

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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Medicare A Bulletin

**Vol. 13, No. 1
 January 2011**

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

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

**Medicare Publications
 1-904-361-0723**

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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

Summary of policies – 2011 Medicare physician fee schedule and the telehealth originating site facility fee payment amount

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

Provider types affected

Physicians and nonphysician practitioners who submit claims to fiscal intermediaries (FI), carriers, and A/B Medicare administrative contractors (MACs) are affected by this article.

What you need to know

This article is based on change request (CR) 7264, which provides a summary of the policies in the calendar year (CY) 2011 Medicare physician fee schedule and announces the telehealth originating site facility fee. Please ensure that your billing staffs are aware of these changes.

Background

The summary of changes is as follows:

Telehealth Services

Section 1834 (m) of the Social Security Act (the Act) established the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare economic index (MEI). The MEI increase for CY 2011 is 0.4 percent.

For calendar year 2011, the payment amount for HCPCS code “Q3014, Telehealth originating site facility fee” is 80 percent of the lesser of the actual charge or \$24.10. The beneficiary is responsible for any unmet deductible amount or coinsurance.

For additional details regarding the expansion of telehealth services in 2011, see the article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7049.pdf>.

Summary of policies in the CY 2011 MPFS

The Act requires the Secretary to establish by regulation before November 1 of each year, fee schedules that establish payment amounts for physicians’ services for the subsequent year. Following is a summary of significant physician fee schedule issues discussed in CMS-1503-FC, Medicare Program; Payment Policies under the Physician Fee Schedule and other revisions to Part B for CY 2011.

Affordable Care Act Provisions

Elimination of deductible and coinsurance for most preventive services: Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services. Specifically, the provision waives both the deductible and coinsurance for Medicare-covered preventive services that have been recommended with a grade of A (“strongly recommends”) or B (“recommends”) by the U.S. Preventive Services Task Force, as well as the initial preventive physical examination and the new annual wellness visit. The Affordable Care Act also waives the Part B deductible for tests that begin as colorectal cancer screening tests but, based on findings during the test, become diagnostic or therapeutic services.

Coverage of annual wellness visit (AWV) providing a personalized prevention plan: The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time initial preventive physical examination (IPPE or the “Welcome to Medicare Visit”), to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the AWV may include at least the following six elements, as determined by the Secretary of Health and Human Services:

- Establish or update the individual’s medical and family history
- List the individual’s current medical providers and suppliers and all prescribed medications
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements
- Detect any cognitive impairment
- Establish or update a screening schedule for the next five to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient’s risk factors, and
- Furnish personalized health advice and appropriate referrals to health education or preventive services.
- CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 - Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for subsequent annual wellness visits (G0439 - Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

Summary of policies – 2011 Medicare physician fee schedule and the telehealth ... (continued)

For more details on the AWW, see the article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7079.pdf>.

Incentive payments to primary care practitioners for primary care services: The Affordable Care Act provides for incentive payments equal to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B, furnished on or after January 1, 2011, and before January 1, 2016. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's MPFS allowed charges for a prior period as determined by the Secretary of Health and Human Services. The law also defines primary care services as limited to new and established patient office or other outpatient visits (*CPT* codes 99201-99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (*CPT* codes 99304-99340); and patient home visits (*CPT* codes 99341-99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for practitioners of eligible specialties to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in health professional shortage areas (HPSAs).

CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

For more details on this program, see the article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7060.pdf>. Also, the article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7115.pdf> has details on this program as they apply to critical access hospitals.

Incentive payments for major surgical procedures in health professional shortage areas: The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the MPFS – that are furnished by physicians in HPSAs on or after January 1, 2011, and before January 1, 2016. To be eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program.

Further details on this program are in the *MLN Matters*[®] article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7063.pdf>.

Revisions to the practice expense geographic adjustment: As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice insurance cost components of each of more than 7,000 types of physicians' services. The final rule with comment period discusses CMS' analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while maintaining the current GPCI cost share weights pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

Payment for bone density tests: The Affordable Care Act increases the payment for two dual-energy x-ray absorptiometry (DXA) *CPT* codes for measuring bone density for CYs 2010 and 2011. This provision requires payments for these preventive services to be based on 70 percent of their CY 2006 RVUs and the CY 2006 conversion factor, and the current year geographic adjustment.

Improved access to certified nurse-midwife services: The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after Jan. 1, 2011.

Misvalued codes under the physician fee schedule: The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule with comment period identifies additional categories of services that may be misvalued, including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA)

Summary of policies – 2011 Medicare physician fee schedule and the telehealth ... (continued)

Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.

Multiple procedure payment reduction policy for therapy services

The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. CMS is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together. The policy, as described in the CY 2011 MPFS final rule with comment period, states that the MPPR for “always” therapy services will reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Since publication of the CY 2011 MPFS final rule with comment period, this policy has been modified by the Physician Payment and Therapy Relief Act of 2010. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent MPPR to therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians’ offices and other settings that are paid under Section 1848 of the Act.

For more details, see the *MLN Matters*[®] article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7050.pdf>.

Modification of equipment utilization factor and modification of multiple procedure payment policy for advanced imaging services:

The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Medicare economic index (MEI)

The MEI is an inflation index for physician practice costs that is used as part of the formula to calculate annual updates to MPFS rates. For CY 2011, CMS is rebasing and revising the MEI to use a 2006 base year in place of a 2000 base year. Prior to the rebasing for CY 2011, CMS rebased the MEI in CY 2004. In addition, the final rule with comment period announces CMS’ plans to convene a technical advisory panel to review all aspects of the MEI, including inputs, input weights, price-measurement proxies, and productivity adjustment; and indicates that CMS will consider the panel’s analysis and recommendations in future rulemaking.

New and revised CPT code issues**Establishment of interim final RVUs for CY 2011:**

On an annual basis, the AMA RUC provides CMS with recommendations regarding physician work values for new, revised, and potentially misvalued codes. Typically, the relevant specialty society surveys physicians to gather information regarding current medical practice that is then used by the AMA RUC in developing recommendations for physician work values. CMS reviews the AMA RUC-recommended work RVUs on a code-by-code basis. CMS then decides either to accept the AMA RUC-recommended work RVUs if CMS believes the valuation is accurate, or determine an alternative value that better reflects our estimate of the physician work for the service. CMS publishes these work RVUs in the PFS final rule as interim final values, subject to public comment.

Comprehensive codes for a bundle of existing component services:

A subset of AMA RUC work RVU recommendations addressed valuing new CY 2011 CPT codes resulting from the bundling of two or more existing component services performed together 95 percent or more of the time. CMS expects this bundling of component services to continue over the next several years as the AMA RUC further recognizes the work efficiencies for services commonly furnished together. Stakeholders should expect that increased bundling of services into fewer codes will generally result in reduced MPFS payment for a comprehensive service by explicitly considering the efficiencies in work and/or PE that may occur when component services are furnished together. For CY 2011, the AMA RUC provided CMS with recommendations for several categories of new comprehensive services that historically have been reported under multiple component codes. For CY 2011 the creation of comprehensive codes for a bundle of existing component services fall into three major clinical categories: endovascular revascularization, computed tomography (CT), and diagnostic cardiac catheterization.

Additional Information

The official instruction, CR 7264, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2129CP.pdf>. If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters[®] Number: MM7264

Related Change Request (CR) #: 7264

Related CR Release Date: December 29, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2129CP

Implementation Date: January 3, 2011

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Emergency update to the CY 2011 Medicare physician fee schedule database

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

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], durable medical equipment Medicare administrative contractors [DME/MACs] and/or Part A/B Medicare administrative contractors [A/B MACs]) for professional services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on change request (CR) 7300, which amends payment files that were issued to Medicare contractors based on the 2011 MPFS final rule. This CR also reinstates three durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) HCPCS L-codes, as described below. Be sure your billing staff is aware of these changes.

Background

Payment files were issued based upon the calendar year (CY) 2011 MPFS final rule, issued on November 2, 2010, and published in the *Federal Register* on November 29, 2010. CR 7300 amends those payment files to include MPFS policy and payment indicator revisions described in the CY 2011 MPFS final rule correction notice, issued in December 30, 2010, ([http://www.ofr.gov/\(X\(1\)S\(zj23h5e5vs3xn5y2yjsecx03\)\)/inspection.aspx?AspxAutoDetectCookieSupport=1](http://www.ofr.gov/(X(1)S(zj23h5e5vs3xn5y2yjsecx03))/inspection.aspx?AspxAutoDetectCookieSupport=1)) to be published in the *Federal Register* on January 11, 2011, as well as relevant statutory changes applicable January 1, 2011. Therefore, new MPFS payment files have been created and are available. CR 7300 also reinstates three DMEPOS Healthcare Common Procedure Coding System (HCPCS) L-codes. Following is a summary of the changes as they impact providers:

Medicare physician fee schedule revisions and updates

Some physician work, practice expense (PE) and malpractice (MP) relative value units (RVUs) published in the CY 2011 MPFS final rule have been revised to align their values with the CY 2011 MPFS final rule policies. These changes are discussed in the CY 2011 MPFS final rule correction notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS final rule correction notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS final rule correction notice public use data files located at <http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp>. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at <http://www.cms.gov/Transmittals/downloads/R828OTN.pdf>.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS final rule has been revised. This CF will be published in the CY 2011 MPFS final rule correction notice. Legislative changes subsequent

to issuance of the CY 2011 MPFS final rule have led to the further revision of the values published in the CY 2011 MPFS final rule correction notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available.

A summary of the recent statutory provisions included in the revised MPFS payment files is as follows.

Physician Payment and Therapy Relief Act of 2010

On November 30, 2010, President Obama signed into law the Physician Payment and Therapy Relief Act of 2010. As a result of the Physician Payment and Therapy Relief Act of 2010 a new reduced therapy fee schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent multiple procedure payment reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Social Security Act. This change is detailed in recently released CR 7050. CMS published *MLN Matters*® article 7050, related to CR 7050, which may be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/MM7050.pdf>. This Act also made the therapy MPPR not budget neutral under the physician fee schedule (PFS) and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

Medicare and Medicaid Extenders Act (MMEA) of 2010

On December 15, 2010, President Obama signed into law the Medicare and Medicaid Extenders Act (MMEA) of 2010. This new legislation contains a number of Medicare provisions which change or extend current Medicare fee-for-service program policies. A summary of MPFS-related provisions follows.

- **Physician payment update**

Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS Final Rule. The MMEA provides for a zero percent update to the MPFS for claims with dates of service January 1, 2011, through December 31, 2011. While the MPFS update will be zero percent, other changes to the RVUs (e.g., miss valued code initiative and rescaling of the RVUs to match the revised Medicare economic index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011, is \$33.9764.

Emergency update to the CY 2011 Medicare physician fee schedule database (continued)

The calculation of the CY 2011 conversion factor is illustrated in the following table.

December 2010 conversion factor		\$36.8729
MMEA “Zero Percent Update”	0.0 percent (1.000)	
CY 2011 RVU Budget Neutrality Adjustment	0.4 percent (1.0043)	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.3 percent (0.9175)	
CY 2011 Conversion Factor		\$33.9764

The revised CY 2011 MPFS payment files will reflect this conversion factor.

• **Extension of Medicare physician work geographic adjustment floor**

Current law requires the payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 3102 of the Affordable Care Act extended the 1.0 floor on the physician work Geographic Practice Cost Index (GPCI) for services furnished through December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. Updated CY 2011 GPCIs may also be found in the attachment to CR 7300 as noted previously.

• **Extension of MPFS mental health add-on**

Section 138 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 increased the Medicare payment amount for specific “Psychiatry” services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the Affordable Care Act extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the Medicare & Medicaid Extenders Act (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy may also be found in the attachment to CR 7300.

• **Extension of exceptions process for Medicare therapy caps**

Under the Temporary Extension Act of 2010, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the Affordable Care Act continued the exceptions process through December 31, 2010. Section 104 of the MMEA extends the exceptions process for outpatient therapy caps through December 31, 2011. Outpatient therapy service providers may continue to submit claims with the modifier KX, when an exception is appropriate, for services furnished on or after January 1, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,870. For occupational therapy services, the limit is \$1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

• **Extension of moratorium that allowed independent laboratories to bill for the technical component (TC) of physician pathology services furnished to hospital patients**

Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a MAC for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the Affordable Care Act extended the payment to independent laboratories for the TC of certain physician pathology services furnished to hospital patients retroactive to January 1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary’s hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011, through December 31, 2011.

Durable medical equipment, prosthetics, orthotics, and supplies updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

- L3660 Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment (SD: Abduct restrainer canvas &web)
- L3670 Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment (SD: Acromio/clavicular canvas & web), and
- L3675 Shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, and prefabricated includes fitting and adjustment (SD: Canvas vest SO).

These three “L” codes will continue to stay active codes for January 1, 2011. Instruction for billing and payment will remain the same for these three “L” codes. Medicare contractors will pay for codes L3660, L3670, and L3675 with dates of service on or after January 1, 2011, using the following 2011 DMEPOS fee schedule amounts:

Emergency update to the CY 2011 Medicare physician fee schedule database (continued)

	JURIS	CATG	L3660	L3670	L3675
AL	D	PO	\$85.06	\$118.57	\$145.25
AR	D	PO	\$85.06	\$97.17	\$145.24
AZ	D	PO	\$100.69	\$124.79	\$141.00
CA	D	PO	\$100.69	\$124.79	\$141.00
CO	D	PO	\$111.02	\$93.60	\$146.04
CT	D	PO	\$113.42	\$93.60	\$141.00
DC	D	PO	\$85.06	\$112.42	\$141.00
DE	D	PO	\$85.06	\$112.42	\$141.00
FL	D	PO	\$85.06	\$118.57	\$145.25
GA	D	PO	\$85.06	\$118.57	\$145.25
IA	D	PO	\$106.53	\$124.79	\$143.74
ID	D	PO	\$85.06	\$97.28	\$141.00
IL	D	PO	\$85.06	\$93.60	\$144.48
IN	D	PO	\$85.06	\$93.60	\$144.48
KS	D	PO	\$106.53	\$124.79	\$143.74
KY	D	PO	\$85.06	\$118.57	\$145.25
LA	D	PO	\$85.06	\$97.17	\$145.24
MA	D	PO	\$113.42	\$93.60	\$141.00
MD	D	PO	\$85.06	\$112.42	\$141.00
ME	D	PO	\$113.42	\$93.60	\$141.00
MI	D	PO	\$85.06	\$93.60	\$144.48
MN	D	PO	\$85.06	\$93.60	\$144.48
MO	D	PO	\$106.53	\$124.79	\$143.74
MS	D	PO	\$85.06	\$118.57	\$145.25
MT	D	PO	\$111.02	\$93.60	\$146.04
NC	D	PO	\$85.06	\$118.57	\$145.25
ND	D	PO	\$111.02	\$93.60	\$146.04
NE	D	PO	\$106.53	\$124.79	\$143.74
NH	D	PO	\$113.42	\$93.60	\$141.00
NJ	D	PO	\$87.06	\$110.96	\$141.00
NM	D	PO	\$85.06	\$97.17	\$145.24
NV	D	PO	\$100.69	\$124.79	\$141.00
NY	D	PO	\$87.06	\$110.96	\$141.00
OH	D	PO	\$85.06	\$93.60	\$144.48
OK	D	PO	\$85.06	\$97.17	\$145.24
OR	D	PO	\$85.06	\$97.28	\$141.00
PA	D	PO	\$85.06	\$112.42	\$141.00
RI	D	PO	\$113.42	\$93.60	\$141.00
SC	D	PO	\$85.06	\$118.57	\$145.25
SD	D	PO	\$111.02	\$93.60	\$146.04
TN	D	PO	\$85.06	\$118.57	\$145.25
TX	D	PO	\$85.06	\$97.17	\$145.24
UT	D	PO	\$111.02	\$93.60	\$146.04
VA	D	PO	\$85.06	\$112.42	\$141.00
VT	D	PO	\$113.42	\$93.60	\$141.00
WA	D	PO	\$85.06	\$97.28	\$141.00
WI	D	PO	\$85.06	\$93.60	\$144.48
WV	D	PO	\$85.06	\$112.42	\$141.00
WY	D	PO	\$111.02	\$93.60	\$146.04
AK	D	PO	\$100.22	\$148.35	\$141.00

Emergency update to the CY 2011 Medicare physician fee schedule database (continued)

	JURIS	CATG	L3660	L3670	L3675
HI	D	PO	\$107.12	\$158.62	\$141.00
PR	D	PO	\$82.83	\$105.08	\$169.21
VI	D	PO	\$87.06	\$110.96	\$169.21

In accordance with the statutory Section 1834(a)(14) of the Social Security Act, the above fee schedule amounts were updated for CY 2011 by applying the CY 2011 -0.1 percent update factor to the CY 2010 fee schedule amounts. The CY 2011 payment amounts for codes L3660, L3670, and L3675 will be posted as a public use file at: <http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp>.

Additional information

The official instruction, CR 7300, issued to your carrier, FI, RHHI, DME MAC, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R828OTN.pdf>.

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

MLN Matters® Number: MM7300

Related Change Request (CR) #:7300

Related CR Release Date: December 29, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R828OTN

Implementation Date: January 3, 2011

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No date set for expanded ordering/referring provider claim edits

Due to recent inquiries, the Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding expanded ordering/referring provider claim edits. CMS has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a record in the provider enrollment, chain, and ownership system (PECOS). CMS will give providers ample notice before claim rejections begin. Recent revisions to change requests 6417 (<http://www.cms.gov/transmittals/downloads/R825OTN.pdf>) and 6421 (<http://www.cms.gov/transmittals/downloads/R823OTN.pdf>) require Medicare administrative contractors to delay rejecting claims until receiving further direction from CMS.

