

MEDICARE A Bulletin

A NEWSLETTER FOR MAC JURISDICTION 9 PROVIDERS

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

Routing Suggestions:

- Medicare Manager
- Reimbursement Director
- Chief Financial Officer
- Compliance Officer
- DRG Coordinator
- _____
- _____
- _____



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Publication Staff

Millie C. Pérez
 Terri Drury
 Mark Willett
 Robert Petty

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

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

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THE FCSO MEDICARE A BULLETIN

About the Medicare A Bulletin

The *Medicare A Bulletin* is a comprehensive publication developed by First Coast Service Options Inc. (FCSO) for Medicare Part A providers in Florida, Puerto Rico and U.S. Virgin Islands in accordance with the Centers for Medicare & Medicaid Services (CMS) notification parameters.

The Provider Outreach and Education Publication team distributes the *Medicare A Bulletin* on a monthly basis. Important notifications requiring communication in between publications are posted to the FCSO Medicare provider education website <http://medicare.fcsso.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

Annual clotting factor furnishing fee update 2011

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

Provider types affected

This article is for providers billing Medicare carriers, fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (MAC), or regional home health intermediaries (RHHI) for services related to the administration of clotting factors to Medicare beneficiaries.

What you need to know

Change request (CR) 7168, from which this article is taken, announces that for calendar year 2011, the clotting factor furnishing fee of \$0.176 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the on the average sales price (ASP) or not otherwise classified (NOC) drug. Please be sure your billing staffs are aware of this fee update.

Additional information

The official instruction, CR 7168 issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2068CP.pdf>.

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

MLN Matters® Number: MM7168

Related Change Request (CR) Number: 7168

Related CR Release Date: October 15, 2010

Related CR Transmittal Number: R2068CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2068, CR 7168

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

Clarification on processing appeals via facsimile or via secure Internet portal

Change request (CR) 6958 updates the current instructions in Chapter 29 of the *Medicare Claims Processing Manual*, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application. Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must obtain prior approval from the Centers for Medicare & Medicaid Services (CMS).

Even though First Coast Service Options Inc. is not utilizing these methods at this time, Chapter 29 changes are not limited to facsimile and Internet portal submissions. Therefore, providers must adhere to all changes not related to facsimile and Internet portal submissions addressed in CR 6958. For additional information, see the MLN Matters article at <http://www.cms.gov/MLNMattersArticles/downloads/mm6958.pdf>.

The MLN Matters® article MM6958 related to CR 6958 was published in the June 2010 *Medicare A Bulletin* (pages 5-7).

Source: CMS Pub. 100-04, Transmittal 1986, CR 6958

Understanding the remittance advice for institutional providers

The *Medicare Learning Network*® (MLN) is now offering the revised “Understanding the Remittance Advice for Institutional Providers” Web-based training (WBT) module. This WBT module is designed to educate all institutional providers who bill Medicare with general remittance advice (RA) information. It includes instructions to help providers to interpret the RA received from Medicare and reconcile it against submitted claims. It provides also guidance on how to read electronic remittance advices (ERAs) and standard paper remittance advices (SPRs), as well as information on balancing an RA.

This activity offers continuing education and is available from the MLN at <http://www.cms.gov/MLNproducts/> by scrolling to the bottom of the page and selecting Web-Based Training Modules from the Related Links Inside CMS section.

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

Source: CMS PERL 201011-22

Update to repetitive billing requirements for institutional claims

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for repetitive pulmonary rehabilitation Part B services provided to Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 7163 which updates the frequency billing requirements to include pulmonary rehabilitation services, revenue code 0948 to the list of repetitive Part B services billable as outpatient services by institutional providers.

Background

The Centers for Medicare & Medicaid Services (CMS) sets limits on the frequency of which particular services may be billed to Medicare. In an effort to lower the volume of submitted bills and to facilitate medical review, frequency limitations have been created to require monthly bill submission of repetitive Part B services.

Repetitive Part B services furnished to a single individual by providers that bill institutional claims will be billed monthly (or at the conclusion of treatment). Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:

Type of service	Revenue code(s)
DME rental	0290 – 0299
Respiratory therapy	0410, 0412, 0419
Physical therapy	0420 – 0429
Occupational therapy	0430 – 0439
Speech-language pathology	0440 – 0449
Skilled nursing	0550 – 0559
Kidney dialysis treatments	0820 – 0859
Cardiac rehabilitation services	0482, 0943
Pulmonary rehabilitation services	0948 (added by CR 7163)

Additional information

The official instruction, CR 7163, issued to your FIs and A/B MACs regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2092CP.pdf>.

If you have any questions, please contact your 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: MM7163

Related Change Request (CR) Number: 7163

Related CR Release Date: November 12, 2010

Related CR Transmittal Number: R2092CP

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

Source: CMS Pub. 100-04, Transmittal 2092, CR 7163

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Welcome to Medicare

If you're new to the Medicare community or if you just need a review of the basics, please visit our Welcome to Medicare page at http://medicare.fcso.com/Welcome_to_Medicare/. You'll find everything you need to build your foundation of Medicare knowledge, from a recommended training curriculum to links to key resources to help you on your way to success as a Medicare provider or biller.

Reminder about important timely filing requirement information

If you are a Medicare fee-for-service (FFS) physician, provider, or supplier submitting claims to Medicare for payment, this is very important information you need to know. Effective immediately, any Medicare FFS claim with date of service on or after January 1, 2010, must be received by your Medicare contractor no later than one calendar year (12 months) from the date of service on the claim or Medicare will deny the claim.

If you have Medicare FFS claims with a service dates from October 1, 2009, through December 31, 2009, those claims must be received by December 31, 2010, or Medicare will deny them. Claims with services dates from January 1, 2009, to October 1, 2009, keep their original December 31, 2010, deadline for filing.

When claims for services require reporting a line item date of service, the line item date will be used to determine the date of service. Change request 7080, issued on July 30, 2010, clarified that for institutional claims containing claim level span dates of service (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim shall be used to determine the date of service for claims filing timeliness. Conversely, professional claims containing claim level span dates of service (i.e., a “From” and “Through” date span on the claim), the “From” date on the claim shall be used to determine the date of service for claim filing timeliness.

For additional information about the new maximum period for claim-submission filing dates, contact your Medicare contractor, or review the *MLN Matters* articles listed below related to this subject:

- MM6960 “Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 – Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months” at <http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf>
- MM7080 “Timely Claims Filing: Additional Instructions” at <http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf>

You may also listen to a podcast on this subject by visiting http://www.cms.gov/CMSFeeds/02_listofpodcasts.asp.

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Source: CMS PERL 201011-22

Partial code freeze prior to ICD-10 implementation

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

Provider types affected

This *MLN Matters*[®] special edition article affects all Medicare fee-for-service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What you need to know

At the ICD-9-CM Coordination & Maintenance (C&M) Committee meeting, held on September 15, 2010, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013.

Considerable interest was expressed in dramatically reducing the number of annual updates to both coding systems. It was suggested that such a reduction in code updates would allow vendors, providers, system maintainers, payers, and educators a better opportunity to prepare for the implementation of ICD-10. Additional public comments on this issue were received prior to this meeting.

The partial freeze will be implemented as follows:

- The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012, there will be only limited code updates to both ICD-9-CM and ICD-10 code sets to capture new technology and new diseases.
- On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new

technologies and diagnoses. There will be no updates to ICD-9 -CM on October 1, 2013, as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

To view the transcript of the meeting, go to the CMS website at http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.

From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the ‘091510_Morning_Transcript’ file. This section appears on page 4 of the 78-page document.

To view the summary report of the meeting, go to the CMS website at http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp.

From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the ‘091510_ICD9_Meeting_Summary_report.pdf’ file.

Partial code freeze prior to ICD-10 implementation (continued)

Information on the code freeze begins on page 5 of the summary report.

Additional information

CMS has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available on the CMS website at <http://www.cms.gov/ICD10>.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources**
Web page: This site links Medicare FFS providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page. Bookmark http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp and check back regularly for access to ICD-10 implementation information of importance to you.
Note: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.
- **CMS sponsored national provider conference calls:** During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are

offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit the CMS website at http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage.

- **Frequently asked questions (FAQs):** To access FAQs related to ICD-10, please visit the CMS ICD-10 Web page at <http://www.cms.gov/ICD10/>, select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”. Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

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

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

MLN Matters® Number: SE1033

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS special edition *MLN Matters*® article SE1033

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Information regarding ACOs and the Medicare shared saving program

The Affordable Care Act seeks to improve the quality of health care services and to lower health care costs by encouraging providers to create integrated health care delivery systems. The integrated systems will test new reimbursement methods intended to create incentives for health care providers to enhance health care quality and lower costs. The Medicare shared savings program under Section 3022 of the Affordable Care Act, which promotes the formation and operation of accountable care organizations (ACOs) is one important delivery system reform where groups or providers meeting the criteria specified by the Secretary may work together to manage and coordinate care for Medicare beneficiaries through an ACO.

In addition, Section 3021 of the Affordable Care Act establishes a center for Medicare & Medicaid innovation (CMMI) within the Centers for Medicare & Medicaid Service (CMS), which is authorized to test innovative payment and service delivery models.

As CMS develops its initial rulemaking for the shared savings program and begins the development of potential models in CMMI, they are seeking request for comments regarding certain aspects of the policies and standards that will apply to accountable care organizations (ACOs) participating in the Medicare program under Section 3021 or 3022 of the Affordable Care Act. To be assured consideration, comments had to be received by December 3, 2010.

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Source: CMS PERL 201011-35

Healthcare Common Procedure Coding System code set update

The Centers for Medicare & Medicaid Services has announced the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at <http://www.cms.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp>. Changes are effective on the date indicated on the update.

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

Source: CMS PERL 201011-17

Additional editing for disaster related claims

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

Provider types affected

This article is for providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries related to a disaster containing condition code DR and/or modifier CR, in which payment for these services or items is conditioned on the presence of a “formal waiver.”

Provider action needed

CMS is implementing additional editing to ensure correct payment for claims related to a disaster containing condition code DR and/or modifiers CR, submitted for services and/or items for which Medicare payment is conditioned on the presence of a “formal waiver.” Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the condition code DR and modifier CR to facilitate the processing of claims affected by a disaster or other general emergency. The condition code DR and modifier CR were also authorized for use on claims for items and services affected by subsequent emergencies. Use of the condition code DR and modifier CR is mandatory for any claim for which Medicare payment is conditioned on the presence of a “formal waiver” as defined below.

Formal waivers: A “formal waiver” is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers. One type is a temporary waiver or modification of a requirement under the authority described in Section 1135 of the Social Security Act (the Act). Although Medicare payment rules themselves are not waivable under this statutory provision, the waiver authority under Section 1135 may permit Medicare payment in a circumstance where such payment would otherwise be barred because of noncompliance with the requirement being waived or modified. The second type of formal waiver is a waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the “three-day qualifying hospital stay” requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Act.

Several conditions must be met for a Section 1135 waiver to be implemented. First, the President must declare an emergency or disaster under the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Such a declaration will specify both an

effective date and the geographic area(s) covered by the declaration. Second, the Secretary of the Department of Health & Human Services must declare – under Section 319 of the Public Health Service Act – that a public health emergency exists within some or all of the areas covered by the Presidential declaration. Third, the Secretary must authorize the waiver of one or more requirements specified in Section 1135 of the Act. Fourth, the Secretary or the Administrator of CMS must determine which Medicare program requirements, if any, may be waived or modified under the Secretary’s authorization and whether specific conditions within the geographic area(s) specified by the Secretary’s declaration warrant waiver or modification of one or more requirements of Title XVIII of the Act. If all of the foregoing conditions are met, the Secretary or CMS Administrator may specify the extent to which a waiver or modification of a specific Medicare requirement is to be applied within the geographic area(s) with respect to which the waiver authority has been invoked.

The waiver of a Medicare requirement based on authority included in the provision of Title XVIII of the Act or its implementing regulations may be made at the discretion of the Administrator of CMS unless otherwise specified. Such a waiver does not require either a Presidential or a Secretarial declaration nor, if such declarations are made, would such a waiver be necessarily limited by the geographic boundaries specified in such declarations. Nevertheless, the Administrator may elect to limit the effect of “Title XVIII waivers” to such geographic areas and to such time frames as are specified by such declarations.

A Medicare requirement established in statute or regulation that is not subject to waiver under either of these types of “formal waiver” generally may not be waived as a matter of administrative discretion. Because most Medicare requirements are not “waivable,” nearly all Medicare entitlement, coverage, and payment rules will remain in effect during a disaster or emergency.

Informal Waivers: An “informal waiver” is a discretionary waiver or relaxation of a procedural norm, when such norm is not required by statute or regulation, but rather is reflected in CMS guidance or policy. Such norm may be waived or relaxed administratively if circumstances warrant. One example of such a norm would be claims filing jurisdiction. In the event of a disaster/emergency that impaired or limited operations at a particular Medicare contractor, alternative claims filing jurisdictions could be established. Informal waivers are made by the CMS Administrator or his/her delegates.

Additional editing for disaster related claims(continued)

Claim processing instructions

Of particular importance for hospitals in CR 7156 is that Medicare contractors will suspend claims received on types of bills 18x and 21x with condition code DR and modifier CR in order to ensure that the admission date/dates of service fall within or overlap a waiver period. If the claims meet the waiver period criteria, they will process. If they contain condition code DR and modifier CR, but do not meet the waiver requirement, the claims will be returned to the provider.

Additional information

The official instruction, CR 7156 issued to your FI or A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R809OTN.pdf>.

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

MLN Matters® Number: MM7156

Related Change Request (CR) Number: 7156

Related CR Release Date: November 12, 2010

Related CR Transmittal Number: R809OTN

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

Source: CMS Pub. 100-20, Transmittal 809, CR 7156

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2011 payment changes announcement for Medicare home health services

Final rule reflects improvements to quality and efficiency of care

The Centers for Medicare & Medicaid Services (CMS) issued a final rule to update the home health prospective payment system (HH PPS) rates for calendar year (CY) 2011. This final rule reflects CMS' ongoing efforts to improve quality of care provided by home health agencies to Medicare beneficiaries. The rule promotes efficiency in payments, implements various Affordable Care Act (ACA) provisions, and enhances Medicare's program integrity.

Home health agency (HHA) payments are estimated to decrease by approximately 4.89 percent – or \$960 million – in 2011. This impact accounts for ACA provisions, wage index and market basket updates, and case-mix coding adjustments. Under the new law, the existing home health agency outlier cap becomes permanent, and HH PPS rates are reduced by an additional 2.5 percent. The rule mandates that CMS apply a one percentage point reduction to the CY 2011 home health market-basket amount; this results in a 1.1 percent market basket update for HHAs in CY 2011.

The rule will be published at the *Federal Register* on November 17, 2010. The effective date is January 1, 2011.

To view the rule, access the following link:

<http://www.cms.gov/HomeHealthPPS/HHPPSRN/itemdetail.asp?itemID=CMS1240989&>.

To read the entire CMS press release issued on November 3, click here:

http://www.cms.gov/apps/media/press_releases.asp

More information is available at <http://www.healthcare.gov/>, a new Web portal from the U.S. Department of Health & Human Services.

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Source: CMS PERL 201011-14

New Web page – physician feedback/value modifier program

The Centers for Medicare & Medicaid Services (CMS) uses claims data to create confidential reports measuring the resources and quality of care involved in furnishing care. In 2010, the physician feedback program is limited to physicians and groups that have been notified – and if you have not received notification then you will not receive a report. Feedback reports will be distributed in a multi-year, phased, implementation schedule to medical professionals and medical group practices.

To learn more about these reports and the legislatively-mandated value modifier, visit the new CMS Web page at <http://www.cms.gov/PhysicianFeedbackProgram>.

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Source: CMS PERL 201011-37

Indian Health Service facilities and tribal provider's use of PECOS

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

Provider types affected

Tribal or Indian Health Service (IHS) providers wanting to enroll or who are currently enrolled in the Medicare program.

Provider action needed

This article is based on change request (CR) 7174, which informs Indian Health Service (IHS) facilities and tribal providers initially enrolling in the Medicare program or submitting changes of enrollment information that they may use the Internet-based provider enrollment, chain and ownership system (PECOS) to do so.

Background

Currently, Indian Health Service (IHS) facilities and tribal providers are permitted to enroll in Medicare Part A and B using the paper enrollment process only. The Internet-based PECOS routes enrollment applications to the correct Medicare contractor based on the provider/supplier type and their practice location, but it is not currently designed to route IHS and tribal enrollment applications to TrailBlazer Health Enterprises, LLC (TrailBlazer), the single designated Medicare contractor responsible for enrolling this provider type. For this reason, IHS facilities and tribal providers have not been able to use Internet-based PECOS.

CR 7174 is establishing an interim process to allow IHS facilities and tribal providers to use Internet-based PECOS to initially enroll in the Medicare program or submit changes of information.

If IHS facilities or tribal providers choose to use Internet-based PECOS, they will be responsible for mailing to TrailBlazer the following as part of the interim process:

1. A cover letter to indicate they are seeking to enroll as an IHS facility or tribal provider or updating their current enrollment information
2. The Internet-based PECOS certification statement
3. Any other applicable supporting documentation.

