MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

In this issue...

FIRST COAST SERVICE OPTIONS INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Features

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

Routing Suggestions:

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

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

Medicare Publications
1-904-361-0723

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

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2010, must be paid before the end of business on March 31, 2010.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 3.125 percent is in effect through December 31, 2010.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable. ❖

Source: Publication 100-04, Chapter 1, Section 80.2.2

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

September flu shot reminder

Vaccinate early to protect against the flu.

The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. Take advantage of each office visit and start protecting your patients as soon as your 2010-2011 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff.

Get your flu vaccine – not the flu.

Remember: Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug.

For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit *http://www.cms.gov/AdultImmunizations*.

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

Source: CMS PERL 201009-30

Audio transcript of the September 13 ICD-10 follow-up conference call

The audio transcript of the Centers for Medicare & Medicaid Services' (CMS) follow-up national provider conference call from September 13, "ICD-10 Implementation in a 5010 Environment" is now available. The audio transcript may be accessed at *http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp*.

Scroll to the bottom of the Web page to the Downloads section to locate the audio file. The audio transcript is approximately one hour and 28 minutes in length. The written transcript will be available soon.

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

Source: CMS PERL 201009-29

Workshop on issues related to accountable care organizations

Updates from the Medicare Learning Network (MLN)

On October 5, the Federal Trade Commission (FTC) co-hosted a workshop on several issues associated with accountable care organizations (ACOs). The ACOs are authorized by the new Affordable Care Act, which seeks to deliver high-quality and efficient health care services to consumers. Joining the FTC in hosting the event were the Centers for Medicare & Medicaid Services (CMS) and the Department of Health & Human Services' Office of Inspector General.

The workshop, which was held at CMS headquarters in Baltimore, Maryland, was free and open to the public. To facilitate providers' efforts to develop ACOs that will provide high quality, lower-cost care to their patients, the workshop addressed and solicited public comments on the legal issues raised by various ACO models being considered by health care providers. Physicians, physician associations, hospitals, health systems, payers, consumers, and other interested parties were invited to participate in the workshop.

The agencies will publish a *Federal Register* notice shortly that will include a more in-depth explanation of the topics covered during the day-long workshop, including the antitrust, physician self-referral, anti-kickback, and civil monetary penalty laws related to ACOs.

The FTC works for consumers to prevent fraudulent, deceptive, and unfair business practices and to provide information to help spot, stop, and avoid them. To file a complaint in English or Spanish, visit the FTC's online complaint assistant at *https://www.ftccomplaintassistant.gov/*, or call 1-877-FTC-HELP (1-877-382-4357).

The FTC enters complaints into Consumer Sentinel, a secure, online database available to more than 1,800 civil and criminal law enforcement agencies in the United States and abroad. The FTC's website provides free information on a variety of consumer topics at *http://www.ftc.gov/consumer*.

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Source: CMS PERL 201009-12

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Use Internet-based PECOS for your Medicare enrollment actions

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

It's easy to use and offers a host of advantages over the paper-based enrollment process.
Want more control over your enrollment information? The Internet-based provider enrollment, chain and ownership system (PECOS) does that.
Learn how to use the system by selecting the appropriate instructions below based on the type of provider:

Physicians and nonphysician practitioners

Want more control when adding or changing a reassignment of benefits? Internet-based PECOS does that, too.

Using Internet-based PECOS is easy

Learn how to use the system by visiting 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 is help available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/ContactInformation.pdf*.

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

Want more control when adding or changing a location or changing ownership information? Internet-based PECOS does that, too.

Using Internet-based PECOS is easy

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

Remember, the process by which an organization provider can use Internet-based PECOS may take several weeks. It is recommended that you begin this process (if you have not already) well in advance of any upcoming enrollment actions. For more information on this setup process, read the Provider and Supplier Organization Overview section on the CMS website at *http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp*.

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.

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

Source: CMS PERL 201008-43 and PERL 201008-44

How to protect your identity using PECOS

Updates from the Medicare Learning Network (MLN)

If you are enrolled, or plan to enroll in Medicare, it is important that you protect your Medicare identity from getting into the hands of dishonest and unscrupulous people -- personal identity thieves and those intending to commit fraud in the Medicare program.

The Centers for Medicare & Medicaid Services (CMS) has developed "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)" as the next in a series of Medicare enrollment fact sheets. This fact sheet provides step-by-step instructions to help fee-for-service (FFS) providers protect their identity in Internet-based PECOS and is available in downloadable format on the CMS website at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf*.

Stay tuned for updates from the *Medicare Learning Network* as future installments of fact sheets designed to educate FFS providers about important Medicare enrollment information are released.

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

Source: CMS PERL 201009-10

ELECTRONIC HEALTH RECORDS

Key step in national initiative toward adoption of electronic health records

The Certification Commission for Health Information Technology (CCHIT), Chicago, Ill. and the Drummond Group Inc. (DGI), Austin, Texas, were named by the Office of the National Coordinator for Health Information Technology (ONC) as the first technology review bodies that have been authorized to test and certify electronic health record (EHR) systems for compliance with the standards and certification criteria that were issued by the U.S. Department of Health & Human Services earlier this year.

Announcement of these ONC-authorized testing and certification bodies (ONC-ATCBs) means that EHR vendors may now begin to have their products certified as meeting criteria to support meaningful use, a key step in the national initiative to encourage adoption and effective use of EHRs by America's health care providers.

Applications for additional ONC-ATCBs are also under review.

Certification of EHRs is part of a broad initiative undertaken by Congress and President Obama under the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act (ARRA) of 2009. HITECH created new incentive payment programs to help health providers as they transition from paper-based medical records to EHRs. Incentive payments totaling as much as $27 billion may be made under the program. Individual physicians and other eligible professionals can receive up to $44,000 through Medicare and almost $64,000 through Medicaid.

Hospitals can receive millions.

For the complete press release, go to Initial EHR Certification Bodies Named available at *http://www.hhs.gov/news/press/2010pres/08/20100830d.html*.

For more information about the ONC certification programs visit *http://healthit.hhs.gov/certification*.

For information about the Medicare and Medicaid incentive programs, visit *http://www.cms.gov/EHRincentiveprograms/*

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

Source: CMS PERL 201009-03

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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/*.

Four states to receive federal matching funds for EHR incentive program

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

EHRs will improve the quality of health care for the citizens of these states and make their care more efficient. The records make it easier for the many providers who may be treating a Medicaid patient to coordinate care.

Additionally, EHRs make it easier for patients to access the information they need to make decisions about their health care.

The releases highlight awards (totaling $6.91 million) of 90 percent federal matching funds for planning activities for the Recovery Act's Medicare and Medicaid electronic health record incentives programs.

This batch is part of a rolling announcement CMS began in November 2009. To date, including these new announcements, CMS will have awarded a total of $81.44 million to 49 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.

North Dakota:	$226,000
Hawaii:	$836,000
Ohio:	$2.29 million
Massachusetts:	$3.56 million
Subtotal:	$6.91 million
Total awards to date:	$81.44 million

The press releases dated September 13, 2010 are available at *https://www.cms.gov/apps/media/press_releases.asp*.

Additional information on implementation of the Medicaid and Medicare related provisions of the Recovery Act's EHR incentive payment programs may be found at *http://www.cms.gov/EHRIncentivePrograms/*.

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

Source: CMS PERL 201009-21

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.