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Source: CMS PERL 201101-23

April 2011 release of modified HCPCS code set

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp. Changes are effective on the date indicated on the update.

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

Source: CMS PERL 201101-23

New tools to prevent and fight fraud

As part of the Obama Administration's ongoing efforts to prevent and fight fraud in our nation's health care system, U.S. Department of Health & Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder announced December 16 that the Centers for Medicare & Medicaid Services (CMS) would be acquiring new state-of-the-art fraud fighting analytic tools to prevent wasteful and fraudulent payments in Medicare, Medicaid and the Children's Health Insurance Program.

Sebelius and Holder made the announcement at the University of Massachusetts, Boston at the fourth regional health care fraud prevention summit. The Attorney General and the HHS Secretary have crisscrossed the country this year bringing together a wide array of federal, state, and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud within the U.S. health care system.

As part of that summit, CMS will issue a solicitation for state-of-the-art fraud fighting analytic tools to help the agency predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. These tools will integrate many of the Agency's pilot programs into the National Fraud Prevention Program and complement the work of the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT).

The recently-enacted Affordable Care Act provides additional tools and resources to fight fraud in the health care system by providing an additional \$350 million over the next ten years through the Health Care Fraud and Abuse Control Account. The Act toughens sentencing for criminal activity, enhances screenings and enrollment requirements, encourages increased sharing of data across government, expands overpayment recovery efforts, and provides greater oversight of private insurance abuses. For information on the 2009 Health Care Fraud and Abuse Control Program Report, please visit <http://www.justice.gov/dag/pubdoc/hcfacreport2009.pdf>.

To read the entire HHS release issued on Thursday, December 16, 2010, please visit <http://www.hhs.gov/news/press/2010pres/12/20101216a.html>.

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Source: CMS PERL 201012-28

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January 2011 average sales price drugs files are now available

The Centers for Medicare & Medicaid Services has posted the January 2011 ASP (revised 12/29/2010) and NOC pricing files and crosswalks, and updated pricing files for October 2010 and July 2010. All are available for download at: <http://www.cms.gov/McrPartBDrugAvgSalesPrice/> (see left menu for year-specific links).

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Source: CMS PERLs 201101-04 & 201012-26

2011 DMEPOS fee schedule update

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

Provider types affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], Medicare administrative contractors [MACs], and/or regional home health intermediaries [RHHIs]) for DMEPOS items or services paid under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule need to be aware of this article.

Provider action needed

This article, based on change request (CR) 7248, advises you of the calendar (CY) 2011 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. The annual update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at <http://www.cms.gov/manuals/downloads/clm104c23.pdf>. Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2011. Be sure your billing staffs are aware of these changes.

Background and key points of CR 7248

The DMEPOS fee schedule file is available for state Medicaid agencies, managed care organizations, and other interested parties at <http://www.cms.gov/DMEPOSFeeSched/>.

2011 update to labor payment rates

2011 fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 1.1 percent effective for dates of service on or after January 1, 2011, through December 31, 2011, and those rates are as follows:

State	K0739	L4205	L7520	State	K0739	L4205	L7520
AK	25.55	29.11	34.25	NC	13.56	20.21	27.44
AL	13.56	20.21	27.44	ND	16.90	29.05	34.25
AR	13.56	20.21	27.44	NE	13.56	20.19	38.26
AZ	16.77	20.19	33.76	NH	14.56	20.19	27.44
CA	20.81	33.19	38.68	NJ	18.30	20.19	27.44
CO	13.56	20.21	27.44	NM	13.56	20.21	27.44
CT	22.65	20.67	27.44	NV	21.61	20.19	37.40
DC	13.56	20.19	27.44	NY	24.98	20.21	27.44
DE	24.98	20.19	27.44	OH	13.56	20.19	27.44
FL	13.56	20.21	27.44	OK	13.56	20.21	27.44
GA	13.56	20.21	27.44	OR	13.56	20.19	39.46
HI	16.77	29.11	34.25	PA	14.56	20.79	27.44
IA	13.56	20.19	32.85	PR	13.56	20.21	27.44
ID	13.56	20.19	27.44	RI	16.17	20.81	27.44
IL	13.56	20.19	27.44	SC	13.56	20.21	27.44
IN	13.56	20.19	27.44	SD	15.15	20.19	36.68
KS	13.56	20.19	34.25	TN	13.56	20.21	27.44
KY	13.56	25.88	35.09	TX	13.56	20.21	27.44
LA	13.56	20.21	27.44	UT	13.60	20.19	42.73
MA	22.65	20.19	27.44	VA	13.56	20.19	27.44
MD	13.56	20.19	27.44	VI	13.56	20.21	27.44
ME	22.65	20.19	27.44	VT	14.56	20.19	27.44
MI	13.56	20.19	27.44	WA	21.61	29.62	35.18
MN	13.56	20.19	27.44	WI	13.56	20.19	27.44
MO	13.56	20.19	27.44	WV	13.56	20.19	27.44
MS	13.56	20.21	27.44	WY	18.91	26.94	38.26
MT	13.56	20.19	34.25				

HCPCS code updates

The following new codes are effective as of January 1, 2011:

- A4566, A9273, and EO446 all of which have no assigned payment category

2011 DMEPOS fee schedule update (continued)

- A7020, E2622, E2623, E2624, and E2625 in the inexpensive/routinely purchased (DME) payment category
- E1831 in the capped rental payment category (DME)
- L3674, L4631, L5961, L8693, Q0478, and Q0479, in the prosthetics/orthotics payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2011 DMEPOS fee schedule update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes, where applicable, from January 1, 2011, through June 30, 2011. The new codes are not to be used for billing purposes until they are effective on January 1, 2011.

The following codes are being deleted from the HCPCS effective January 1, 2011, and are therefore being removed from the DMEPOS fee schedule files:

- E0220, E0230, and E0238
- K0734, K0735, K0736, and K0737
- L3660, L3670, L3672, L3673, and L3675.

For gap-filling purposes, the 2010 deflation factors by payment category are listed as follows:

Factor	Category
0.502	Oxygen
0.506	Capped rental
0.507	Prosthetics and orthotics
0.643	Surgical dressings
0.700	Parenteral and enteral nutrition

Specific coding and pricing issues

Therapeutic shoes and insert fee schedule amounts were implemented as part of the January 2005 fee schedule update as described in CR 3574 (Transmittal 369) which may be reviewed at <http://www.cms.gov/transmittals/Downloads/R369CP.pdf>. The payment amounts for shoe modification codes A5503 through A5507 were established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). The fees for codes A5512 and A5513 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004.

As part of this update, CMS is revising the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code as follows:

- Fees for A5512 and A5513 will be weighted based on the approximate total allowed services for each code for items furnished during the calendar year 2009
- The fee schedules for codes A5503 through A5507 are being revised effective January 1, 2011, to reflect this change.

Power-driven wheelchairs

In accordance with Section 3136(a)(1) of The Affordable Care Act of 2010, effective for claims with dates of service on or after January 1, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule for power-driven wheelchairs furnished on or after January 1, 2011, is revised to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly rental method and 6 percent (instead of 7.5 percent) for each of the remaining rental months 4 through 13. Payment amounts will be based on the lower of the supplier's actual charge and the fee schedule amount. As part of this update, the CY 2011 rental fees for power-driven wheelchairs included in the 2011 DMEPOS fee schedule Part B file have been revised to represent 15 percent of the purchase price amount. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR 7248, which is at <http://www.cms.gov/Transmittals/downloads/R2118CP.pdf>. This attachment identifies those codes where payment, when applicable, will be made at 15 percent of the purchase price for months 1 through 3 and 6 percent of the purchase price for months 4 through 13.

These changes do not apply to rented power-driven wheelchairs for which the date of service for the initial rental month is prior to January 1, 2011. For these items, payment for rental claims with dates of service on or after January 1, 2011, will continue to be based on 10 percent of the purchase price for rental months 2 and 3 and 7.5 percent of the purchase price for rental months 4 through 13.

Also, Section 3136(c)(2) of The Affordable Care Act specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the Medicare DMEPOS Competitive Bidding Program. *MLN Matters*[®] article MM7181 at <http://www.cms.gov/MLNArticles/downloads/MM7181.pdf> discusses these changes.

For power-driven wheelchairs furnished on a rental basis with dates of service prior to January 1, 2006, for which the beneficiary did not elect the purchase option in month 10 and continues to use, contractors shall continue to pay the maintenance and servicing payment amount at 10 percent of the purchase price. In these instances, suppliers should continue to use the following HCPCS codes, with the modifier MS, for billing maintenance and servicing, as appropriate:

Waiver of coinsurance and deductible for preventive services (continued)

K0010 Standard- Weight Frame Motorized/Power Wheelchair

K0011 Standard- Weight Frame Motorized/Power Wheelchair with Programmable Control Parameters for Speed Adjustment, Tremor Dampening, Acceleration Control and Braking

K0012 Lightweight Portable Motorized/Power Wheelchair

K0014 Other Motorized/Power Wheelchair Base

The rental fee schedule payment amounts for codes K0010, K0011 and K0012 will continue to reflect 10 percent of the wheelchair's purchase price.

CY 2011 fee schedule update factor

The DMEPOS fee schedule amounts are to be updated for 2011 by the percentage increase in the consumer price index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. Also beginning with CY 2011, Section 3401 of The Affordable Care Act requires that the increase in the CPI-U be adjusted by changes in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The amendment specifies the application of the MFP may result in an update "being less than 0.0 for a year, and may result in payment rates being less than such payment rates for the preceding year". For CY 2011, the MFP adjustment is 1.2 percent and the CPI-U update factor is 1.1 percent. Thus, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent MFP resulting in a -0.1 percent MFP-adjusted update factor or a 0.1 percent reduction to the applicable CY 2011 DMEPOS fee schedule amounts.

2011 national monthly payment amounts for stationary oxygen equipment

CMS will also implement the 2011 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2011. The fee schedule file is being revised to include the new national 2011 monthly payment rate of \$173.31 for stationary oxygen equipment. The payment rates are being adjusted on an annual basis, as necessary, to ensure budget neutrality of the addition of the new oxygen generating portable equipment (OGPE) class. The revised 2011 monthly payment rate of \$173.31 includes the -0.1 percent MFP-adjusted update factor. The budget neutrality adjustment and the MFP-adjusted covered item update factor for 2011 caused the 2010 rate to change from \$173.17 to \$173.31.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2011 maintenance and service payment amount for certain oxygen equipment

Payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36-month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the modifier MS. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

The 2010 maintenance and servicing fee for certain oxygen equipment is based on 10 percent of the average price of an oxygen concentrator which resulted in a payment of \$66 for CY 2010. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Social Security Act. The 2010 maintenance and servicing fee is adjusted by the -0.1 percent MFP-adjusted covered item update factor to yield a CY 2011 maintenance and servicing fee of \$65.93 for oxygen concentrators and transfilling equipment.

Specific billing issues

Effective January 1, 2011, the payment category for code E0575 (Nebulizer, Ultrasonic, Large Volume) is being revised to move the nebulizer from the DME payment category for frequent and substantial servicing to the DME payment category for capped rental items. The first claim received for each beneficiary for this code with a date of service on or after January 1, 2011, will be counted as the first rental month in the cap rental period.

Code A7020 (Interface for Cough Stimulating Device, Includes All Components, Replacement Only) is added to the HCPCS file effective January 1, 2011. Items coded under this code are accessories used with the capped rental DME cough stimulating device coded at E0482. Section 110.3, Chapter 15 of the *Medicare Benefit Policy Manual* at <http://www.cms.gov/Manuals/downloads/bp102c15.pdf> provides reimbursement for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary DME only if the beneficiary owns or is purchasing the equipment. Therefore, separate payment will not be made for the replacement of accessories described by code A7020 until after the 13-month rental cap has been reached for capped rental code E0482.

The following new codes are being added to the HCPCS file, effective January 1, 2011, to describe replacement accessories for ventricular assist devices (VADs):

- Q0478 (Power Adaptor for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type), and
- Q0479 (Power Module for Use with Electric/Pneumatic Ventricular Assist Device, Replacement Only).

Similar to the other VAD supplies and accessories coded at Q0480 thru Q0496, Q0497 thru Q0502, Q0504 and Q0505,

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines (continued)

CMS has determined the reasonable useful lifetime for codes Q0478 and Q0479 to be one year. CMS is establishing edits to deny claims before the lifetime of these items has expired. Suppliers and providers will need to add HCPCS modifier RA to claims for codes Q0478 and Q0479 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Additionally, code Q0489 (Power Pack Base for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only) should not be used to bill separately for a VAD replacement power module or a battery charger in instances where the power module and battery charger are not integral and are furnished as separate components.

Additional information

The official instruction, CR 7248, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2118CP.pdf>.

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

MLN Matters® Number: MM7248

Related Change Request (CR) #:7248

Related CR Release Date: December 9, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2118CP

Implementation Date: January 3, 2011

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Inpatient psychiatric facility prospective payment system PC PRICER

The inpatient psychiatric facility prospective payment system personal computer (IPF PPS PC) PRICER needed corrected date edit logic for rate year (RY) 2011 and has been updated on the CMS Web page for claim dates from October 1, 2010, through June 30, 2011. If you use the IPF PPS PC PRICER for RY 2011, please go to http://www.cms.gov/PCPricer/09_inppsy.asp and download the latest version of the IPF PPS RY 2011 PC PRICERs, posted January 13, in the *Downloads* section.

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Source: CMS PERL 201101-34

Prompt payment interest rate revision

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

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

The new rate of 2.625 percent is in effect through June 30, 2011.

Interest is not paid on:

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

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

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

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Notice of interest rate for Medicare overpayments and underpayments

Medicare Regulation 42 CFR section 405.378 provides for the assessment of interest at the higher of the current value of funds rate (one percent for calendar year 2011) or the private consumer rate (PCR) as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health & Human Services that the PCR will remain at **11.25 percent, effective January 24, 2011**. The PCR will remain in effect until a new rate change is published. The following table lists previous interest rates.

Period	Interest Rate
October 22, 2010 – January 23, 2011	10.75%
July 21, 2010 – October 21, 2010	11.00%
April 23, 2010 – July 20, 2010	10.875%
January 25, 2010 – April 22, 2010	11.25%
October 22, 2009 – January 24, 2010	10.875%
July 17, 2009 – October 21, 2009	11.25%

Source: CMS Pub. 100-06, Transmittal 182, CR 7154

Medical nutrition therapy manual correction

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

Provider types affected

This article is for physicians and other providers, including home health agencies (HHAs) who bill Medicare carriers, fiscal intermediaries (FI), Medicare administrative contractors (A/B MAC), or regional home health intermediaries (RHHI) for providing medical nutrition therapy (MNT) services to Medicare beneficiaries.

What you need to know

Change request (CR) 7262, from which this article is taken, corrects an error in the “*Medicare Claims Processing Manual*”, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and Outpatient Prospective Payment System (OPPS)), Section 300 (Medicare Nutrition Therapy (MNT) Services), which incorrectly defines renal disease.

Specifically, the manual currently defines renal disease as “chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 6 months”. CR 7262 corrects this “6 month” language to read “36 months”. All other information relating to MNT remains the same.

Additional information

You may find more information about MNT by going to CR 7262, located at <http://www.cms.gov/Transmittals/downloads/R2127CP.pdf>. You will find the corrected “*Medicare Claims Processing Manual*”, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and Outpatient Prospective Payment System (OPPS)), Section 300 (Medicare Nutrition Therapy (MNT) Services) as an attachment to that CR.

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

MLN Matters® Number: MM7262

Related Change Request (CR) #: 7262

Related CR Release Date: December 29, 2010

Effective Date: January 1, 2002

Related CR Transmittal #: R2127CP

Implementation Date: March 29, 2011

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Place of service indicator revised for HCPCS codes G0339 and G0340

The pricing indicator code on the alpha-numeric Healthcare Common Procedure Coding System (HCPCS) file has been changed from “00” (Service not separately priced by Part B) to “13” (Price established by carriers) for HCPCS codes G0339 and G0340. This change is effective for services furnished in calendar year (CY) 2006-CY 2010.

Source: JSM 11066

CMS launches the 2011 Medicare Contractor Provider Satisfaction Survey

It's that time again – time for you to let your voice be heard. The Centers for Medicare & Medicaid Services (CMS) has launched its annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare fee-for-service (FFS) providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions:

- Provider inquiries
- Provider outreach & education
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

The survey was sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who were selected to participate in the 2011 MCPSS were notified in December 2010. CMS understands that providers and suppliers themselves may not be able to respond directly to the survey but may have a staff member who can act as a proxy to respond on their behalf. The respondent can be anyone within the provider's organization that is knowledgeable of the Medicare claims process and is designated to respond to the MCPSS.

If you are selected to participate, please take the time to complete this important survey. CMS encourages providers and suppliers to complete the survey on the Internet via a secure website. Other modes of participation are available by mail, fax, or telephone. It will take no more than 20 minutes. You may also respond by mail, fax, or telephone.

CMS is listening and wants to hear from you.

To learn more about the MCPSS, please visit the CMS website at <http://www.cms.gov/MCPSS>. If you have any questions or concerns, please call our toll-free MCPSS Provider Helpline number at 1-800-654-1431 or send an e-mail to MCPSS_survey@scimetrika.com.