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The TrailBlazers addresses are as follows:

Part A

Part A Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650458
Dallas, TX 75265-0458

Part B

Part B Provider Enrollment
TrailBlazer Health Enterprises, LLC
Provider Enrollment
P.O. Box 650544
Dallas, TX 75265-0544

This interim process shall remain in effect until PECOS system changes are implemented to route all electronic enrollment applications received from IHS facilities and tribal providers directly to TrailBlazer.

Additional information

The official instruction, CR 7174, issued to your carriers, fiscal intermediaries (FIs), and Part A/Part B Medicare administrative contractors (A/B MACs) regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R358PI.pdf>.

If you have any questions, please contact your carriers, 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: MM7174
Related Change Request (CR) Number: 7174
Related CR Release Date: October 28, 2010
Related CR Transmittal Number: R358PI
Effective Date: November 29, 2010
Implementation Date: November 29, 2010

Source: CMS Pub. 100-08, Transmittal 358, CR 7174

DMEPOS contract suppliers announced

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the round 1 rebid of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program.

The list of contract suppliers is now available at

http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp#TopOfPage.

Visit the CMS website at <http://www.cms.gov/DMEPOSCompetitiveBid/> to view additional information.

To view the press release, please click: http://www.cms.gov/apps/media/press_releases.asp.

To view the fact sheet, please click: http://www.cms.gov/apps/media/fact_sheets.asp.

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Source: CMS PERL 201011-08

Medicare DMEPOS rules effective in 2011

The Centers for Medicare & Medicaid Services (CMS) has announced that the following final rule is on display at the *Federal Register: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011*. The rule (CMS-1503-FC) may be viewed at <http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp>.

This final rule includes provisions regarding the following DMEPOS subjects that impact the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program:

- The establishment of an appeals process for competitive bidding contract suppliers that are notified that they are in breach of contract
- The subdivision of metropolitan statistical areas (MSAs) with populations over 8,000,000 into smaller competitive bidding areas (CBAs), in particular Chicago, New York, and Los Angeles
- The addition of 21 MSAs to the 70 MSAs already included in the round 2 competitive bidding program, for a total of 91 MSAs
- The addition of the following policies affecting future competitions for diabetic testing supplies following round 1:
 - ♦ Revision of the definition of a “mail order” item to include any item shipped or delivered to a beneficiary’s home, regardless of the method of delivery
 - ♦ Requirement that bidding suppliers demonstrate that their bid covers types of diabetic testing strip products that, in the aggregate and taking into account volume for the different products, cover at least 50 percent of the types of test strips products on the market
 - ♦ Prohibition of contract suppliers from influencing or incentivizing beneficiaries to switch types of test strips or glucose monitors
- The exemption of off-the shelf orthotics from competitive bidding when provided by a physician to his or her own patients or a hospital to its own patients
- The elimination of the lump sum purchase option for standard power wheelchairs furnished on or after January 1, 2011, and adjustments to the amount of the capped rental payments for both standard and complex rehabilitative power wheelchairs

Appeals process

CMS finalized, in the final rule, an appeals process for suppliers who have been notified that they are in breach of their DMEPOS competitive bidding contract. Depending on the circumstances, suppliers initially will either be afforded a process for submitting a corrective action plan or request a hearing prior to termination of the contract. The appeals process will ensure that suppliers have appeal rights and that they receive an opportunity to be heard before their contract is terminated.

Subdivision of the metropolitan statistical areas

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) allows us to subdivide metropolitan

statistical areas (MSAs) with populations over 8,000,000 into smaller CBAs. CMS will subdivide the three largest MSAs: Chicago-Naperville-Joliet, Illinois-Indiana-Wisconsin; Los Angeles-Long Beach-Santa Ana, California; and New York-Northern New Jersey-Long Island, NY-NJ-PA. CMS finalized the regulation to subdivide MSAs along county lines as CMS believe county lines are well-defined and more static.

Addition of metropolitan statistical areas

The Affordable Care Act requires that CMS expand round 2 of the competitively bidding program by adding an additional 21 of the largest MSAs based on total population to the original 70 already selected for round 2. CMS have included this requirement in the regulation.

Diabetic testing supplies

MIPPA specifies that a national competition for mail order items and services is to be phased in after 2010. The regulation includes provisions to implement a national mail order competition for diabetic supplies in 2011 that includes all home deliveries while maintaining the local pharmacy pickup choice for beneficiaries. CMS are also implementing the special “50 percent rule” mandated by MIPPA and implementing an anti-switching requirement as part of the terms of the competitive bidding contract.

Exemption of off-the shelf orthotics

This regulation implements the MIPPA requirement to extend the competitive bidding exception to off-the shelf (OTS) orthotics furnished by: (1) a physician or other practitioner (as defined by the Secretary) to the physician’s or practitioner’s own patients as part of the physician’s or practitioner’s professional service; or (2) a hospital to the hospital’s own patients during an admission or on the date of discharge from the hospital.

Elimination of additional rental payments

The regulation also solicited comments on whether to maintain the additional rental payments made to contract suppliers when a beneficiary does not continue to get capped rental or oxygen equipment from his or her current supplier. CMS received nine public comments on this rule and will take them under consideration for future proposed rulemaking.

In addition to the competitive bidding rules, this regulation addresses the following payment policies for power-driven wheelchairs and oxygen and oxygen equipment:

Lump sum purchase option for standard power wheelchairs

Sections 3136(a)(1) and (2) of the Affordable Care Act required revisions to the regulations to eliminate lump sum (up-front) purchase payment for standard power-driven wheelchairs and permit payment only on a monthly rental basis for standard power-driven wheelchairs. For complex rehabilitative power-driven wheelchairs, the regulations will continue to permit

Medicare DMEPOS rules to take effect in 2011 (continued)

payment to be made on a lump sum purchase method or a monthly rental method. Also, payment adjustments required by the statute were made for power-driven wheelchairs under the Medicare Part B DMEPOS fee schedule to pay 15 percent instead of 10 percent) of the purchase price for the first three months under the monthly rental method and six percent (instead of 7.5 percent) for remaining rental months. Payment is based on the lower of the supplier's actual charge and the fee schedule amount. These changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of the Medicare DMEPOS competitive bidding program.

Oxygen and oxygen equipment

CMS have decided not to finalize this proposed revision for situations where a beneficiary relocates on or after the 18th month rental payment and before the 36-month

rental at this time due to evidence that beneficiaries who relocate before the 36th month find suppliers to furnish the oxygen and oxygen equipment. CMS will consider implementing this regulatory change in the future if they determine that beneficiaries are having difficulty locating suppliers when they relocate during the 36-month rental period.

These provisions are found in Sections H, N, P, Q, and R of the 2011 physician fee schedule final rule, which is now on display at the Office of the Federal Register. The final rule (CMS-1503-FC) is available at <http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp>.

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Source: CMS PERL 201011-09

AMBULANCE SERVICES

Air ambulance services

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

Provider types affected

Air ambulance providers submitting claims to fiscal intermediaries (FI), carriers, and Part A/B Medicare administrative contractors (MAC) are affected.

Provider action needed

This article is based on change request (CR) 7161, which updates Chapter 10, Section 10.4.6 of the *Medicare Benefit Policy Manual* to better describe special payment limitations for air ambulance services. No new policy is announced by CR 7161. Please ensure that your staffs are aware of this clarification.

Background

Section 10.4.6, Special Payment Limitations, of the *Medicare Benefit Policy Manual* has been updated and states that:

“If a determination is made **to order** transport by air ambulance, but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport. If the air transport was medically appropriate (that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.”

Additional information

The official instruction, CR 7161, issued to your FI, carrier, and A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R133BP.pdf>.

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

MLN Matters® Number: MM7161

Related Change Request (CR) Number: 7161

Related CR Release Date: October 22, 2010

Related CR Transmittal Number: R133BP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-02, Transmittal 133, CR 7161

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Ambulance services comparative billing report

In November, the Centers for Medicare & Medicaid Services (CMS) released its third national provider comparative billing report (CBR). This report is centered on emergency transports and non-emergency transports related to end-stage renal disease provided by ambulance providers. The CBRs will be released to approximately 5,000 ambulance providers nationwide.

The CBRs, produced by SafeGuard Services under contract with CMS, provide comparative data on how an individual health care provider compares to other providers by looking at utilization patterns for services, beneficiaries, and diagnoses billed. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

These reports are not available to anyone but the provider who receives them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers comply with Medicare billing rules and improve the level of care they furnish to their Medicare patients. For more information and to review a sample of the ambulance CBR, please visit the CBR Services website (<http://www.safeguard-servicesllc.com/cbr/>), or call the SafeGuard Services' provider help desk support team (530-896-7080).

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Source: CMS PERL 201011-37

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ELECTRONIC HEALTH RECORDS

ONC reaches out to vendor community to help reduce health disparities

The Office of the National Coordinator for Health Information Technology (ONC) and the Office of Minority Health (OMH) believe that electronic health records (EHRs) can help improve health care for low-income and minority communities who remain disproportionately affected by chronic illnesses. However, EHR adoption rates among providers who serve these communities remain low.

In an effort to prevent health disparities caused by a "digital divide," Dr. David Blumenthal, National Coordinator for Health Information Technology, and Dr. Garth Graham, Director of the OMH, encourage vendors to work together to help providers serving low-income and minority communities adopt EHRs. Read more in Dr. Blumenthal's new letter to the vendor community, available at <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3197>.

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Source: CMS PERL 201010-45

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Electronic health record incentive program – certified product list

Providers must use certified electronic health record (EHR) technology in order to earn incentives under the Medicare and Medicaid EHR incentive programs. How to be sure which EHR technology has been certified?

The Office of the National Coordinator for Health Information Technology (ONC) has published the certified health it product list (CHPL), a comprehensive listing of complete EHRs and EHR modules that have been tested and certified under the temporary certification program. Each complete EHR and EHR module included in the CHPL has been tested and certified by an ONC-authorized testing and certification body (ATCB), and reported to ONC by an ONC-ATCB, with reports validated by ONC. Only those EHR technologies appearing on the ONC-CHPL may be granted the reporting number that will be accepted by CMS for purposes of attestation under the EHR incentive programs.

The listing will be updated as additional products are certified by ONC-ATCBs and reported to ONC for validation. For more information about this product listing, please visit <http://healthit.hhs.gov/CHPL>. For more information on the Medicare and Medicaid EHR incentive programs, visit <http://www.cms.gov/EHRIncentivePrograms>.

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Source: CMS PERL 201011-03

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RECOVERY AUDIT CONTRACTOR

Recovery audit contractor demonstration high-risk medical necessity vulnerabilities for inpatient hospitals

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*[®] special edition article SE1027 to add to the list of vulnerabilities. Those additions include diagnosis-related groups (DRG) 316, DRG 395 and DRG 141. All other information is the same. The article was published in the October 2010 *Medicare A Bulletin* (pages 19-21).

This is the second in a series of articles that will disseminate information on recovery audit contractor (RAC) demonstration high dollar improper payment vulnerabilities. The purpose of this article is to provide inpatient hospital education regarding 20 RAC demonstration-identified medical necessity vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC program and the initiation of complex medical necessity review in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Provider types affected

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

Provider action needed

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

Background

The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. The Centers for Medicare & Medicaid Services (CMS) directed the RAC staff to organize their efforts primarily to attain that goal. Supplemental goals, such as correcting identified vulnerabilities, were identified after the fact and were not required tasks. CMS did collect improper payment information from the RACs. However, it was on a voluntary basis, and was done at the claim level and focused on the collection. Some of these high risk medical necessity inpatient hospital vulnerabilities are listed in Table 1. These claims were denied because the demonstration RACs determined that the documentation submitted did not support that the services provided required an inpatient level of care and could have been performed in a less intensive setting.

Table 1

	Provider type	Improper payment amount (pre-appeal)	RAC demonstration findings
1	Inpatient hospital	\$64,739,662	Cardiac defibrillator implant (DRG 514/515)
2	Inpatient hospital	\$34,155,158	Heart failure and shock (DRG 127)
3	Inpatient hospital	\$21,956,139	Other cardiac pacemaker implantation (DRG 116)
4	Inpatient hospital	\$19,169,815	Chest pain (DRG 143)
5	Inpatient hospital	\$14,374,696	Misc. digestive disorders (DRG 182)
6	Inpatient hospital	\$13,881,479	Other vascular procedure (DRG 478)
7	inpatient hospital	\$10,359,085	COPD (DRG 88)
8	Inpatient hospital	\$9,978,346	Medical back problems (DRG 243)
9	Inpatient hospital	\$8,467,551	Renal failure (DRG 316)
10	Inpatient hospital	\$7,355,002	Nutritional & misc. metabolic disorders (DRG 296)
11	Inpatient hospital	\$6,979,129	Transient ischemia (DRG 524)
12	Inpatient hospital	\$6,689,870	Syncope and collapse (DRG 141)
13	Inpatient hospital	\$6,228,919	Other circulatory system diagnoses (DRG 144)
14	Inpatient hospital	\$4,758,678	Kidney & UTI (DRG 320)

Recovery audit contractor demonstration high-risk medical necessity vulnerabilities for inpatient hospitals (continued)

	Provider type	Improper payment amount (pre-appeal)	RAC demonstration findings
15	Inpatient hospital	\$3,239,751	Cardiac arrhythmia (with CC DRG-138)
16	Inpatient hospital	\$3,191,084	Red blood cell disorder (DRG 395)
17	Inpatient hospital	\$2,912,155	Degenerative nervous system disorders (DRG 012)
18	Inpatient hospital	\$2,889,840	Atherosclerosis (with CC DRG-132)
19	Inpatient hospital	\$2,545,289	Other digestive system diagnosis (DRG 188)
20	Inpatient hospital	\$2,314,001	Percutaneous cardiac procedure (DRG 517)

Note: This listing describes what the RACs found the majority of the time when an improper payment was identified. Since each admission is unique, the root causes of each improper payment determination are also unique. *The collection figures identified do not take into account the results of appeals.* In addition to the list above, there are three other general categories of denials which included:

- Medical necessity denials for multiple codes (not mentioned above).
- ASC list violations for codes paid at the inpatient rate that should have been paid as outpatient (no complications identified to justify inpatient stay).
- Other outpatient charges that should have been billed since services were not medically necessary in the inpatient setting.

These three catch-all categories of medical necessity denials impacted multiple codes and no specific coding trends were self-reported by the RACs for these categories.

Summary of RAC demonstration findings

The inpatient hospital vulnerabilities listed in Table 1 were denied because the services were not medically necessary for the setting billed. In many instances, the service/procedure was medically necessary but the services could have been performed in a less-intensive setting. Often, these denials occurred because the submitted medical documentation did not contain sufficient, accurate information to: 1) support the diagnosis, 2) justify the treatment/procedures, 3) document the course of care, 4) identify treatment/diagnostic test results, and 5) promote continuity of care among health care providers.

Inpatient hospital medical documentation reminders

CMS reminds providers that the medical record must contain sufficient documentation to demonstrate that the beneficiary's signs and/or symptoms were severe enough to warrant the need for inpatient medical care. See Chapter 6, Section 6.5.2 of Medicare's *Program Integrity Manual* at <http://www.cms.gov/manuals/downloads/pim83c06.pdf> for more detailed information.

CMS recommends that providers document any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. (For more details see the manual chapter cited in the preceding paragraph.) Some factors that providers should consider when making the decision to admit may include:

- The severity of the signs and symptoms exhibited by the patient.
- The medical predictability of something adverse happening to the patient.
- The need for diagnostic studies.
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital (see Chapter 1, Section 10 of the *Medicare Benefit Policy Manual* on the CMS website at <http://www.cms.gov/manuals/downloads/bp102c01.pdf>).

Documentation that is not legible has a direct affect on the RAC reviewer's ability to support that the services billed were medical necessary and were provided in an appropriate setting. CMS encourages providers to ensure that all fields on documentation tools (such as assessments, flow sheets, checklists, etc.) are completed, as appropriate. If a field is not applicable, CMS recommends that providers use an entry like "N/A" to show that the questions were reviewed and answered. Fields that are left blank often lead the reviewer to make an inaccurate determination.

CMS encourages providers to comply with CMS inpatient hospital policy and Coding Clinic guidance. In the absence of a specific Medicare policy, Medicare contractors may use clinical review judgment to assist in making a payment determination (See the *Program Integrity Manual* Chapter 3, Section 3.14 on the CMS website at <http://www.cms.gov/manuals/downloads/pim83c03.pdf>).

Recovery audit contractor demonstration high-risk medical necessity vulnerabilities for inpatient hospitals (continued)

During the RAC demonstration, reviewers noted that entries in the medical records were not consistent. CMS encourages providers to ensure all entries are consistent with other parts of the medical record (assessments, treatment plans, and physician orders, nursing notes, medication and treatment records, etc. and other facility documents such as admission and discharge data, pharmacy records, etc.). If an entry is made that contradicts previous documentation, CMS recommends providers include documentation that explains why there is a contradiction.

Demonstration review staff often noted that providers failed to adequately document significant changes in the patient's condition or care issues that in some instances impacted the review determination. CMS recommends that providers document any changes in the patient's condition or care.

