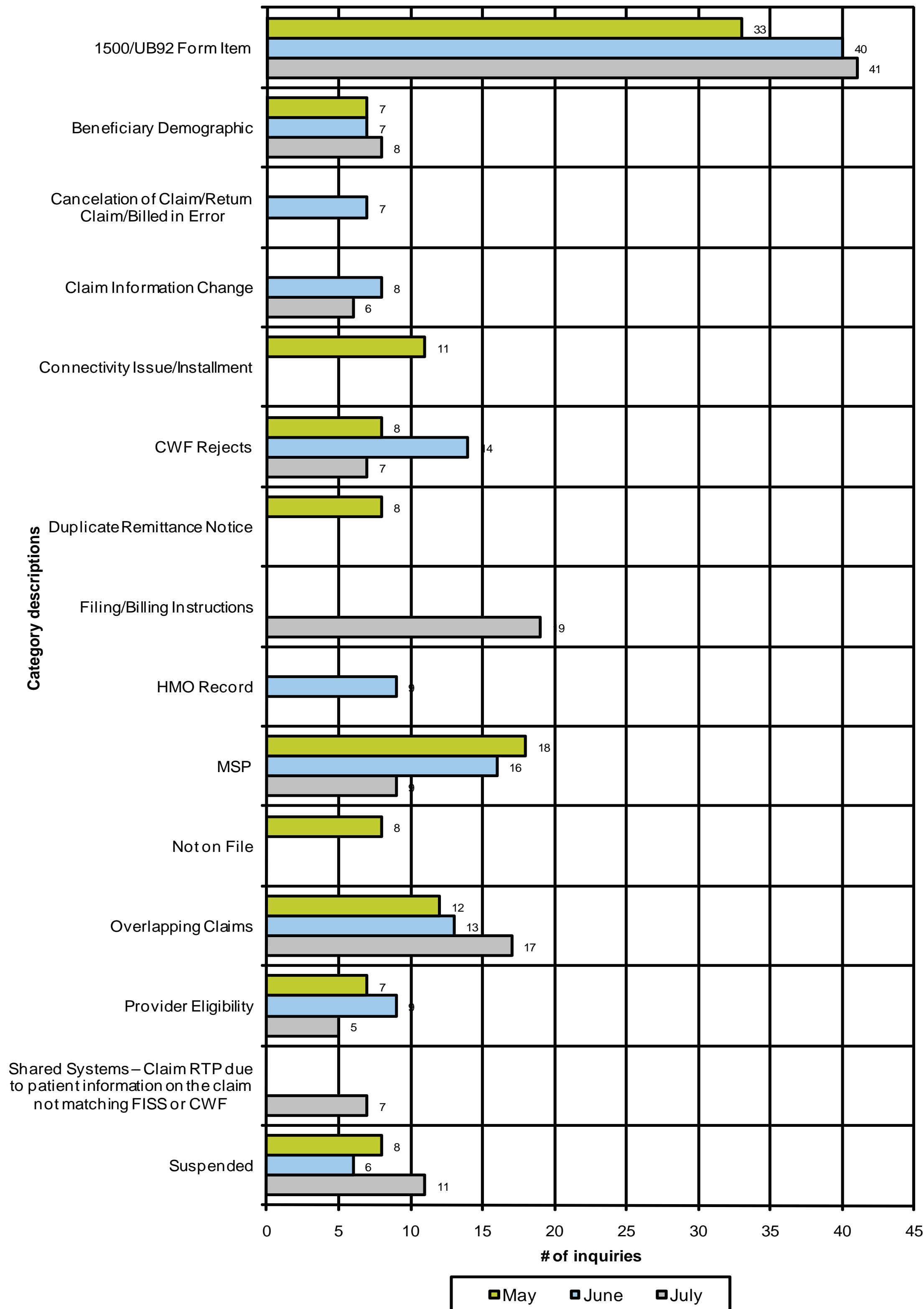
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for May-July 2010



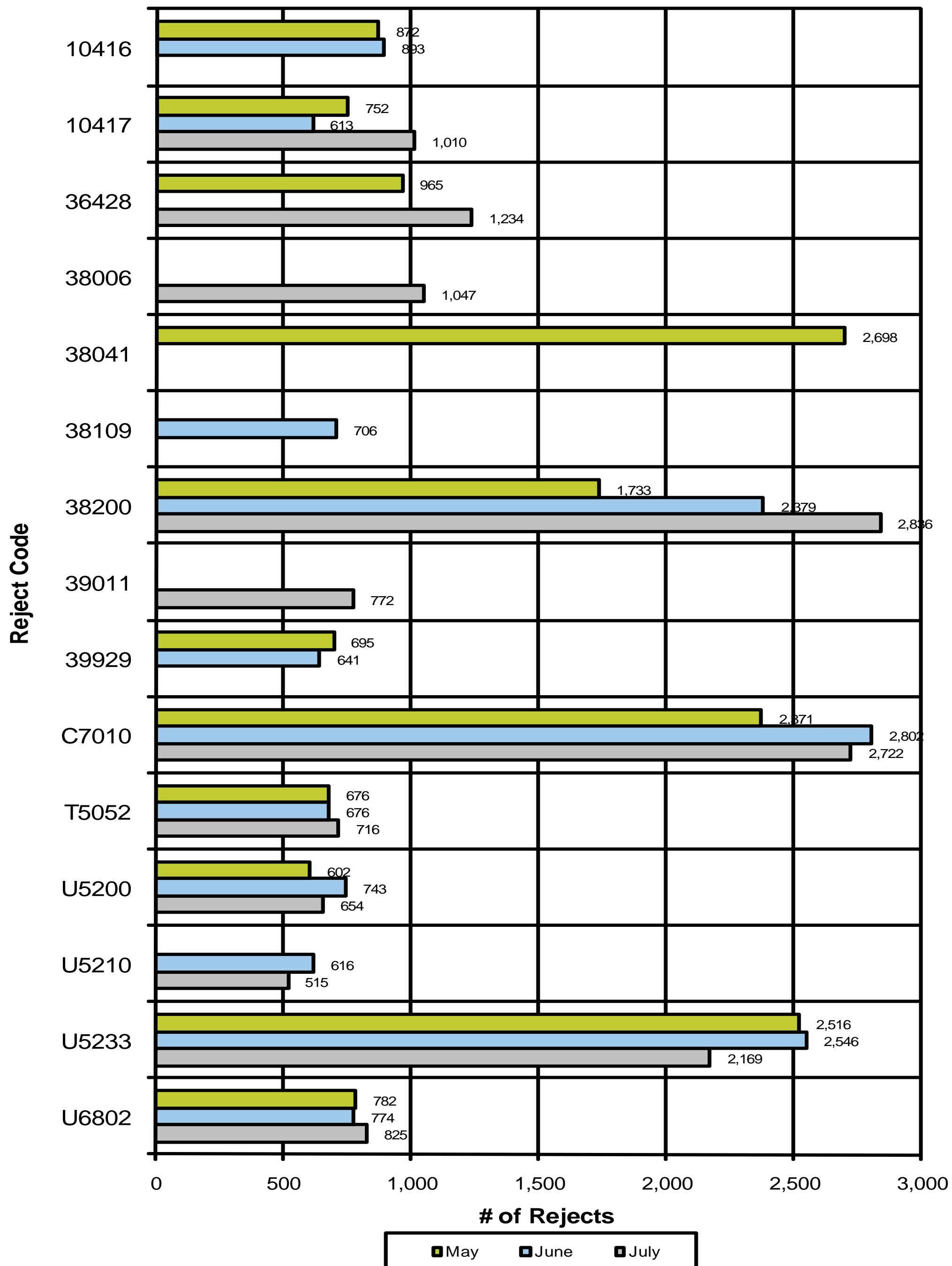
Top inquiries, return to provider, and reject claims for May-July 2010 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for May-July 2010



Top inquiries, return to provider, and reject claims for May-July 2010 (continued)