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

Source: CMS PERL 201101-08, 201012-18

2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks now available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the general equivalence mappings (GEMs), on the ICD-10 website at <http://www.cms.gov/ICD10>. See the links on this page for *2011 ICD-10-CM and GEMs* and *2011 ICD-10-PCS and GEMs*.

These updated files complete the requirements of Section 10109(c) of the Affordable Care Act of 2010. The Affordable Care Act required the Secretary of Health and Human Services to task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting before January 1, 2011, to receive stakeholder input regarding the crosswalks between ICD-9-CM and ICD-10 for the purpose of making appropriate revisions to said crosswalks. Section 10109(c) further requires that these revisions to the crosswalks be posted to the CMS website and treated as a code set for which the Secretary has adopted a standard.

In addition, CMS also has posted *ICD-10 GEMs 2011 Version Update, Update Summary*. This document describes the number of comments we received, the type of changes recommended, the types of changes made based on the comments, and the types of comments not accepted and reasons why some comments were not accepted.

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

Source: CMS PERL 201012-30

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.fcso.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.

Implementation of home health agency payment safeguard provisions

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

Provider types affected

Home health agency's (HHAs) submitting claims to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (A/B MACs) are affected by this article.

Provider action needed

This article advises HHAs that change request (CR) 7256 directs Medicare contractors to implement the provisions related to HHAs regarding: (1) changes in majority ownership, and (2) capitalization. These provisions were implemented in the Centers for Medicare & Medicaid Services's (CMS) final rule, entitled: "CMS-1510-F: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices."

You are urged to review these new policies in the section below, titled "What you need to know."

CR 7256 also explains that the provisions in Section 27.1, regarding HHA deactivations, have been in effect since January 1, 2010, and are merely being inserted into the *Medicare Program Integrity Manual*, Pub.100-08, Chapter 15. Be sure to inform your staffs of these changes.

What you need to know

The final rule, CMS-1510-F, provides the following policies for HHAs that are undergoing a change in ownership:

1. Changes in Majority Ownership

a. General Provisions

Effective January 1, 2011, and in accordance with 42 Code of Federal Regulations (CFR), Section 424.550(b)(1), if there is a change in majority ownership of an HHA by sale (including asset sales, stock transfers, mergers, and consolidations) within 36 months after the effective date of the HHA's initial enrollment in Medicare or within 36 months after the HHA's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

- Enroll in the Medicare program as a new (initial) HHA under the provisions of Section 424.510, and
- Obtain a state survey or an accreditation from an approved accreditation organization.

For purposes of Section 424.550(b)(1), a "change in majority ownership" (as defined in Section 424.502) occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sales, stock transfers, mergers, or consolidations). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

There are several exceptions to these provisions. The requirements of Section 424.550(b)(1) do not apply if:

- The HHA has submitted two consecutive years of full cost reports. (For purposes of this exception, low utilization or no utilization cost reports do not qualify as full cost reports.)
- The HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.
- The HHA is changing its existing business structure – such as from a corporation, a partnership (general or limited), or an LLC to a corporation, a partnership (general or limited) or an LLC - and the owners remain the same.
- An individual owner of the HHA dies, regardless of the percentage of ownership the person had in the HHA.

In addition, Section 424.550(b)(1) does not apply to "indirect" ownership changes.

Note: If none of the above exceptions apply, the new owner must enroll as a new provider, and the Medicare contractor will send a letter to the HHA, notifying them. In addition, if the sale has already occurred, the HHA's billing privileges will be deactivated.

b. Effective Date

These provisions apply only to HHA ownership transactions whose effective date is on or after January 1, 2011. However, the provisions can apply irrespective of when the HHA first enrolled in Medicare. Consider the following illustrations:

Example 1 – Smith HHA initially enrolls in Medicare effective July 1, 2009. Smith undergoes a change in majority ownership effective September 1, 2011. The provisions of § 424.550(b)(1) apply to Smith because it underwent a change in majority ownership within 36 months of its initial enrollment.

Example 2 – Jones HHA initially enrolls in Medicare effective July 1, 2007. Jones undergoes a change in majority ownership effective February 1, 2011. Section 424.550(b)(1) does not apply to this transaction because it occurred more than 36 months after Jones's initial enrollment. Suppose, however, that Jones undergoes another change in majority ownership effective February 1, 2012. Section 424.550(b)(1) does apply to this transaction because it took place within 36 months after Jones's most recent change in majority ownership (i.e., on February 1, 2011).

Implementation of home health agency payment safeguard provisions (continued)

Example 3 – Johnson HHA initially enrolls in Medicare effective July 1, 2006. It undergoes a change in majority ownership effective October 1, 2010. This transaction is not affected by Section 424.550(b)(1) – as enacted in CMS-6010-F – because: (1) its effective date was prior to January 1, 2011, and (2) it occurred more than 36 months after the effective date of Johnson’s initial enrollment. Johnson undergoes another change in majority ownership effective October 1, 2012. This change is affected by Section 424.550(b)(1) because it occurred within 36 months of the HHA’s most recent change in majority ownership (i.e., on October 1, 2010).

Example 4 – Davis HHA initially enrolls in Medicare effective July 1, 1999. It undergoes its first change in majority ownership effective February 1, 2011. This change is not affected by Section 424.550(b)(1) because it occurred more than 36 months after Davis’s initial enrollment. Davis undergoes another change in majority ownership effective July 1, 2014. This change, too, is unaffected by Section 424.550(b)(1), as it occurred more than 36 months after the HHA’s most recent change in majority ownership (i.e., on February 1, 2011). Davis undergoes another majority ownership change on July 1, 2016. This change is impacted by Section 424.550(b)(1), since it occurred within 36 months of the HHA’s most recent change in majority ownership (i.e., on July 1, 2014).

2. Capitalization

Effective January 1, 2011, and pursuant to 42 CFR Sections 489.28(a) and 424.510(d)(9), an HHA entering the Medicare program - including a new HHA as a result of a change of ownership if the change of ownership results in a new provider number being issued - must have available sufficient funds, which we term “initial reserve operating funds,” at (1) the time of application submission, and (2) all times during the enrollment process, to operate the HHA for the three month period after Medicare billing privileges are conveyed by the Medicare contractor (exclusive of actual or projected accounts receivable from Medicare). This means that the HHA must also have available sufficient initial reserve operating funds during the three month period following the conveyance of Medicare billing privileges.

Additional information

The official instruction, CR 7256, issued to your FI, RHHI or A/B MAC, regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R362PI.pdf>.

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

The CMS final rule, titled: “CMS-1510-F: Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices,” may be found at <http://edocket.access.gpo.gov/2010/pdf/2010-27778.pdf>.

MLN Matters® Number: MM7256

Related Change Request (CR) #: 7256

Related CR Release Date: December 17, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R362PI

Implementation Date: January 1, 2011

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Home health prospective payment system rate update for calendar year 2011

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

Provider types affected

Home health agencies (HHAs) submitting claims to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (A/B MACs) for Medicare beneficiaries are affected.

Provider action needed

This article informs you that change request (CR) 7253 directs Medicare contractors to update the 60-day national episode rates, national per-visit rates, low utilization payment adjustment (LUPA) add-on amount, and non-routine supplies (NRS) payment amounts under the HH PPS for CY 2011. The attached recurring update notification applies to Chapter 10, Section 10.1.6 of the *Medicare Claims Processing Manual* (Pub. 100-04). Please be sure to inform your staff of the information in the *Background* and *Policy* sections of this article.

Background

Section 1895 (b)(3)(B)(v) of the Social Security Act provides that Medicare payments be updated by the applicable market basket percentage increase for CY 2011. Section 3401(e) of The Affordable Care Act amended Section 1895(b)(3)(B) of The Social Security Act by adding a new clause (vi) which states, "After determining the HH market basket percentage increase ... the Secretary shall reduce such percentage ... for each of 2011, 2012, and 2013, by 1 percentage point. The application of this clause may result in the HH market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year." The HH market basket percentage increase for CY 2011 is 2.1 percent. However, after reducing it by 1 percentage point as required by the Affordable Care Act, the HH market basket update for CY 2011 becomes 1.1 percent. In addition, Section 1895 (b)(3)(B)(v) of the Social Security Act requires that HHAs report such quality data as determined by the Secretary of Health and Human Services. HHAs that do not report the required quality data will receive a 2 percent reduction to the HH market basket percentage increase of -0.9 percent for CY 2011.

Section 3131(b)(1) of The Affordable Care Act amended Section 1895(b)(3)(C) of the Social Security Act, "Adjustment for outliers," to state, "The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to HH services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period." In addition, Section 3131(b)(2) of the Affordable Care Act amended Section 1895(b)(5) of The Social Security Act by re-designating the existing language as Section 1895(b)(5)(A) of the Social Security Act, and revising it to state that the Secretary, "may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year." As such, the Centers for Medicare & Medicaid Services (CMS) HH PPS outlier policy must reduce payment rates by 5 percent, and target up to 2.5 percent of total estimated HH PPS payments to be paid as outlier payments.

For CY 2010, CMS implemented a one-year agency-level cap by limiting HH outlier payments to be no more than 10 percent of an agency's total payments. Section 3131(b)(2)(C) of the Affordable Care Act makes this 10 percent agency-level cap a statutory requirement, by adding a paragraph, (B) "Program Specific Outlier Cap", to Section 1895(b)(5) of the Social Security Act. The new paragraph states, "The estimated total amount of additional payments or payment adjustments made ... with respect to a HHA for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the HHA for the year". Therefore, the 10 percent agency-level outlier cap will continue in CY 2011 and subsequent calendar years.

In addition, Section 3131(c) of the Affordable Care Act amended Section 421(a) of the Medicare Modernization Act (MMA), which was amended by Section 5201(b) of the Deficit Reduction Act of 2005 (DRA). The amended Section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Social Security Act for HH services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Social Security Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Social Security Act applicable to HH services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Specifics of the HH PPS update for 2011 are as follows:

1) Market basket update

The HH market basket percentage increase for CY 2011 is 2.1 percent. After reducing it by 1 percentage point as required by the Affordable Care Act, the HH market basket update for CY 2011 becomes 1.1 percent. HHAs that do not report the required quality data will receive a two percent reduction to the HH market basket update of 1.1 percent resulting in a HH market basket update of -0.9 percent for CY 2011.

2) Outlier payments

Section 3131(b) of the Affordable Care Act requires the following outlier policy: (1) reduce the standard payment amount (or amounts) by five percent; (2) target to pay no more than 2.5 percent of estimated total payments for outliers; and

Home health prospective payment system rate update for calendar year 2011 (continued)

(3) apply a 10 percent agency-level cap on outlier payments as a percentage of total HH PPS payments.

CMS will first return the 2.5 percent held for the target CY 2010 outlier pool to the CY 2011 payment rates. CMS will then reduce these rates by five percent as required by Section 1895(b)(3)(C) of the Social Security Act, as amended by Section 3131(b)(1) of the Affordable Care Act. For CY 2011 and subsequent calendar years, the total amount of the additional payments or payment adjustments made may not exceed 2.5 percent of the total payments projected or estimated to be made based on the PPS in that year as required by Section 1895(b)(5)(A) of the Social Security Act, as amended by Section 3131(b)(2)(B) of the Affordable Care Act. Per Section 3131(b)(2)(C) of The Affordable Care Act, outlier payments to HHAs will be capped at 10 percent of that HHA's total HH PPS payments.

The fixed dollar loss ratio of 0.67 and the loss-sharing ratio of 0.80, used to calculate outlier payments for CY 2010, remain unchanged for CY 2011.

3) Rural add-on

As stipulated in Section 3131(c) of The Affordable Care Act, the three percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit rates, low utilization payment adjustment (LUPA) add-on payment, and non-routine medical supply conversion factor when HH services are provided in rural (non-CBSA) areas.

4) Payment calculations and rate tables

In order to calculate the CY 2011 national standardized 60-day episode payment rate, CMS will first increase the CY 2010 national standardized 60-day episode payment rate to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010. CMS will then reduce that adjusted payment amount by five percent, to account for the new outlier policy as established per Section 3131(b)(1) of the Affordable Care Act. Next, CMS updates the payment amount by the CY 2011 HH market basket update of 1.1 percent (the 2.1 percent HH market basket update percentage minus one percentage point, per Section 3401(e)(2) of the Affordable Care Act).

CMS' updated analysis of the change in case-mix that is not due to an underlying change in patient health status reveals additional increase in nominal change in case-mix. Therefore, CMS next reduced rates by 3.79 percent resulting in an updated CY 2011 national standardized 60-day episode payment rate. The updated CY 2011 national standardized 60-day episode payment rate for an HHA that submits the required quality data is shown in Table 1. These payments are further adjusted by the individual episode's case-mix weight and wage index.

Table 1 - For HHAs that DO submit quality data – national 60-day episode amounts updated by the HH market basket update for CY 2011 before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary

Total CY 2010 national standardized 60-day episode payment rate	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by five percent due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the HH market basket update of 1.1 percent	Reduce by 3.79 percent for nominal change in case-mix	CY 2011 national standardized 60-day episode payment rate
\$2,312.94	÷ 0.975	X 0.95	X 1.011	X 0.9621	\$2,192.07

The updated CY 2011 national standardized 60-day episode payment rate for an HHA that does not submit the required quality data is subject to a HH market basket update of 1.1 percent reduced by two percentage points as shown in Table 2. These payments are further adjusted by the individual episode's case-mix weight and wage index.

Table 2 - For HHAs that DO NOT submit quality data – national 60-day episode payment amount updated by the HH market basket update (minus two percentage points) for CY 2011 before case-mix adjustment and wage adjustment based on the site of service for the beneficiary

CY 2010 national standardized 60-day episode payment rate	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by five percent due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the HH market basket update of 1.1 percent minus two percentage points (-0.9 percent)	Reduce by 3.79 percent for nominal change in case-mix	CY 2011 national standardized 60-day episode payment rate.
\$2,312.94	÷ 0.975	X 0.95	X 0.991	X 0.9621	\$2,148.71

In calculating the CY 2011 national per-visit rates used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations, the CY 2010 national per-visit rates for each discipline are first adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010. These national per-visit rates are then reduced by five percent as mandated by Section 1895(b)(3)(C) of the Social Security Act, as amended by Section 3131(b)(1) of the Affordable Care Act. Finally, the national per-visit rates are updated by the CY 2011 HH market basket update of 1.1 percent for HHAs that submit quality data, and by 1.1 percent minus two percentage points (-0.9 percent) for HHAs that do not submit quality data.

GENERAL INFORMATION

Home health prospective payment system rate update for calendar year 2011 (continued)

The CY 2011 national per-visit rates per discipline are shown in Table 3. The six HH disciplines are as follows:

- HH aide (HH aide)
- Medical social services (MSS)
- Occupational therapy (OT)
- Physical therapy (PT)
- Skilled nursing (SN), and
- Speech language pathology therapy (SLP).

Table 3 -National per-visit amounts for LUPAs (not including the LUPA add-on amount for a beneficiary's only episode or the initial episode in a sequence of adjacent episodes) and outlier calculations updated by the CY 2011 HH market basket update, before wage index adjustment							
				For HHAs that DO submit quality data		For HHAs that DO NOT submit quality data	
HH discipline type	CY 2010 per-visit amounts per 60-day episode	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by 5 percent due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the HH market basket update of 1.1 percent	CY 2011 per-visit payment amount for HHAs that DO submit the required quality data	Multiply by the HH market basket update of 1.1 percent minus two percentage points (-0.9 percent)	CY 2011 per-visit payment amount for HHAs that DO NOT submit the required quality data
HH aide	\$51.18	÷ 0.975	X 0.95	X 1.011	\$50.42	X 0.991	\$49.42
MSS	\$181.16	÷ 0.975	X 0.95	X 1.011	\$178.46	X 0.991	\$174.93
OT	\$124.40	÷ 0.975	X 0.95	X 1.011	\$122.54	X 0.991	\$120.12
PT	\$123.57	÷ 0.975	X 0.95	X 1.011	\$121.73	X 0.991	\$119.32
SN	\$113.01	÷ 0.975	X 0.95	X 1.011	\$111.32	X 0.991	\$109.12
SLP	\$134.27	÷ 0.975	X 0.95	X 1.011	\$132.27	X 0.991	\$129.65

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. The CY 2011 LUPA add-on payment is updated in Table 4.

Table 4 - CY 2011 LUPA add-on amounts							
				For HHAs that DO submit quality data		For HHAs that DO NOT submit quality data	
CY 2010 LUPA add-on amount adjusted to return the outlier funds that paid for the original five percent target for outliers	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by five percent due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the HH market basket update of 1.1 percent	CY 2011 LUPA add-on amount for HHAs that DO submit required quality data	Multiply by the HH market basket update of 1.1 percent minus two percentage points (-0.9 percent)	CY 2011 LUPA add-on amount for HHAs that DO NOT submit required quality data	
\$94.72	÷ 0.975	X 0.95	X 1.011	\$93.31	X 0.991	\$91.46	

Payments for NRS are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. The NRS conversion factor for CY 2011 payments is updated in Table 5a.

Table 5a - CY 2011 NRS conversion factor for HHAs that DO submit quality data				
CY 2010 NRS conversion factor	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by five percent due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the HH market basket update (1.1 percent)	CY 2011 NRS conversion factor
53.34	÷ 0.975	X 0.95	X 1.011	\$52.54

Home health prospective payment system rate update for calendar year 2011 (continued)

The payment amounts for the various NRS severity levels based on the updated conversion factor are shown in Table 5b.