Lastly, CMS reminds providers to ensure that any information that affects the billed services and is acquired after physician documentation is complete must be added to the existing documentation in accordance with accepted standards for amending medical record documentation.

Additional information

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

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

MLN Matters® Number: SE1027 – [Revised](#)

Related Change Request (CR) Number: N/A

Related CR Release Date: N/A

Related CR Transmittal Number: N/A

Effective Date: N/A

Implementation Date: N/A

Source: CMS Special Edition *MLN Matters*® Article SE1027

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Use the PDS report to improve your Medicare billing operations

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

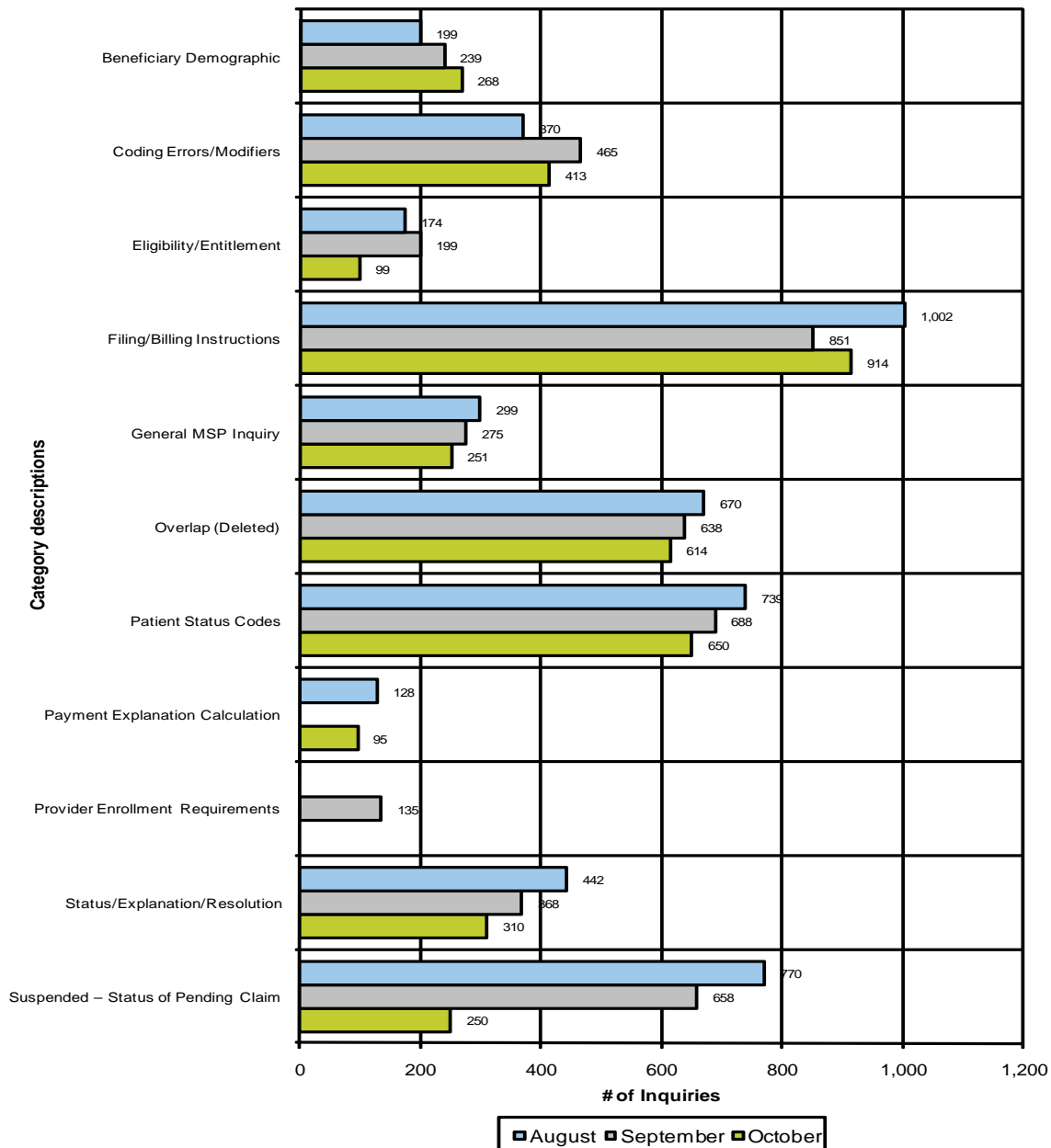
CLAIM AND INQUIRY SUMMARY DATA

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

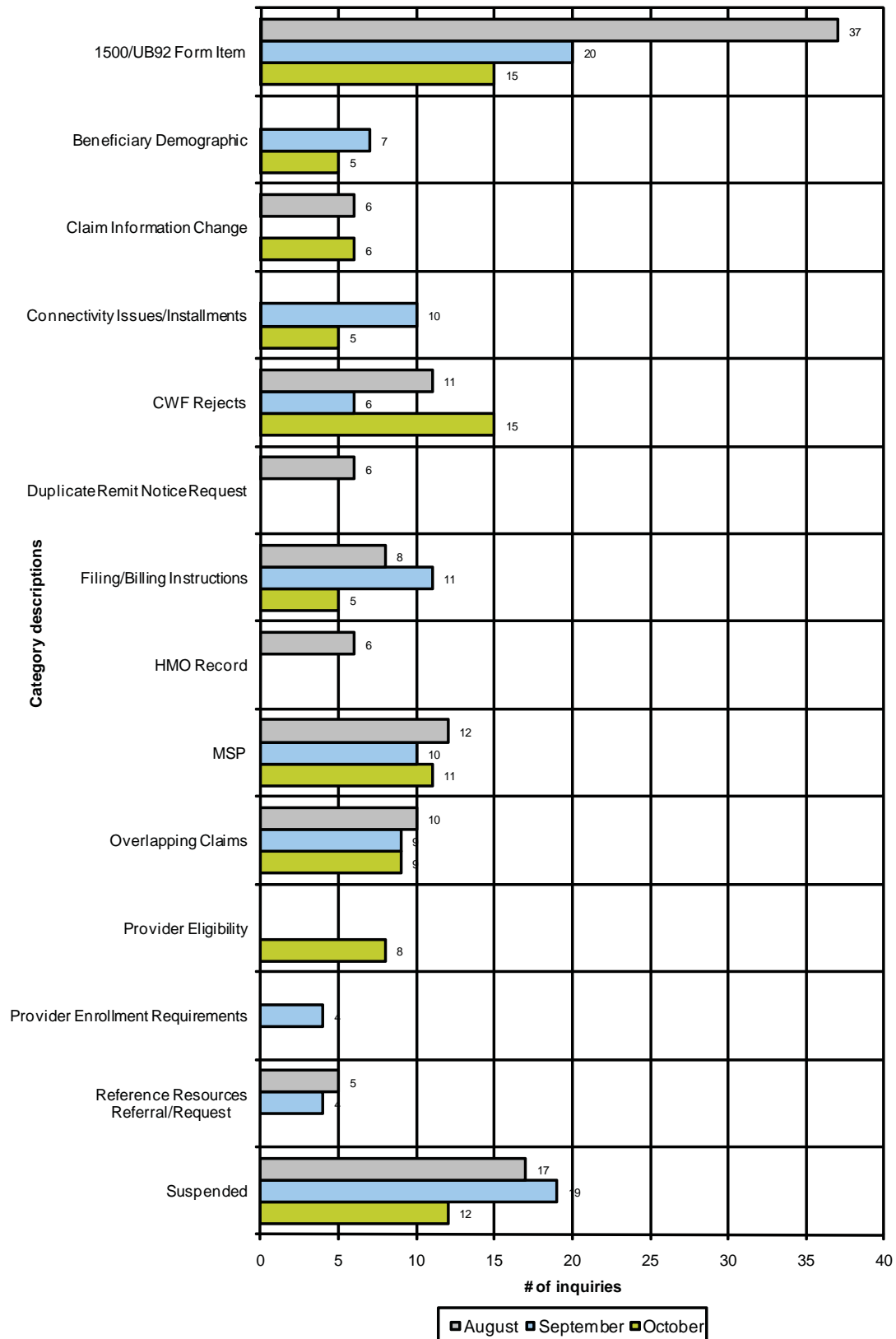
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Florida Part A top inquiries for August-October 2010



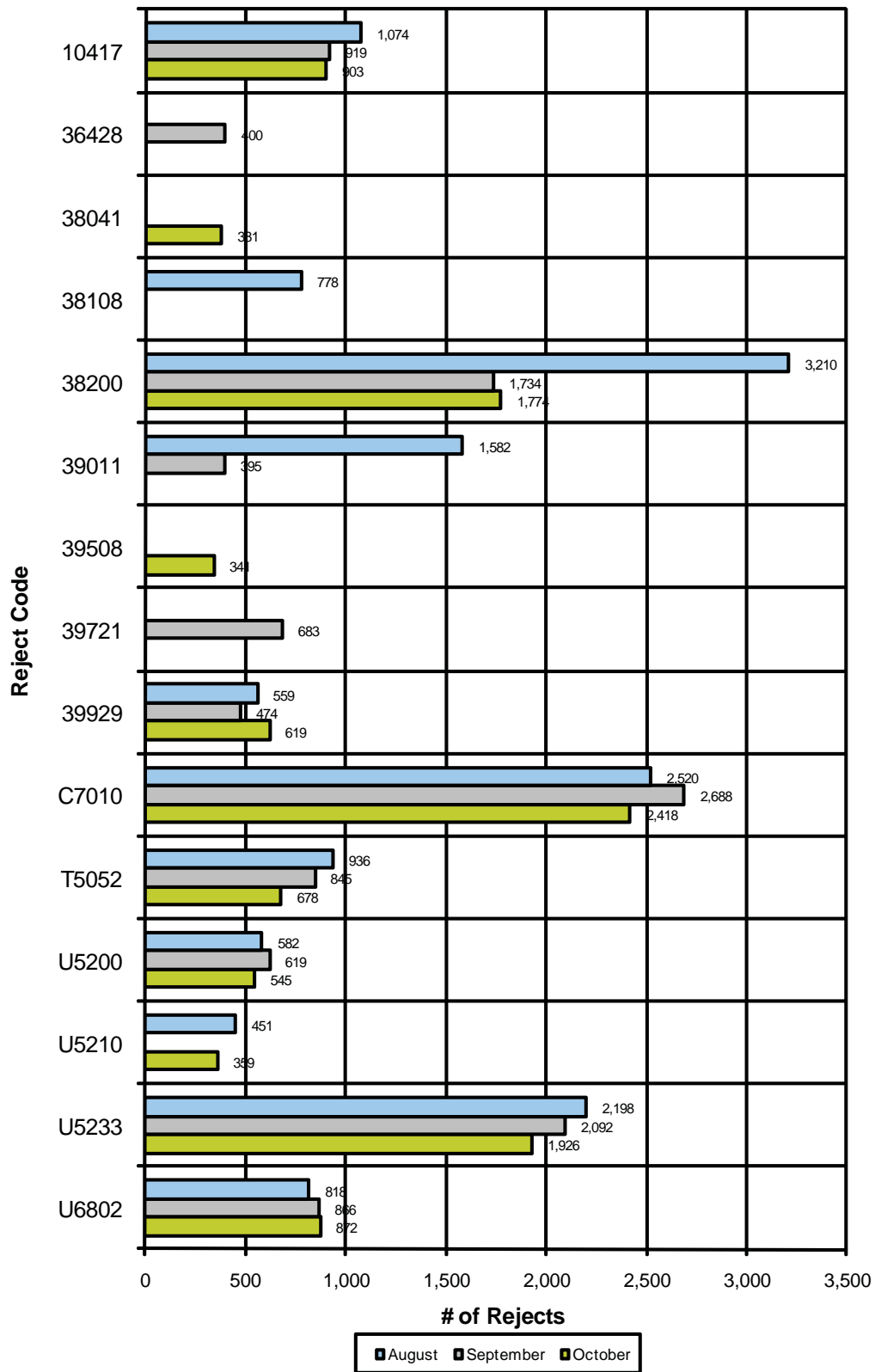
Top inquiries, return to provider, and reject claims for August-October 2010 (continued)

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



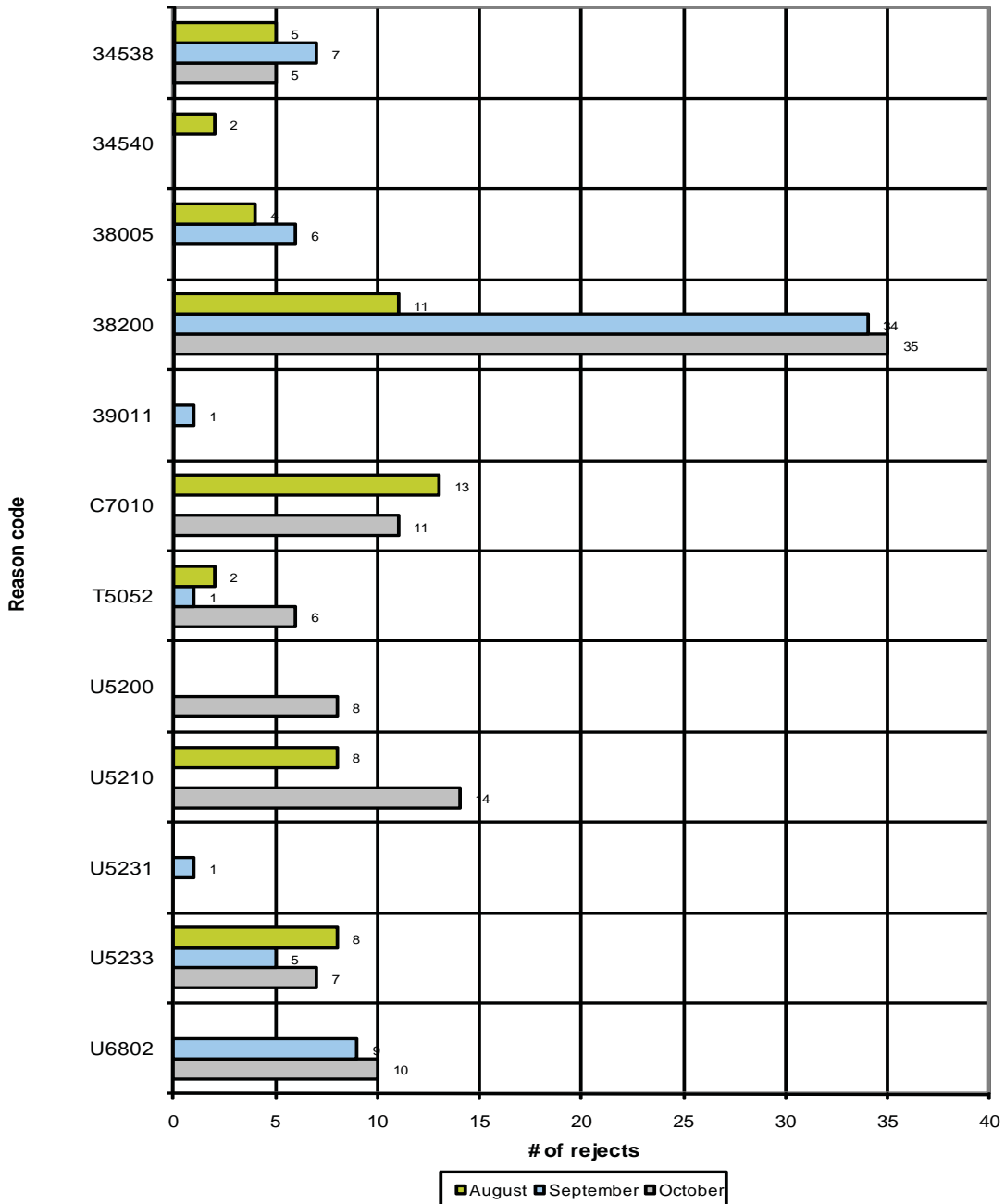
Top inquiries, return to provider, and reject claims for August-October 2010 (continued)