Florida Part A top rejects for May-July 2010

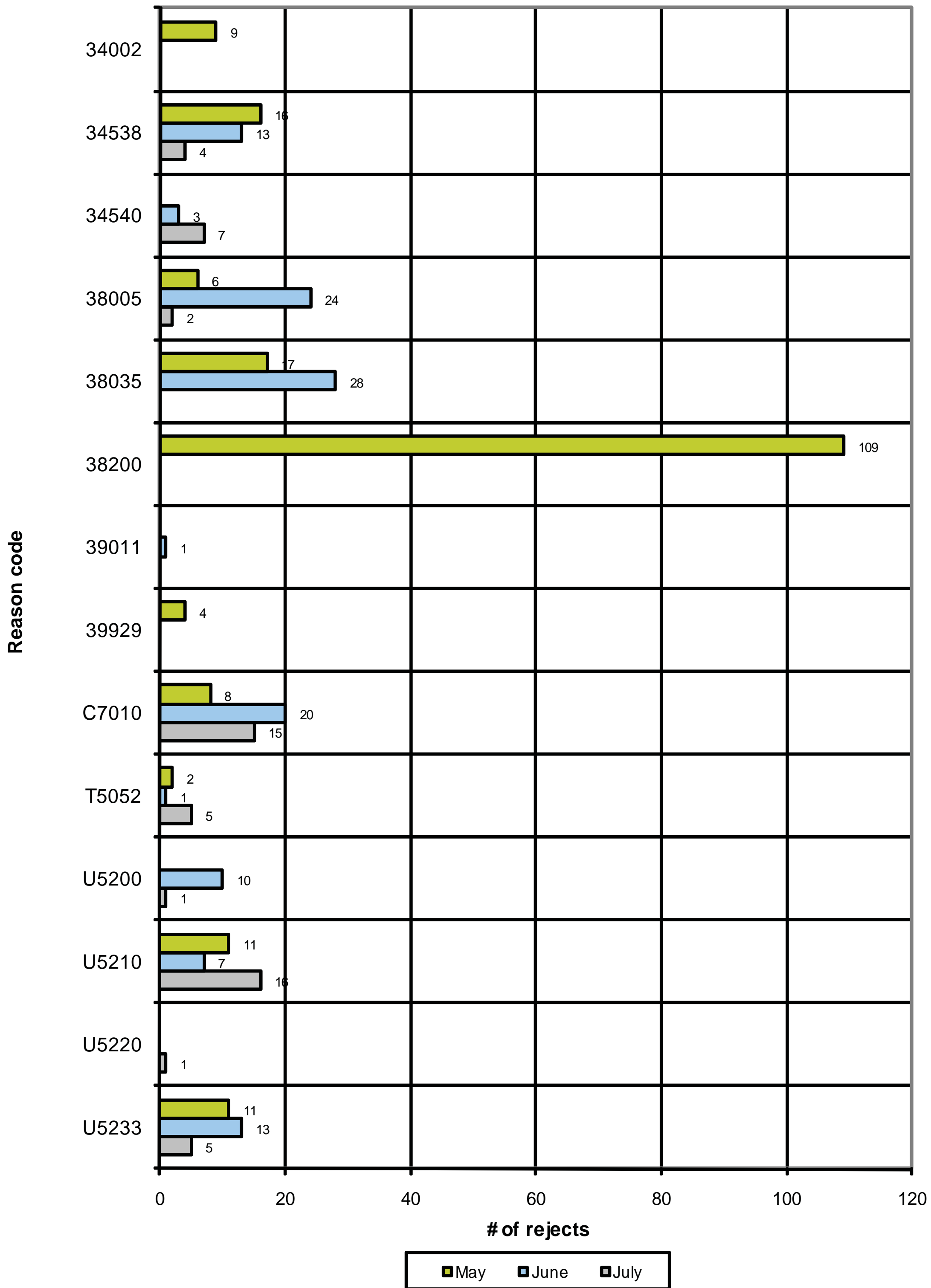


Keep Informed

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.

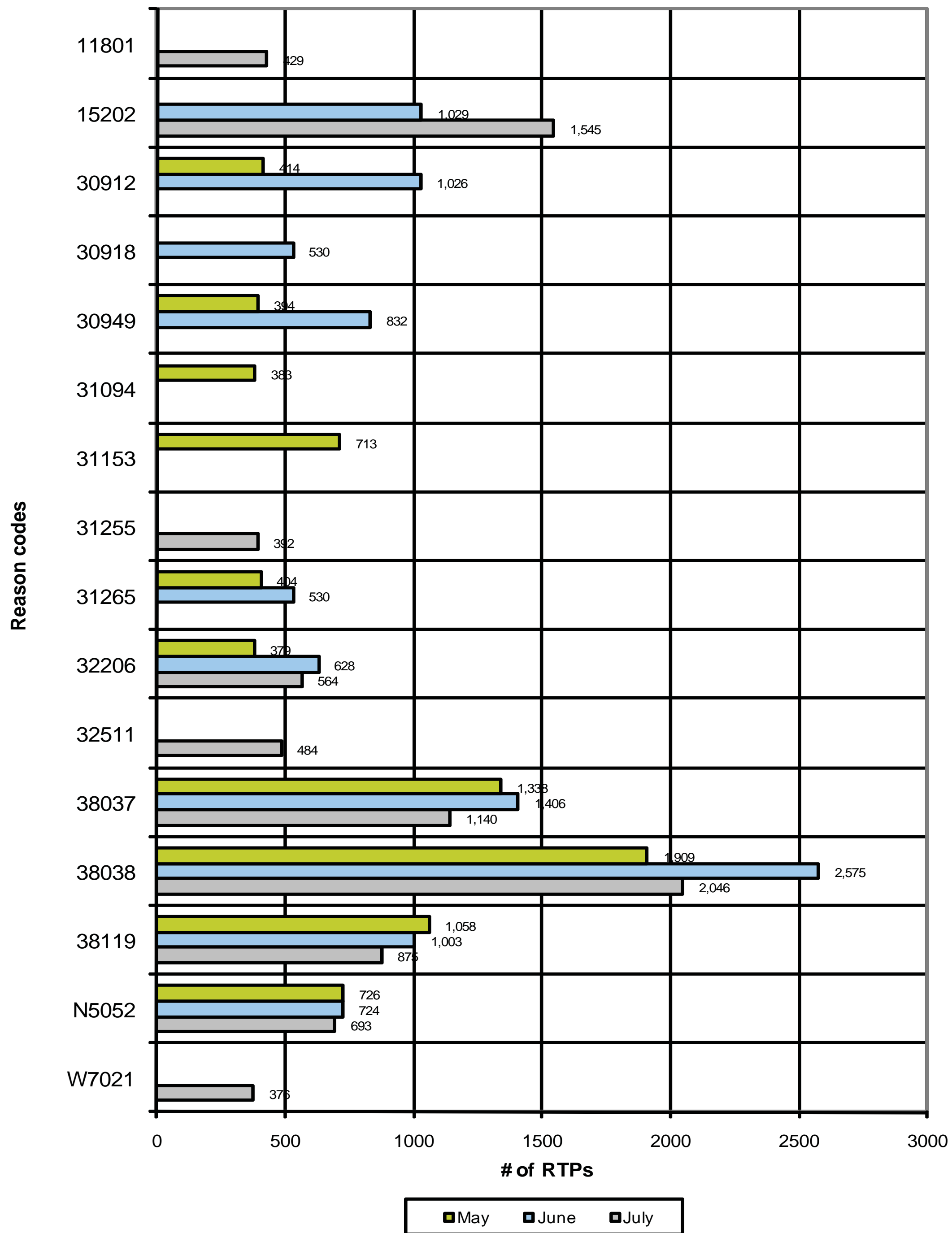
Top inquiries, return to provider, and reject claims for May-July 2010 (continued)

U.S. Virgin Islands Part A top rejects for May-July 2010



Top inquiries, return to provider, and reject claims for May-July 2010 (continued)

Florida Part A top return to providers (RTPs) for May-July 2010

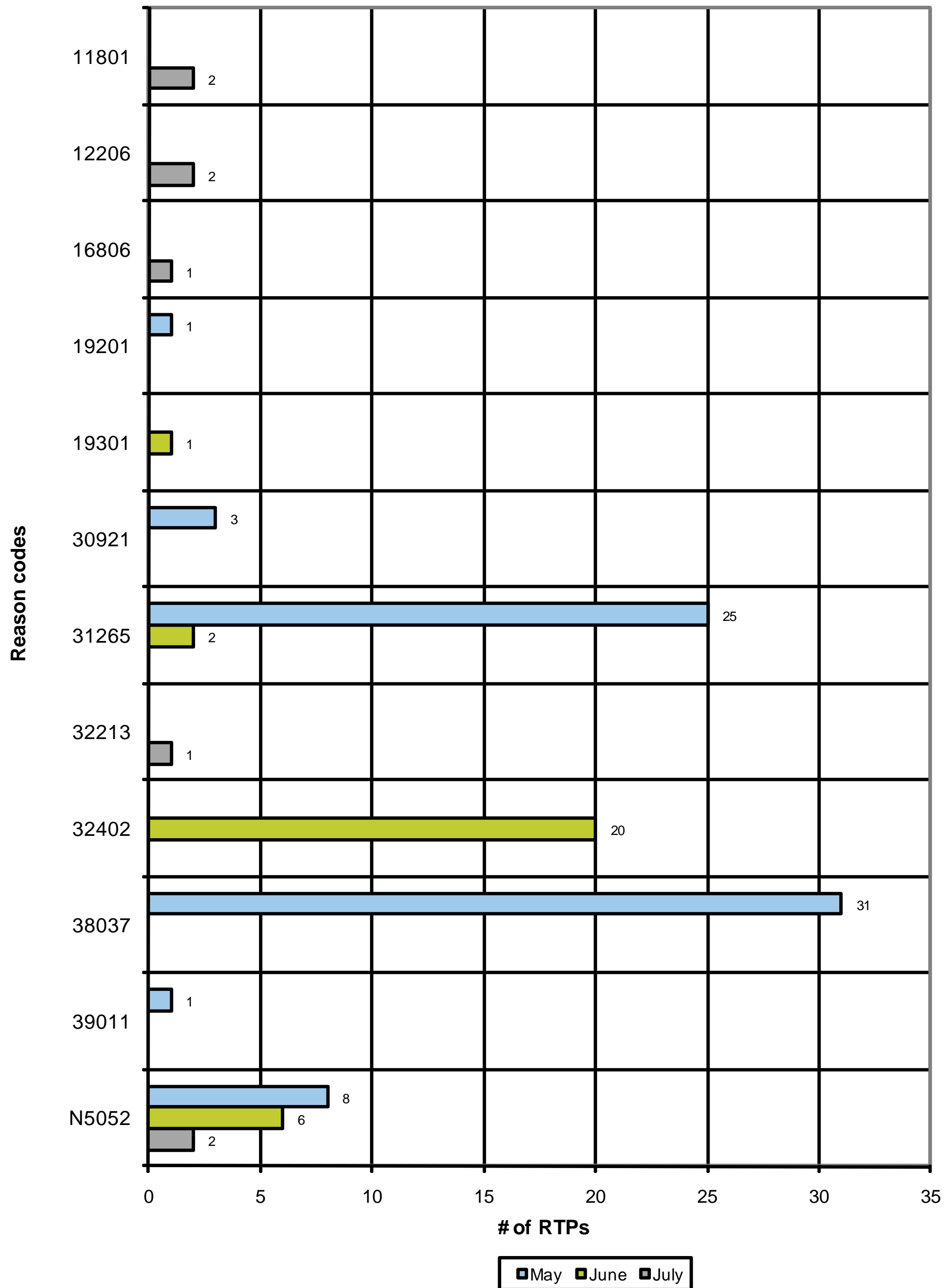


Educational Resources

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 May-July 2010 (continued)

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



General Coverage

Revisions and re-issuance of audiology policies

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 MM6447 to include the revised effective and implementation dates, the revised change request (CR) release date, transmittal numbers, and Web addresses for accessing the transmittals. In addition, claim adjustment reason codes and remittance advice remark codes have been added, where appropriate. The Web address for accessing the audiology code list was also revised. All other information is the same. The article was published in the June 2010 *Medicare A Bulletin* (pages 36-38).