Table 5b - Relative weights for the 6-severity NRS system for HHAs that DO submit quality data			
Severity level	Points (scoring)	Relative weight	NRS payment amount
1	0	0.2698	\$14.18
2	1 to 14	0.9742	\$51.18
3	15 to 27	2.6712	\$140.34
4	28 to 48	3.9686	\$208.51
5	49 to 98	6.1198	\$321.53
6	99+	10.5254	\$553.00

The NRS conversion factor for HHAs that do not submit quality data is shown in Table 6a.

Table 6a - CY 2011 NRS conversion factor for HHAs that DO NOT submit quality data				
CY 2010 NRS conversion factor	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by five percent due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the HH market basket update (1.1 percent) minus two percentage points (-0.9 percent)	CY 2011 NRS conversion factor
53.34	÷ 0.975	X 0.95	X 0.991	\$51.50

The payment amounts for the various NRS severity levels based on the updated conversion factor are shown in Table 6b.

Table 6b - Relative weights for the 6-severity NRS system for HHAs that DO NOT submit quality data			
Severity level	Points (scoring)	Relative weight	NRS payment amount
1	0	0.2698	\$13.89
2	1 to 14	0.9742	\$50.17
3	15 to 27	2.6712	\$137.57
4	28 to 48	3.9686	\$204.38
5	49 to 98	6.1198	\$315.17
6	99+	10.5254	\$542.06

The three percent rural add-on, per Section 3131(c) of the Affordable Care Act, is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when HH services are provided in rural (non-CBSA) areas. Refer to tables 7 thru 10b for these payment rates.

Table 7 - CY 2011 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustment					
For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2011 national standardized 60-day episode payment rate	Multiply by the three percent rural add-on	Total CY 2011 national standardized 60-day episode payment rate	CY 2011 national standardized 60-day episode payment rate	Multiply by the three percent rural add-on	Total CY 2011 national standardized 60-day episode payment rate
\$2,192.07	X 1.03	\$2,257.83	\$2,148.71	X 1.03	\$2,213.17

Table 8 - Per-visit amounts for services provided in a rural area, before wage index adjustment						
HH discipline type	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
	CY 2011 per-visit rate For HHAs that DO submit quality data	Multiply by the three percent rural add-on	Total CY 2011 per-visit rate for rural area	CY 2011 per-visit rate for HHAs that DO NOT submit quality data	Multiply by the three percent rural add-on	Total CY 2011 per-visit rate for rural areas
HH aide	\$50.42	X 1.03	\$51.93	\$49.42	X 1.03	\$50.90
MSS	\$178.46	X 1.03	\$183.81	\$174.93	X 1.03	\$180.18
OT	\$122.54	X 1.03	\$126.22	\$120.12	X 1.03	\$123.72
PT	\$121.73	X 1.03	\$125.38	\$119.32	X 1.03	\$122.90
SN	\$111.32	X 1.03	\$114.66	\$109.12	X 1.03	\$112.39
SLP	\$132.27	X 1.03	\$136.24	\$129.65	X 1.03	\$133.54

Home health prospective payment system rate update for calendar year 2011 (continued)

Table 9 - Total CY 2011 LUPA add-on amounts for services provided in rural areas					
For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2011 LUPA add-on amount For HHAs that DO submit quality data	Multiply by the three percent rural add-on	Total CY 2011 LUPA add-on amount for rural areas	CY 2011 LUPA add-on amount For HHAs that DO NOT submit quality data	Multiply by the three percent rural add-on	Total CY 2011 LUPA add-on amount for rural areas
\$93.31	X 1.03	\$96.11	\$91.46	X 1.03	\$94.20

Table 10a - Total CY 2011 conversion factor for services provided in rural areas					
For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2011 conversion factor for HHAs that DO submit quality data	Multiply by the three percent rural add-on	Total CY 2011 conversion factor for rural areas	CY 2011 conversion factor for HHAs that DO NOT submit quality data	Multiply by the three percent rural add-on	Total CY 2011 conversion factor for rural areas
\$52.54	X 1.03	\$54.12	\$51.50	X 1.03	\$53.05

Table 10b - Relative weights for the 6-severity NRS system for services provided in rural areas					
		For HHAs that DO submit quality data (NRS conversion factor=\$54.12)		For HHAs that DO NOT submit quality data (NRS conversion factor=\$53.05)	
Severity level	Points (scoring)	Relative weight	Total NRS payment amount for rural areas	Relative weight	Total NRS payment amount for rural areas
1	0	0.2698	\$14.60	0.2698	\$14.31
2	1 to 14	0.9742	\$52.72	0.9742	\$51.68
3	15 to 27	2.6712	\$144.57	2.6712	\$141.71
4	28 to 48	3.9686	\$214.78	3.9686	\$210.53
5	49 to 98	6.1198	\$331.20	6.1198	\$324.66
6	99+	10.5254	\$569.63	10.5254	\$558.37

Additional information

The official instruction, CR 7253 issued to your FI, RHHI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2116CP.pdf>. If you have any questions, please contact your FI, RHHI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7253
 Related Change Request (CR) #: 7253
 Related CR Release Date: December 10, 2010
 Effective Date: January 1, 2011
 Related CR Transmittal #: R2116CP
 Implementation Date: January 3, 2011

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Feedback page

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

Claim modifiers for use in the DMEPOS Competitive Bidding Program

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

Provider types affected

All Medicare fee-for-service (FFS) providers and suppliers who provide durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to Medicare beneficiaries with original Medicare who reside in a Competitive Bidding Area (CBA), including: contract and non-contract suppliers; physicians and other treating practitioners providing walkers to their own patients; hospitals providing walkers to their own patients; and skilled nursing facilities (SNFs) and nursing facilities (NFs) that provide enteral nutrition to residents with a permanent residence in a CBA.

Background

Under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding program, beneficiaries with original Medicare who obtain competitive bidding items in designated CBAs are required to obtain these items from a contract supplier, unless an exception applies. The first phase of the program begins on January 1, 2011, in nine CBAs for nine product categories.

In order for Medicare to make payment, where appropriate, for claims subject to competitive bidding, it is important that all providers and suppliers who provide DMEPOS affected by the program use the appropriate modifiers on each claim.

Note: To ensure accurate claims processing, it is critically important for suppliers to submit each claim using the billing number/national provider identifier (NPI) of the location that furnished the item or service being billed.

Competitive bidding modifiers

New Healthcare Common Procedure Coding System (HCPCS) modifiers have been developed to facilitate implementation of various policies that apply to certain competitive bidding items. The new HCPCS modifiers used in conjunction with claims for items subject to competitive bidding are defined as follows:

J4: DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished by a Hospital Upon Discharge.

KG: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1.

KK: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2.

KU: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3.

KW: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4.

KY: DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5.

KL: DMEPOS Item Delivered via Mail.

KV: DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished as Part of a Professional Service.

KT: Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Area and Receives a Competitive Bid Item.

Suppliers should submit claims for competitive bidding items using the appropriate HCPCS code and corresponding competitive bidding modifier in effect during a contract period. The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The modifiers associated with particular competitive-bid codes, such as modifiers KG, KK, or KL, are listed by competitive-bid product category on the single payment amount public use charts found under the supplier page at <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf>.

Failure to use or inappropriate use of a competitive bidding modifier on a competitive bidding claim leads to claims denial. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Another modifier was developed to facilitate implementation of DMEPOS fee schedule policies that apply to certain competitive bidding items that were bid prior to July 1, 2008, under the initial Round I of the DMEPOS Competitive Bidding Program. The modifier KE is defined as follows:

KE: DMEPOS Item Subject to DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment.

How to use the modifiers

Hospitals providing walkers and related accessories to their patients on the date of discharge - modifier J4

Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Please note that separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who

Claim modifiers for use in the DMEPOS Competitive Bidding Program (continued)

live in a CBA must affix the modifier J4, to claims submitted for these items.

The modifier J4 should not be used by contract suppliers.

Modifiers for HCPCS accessory or supply codes furnished in multiple product categories – modifiers KG, KK, KU, and KW

The modifiers KG, KK, KU, and KW are used to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and non-competitively bid items. For example, HCPCS code E0981 (*Wheelchair Accessory, Seat Upholstery, Replacement Only, Each*) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a standard power wheelchair shall submit E0981 claims using the modifier KG. Contract suppliers for the complex rehabilitative power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a complex power wheelchair shall submit claims for E0981 using the modifier KK. Another example of the use of the modifier KG modifier is with code A4636 (*Replacement, Handgrip, Cane, Crutch, or Walker, Each*). Contract suppliers for the walkers and related accessories product category in addition to other suppliers submitting claims for this accessory item when used with a walker shall submit A4636 claims using the modifier KG.

All suppliers that submit claims for beneficiaries that live in a CBA, including contract, non-contract, and grandfathered suppliers, should submit claims for competitive-bid items using the above mentioned competitive bidding modifiers. Non-contract suppliers that furnish competitively bid supply or accessory items to traveling beneficiaries who live in a CBA must use the appropriate modifier KG or KK with the supply or accessory HCPCS code when submitting their claim. Also, grandfathered suppliers that furnish competitively bid accessories or supplies used in conjunction with a grandfathered item must include the appropriate modifier KG or KK when submitting claims for accessory or supply codes. The modifier KG and KK are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the modifier KU and KW are reserved for future program use.

The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers (i.e. KG, KK, KL) are denoted in the single payment amount public-use charts found under the supplier page at <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf>.

Purchased accessories and supplies for use with grandfathered equipment – modifier KY

Non-contract grandfathered suppliers must use the modifier KY on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011, for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the modifier KY is authorized:

- Continuous positive airway pressure devices, respiratory assistive devices, and related supplies and accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562
- Hospital beds and related accessories – E0271, E0272, E0280, and E0310, and
- Walkers and related accessories – E0154, E0156, E0157 and E0158

Until notified otherwise, grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. The single payment amounts for items included in the Round 1 Rebid of the DMEPOS Competitive Bidding Program may be found under the Single Payment Amount tab on the following website: <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/docsCat/Suppliers>. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the modifier KY will be denied. Also, claims submitted with the modifier KY for HCPCS codes other than those listed above will be denied.

After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

Mail order diabetic supplies – modifier KL

Contract suppliers must use the modifier KL on all claims for diabetic supply codes that are furnished via mail order. Non-contract suppliers that furnish mail-order diabetic supplies to beneficiaries who do not live in CBAs must also continue to use the modifier KL with these codes. Suppliers that furnish mail-order diabetic supplies that fail to use the HCPCS modifier KL on the claim may be subject to significant penalties. For claims with dates of service prior to implementation of a national mail order competitive bidding program, the modifier KL is not used with diabetic supply codes that are not delivered to the beneficiary's residence via mail order or are obtained from a local supplier storefront. Once a national mail order competitive bidding program is implemented, the definition for mail order item will change to include all diabetic supply codes delivered to the beneficiary via any means. At this time, the modifier KL will need to be used for all diabetic supply codes except for claims for items that a beneficiary or caregiver picks up in person from a local pharmacy or supplier storefront.

*Claim modifiers for use in the DMEPOS Competitive Bidding Program (continued)***Physicians and treating practitioners who furnish walkers and related accessories to their own patients but who are not contract suppliers – modifier KV**

The modifier KV is to be used by physicians and treating practitioners who are not contract suppliers and who furnish walkers and related accessories to beneficiaries in a CBA. Walkers that are appropriately furnished in accordance with this exception will be paid at the single payment amount.

To be paid for walkers as a non-contract supplier, physicians and treating practitioners should use the modifier KV in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. On the claim billed to the durable medical equipment Medicare administrative contractor (DME MAC), the walker line item must have the same date of service as the professional service office visit billed to the Part A/Part B MAC. Physicians and treating practitioners are advised to submit the office visit claim and the walker claim on the same day to ensure timely and accurate claims processing.

Physicians and treating practitioners who are located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries who live in a CBA must affix the modifier KV to claims submitted for these items.

The modifier KV should not be used by contract suppliers.

Traveling beneficiaries - modifier KT

Suppliers must submit claims with the modifier KT for non-mail-order DMEPOS competitive bidding items that are furnished to beneficiaries who have traveled outside of the CBA in which they reside. If a beneficiary who lives in a CBA travels to an area that is not a CBA and obtains an item included in the competitive bidding program, the non-contract supplier must affix this modifier to the claim. Similarly, if a beneficiary who lives in a CBA travels to a different CBA and obtains an item included in the competitive bidding program from a contract supplier for that CBA, the contract supplier must use the modifier KT.

SNFs and NFs that are not contract suppliers and are not located in a CBA must also use the modifier KT on claims for enteral nutrition items furnished to residents with a permanent home address in a CBA. SNF or NF claims that meet these criteria and are submitted without the modifier KT will be denied.

Claims for mail-order competitive bidding diabetic supplies submitted with the modifier KT will be denied. Contract suppliers must submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary's permanent home address.

To determine if a beneficiary permanently resides in a CBA, a supplier should follow these two simple steps:

1. Ask the beneficiary for the ZIP code of his or her permanent residence. This is the address on file with the Social Security Administration (SSA).
2. Enter the beneficiary's ZIP code into the CBA finder tool on the home page of the Competitive Bidding Implementation Contractor (CBIC) website, found at www.dmecompetitivebid.com.

Modifier KE

Section 154(a)(2) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandated a fee schedule covered item update of -9.5 percent for 2009 for items included in the Round I of the DMEPOS Competitive Bidding Program. This covered item update reduction to the fee schedule file applies to items furnished on or after January 1, 2009, in any geographical area. In order to implement the covered item update required by MIPPA, the modifier KE was added to the DMEPOS fee schedule file in 2009 to identify Round I competitively bid accessory codes that could be used with both competitively-bid and non-competitively bid base equipment. All suppliers must use the modifier KE on all Part B fee-for-service claims to identify when a Round I bid accessory item is used with a non-competitively-bid base item (an item that was not competitively bid prior to July 2008).

For example, HCPCS code E0950 (*Wheelchair Accessory, Tray, Each*) can be used with both Round I competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). All suppliers must use the modifier KE with the accessory code to identify when E0950 is used in conjunction with a non-competitively bid manual wheelchair (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). The modifier KE should not be used with competitive-bid accessory HCPCS codes that are used with any competitive-bid base item that was included in the initial Round I of the competitive bidding program prior to July 1, 2008. Therefore, in the above example, modifier KE is not valid for use with accessory code E0950 when used with standard power wheelchairs, complex rehabilitative power wheelchairs (Group 2 or Group 3), or any other item selected for competitive bidding prior to July 1, 2008.

For beneficiaries living in competitive-bid areas on or after January 1, 2011, suppliers should not use the modifier KE to identify competitively bid accessories used with base equipment that was competitively bid under the Round I Rebid Competitive Bidding Program. Rather, such claims should be submitted using the appropriate modifiers KG or KK as identified on the single payment amount public-use charts found under the supplier page at www.dmecompetitivebid.com/Palmetto/Cbic.nsf.

The following page contains a chart that illustrates the relationship between the competitive-bid modifiers (KG, KK, KU, and KW) and the modifier KE using competitively bid accessory code E0950:

Claim modifiers for use in the DMEPOS Competitive Bidding Program (continued)

Accessory code E0950 used with a:	Base code competitive-bid status	Claim for a beneficiary who permanently lives in a CBA	Claim for a beneficiary who permanently lives Outside a CBA*
Manual wheelchair (K0001 thru K0009) or miscellaneous power wheelchair (K0898)	non-bid	Bill with modifier KE	Bill with modifier KE
Standard power wheelchair (K0813 thru K0829)	Bid in Round 1 and the Round 1 Rebid	Bill with modifier KG	Bill without modifier KE
Complex rehabilitative group 2 power wheelchair (K0835 thru K0843)	Bid in Round 1 and the Round 1 Rebid	Bill with modifier KK	Bill without modifier KE
Complex rehabilitative group 3 power wheelchair (K0848 thru K0864)	Bid in Round 1	Bill without modifier KE, KK or KG	Bill without modifier KE

* The competitive bid modifiers (KG, KK, KU, and KW) are only used on claims for beneficiaries that live in a competitive bidding area (CBA).

Additional information

The Medicare Learning Network® (MLN) has prepared several fact sheets with information for non-contract suppliers and referral agents, including fact sheets on the hospital and physician exceptions, enteral nutrition, mail-order diabetic supplies, and traveling beneficiaries, as well as general fact sheets for non-contract suppliers and referral agents. They are all available, free of charge, at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf.

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>.

Information for contract suppliers may be found at the CBIC website at <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home>. Beneficiary-related information may be found at <http://www.medicare.gov>.

MLN Matters Number: SE1035
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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DMEPOS competitive bidding updates

There are three updates that will be of interest to the provider community regarding the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program:

Information mailed to referral agents

The DMEPOS competitive bidding program went into effect for nine product categories in nine competitive bidding areas (CBAs) on January 1, 2011. When the program became effective, beneficiaries with original Medicare who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies.

The nine product categories are:

- Oxygen, oxygen equipment, and supplies
- Standard power wheelchairs, scooters, and related accessories
- Complex rehabilitative power wheelchairs and related accessories (group 2 only)
- Mail-order diabetic supplies
- Enteral nutrients, equipment, and supplies
- Continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories, and
- Support surfaces (group 2 mattresses and overlays in Miami-Fort Lauderdale-Pompano Beach, FL only).