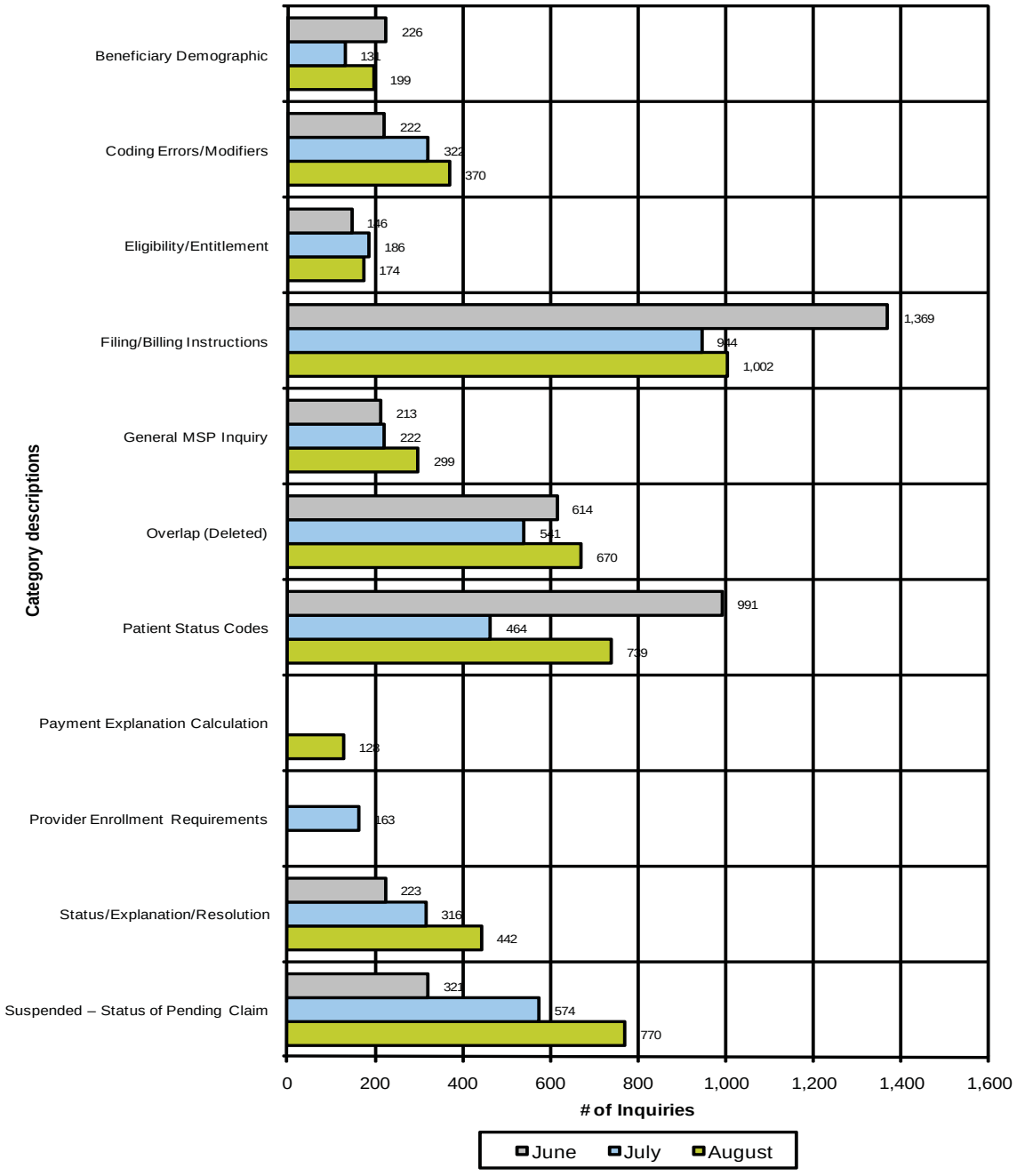
CLAIM AND INQUIRY SUMMARY DATA

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

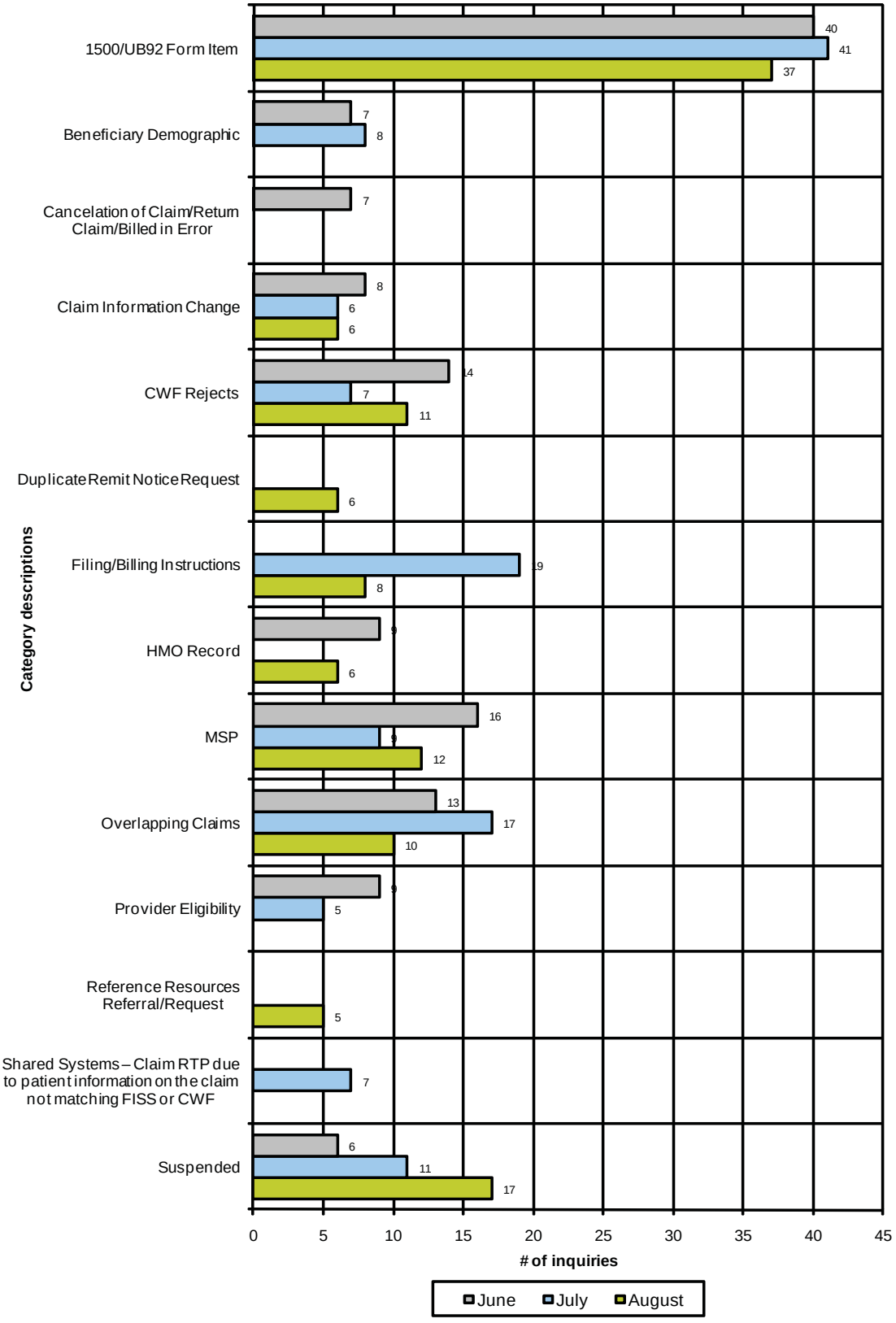
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries for June-August 2010