Florida Part A top rejects for August-October 2010



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

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

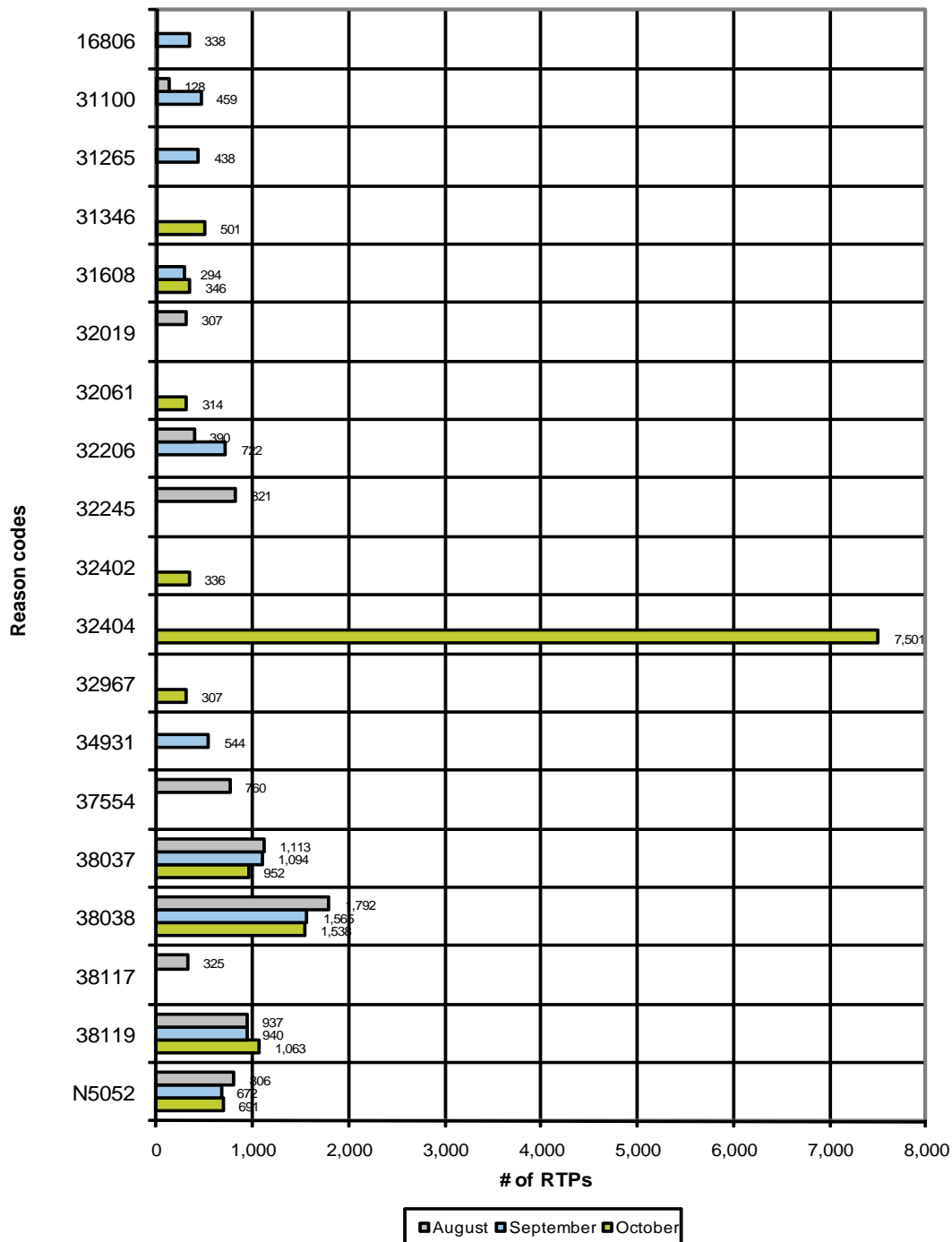


Keep Informed

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 August-October 2010 (continued)

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



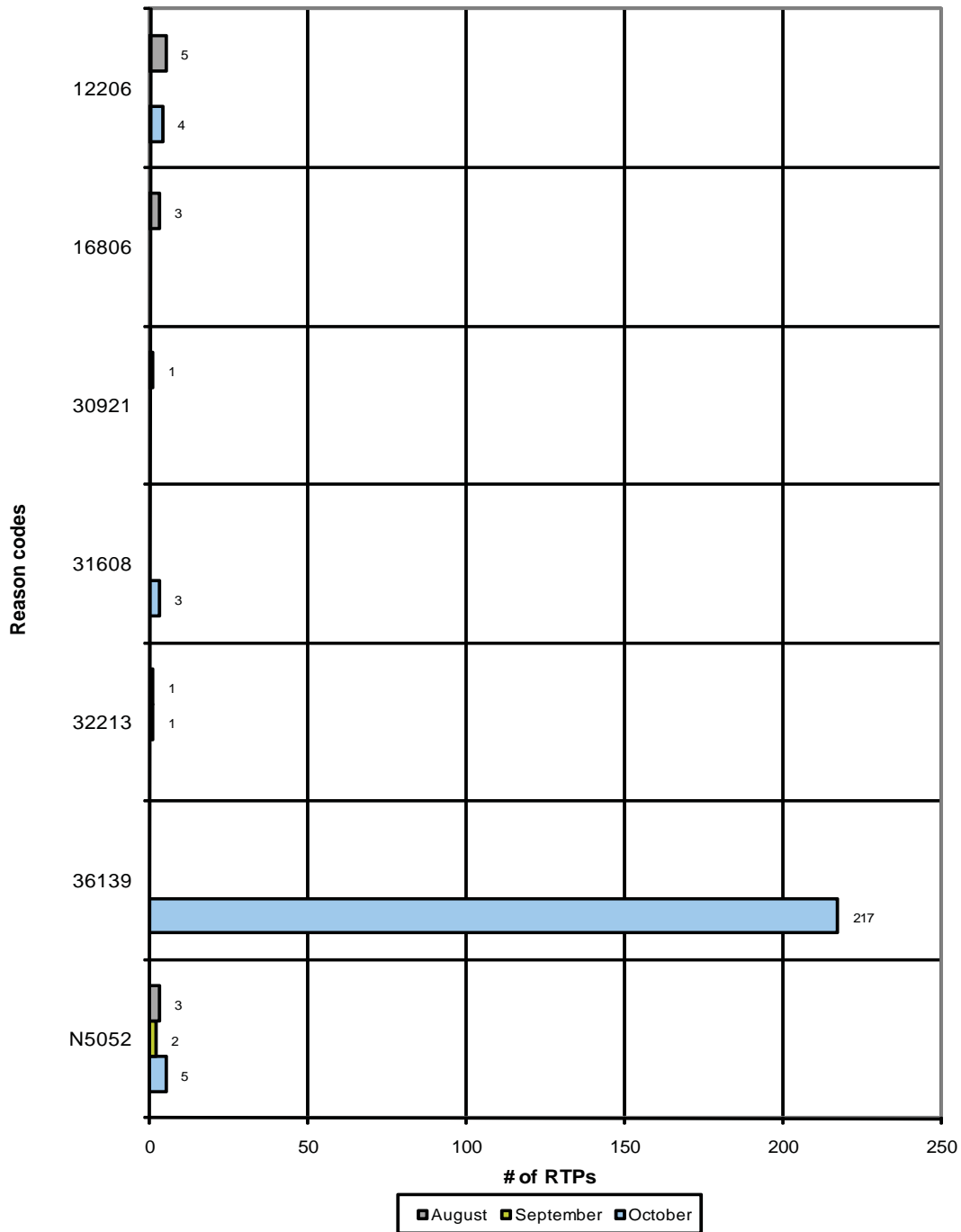
Educational Resources

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

GENERAL INFORMATION

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

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



GENERAL COVERAGE

January 2011 changes to the laboratory national coverage determination edit software

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

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 7204, which announces the changes that will be included in the January 2011 release of Medicare edit module for clinical diagnostic laboratory national coverage determinations (NCDs). The last quarterly release of the edit module was issued in October 2010.

These changes become effective for services furnished on or after January 1, 2011. The changes that are effective for dates of service on and after January 1, 2011, are as follows:

For thyroid testing

ICD-9-CM code 780.66 is added to the list of covered ICD-9-CM codes for the thyroid testing (190.22) NCD.

For gamma glutamyl transferase

ICD-9-CM code 780.66 is deleted from the list of covered ICD-9-CM codes for the gamma glutamyl transferase (190.32) NCD

Please ensure that your billing staffs are aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking

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committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, available on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/manuals/downloads/clm104c16.pdf>, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

Additional information

The official instruction, CR 7204 issued to your carrier, FI or A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2080CP.pdf>.

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

MLN Matters® Number: MM7204

Related Change Request (CR) Number: 7204

Related CR Release Date: October 29, 2010

Related CR Transmittal Number: R2080CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2080, CR 7204

Find fees faster: Try FCSO's fee schedule lookup

Now you can find the fee schedule information you need faster than ever before with FCSO's redesigned fee schedule lookup, located at http://medicare.fcso.com/Fee_lookup/fee_schedule.asp. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Payment for certified nurse-midwife services

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

Provider types affected

Certified nurse midwives (CNMs), submitting claims to Medicare contractors (carriers, fiscal intermediaries [FI], and Part A/B Medicare administrative contractors [A/B MACs]) for Medicare Part B services provided to Medicare beneficiaries are impacted by this article.

Provider action needed

This article is based on change request (CR) 7005, which explains that, effective on or after January 1, 2011, Medicare contractors will pay CNMs for their services at 80 percent of the lesser of the actual charge or 100 percent of the Medicare physician fee schedule (MPFS) amount that would be paid for the same service if furnished by a physician.

In addition, changes have been made regarding the services that CNMs furnish to patients in critical access hospitals (CAHs) paid under the optional method. These changes reflect the increase in payment for CNM services effective January 1, 2011, and specify the appropriate modifier that must be used when billing for CNM services furnished to patients in the setting.

Please ensure that your billing staffs are aware of these payment changes.

Background

Section 3114 of the Affordable Care Act of 2009, increased the amount of payment that the Medicare program will make to CNMs for their personal professional services and for services furnished incident to their professional services. For services on or after January 1, 1992, through December 31, 2010, Medicare payment has been made at 80 percent of the lesser of the actual charge or 65 percent of the MPFS amount that would be paid for the same service furnished by a physician.

To summarize, for services on or after January 1, 1992, through December 31, 2010:

- Medicare contractors will pay CNMs for their services and services furnished incident to their professional services at 80 percent of the lesser of the actual charge or 65 percent of the physician fee schedule amount that would be paid to a physician for the same service.
- Contractors will pay CNMs for their care in connection with a global service at 65 percent of what a physician would have been paid for the total global fee.

For services on or after January 1, 2011:

- Medicare will pay CNMs for their services and services furnished incident to their professional services at 80 percent of the lesser of the actual charge or 100 percent of the physician fee schedule amount that would be paid to a physician for the same service.
- Medicare will pay CNMs for their care in connection with global services at 80 percent of the lesser of the

actual charge or 100 percent of what a physician would have been paid for the total global fee.

- Medicare will pay for CNM services furnished to CAH patients paid under the optional method on TOB 85x with revenue code 96x, 97x or 98x and **modifier SB** (certified nurse-midwife) based on the lesser of the actual charge or 100 percent of the MPFS amount as follows: [(facility- specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

Payment for CNM services is made directly to CNMs for their professional services and for services furnished incident to their professional services. CNMs are required to accept assigned payment for their services. Accordingly, when CNMs bill for their services under specialty code 42, billing does not have to flow through a physician or facility unless the CNM reassigns their benefits to another billing entity. For reassigned CNM services, the entity bills for CNM services using the specialty code 42 to signify that payment for CNM services is being claimed.

Payment for covered drugs and biologicals furnished incident to CNMs' services is made according to the Part B drug/biological payment methodology. Covered clinical diagnostic laboratory services furnished by CNMs are paid according to the clinical diagnostic laboratory fee schedule.

When CNMs furnish outpatient treatment services for mental illnesses, these services could be subject to the outpatient mental health treatment limitation (the limitation). The appropriate percentage payment reduction under the limitation is applied first to the approved amount for the mental health treatment services before the actual payment amount is determined for the CNMs' services. Please refer to the *Medicare Claims Processing Manual*, Chapter 12, Section 210, available on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/manuals/downloads/clm104c12.pdf>, to determine the appropriate percentage payment reduction under the limitation.

When a certified nurse-midwife is providing most of the care to a Medicare beneficiary that is part of a global service and a physician also provides a portion of the care for this same global service, the fee paid to the CNM for his or her care is based on the portion of the global fee that would have been paid to the physician for the care provided by the CNM.

For example, a CNM requests that the physician examine the beneficiary prior to delivery. The CNM has furnished the ante partum care and intends to perform the delivery and post partum care. The MPFS amount for the physician's total obstetrical care (global fee) is \$1,000. The MPFS amount for the physician's office visit is \$30. The following calculation shows the maximum allowance for the CNM's service:

Payment for certified nurse-midwife services (continued)

MPFS amount for total obstetrical care	\$1,000.00
MPFS amount for visit	- \$30.00
Result	\$ 970.00
Fee schedule amount for certified nurse-midwife (65% x \$970, effective 1/1/1992-12/31/2010)	\$ 630.50
Fee schedule amount for certified nurse-midwife (100% x 970, effective 1/1/2011)	\$ 970.00

Therefore, the certified nurse-midwife would be paid no more than 80 percent of \$630.50 or, 80 percent of \$970.00 for services furnished on or after 1/1/2011, for the care of the beneficiary. This calculation also applies when a physician provides most of the services and calls in a certified nurse-midwife to provide a portion of the care.

Physicians and certified nurse midwives use reduced service modifiers to report that they have not provided all the services covered by the global allowance.

Additional information

The official instruction issued to your Medicare carrier, FI, and/or A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2024CP.pdf>.

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

MLN Matters® Number: MM7005

Related Change Request (CR) Number: 7005

Related CR Release Date: August 6, 2010

Related CR Transmittal Number: R2024CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2024, CR 7005

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Collection of federally qualified health center data and updates to preventive services

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

Provider types affected

This article is for federally qualified health centers (FQHCs) billing Medicare contractors (fiscal intermediaries [FIs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7038 which describes the information FQHCs are required to submit in order for the Centers for Medicare & Medicaid Services (CMS) to develop and implement a prospective payment system (PPS) for Medicare FQHCs. The Affordable Care Act mandates the collection of the data begin no later than January 1, 2011. The Affordable Care Act also expands the definition of FQHC preventive services. Be sure that your billing staff is aware of these changes.

Background

Section 10501(i)(3)(A) of The Affordable Care Act amended Section 1834 of The Social Security Act by adding a new subsection (o), which provides the statutory framework for development and implementation of a PPS for Medicare FQHCs. Section 1834(o)(1)(B), as amended by The Affordable Care Act, addresses collection of data

necessary to develop and implement the new Medicare FQHC PPS. Specifically, The Affordable Care Act grants the Secretary of Health & Human Services the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC PPS, including the reporting of services using Healthcare Common Procedure Coding System (HCPCS) codes. The Affordable Care Act requires that the Secretary impose this data collection submission requirement no later than January 1, 2011.

Beginning with dates of service on or after January 1, 2011, when billing Medicare, FQHCs must report all pertinent services provided and list the appropriate HCPCS code for each line item along with revenue code(s) for each FQHC visit. The additional line item(s) and HCPCS reporting are for informational and data gathering purposes only, and will not be utilized to determine current Medicare payment to FQHCs. Until the FQHC PPS is implemented in 2014, the Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.

Section 10501(i)(2) of The Affordable Care Act amended the definition of FQHC services as defined in Section 1861(aa)(3)(A) of The Social Security Act by removing the specific references to services provided under

Collection of federally qualified health center data and updates to preventive services (continued)

section 1861(qq) and (vv) and by adding preventive services as defined in section 1861(ddd)(3), as amended by The Affordable Care Act. The Affordable Care Act establishes a new Medicare FQHC preventive services definition by referencing preventive services as defined in section 1861(ddd)(3) of The Social Security Act, as amended by The Affordable Care Act. In accordance with 1833 (a) (3) of The Social Security Act, preventive services listed in 1861(ddd)(3) are paid in the same manner as all other Medicare FQHC services (with the exception of 1861(s) (10) services, i.e., pneumococcal and influenza vaccines and administration which are paid at 100 percent).

Thus, beginning with dates of service on or after January 1, 2011, The Affordable Care Act revised the list of preventive services paid for in the FQHC setting. Effective January 1, 2011, the professional component of the following preventive services will be covered FQHC services when provided by an FQHC:

- Initial preventive physical examination (IPPE)
- The following screening and other preventive services:
 - ♦ Pneumococcal, influenza, and hepatitis B vaccine and administration under subsection (s)(10)
 - ♦ Screening mammography as defined in 1861(jj)
 - ♦ Screening Pap smear and screening pelvic exam as defined in 1861 (nn)
 - ♦ Prostate cancer screening tests as defined in 1861(oo)
 - ♦ (E) Colorectal cancer screening tests as defined in 1861 (pp)
 - ♦ Diabetes outpatient self-management training services as defined in 1861 (qq)(1)
 - ♦ Bone mass measurement as defined in 1861 (rr)
 - ♦ Screening for glaucoma as defined in 1861 (uu)
 - ♦ Medical nutrition therapy services as defined in 1861 (vv)
 - ♦ Cardiovascular screening blood tests as defined in 1861 (xx)(1)
 - ♦ Diabetes screening tests as defined in 1861 (yy)
 - ♦ Ultrasound screening for abdominal aortic aneurysm as defined in 1861 (bbb)
 - ♦ Additional preventive services (as defined in 1861 (ddd)(1).
- The personalized prevention plan services as defined in Section 1861 (hhh)(1) of The Social Security Act.

CR 7038 does not impact claims for supplemental payments to FQHCs under contract with Medicare Advantage plans.