Provider types affected

This article is for physicians, nonphysician practitioners, audiologists, and speech-language pathologists submitting claims to Medicare administrative contractors (A/B MACs), carriers and fiscal intermediaries (FIs) for services provided to hearing impaired Medicare beneficiaries.

Provider action needed

This article is based on CR 6447. CMS issued CR 6447 to respond to provider requests for clarification of some of the language in CR 5717 and CR 6061. Special attention is given to clarifying policy concerning services incident to physician services that are paid under the Medicare physician fee schedule (MPFS). See the *Key points* section of this article for the clarifications provided by CR 6447.

Background

Key parts of the clarified policy are in the revised Chapter 12, Section 30.3 of the *Medicare Claims Processing Manual* and in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual*. These revised manual sections are attached to CR 6447. As mentioned in these revised sections of the manuals and per Section 1861 (II)(3) of the Social Security Act, "audiology services" are defined as such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under state law (or the state regulatory mechanism provided by state law), as would otherwise by covered if furnished by a physician. These hearing and balance assessment services are termed "audiology services," regardless of whether they are furnished by an audiologist, physician, nonphysician practitioner (NPP), or hospital.

Because audiology services are diagnostic tests, when furnished in an office or hospital outpatient department, they must be furnished by or under the appropriate level of supervision of a physician as established in 42 CFR 410.32(b)(1) and 410.28(e). If not personally furnished by a physician, audiologist, or NPP, audiology services must be performed under direct physician supervision. As specified in 42 CFR 410.32(b)(2)(ii) or (v), respectively, these services are excepted from physician supervision when they are personally furnished by a qualified audiologist or performed by a nurse practitioner or clinical nurse specialist authorized to perform the tests under applicable state laws.

Note: References to technicians in CR 6447 and this article apply also to other qualified clinical staff. The qualifications for technicians vary locally and may also depend on the type of test, the patient, and the level of participation of the physician who is directly supervising the test. Therefore, an individual must meet qualifications appropriate to the service furnished as determined by the Medicare contractor to whom the claim is billed. If it is necessary to determine whether the individual who furnished the labor for appropriate audiology services is qualified, contractors may request verification of any relevant education and training that has been completed by the technician, which shall be available in the records of the clinic or facility.

Audiology services, like all other services, should be reported under the most specific HCPCS code that describes the service that was furnished and in accordance with all *CPT* guidance and Medicare national and local contractor instructions.

See the CMS website at *http://www.cms.gov/therapyservices* for a listing of all *CPT* codes for audiology services. For information concerning codes that are not on the list, and which codes may be billed when furnished by technicians, contractors shall provide guidance. The MPFS at *http://www.cms.gov/PFSlookup/* allows you to search pricing amounts, various payment policy indicators, and other MPFS data.

Qualification discussion

The individuals who furnish audiology services in all settings must be qualified to furnish those services. The qualifications of the individual performing the services must be consistent with the number, type and complexity of the tests, the abilities of the individual, and the patient's ability to interact to produce valid and reliable results. The physician who supervises and bills for the service is responsible for assuring the qualifications of the technician, if applicable, are appropriate to the test.

When a professional personally furnishes an audiology service, that individual must interact with the patient to provide professional skills and be directly involved in decision-making and clinical judgment during the test.

The skills required when professionals furnish audiology services for payment under the MPFS are masters or doctoral level skills that involve clinical judgment or assessment and specialized knowledge and ability including, but not limited to, knowledge of anatomy and physiology, neurology, psychology, physics, psychometrics, and interpersonal communication. The interactions of these knowledge bases are required to attain the clinical expertise

Revisions and re-issuance of audiology policies (continued)

for audiology tests. Also required are skills to administer valid and reliable tests safely, especially when they involve stimulating the auditory nerve and testing complex brain functions.

Diagnostic audiology services also require skills and judgment to administer and modify tests, to make informed interpretations about the causes and implications of the test results in the context of the history and presenting complaints, and to provide both objective results and professional knowledge to the patient and to the ordering physician.

Examples include, but are not limited to the following:

- Comparison or consideration of the anatomical or physiological implications of test results or patient responsiveness to stimuli during the test.
- Development and modification of the test battery and test protocols.
- Clinical judgment, assessment, evaluation, and decision-making.
- Interpretation and reporting observations, in addition to the objective data, that may influence interpretation of the test outcomes.
- Tests related to implantation of auditory prosthetic devices, central auditory processing, contra-lateral masking.
- Tests to identify central auditory processing disorders, tinnitus, or nonorganic hearing loss.

Key points of change request 6447

- For claims with dates of service on or after October 1, 2008, audiologists are required to be enrolled in the Medicare program and use their national provider identifier (NPI) on all claims for services they render in office settings.
- For audiologists who are enrolled and bill independently for services they render, the audiologist's NPI is required on all claims they submit. For example, in offices and private practice settings, an enrolled audiologist shall use his or her own NPI in the rendering loop to bill under the MPFS for the services the audiologist furnished. If an enrolled audiologist furnishing services to hospital outpatients reassigns his/her benefits to the hospital, the hospital may bill the Medicare contractor for the professional services of the audiologist under the MPFS using the NPI of the audiologist. If an audiologist is employed by a hospital but is not enrolled in Medicare, the only payment for a hospital outpatient audiology service that can be made is the payment to the hospital for its facility services under the hospital outpatient prospective payment system (OPPS) or other applicable hospital payment system. No payment can be made under the MPFS for professional services of an audiologist who is not enrolled.
- Audiology services may be furnished and billed by audiologists and, when these services are furnished by an audiologist, no physician supervision is required.
- When a physician or supplier furnishes a service that is covered by Medicare, then it is subject to the mandatory claim submission provisions of Section 1848(g)(4) of the Social Security Act. Therefore, if an audiologist charges or attempts to charge a beneficiary any remuneration for a service that is covered by Medicare, then the audiologist must submit a claim to Medicare.
- Medicare pays for diagnostic audiological tests under the MPFS when they meet the requirements of audiology services as shown in Chapter 15, Section 80.3 of the *Medicare Benefit Policy Manual* as attached to CR 6447.
- For claims with dates of service on or after October 1, 2008, the NPI of the enrolled audiologist is required on claims in the appropriate rendering and billing fields.
- Medicare will not pay for services performed by audiologists and billed under the NPI of a physician. In denying such claims, Medicare will use:
  - CARC 170 (Payment is denied when performed/billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), and
  - Remittance advice remark code (RARC) MA102 (Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.)
- Medicare will not pay for an audiological test under the MPFS if the test was performed by a technician under the direct supervision of a physician if the test requires professional skills. Such claims will be denied using claim adjustment reason code (CARC) 170 (Payment is denied when performed/billed by this type of provider. **Note**: Refer to the 835 health care policy identification segment (loop 2110 service payment information REF), if present).
- Medicare will not pay for audiological tests furnished by technicians unless the service is furnished under the direct supervision of a physician. In denying claims under this provision, Medicare will use:
  - CARC 185 (The rendering provider is not eligible to perform the service billed. **Note**: Refer to the 835 health care policy identification segment (loop 2110 service payment information REF), if present).
  - RARC M136 (Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician).
- Medicare will pay for the technical component (TC) of diagnostic tests that are not on the list of audiology services when those tests are furnished by audiologists under the designated level of physician supervision for the service and the audiologist is qualified to perform the service. (Once again, the list of audiology services is posted on the CMS website at *http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp*.)