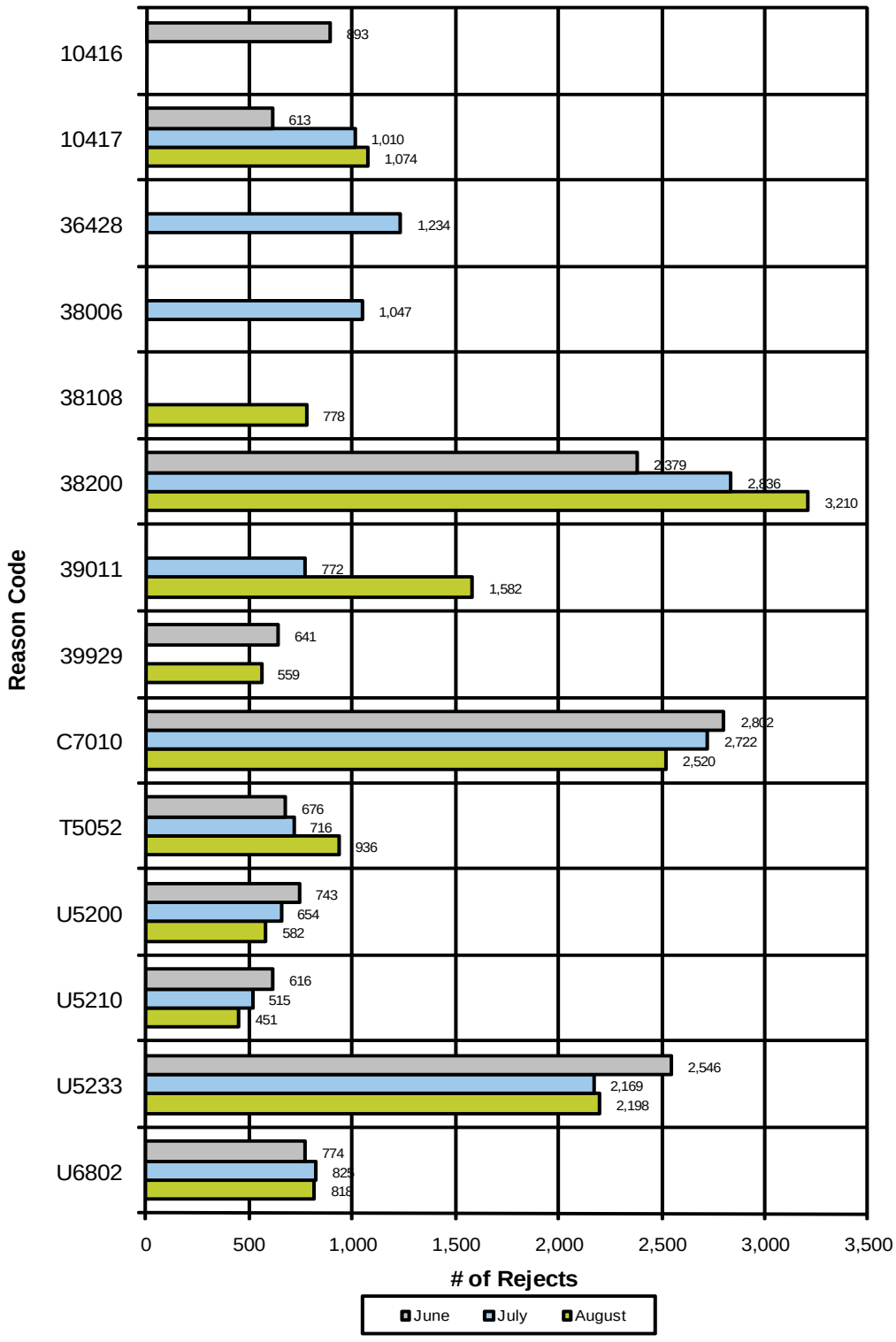
Top inquiries, return to provider, and reject claims for June-August 2010 (continued)

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



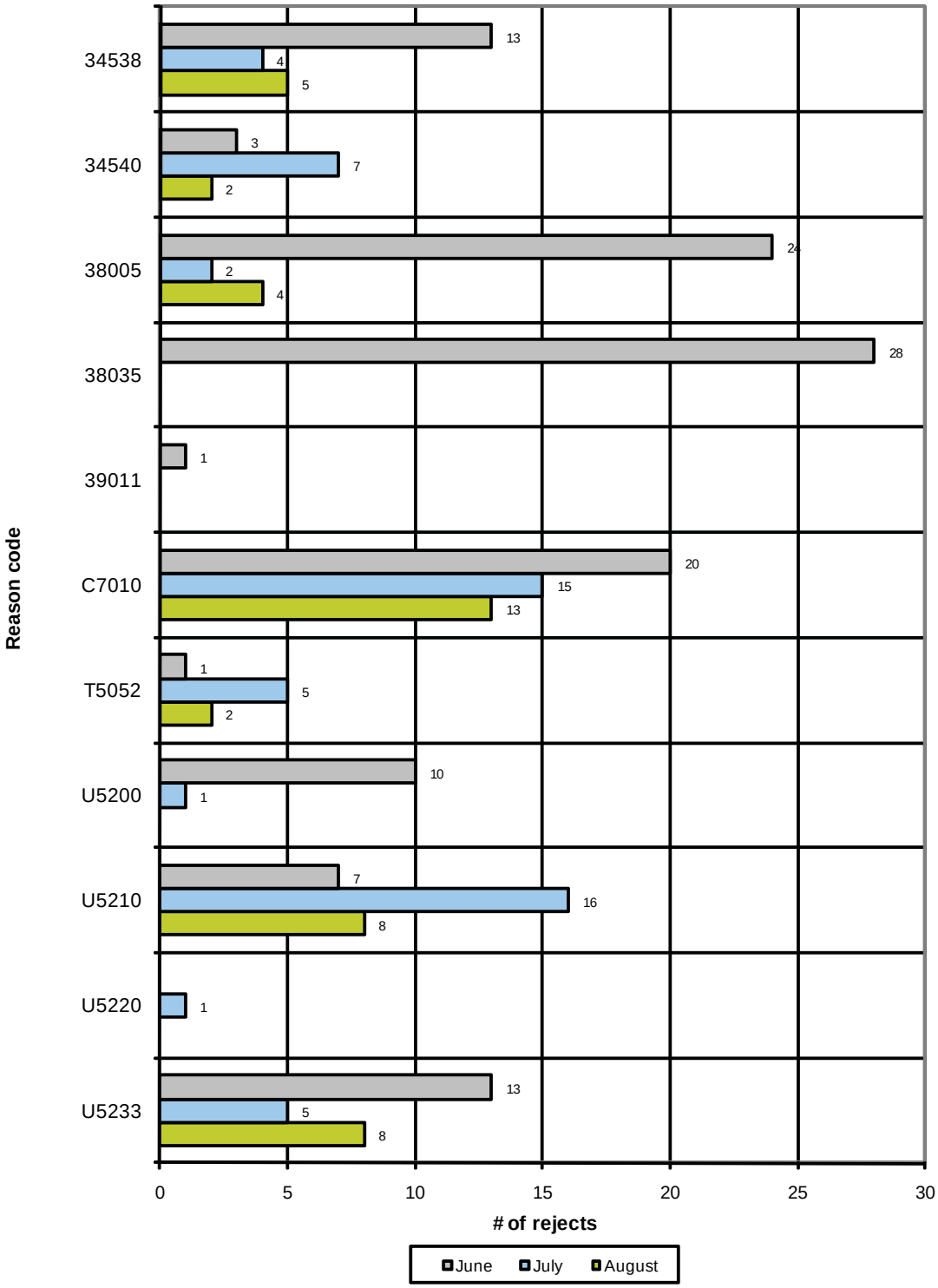
Top inquiries, return to provider, and reject claims for June-August 2010 (continued)