Key points of change request 7038

For all Medicare FQHC fee-for-service claims on type of bill (TOB) 77x with dates of service on or after January 1, 2011:

- If all the service lines do not contain valid HCPCS code(s) the claim will be returned to the provider, except for those revenue codes that do not permit HCPCS code reporting, i.e., revenue code 025x.
 - All claims with any service lines with any of the following revenue codes will be returned to the provider: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.
 - Medicare will make one payment at 80 percent of the all-inclusive rate for each date of service which contains a valid HCPCS code and one of the following revenue codes: 0521, 0522, 0524, 0525, or 0527 or 0528. Medicare will make a second payment at 80 percent of the all-inclusive rate for a second visit on the same date of service (DOS) when the service line contains revenue codes 0521, 0522, 0524, 0525, 0527, or 0528 with a valid HCPCS code with **modifier 59**, which denotes the conditions being treated are totally unrelated and services are provided at separate times of the day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon. Medicare systems will also make one payment at 80 percent of the all-inclusive rate for each DOS which contains one of the following revenue codes 0521, 0522, 0524, 0525, or 0527 and HCPCS code G0108 for an individual diabetes self management training (DSMT) session or CPT codes 97802, 97803 or HCPCS code G0270 for an individual medical nutrition therapy (MNT) session. Note, however, that Medicare will not make payment for both DSMT and MNT sessions on the same DOS.
- Note:** Service lines containing revenue code 0520 will not receive the all-inclusive rate. The specific site of service revenue code 0521, 0522, 0524, 0525, 0527 or 0528 should be used to report an encounter/visit.
- Medicare will make payment subject to the outpatient mental health treatment limitation for each DOS which contains revenue code 0900 and a valid HCPCS code.
 - Medicare will make payment at 80 percent of the lesser of the charge or the applicable originating site facility fee for each DOS which contains revenue code 0780 and HCPCS Q3014.
 - When claims service lines contain a valid HCPCS code, but do not contain a revenue code identified in the above bullet points as payable on a TOB 77x, Medicare will not make payment on those service lines and will show this action by returning group code CO (contractual obligation) and claim adjustment reason code 97 (Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.).
 - Medicare will not apply the Medicare deductible to payments for FQHC services. Medicare will apply the Medicare deductible to the telehealth originating site facility fee. (The telehealth originating site facility fee is not an FQHC service.)

Collection of federally qualified health center data and updates to preventive services (continued)

- Medicare will apply the Medicare FQHC co-insurance of 20 percent of charges to all FQHC services, except effective for dates of service on or after January 1, 2011, coinsurance and deductible are being waived for all preventive services as enacted in Section 4104 of the Affordable Care Act.
- Medicare will apply the standard Medicare co-insurance of 20 percent to the telehealth originating site facility fee. (The telehealth originating site facility fee is not an FQHC service.)

Additional information

The official instruction (CR 7038) issued to your Medicare A/B MAC and/or FI is available on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2034CP.pdf>.

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

MLN Matters® Number: MM7038

Related Change Request (CR) Number: 7038

Related CR Release Date: August 24, 2010

Related CR Transmittal Number: R2034CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2034, CR 7038

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Website Welcome screen – new bookmark feature

Upon entry to either provider website, visitors are asked to indicate their line of business and geographic location before proceeding to the homepage. The purpose of this feature is to allow providers to find the information they need more quickly by focusing content based upon their selections. Since frequent site visitors may prefer not to have to indicate their references at the beginning of every visit, a Bookmark this page link is not only featured on every page of the provider website but also has been added to the site's Welcome pop-up screen. This new feature will allow visitors to save their preferences by bookmarking the homepage. More information is available at <http://medicare.fcso.com/Help/171993.asp>.

LOCAL COVERAGE DETERMINATIONS

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

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Advance beneficiary notice

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

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

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ADDITIONS/REVISIONS TO EXISTING LCDs

AJ9355: Trastuzumab (Herceptin®) – revision to the LCD

LCD ID Number: L28998 (Florida)

LCD ID Number: L29030 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for trastuzumab (Herceptin®) 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, language in the LCD has been revised/updated to include categories and testing for human epidermal growth factor receptor 2 (HER2) tumors and to add current off-label indications for breast cancer as outlined in the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium.

Also, the “Sources of Information and Basis for Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for services provided **on or after October 26, 2010**.

In addition, language in the LCD has been revised/updated under the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD to include the Food and Drug Administration (FDA) indications for metastatic gastric or gastroesophageal junction adenocarcinoma.

Under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, ICD-9-CM code range 150.0-150.9 for malignant neoplasm of esophagus, and ICD-9-CM code 151.0 for malignant neoplasm of cardia were added.

Also, the “CMS National Coverage Policy” and “Sources of Information and Basis for Decision” sections of the LCD were updated.

Effective date

This LCD revision is effective for claims processed **on or after November 18, 2010**, for services provided **on or after October 20, 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. ❖

A93303: Transthoracic echocardiography (TTE) – article correction

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 most recently revised on October 14, 2010. An article was previously published in the September 2010 *Medicare A Bulletin* (page 19). The article informed providers that effective for **services provided on or after October 14, 2010**, the “Revenue Codes” section of the LCD was revised with the addition of revenue code 483 – cardiology, echocardiology. Since that time, the “Revision History-Explanation of Revision:” section of the LCD has been revised to reflect that the effective date of the LCD revision is based on **process date (claims processed 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. ❖

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? FCSO’s LCD lookup, available at http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp, helps you find the coverage information you need quickly and easily. Just enter a procedure code or the LCD’s “L number,” click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

HOSPITAL SERVICES

Clarification of payment window for outpatient services treated as inpatient services

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

Provider types affected

This article is for Inpatient Acute Care hospitals that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Make sure your billing staff is aware of the following changes to the Medicare policy for payment of outpatient services on either the date of an inpatient admission or during the three calendar days immediately preceding an inpatient date of admission. These changes impact dates of service on or after June 25, 2010.

Background

Section 102 of the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010” pertains to Medicare’s policy for payment of outpatient services provided on either the date of a beneficiary’s inpatient admission or during the three calendar days immediately preceding the date of a beneficiary’s inpatient admission to a “subsection (d) hospital” subject to the inpatient prospective payment system (or during the one calendar day preceding the date of a beneficiary’s inpatient admission to a non-subsection (d) hospital).

Under the three-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include, on the claim for a beneficiary’s inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services provided during the payment window. The new law makes the policy pertaining to admission-related outpatient nondiagnostic services more consistent with common hospital billing practices. All services other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital), provided on the same date of the inpatient admission are deemed related to the admission and are not separately billable.

Additionally, outpatient nondiagnostic services, other than ambulance services (as denoted by revenue code 054x on the claim line) and maintenance renal dialysis services (type of bill 072x or type of bill 13x with HCPCS code G0257 along with other dialysis service lines identified by revenue codes 0270, 0304, 0634, 0635 and/or 0636 on the same date as HCPCS code G0257), provided by the hospital

(or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary’s admission are deemed related to the admission; and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the inpatient hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary’s admission) by adding a condition code 51 to the separately billed outpatient non-diagnostic services claim.

Providers may submit outpatient claims with condition code 51 starting April 1, 2011. Outpatient claims processed prior to April 4, 2011, but with dates of service on or after June 25, 2010, may need to be adjusted by the provider if they were rejected by Medicare. Such adjustments should be made after April 4, 2010.

The statute makes no changes to the existing policy regarding billing of diagnostic services. All diagnostic services provided to a Medicare beneficiary by a subsection (d) hospital subject to the inpatient prospective payment system (IPPS), or an entity wholly owned or operated by the hospital, on the date of the beneficiary’s inpatient admission and during the three calendar days (one calendar day for a non-subsection (d) hospital) immediately preceding the date of admission would continue to be required to be included on the bill for the inpatient stay.

Additional information

The official instruction, CR 7142, issued to your FI or MAC regarding this change may be viewed on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/Transmittals/downloads/R796OTN.pdf>.

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

MLN Matters® Number: MM7142
 Related Change Request (CR) Number: 7142
 Related CR Release Date: October 29, 2010
 Related CR Transmittal Number: R796OTN
 Effective Date: June 25, 2010
 Implementation Date: April 4, 2011

Source: CMS Pub. 100-20, Transmittal 796, CR 7142

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National Uniform Billing Committee point of origin code updates

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

Provider types affected

Hospitals and other providers and suppliers submitting claims to fiscal intermediaries (FI) and Part A/B Medicare administrative contractors (A/B MAC) are affected.

What you need to know

This article, which is based on change request (CR) 7144, informs Medicare contractors that they will no longer require a point of origin code on type of bills 14x. Medicare contractors will accept point of origin code 9 on all bill types. Please be sure to inform your billing staffs of this update.

Background

The following two points of origin code updates will be implemented April 2011:

- Points of origin codes are no longer required on type of bills 14x. The National Uniform Billing Committee NUBC decided point of origin codes need not be reported because the bill type is used for non-patient laboratory specimens and the point of origin would not be known.
- As of April 1, 2011, all type of bills will be accepted with point of origin code 9 – information not available.

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The NUBC approved these code updates at their August 2010 meeting.

Additional information

The official instruction, CR 7144, issued to your FI or A/B MAC regarding this change, may be viewed on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/Transmittals/downloads/R793OTN.pdf>.

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

MLN Matters® Number: MM7144

Related Change Request (CR) Number: 7144

Related CR Release Date: October 29, 2010

Related CR Transmittal Number: R793OTN

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

Source: CMS Pub. 100-20, Transmittal 793, CR 7144

2011 hospital outpatient and ambulatory surgical center rates Final rule eliminates out-of-pocket costs for most preventive services

Medicare beneficiaries will see a decline in their out-of-pocket costs for services they receive in hospital outpatient departments (HOPDs) in calendar year (CY) 2011 under provisions in a final rule with comment period issued by the Centers for Medicare & Medicaid Services (CMS). The final rule with comment period updates payment rates and policies for services furnished in HOPDs and ambulatory surgical centers (ASCs), and implements changes required by the Affordable Care Act of 2010.

The Affordable Care Act, which was enacted as the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, waives beneficiary cost-sharing for most Medicare-covered preventive services, such as screening mammograms and screening colonoscopies. This means that, for most preventive services, beneficiaries will not have to satisfy their Part B deductible before Medicare will pay. In addition, for these services, beneficiaries will not have to pay their co-payment (typically 20 percent of the Medicare payment amount) for the physician's or the facility's portion of the service.

"We hope that by eliminating these out-of-pocket costs, more beneficiaries will make full use of their Medicare preventive benefits," said CMS administrator Donald Berwick, M.D. "We know that prevention, early detection and early treatment of diseases can promote better outcomes for patients and lower long-term health spending."

The changes are included in a final rule with comment period which applies updates to the policies and payment rates for covered outpatient department services furnished on or after January 1, 2011, by HOPDs in more than 4,000 hospitals that are paid under the outpatient prospective payment system (OPPS). The final rule with comment period also updates policies and payment rates for services in approximately 5,000 Medicare-participating ASCs, under a payment system that aligns ASC payments with payments for the corresponding services in HOPDs. CY 2011 is the first year the revised ASC payment system rates will be fully implemented based on the ASC standard rate-setting methodology. CMS projects total Medicare payments of approximately \$39 billion to HOPDs and \$4 billion to ASCs for CY 2011.

The final rule with comment period also implements the direct and indirect graduate medical education (GME/IME) provisions of the Affordable Care Act. The law requires CMS to identify unused residency slots and redistribute them to certain hospitals with qualified residency programs, with a special emphasis on increasing the number of primary care physicians. The law also requires CMS to redistribute residency slots from certain closed hospitals and hospitals that close down to other teaching hospitals, giving preference to hospitals in the same or a contiguous area as the closed hospital. In addition, the law specifies how hospitals should count hours a resident spends in certain

2011 hospital outpatient and ambulatory surgical center rates continued)

training and research activities, and in patient care activities in a nonhospital setting, such as a physician’s office.

This rule also implements a provision in the Affordable Care Act prohibiting the development of new physician-owned hospitals and the expansion of existing physician-owned hospitals.

The final rule with comment period will make several other significant changes in addition to those required by the Affordable Care Act. These changes include:

- Modifying a number of the supervision requirements for outpatient therapeutic services by:
 - ♦ Requiring direct physician supervision for only the initiation of certain services and allowing general supervision once the treating practitioner deems the patient medically stable. This two-tiered approach to supervision applies to a limited set of non-surgical extended duration services, including observation services.
 - ♦ Extending through CY 2011 the notice of non-enforcement regarding the direct supervision requirements for outpatient therapeutic services furnished in critical access hospitals (CAHs) and expanding the scope of the notice to include small rural hospitals with 100 or fewer beds.
 - ♦ Redefining direct supervision for all hospital outpatient services to require “immediate availability” without reference to the boundaries of a physical location.
- Committing to establish through future rulemaking an independent committee to consider on an annual basis industry requests for the assignment of supervision levels other than direct supervision for certain individual services and to make recommendations to the agency.
- Establishing four separate ambulatory payment classifications (APCs) for partial hospitalization

programs (PHPs), two for community mental health center (CMHC) PHPs and two for hospital-based PHPs, while continuing to pay different per diem rates within each provider type depending on the number of PHP services provided each day; that is, one APC for three services and a separate one for four or more services.

- Paying for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status furnished in HOPDs at 105 percent of the manufacturers’ average sales prices.
- Expanding the set of quality measures that must be reported by HOPDs to qualify for the full annual payment update factor. The final rule with comment period lists the measure set that will apply to the CY 2012, CY 2013, and CY 2014 payment updates. This new focus on a three year time period should assist hospitals in preparing for the changing reporting requirements and targeting their quality improvement efforts.

The CY 2011 OPPS/ASC final rule with comment period will appear in the Nov. 24, 2010, *Federal Register*. Comments on designated provisions are due by 5:00 p.m. ET on January 3, 2011. CMS will respond to comments in the CY 2012 OPPS/ASC final rule.

To view the rule and for more information on the final CY 2011 policies for the OPPS and ASC payment system, please see the CMS website at:

- OPPS: <http://www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?itemID=CMS1240960&>
- ASC payment system: <http://www.cms.gov/ASCPayment/ASCRN/itemdetail.asp?itemID=CMS1240939&>

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

Source: CMS PERL 201011-15

Medicare disproportionate share payment eligibility data

The Centers for Medicare & Medicaid Services (CMS) has developed a limited view of the Health Insurance Portability and Accountability Act (HIPAA) eligibility transaction system (HETS) to allow hospitals that receive Medicare disproportionate share (DSH) payments to view Medicare enrollment information for their hospital inpatients.

The data available via HETS 270/271 DSH will allow hospitals to verify that patients eligible for Medicaid are not also entitled to Medicare Part A benefits. In addition, hospitals can verify Medicare enrollment for their hospital inpatients, including whether a patient is entitled to Medicare Part A benefits, is enrolled in a Medicare managed care plan, or has Medicare as his or her secondary insurance.

HETS 270/271 is an electronic data interchange (EDI) system that uses current ANSI X12 formatting standards.

Submitters must connect to HETS 270/271 via the Medicare data communication network (MDCN).

Additional information about the HETS 270/271 system, including connectivity and file formatting requirements, is available online at <http://www.cms.gov/hets/help/>.

Applicants interested in receiving the HETS 270/271 DSH view may contact the Medicare customer assistance regarding eligibility (MCARE) help desk Monday-Friday 7:00 a.m. to 9:00 p.m. ET at 1-866-324-7315, or send an e-mail to mcare@cms.hhs.gov for additional information.

The MCARE help desk will work with you and provide you with all documentation necessary to obtain access to the Medicare DSH view.

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

Source: CMS PERL 201011-11

Expansion of IPPS transfer policy to include critical access hospitals and nonparticipating hospitals

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

Provider types affected

This article is for inpatient acute care prospective payment system hospitals that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Effective October 1, 2010, the transfer regulations at 42 CFR 412.40(b) (see http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr412.4.pdf on the Internet) include transfers to critical access hospitals (CAHs) and nonparticipating hospitals. Make sure your billing staff is aware of these changes.

Background

A discharge of an acute hospital inpatient is considered to be a transfer for purposes of payment if the discharge is made from the acute hospital to the care of another inpatient prospective payment system (IPPS) hospital. This policy is also in effect for patients who leave against medical advice, known as LAMAs. For patients who are admitted to another IPPS hospital on the same day they leave an IPPS hospital, the “transferring” hospital will be subject to the payment outlined by the transfer policy. Only IPPS hospitals are subject to this transfer policy prior to October 1, 2010.

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Effective October 1, 2010, the transfer regulations at 42 CFR 412.4(b) include IPPS hospital transfers to a critical access hospital (CAH) and a transfer to a nonparticipating hospital.

Additional information

The official instruction, CR 7141 issued to your FI or MAC regarding this change may be viewed on the Centers for Medicare & Medicaid (CMS) website at <http://www.cms.gov/Transmittals/downloads/R807OTN.pdf>.

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

MLN Matters® Number: MM7141

Related Change Request (CR) Number: 7141

Related CR Release Date: November 12, 2010

Related CR Transmittal Number: R807OTN

Effective Date: October 1, 2010

Implementation Date: April 4, 2011

Source: CMS Pub. 100-20, Transmittal 807, CR 7141

October 2010 quarterly provider specific file update

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

The text data files are available in the *Downloads* section on the CMS website at http://www.cms.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp.

If you use the provider specific text or SAS file data, you may download the latest versions of the PSF files from their respective pages.