Revisions and re-issuance of audiology policies (continued)

- Medicare will pay physicians and NPPs for treatment services furnished by audiologists incident to physicians' services when the services are not on the list of audiology services on the CMS website at *http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp* and are not "always" therapy services and the audiologist is qualified to perform the service.
- All audiological diagnostic tests must be documented with sufficient information so that Medicare contractors may determine that the services do qualify as an audiological diagnostic test.
- The interpretation and report shall be written in the medical record by the audiologist, physician, or NPP who personally furnished any audiology service, or by the physician who supervised the service. Technicians shall not interpret audiology services, but may record objective test results of those services they may furnish under direct physician supervision. Payment for the interpretation and report of the services is included in payment for all audiology services, and specifically in the professional component (PC), if the audiology service has a professional component/technical component split.
- When Medicare contractors review medical records of audiological diagnostic tests for payment under the MPFS, they will review the technician's qualifications to determine whether, under the unique circumstances of that test, a technician is qualified to furnish the test under the direct supervision of a physician.
- The PC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. (Note this is also true in the facility setting.) A physician or NPP may bill for the PC when the physician or NPP furnish the PC and an (unsupervised) audiologist furnishes and bills for the TC. The PC may not be billed if a technician furnishes the service. A physician or NPP may not bill for a PC service furnished by an audiologist.
- The TC of a PC/TC split code may be billed by the audiologist, physician, or NPP who personally furnishes the service. Physicians may bill the TC for services furnished by technicians when the technician furnishes the service under the direct supervision of that physician. Audiologists and NPPs may not bill for the TC of the service when a technician furnishes the service, even if the technician is supervised by the NPP or audiologist.
- The "global" service is billed when both the PC and TC of a service are personally furnished by the same audiologist, physician, or NPP. The global service may also be billed by a physician, but not an audiologist or NPP, when a technician furnishes the TC of the service under direct physician supervision and that physician furnishes the PC, including the interpretation and report.
- Tests that have no appropriate *CPT* code may be reported under *CPT* code *92700* (Unlisted otorhinolaryngological service or procedure).
- Audiology services may not be billed when the place of service is a comprehensive outpatient rehabilitation facility (CORF) or a rehabilitation agency.
- The opt-out law does not define "physician" or "practitioner" to include audiologists; therefore, they may not opt-out of Medicare and provide services under private contracts.

Additional information

There are two transmittals related to CR 6447, the official instruction issued to your Medicare A/B MAC, FI and/or carrier. The first modifies the *Medicare Benefit Policy Manual* and that transmittal is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R129BP.pdf*.

The other transmittal modifies the *Medicare Claims Processing Manual* and it is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2007CP.pdf*.

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

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Source: CMS Pub. 100-04, Transmittal 2007, CR 6447

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Website survey

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

Local Coverage Determinations

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

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Advance beneficiary notice

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

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

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NEW LCD IMPLEMENTATION

A86003: Allergy testing – new LCD

LCD ID Number: L31267 (Florida/Puerto Rico/U.S. Virgin Islands)

Allergy is a form of exaggerated sensitivity or hypersensitivity to a substance that is either inhaled, ingested, injected, or comes in contact with the skin or eye. The term allergy is used to describe situations where hypersensitivity results from heightened or altered reactivity of the immune system in response to external substances. Allergic or hypersensitivity disorders may be manifested by generalized systemic reactions as well as localized reactions in any part of the body. The reactions may be acute, subacute, or chronic, immediate or delayed, and may be caused by a variety of offending agents; pollen, molds, mites, dust, feathers, animal fur or dander, venoms, foods, drugs, etc.

Allergy testing is performed to determine a patient's immunologic sensitivity or reaction to particular allergens for the purpose of identifying the cause of the allergic state, and is based on findings during a complete medical and immunologic history and appropriate physical exam obtained by face-to-face contact with the patient.

Effective date

This new LCD is effective for services provided **on or after September 30, 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. ❖

A88182: Flow cytometry – new LCD

LCD ID Number: L31231 (Florida/Puerto Rico/U.S. Virgin Islands)

Flow cytometry (FCM) is a procedure which simultaneously measures and analyzes multiple physical characteristics of single cells, as they flow in a fluid stream through a beam of light. The light activates fluorescent molecules, resulting in light scatter, which forms a pattern that can be analyzed for cell characteristics. FCM can be used to analyze blood, body fluids, CSF, bone marrow, lymph node, tonsil, spleen and other solid organs. Information from the analyzed cells may help determine prognosis, aid in the analysis of effusions, urine, or other fluids in which cancer cells may be few or mixed with benign cells, detect metastases in lymph nodes or bone marrow, or to supplement fine needle aspiration.

The flow cytometer is made up of three main systems: fluidics, optics and electronics. The fluidic system transports particles in a stream to the laser beam. The optics system consists of lasers to illuminate the particles in the sample stream and optical filters to direct the resulting light signals to the appropriate detectors. The electronics system converts the detected light signals into electronic signals that can be processed by the computer. Some flow cytometers have a sorting feature which allows the electronic system to initiate sorting decisions to charge and deflect particles.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. A "Coding Guidelines" LCD attachment has also been developed for this service, which includes billing information.

Effective date

This new LCD is effective for services provided **on or after September 30, 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*.

A95990: Implantable infusion pump for the treatment of chronic intractable pain – new LCD

LCD ID Number: L31249 (Florida/Puerto Rico/U.S. Virgin Islands)

The implantable infusion pump is a drug delivery system that is used to deliver a solution containing parenteral drug(s) under continuous or intermittent infusion with a regulated flow rate. Its purpose is to deliver a therapeutic level of a drug to a specific site within the body.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT* codes, documentation requirements, and utilization guidelines for implantable infusion pump for the treatment of chronic intractable pain.

In addition, a "Coding Guidelines" LCD attachment has been developed for this service which includes information regarding coding and billing for compounded drugs.

Effective date

This new LCD is effective for services provided **on or after September 30, 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. ❖

AQutenza: Qutenza® (capsaicin) 8% patch – new LCD

LCD ID Number: L31225 (Florida/Puerto Rico/U.S. Virgin Islands)

Postherpetic neuralgia (PHN) is a rare painful complication of shingles (herpes zoster), a result of nerve damage caused by the shingles virus. The pain can persist long after the shingles rash clears up and can disrupt sleep, mood, work, and activities of daily living. Qutenza® is a high concentration capsaicin patch intended to treat neuropathic pain associated with PHN. According to the labeling approved by the Food and Drug Administration (FDA), the patch should be administered only under clinical supervision, with continuous clinical monitoring throughout its administration, and should not be dispensed to patients for self-administration.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. A "Coding Guidelines" LCD attachment has also been developed for this drug, which includes billing information.

Effective date

This new LCD is effective for services provided **on or after September 30, 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. ❖

AXiaflex: Collagenase clostridium histolyticum (Xiaflex®) – new LCD

LCD ID Number: L31223 (Florida/Puerto Rico/U.S. Virgin Islands)

Dupuytren's contracture affects the palmer fascia of the hands. It is characterized by a thickening of the fibrous tissue underneath the skin of the hand, with resulting nodule and contracture formation. These contractures cause the finger(s) to palmar flex (into the hand). The contractures are usually painless, but they can cause disability of the hand as the disease progresses. The two joints most commonly affected by Dupuytren's contracture are the metacarpophalangeal (MCP) and the proximal interphalangeal (PIP) joints.

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage, ICD-9-CM codes that support medical necessity, documentation requirements, and utilization guidelines. A "Coding Guidelines" attachment has also been developed for this drug, which outlines the specific billing instructions for this drug.

Effective date

This new LCD is effective for services provided **on or after September 30, 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. ❖

ADDITIONS/REVISIONS TO EXISTING LCDS

A70450: Computed tomography scans of the head or brain – revision to the LCD

LCD ID Number: L28808 (Florida)
LCD ID Number: L28815 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomography scans of the head or brain was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Documentation Requirements" section of the LCD has been revised by removing verbiage pertaining to ordering contrast, for consistency with other LCDs. In addition, references were updated under the "Sources of Information and Basis for Decision" section of the LCD.

Effective date

This LCD revision is effective for services provided **on or after August 17, 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. ❖

A72192: Computed tomography of the abdomen and pelvis – revision to the LCD

LCD ID Number: L28806 (Florida)
LCD ID Number: L28813 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomography of the abdomen and pelvis was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Documentation Requirements" section of the LCD has been revised by removing verbiage pertaining to ordering contrast, for consistency with other LCDs. In addition, references were updated under the "Sources of Information and Basis for Decision" section of the LCD.

Effective date

This LCD revision is effective for services provided **on or after August 17, 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. ❖

AJ2778: Ranibizumab (Lucentis®) – revision to the LCD

LCD ID Number: L28977 (Florida)
LCD ID Number: L29010 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) was effective for services provided on or after February 16, 2009, for Florida, and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands, as a Medicare administrative contractor (MAC) LCD for jurisdiction 9 (J9). Since that time, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been revised to add language regarding the approval of ranibizumab by the Food and Drug Administration (FDA) on June 22, 2010, for the treatment of patients with macular edema following retinal vein occlusion (RVO). The recommended dosage and frequency of treatment is 0.5 mg/0.05 mL (10mg/mL), administered by intravitreal injection once a month (approximately 28 days) for six months.

Ranibizumab (Lucentis®) is supplied as a preservative-free, sterile solution in a single-use glass vial designed to provide 0.05 mL of 10 mg/mL solution for intravitreal injection. Each vial should only be used for the treatment of a single eye. If the contralateral eye requires treatment, a new vial should be used.

The "ICD-9 Codes that Support Medical Necessity" section of the LCD has been revised to add the following ICD-9-CM codes: 362.07, 362.35, 362.36, 362.53 and 362.83.

The following language was also added to this section of the LCD:

Macular edema following retinal vein occlusion (RVO) should be reported as follows:

- Report macular edema with one of the following ICD-9-CM codes: 362.07*, 362.53 or 362.83; AND

AJ2778: Ranibizumab (Lucentis®) – (continued)

- Report retinal vein occlusion (RVO) with one of the following ICD-9-CM codes: 362.35 or 362.36.
- Addition, when reporting ICD-9-CM code 362.07: Per the ICD-9-CM coding manual, ICD-9-CM code 362.07 requires a dual diagnosis. Therefore, ICD-9-CM code 362.07 must be used with a code for diabetic retinopathy (ICD-9-CM codes 362.01-362.06).