Florida Part A top rejects for June-August 2010



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

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

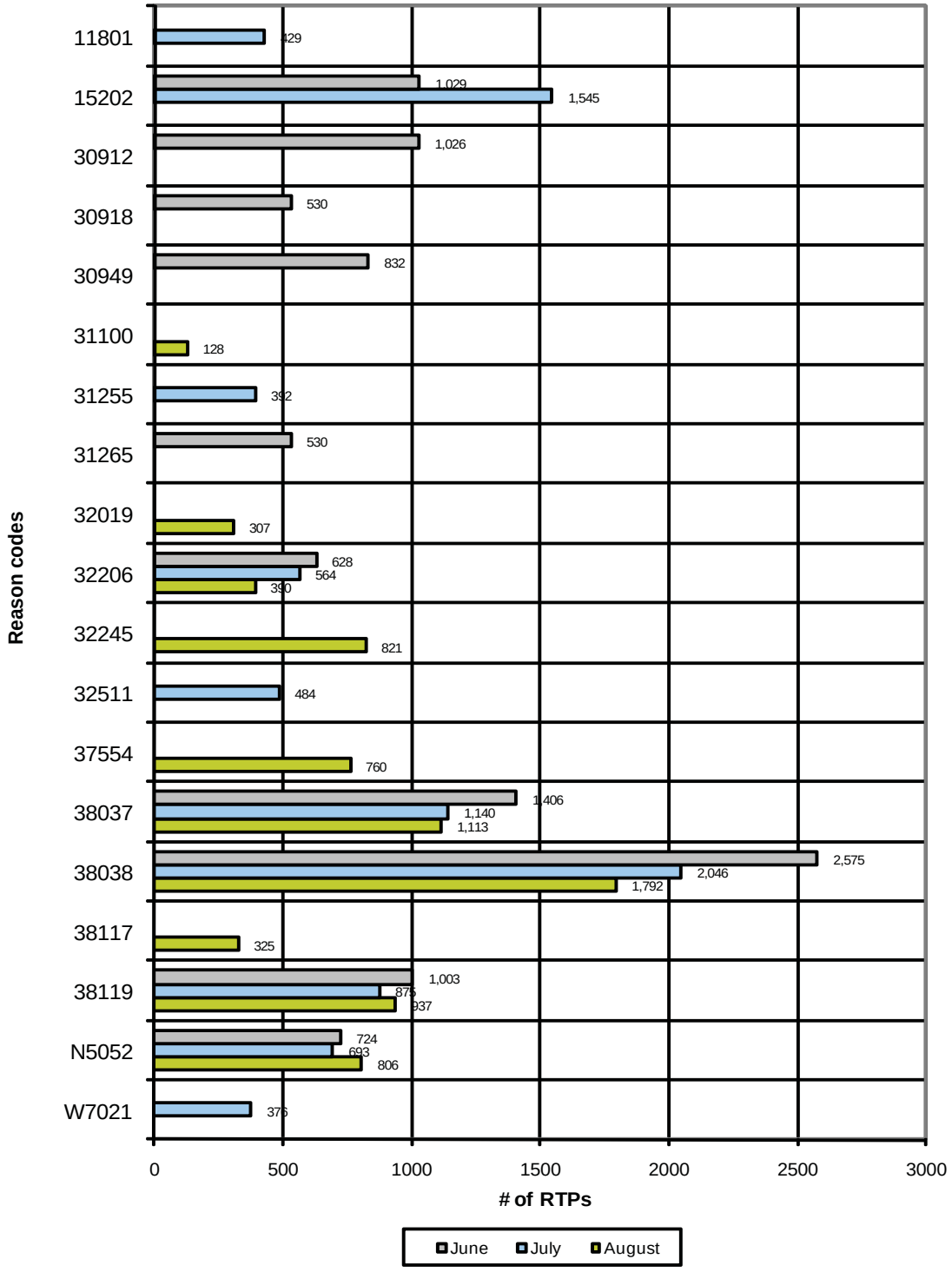


Keep Informed

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 June-August 2010 (continued)

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

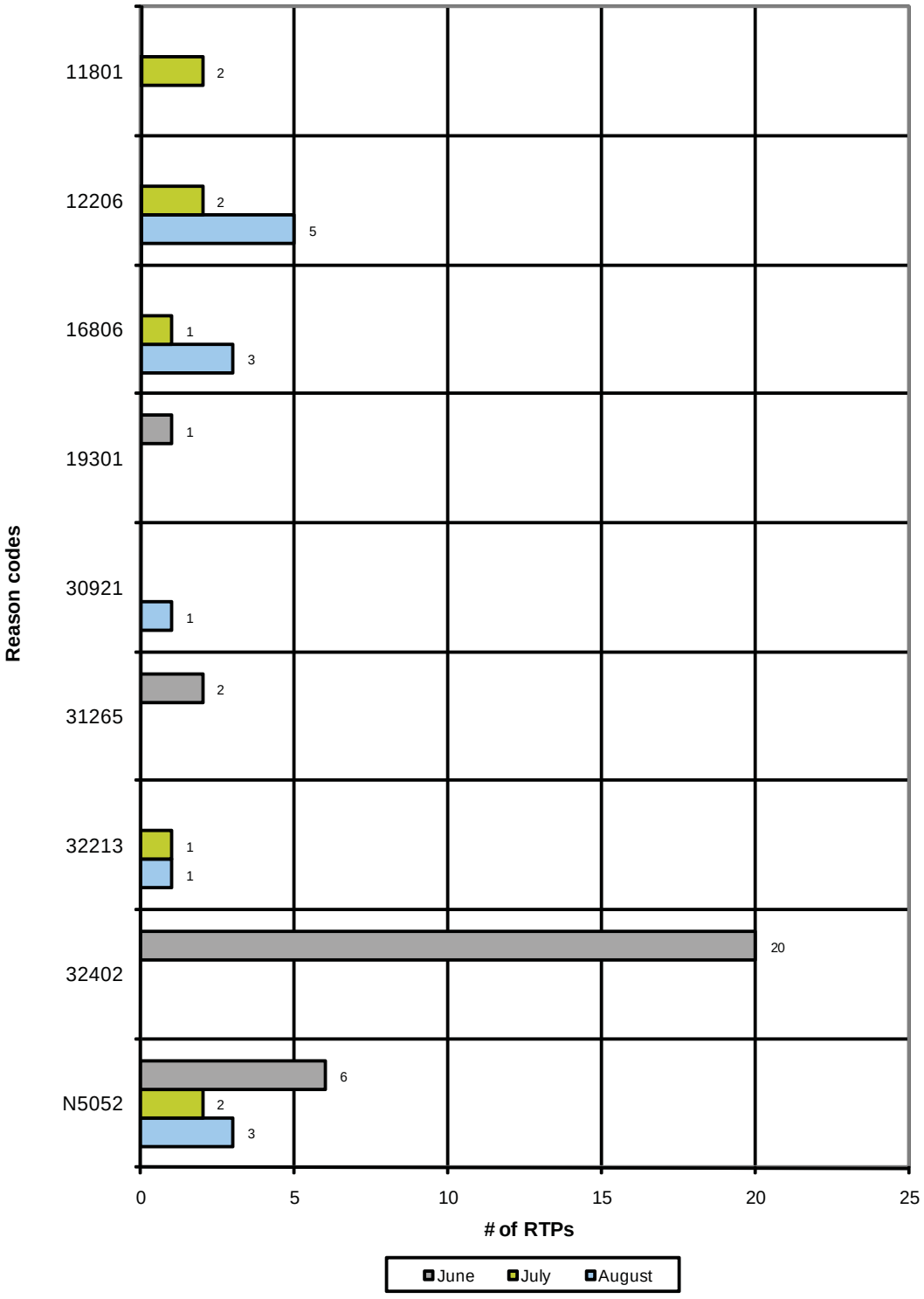


Educational Resources

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 June-August 2010 (continued)

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



GENERAL COVERAGE

Discarded drugs and biologicals policy at contractor discretion

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs] and/or durable medical equipment [DME] MACs) for drugs or biologicals administered to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7095 which is being issued in response to inquiries related to CR 6711 pertaining to the use of **modifier JW** (drug or biological amount discarded/not administered to any patient) for discarded drugs and biologicals.

Caution – what you need to know

CR 7095 instructs that each Medicare contractor 1) has the individual discretion to determine whether **modifier JW** is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and 2) will notify their respective providers of such requirements associated with the use of **modifier JW**.

Go – what you need to do

Your Medicare contractor will provide you with details concerning the use of **modifier JW** for discarded drugs and biological. Be sure to follow those requirements.

Background

Previously, the Centers for Medicare & Medicaid Services (CMS) issued CR 6711 (see the *MLN Matters*® article related to CR 6711 on the CMS website at *http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf*), which updated the *Medicare Claims Processing Manual* (Chapter 17, Section 40) and provided policy on the appropriate use of **modifier JW** (drug or biological amount discarded/not administered to any patient) for discarded drugs or biologicals. After issuing CR 6711, CMS received several inquiries from various providers regarding how **modifier JW** is to be used for their Medicare Part B drug claims.