The nine competitive bidding areas are:

- Charlotte-Gastonia-Concord, NC-SC
- Cincinnati-Middletown, OH-KY-IN
- Cleveland-Elyria-Mentor, OH
- Dallas-Fort Worth-Arlington, TX
- Kansas City, MO-KS
- Miami-Fort Lauderdale-Pompano Beach, FL
- Orlando-Kissimmee, FL
- Pittsburgh, PA
- Riverside-San Bernardino-Ontario, CA

It is crucial that health care professionals who order items included in the program understand how this program affects their Medicare patients so that Medicare will continue to pay for covered services. Therefore, the Centers for Medicare & Medicaid Services (CMS) began mailing a letter to referral agents in CBAs to remind them that the program started January 1, 2011. For purposes of the Medicare DMEPOS competitive bidding program, “referral agent” includes such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, and pharmacists who refer beneficiaries for services in a CBA. A copy of the letter is now available on the CMS website at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp.

Supplier locator tool updated for DMEPOS competitive bidding

CMS has updated its online supplier locator tool with new features for the DMEPOS competitive bidding program. Here’s how to access a list of DMEPOS competitive bidding contract suppliers for a particular beneficiary’s competitive bidding area using the updated online supplier locator tool:

Visit <http://www.Medicare.gov/supplier>.

- Enter the Medicare beneficiary’s zip code and click “Submit.”
- A list of product categories will appear; those product categories with a star icon next to them are included in the competitive bidding program.
- After selecting a competitive bidding product category, click “View Results.”
- A page will display stating you’ve selected a competitive bidding product category and briefly explain the program; click “Continue.”
- A list of all Medicare contract supplier locations in the competitive bidding area will appear.

A list of the CMS-designated Medicare DMEPOS competitive bidding program contract suppliers for each CBA may also be found at http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp.

DMEPOS Competitive Bidding Program “Repairs and Replacements Fact Sheet”

The DMEPOS Competitive Bidding Program “Repairs and Replacements Fact Sheet” is now available to download, free of charge, from the *Medicare Learning Network*[®].

Effective 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. One exception occurs when an item of DMEPOS that a beneficiary already owns needs to be repaired.

This fact sheet contains helpful information on competitive bidding program rules that apply when an item of DMEPOS that is owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services noncontract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, Scroll down to “Downloads,” and select “DMEPOS Competitive Bidding Fact Sheets.”

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Source: CMS PERL 201012-29

ELECTRONIC HEALTH RECORDS

First payments issued under the Medicaid EHR incentive program

The first payments under the Medicaid electronic health record (EHR) incentive program were issued by Oklahoma and Kentucky on January 5. Kentucky processed payment to the University of Kentucky's teaching hospital, University of Kentucky Healthcare. The first payment, \$2.86 million, was one-third of the hospital's overall expected amount for participating in the program. Oklahoma issued payments to two physicians at the Gastorf Family Clinic of Durant, Okla. for \$21,250 each, for having adopted certified EHRs. These incentive payments for the adoption of certified EHR technology are federally-funded under the Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the American Recovery and Reinvestment Act of 2009.

For additional information on these actions by Oklahoma and Kentucky, please visit their websites:

<http://www.okhca.org/EHR-incentive> and <http://chfs.ky.gov/dms/EHR.htm>.

For more information on the Medicare and Medicaid electronic health records incentive programs, please visit CMS' EHR website at <http://www.cms.gov/EHRIncentivePrograms/>.

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Registration for Medicare & Medicaid EHR incentive programs now open

The Centers for Medicare & Medicaid Services (CMS) encourages eligible professionals, eligible hospitals, and critical access hospitals to register for the Medicare and/or Medicaid EHR incentive program(s) as soon as possible. You can register before you have a certified EHR. Register even if you do not have an enrollment record in the provider enrollment, chain and ownership system (PECOS).

The registration and attestation page (http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp) on the EHR Web page now contains the following:

- Instructions to promote a smooth registration process
- User guides
- Link to the registration site

Click on the tabs to the left of this page for more general information on the EHR incentive programs.

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

Source: CMS PERL 201101-13

Electronic health records incentive programs – information about provider registration

Registration began January 3, 2011 – are you ready? The new electronic health records (EHR) Web page may help. CMS is happy to announce an updated, reorganized, and more user-friendly website for the EHR incentive programs, still located at <http://www.CMS.gov/EHRIncentivePrograms>. Highlights of this update are described in this message.

We encourage providers to register for the Medicare and/or Medicaid EHR incentive programs as soon as possible. You can register before you have a certified EHR and should do so even if you do not have an enrollment record in PECOS.

- **Hospitals:** Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select “Both Medicare and Medicaid” during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select “Both Medicare and Medicaid” from the start of registration in order to maintain this option. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to “Both Medicare and Medicaid” or from one program to the other) after a payment is initiated, and this may cause significant delays in receiving a Medicare EHR incentive payment.
- **Eligible professionals:** Professionals eligible for both the Medicare and Medicaid EHR incentive programs must choose which incentive program they wish to participate in when they register. Until 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR incentive program.

Electronic health records incentive programs – information about provider registration (continued)

- **Registration:** Learn how you can prepare at registration. This is also where you will find the link to register. Information on when registration will be available for Medicaid EHR incentive programs in specific states is posted at Medicaid state information.

Highlights of the Web update include:

- **Path to payment:** What steps must you take to receive an EHR incentive payment? Review this page to find out.
- **Meaningful use:** What is “meaningful use?” What are the criteria for meaningful use? How do I meet the meaningful use requirements? Learn answers to these questions and more. The EHR page now includes meaningful use objectives specification sheets for the Medicare and Medicaid EHR incentive programs. These bring together critical information on each objective to help eligible professionals and eligible hospitals/critical access hospitals understand what they need to do to demonstrate meaningful use successfully.
- **Educational materials:** Want to learn about eligibility, payment, and meaningful use? See these educational products to learn more.
- **Frequently asked questions:** Have questions? See these responses to frequently asked questions on topics including eligibility, program timeline, and meaningful use.

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

Source: CMS PERL 201012-43

Electronic health records incentives – registration opens Resources outlined to assist eligible providers

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced the availability of registration for the Medicare and Medicaid electronic health record (EHR) incentive programs. CMS and ONC encouraged broad participation and outlined online and in-person resources that are in place to assist eligible professionals and eligible hospitals who wish to participate.

Registration became available for eligible health care professionals and eligible hospitals who wish to participate in the Medicare EHR incentive program on January 3. Registration in the Medicaid EHR incentive program also is available in Alaska, Iowa, Kentucky, Louisiana, Oklahoma, Michigan, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. In February, registration will open in California, Missouri, and North Dakota. Other states likely will launch their Medicaid EHR incentive programs during the spring and summer of 2011.

“With the start of registration, these landmark programs get underway, and patients, providers, and the nation can begin to enjoy the benefits of widespread adoption of electronic health records,” said CMS Administrator Donald Berwick, MD. “CMS has many resources available to help providers register and participate, and we look forward to working with eligible professionals and eligible hospitals to facilitate the process, beginning on January 3 and going forward.”

“It’s time to get connected,” said David Blumenthal, MD, MPP, National Coordinator for Health Information Technology. “ONC and CMS have worked together over many months to prepare for the startup on January 3. ONC’s [Certified HIT Product List](#) includes more than 130 certified EHR systems or modules and is updated frequently. ONC also has hands-on assistance available across the country through [62 Regional Extension Centers](#). We look forward to continuing to work with CMS to assist eligible providers in 2011 and future years.”

Eligible professionals and eligible hospitals must register in order to participate in the Medicare and Medicaid EHR incentive programs. They can do so, starting January 3, 2011, at a registration site maintained by CMS.

To prepare for registration, interested providers should first familiarize themselves with the incentive programs’ requirements by visiting CMS’ [official Web page for the Medicare and Medicaid EHR incentive programs](#). The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

CMS announced the following key dates for the Medicare and Medicaid incentive programs’ first year:

- January 3, 2011 – registration for the Medicare EHR incentive program begins.
- January 3, 2011 – states that are ready may launch their incentive programs for Medicaid providers.
- January 2011 – some state agencies begin issuing Medicaid EHR incentive payments.
- April 2011 – attestation for the Medicare EHR incentive program begins.
- May 2011 – issuing of Medicare EHR incentive payments expected to begin.
- July 3, 2011 – last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR incentive program for federal FY 2011.
- September 30, 2011 – federal FY 2011 payment year ends at midnight for eligible hospitals and critical access hospitals (CAHs).

Electronic health records incentives – registration started January 3 (continued)

- October 3, 2011 – last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 to demonstrate meaningful use for the Medicare EHR incentive program.
- November 30, 2011 – last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for federal fiscal year 2011.
- December 31, 2011 – calendar 2011 payment year ends for eligible professionals.

Under the Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009, Medicare and Medicaid incentive payments will be available to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) when they adopt certified EHR technology and successfully demonstrate “meaningful use” of the technology in ways that improve quality, safety, and effectiveness of patient-centered care.

Professionals who meet the eligibility requirements for both the Medicare and Medicaid EHR incentive programs must select which program they wish to participate in when they register. They cannot participate in both programs; however, after receiving payment, they may change their program selection once before 2015. Hospitals that are eligible for both programs can receive payments from both Medicare and Medicaid.

Some states will launch their Medicaid EHR incentive programs beginning Jan. 3, 2011, but most will launch their programs during the spring and summer. Eligible providers with questions about their state’s launch date should contact their state Medicaid agency. Eligible providers seeking to participate in the Medicaid programs must initiate registration at CMS’ registration site but must complete the process through an eligibility verification site maintained by their state Medicaid agency.

Under the EHR incentive programs, eligible professionals can receive as much as \$44,000 over a five-year period through Medicare. For Medicaid, eligible professionals can receive as much as \$63,750 over six years. Under both Medicare and Medicaid, eligible hospitals may receive millions of dollars for implementing and meaningfully using certified EHR technology.

“The benefits of EHRs are widely recognized, and support for the incentive programs is strong in the health care field and among policymakers,” Dr. Berwick said. “The changeover from paper to electronic records will be challenging for clinicians and hospitals, but CMS and ONC have taken steps to ease the transition. We’ve provided flexibility in meeting the meaningful use requirements, both agencies have conducted extensive outreach, and we have the resources in place to help providers acquire certified EHR technology and meet the programs’ requirements. Immediate registration is not required, but we encourage eligible providers to sign up as soon as they have certified EHR technology and are prepared to participate. We are ready to help.”

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

Source: CMS PERL 201012-37

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

Educational Resources

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

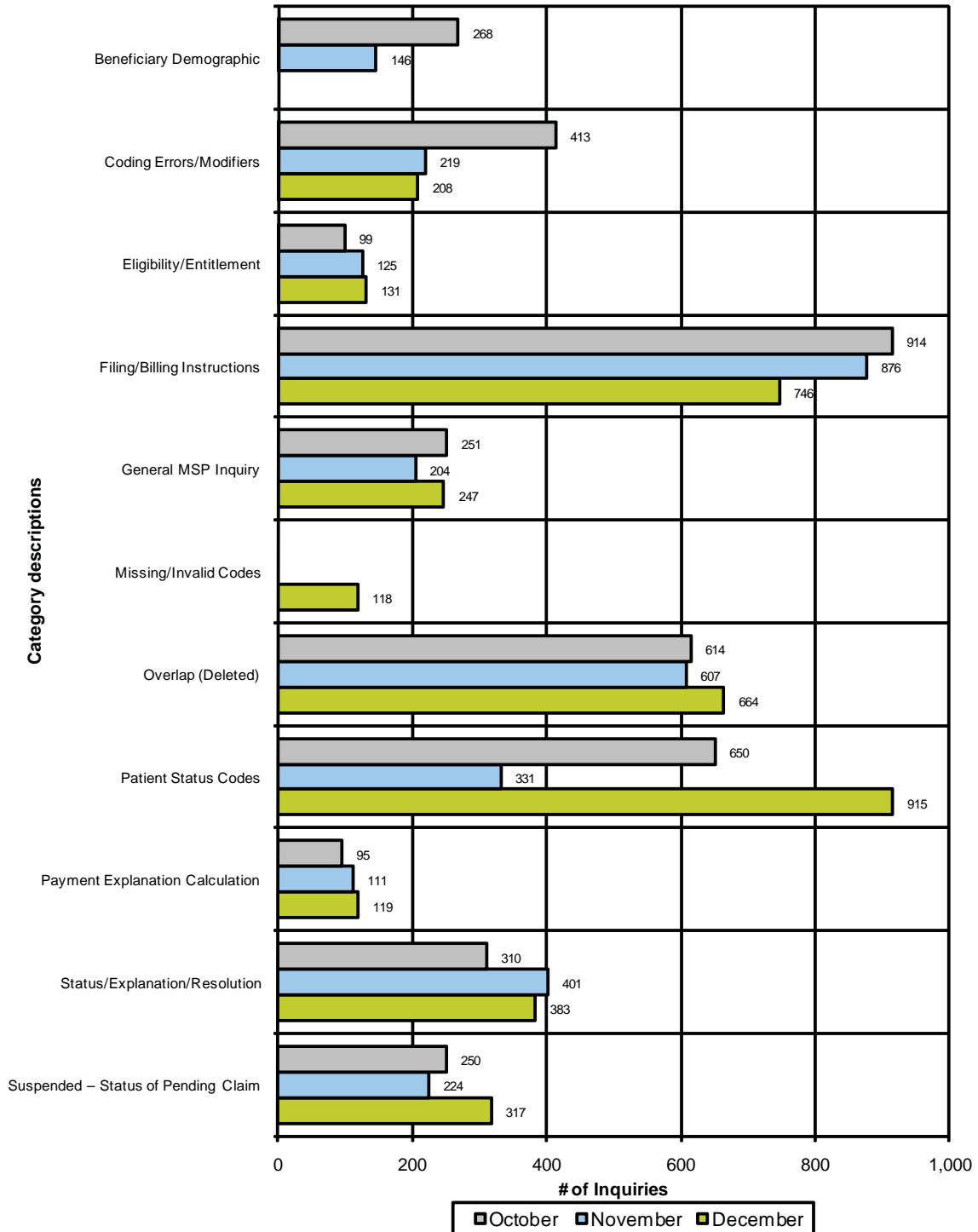
CLAIM AND INQUIRY SUMMARY DATA

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

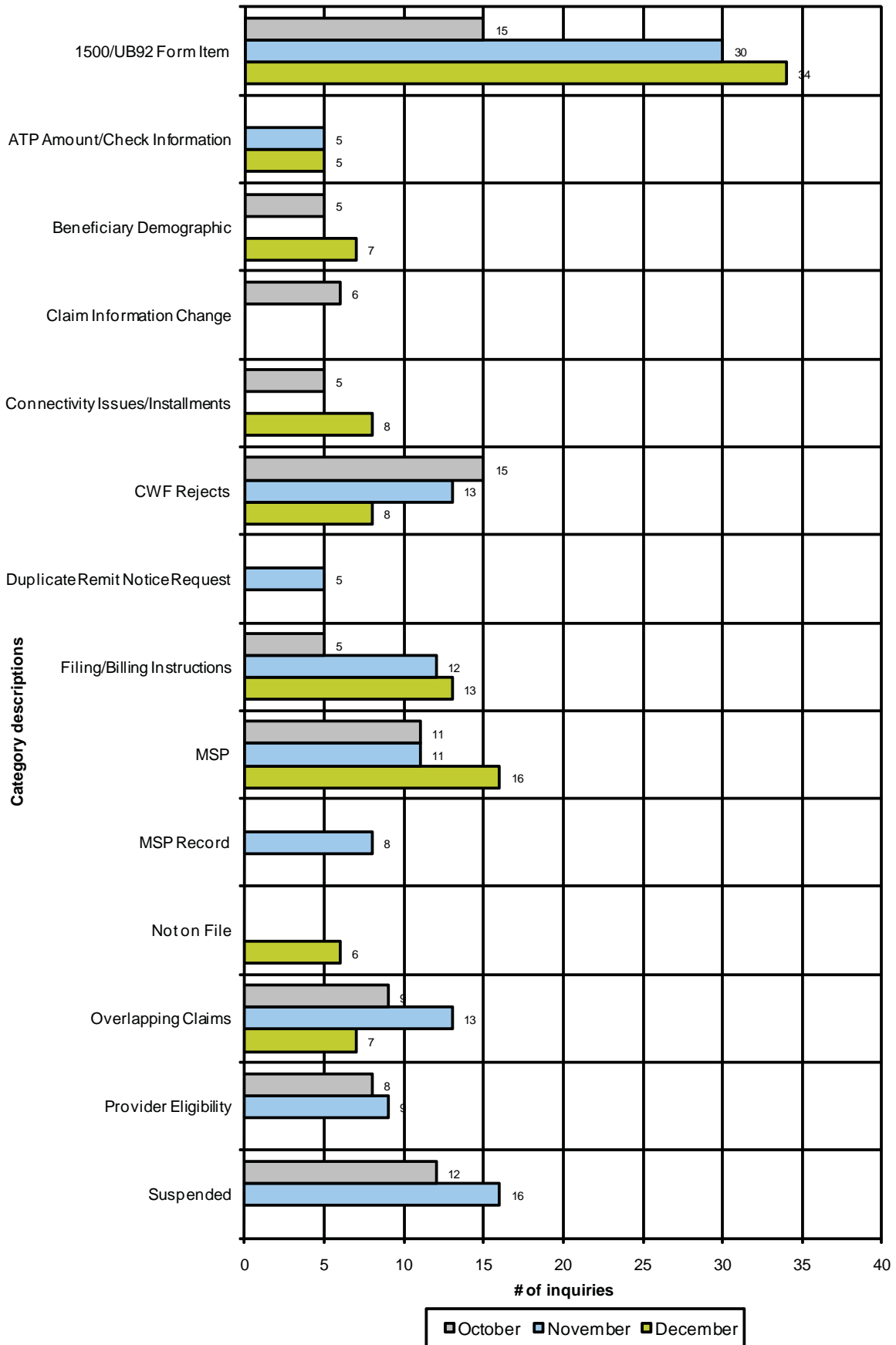
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at http://medicare.fcsoc.com/Inquiries_and_denials/index.asp.