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

Source: CMS PERL 201011-12

Fiscal year 2011 inpatient prospective payment system PRICER update

The fiscal year (FY) 2011 inpatient prospective payment system (PPS) personal computer (PC) PRICER has been updated on the Centers for Medicare & Medicaid Services (CMS) website.

If you use the FY 2011 inpatient PPS PC PRICER, please access the CMS Web page at http://www.cms.gov/PCPricer/03_inpatient.asp, and download the latest version of the FY 2011 PC PRICER. This PC PRICER is for claims dated from October 1, 2010, to September 30, 2011. The update is dated November 10, 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 201011-42

Graduate medical education provisions from the Affordable Care Act

On November 2, 2010, the Centers for Medicare & Medicaid Services (CMS) issued final regulations regarding the graduate medical education (GME) provisions included in the Affordable Care Act (ACA). The final regulations are a part of the calendar year 2011 hospital outpatient prospective payment system final rule (http://www.ofr.gov/OFRUpload/OFRData/2010-27926_PI.pdf).

Two of these GME provisions, Section 5503 and Section 5506, establish processes for redistribution of full-time equivalent (FTE) resident cap slots, and are time-sensitive in nature.

Section 5503 of the Affordable Care Act provides for reductions in the direct GME and indirect medical education (IME) FTE resident caps for certain hospitals, and authorizes “redistribution” to certain hospitals of the estimated number of FTE resident slots that result from the reductions. The provision is effective for portions of cost reporting periods occurring on or after July 1, 2011, for direct GME and IME. Applications for hospitals requesting slots under Section 5503 must be received by (i.e., not postmarked by) the CMS regional office and CMS central office by Friday, January 21, 2011.

Section 5506 of the ACA instructs the Secretary of U.S. Department of Health & Human Services to establish

a process by regulation that would redistribute FTE resident cap slots from teaching hospitals that close to hospitals that meet certain criteria, with priority given to hospitals located in the same core based statistical area (CBSA) or in a contiguous CBSA as the closed hospital. Section 5506 applies to teaching hospitals that closed on or after March 23, 2008, and to future teaching hospital closures. For teaching hospital closures that occurred on or after March 23, 2008, through August 3, 2010, applications for receipt of slots must be received by (i.e., not postmarked by) the CMS regional office and CMS central office by April 1, 2011. All teaching hospital closures occurring after August 3, 2010, will be handled as part of a separate notification and application process.

Hospitals should refer to the direct GME website (http://www.cms.gov/AcuteInpatientPPS/06_dgme.asp) for more information on Section 5503 and Section 5506, and for a link to download the relevant application forms for these two provisions.

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Source: CMS PERL 201011-30

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Inpatient psychiatric facility prospective payment system PRICER update

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 and for claims with dates from July 1, 2010 to September 30, 2010, and from October 1, 2010, to June 30, 2011.

If you use the IPF PPS PC PRICER for RY 2011, please access the following 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 November 8, 2010, for claims under the Downloads section.

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

Source: CMS PERL 201011-38

Fiscal year 2011 inpatient rehabilitation facility PPS PC PRICER update

The fiscal year (FY) 2011 inpatient rehabilitation facility (IRF) prospective payment system (PPS) personal computer (PC) PRICER is ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at http://www.cms.gov/PCPricer/06_IRF.asp.

If you use the IRF PPS PC PRICER, please access the page above and download the latest version of the FY 2011 PRICER, posted November 16, 2010, in the Downloads section.

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

Source: CMS PERL 201011-43

Implementation of edits for the emergency department adjustment policy under the IPF PPS

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

Provider types affected

Critical access hospitals (CAH) inpatient psychiatric facilities (IPF) under the prospective payment system (PPS) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and Medicare administrative contractors [MAC]) for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7072, which implements system edits to verify that the emergency department (ED) adjustment policy is correctly applied. As specified in 42 CFR 412.424(d)(1)(v)(B), the ED adjustment is not made where an inpatient is discharged from an acute care hospital or critical access hospital (CAH) and the date of such discharge is the same as the date of admission on a claim from the same hospital's or CAH's psychiatric unit. An ED adjustment is not made in these cases because the costs associated with ED services are reflected in the diagnosis-related group (DRG) payment to the acute care hospital or through the reasonable cost payment made to the CAH. Please ensure that your billing staffs are aware of this notice and of the need to properly code the source of admission code (of D) in these situations as noted in *MLN Matters*[®] article SE1020, which is on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/MLNMattersArticles/downloads/SE1020.pdf>.

Background

Section 124 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) mandated that

the Secretary of Health & Human Services develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units. The IPF PPS was implemented January 2005. One aspect of the IPF PPS included an ED adjustment policy.

Recently, the Office of Inspector General drafted a report, entitled: Nationwide Review of Medicare Part A Emergency Department Adjustments for Inpatient Psychiatric Facilities for Calendar Years 2006 and 2007, (A-01-09-00504). Based on findings in this report, CMS is implementing edits for ED adjustments where the costs for the emergency department services are already covered by another Medicare payment.

Additional information

The official instruction, CR 7072, issued to your Medicare carrier and/or MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2089CP.pdf>.

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

MLN Matters[®] Number: MM7072

Related Change Request (CR) Number: 7072

Related CR Release Date: November 12, 2010

Related CR Transmittal Number: R2089CP

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

Source: CMS Pub. 100-04, Transmittal 2089, CR 7072

Outpatient prospective payment system PRICER update

The calendar year (CY) 2010 outpatient prospective payment system (OPPS) PRICER Web page has been updated to include the October 2010 update for outpatient provider data. Users may access the October provider data update on the Web page at <http://www.cms.gov/PCPricer/OutPPS/list.asp#TopOfPage>.

Download the "4th Quarter 2010 files" and select the file titled "OPSF October update file."

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

Source: CMS PERL 201011-45

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

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

Note: The Centers for Medicare & Medicaid Services (CMS) has revised MLN Matters® article MM7044 to reflect the revised change request (CR) 7044 that was issued on October 29, 2010. The CR release date, transmittal number and the Web address for accessing the CR were changed. In addition, the remittance advice remark code bullet point on was revised. All other information remains the same. The article was published in the August 2010 *Medicare A Bulletin* (page 33).

Provider types affected

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

What you need to know

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

Background

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

Key points of change request 7044

- An interrupted stay is a case in which a patient is discharged from an IPF and is readmitted to the same or another IPF before midnight on the third consecutive day following discharge from the original IPF stay.
- Interrupted stays are considered to be continuous for the purposes of applying the variable per diem adjustment regardless if the interrupted stay is to the same IPF or not.
- Interrupted stays are considered to be continuous in determining outlier payments only when the interrupted stay is to the same IPF.
- In other words, an interrupted stay is treated as one stay and one discharge for the purpose of the IPF PPS payment.

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- Medicare system edits will be put in place to identify claims that qualify as interrupted stays by examining incoming claims and comparing them to other IPF claims in Medicare's claims history files.
- When Medicare detects a claim that shows an interrupted stay, the Medicare contractor will adjust the appropriate claim(s) (including claims in history, if necessary) in date of service sequence order to reflect a reduction in payment due to the variable per diem adjustment being applied from an interrupted stay.
- When Medicare performs the above adjustment, it will use the following messages to alert the IPF:
 - ♦ Claim adjustment reason code of 45 (contractual adjustment)
 - ♦ Remittance advice remark code of N540 (PPS (payment adjusted based on the interrupted stay policy.)
 - ♦ Contractual obligation code of CO.

Additional information

The official instruction associated with this CR 7044, issued to your Medicare FI or AB MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2083CP.pdf>.

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

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

MLN Matters® Number: MM7044 – Revised
 Related Change Request (CR) Number: 7044
 Related CR Release Date: October 29, 2010
 Related CR Transmittal Number: R2083CP
 Effective Date: January 1, 2011
 Implementation Date: January 3, 2011

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

CRITICAL ACCESS HOSPITAL SERVICES

Incentive payment program for major surgical procedures furnished in health professional shortage areas

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

Provider types affected

This article is for general surgeons and critical access hospitals (CAHs) submitting claims to Medicare contractors (fiscal intermediaries [FIs] and/or A/B Medicare administrative contractors [A/B MACs]) for services provided in health professional shortage areas (HPSAs) to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7146 regarding the new HPSA surgical incentive payment program (HSIP) and the new primary care incentive payment program (PCIP) that will be implemented in conjunction with one another for calendar year (CY) 2011.

Caution – what you need to know

CR 7115 gives specific requirements for the PCIP, and CR 7146 includes the business requirements for the actions and costs associated with these incentive payments. Once CR 7115 is released, a related *MLN Matters*® article will be available on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/MLN MattersArticles/downloads/MM7115.pdf>.

GO – what you need to do

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

Background

The Affordable Care Act (Section 5501(b)) (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ148.111.pdf) revises the Social Security Act (Section 1833(m); http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) and authorizes an incentive payment program for major surgical services furnished by general surgeons in HPSAs. The section provides for additional payments (on a monthly or quarterly basis) in an amount equal to 10 percent of the payment for physicians' professional services under Part B.

The incentive payment also applies to surgical procedures (defined as 10 and 90-day global procedures on the payment policy indicator file) furnished in an area designated as a HPSA (on or after January 1, 2011, and before January 1, 2016), by an O2-general surgeon who has reassigned their billing rights to a CAH paid under the optional method.

The HPSA are those ZIP codes designated as such by the Secretary of Health & Human Services as of December 31 of the prior year. This list of ZIP codes is also utilized for automatic payments under the HSIP program.

Modifier AQ should be appended to the 10 or 90-day global surgical procedure on claims submitted for payment, similar to the current process for payment of the Medicare HPSA physician bonus when the HPSA is not a HPSA identified for automatic payment.

Medicare Contractors will use the existing HPSA **modifier AQ** submitted on claims along with the physician specialty code 02 to identify circumstances when general surgeons furnish services in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of ZIP codes eligible for automatic payment. Information regarding the payment policy indicator file and other aspects of the Medicare physician fee schedule is available on the CMS website at <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

To be consistent with the Medicare HPSA physician bonus program, HSIP payments are calculated by Medicare contractors based on the identification criteria for payment discussed below and paid on a quarterly basis to CAHs, on behalf of the qualifying general surgeon for the qualifying surgical procedures.

The additional HSIP payment will be combined, as appropriate, with the HPSA physician bonus payment. The special remittance advice for the incentive payments to CAHs will be revised to inform CAHs as to the type(s) of incentive payments, i.e., the HPSA physician, HSIP, or PCIP. In addition the remittance for the optional method CAHs will identify the NPI of the surgeon in the "operating provider" field.

Coordination with other payments

The Affordable Care Act (Section 5501(b)(4)) provides payment under the HSIP as an additional payment amount for specified surgical services without regard to any additional payment for the service under the Social Security Act (Section 1833(m)). Therefore, a general surgeon may receive both a HPSA physician bonus payment under the established program and an HSIP payment under the new program beginning in CY 2011.

Note: The current HPSA physician bonus program requirements for contractors will remain intact. The additions mentioned in the requirements below are for the HSIP and are based on The Affordable Care Act.

Payment to critical access hospitals

Physicians and nonphysician practitioners billing on type of bill (TOB) 85x (CAH) for professional services rendered in a CAH paid under the optional method have the option of reassigning their billing rights to the CAH. When

Incentive payment program for major surgical procedures furnished in health professional shortage areas (continued)

the billing rights are reassigned to CAHs paid under the optional method, payment is made for professional services (revenue codes (RC) 96x, 97x, or 98x).

For major surgical services furnished on January 1, 2011, and before January 1, 2016, CAHs paid under the optional method will be paid an additional 10 percent incentive based on the amount actually paid for those services when furnished by general surgeons in HPSAs. Quarterly incentive payments will be made to CAHs paid under the optional method on behalf of physicians.

Additional information

The official instruction, CR 7146, issued to your FIs and/or A/B MACs regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2078CP.pdf>.

If you have any questions, please contact your 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: MM7146

Related Change Request (CR) Number: 7146

Related CR Release Date: October 28, 2010

Related CR Transmittal Number: R2078CP

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

Source: CMS Pub. 100-04, Transmittal 2078, CR7146

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Informational only claims with condition code 04 on the PS&R report

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

Provider types affected

This article applies to all critical access hospitals (CAHs) and Maryland waiver hospitals that bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Currently, claims submitted for indirect medical education (IME), graduate medical education (GME) and nursing and allied health (N&AH) with both condition codes 04 and 69 are sent to the provider statistical and reimbursement report (PS&R). With the release of change request (CR) 7145, the Centers for Medicare & Medicaid Services (CMS) announces that effective for claims for discharges on or after October 1, 2010, and processed on or after April 4, 2011, by Medicare, claims submitted by CAHs and Maryland waiver hospitals with condition code 04 will begin to accumulate on the PS&R report type 118. As a result, that data will be available to both providers and Medicare contractors.

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Additional information

The official instruction, CR 7145 issued to your FI or MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R794OTN.pdf>.

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

MLN Matters® Number: MM7145

Related Change Request (CR) Number: 7145

Related CR Release Date: October 29, 2010

Related CR Transmittal Number: R794OTN

Effective Date: October 1, 2010

Implementation Date: April 4, 2011

Source: CMS Pub. 100-20, Transmittal 794, CR 7145

ESRD SERVICES

News and updates from the Medicare Learning Network for ESRD providers

The Medicare Learning Network has the following provider educational materials:

- End-Stage Renal Disease Prospective Payment System**
 The new publication titled “End-Stage Renal Disease Prospective Payment System” (September 2010) provides information about the Medicare end-stage renal disease prospective payment system (ESRD PPS) that will be implemented on January 1, 2011, including the one-time election and transition period, payment rates for adult and pediatric patients, home dialysis, laboratory services and drugs, and beneficiary deductible and coinsurance. This fact sheet is now available in print format from the Medicare Learning Network®. To place your order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”
- End-Stage Renal Disease Composite Payment Rate System publication revised**
 The revised publication titled “End-Stage Renal Disease Composite Payment Rate System” (September 2010) (previously titled “Outpatient Maintenance Dialysis – End-Stage Renal Disease”) provides information about the Medicare end-stage renal disease composite payment rate system, the one-time election and transition period, and separately billable items and services. This fact sheet is now available in print format by visiting <http://www.cms.gov/MLNGenInfo>, scrolling to “Related Links Inside CMS” and selecting “MLN Product Ordering Page.”
- Written transcript of end-stage renal disease prospective payment system 2011 conference call**
 The written transcript of the Medicare program ESRD PPS 2011 conference call, which provides an overview of the ESRD PPS that will be effective on January 1, 2011, is now available at http://www.cms.gov/ESRDPayment/10_CMS_Sponsored_Calls.asp.

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

Source: CMS PERL 201011-39

End-stage renal disease prospective payment system updates

The Centers for Medicare & Medicaid Services has created an end-stage renal disease prospective payment system (ESRD PPS) resource mailbox that may be used to submit questions specific to the ESRD PPS. Also, a section dedicated to frequently asked questions (FAQs) has been created and categorized based on subject matter. Both the resource mailbox and FAQs (under development) are available at <http://www.cms.gov/ESRDPayment/>.

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

Source: CMS PERL 201011-07

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.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised *MLN Matters*® article MM7064 to reflect the revised change request (CR) 7064 that was issued on November 17, 2010. CR 7064 was revised to reflect a revised end-stage renal disease (ESRD) PRICER layout, the deletion of several drugs, the identification of drugs that may be eligible for the ESRD outlier payment, to provide an additional list of laboratory tests that comprise the AMCC and to delete several laboratory tests. There were no changes in policy. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7064 were revised. All other information is the same. The article was published in the September 2010 *Medicare A Bulletin* (pages 24-27).

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.

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

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.

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 on the Internet <http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331>) requires 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
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.

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

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 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

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

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 laboratory 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.
- 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/R2094CP.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

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

- 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: November 17, 2010

Related CR Transmittal Number: R2094CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2094, CR 7064

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SKILLED NURSING FACILITY SERVICES

Fiscal year 2011 skilled nursing facility PPS PRICER update

The fiscal year (FY) 2011 skilled nursing facility (SNF) prospective payment system (PPS) personal computer (PC) PRICER has been updated on the page/URL http://www.cms.gov/PCPricer/04_SNF.asp, under the “Skilled Nursing Facilities (SNF PPS) PC PRICER.”

If you use the FY 2011 SNF PC PRICER please go to the page above and download the SNP PC PRICER with the revised provider data.

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

Source: CMS PERL 201011-41

Addition of health insurance prospective payment system code HD141

The Centers for Medicare & Medicaid Services (CMS) has informed contractors that with the implementation of the skilled nursing facility (SNF) health insurance prospective payment system (HIPPS) coding update, HIPPS code HD141 was not included in the list of new HIPPS codes effective for date of service on or after October 1, 2010.

The fiscal intermediary share system has been updated with HIPPS code HD141, billable on type of bill 18x and 21x with revenue code 0022, effective for date of service on or after October 1, 2010.

Action required by providers

SNF and swing-bed providers that have claims returned to provider due to HIPPS code HD141 for date of service on or after October 1, 2010, may resubmit these claims for processing. ❖

Source: CMS JSM 11033, November 8, 2010

Five-star quality rating system – news for November

Starting November 2010, the five-star ratings will update on Nursing Home Compare on the third Thursday of every month. The five-star preview reports for November was available no later than Monday, November 15, 2010. Providers, in order to access your five star preview report, access the minimum data set (MDS) state welcome page available on the state servers where you submit MDS data and select the CASPER reporting link located at the bottom of the page.