CR 7095 is being issued in response to these inquiries, and it instructs that each Medicare contractor:

- Has the individual discretion to determine whether **modifier JW** is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim
- Will notify their respective providers of such requirements associated with the use of **modifier JW**.

Additional information

The official instruction, CR 7095, issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R758OTN.pdf*.

If you have any questions, please contact your carrier, FI, 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: MM7095
Related Change Request (CR) Number: 7095
Related CR Release Date: August 20, 2010
Related CR Transmittal Number: R758OTN
Effective Date: July 30, 2010
Implementation Date: September 21, 2010

Source: CMS Pub. 100-20, Transmittal 758, CR 7095

Modifier JW for discarded drugs and biologicals not required

In response to inquiries related to change request 6711 pertaining to the use of the modifier JW, the Centers for Medicare & Medicaid Services (CMS) recently released CR 7095 (Discarded drugs and biologicals policy at contractor discretion). The purpose and intent of the CR is to reiterate to providers that contractors have the option to require or not require the modifier.

FCSO made the decision to not require the **modifier JW** (see article published in the May 2010 *Medicare A Bulletin* (page 43). ❖

Source: CMS Pub. 100-20, Transmittal 758, CR 7095

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 reflect the revised change request (CR) 6447 that was issued on September 3. As a result, the article shows revised effective and implementation dates, a revised CR release date, transmittal numbers, and Web addresses for accessing the CR 6447 transmittals. In addition, the remittance advice remark code (RARC) N290 has been corrected to be consistent with the revised CR. All other information is the same. The article was published in the August 2010 *Medicare A Bulletin* (pages 20-22).

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 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

Revisions and re-issuance of audiology policies (continued)

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) N290 (Missing/incomplete/invalid rendering provider primary identifier.)
- 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*.)
- 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.

Revisions and re-issuance of audiology policies (continued)

- 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/R132BP.pdf*.

The other transmittal modifies the *Medicare Claims Processing Manual* and it is on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2044CP.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*.

MLN Matters® Number: MM6447 – Revised
Related Change Request (CR) Number: 6447
Related CR Release Date: September 3, 2010
Related CR Transmittal Number: R132BP and R2044CP
Effective Date: September 30, 2010
Implementation Date: September 30, 2010

Source: CMS Pub. 100-04, Transmittal 2044, CR 6447

LOCAL COVERAGE DETERMINATIONS

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Table of contents

Additions/revisions to existing LCDs

Advance beneficiary notice

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

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

Additions/Revisions to Existing LCDs

A93303: Transthoracic echocardiography (TTE) – revision to the LCD

LCD ID Number: L28997 (Florida)
LCD ID Number: L29029 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for transthoracic echocardiography (TTE) 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 "Revenue Codes" section of the LCD has been revised with the addition of revenue code 483 – cardiology, echocardiology.

Effective date

This LCD revision is effective for services provided **on or after October 14, 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. ❖

AG0104: Colorectal cancer screening – revision to the LCD

LCD ID Number: L28803 (Florida)
LCD ID Number: L28805 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for colorectal cancer screening 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 LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS), Transmittal 1953, Change Request (CR) 6760, dated April 28, 2010, to add bill type 12x under the "Type of Bill" section of the LCD.

In addition, based on CMS CR 6760, the following language was added under the "Coding Guidelines" attachment of the LCD:

- *When test/procedures are provided to inpatients of a hospital or when Part A benefits have been exhausted, they are covered under this benefit. However, the provider bills on bill type 12x using the discharge date of the hospital stay to avoid editing in the common working file (CWF) as a result of the hospital bundling rules.*

Effective date

This LCD revision is effective for claims processed **on or after October 4, 2010**, for services provided **on or after October 1, 2010.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/mcd/overview.asp*.

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

Find LCDs faster on our new medical coverage page

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

2011 ICD-9-CM changes

The 2011 update to the ICD-9-CM diagnosis coding structure **is effective for services provided on or after October 1, 2010.** Providers are required to use the 2011-updated ICD-9-CM coding effective for all hospital discharges and outpatient services occurring on **or after October 1, 2010.** Due to the direct relationship between coding and reimbursement, it is particularly important that providers reimbursed under the outpatient prospective payment system (OPPS) used the appropriate ICD-9-CM coding. Other providers that code diagnoses and procedures (non-OPPS providers) are also affected. In addition, the new diagnosis coding is used in hospital outpatient billing. First Coast Service Options, Inc. (FCSO) has revised the local coverage determinations (LCDs), for procedure codes with specific diagnosis criteria that are affected by the 2011 ICD-9-CM update. The following table lists the LCDs affected and the specific conditions revised as a result of the 2011 ICD-9-CM update.

LCD title	2011 changes
A0171T – Interspinous Process Decompression	• Removed diagnosis code 724.02 for procedure codes *0171T*, *0172T*, and C1821 • Added diagnosis code 724.03 for procedure codes *0171T*, *0172T*, and C1821.
A43235 – Diagnostic and Therapeutic Esophagogastroduodenoscopy	• Added diagnosis code 784.52 for procedure codes *43235*, *43236*, *43237*, *43238*, *43239*, *43241*, *43243*, *43244*, *43245*, *43246*, *43247*, *43248*, *43249*, *43250*, *43251*, *43255*, and *43258*.
A44388 – Diagnostic Colonoscopy	• Removed diagnosis code 787.6 for procedure codes *44388*, *44389*, *44390*, *44391*, *44392*, *44393*, *44394*, *44397*, *45355*, *45378*, *45379*, *45380*, *45381*, *45382*, *45383*, *45384*, *45385*, *45386*, *45387*, *45391*, and *45392*. • Added diagnosis code range 787.60-787.63 for procedure codes *44388*, *44389*, *44390*, *44391*, *44392*, *44393*, *44394*, *44397*, *45355*, *45378*, *45379*, *45380*, *45381*, *45382*, *45383*, *45384*, *45385*, *45386*, *45387*, *45391*, and *45392*.
A51784 – Anorectal Manometry and EMG of the Urinary and Anal Sphincters	• Removed diagnosis code 787.6 for procedure codes *51784*, *51785*, and *91122*. • Added diagnosis code range 787.60-787.63 for procedure codes *51784*, *51785*, and *91122*.
62263 – Endoscopic and Percutaneous Lysis of Epidural Adhesions	• Changed descriptor for diagnosis code 724.02 for procedure codes *62263*, *62264*, and *64999*. • Added diagnosis code 724.03 for procedure codes *62263*, *62264*, and *64999*.
A70540 – Magnetic Resonance Imaging of the Orbit, Face, and/or Neck	• Added diagnosis code 784.92 for procedure codes *70540*, *70542*, and *70543*.
A70544 – Magnetic Resonance Angiography (MRA)	• Removed diagnosis code 786.3 for procedure codes *71555*, C8909, C8910, and C8911. • Added diagnosis codes 786.30 and 786.39 for procedure codes *71555*, C8909, C8910, and C8911.
A71275 – Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries	• Removed diagnosis code 786.3 for procedure code *71275*. • Added diagnosis codes 786.30 and 786.39 for procedure code *71275*.
A73218 – Magnetic Resonance Imaging of Upper Extremity	• Added diagnosis codes 237.73, 237.79, and 447.70-447.73 for procedure codes *73218*, *73219*, *73220*, *73221*, *73222*, and *73223*.
A82330 – Ionized Calcium	• Added diagnosis code 780.66 for procedure code *82330*.
A84100 – Serum Phosphorus	• Added diagnosis codes 799.51, 799.52, 799.54, and 799.55 for procedure code *84100*.
A86706 – Hepatitis B Surface Antibody and Surface Antigen	• Added diagnosis code 780.66 for procedure code *87340*.