Florida Part A top inquiries for October-December 2010



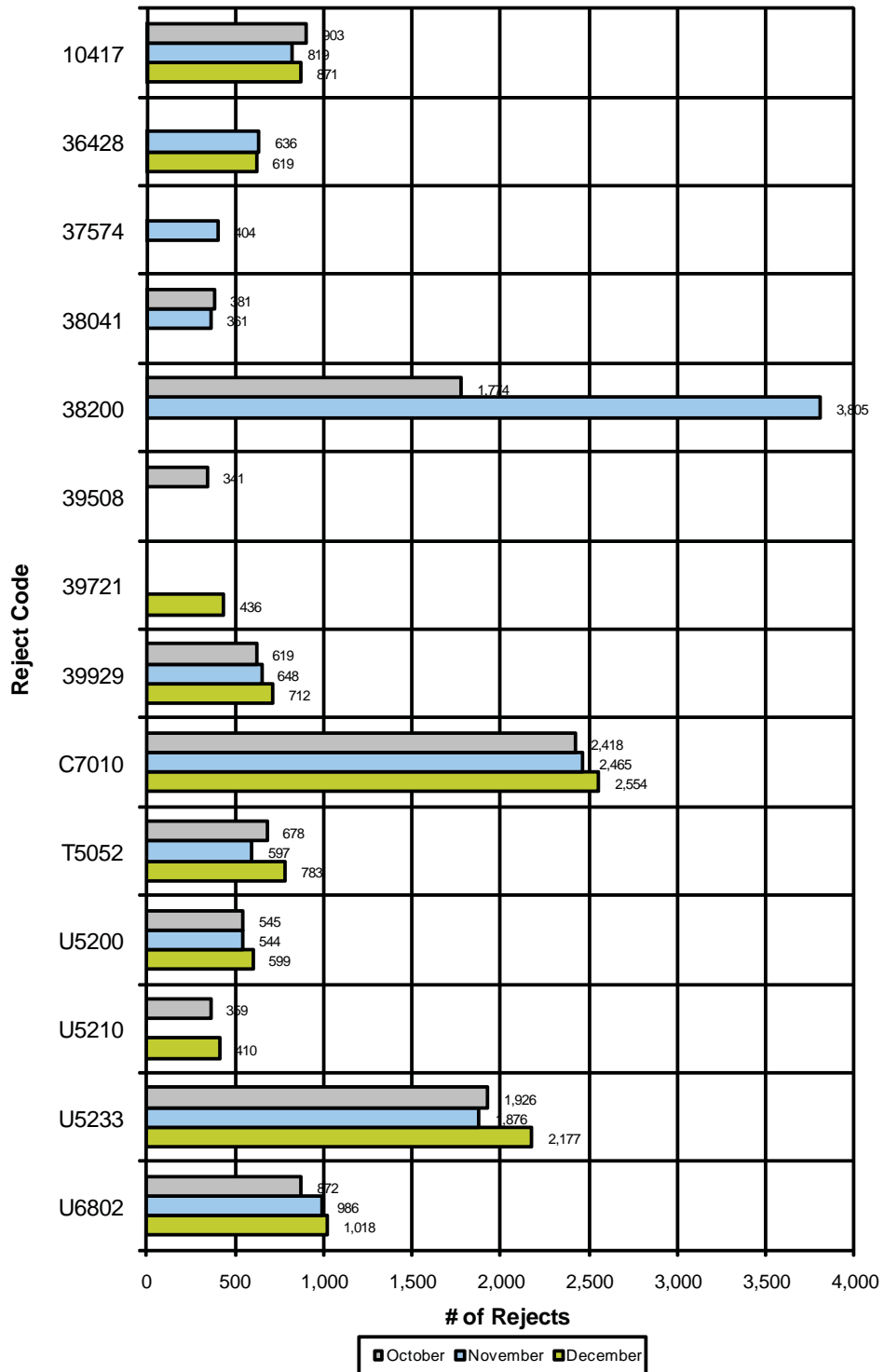
Top inquiries, return to provider, and reject claims for October-December 2010 (continued)

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



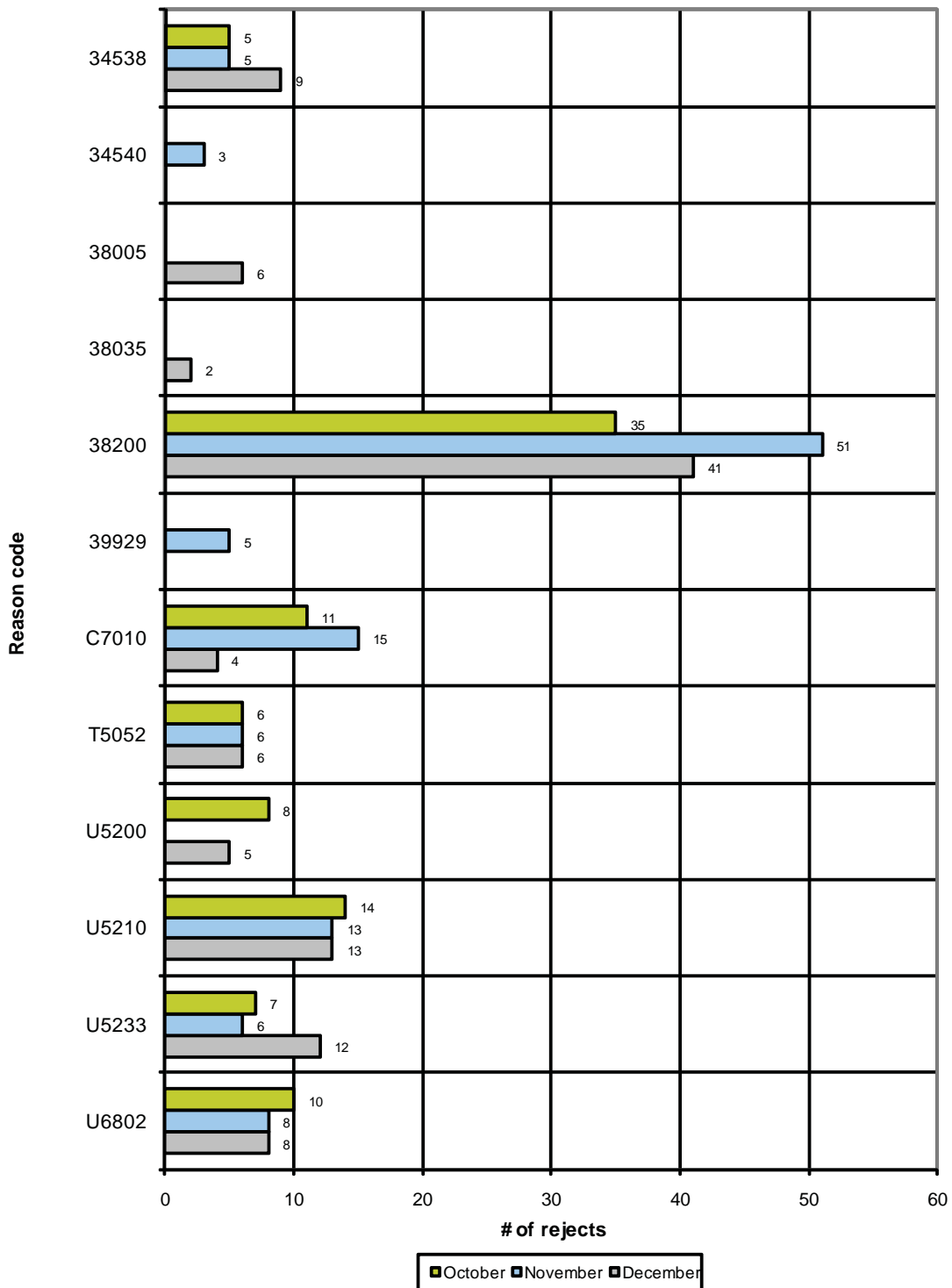
Top inquiries, return to provider, and reject claims for October-December 2010 (continued)

Florida Part A top rejects for October-December 2010



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

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

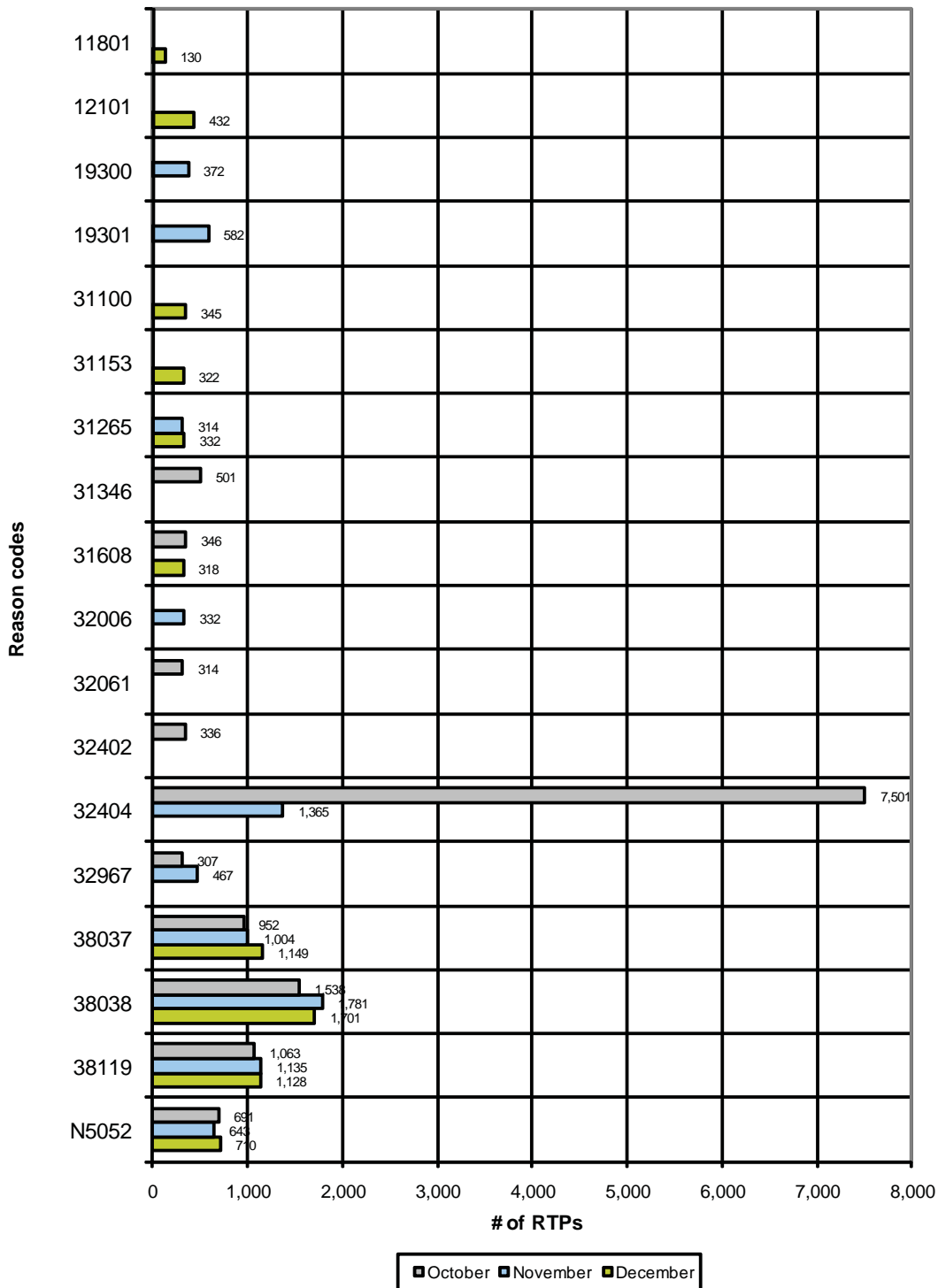


Keep Informed

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 October-December 2010 (continued)

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

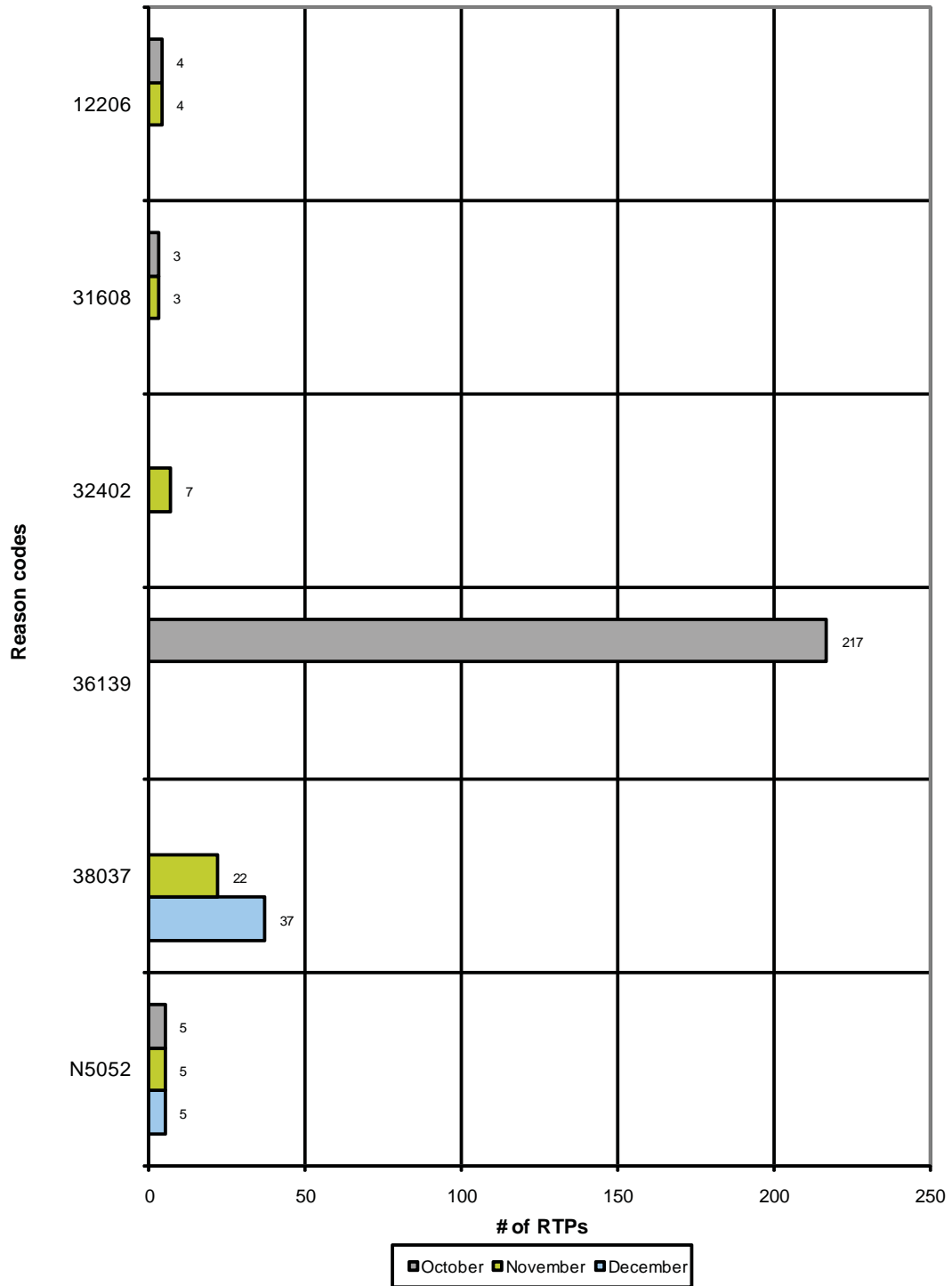


Educational Resources

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

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

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



GENERAL COVERAGE

Manual updates – ambulance claims billing instructions and fee schedule payment rates

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

Provider types affected

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

What you need to know

This article is based on change request (CR) 7018 which updates the *Medicare Claims Processing Manual* to note provisions extending several ambulance payment rate increases that were recently enacted by the Affordable Care Act of 2010. Specifically, the Affordable Care Act extends the increases of three percent for rural services and 2 percent for urban services through December 31, 2010. These increases had been initially required by the Medicare Modernization Act and were extended by the Medicare Improvements for Patients and Providers Act of 2008. CR 7018 also corrects the same manual's Chapter 15, Section 30.1.2 to specify that the correct field for reporting the ZIP code of the point-of-pickup of an ambulance trip in Item 23 of the CMS-1500, instead of item 32 as previously mentioned in that manual section.

If entities billing for ambulance services choose to submit claims in the 5010 837P electronic claim format on or after January 1, 2011, they must comply with the requirement that a diagnosis code be included on the claim. CMS will not be capable of accepting claims submitted under the 5010 version of the 837P that do not comply with this requirement. (See *MLN Matters* article SE1029, released September 24, 2010, at <http://www.cms.gov/MLN MattersArticles/downloads/SE1029.pdf> for details.) In addition, the loaded ambulance trip's destination information will be required on the 5010 837P electronic claim format. CR 7018 amends Chapter 15 to include these instructions.