The LCD "Coding Guidelines" attachment has been revised to add coding and billing information in reporting ranibizumab for the treatment of exudative senile macular degeneration and macular edema following retinal vein occlusion (RVO).

As a reminder, when performing an injection on both eyes, modifier 50 should be used and modifier RT or LT should be used for unilateral services.

Effective date

This LCD revision is effective for claims processes **on or After October 3, 2010,** for services provided **on or after June 22, 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 July 1, 2010. Since that time, a revision was made to add Category III *CPT* codes *0223T, 0224T, 0225T; 0228T, 0229T, 0230T, 0231T, 0232T*, and *0233T* to the LCD based on an evaluation of these services.

Under the "CPT/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD, the following Category III *CPT* codes were added:

0223T *Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report*

0224T *Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; multiple, including serial trended analysis and limited reprogramming of device parameter – AV or VV delays only, with interpretation and report*

0225T *Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; multiple, including serial trended analysis and limited reprogramming of device parameter – AV and VV delays, with interpretation and report*

0228T *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level*

0229T *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)*

0230T *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level*

0231T *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)*

0232T *Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed*

0233T *Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy*

In addition, *CPT* code *46999* for transanal radiofrequency therapy for fecal incontinence (e.g., Secca® System) and *CPT* code *93799* for noninvasive assessment of central blood pressure (e.g., SphygmoCor System/Device) were added to the LCD under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section based on an evaluation of these services.

The title of the LCD has also been changed from "the list of Medicare noncovered services" to "noncovered services."

Effective date

This LCD revision is effective for services provided **on or after September 30, 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. ❖

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Hospital Services

Changes to present on admission indicator 1 and K3 segment – HIPAA version 5010 implementation

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

Provider types affected

Hospitals who submit claims to Medicare administrative contractors (MACs) and/or fiscal intermediaries (FIs) for services to Medicare beneficiary inpatient services are affected.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7024 to alert hospitals that effective with the implementation of HIPAA version 5010 inpatient prospective payment system (IPPS) hospitals will no longer report the present on admission (POA) indicator of '1'. International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are exempt from the POA reporting requirement should be left 'blank' instead of populating a '1'.

In addition, the K3 segment, which was required for reporting POA in the 4010A1 version of the 837I, is no longer be used to report POA. The POA indicators will instead follow the diagnosis code in the appropriate 2300 HI segment.

Make certain your billing staffs are aware of these requirements and that your physicians and other practitioners and coders are collaborating to ensure complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Background

On February 8, 2006, the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the identification of conditions that are:

- High cost or high volume or both
- Result in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis
- Could reasonably have been prevented through the application of evidence-based guidelines. Section 5001(c) provides that CMS may revise the list of conditions from time to time, as long as it contains at least two conditions.

For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.

CMS also required hospitals to report POA information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.

The table below outlines the payment implications for each of the different POA Indicator reporting options.

CMS POA indicator options and definitions

Code	Reason for code
Y	Diagnosis was present at time of inpatient admission. CMS will pay the complicating condition/major complicating condition (CC/MCC) DRG for those selected hospital acquired conditions (HACs) that are coded as "Y" for the POA indicator.
N	Diagnosis was not present at time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA indicator.
1	Unreported/not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA indicator. The "1" POA indicator should not be applied to any codes on the HAC list.

Changes to present on admission indicator 1 and K3 segment – HIPAA version 5010 implementation (continued)

Key points of change request 7024

- IPPS hospitals will no longer report the POA indicator of '1'.
- ICD-9-CM diagnosis codes that are exempt from the POA reporting requirement should be left 'blank' instead of populating a '1'.
- In addition, the K3 segment, which was required for reporting POA in the 4010A1 version of the 837I, is no longer be used to report POA.
- The POA indicators will instead follow the diagnosis code in the appropriate 2300 HI segment.

Additional information

The official instruction associated with this CR 7024, issued to your Medicare A/B MAC, and/or FI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R756OTN.pdf*.

You may find further information concerning HACs and POAs on the CMS website at *https://www.cms.gov/HospitalAcqCond/*.

You may also want to review related *MLN Matters*® articles MM5499, SE0841 and MM6086, which are respectively at: *http://www.cms.gov/MLNMattersArticles/downloads/MM5499.pdf*

http://www.cms.gov/MLNMattersArticles/downloads/MM6086.pdf

http://www.cms.gov/MLNMattersArticles/downloads/SE0841.pdf.

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

MLN Matters® Number: MM7024
Related Change Request (CR) Number:
Related CR Release Date: August 13, 2010
Related CR Transmittal Number: R756OTN
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-20, Transmittal 756, CR 7024

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Tip sheets for hospitals now available on the CMS EHR incentive program website

The following tip sheets for hospitals are now available on the Centers for Medicare & Medicaid Services (CMS) electronic health record (EHR) incentive program website *http://www.cms.gov/EHRIncentivePrograms*:

- EHR incentive program for Medicare hospitals

  Learn which Medicare hospitals are eligible for incentive payments. (See the separate tip sheet addressing critical access hospitals [CAHS] below.) This sheet provides user friendly information about the factors which impact incentive payment amounts and provides sample payment calculations.

- EHR incentive program for critical access hospitals

  How are Medicare incentive payments calculated for CAHs? When can they be earned? Learn more in this informative discussion of the calculation of incentive payments. Sample calculations are provided. This sheet also provides information on how reimbursement will be reduced for CAHs which have not demonstrated meaningful use of certified EHR technology by 2015.

  On the EHR incentive program website, select the hospitals tab on the left, and then scroll to "Downloads."

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

Source: CMS PERL 201007-51

Policy and payment rate changes for certain hospitals in fiscal year 2011

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on July 30 establishing fiscal year (FY) 2011 policies and payment rates for inpatient services furnished to people with Medicare by acute care hospitals, long-term care hospitals (LTCHs), and certain excluded hospitals. Due to the timing of the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"), CMS issued a FY 2011 inpatient prospective payment system (IPPS)/LTCH proposed rule, as well as a supplemental proposed rule that addressed certain changes made by the Affordable Care Act. The final rule responds to comments received by CMS on both the proposed rule and the supplemental proposed rule, which appeared in the May 4 and June 2 issues of the *Federal Register*, respectively.

The final rule applies to approximately 3,500 acute care hospitals paid under the IPPS, and approximately 420 long-term care hospitals paid under the LTCH PPS, for discharges occurring on or after October 1, 2010. It also updates the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The updated rate-of-increase limits are effective for cost reporting periods beginning on or after October 1, 2010.

"The final rule we are issuing today will ensure that Medicare pays hospitals accurately for inpatient services for Medicare beneficiaries while fostering continuing improvements in the quality and safety of care," said CMS Administrator Donald Berwick.

With this action, CMS is updating acute care hospital rates by 2.35 percent. This update reflects a market basket increase of 2.6 percent for inflation, which is a slight increase over the FY 2010 inflation rate. The final rule reduces the 2.6 percent inflation update by 0.25 percent, as required by the Affordable Care Act. Further, CMS will apply a "documentation and coding" adjustment of -2.9 percent. Hospital coding practices following adoption of the Medicare severity-diagnosis related groups (MS-DRGs) increased aggregate payments to hospitals, but did not reflect actual increases in patients' severity of illness. Under legislation passed in 2007, CMS is required to recoup the entire amount of FY 2008 and 2009 excess spending due to changes in hospital coding practices no later than FY 2012. CMS has determined that a -5.8 percent adjustment is necessary to recoup these overpayments. The -2.9 percent adjustment for FY 2011 is one-half of this amount. CMS estimates that payments to general acute care hospitals for operating expenses in FY 2011 will decline by 0.4 percent, or $440 million, compared with FY 2010 under the final rule, taking into account all factors that would affect spending.

CMS is similarly updating LTCH rates by 2.5 percent for inflation, but reducing the inflation update by 0.5 percentage point as required by the Affordable Care Act. Further, CMS will apply an adjustment of -2.5 percent to the LTCH standard federal rate for the estimated increase in spending in FYs 2008 and 2009 due to documentation and coding that did not reflect increases in patients' severity of illness. CMS estimates that aggregate payments to LTCHs would increase by approximately 0.5 percent or $22 million taking into account all provisions in the final rule that would affect spending.

Under current law, hospitals that successfully report quality measures included in the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program will receive the full update for 2011. Hospitals that do not participate in the quality reporting program will get the update less two percentage points. Based on the reporting in 2009, 96 percent of participating hospitals are receiving the full update this year.

The final rule adds 12 measures to the RHQDAPU set, and retires one current measure – mortality for selected surgical procedures (composite). However, only 10 of the new measures – including rates of occurrence for eight of 10 categories of conditions that are subject to the hospital-acquired conditions (HACs) policy – will be considered in determining a hospital's FY 2012 update. The remaining two measures to be reported in 2011 would be considered in determining the hospital's FY 2013 update.

The Medicare law requires hospitals to include diagnostic services and most admission-related non-diagnostic services provided in the hospital outpatient department on the day of admission or three calendar days prior to admission (one day for hospital not paid under the IPPS) as part of the inpatient stay. The policy protects Medicare and the beneficiary from paying separately under Medicare Part B for services that should be included in the Part A payment for the inpatient stay.