2011 ICD-9-CM changes (continued)

LCD title	2011 changes
A90901 – Biofeedback	• Removed diagnosis code 787.6 for procedure code *90911*. • Added diagnosis code range 787.60-787.63 for procedure code *90911*.
A90999 – Frequency of Hemodialysis Services	• Removed diagnosis code 276.6 for procedure code *90999*. • Added diagnosis code 276.69 for procedure code *90999*.
A93000 – Electrocardiography	• Removed diagnosis code 276.61 from diagnosis code range 276.0-276.9 for procedure codes *93000*, *93005*, and *93010* as it is not appropriate. • Added diagnosis code 276.69 for procedure codes *93000*, *93005*, and *93010*.
A93303 – Transthoracic Echocardiography (TTE)	• Removed diagnosis code 275.0 for procedure codes *93306*, *93307*, *93308*, C8923, and C8924. • Added diagnosis code range 275.01-275.09 for procedure codes *93306*, *93307*, *93308*, C8923, and C8924.
A93312 – Transesophageal Echocardiogram	• Added diagnosis code 278.03 for procedure codes *93312*, *93313*, *93314*, *93315*, *93316*, *93317*, *93318*, C8925, C8926, and C8927.
A93965 – Non-Invasive Evaluation of Extremity Veins	• Removed diagnosis code 786.3 for procedure codes *93965*, *93970*, and *93971*. • Added diagnosis codes 786.30 and 786.39 for procedure codes *93965*, *93970*, and *93971*.
A93975 – Duplex Scanning	• Removed diagnosis code 784.52 from diagnosis code range 784.51-784.59 for procedure codes *93978* and *93979* as it is not appropriate.
A94640 – Diagnostic Aerosol or Vapor Inhalation	• Removed diagnosis code 786.3 for procedure code *94640*. • Added diagnosis codes 786.30 and 786.39 for procedure code *94640*.
AJ0881 – Erythropoiesis Stimulating Agents	• Changed descriptor for diagnosis code V07.8 for procedure code J0885 (List 1).
AJ2505 – Pegfilgrastim (Neulasta)	• Changed descriptor for diagnosis code V07.8 for procedure code J2505.
AJ2792 – Rho (D) Immune Globulin Intravenous	• Removed diagnosis code 999.7 for procedure codes J2788, J2790, J2791, and J2792. • Added diagnosis code range 999.70-999.79 for procedure codes J2788, J2790, J2791, and J2792.
APULMDIAGSVCS – Pulmonary Diagnostic Services	• Removed diagnosis code 786.3 for procedure codes *93720*, *93721*, *93722*, *94010*, *94060*, *94070*, *94150*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, and *94750*. • Added diagnosis codes 786.30 and 786.39 for procedure codes *93720*, *93721*, *93722*, *94010*, *94060*, *94070*, *94150*, *94200*, *94240*, *94250*, *94260*, *94350*, *94360*, *94370*, *94375*, *94620*, *94621*, *94720*, *94725*, and *94750*.

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

HOSPITAL SERVICES

Outpatient services treated as inpatient – three/one-day payment window policy

During the hospital open door forum call on August 26th, 2010, hospitals expressed concerns regarding billing for procedures performed in the outpatient setting that must be bundled on the inpatient hospital bill in order to comply with the three-day (or one-day) payment window policy. The Centers for Medicare & Medicaid Services (CMS) recently issued a memorandum to providers regarding a statutory change in the policy pertaining to admission-related outpatient non-diagnostic services (*http://www.cms.gov/AcuteInpatientPPS/Downloads/JSMTDL-10382%20ATTACHMENT.pdf*).

Some hospitals were concerned that the Medicare claim processing systems may have edits that do not allow hospitals to bill the ICD-9-CM procedure code dates correctly for outpatient non-diagnostic services provided during the three calendar days (or one calendar day) immediately preceding the admission date on the inpatient claim.

CMS has verified that the Medicare claim processing system does allow the ICD-9-CM procedure code dates for non-diagnostic services provided up to three calendar days prior to the admission date on the inpatient claim.

Therefore, hospitals are able to bill correctly for admission-related outpatient non-diagnostic services (that is, bundle the services on the inpatient hospital claim) without modifying dates on the inpatient claim. CMS foresees no system issues that prevent hospitals from billing appropriately according to the three-day (or one-day) payment window policy. If providers encounter system difficulties, they should contact their local contractor, CMS regional office, or CMS central office, accordingly.

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

Source: CMS PERL 201009-18

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

The inpatient psychiatric facility (IPF) prospective payment system (PPS) personal computer (PC) PRICER for rate year (RY) 2011 has been updated on the Centers for Medicare & Medicaid Services (CMS) website to correct comorbidity logic.

If you use the IPF PPS PC PRICER for RY 2011, 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 RY2011 PC PRICER, posted on August 31, 2010.

Note: On July 1, 2010, the IPF PPS PC PRICER was updated for RY 2011; however, there was an error in the comorbidity table in both the mainframe and the PC versions of the software. The PC PRICER is now corrected per this release while the mainframe version will not be corrected until October 2010. Contractors will be instructed to adjust all IPF claims with discharges on or after July 1, 2010, through September 30, 2010, that were received prior to the installation of the corrected PRICER.

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

Source: CMS PERL 201009-09

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.

Inpatient rehabilitation facility patient assessment instrument clinical help desk changes

Effective September 1, 2010, inpatient rehabilitation facility-patient assessment instrument (IRF-PAI) clinical help desk coverage hours and contact information changed.

The Centers for Medicare & Medicaid Services (CMS) expanded help desk is now available to answer all questions related to recording data on the IRF-PAI and using the inpatient rehabilitation validation entry (IRVEN) software:

Coverage hours: 8:00 a.m. to 8:00 p.m. ET Monday through Friday.

Contact information:

E-mail: help@qtso.com

Phone: 1-800-339-9313

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

Source: CMS PERL 201009-06

Reminder of special billing procedures when more than 10 occurrence span codes apply to a single stay

When a provider paid under a prospective payment system encounters a situation in which **10 or more** occurrence span codes (OSCs) are to be billed on Form CMS-1450 or electronic equivalent, the provider must bill for the entire stay up to the through date of the 10th OSC for the stay. As the stay continues, the provider must bill as an adjustment for the **11th through the 20th** OSC for the stay, if applicable. Once the twentieth OSC is applied to the claim, the provider must bill another adjustment for the **21st through the 30th** OSC for the stay, if applicable.

The Medicare fiscal intermediary shared system (FISS) retains the history of all OSCs billed for the stay to ensure proper processing (as if no OSC limitation exists on the claim).

Implementation of these guidelines is effective October 1, 2010, for claims and adjustments submitted by long-term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), and inpatient rehabilitation facilities (IRFs).

Additional information

The official instruction regarding this change was issued under change request (CR) 6777 and is available on the CMS Web site at *http://www.cms.gov/Transmittals/downloads/R1946CP.pdf*.

A detailed set of billing scenarios is presented within CR 6777 to show how to bill for stays where more than 10 OSCs occur.

Source: CMS Pub. 100-04, Transmittal 1946, CR 6777

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ESRD Services

End-stage renal disease prospective payment system and consolidated billing for limited Part B services

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for end-stage renal disease (ESRD) services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7064, which announces the implementation of an ESRD bundled prospective payment system (PPS) effective January 1, 2011.

Caution – what you need to know

Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a four-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

> The ESRD PPS provides ESRD facilities a four-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment.

Go – what you need to do

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one-time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the *Background* and *Additional information* sections of this article for further details regarding the ESRD PPS.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see *http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331*) requires the Centers for Medicare & Medicaid services (CMS) to implement an ESRD bundled PPS effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located
- Patient-level adjustments for case mix
- An outlier adjustment (if applicable)
- Facility-level adjustments
- A training add-on (if applicable)
- A budget neutrality adjustment during the transition period through 2013.