Additional information

The official instruction, CR 7018, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2124CP.pdf>.

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

MLN Matters® Number: MM7018

Related Change Request (CR) #: 7018

Related CR Release Date: December 23, 2010

Effective Date: January 25, 2011

Related CR Transmittal #: R2124CP

Implementation Date: January 25, 2011

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Face validity assessment of advance beneficiary notice for complex medical record review

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 6988. This CR advises contractors about the addition of Section 3.15, ABN and Complex Medical Record Review, to Chapter 3 of the *Medicare Program Integrity Manual (PIM)*. This addition directs contractors to request, as part of the additional documentation requests (ADRs), required advance beneficiary notices (ABNs) when performing a complex medical record review on all claims. Please ensure that your staffs are aware of this change.

*Face validity assessment of advance beneficiary notice for complex medical record review (continued)***Background**

Requesting required ABNs on all claims undergoing complex medical record reviews and conducting face validity assessments of mandatory ABNs will assist in ensuring that liability is assigned appropriately in accordance with the Limitation on Liability Provisions of Section 1879 of the Social Security Act.

The instructions in the *Medicare Claims Processing Manual* Chapter 30 Section 50.6.3 address how to complete an ABN. In CR 6563, Healthcare Common Procedure Coding System (HCPCS) level II modifiers have been updated in order to distinguish between voluntary and required uses of liability notices. The *MLN Matters*[®] article related to CR 6563 may be viewed at <http://www.cms.gov/MLNMattersArticles/downloads/MM6563.pdf>.

Additional information

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

The official instruction, CR 6988, issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R361PI.pdf>.

MLN Matters[®] Number: MM6988

Related Change Request (CR) #: 6988

Related CR Release Date: December 10, 2010

Effective Date: January 12, 2011

Related CR Transmittal #: R361PI

Implementation Date: January 12, 2011

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Changes to the laboratory national coverage determination edit software for April 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 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) 7290, which announces the changes that will be included in the April 2011 release of Medicare's edit module for clinical diagnostic laboratory national coverage determinations (NCDs).

The change that is effective for dates of service on and after April 1, 2011, is as follows:

For blood counts

ICD-9-CM code V49.87 will be added to the list of "Do Not Support Medical Necessity" ICD-9-CM codes for the blood counts (190.15) NCD.

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

Background

NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the

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

Additional information

The official instruction, CR 7290, issued to your FI, carrier and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2133CP.pdf>.

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

MLN Matters[®] Number: MM7290

Related Change Request (CR) #: 7290

Related CR Release Date: January 14, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2133CP

Implementation Date: April 4, 2011

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Payment for 510k post-approval extension studies using 510k-cleared embolic protection devices during carotid artery stenting procedures

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

Provider types affected

This article is for physicians, hospitals, or other providers who submit claims to Medicare carriers, fiscal intermediaries (FIs), or Medicare administrative contractors (A/B MACs) for providing carotid artery stenting (CAS) procedures, in post approval extension studies, using 510k-cleared embolic protection devices.

What you need to know

Change request (CR) 7249, from which this article is taken, announces that, effective October 22, 2010, the Centers for Medicare & Medicaid Services (CMS) has determined that all 510k post-approval extension studies must be reviewed by the Food and Drug Administration (FDA) via its pre-investigational device exemption (IDE) process. It specifically discusses the coverage of proximal embolic protection devices (EPDs) used in carotid artery stenting (CAS) procedures performed in FDA-approved 510K post-approval extension studies, announcing that these patients (similar to patients covered in traditional post-approval extension studies) are eligible for coverage under the current coverage policy.

In order to receive Medicare coverage for patients participating in these 510k post-approval extension studies, you will need to follow the same billing processes as explained in the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 160.2.1 (CAS for Post-Approval Studies), except that you should report 510k-cleared devices with a pre-IDE number beginning with an “I”, instead of an IDE number beginning with a “P” (post-market approval). You may find this manual section at

<http://www.cms.gov/manuals/downloads/clm104c32.pdf>.

You should make sure that your billing staffs are aware of these coverage changes.

Background

In 2004, CMS gave Medicare contractors instructions on processing claims for CAS procedures performed in FDA-approved post-approval studies. (Please refer to *MLN Matters*® article MM3489, released on October 15, 2004, entitled Percutaneous Transluminal Angioplasty (PTA), which you may find at <http://www.cms.gov/MLN MattersArticles/downloads/MM3489.pdf>).

As these post-approval studies began to end, CMS received requests to extend coverage for them. On May 12, 2006, CMS released CR 5088 which updated the *Medicare Claims Processing Manual* and explained that patients participating in post-approval extension studies are also included in the covered population of patients participating in FDA-approved post-approval studies. CR 5088 also provided claims processing instructions specific to post approval extension studies. Please refer to *MLN Matters*® article MM5088 entitled Payment for Carotid Artery Stenting (CAS) Post Approval Extension Studies, which you may find at <http://www.cms.gov/MLN MattersArticles/downloads/MM5088.pdf> and to the *Medicare National Coverage Determinations* [NCD] Manual, Chapter 1 [Coverage Determinations], Section 20.7 (Percutaneous

Transluminal Angioplasty [PTA]), which is available at http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf.

Coverage of proximal embolic protection devices in carotid artery stenting procedures

Recently, the FDA issued 510k approvals for proximal EPDs used in CAS procedures. However, while the NCD requires use of an EPD, the 510k process (unlike traditional FDA marketing approval requirements) does not involve a post-approval study requirement; and CMS received requests to include, under the current coverage policy, patients participating in studies that followed FDA 510k approval of these devices.

In response, effective October 22, 2010, CMS determined that patients in these studies (similar to patients covered in traditional post-approval extension studies as discussed above) are eligible for coverage under the current coverage policy referenced in Section 20.7 in the *NCD Manual* previously referenced.

Moreover, while the FDA does not require devices approved through the 510k process to undergo further study following clearance (as such, these studies are neither required by, nor subject to, FDA approval), CMS has determined that the FDA must review all 510k post-approval extension studies through its pre-IDE process. As a result of this process, each study is assigned, and identified by, a single, 6-digit number preceded by the letter ‘I’ (i.e., I123456). (For example, the FREEDOM study, examining the 510k-cleared Gore Flow Reversal System, was assigned I090962, and must be identified as such on all claims.)

Notification process

Following this review process, the FDA will issue CMS an acknowledgement letter stating that the extension study is scientifically valid and will generate clinically relevant post-market data. CMS, upon receipt of this letter and review of the 510k post-approval extension study protocol, will issue a letter to the study sponsor indicating that Medicare will cover the study under review.

Billing

Your carrier, FI, or A/B MAC will follow the same procedures for processing post-approval study devices that are currently in place for category B IDEs. In order to receive Medicare coverage for patients participating in 510k post-approval extension studies, you will need to submit both the FDA acknowledgement letter and the CMS letter providing coverage for the extension study to your contractor, and any other materials they might require for FDA-approved post-approval studies or post-approval extension studies. Further, you should follow the process (as established in CR 3489) for informing them of the patients’ participation in the studies, utilizing the most current and appropriate codes when submitting your claims. This process is as follows:

For billing carriers

- Place the IDE number (that begins with an “I”) in either item 23 of the CMS-1500 paper claim format or in the 2300 IDE Number Ref Segment, data element REF02 (REF01=LX) of the 837p claim format

Payment for 510k post-approval extension studies using 510k-cleared ... (continued)

- Use the modifier Q0, instead of QA
- Use the most current ICD-9-CM procedure codes
- Use the most current ICD-9-CM diagnostic codes

For billing FIs

- Use the most current ICD-9-CM procedure codes
- Place no more than one IDE number (that begins with an “I”) in form locator 43 of the CMS-1450 or in 2300 IDE Number Ref Segment, data element REF02 (REF01=LX) of the 837i
- Use revenue code 0624 for post-approval study devices in form locator 42 of the CMS-1450 paper claim form or 2400 Institutional Service Line SV201 Segment, data element 234 of the 837i
- Use the most current ICD-9-CM diagnostic codes

You should also be aware that your contractor is not required to mass-adjust claims for dates of service between the October 22, 2010, effective date and this CR’s implementation date, but they may adjust claims that you bring to their attention.

Additional information

You may find more information about payment for 510k post-approval extension studies using 510k-cleared EPDs during CAS procedures by going to CR 7249, located at <http://www.cms.hhs.gov/Transmittals/downloads/R2113CP.pdf>.

You will find the updated *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Section 160.4 (510k Post-Approval Studies using 510k-Cleared Embolic Protection Devices during Carotid Artery Stenting (CAS) Procedures) as an attachment to the CR.

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

MLN Matters® Number: MM7249

Related Change Request (CR) #: 7249

Related CR Release Date: December 10, 2010

Effective Date: October 22, 2010

Related CR Transmittal #: R2113CP

Implementation Date: January 12, 2011

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Pharmacy billing for drugs provided “incident to” a physician’s service

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, pharmacies, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], A/B Medicare administrative contractors [A/B MACs], and/or regional home health intermediaries [RHHIs]) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7109 which clarifies the Centers for Medicare & Medicaid Services (CMS) policy with respect to restrictions on pharmacies billing for drugs provided “incident to” a physician’s service. CR 7109 also clarifies the CMS policy for the local determination of payment limits for drugs that are not nationally determined.

Background

Pharmacies may bill Medicare for certain classes of drugs including:

- Immunosuppressive drugs
- Oral anti-emetic drugs
- Oral anti-cancer drugs, and
- Drugs administered through any piece of durable medical equipment (DME).

Claims for these drugs are generally submitted to the DME MAC, and the DME MAC makes payment for these drugs (when deemed to be covered and reasonable and necessary) to the pharmacy. One exception is that claims for drugs administered through implanted durable medical equipment such as an implanted infusion pump are submitted to the A/B MAC or local carrier. All bills submitted to the DME MAC must be submitted on an assigned basis by the pharmacy. (*Medicare Claims Processing Manual* (Chapter 17, Section 50.B; see <http://www.cms.gov/manuals/downloads/clm104c17.pdf>).

Pharmacies, suppliers, and providers may not bill Medicare for drugs purchased directly by beneficiaries for administration “incident to” a physician service. Medicare will deny such claims. (See the *Medicare Claims Processing Manual*, Chapter 17, Section 50.B at <http://www.cms.gov/manuals/downloads/clm104c17.pdf>) Pharmacies also may not bill for drugs purchased by a physician for administration to a Medicare beneficiary. These drugs are being furnished “incident to” the physician’s service and as such must be billed by the physician. (See *Medicare Benefit Policy Manual*, Chapter 15,

Pharmacy billing for drugs provided “incident to” a physician’s service (continued)

Section 50.3; at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>.

The payment limits for drugs and biologicals that are not included in 1) the average sales price (ASP) Medicare Part B drug pricing file or 2) the not otherwise classified (NOC) pricing file are based on the published wholesale acquisition cost (WAC) or invoice pricing except under outpatient prospective payment system (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Additional information

The official instruction, CR 7109, issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2115CP.pdf>. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7109

Related Change Request (CR) #: 7109

Related CR Release Date: December 10, 2010

Effective Date: March 14, 2011

Related CR Transmittal #: R2115CP

Implementation Date: March 14, 2011

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The Pre-Existing Condition Plan – a new health coverage option for the uninsured

Are you providing care to uninsured patients who have a pre-existing condition and can’t find health coverage? If so, a new federal program – the Pre-Existing Condition Insurance Plan – can change or save the lives of your patients who’ve been locked out of the health coverage market because of a medical condition.

This program does not base eligibility on income and enrollees receive comprehensive health coverage at the same price that healthy people pay.

To qualify for the program, applicants must meet the following criteria:

- Be a citizen of the United States or residing here legally
- Have been uninsured for at least six months, and
- Have a pre-existing condition or have been denied coverage because of a medical condition.

The plan covers physician and hospital services and prescription drugs. All insurance benefits are available to enrollees – even to treat a pre-existing condition. Premiums vary by state and annual out-of-pocket expenses for enrollees are capped.

Each state may use different methods to determine whether a person applying for the plan has a pre-existing condition or whether he or she has been denied health coverage. As such, people need to check on how to establish eligibility in their state. For more information about the plan and how to apply, visit www.PCIP.gov or, between the hours of 8:00 a.m. and 11:00 p.m. ET, call 866-717-5826 (TTY: 866-561-1604).

We hope you will tell your patients and colleagues about this important new health coverage option.

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

Source: CMS PERL 201101-30

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Discover your passport to Medicare training

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

Learn more on FCSO’s Medicare training website

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

AJ9010: Alemtuzumab (Campath®) – revision to the LCD

LCD ID number: L28777 (Florida)

LCD ID number: L28781 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for alemtuzumab (Campath®) 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, under the “Indications and Limitations of Coverage and/or Medical necessity” section of the LCD, the approved Food and Drug Administration (FDA) indications were updated to read as follows:

Alemtuzumab (Campath®) is FDA-approved as a single agent for the treatment of B-cell chronic lymphocytic leukemia (B-CLL).

In addition, 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 January 11, 2011**, for services provided **on or after September 19, 2007**. 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.

AJ9181: Etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) – revision to the LCD

LCD ID number: L28837 (Florida)

LCD ID number: L28870 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for etoposide (Etopophos®, Toposar®, Vepesid®, VP-16) 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, based on a reconsideration request, the indication of neuroendocrine tumors (malignant poorly differentiated) was added under the off-labeled indications portion of the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD. Also, under the “ICD-9 Codes that Support Medical Necessity” section of the LCD, ICD-9-CM code 209.30 (Malignant poorly differentiated neuroendocrine carcinoma, any site) was added. In addition, 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 services provided **on or after February 3, 2011**. 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

ANPRM – applicability to hospital inpatients and hospitals with specialized capabilities

The Centers for Medicare & Medicaid Services (CMS) released an advance notice of proposed rulemaking (ANPRM) soliciting public comments on the need to revisit through a notice of proposed rulemaking CMS' current policy on the applicability of the emergency medical treatment and labor act (EMTALA) to hospital inpatient and to hospitals with specialized capabilities.

There have been several court cases involving the applicability of EMTALA to hospital inpatients. Some courts have ruled that EMTALA extends to individuals even beyond their admission as hospital inpatients, while other courts have concluded that a hospital's obligations under EMTALA end at the time that a hospital admits an individual to the facility as an inpatient. Most recently an appeals court concluded that a hospital's EMTALA obligations to an individual continue until that individual's emergency medical condition is stabilized regardless of the individual's status as an inpatient or outpatient.

As a result of the split circuit court decisions, consideration has been given as to whether the U.S. Supreme Court should take up the issue of the applicability of EMTALA to hospital inpatients. A commitment was made to the U.S. Supreme Court by the solicitor general that CMS would prepare a request for comment on EMTALA and its applicability to hospital inpatients in calendar year 2010.

The purpose of this ANPRM is to solicit public comments on the need to revisit through a notice of proposed rulemaking CMS' current policy on the applicability of EMTALA to hospital inpatients and to hospitals with specialized capabilities. These policies were discussed in a September 9, 2003, stand-alone final rule on EMTALA and the August 19, 2008, inpatient prospective payment system rule, respectively.

In the ANPRM, CMS provides background on the history of CMS' rules related to the applicability of EMTALA to hospital inpatients and responsibilities of hospitals with specialized capabilities. CMS reviews the EMTALA technical advisory group's recommendation regarding the responsibilities of hospitals with specialized capabilities and makes note of some of the court cases involving the applicability of EMTALA to hospital inpatients.

CMS also solicits comments from the general public on the following issues:

- Specific real-world examples demonstrating whether it would be beneficial to revisit these specific policies within EMTALA
- Examples of situations where a patient with an emergency medical condition may have been transferred to another facility, even when the transferring hospital had the capacity and capability to treat the patient's condition, and
- Comments regarding CMS' statement in the fiscal year 2009 final rule that a hospital with specialized capabilities would accept the transfer of an inpatient with an unstabilized emergency medical condition absent an EMTALA obligation. CMS is particularly interested in examples of instances where a patient with an unstabilized emergency medical condition (EMC) was admitted as an inpatient and continued to have an unstabilized EMC requiring the services of a hospital with specialized capabilities that refused to accept the transfer of the individual because current policy does not obligate hospitals with specialized capabilities to do so.

Comments on the ANPRM are due to CMS no later than 5:00 p.m. ET, February 22, 2011. A copy of the regulation is available at <http://edocket.access.gpo.gov/2010/pdf/2010-32267.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 201012-39

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Post acute transfer calculations

The Centers for Medicare & Medicaid Services (CMS) has discovered an error with the "POST ACUTE TRANSFER" calculation in the fiscal year (FY) 2009 inpatient prospective payment system (IN PPS) personal computer (PC) PRICER. The PRICER has been updated to correct the issue. If you use the FY 2009 IN PPS PC PRICER, please access the Centers for Medicare & Medicaid Services (CMS) Web page at http://www.cms.gov/PCPricer/03_inpatient.asp and download the latest version of the PC PRICER. The update is dated December 22, 2010.

Source: CMS PERL 201012-34

New hospital value-based purchasing program

CMS hospital inpatient value-based purchasing program would promote high-quality health care in Medicare hospitals

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would establish a new hospital value-based purchasing program designed to reward hospitals for providing high quality, safe care for patients. Under the program, hospitals that perform well on quality measures relating both to clinical process of care and to patient experience of care, or those making improvements in their performance on those measures, would receive higher payments under the program.