Congress recently clarified the situations in which these non-diagnostic services should be considered part of a beneficiary's inpatient stay. The clarification, which was included in the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 ("Preservation of Access to Care Act"), is consistent with how CMS understands hospitals have largely billed Medicare in the past. This provision was effective for services furnished on or after June 25, 2010, and CMS is implementing this provision through an interim final rule. The comment period for this interim final rule closes on Sept. 28, 2010.

The final rule was placed on display at the *Federal Register* on July 30, and may be found under special filings at *http://www.ofr.gov/OFRUpload/OFRData/2010-19092_PI.pdf* or *http://www.ofr.gov/inspection.aspx#special*.

For more information, please see: *http://www.cms.gov/AcuteInpatientPPS/01_overview.asp*.

CMS issued three fact sheets on July 30 with additional details available at *http://www.cms.gov/apps/media/fact_sheets.asp*.

Note: More information about the proposed rule, including the documentation and coding adjustment and the RHQDAPU program changes and HAC discussion, will be included in fact sheets to be posted on the CMS Web page at *http://www.cms.gov/apps/media/fact_sheets.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 201008-01

Override edit for kidney transplant donor claims when the kidney recipient is deceased

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 carriers, fiscal intermediaries (FIs), RHHIs, or Part A/B Medicare administrative contractors (A/B MACs) for live kidney donor and related services for Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 6978 which instructs Medicare contractors to override certain edits on claims for donor expenses when the kidney recipient is deceased. Please make sure your billing staff is aware of these changes.

Background

Medicare instructions allow donor expenses incurred after the death of the kidney recipient to be treated as incurred before the death of the kidney recipient. However, some of these claims are being rejected by Medicare systems. CR 6978 corrects this problem for services performed on or after January1, 2011.

Key points of change request 6978

- All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed.
- All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number). Modifier Q3 (Live kidney donor and related services) must appear on the claim.
- For institutional claims which do not require modifiers, Medicare contractors may process the claim when the donor is receiving institutional services related to the donation of the kidney where the transplant recipient has died and the donor receives those services subsequent to the recipient's death.

Additional Information

The official instruction (CR 6978) issued to your Medicare MAC, carrier, and/or FI may be found on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/Transmittals/downloads/R2008CP.pdf*.

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

MLN Matters® Number: MM6978
Related Change Request (CR) Number: 6978
Related CR Release Date: July 30, 2010
Related CR Transmittal Number: R2008CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2008, CR 6978

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Update to the fiscal year 2010 inpatient prospective payment system PC PRICER

The fiscal year (FY) 2010 inpatient prospective payment system (PPS) personal computer (PC) PRICER has been updated to correct an HSP display issue. 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*, 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 26, 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 201007-50

Outpatient prospective payment system PRICER update

The outpatient prospective payment system (PPS) PRICER Web page located on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/PCPricer/OutPPS/list.asp* was recently updated to include the July 2010 update for outpatient provider data. Users may now access the July provider data update by downloading the "3rd Quarter 2010 Files" and selecting the file entitled "OPSF July 2010 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 201007-56

Inpatient Rehabilitation Services

Inpatient rehabilitation facility annual update – PPS PRICER changes for fiscal year 2011

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

Provider types affected

This article is for inpatient rehabilitation facilities (IRFs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7076 which provides updated rates used to correctly pay IRF prospective payment system (PPS) claims for FY 2011. Be sure your billing staff is aware of these changes.

Background

On August 7, 2001, the Centers for Medicare & Medicaid services (CMS) published a final rule that established the PPS for IRFs, as authorized under Section 1886(j) of the Social Security Act (the Act). In that final rule, which was published in the *Federal Register*, CMS set forth per discharge federal rates for federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by Section 1886(j)(3)(C) of the Act.

The FY 2011 IRF PPS update notice published on July 22, 2010, sets forth the prospective payment rates applicable for IRFs for FY 2011. A new IRF PRICER software package will be released prior to October 1, 2010 that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2010 through September 30, 2011.

PRICER updates for IRF PPS FY 2011 (October 1, 2010-September 30, 2011)

- The standard federal rate is $13,860
- The fixed loss amount is $11,410
- The labor-related share is 0.75271
- The non-labor related share is 0.24729
- Urban national average cost-to-charge ratio (CCR) is 0.489
- Rural national average CCR is 0.620
- The low income patient (LIP) adjustment is 0.4613, which represents no change from FY 2010
- The teaching adjustment is 0.6876, which is no change form FY 2010
- The rural adjustment is 1.1840, which is also the same as FY2010.

Note also that for atypical cases effective January 1, 2010, the HCPCS/rates must contain a five-digit health insurance PPS (HIPPS) rate/case-mix group (CMG) code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay payment for three days or less (HIPPS rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than three. In this scenario only, if the patient is discharged/transferred on or after day four, CMS instructs IRFs to bill HIPPS rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within three days, the IRF will only be eligible for and receive the IRF short stay payment for three days or less (HIPPS rate/CMG A5001).

Additional information

The official instruction (CR 7076) issued to your Medicare MAC and/or FI is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2026CP.pdf*.

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

MLN Matters® Number: MM7076
Related Change Request (CR) Number: 7076
Related CR Release Date: August 13, 2010
Related CR Transmittal Number: R2026CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2026, CR 7076

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Inpatient Psychiatric Services

Implementation of the interrupted stay policy under the inpatient psychiatric facility prospective payment system

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

Provider types affected

This article is for inpatient psychiatric facilities (IPFs) submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for services provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7014 in response to the findings of the report issued by the Office of Inspector General (OIG) entitled: Nationwide Review of Medicare Payments for Interrupted Stays at Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007, (A-01-09-00508). Based on findings in this report, CMS is implementing the interrupted stay policy where the patient is admitted to another IPF before midnight on the third consecutive day following discharge from the original IPF stay.

Background

Section 124 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L.106-113) mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units. The IPF PPS was implemented in January 2005. One aspect of the IPF PPS included an interrupted stay policy.

Key points of change request 7044

- An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay.
- Interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment regardless if the interrupted stay is to the same IPF or not.
- Interrupted stays are considered to be continuous in determining outlier payments only when the interrupted stay is to the same IPF.
- In other words, an interrupted stay is treated as one stay and one discharge for the purpose of the IPF PPS payment.
- Medicare system edits will be put in place to identify claims that qualify as interrupted stays by examining incoming claims and comparing them to other IPF claims in Medicare's claims history files.
- When Medicare detects a claim that shows an interrupted stay, the Medicare contractor will adjust the appropriate claim(s) (including claims in history, if necessary) in date of service sequence order to reflect a reduction in payment due to the variable per diem adjustment being applied from an interrupted stay.
- When Medicare performs the above adjustment, it will use the following messages to alert the IPF:
    - Claim adjustment reason code of 45 (contractual adjustment)
    - Remittance advice remark code of NXX (PPS (prospective payment system) payment adjusted during adjudication. Variable per diem adjustment changed due to interrupted stay policy.)
    - Contractual obligation code of CO.

Additional information

The official instruction associated with this CR 7044, issued to your Medicare FI or AB MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2009CP.pdf*.

To review a fact sheet discussing the IPF PPS, go to the CMS website *http://www.cms.gov/MLNProducts/downloads/InpatientPsychFac.pdf*.

If you have questions, please contact your Medicare FI or AB 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: MM7044
Related Change Request (CR) Number: 7044
Related CR Release Date: July 29, 2010
Related CR Transmittal Number: R2009CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2009, CR 7044

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Revised fact sheet for inpatient psychiatric facility prospective payment system

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 payment rates are set, and provides the rate year 2011 update to the IPF PPS, is now available in print format from the Medicare Learning Network. To place your order, visit *http://www.cms.gov/MLNGenInfo*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

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

Source: CMS PERL 201007-58

Inpatient psychiatric facility PPS PC PRICER – July 2010 provider data update

The inpatient psychiatric facility (IPF) prospective payment system (PPS) personal computer (PC) PRICER for rate year (RY) 2011 has been added to the Centers for Medicare & Medicaid services (CMS) website. The RY 2010 has also been updated with July 2010 provider data on the CMS website.

If you use the IPF PPS PC PRICER for RY 2011 or RY 2010, please go to the page, *http://www.cms.gov/PCPricer/09_inppsy.asp*, under the Downloads section, and download the latest versions of the IPF PPS RY 2011 and RY 2010 PC PRICERS, posted on July 23, 2010.

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Source: CMS PERL 201007-49

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ESRD Services

CMS announces new PPS for end-stage renal disease facilities

The program would reward efficient, high quality care for people with end-stage renal disease (ESRD).

The Centers for Medicare & Medicaid Services (CMS) has issued a final rule that will change how Medicare pays for dialysis services for Medicare beneficiaries who have ESRD. CMS also issued a proposed rule that would establish a new quality incentive program (QIP) to promote high quality services in dialysis facilities by linking a facility's payments to performance standards. The QIP is the first pay-for-performance program in a Medicare fee-for-service payment system.

"The new payment system and quality incentive program for dialysis services have significant potential to improve patient outcomes and promote efficient delivery of health care services," said CMS Administrator Donald Berwick, M.D. "In addition, for the first time in any of our payment systems, the quality of care facilities furnish to patients will be reflected in their payment rates." Currently, facilities only report on whether they have complied with quality measures.