Patient-level adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier adjustment

ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B

ESRD prospective payment system and consolidated billing for limited Part B services (continued)

3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B, and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level adjustments

The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from core based statistical areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training add-on

Facilities that are certified to furnish training services will receive a training add-on payment amount of $33.44, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments specific to pediatric patients

The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

Treatments furnished to pediatric patients

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

ESRD PPS four-year phase-in (transition) period

The ESRD PPS provides ESRD facilities with a four year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

ESRD PPS four-year transition period blended rate determination

Calendar year	Blended rate
2011	75 percent of the old payment methodology **and** 25 percent of new PPS payment
2012	50 percent of the old payment methodology **and** 50 percent of the new PPS payment
2013	25 percent of the old payment methodology **and** 75 percent of the new PPS payment
2014	100 percent of the PPS payment

For calendar year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

The ESRD PPS base rate is $229.63, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where:

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments
- Outlier adjustments
- Facility-level adjustments
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These

ESRD prospective payment system and consolidated billing for limited Part B services (continued)

reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: Providers wishing to opt-out of the transition period blended rate must notify their Medicare contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.

Three new adjustments applicable to the adult rate

1. **Comorbid adjustments**: The new ESRD PPS provides for **three categories of chronic comorbid conditions and three categories for acute comorbid conditions.** A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than four consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. **The three chronic comorbid categories** eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia
   - Monoclonal gammopathy (in the absence of multiple myeloma)
   - Myelodysplastic syndrome

   The three acute comorbid categories eligible for a payment adjustment are:
   - Bacterial pneumonia
   - Gastrointestinal bleeding
   - Pericarditis
2. **Onset of dialysis adjustment:** An adjustment will be made for patients that have Medicare ESRD coverage during their first four months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's common working file as provided on the CMS form 2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.
3. **Low-volume facility adjustment:** Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year. The three years preceding treatment data should be reflected on the last two settled cost reports and the most recent must be filed. The provider must notify their Medicare contractor if they believe they are eligible for the low-volume adjustment.

Change in processing home dialysis claims

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under method II, regardless of home treatment modality, are included in the ESRD PPS payment rate. Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility
- Will be processed as method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the **modifier AY**.

Consolidated billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new modifier AY to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the **modifier AY**.

Other billing reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS code Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without **modifier AY** for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign group code CO.

ESRD prospective payment system and consolidated billing for limited Part B services (continued)

- All 72x claims from method II facilities with condition code 74 will be treated as method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp® and ESRD-related epoetin alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, Section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2033CP.pdf*.

Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services
- Attachment 4, which is a list of DME ESRD supply HCPCS codes used in for ESRD PPS consolidated billing edits
- Attachment 5, which contains a list of DME ESRD supply HCPCS codes that are NOT payable to DME suppliers
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing, and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

If you have any questions, please contact your carriers, DME MACs, FIs, and/or A/B MACs 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: MM7064
Related Change Request (CR) Number: 7064
Related CR Release Date: August 20, 2010
Related CR Transmittal Number: R2033CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2033, CR 7064

Website survey

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

SKILLED NURSING FACILITY SERVICES

2011 annual update of HCPCS codes for skilled nursing facility consolidated billing

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

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment (DME) Medicare administrative contractors (MACs), fiscal intermediaries (FIs), and/or A/B MACs) for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7159, which provides the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (CB) and how the updates affect edits in Medicare claims processing systems.

Caution – what you need to know

Physicians and providers are advised that, by the first week in December 2010, new code files will be posted on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.

Note: This site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update listed on the CMS website at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Go – what you need to do

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

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs), which is available on the CMS website at *http://www.cms.gov/manuals/downloads/clm104c06.pdf*.

These edits only allow services that have been excluded from CB to be separately paid by Medicare contractors.

Additional information

The official instruction, CR 7159, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2048CP.pdf*.

If you have any questions, please contact your carriers, DME MACs, FIs, or A/B MACs 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: MM7159
Related Change Request (CR) Number: 7159
Related CR Release Date: September 10, 2010
Related CR Transmittal Number: R2048CP
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2048, CR 7159

Minimum data set 3.0 training material update for August 2010

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

- A new naming convention is now being used for the MDS 3.0 resident assessment instrument (RAI) manual.
- Any sections or chapters that have had revisions will now have an updated version number along with the month and year that the information was revised (e.g. MDS 3.0 Chapter 4 V1.03 August 2010). Subsequent revisions of any section or chapter of the manual will have updated version numbers (e.g. V1.04, V1.05, etc…).
- Any sections or chapters that have not been revised will have the same version number, month, and year that that version was last published (e.g. MDS 3.0 RAI Manual Chapter 3 Section A V1.02 July 2010). However, you will notice that the "day" has been dropped from the file name now that the Centers for Medicare & Medicaid Services (CMS) does not have frequent updates to the manual.
- Any changes from the previous version of all Chapter 3 sections are now listed at the beginning of each respective section.

MDS 3.0 RAI manual Chapter 4 has been reposted and is available for download in the file labeled "MDS 3.0 RAI Manual August 2010."

- MDS 3.0 RAI manual Chapter 3 updates: V1.03 of the following sections – A, C, D, E, F, G, K, M, O, P, X, and Z.
- VIVE – Video on Interviewing Vulnerable Elders – will be available for ordering from CMS beginning the week of August 16, 2010. Please visit *http://productordering.cms.hhs.gov/* to order a copy of the DVD (CMS Product No. 11479-CD). This Video on Interviewing Vulnerable Elders (VIVE) was funded by the Picker Institute and produced by the UCLA/JH Borun Center.

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

Source: CMS PERL 201008-39

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.

YouTube training videos for minimum data set 3.0

Resident assessment instrument manual, Chapter 3, Sections B, C, D, K, and P now available

Please click on the appropriate YouTube link under "Related Links Outside of CMS" on the Center for Medicare & Medicaid Services (CMS) Nursing Home Quality Initiatives website (*http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp*).

Additional postings to be added as they are completed. You may also visit the "CMS YouTube Channel" at *http://www.youtube.com/cmshhsgov*.

Minimum data set 3.0 training slides and instructor guides

- MDS 3.0 Training Materials Change Document September 2010 – this document reflects any changes to the training slides and instructor guides from previously published versions. (Updated September 15, 2010.)
- MDS 3.0 Training Aide – contains algorithms and assessment aides that may be helpful when performing assessments or coding the MDS. (Updated September 15, 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 201009-25

Revised skilled nursing facility prospective payment system fact sheet

The *Skilled Nursing Facility Prospective Payment System* fact sheet (revised July 2010), which provides the elements of the skilled nursing facility prospective payment system, is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf*.

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

Source: CMS PERL 201009-30

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

October 2010 integrated outpatient code editor specifications version 11.3

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

Provider types affected

This article is for providers submitting claims to Medicare contractors (fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for outpatient services provided to Medicare beneficiaries and for claims for limited services when provided in a home health agency not under the home health prospective payment system or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider action needed

This article is based on change request (CR) 7111, which describes changes to the integrated outpatient code editor (I/OCE) and outpatient prospective payment system (OPPS) to be implemented in the October 2010 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR 7111 describes changes to billing instructions for various payment policies implemented in the October 2010 OPPS update. The October 2010 I/OCE changes are also discussed in CR 7111.

Note: The full list of I/OCE specifications may now be found on the CMS website at *http://www.cms.gov/OutpatientCodeEdit/*.

A summary of the changes for October 2010 is within Appendix M of Attachment A of CR 7111 and that summary is captured in the following key points:

- Effective December 23, 2009, Medicare will apply a mid-quarter Food and Drug Administration-approval date to code 90662. Edit 67 is affected.
- Effective October 1, 2010, Medicare will:
  - Bypass edit 9 for HCPCS code G0428 (code has SI = E). Edit 9 is affected.
  - Make HCPCS/APC/SI changes (data change files); (See the attachment to CR 7111 on the Centers for Medicare & Medicaid Services (CMS) website for a complete list of these code updates at *http://www.cms.gov/Transmittals/downloads/R2042CP.pdf*.)
  - Update the valid diagnoses code list with ICD-9-CM changes. Edit 1 is affected.
  - Update diagnosis/age and diagnosis/sex conflict edits with Medicare code editor (MCE) changes. Edits 2 and 3 are affected.
  - Implement version 16.2 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers). Edits 19, 20, 39 and 40 are affected.
- The following ambulatory payment classifications (APCs) were added to the I/OCE, effective October 1, 2010.