Once in the CASPER reporting system, click on the “Folders” button. Then click on “My Inbox” on the left hand side of the screen and access the five-star report in your “st LTC facid” folder, where “st” is the two-digit postal code of the state in which your facility is located and “facid” is the state assigned facid of your facility.

Nursing Home Compare website updated on November 18, 2010, with the five-star data from November.

Note: The five-star help line was available from November 15-19, 2010. Provider preview reports will continue to be available on a monthly basis in advance of public posting and will include the dates and hours of helpline availability.

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

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

Source: CMS PERL 201011-31

Take advantage of FCSO’s exclusive PDS report

Did you know that FCSO’s exclusive provider data summary (PDS) report can help you improve the accuracy and efficiency of the Medicare billing? Accessible through FCSO’s PDS’s portal at <https://medicare.fcsoc.com/reporting/index.asp>, this free online report helps J9 providers identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specific time period). Best of all, the PDS report allows you to respond proactively to prevent the recurrence of avoidable errors that could negatively impact your business bottom line.

CORF/ORF SERVICES

Reporting of modifiers and revenue codes on claims for therapy services

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

Provider types affected

Institutions that provide outpatient rehabilitation services to Medicare beneficiaries and bill Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs).

Provider action needed

Stop – impact to you

This change request (CR) 7170 creates new edits in Medicare claims processing systems to ensure correct billing of therapy-related codes on institutional claims.

Caution – what you need to know

Claims that report conflicting combinations of these codes will be returned to the provider for correction.

Go – what you need to do

See the *Background* and *Key points* sections below for specifics.

Background

On Medicare institutional claims, outpatient rehabilitation services are identified by the provider reporting revenue code 042x (physical therapy), 043x (occupational therapy), or 044x (speech-language pathology). Individual procedures are also identified as being provided under an outpatient rehabilitation plan of care by the provider reporting **modifier GN** (speech-language pathology), **GO** (occupational therapy), or **GP** (physical therapy).

During analysis of Medicare claims data for outpatient rehabilitation services, CMS has found that these codes are not always used in a correct and consistent manner. For

example, CMS has found outpatient rehabilitation claims that report both **modifier GO** and **GP** for the same service.

These claims represent non-compliant billing by outpatient rehabilitation providers. They also complicate CMS ability to analyze claims data for purposes of Medicare program improvements.

New edit in change request 7170

Medicare contractors will edit to make certain that only one occurrence of **modifiers GN, GO, or GP** are reported on the same service line on all institutional claims.

Any claim that reports more than one of these modifiers on the same line will be returned to the provider for correction.

Additional information

The official instruction, CR 7170 issued to your A/B MAC, FI, or RHHI regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2091CP.pdf>.

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

MLN Matters® Number: MM7170

Related Change Request (CR) Number: 7170

Related CR Release Date: November 12, 2010

Related CR Transmittal Number: R2091CP

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

Source: CMS Pub. 100-04, Transmittal 2091, CR 7170

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Comprehensive Outpatient Rehabilitation Facility fact sheet

A new Medicare Learning Network® publication titled *Comprehensive Outpatient Rehabilitation Facility* fact sheet is now available in downloadable format at http://www.cms.gov/MLNProducts/downloads/Comprehensive_Outpatient_Rehabilitation_Facility_Fact_Sheet_ICN904085.pdf.

This fact sheet provides information about basic, core, and optional comprehensive outpatient rehabilitation facility (CORF) services, place of treatment requirements, rehabilitation plan of care requirements, and CORF payments.

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

Source: CMS PERL 201011-04

Outpatient therapy cap values for calendar year 2011

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, Medicare administrative contractors [MACs], fiscal intermediaries [FIs], and/or regional home health intermediaries [RHHIs]) for therapy services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7107, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for calendar year (CY) 2011. No change to the exceptions process is anticipated, if it should be extended into 2011. Be sure billing staff is aware of the updates.

Background

The Balanced Budget Act of 1997 set therapy caps, which change annually, for Part B Medicare patients. The Deficit Reduction Act of 2005 allowed CMS to establish a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended exceptions to therapy caps through December 31, 2010.

Therapy caps for 2011 will be \$1,870.00. The exceptions process will continue unchanged for the time frame directed by the Congress.

Note that the limitations apply to outpatient services and do not apply to skilled nursing facility (SNF) residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global

Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services billed under the home health PPS, inpatient hospitals or the outpatient department of hospitals, including critical access hospitals.

Additional information

The official instruction, CR [7107], issued to your FI, carrier, A/B MAC, or RHHI regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2073CP.pdf>.

Additional information concerning outpatient therapy services may be found on the CMS website at <http://www.cms.gov/therapyservices>.

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

MLN Matters® Number: MM7107
 Related Change Request (CR) Number: 7107
 Related CR Release Date: October 22, 2010
 Related CR Transmittal Number: R2073CP
 Effective Date: January 1, 2011
 Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2073, CR 7107

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

Multiple procedure payment reduction for selected therapy services

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7050, which announces that Medicare is applying a new multiple procedure payment reduction (MPPR) to the practice expense (PE) component of payment of select therapy services paid under the MPFS. Make sure your billing staff is aware of these payment reductions.

Background

Section 3134 of The Affordable Care Act added Section 1848(c)(2)(K) of the Social Security Act, which specifies that the Secretary of Health & Human Services shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service. As a step in implementing this provision, Medicare is applying a new MPPR to the PE

component of payment of select therapy services paid under the MPFS. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures. This policy is discussed in the CY 2011 MPFS final rule.

Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 75 percent payment for the PE.

For therapy services furnished by a group practice or “incident to” a physician’s service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines; for example, physical therapy, occupational therapy, or speech-language pathology.

Multiple procedure payment reduction for selected therapy services(continued)

The reduction applies to the HCPCS codes contained on the list of “always therapy” services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, home health agencies [HHAs], and comprehensive outpatient rehabilitation facilities [CORFs], etc.). The MPPR applies to the codes on the list of procedures included with CR 7050 as Attachment 1. CR 7050 is available on the CMS website at <http://www.cms.gov/Transmittals/downloads/R800OTN.pdf>.

Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example:

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Current Total Payment	Proposed Total Payment	Proposed Payment Calculation
Work	\$7.00	\$7.00	\$11.00	\$25.00	\$25.00	no reduction
PE	\$10.00	\$10.00	\$8.00	\$28.00	\$23.50	\$10 + (.75 x \$10) + (.75 x \$8)
Malpractice	\$1.00	\$1.00	\$1.00	\$3.00	\$3.00	no reduction
Total	\$18.00	\$18.00	\$20.00	\$56.00	\$51.50	\$18 + (\$18-\$10) + (.75 x \$10) +(\$20-\$8) + (.75 x \$8)

Where claims are impacted by the MPPR, Medicare will return a claim adjustment reason code of 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) and a group code of contractual obligation (CO).

Additional information

The official instruction, CR 7050, issued to your carrier, FI, or A/B MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R800OTN.pdf>.

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

MLN Matters® Number: MM7050

Related Change Request (CR) Number: 7050

Related CR Release Date: November 3, 2010

Related CR Transmittal Number: R800OTN

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-20, Transmittal 800, CR 7050

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Use the PDS report to improve your Medicare billing operations

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

RURAL HEALTH CLINIC SERVICES

Waiver of coinsurance and deductible for preventive services for rural health clinics

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

Provider types affected

Rural health clinics (RHCs) that submit claims to fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (MACs) for services rendered to Medicare beneficiaries are affected.

What you need to know

This article, based on change request (CR) 7208, explains how RHCs should bill for certain preventive services under the Affordable Care Act. You should make sure that your billing staffs are aware of this change.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the initial preventive physical examination (IPPE), the annual wellness visit, and other Medicare covered preventive services provided by RHCs. However, to ensure coinsurance and deductible are not applied, you must provide detailed Healthcare Common Procedure Coding System (HCPCS) coding for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B.

The Affordable Care Act also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

Background

Provisions of the Affordable Care Act waive coinsurance and deductible for the IPPE, the annual wellness visit, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services when submitted by RHCs on type of bill 71x with dates of service on or after January 1, 2011.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. When one or more preventive service that meets the specified criteria is

provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayments and deductibles.

Example: If the total charge for the visit is \$150.00, and \$50.00 of that is for a qualified preventive service, the beneficiary copayment and deductible is based on \$100 of the total charge. If no other RHC service took place along with the preventive service, there would be no copayment or deductible applied.

Note: Although the Medicare system changes are not being implemented until April 4, 2011, providers shall begin submitting detailed HCPCS code reporting for preventive services starting January 1, 2011, as indicated above.

Additional information

The official instruction, CR 7208, issued to your FI or A/B MAC regarding this change, may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2093CP.pdf>.

Attachment A of CR 7208 contains a list of the current HCPCS codes for which the coinsurance and deductible are waived when provided by RHCs a result of Section 4104 of the Affordable Care Act.

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

MLN Matters® Number: MM7208
 Related Change Request (CR) Number: 7208
 Related CR Release Date: November 12, 2010
 Related CR Transmittal Number: R2093
 Effective Date: January 1, 2011
 Implementation Date: April 4, 2011

Source: CMS Pub. 100-04, Transmittal 2093, CR 7208

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Website survey

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

ELECTRONIC DATA INTERCHANGE

Healthcare provider taxonomy code updates effective January 1, 2011

Effective January 1, 2011, the healthcare provider taxonomy codes (HPTC) will be updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The latest version of HPTC is available from the Washington Publishing Company website at <http://www.wpc-edi.com/codes/taxonomy>.

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

Source: CMS Pub. 100-04, Transmittal 2046, CR 7130

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Deadline announced for requests for modifications to the ASC X12 implementation guides

On October 20, 2010, the Accredited Standards Committee X12 (ASC X12) announced that February 4, 2011, is the deadline to submit revision requests related to the ASC X12 005010 type 3 technical reports (TR3), also known as implementation guides.

Requests for revisions to the ASC X12 technical reports mandated under HIPAA may be submitted via the Designated Standard Maintenance Organizations (DSMO) website at <http://www.hipaa-dsmo.org>.

Requests for revisions to other ASC X12 technical reports may be submitted to <http://www.x12.org/TR3ChangeRequest>.

To be considered for inclusion in the 006020 implementation guides, requests must include all of the detailed information requested on the on-line submission forms. Change requests submitted after the deadline will be considered for inclusion in a future version.

The ASC X12 insurance subcommittee (ASC X12N) has implemented a new process for managing change requests, beginning with this ASC X12 006020 maintenance cycle. The new process shortens the timeline for revisions to ASC X12 TR3s by as much as 15 months, to approximately 21 months.

For additional information, please visit <http://www.x12.org/dsmo/help> or contact info@disa.org.

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

Source: CMS PERL 201010-46

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Medicare Remit Easy Print enhancement

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

Provider types affected

This article is for physicians, providers, and suppliers using the Medicare Remit Easy Print (MREP) software supplied through Medicare contractors (carriers, fiscal intermediaries [FIs], DME Medicare administrative contractors [DME MACs] and/or Part A/B Medicare administrative contractors [MACs]).

What you need to know

The Centers for Medicare & Medicaid Services (CMS) announces in change request (CR) 7178, the following list of enhancements to the MREP:

- The MREP demo function has been updated to reflect current functionalities
- A report may be run now for Medicare secondary payer (MSP) claims to distinguish the Medicare secondary payments from the primary payments.

If you use the MREP software, be sure to obtain the new version in January and install it to begin benefiting from these enhancements.

*Medicare Remit Easy Print enhancement (continued)***Background**

CMS developed the free MREP software to enable providers/suppliers to read and print the HIPAA-compliant electronic remittance advice (ERA), also known as transaction 835. MREP was first implemented in October 2005, and MREP has been enhanced continuously based on requests/comments received from users. These enhancements are based on requests received either through the carriers, MACs, DME MACs or through the CMS MREP website.

Additional information

The official instruction, CR 7178 issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2064CP.pdf>.

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

MLN Matters® Number: MM7178

Related Change Request (CR) Number: 7178

Related CR Release Date: October 8, 2010

Related CR Transmittal Number: R2064CP

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

Source: CMS Pub. 100-04, Transmittal 2064, CR 7178

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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.

Note: The Centers for Medicare & Medicaid Services (CMS) has revised MLN Matters® article MM7041 to reflect the revised change request (CR) 7041 that was issued on November 12, 2010. The effective and implementation dates have been changed. In addition, the CR transmittal number, release date, and the Web address for accessing CR 7041 were revised. All other information is the same. The article was published in the September 2010 *Medicare A Bulletin* (page 31).

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 [DME] MACs, 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 and 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 which 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/R806OTN.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.

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

- Medicare contractors will allow seven calendar “waiting” days (from the date of receipt) for additional information to be faxed or 10 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 10 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/R806OTN.pdf>.

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

MLN Matters® Number: MM7041 – Revised
 Related Change Request (CR) Number: 7041
 Related CR Release Date: November 10, 2010
 Related CR Transmittal Number: R806OTN
 Effective Date for Providers: July 1, 2011
 Implementation Date: July 5, 2011

Source: CMS Pub. 100-20, Transmittal 806, CR 7041

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HIPAA VERSION 5010 IMPLEMENTATION

CMS is here to help in the transitions to HIPAA version 5010 and ICD-10

Have questions about the Health Insurance Portability and Accountability Act (HIPAA) version 5010 and the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) transition? The Centers for Medicare & Medicaid Services (CMS) is here to help.

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

- The ICD-10 Transition: An Introduction – <http://www.cms.gov/ICD10/Downloads/ICD10IntroFactSheet20100409.pdf>
- ICD-10 Basics for Medical Practices – <http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoVendorforMedicalPractices20100409.pdf>
- Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices – <http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoVendorforMedicalPractices20100409.pdf>
- Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors – <http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoCustomersforVendors20100409.pdf>

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

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

Please visit <http://www.cms.gov/icd10/> for the latest news and to 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 201011-47

Implementation of errata version 5010 of HIPAA transactions and updates

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

Provider types affected

This article is for physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], Part A/B Medicare administrative contractors [A/B MACs], durable medical equipment [DME] MACs, and regional home health intermediaries [RHHI]), for services provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7202 to alert and update providers about the Administrative Simplification provisions of HIPAA regulations that the Secretary of the Department of Health & Human Services (DHHS) is required to adopt regarding standard electronic transactions and code sets. Currently, CMS is in the process of implementing an errata version of 5010 of the HIPAA transactions as well as the updates to the 837I, 837P, and 835 flat files. **Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.**

Background

The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA-covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective date of the regulation: March 17, 2009
- Level I compliance by December 31, 2010
- Level II compliance by December 31, 2011
- All covered entities have to be fully compliant on January 1, 2012

To review the explanation of these levels you may go to an earlier *MLN Matters*[®] article, MM6975 on the Additional Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 5010 for Transaction 835-Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR) at <http://www.cms.gov/MLNMattersArticles/downloads/MM6975.pdf>.

Key points of CR 7202

CMS is working with your Medicare contractors to implement the new HIPAA standard (version 5010) correctly and:

- CMS expects that external testing will start on January 2011, but no sender/receiver will be migrated to 5010A1 production before April 2011
- During the transition period January-March 2011, Medicare contractors will be ready to receive/send transactions in version 4010A1 as well as test in version

5010. From April-December 2011, contractors will be ready to receive/send transactions in version 4010A1 as well as test and receive/send all transactions in version 5010 or the appropriate errata versions, and

- All Medicare claims processing systems will use appropriate X12 based flat file layouts for transactions 837I, 837P, and 835, as attached to CR 7202. (To review the file descriptions, go to <http://www.cms.gov/Transmittals/downloads/R2090CP.pdf>)
- Over the past year, there has been discussion about modifications needed to implement 5010 correctly. As a result, X12N released the errata modifications, and they were adopted by DHHS. CMS will implement the changes that impact Medicare and update the relevant flat files even if specific modifications do not impact Medicare.
- The **errata** are basically modifications to some of the TR3s. For Medicare the following TR3 name changes will be required per:
 - ♦ 005010X279A1 270/271 Health Care Eligibility Benefit Inquiry and Response (a separate CR will be issued for the 270/271)
 - ♦ 005010X221A1 835 Health Care Claim Payment/Advice
 - ♦ 005010X222A1 837 Health Care Claim: Professional
 - ♦ 005010X223A2 837 Health Care Claim: Institutional
 - ♦ 005010X231A1 999 Implementation Acknowledgment for Health Care Insurance.

Additional information

The official instruction, CR 7202 issued to your carrier, A/B MAC, and RHHI regarding this change may be viewed on the CMS website at <http://www.cms.gov/Transmittals/downloads/R2090CP.pdf>.