In addition to finalizing the ESRD prospective payment system (PPS) policies and rates for calendar year 2011, CMS issued a proposed rule that would establish performance standards and a scoring methodology for the quality incentive program required by the Medicare Improvements for Patients and Providers Act of 2008 to ensure quality of care for patients with ESRD.

To read the entire CMS press release issued on July 26 is available on the CMS website at *http://www.cms.gov/apps/media/press_releases.asp*.

Also, for additional information please see the CMS fact sheet (7/26) on the CMS website at *https://www.cms.gov/apps/media/fact_sheets.asp*.

A link to the proposed rule, which will be published in the *Federal Register* on August 12, 2010, will be available at *http://www.ofr.gov/OFRUpload/OFRData/2010-18466_PI.pdf* or *http://www.ofr.gov/inspection.aspx*.

CMS will accept comments on the QIP proposed rule until Sept. 24, 2010, and will respond to them in a final rule to be issued 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 201007-47

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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.

Skilled Nursing Facility Services

Medicare Part A skilled nursing facility prospective payment system PRICER update for fiscal year 2011

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7034 which describes the updates to the payment rates used under the PPS for SNFs, for fiscal year (FY) 2011, as required by statute. Be sure your billing staff is aware of these changes.

Background

Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the BBRA), and the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (the BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

The Centers for Medicare & Medicaid Services (CMS) published the SNF payment rates for FY 2011 (that is, beginning October 1, 2010 through September 30, 2011), in the *Federal Register* on July 22, 2010 (75 FR 42886). The updated methodology is identical to that used in the previous year and will include the MMA reimbursement for beneficiaries with acquired immunodeficiency syndrome (AIDS). This update includes new case-mix indexes using the recalculated case-mix adjustments based on actual data. The statute mandates an update to the federal rates using the latest SNF full-market basket.

The enactment of the Affordable Care Act (ACA) includes several provisions that affect the SNF PPS. CMS is currently finalizing a strategy for completing the complex infrastructure changes necessary to accurately implement these changes. CMS has concluded that the best way to minimize risk will be to establish an interim payments mechanism that utilizes the MDS 3.0 and the new RUG-IV system in its entirety as finalized in the FY 2010 SNF PPS final rule (74 FR 40288, August 11, 2009). The PRICER software update issued to CMS contractors reflects this interim payment approach. Once the necessary infrastructure is in place, CMS will then issue a revised PRICER program and instructions to contractors to retroactively adjust claims to reflect the applicable provisions of the ACA.

This approach will allow CMS to make payments with the least disruption for providers and beneficiaries. CMS will publish the specific payment rates for the upcoming fiscal year in the *Federal Register*, and provide additional guidance concerning implementation of the FY 2011 payments in the near future.

Additional information

MLN Matters® article, MM6916, contains information on new and deleted health insurance prospective payment system (HIPPS) codes resulting from the conversion to the new resource utilization group (RUG-IV) coding system. The new five-digit HIPPS codes include two components: the three-digit classification code assigned to each RUG group, and newly defined two-digit assessment indicators that specify the type of assessment used to support billing. You may review this article on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6916.pdf*.

The official instruction (CR 7034) issued to your Medicare A/B MAC and/or FI is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2023CP.pdf*.

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

MLN Matters® Number: MM7034
Related Change Request (CR) Number: 7034
Related CR Release Date: August 6, 2010
Related CR Transmittal Number: R2023CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2023, CR 7034

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August five star preview reports

The five-star preview reports were available by 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.

Nursing Home Compare website will update the five star report with the August data on August 26, 2010.

Note: The five star help line was available from August 23 through August 27, 2010. Provider preview reports will continue to be available on a monthly basis in advance of public posting and will include the dates and hours of helpline availability.

BetterCare@cms.hhs.gov is an alternative communication medium to direct inquiries.

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 201008-32

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

Electronic Data Interchange

Claim adjustment reason code and remittance advice remark code update

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

Provider types affected

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

Provider action needed

Change request (CR) 7089, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs), effective October 1, 2010, for Medicare. These are the changes that have been added since CR 6901. Be sure billing staff are aware of these changes.

Background

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

The lists at the end of this article summarize the latest changes to these lists, as announced in CR 7089.

Additional information

To see the official instruction (CR 7089) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC refer to the CMS website at *http://www.cms.gov/Transmittals/downloads/R2019CP.pdf*.

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

New codes – CARC

Code	Current narrative	Effective date per WPC posting
235	Sales Tax.	6/6/2010

Modified codes – CARC

None

Deactivated codes – CARC

None

New codes – RARC

Code	Current narrative	Medicare initiated
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.	No
N534	This is an individual policy, the employer does not participate in plan sponsorship.	No
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.	Yes
N536	We are not changing the prior payer’s determination of patient responsibility, which you may collect, as this service is not covered by us.	No
N537	We have examined claims history and no records of the services have been found.	No
N538	A facility is responsible for payment to outside providers who furnish these services/ supplies/drugs to its patients/residents.	No
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.	No

Claim adjustment reason code and remittance advice remark code update (continued)

Modified codes – RARC

Code	Modified narrative	Medicare initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	Yes
N115	This decision was based on a local coverage determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	Yes

Modified codes – RARC

Code	Modified narrative	Medicare initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	Yes
N115	This decision was based on a local coverage determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	Yes
N386	The 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 www.cms.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD.	No
N528	Patient is entitled to benefits for institutional services only.	No
N529	Patient is entitled to benefits for professional services only.	No
N530	Not qualified for recovery based on enrollment information	No

Deactivated codes – RARC

Code	Current narrative	Note
M118	Letter to follow containing further information.	Consider using N202
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Consider using N130

MLN Matters® Number: MM7089
Related Change Request (CR) Number: 7089
Related CR Release Date: August 6, 2010
Related CR Transmittal Number: R2019CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2019, CR 7089

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

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.

HIPAA version 5010 Implementation

ICD-10 implementation in a HIPAA version 5010 environment – national provider call

The Centers for Medicare & Medicaid Services will host a follow-up national provider conference call on ICD-10 implementation in a HIPAA version 5010 environment. This toll-free teleconference will focus on:

- ICD-10 implementation issues (including proposals to partially freeze code updates)
- Implementation updates for versions 5010 and D.0 (including implemented readiness review)
- How 5010 updates impact ICD-10 implementation
- Advice for providers in moving toward 5010 implementation

Subject matter experts will review basic information on both ICD-10 and HIPAA version 5010 and explain how they are interrelated. A question and answer session will follow the presentations.

Conference call details

Title: ICD-10 implementation in a HIPAA version 5010 environment follow-up national provider call

When: Monday, September 13

Time: Noon-1:30 p.m. ET

Target audience: Medical coders, physician office staff, provider billing staff, health records staff, vendors, educators, system maintainers, and all Medicare fee-for-service providers.

Agendas

ICD-10

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

HIPAA version 5010

- Compliance dates and timelines (no contingencies)
- 5010 before and after ICD-10 implementation
- Readiness review for implementing HIPAA version 5010 and D.0
- What you need to be doing to prepare
- Medicare fee-for-service activities update
- Other issues and considerations

This toll-free teleconference will include a question and answer session. For more information and to register for this informative session, please go to *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*.

Registration will close at noon ET on September 10 or when available space has been filled. No exceptions will be made. Please register early.

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

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

Source: CMS PERL 201008-28

Website survey

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

Information and reminders about the upcoming HIPAA version 5010 and ICD-10 transitions

Have questions about the version 5010 and ICD-10 transition? The Centers for Medicare & Medicaid Services (CMS) is here to help in the transitions to HIPAA version 5010 and ICD-10.

CMS has resources for providers, vendors, and payers to prepare for the transition. Fact sheets available for educating staff and others about the transition include:

- The ICD-10 Transition: An Introduction
- ICD-10 Basics for Medical Practices
- Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices
- Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors

Compliance timelines, materials from CMS-sponsored calls and conferences, and links to resources are available at *http://www.cms.gov/icd10/*. Check back often for the latest information and updates.

Keep up-to-date on HIPAA version 5010 and ICD-10

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

HIPAA 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 201008-17

News Flash

On January 1, 2012, standards for electronic health care transactions change from version 4010/4010A1 to version 5010. These electronic health-care transactions include, among others, claims processing, eligibility inquiries, and remittance advice. Unlike the current version 4010/4010A1, version 5010 accommodates the International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes, and must be in place first before the changeover to ICD-10. The transition to ICD-10 is dependent on a successful version 5010 implementation. The version 5010 change occurs well before the ICD-10 implementation date to allow adequate version 5010 testing and implementation time.

Failure to prepare now for these changes may result in rejection of claims or other transactions and delays in claim reimbursement.

Important dates to remember

- **January 1, 2011 –** payers and providers should begin external testing of version 5010 for electronic claims.
- **January 1, 2012 –** all electronic claims must use version 5010.
- **October 1, 2013 –** transition to ICD-10-CM (diagnoses codes) and ICD-10-PCS (procedures codes).

Keep up-to-date on version 5010 and ICD-10

Please visit the websites at *http://www.cms.gov/icd10* and *http://www.cms.gov/Versions5010andD0/*, for the latest news and sign up for version 5010 and ICD-10 e-mail updates. ❖

Educational Events

Upcoming provider outreach and educational events

September 2010

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

Topic – HIGLASS post-transition

When: Wednesday, September 15, 2010

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

Type of Event: Webcast **Focus:** 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. ❖

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.