APC	APC description	Status indicator
01749	Endo, colon,retro imaging	H
09269	C-1 esterase, berinert	G
09270	Gammaplex IVIG	G
09271	Velaglucerase alfa	G
09272	Inj, denosumab	G
09273	Sipuleucel-T, per fusion	G

- APC 01310 is deleted from the I/OCE effective April 1, 2010.
- Added new diagnosis code 31535 to the list of mental health (MH) diagnoses used for partial hospitalization, effective October 1, 2010.
- Effective June 3, 2010, added new HCPCS codes C8931, C8932, C8934, C8935, and C8936 with mid-quarter national coverage determination (NCD)-approval.
- Effective August 26, 2010, apply NCD-approval date for C9801 and C9802
- Apply approval date of June 3, 2010, to *CPT* codes *72159* and *73225*.

Additional information

The official instruction, CR 7111 issued to your MAC, RHHI or FI regarding this change may be viewed on the CMS website at *http://www.cms.gov/Transmittals/downloads/R2042CP.pdf*.

If you have any questions, please contact your MAC, RHHI 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: MM7111
Related Change Request (CR) Number: 7111
Related CR Release Date: September 3, 2010
Related CR Transmittal Number: R2042CP
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Source: CMS Pub. 100-04, Transmittal 2042, CR 7111

ELECTRONIC DATA INTERCHANGE

Implementation of the PWK (paperwork) segment for X12N version 5010

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

Provider action needed

This article is based on change request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N version 5010. Be sure your billing staff is aware of these changes.

Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 professional and institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving optical character recognition (OCR)/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claim examiners. Having the documentation available to claim examiners eliminates the need for costly automated development.

Key points for Medicare billers

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business that must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R763OTN.pdf*.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation **after** the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional information

The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available on the CMS website at *http://www.cms.gov/Transmittals/downloads/R763OTN.pdf*.

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

MLN Matters® Number: MM7041
Related Change Request (CR) Number: 7041
Related CR Release Date: August 27, 2010
Related CR Transmittal Number: R763OTN
Effective Date for Providers: April 1, 2011
Implementation Date: April 4, 2011

Source: CMS Pub. 100-20, Transmittal 763, CR 7041

HIPAA Version 5010 Implementation

Closing in on the target testing date of January 2011 for HIPAA version 5010

Health-care providers, health plans, clearinghouses and vendors should be finished with their internal testing of the HIPAA version 5010 electronic health-care transaction standards by the first recommended deadline for internal testing, December 31, 2010, and be ready to start testing with their external partners, beginning in January 2011, just about four months away.

Beginning January 2011, CMS' Medicare fee-for-service program will be ready to test HIPAA version 5010 transaction standards with its external partners, and other industry segments should be poised to follow suit.

This recommended external testing start date will give the industry adequate time to ensure that their HIPAA version 5010 transactions are being conducted correctly, in preparation for mandatory HIPAA version 5010 compliance by January 1, 2012.

Don't fall behind on this important testing process. Make sure you communicate with your external partners about your HIPAA version 5010 testing plans. Incorporate your HIPAA version 5010 testing messages into your existing communication vehicles, including website links, customer service encounters, etc., to let everyone know when you will be ready to start testing HIPAA version 5010 transactions with them.

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 HIPAA 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 201008-37

Health Insurance Portability and Accountability Act version 5010 and D.0 national calls

Throughout the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 and D.0 transaction standards, the Centers for Medicare & Medicare Services (CMS) will be hosting a series of national education calls that will inform the Medicare fee-for-service provider community of the steps that they need to take in order to be ready for implementation. These calls will also give participants an opportunity to ask questions of Medicare subject matter experts.

Please bookmark this link *http://www.cms.gov/Versions5010andD0/V50/list.asp* to the new 5010/D.0 national calls Web page to stay current on upcoming calls and view materials from past calls.

Keep up-to-date on HIPAA version 5010/D.0 and ICD-10.

For the latest news and resources, please visit *http://www.cms.gov/Versions5010andD0* for version 5010 and *http://www.cms.gov/ICD10/* for ICD-10 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 201009-24

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.

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
October 2010-January 2011

Topic – Medifestival Puerto Rico

When: October 19-26, 2010

Time: 9:00 a.m. – 4:00 p.m. ET **Delivery language:** Spanish

Type of Event: In person seminar/symposium **Focus:** Puerto Rico

Topic – Hot topics

When: Tuesday, November 9, 2010

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

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

Topic – Hot topics – not yet open for registration

When: Tuesday, January 11, 2011

Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English

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

Two easy ways to register

Online – Visit our provider training Web site at *www.fcsomedicaretraining.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

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

Please Note:

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

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

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

PREVENTIVE SERVICES

September is Prostate Cancer Awareness Month

The Centers for Medicare & Medicaid Services (CMS) is asking the provider community to keep their patients with Medicare healthy by encouraging them to take advantage of Medicare-covered prostate cancer screenings. Medicare provides coverage for digital rectal exams (DREs) and prostate specific antigen tests (PSAs) for qualified beneficiaries.

What can you do?

As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by encouraging them to take advantage of Medicare-covered screenings, including prostate cancer screenings that are appropriate for them.

For more information

CMS has developed several educational products related to Medicare-covered prostate cancer screenings. They are all available, free of charge, from the *Medicare Learning Network*®:

- *The MLN Preventive Services Educational Products Web Page* – provides descriptions and ordering information for MLN educational products for health care professionals related to Medicare-covered preventive services, including prostate cancer screening.

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

- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals* – provides coverage and coding information on Medicare-covered preventive services and screenings, including prostate cancer screening.

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

- *Quick Reference Information: Medicare Preventive Services* – this chart provides coverage and coding information on Medicare-covered preventive services, including prostate cancer screenings.

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

- *The Medicare Preventive Services Series: Part 3 Web-based-training (WBT) course* – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including prostate cancer screenings. To access the course, please visit the MLN home page at http://www.cms.gov/mlngeninfo on the internet. Scroll down to "Related Links Inside CMS" and click on "Web Based Training (WBT) Modules".

- *The Cancer Screenings* brochure – this brochure provides information on coverage for Medicare-covered cancer screenings, including prostate cancer screenings.

  http://www.cms.gov/MLNProducts/downloads/cancer_screening.pdf

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products. For more information on Prostate Cancer Awareness Month, please visit *Zero – The Project to End Prostate Cancer* at *http://www.zerocancer.org/index.html*.

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

Source: CMS PERL 201009-08

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

Educational 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.

OTHER EDUCATIONAL RESOURCES

Updates from the Medicare Learning Network

The *Medicare Learning Network*® has updated the following provider educational materials:

- The "*Advanced Beneficiary Notice of Noncoverage (ABN)*" booklet, which provides information on when providers should use an ABN, ABN policies, how to properly complete an ABN and ABN modifiers, is now available **in hardcopy format** from the *Medicare Learning Network*®. To order your copy, free of charge, please visit the MLN Products page on the Internet at *http://www.cms.gov/MLNProducts/01_Overview.asp*. Scroll down to the "Related Links Inside CMS" section and choose "MLN Product Ordering Page". To view the online version, please visit *http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf*.
- The publication titled "*The Medicare Overpayment Collection Process*" (previously titled "What Physicians and Other Suppliers Should Know About Medicare Overpayments"), which provides the definition of an overpayment and information about the collection of Medicare physician and supplier overpayments, is now available *in downloadable format* from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/OverpaymentBrochure508-09.pdf*.

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

Source: CMS PERL 201009-17

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 2010 through September 2011.	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

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Jacksonville, FL 32232-5097

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P. O. Box 44021
Jacksonville, FL 32231-4021

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

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Jacksonville, FL 32202-4914

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

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medicare.fcso.com
Centers for Medicare & Medicaid Services
www.cms.gov

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

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