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

MLN Matters[®] Number: MM7202

Related Change Request (CR) Number: 7202

Related CR Release Date: November 10, 2010

Related CR Transmittal Number: R2090CP

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

Source: CMS Pub. 100-04, Transmittal 2090, CR 7202

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Taking electronic billing and electronic data interchange to the next level Now available to order in hardcopy format

The new *Medicare Learning Network*[®] product titled “5010: Taking Electronic Billing and Electronic Data Interchange (EDI) to the Next Level” is now available in both downloadable and hardcopy formats. This educational tool is designed to provide education on the upcoming implementation of Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.0, which will replace the current version that covered entities must use when conducting electronic HIPAA transactions. It includes a timeline and list of resources related to the implementation. This product is suggested for all Medicare fee-for-service providers. To order a hardcopy, free of charge, please visit <http://www.cms.gov/MLNGenInfo/> and click on “MLN Product Ordering Page” under the “Related Links Inside CMS” section at the bottom of the page.

This product is also available in downloadable format at

http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.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 201011-39

HIPAA 5010 implementation timeline

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

January 2011-February 2011

Topic – Bimonthly ACT: Medicare changes and hot issues

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

Topic – Bimonthly ACT: Medicare data and CMS initiative

When: Tuesday, January 18, 2011
 Time: 2:30-3:30 p.m. ET **Delivery language:** English
 Type of Event: Webcast **Focus:** Florida, Puerto Rico, and U.S. Virgin Islands

Topic – Virtual Medifest 2011 – not open for registration yet

When: Monday-Friday, February 21-25, 2011
 Time: 8:00 a.m. – 5:00 p.m. ET **Delivery language:** English and Spanish
 Type of Event: Face-to-face seminar **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.fcsso.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

Lung Cancer Awareness Month and the Great American Smokeout are in November

The Centers for Medicare & Medicaid Services (CMS) asks the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered smoking and tobacco use cessation and counseling to prevent tobacco use services.

Tobacco continues to be the leading cause of preventable death in the United States. Smoking can contribute to and exacerbate lung disease, including lung cancer, as well as other diseases, such as heart disease, stroke, hypertension and diabetes. Medicare provides coverage for smoking and tobacco-use cessation counseling services for certain symptomatic beneficiaries. In addition, effective August 25, 2010, Medicare began covering counseling to prevent tobacco use for certain asymptomatic beneficiaries.

What providers can do?

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

For more information

CMS has developed several educational products related to Medicare-covered tobacco counseling services. 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 *Medicare Learning Network*[®] educational products for health care professionals related to Medicare-covered preventive services. Visit http://www.cms.gov/MLNProducts/35_PreventiveServices.asp.
- *MLN Matters* article MM7133 Counseling to Prevent Tobacco Use – this educational article provides coverage, coding and payment information on counseling to prevent tobacco use for asymptomatic beneficiaries. Available as a downloadable PDF only at <http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf>.
- *The Smoking and Tobacco-Use Cessation Counseling Services brochure* – this brochure provides information on coverage for smoking and tobacco-use cessation counseling services for symptomatic beneficiaries. This product is available in hardcopy or as a downloadable PDF at <http://www.cms.gov/MLNProducts/downloads/smoking.pdf>.
- *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. Available as a downloadable PDF only at 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. Visit http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- The Medicare Preventive Services Series: Part 2 Web-based-training course – includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including smoking and tobacco use cessation counseling services for symptomatic beneficiaries. To access the course, please visit the MLN home page at <http://www.cms.gov/MLNGenInfo>, scroll down to “Related Links Inside CMS,” and click on “Web-Based Training (WBT) Modules.”

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

For more information on Lung Cancer Awareness Month, please visit the Lung Cancer Alliance’s official page at http://www.lungcanceralliance.org/involved/lcam_month.html.

For additional information on the Great American Smokeout, celebrated on Thursday November 18, please visit the American Cancer Society’s official page at <http://www.cancer.org/Healthy/StayAwayfromTobacco/GreatAmericanSmokeout/index>.

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

Source: CMS PERL 201011-22

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.

National Diabetes Awareness Month and Diabetic Eye Disease Month

November is National Diabetes Awareness Month and Diabetic Eye Disease Month. Diabetes can lead to severe complications such as heart disease, stroke, and kidney failure. It is also a significant risk factor for developing glaucoma.

The Centers for Medicare & Medicaid Services (CMS) asks the provider community to keep their patients with Medicare healthy by encouraging eligible patients to take advantage of Medicare-covered diabetes-related services. Medicare provides coverage of several diabetes-related preventive services for eligible beneficiaries, including:

- Diabetes screening tests
- Diabetes self-management training
- Medical nutrition therapy
- Diabetes-related supplies
- Glaucoma screening

What can you do?

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

Additional information

CMS has developed several educational products related to Medicare-covered diabetes-related services. 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 *Medicare Learning Network*[®] (MLN) educational products for health care professionals related to Medicare-covered preventive services. Visit http://www.cms.gov/MLNProducts/35_PreventiveServices.asp.
- *The Diabetes-Related Services brochure* – provides information on coverage for Medicare-covered diabetes-related services. This product is available in hardcopy or as a downloadable PDF. Visit <http://www.cms.gov/MLNProducts/downloads/DiabetesSvcs.pdf>.
- *The Glaucoma Screening brochure* – provides information on coverage for Medicare-covered glaucoma screening. This product is available in hardcopy or as a downloadable PDF. Visit <http://www.cms.gov/MLNProducts/downloads/glaucoma.pdf>.
- *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. Available as a downloadable PDF only. Visit 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. Visit http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- The Medicare Preventive Services Series: Part 2 Web-based training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including diabetes-related services. To access the course, please visit the MLN homepage at <http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “Web Based Training (WBT) Modules.”
- The Medicare Preventive Services Series: Part e Web-based training (WBT) course – this WBT includes lessons on coverage, coding, and billing for Medicare-covered preventive services, including glaucoma screening. To access the course, please visit the MLN homepage at <http://www.cms.gov/mlngeninfo>. Scroll down to “Related Links Inside CMS” and click on “Web Based Training (WBT) Modules.”

Please visit the *Medicare Learning Network* for more information on these and other Medicare fee-for-service educational products. For more information on National Diabetes Awareness Month, please visit the American Diabetes Association’s official page at <http://www.diabetes.org/in-my-community/programs/american-diabetes-month>.

For additional information on National Diabetes Awareness Month, please visit the National Diabetes Education Program (NDEP) website at <http://ndep.nih.gov/whats-new/posting.aspx?id=23>.

For more information on diabetic eye disease, please visit the Prevent Blindness America website at <http://www.preventblindness.org>. For more information to share with your patients about diabetes, please visit the NDEP website at <http://www.ndep.nih.gov>.

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

Source: CMS PERL 201011-04

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Flu shot reminder

Every office visit is an opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90 percent of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high-risk patients. Don't forget to immunize yourself and your staff.

Protect your patients. Protect your family. Protect yourself. 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 the following CMS websites:

http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and

<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 201011-06

OTHER EDUCATIONAL RESOURCES

Rural health clinic fact sheet

A revised *Medicare Learning Network*[®] publication titled *Rural Health Clinic* is now available in downloadable format at <http://www.cms.gov/MLNProducts/downloads/RuralHlthClinfctshf.pdf>.

This fact sheet provides information about rural health clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation.

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

Source: CMS PERL 201011-04

'Caregiving Education' publications

A new publication titled "Caregiving Education" (September 2010) is now available in downloadable format from the *Medicare Learning Network*[®] at http://www.cms.gov/MLNProducts/downloads/MLN_CaregivingEducation.pdf.

Medicare will pay for certain types of caregiver education when it is provided as part of a patient's medically necessary face-to-face visit.

This publication provides information on how to bill for caregiver education under Medicare Parts A and B.

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

Source: CMS PERL 201011-22

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.

DMEPOS competitive bidding program traveling beneficiary fact sheet

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Traveling Beneficiary* fact sheet is now available, free of charge, from the *Medicare Learning Network*[®].

Once the DMEPOS competitive bidding program becomes effective on January 1, 2011, beneficiaries with original Medicare who obtain competitively-bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. This includes beneficiaries who do not live in a CBA but who obtain competitively-bid items while traveling to a CBA. This fact sheet contains helpful information on competitive bidding program rules that apply when a beneficiary travels.

To learn more, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp. Select the link titled "DMEPOS Competitive Bidding Fact Sheets [PDF, 40KB]" in the "Downloads" section to obtain a list of all fact sheets related to the DMEPOS competitive billing program.

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

Source: CMS PERL 201010-44

Fact sheets on walker exceptions to the DMEPOS competitive bidding program

The *Medicare Learning Network*[®] has released the following two fact sheets related to exceptions for walkers under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program:

- *DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers* fact sheet
- *DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers* fact sheet

Under the DMEPOS competitive bidding program, beneficiaries with original Medicare who obtain competitive bidding items in designated competitive bidding areas (CBAs) are required to obtain these items from a contract supplier, unless an exception applies. For the first phase of competitive bidding, which is effective January 1, 2011, one of these exceptions allows hospitals to furnish competitively bid walkers in a CBA to their own patients, without submitting a bid and being selected as a contract supplier. Similarly, another of these exceptions allows physicians and other treating practitioners who are enrolled Medicare DMEPOS suppliers to furnish competitively bid walkers in a CBA to their own patients without submitting a bid and being selected as a contract supplier.

To learn more and download these fact sheets, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, then select the appropriate link in the "Downloads" section.

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

Source: CMS PERL 201011-02

DMEPOS grandfathering requirements for non-contract supplier fact sheets

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers* fact sheet is now available, free of charge, from the *Medicare Learning Network*[®].

Once the DMEPOS competitive bidding program becomes effective on January 1, 2011, beneficiaries with original Medicare who obtain competitively-bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies.

All non-contract suppliers that furnish competitively bid rented durable medical equipment (DME) or oxygen and oxygen equipment to beneficiaries in CBAs must decide if they will elect to become grandfathered suppliers, notify beneficiaries of their grandfathering decisions, and fulfill other requirements.

A non-contract supplier that elected to become a grandfathered supplier had to provide written notification to the Centers for Medicare & Medicaid Services (CMS) of this decision by November 17, 2010.

This fact sheet contains helpful information on competitive bidding program rules and requirements related to grandfathering. To learn more, please visit the DMEPOS Competitive Bidding Educational Resources page on the CMS website at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp and scroll to the "Downloads" section.

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

Source: CMS PERL 201011-21

New DMEPOS competitive bidding program fact sheets now available

The following new fact sheets related to the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program are now available in downloadable format from the *Medicare Learning Network*[®].

- *DMEPOS Competitive Bidding Program Traveling Beneficiary* fact sheet
- *DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers* fact sheet
- *DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers* fact sheet

On January 1, 2011, when the DMEPOS competitive bidding program goes into effect in nine competitive bidding areas (CBAs), beneficiaries with original Medicare who obtain competitively bid items in CBAs must obtain those items from a contract supplier in order for Medicare to pay, unless an exception applies.

To learn more, view the fact sheets at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp and click on the appropriate links in the “Downloads” section.

For more information about the DMEPOS competitive bidding program, including a list of the first nine CBAs and items included in the program, visit <http://www.cms.gov/DMEPOSCompetitiveBid>.

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

Source: CMS PERL 201010-42

Release of additional DMEPOS competitive bidding program fact sheets

The *Medicare Learning Network*[®] has released three new fact sheets related to the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program:

- *The DMEPOS Competitive Bidding Program Non-Contract Supplier* fact sheet – designed to educate suppliers on a broad variety of requirements for non-contract suppliers under the DMEPOS competitive bidding program.
- *The DMEPOS Competitive Bidding Program Enteral Nutrition* fact sheet – designed to educate suppliers on rules for providing enteral nutrition under the DMEPOS competitive bidding program.
- *The DMEPOS Competitive Bidding Program Mail Order Diabetic Supplies* fact sheet – designed to educate suppliers on rules regarding providing mail order diabetic supplies under the DMEPOS competitive bidding program.

To learn more, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, then select the “DMEPOS Competitive Bidding Fact Sheets” link in the “Downloads” section.

Also, CMS would like to remind all non-contract suppliers that furnish competitively-bid rented durable medical equipment (DME) or oxygen and oxygen equipment to beneficiaries in competitive bidding areas (CBAs) of the following upcoming deadlines:

- A non-contract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary who resides in a CBA and is currently renting competitively bid oxygen and oxygen equipment or DME from that supplier. These notifications must be sent by November 17. A non-contract supplier that elects to become a grandfathered supplier must also provide written notification to the Centers for Medicare & Medicaid Services (CMS) of this decision by November 17.
- A non-contract supplier that elects not to become a contract supplier is required to pick-up the item it is currently renting to the beneficiary from the beneficiary’s home after proper notification. Proper notification includes a 30-day, a 10-day, and a two-day notice of the supplier’s decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting competitively-bid DME or oxygen and oxygen equipment and who reside in a CBA. The 30-day written notification to the beneficiary must be sent by November 17.

For more information on grandfathering requirements, please see the DMEPOS Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet, which is now available, free of charge, from the *Medicare Learning Network*[®] at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp in the “Downloads” section.

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

Source: CMS PERL 201011-25

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 [<input type="checkbox"/>] Español [<input type="checkbox"/>]				
<i>Please write legibly</i>			Subtotal	\$
			Tax (<i>add % for your area</i>)	\$
			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

Other important addresses

REGIONAL HOME HEALTH & HOSPICE INTERMEDIARY Home health agency claims Hospice claims

Palmetto Government Benefit
 Administrators
 Medicare Part A
 P.O. Box 100238
 Columbia, SC 29202-3238

RAILROAD MEDICARE

Railroad retiree medical claims
 Palmetto Government Benefit
 Administrators
 P. O. Box 10066
 Augusta, GA 30999-0001

POST-PAY MEDICAL REVIEW

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

OVERPAYMENT COLLECTIONS

Repayment plans for Part A
Participating providers
Cost reports (original and amended)
Receipts and acceptances
Tentative settlement determinations
Provider statistical and
reimbursement (PS&R) reports
Cost report settlement (payments due
to provider or program)
Interim rate determinations
TEFRA target limit and SNF routine
Cost limit exceptions

Provider Audit and Reimbursement
 Department (PAR)D
 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 (PAR)D
 Attn: FOIA PAR)D – 16T
 P. O. Box 45268
 Jacksonville, FL 32232-5268
 1-904-791-8430

PROVIDER ENROLLMENT

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

PROVIDER ENROLLMENT American Diabetes Association certificates

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

SPECIAL DELIVERY

Overnight mail and/or other special courier services

First Coast Service Options Inc.
 532 Riverside Av.
 Jacksonville, FL 32202-4914

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable medical equipment claims
Orthotic and prosthetic device claims
Take home supplies
Oral anti-cancer drugs
 CIGNA Government Services
 P. O. Box 20010
 Nashville, Tennessee 37202

Telephone numbers

PROVIDERS

Customer service center toll-free
 1-888-664-4112

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

Speech and hearing impaired
 1-877-660-1759

BENEFICIARY

Customer service center toll-free
 1-800-MEDICARE

1-800-633-4227
Speech and hearing impaired
 1-800-754-7820

ELECTRONIC DATA INTERCHANGE

1-888-670-0940

Option 1

Transaction support

Option 2

PC-ACE support

Option 3

Direct data entry (DDE) support

Option 4

Enrollment support

Option 5

Electronic funds
(check return assistance only)

Option 6

Automated response line

PROVIDER EDUCATION & OUTREACH

Seminar registration hotline
 1-904-791-8103

Seminar registration fax number
 1-904-361-0407

PROVIDER ENROLLMENT

1-877-602-8816

CREDIT BALANCE REPORT

Debt recovery
 1-904-791-6281

Fax

1-904-361-0359

Medicare websites

PROVIDERS

Florida Medicare contractor
medicare.fcso.com

Centers for Medicare & Medicaid
 Services

www.cms.gov

BENEFICIARIES

Centers for Medicare & Medicaid
 Services

www.medicare.gov

Addresses

CLAIMS/CORRESPONDENCE

Claim status
Additional development
General correspondence
Coverage guidelines
Billing issues regarding
outpatient services, CORF, ORF, PHP
 First Coast Service Options Inc.
 P. O. Box 45071
 Jacksonville, FL 32232-5071

REDETERMINATION and REDETERMINATION OVERPAYMENTS

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

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 Jacksonville, FL 32232-5267

General MSP Information Completion of UB-04 (MSP related) Conditional payment

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 Jacksonville, FL 32231-4179

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 Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Complaint Processing Unit
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 Jacksonville, FL 32232-5087

Other important addresses

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 Medicare Part A
 P.O. Box 100238
 Columbia, SC 29202-3238

RAILROAD MEDICARE

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

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 P. O. Box 44159
 Jacksonville, FL 32231-4159

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Participating providers
Cost reports (original and amended)
Receipts and acceptances
Tentative settlement determinations
Provider statistical and
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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
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 Jacksonville, FL 32231-0048

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special courier services
 First Coast Service Options Inc.
 532 Riverside Av.
 Jacksonville, FL 32202-4914

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)

Durable medical equipment claims
 Orthotic and prosthetic device
 claims
Take home supplies
Oral anti-cancer drugs
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 1-800-754-7820

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CREDIT BALANCE REPORT

Debt recovery
 1-904-791-6281

Fax
 1-904-361-0359

Medicare websites

PROVIDERS

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