Preventive Services

August is National Immunization Awareness Month

This annual health observance is a great opportunity to educate seniors and other people with Medicare about the importance of disease control and prevention through immunization. Vaccine-preventable disease levels are at or near record lows. Yet, many adults remain under-immunized, missing opportunities to protect themselves against diseases such as hepatitis B, seasonal influenza, and pneumococcal disease.

The Centers for Medicare & Medicaid Services (CMS) ask all health-care providers who provide care to Medicare patients to join CMS during National Immunization Awareness Month to help protect your Medicare patients from vaccine-preventable diseases by checking to make sure their immunizations are up-to-date and encouraging utilization of Medicare-covered immunizations that are appropriate for them.

Medicare Part B immunization benefits

Medicare provides coverage for seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration, under Medicare Part B, for qualified beneficiaries as preventive immunizations. Providers who accept the Medicare-approved payment amount for these services are reimbursed under Medicare Part B.

Seasonal influenza immunization

Medicare provides payment for the seasonal influenza vaccine and its administration for all people with Medicare, once per influenza season, in the fall or winter. Medicare may cover additional influenza vaccinations, if medically necessary.

Note: According to the Centers for Disease Control and Prevention, the 2010-2011 influenza vaccine will protect against the 2009 H1N1, and two other influenza viruses *http://www.cdc.gov/flu/about/disease/*.

Pneumococcal immunization

Medicare provides payment for the pneumococcal vaccine and its administration for all beneficiaries, generally once in a lifetime. Medicare may cover additional vaccinations based on risk.

Hepatitis B immunization

Medicare provides payment for the hepatitis B vaccine and its administration for beneficiaries at medium to high risk of contracting hepatitis B.

For more information

CMS Adult Immunizations Web page
http://www.cms.gov/AdultImmunizations/

Please note: The "Immunizers' Question & Answer Guide to Medicare Coverage of Seasonal Influenza and Pneumococcal Vaccinations", which provides administration and flu vaccine payment rates for use by mass immunizers and physician practices, will be updated and posted to this site sometime in early October, 2010.

CMS *Medicare Learning Network* (*MLN*) Preventive Services Educational Products Web page

This site provides access to *MLN* educational resources developed by CMS for fee-for-service providers related to Medicare-covered preventive services, including adult immunizations.*http://www.cms.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*

For information about National Immunization Awareness Month, please visit the Centers for Disease Control and Prevention website at *http://www.cdc.gov/vaccines/events/niam/default.htm*.

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

Source: CMS PERL 201008-12

Web-based training – Medicare preventive service

Did you know that the *Medicare Preventive Services Series Part 2 Web-based training course (WBT)* is currently available free of charge, on the Centers for Medicare & Medicaid Services (CMS) website?

This course includes coverage, coding, and billing information for Medicare coverage of the following preventive services:

- The initial preventive physical exam (IPPE)
- Ultrasound screening for abdominal aortic aneurysms (AAA)
- Colorectal cancer screening
- Cardiovascular screening blood tests
- Diabetes screening tests
- Supplies and other services for beneficiaries with diabetes
- Diabetes self-management training and medical nutritional therapy
- Smoking and tobacco-use cessation counseling services

Taking this online course will help you and your staff understands Medicare rules surrounding these important benefits. Not only that, but if you pass this course, you can earn continuing education credit. You can take this course, free of charge, at any time, by visiting the Preventive Services Educational products page at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*. Scroll down to the "Related Links Inside CMS" section and click on "Web Based Training Modules" to take the course.

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

Source: CMS PERL 201008-14

Other Educational Resources

Updates from the Medicare Learning Network

Web-based training courses

Need to know the Medicare basics? The *Medicare Learning Network* (*MLN*) offers a series of Web-based training (WBT) courses to teach health care professionals the fundamentals of the Medicare program. The first in the series, the World of Medicare, offers a basic introduction to Medicare. The second in the series, Your Office in the World of Medicare, focuses on Medicare knowledge required by health care professionals and their office personnel. Both activities now offer continuing education and are available from the *MLN* at *http://www.cms.gov/MLNproducts/* by scrolling to the bottom of the page and selecting "Web-based Training Modules" from the "Related Links Inside CMS" section.

How to use the national correct coding initiative (NCCI) tools

Get the new *How to Use the National Correct Coding Initiative (NCCI) Tools* booklet from the *MLN* and learn how to navigate the CMS NCCI Web page. This new *MLN* product explains how to look up Medicare code pair edits and medically unlikely edits (MUEs). NCCI tools can help providers avoid coding and billing errors and subsequent payment denials. If you want to become familiar with the *National Correct Coding Initiative Policy Manual* and the tools on the NCCI Web page, this is your best resource. Go to *http://www.cms.gov/MLNProducts/MPUB/list.asp* and enter "How to" to find this and other *MLN* "How to" series publications.

We Heard the Bells: The Influenza of 1918

The Spanish language version of "We Heard the Bells: The Influenza of 1918, a documentary that explores the experiences of Americans during the influenza pandemic of 1918, is now available to order, free of charge, on DVD. The documentary features stories from survivors of the influenza pandemic that swept the United States in 1918. These stories serve to frame the key questions that apply to the current H1N1 pandemic. Award-winning actress S. Epatha Merkerson (Law & Order) narrates the documentary that includes information about seasonal vs. pandemic influenza, symptoms, immunizations, treatment, and research. To order a copy of the DVD in either English or Spanish, please visit the *MLN* page at *http://www.cms.gov/MLNProducts/*, and then click on "MLN Product Ordering Page" under the "Related Links Inside CMS" section.

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

Source: CMS PERL 201007-48

Updates from the Medicare Learning Network on social media

The Centers for Medicare & Medicaid Services (CMS) continues to break new ground, to enhance outreach efforts to the public. CMS is now using social media outlets to get information out to their audience as fast as possible.

- **LinkedIn**: Join the CMS group at *http://www.linkedin.com/in/CMSGov*.
- **YouTube**: Log on to the official CMS YouTube channel at *http://www.youtube.com/CMSHHSGov* to view several videos currently available and more to come in the upcoming months.
- **Twitter**: Follow CMS' two accounts to get the latest updates on information you need know about CMS (including *Medicare Learning Network* updates) and *Insure Kids Now*.
    1. For CMS & *Medicare Learning Network* updates, visit *http://twitter.com/CMSGov* (Twitter handle = @CMSGov)
    2. For *Insure Kids Now* updates, visit *http://twitter.com/IKNGov* (Twitter handle = @IKNGov)

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Source: CMS PERL 201008-26

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Medicare Learning Network is now podcasting

A podcast is a multimedia version of a really simple syndication (RSS) feed that allows you to receive audio or video content from the Centers for Medicare & Medicaid Services (CMS) website whenever new information is added.

Podcasting is a new feature on the CMS website. You can subscribe to a wide variety of podcasts including speeches, testimonies, and other informative episodes. You have the option to subscribe to the entire podcast series using software on your personal computer.

Just released

The CMS premier production of "New Maximum Period for the Submission of Medicare Claims," reminding Medicare fee-for-service providers of the current claims submission deadlines, is now available. To access the podcast, go to *http://www.cms.gov/CMSFeeds/02_listofpodcasts.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 201008-14

Discover your passport to Medicare training

- Register for live events.
- Explore online courses.
- Find CEU information.
- Download recorded events.

Learn more on FCSO's Medicare training Web site.

Order form for Medicare Part A materials

The following materials are available for purchase. To order these items, please complete and submit this form along with your check/money order payable to FCSO Account # (use appropriate account number)

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2009 through September 2010.	40-500-150	Hardcopy $33		
		CD-ROM $55		
Language preference for subscription: **English [ ] Español [ ]**				
Please write legibly			Subtotal	$
			Tax (***add % for your area***)	$
			Total	$

Mail this form with payment to:

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

Contact Name:

Provider/Office Name:

Telephone Number (include area code):

Mailing Address:

City:

State, ZIP Code:

(CHECKS MADE TO "PURCHASE ORDERS" NOT ACCEPTED)
ALL ORDERS MUST BE PREPAID – DO NOT FAX – PLEASE PRINT

Addresses

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

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

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

General MSP Information
Completion of UB-04 (MSP Related)
Conditional Payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

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

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

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

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

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

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

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

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

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

Other Important Addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY
Home Health Agency Claims
Hospice Claims
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

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

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)
Durable Medical Equipment Claims
Orthotic and Prosthetic Device Claims
Take Home Supplies
Oral Anti-Cancer Drugs
CIGNA Goverment Services
P. O. Box 20010
Nashville, Tennessee 37202

Telephone Numbers

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

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

Speech and Hearing Impaired
1-877-660-1759

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

ELECTRONIC DATA INTERCHANGE
1-888-670-0940

Option 1
Transaction Support

Option 2
PC-ACE Support

Option 3
Direct Data Entry (DDE) Support

Option 4
Enrollment Support

Option 5
Electronic Funds
(check return assistance only)

Option 6
Automated Response Line

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

Seminar Registration Fax Number
1-904-361-0407

PROVIDER ENROLLMENT
1-877-602-8816

CREDIT BALANCE REPORT
Debt Recovery
1-904-791-6281
Fax
1-904-361-0359

Medicare Websites

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

Addresses

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

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

MEDICARE SECONDARY PAYER
Information on Hospital Protocols
Admission Questionnaires, Audits
MSP – Hospital Review
P. O. Box 45267
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Jacksonville, FL 32231-0021

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Jacksonville, FL 32231-4071

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Jacksonville, FL 32232-5087

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

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

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

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