“Today’s proposal is a huge leap forward in improving the quality and safety of America’s hospitals for both Medicare beneficiaries and all Americans,” said CMS Administrator Donald Berwick, M.D. “The hospital value-based purchasing program will reward hospitals for improving patients’ experiences of care, while making care safer by reducing medical mistakes.”

The hospital value-based purchasing program, which would apply beginning in fiscal year (FY) 2013 to payments for discharges occurring on or after October 1, 2012, would make value-based incentive payments to acute care hospitals, based either on how well the hospitals perform on certain quality measures or how much the hospitals’ performance improves on certain quality measures from their performance during a baseline period. The higher a hospital’s performance or improvement during the performance period for a fiscal year, the higher the hospital’s value-based incentive payment for the fiscal year would be.

The program, which was required by the Affordable Care Act, would apply to Medicare payments under the inpatient prospective payment system (IPPS) for inpatient stays in more than 3,000 acute care hospitals. The financial incentives would be funded by a reduction in the base operating diagnosis-related group (DRG) payments for each discharge, which under the statute will be one percent in FY 2013, rising to two percent by FY 2017. The hospital value-based purchasing program is one of multiple reforms that are dramatically changing how Medicare pays hospitals. Other changes that will increasingly tie payments to how effectively hospitals deliver quality care for patients include incentives for implementing electronic health records, payment adjustments based on hospitals rates of hospital-acquired conditions, and rates of readmissions.

It would be a permanent part of the IPPS and would make it possible for all hospitals paid under the IPPS to receive value-based incentive payments.

CMS has been collecting quality and patient experience information from acute care hospitals on a voluntary basis since 2004, the initial year of the hospital inpatient quality reporting (IQR) program. The IQR program was authorized by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and amended by Section 5001(b) of the Deficit Reduction Act of 2005. In recent years, a vast majority of hospitals chose to participate in the program in order to be eligible for the full annual percentage increase each year, as a result of legislation requiring Medicare to reduce the annual percentage increase for hospitals that did not participate in the reporting program. More than 95 percent of eligible hospitals have participated successfully in this IQR program, formerly called reporting hospital quality data for annual payment update (RHQDAPU), receiving their full annual percentage increase each year since the program went into effect.

“The hospital value-based purchasing program proposal expands upon CMS’ long-standing pay-for-reporting program to reward hospitals not just for reporting data, but for the results of that data,” said Administrator Berwick. “Value-based purchasing repositions Medicare from an observer of nationwide hospital quality to a formidable force in shaping quality going forward.”

CMS will accept comments on the hospital value-based purchasing program proposed rule until March 8, 2010, and will respond to them in a final rule to be issued next year.

The proposed rule has been placed on display at the *Federal Register* and may be found under Special Filings at: www.ofr.gov/inspection.aspx#special. For more information, please see: www.cms.gov/hospitalqualityinits.

Note: More information about the proposed rule, including the measures CMS proposes to use in the program, as well as CMS’ proposed scoring methodology, is included in a fact sheet posted on CMS’ Web page at: www.cms.gov/apps/media/fact_sheets.asp.

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Source: CMS PERL 201101-25

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Fiscal year 2010 inpatient prospective payment system PC PRICER update

Errors were discovered with the “POST ACUTE TRANSFER” calculation in the fiscal year (FY) 2010 inpatient PPS PC PRICERs. The PRICERs have been updated to correct the issue. If you use the FY 2010 inpatient PPS PC PRICERs, please go to the Centers for Medicare & Medicaid Services (CMS) Web page at http://www.cms.hhs.gov/PCPricer/03_inpatient.asp and download the latest version of the PC PRICERs. Note there are now two PRICERs for FY 2010: One is for claims dated from October 1, 2009, to March 31, 2010, and the other is for claims dated from April 1, 2010, to September 30, 2010. Both download modules have changed. The update is dated December 15, 2010.

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

Source: CMS PERL 201012-27

FY 2011 Inpatient rehabilitation facility prospective payment system PC PRICER

The fiscal year (FY) 2011 inpatient rehabilitation facility prospective payment system personal computer (PC) PRICER has been updated with corrected date edit logic. The PC PRICER is ready for download from the Centers for Medicare & Medicaid Services Web page at http://www.cms.gov/PCPricer/06_IRF.asp. If you use the IRF PPS PC PRICERs, please go to the page above and download the latest version of the 2011 PRICER – posted January 14, 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 201101-35

Calendar year 2011 outpatient prospective payment system PRICER file update

The outpatient prospective payment system (OPPS) PRICER Web page has been updated with new payment files for the 2011 update to the OPPS, as specified in change request (CR) 7271. The files are ready for download from the “1st Quarter 2011 Files” section of the OPPS PRICER Web page at <http://www.cms.gov/PCPricer/OutPPS/list.asp>. If you use OPPS PRICER files, please go to this page and download the above files.

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

Source: CMS PERL 201101-05

Revised ‘Sole Community Hospital’ fact sheet available in hard copy

The revised fact sheet titled “Sole Community Hospital” (October 2010), which provides information about sole community hospital (SCH) classification criteria and SCH payments, is now available in print format from the *Medicare Learning Network*®. To place an order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

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

Source: CMS PERL 201101-31

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.

CRITICAL ACCESS HOSPITAL SERVICES

Expansion of the current scope of editing for critical access hospital claims

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

Note: This article was re-issued on December 15, 2010, to reflect numerous revisions made to change request (CR) 7046 on December 14, 2010. Please review the revised article in its entirety. This information was previously published in the October 2010 *Medicare A Bulletin*, page 56.

Provider types affected

Critical access hospitals (CAH) submitting claims that include attending, operating, or other physician or nonphysician practitioner providers for services provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on CR 7046. You should know that, currently, Medicare does not have the capability to identify the specialty codes associated with the physician or nonphysician practitioner provider that are in an approved status on the provider enrollment, chain and ownership system (PECOS) file when a claim is submitted by a CAH. Please ensure that your billing staffs are aware of these changes.

Background

Currently, the Centers for Medicare & Medicaid Services (CMS) does not have the capability to identify the specialty codes associated with the physician or nonphysician practitioner provider that are in an approved status on the PECOS file when a claim is submitted by a CAH.

In this document, the word "claim," means both electronic and paper claims and the following are the only physicians and nonphysician practitioners on the initial and nightly PECOS files. A future change request will address the receipt of the PECOS file for all physician and nonphysician practitioners in an approved status:

- doctor of medicine or osteopathy
- dental medicine
- dental surgery
- podiatric medicine
- optometry
- chiropractic medicine
- physician assistant
- certified clinical nurse specialist
- nurse practitioner
- clinical psychologist
- certified nurse midwife, and
- licensed clinical social worker.

The Fiscal Intermediary Shared System (FISS) will receive a national file from PECOS of only the physicians and nonphysician practitioners, who are enrolled in PECOS, are in an approved status and who are one of the specialties listed above. Nightly thereafter, FISS will receive a national PECOS file of newly added physicians and nonphysician practitioners whose enrollment data has been updated. FISS is the Medicare system that processes CAH claims.

Legislation under the Affordable Care Act requires Medicare to identify certain physician and nonphysician practitioner specialty codes in order to make incentive payments that are dependent on the specialty code and HCPCS code.

Additional information

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

The official instruction issued to your FI or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R822OTN.pdf>.

MLN Matters® Number: MM7046 *Revised*

Related Change Request (CR) #: 7046

Related CR Release Date: December 14, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R822OTN

Implementation Date: January 3, 2011

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ESRD SERVICES

CMS implements value-based purchasing for dialysis facilities Program establishes performance standards, payment penalties

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on December 29, 2010, that establishes performance standards for dialysis facilities and provide payment adjustments to individual end-stage renal disease (ESRD) facilities based on how well they meet these standards. The ESRD quality incentive program (QIP) is designed to promote high-quality dialysis services at Medicare facilities by linking CMS payments directly to facility performance on quality measures.

CMS Administrator Dr. Donald Berwick lauded the ESRD QIP as “a landmark advance for improving the quality and safety of care that Medicare beneficiaries receive while on dialysis treatment. Since most patients with ESRD are also Medicare beneficiaries, the ESRD QIP is an especially powerful tool in transforming care in America’s dialysis centers.”

Individuals are diagnosed with ESRD when their kidneys are no longer able to remove excess fluids and toxins from their blood. ESRD can be cured only with a kidney transplant. ESRD patients who have not received a transplant rely on dialysis to perform the life-saving filtering function. Nearly 350,000 individuals in the United States are being treated for ESRD under Medicare, at a cost of nearly \$9 billion each year.

CMS has previously implemented programs in a variety of settings that pay for reporting of quality measures and has used its demonstration authority to test whether pay-for-performance can improve the quality of care in hospitals and physicians’ offices. The ESRD QIP takes the next step, implementing a permanent pay-for-performance program that could affect payments to all dialysis facilities. It also supports the transition of ESRD payments to a new ESRD prospective payment system (PPS). While the ESRD PPS will promote the efficient provision of care to patients with ESRD, the ESRD QIP will help ensure that facilities provide high quality, patient-centered care.

The ESRD QIP was mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) as a companion to the ESRD PPS. In the ESRD PPS final rule, issued July 26, 2010, and published in the August 12, 2010, Federal Register, CMS finalized three measures as the initial measure set during the first program year. Two of these measures are designed to assess whether patients’ hemoglobin levels are maintained in an acceptable range, while the third measures the effectiveness of the dialysis treatment in removing waste products from patients’ blood. The three measures were chosen because they represent important indicators of patient outcomes and quality of care.

The final rule issued today establishes the ESRD QIP performance standards, sets out the scoring methodology CMS will use to rate providers’ quality of dialysis care, and establishes a sliding scale for payment adjustments based on the facility’s performance. CMS will assess each dialysis facility on how well its performance meets the standard for each measure and will calculate each facility’s total performance score. The maximum total performance score a facility can achieve is 30 (10 points per measure). Facilities that do not meet or exceed performance standards will be subject to a payment reduction of up to two percent depending on how far their performance deviates from the standards.

In future years CMS may add quality measures and establish additional performance standards that facilities will need to meet to receive full payment for the services they furnish to Medicare beneficiaries.

The period of performance under which facilities will be evaluated is payment year (PY) 2010, running from January 1, 2010, through December 31, 2010. CMS will give providers and facilities the opportunity to review their scores and any resulting payment adjustments prior releasing the ESRD QIP scores and payment reductions publicly. The ESRD QIP payment adjustments will apply to payments under the ESRD PPS for outpatient maintenance dialysis items and services furnished to Medicare beneficiaries by ESRD facilities between January 1, 2012, and December 31, 2012.

After ESRD facility scores and payment determinations are finalized, CMS will furnish each facility with a PY 2012 certificate noting the facility’s Total Performance Score as well as its score on each individual measure. Each facility is required to post its certificate in a prominent location in a patient care area for the duration of the payment year. CMS will furnish each facility with a new certificate annually. In addition, CMS will post on the Internet each facility’s total performance score, as well as the scores that facilities earned on the individual measures.

“For over 30 years, Medicare has been monitoring quality for patients with ESRD,” said Berwick. “The new ESRD QIP allows us to build up from that foundation a program that aligns payment for dialysis treatment with the outcomes that matter most to patients.”

The final rule was placed on display at the *Federal Register* January 5, 2011, and may be found under “Special Filings” at: www.ofr.gov/inspection.aspx#special. For more information, please see www.cms.gov/ESRDQualityImproveInit.

Note: More information about the proposed rule, including the measures CMS proposes to use in the program, as well as CMS’ proposed scoring methodology, is included in a fact sheet posted on the CMS website at: www.cms.gov/apps/media/fact_sheets.asp.

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Source: CMS PERL 201101-03

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Reminders for those receiving monthly Medicare payments to manage ESRD patients

Resources outlined to assist eligible providers

The following reminders are for end-stage renal disease (ESRD) facilities, physicians, and practitioners who receive monthly Medicare payments to manage ESRD patients (MCPs) that pertain to the Centers for Medicare & Medicaid Services' (CMS's) requirements for ESRD beneficiaries to access ESRD-related drugs effective January 1, 2011. These requirements will ensure that patients receive their medications and that appropriate payment is made for their medications.

- ESRD facilities must instruct patients to obtain their ESRD-related medications from ESRD facilities' contracted pharmacies to ensure that pharmacies receive payment from the ESRD facilities and patients receive their medications with no financial obligation.
- ESRD facilities must instruct physicians and practitioners who receive monthly Medicare payments to manage ESRD patients (MCPs) to direct their patients to use ESRD facility-contracted pharmacies to ensure that pharmacies receive payment from the ESRD facilities and patients receive their medications.
- MCPs must indicate on an ESRD patient's prescription if prescribed medications are not ESRD-related to ensure that payment for these non-ESRD-related medications can be made under Part D. ESRD patients may obtain covered Part D, non-ESRD related prescription drugs from a network pharmacy or an out-of-network pharmacy in accordance with Part D rules.
- ESRD facilities must indicate on the ESRD claims, each ESRD-related drug (except for composite rate drugs) furnished to an ESRD patient either directly or through a prescription filled by a pharmacy.
- ESRD facilities must use the AY modifier on the ESRD claims for each non-ESRD-related drug furnished to an ESRD patient.
- ESRD facilities must instruct home dialysis patients currently under Method II, about any changes in the arrangements for ESRD-related home dialysis supplies on and after January 1, 2011.
- ESRD facilities must instruct home dialysis patients currently under Method II, that patients no longer have any financial obligation to suppliers for ESRD-related supplies on and after January 1, 2011.

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

Source: CMS PERL 201012-38

ESRD PPS 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: This article was revised on November 18, 2010, to reflect the revised change request (CR) 7064, issued 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 automated multi-channel chemistry (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. This information was previously published in the November 2010 *Medicare A Bulletin* pages 39-43.

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors [DME MACs], fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for ESRD services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on 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.

*ESRD PPS and consolidated billing for limited Part B services (continued)***Go – what you need to do**

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

Background

The Medicare Improvements for Patients and Providers Act (MIPPA); Section 153(b); see <http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331>) requires the Centers for Medicare & Medicaid services (CMS) to implement an ESRD bundled prospective payment system (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), and
- 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.

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.

ESRD PPS and consolidated billing for limited Part B services (continued)

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:

The 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 \times (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, and
- 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), and
- Myelodysplastic syndrome.

The three acute comorbid categories eligible for a payment adjustment are:

- Bacterial pneumonia
- Gastrointestinal bleeding, and
- Pericarditis.

2. Onset of dialysis adjustment: An adjustment will be made for patients that have Medicare ESRD coverage during their first 4 months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's common working file as provided on the CMS-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.

ESRD PPS and consolidated billing for limited Part B services (continued)

- 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 3 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, and
- 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 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.

Consolidated billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier 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 AY modifier.

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 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 the 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 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

ESRD PPS 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 at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7064 *Revised*

Related Change Request (CR) #: 7064

Related CR Release Date: November 17, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2094CP

Implementation Date: January 3, 2011

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OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

January 2011 integrated outpatient code editor specifications version 12.0

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

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7252, which describes changes to the I/OCE and OPPS to be implemented in the January 2011 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR 7252 describes changes to billing instructions for various payment policies implemented in the January 2011 OPPS update. The January 2011 integrated outpatient code editor (I/OCE) changes are also discussed in CR 7252.

Note: The full list of I/OCE specifications can now be found at <http://www.cms.gov/OutpatientCodeEdit/>.

A summary of the changes for January 2011 is within Appendix M of Attachment A of CR 7252 and that summary is captured in the following key points:

- Effective April 20, 2010, Medicare will add a new Gulf oil spill-related modifier CS to the valid modifier list. Edit 22 is affected.
- Effective August 25, 2010, Medicare will change the mid-quarter national coverage determination approval date for codes C9801 and C9802 from August 26, 2010, to August 25, 2010. Edit 68 is affected.
- Effective January 1, 2011, Medicare will:
 - Modify the partial hospitalization program (PHP) logic to assign separate/different PHP ambulatory payment classification (APC), Level I and Level II, for hospital-based (bill type 13x with cc 41) and community mental health center (CMHC) (bill type 76x) PHPs (Appendix C of CR 7252)
 - Modify the mental health logic to cap the payment rate for APC 34 at the rate for new APC 176
 - For a specified group of ancillary services codes, change the Q[#] status indicator (SI) to "N" if present on the same date of service as 99291 (critical care); otherwise, change the Q[#] SI to the standard SI and APC for the specified code.

Exception: If modifier 59 is present on any line with the same date of service as 99291, Medicare will not package the specified ancillary codes, and will assign the standard SI and APC instead:

- Extend the use of modifier FB to nuclear medicine procedures when the associated diagnostic radiopharmaceutical is obtained at no cost to the provider – assign payment adjustment flag #7 to any nuclear medicine procedure code from a specified list if submitted with modifier FB appended
- Make HCPCS/APC/SI changes (data change files) as defined in the appendixes to CR 7252
- Add new modifiers AY, AZ, DA, GU, NB, and PT to the valid modifier list
- Update composite APC requirements (add/delete codes as specified in the appendixes to CR 7252)
- Update procedure/device and device/procedure edit requirements
- Implement version 16.3 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers). Edits 19, 20, 39, and 40 are affected, and
- Create 508-compliant versions of the specifications and summary of data changes documents for publication on the CMS website.

Additional information

The official instruction, CR 7252 issued to your Medicare MAC, RHHI, or FI regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R2114CP.pdf>.

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

MLN Matters® Number: MM7252

Related Change Request (CR) #: 7252

Related CR Release Date: December 17, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2114CP

Implementation Date: January 3, 2011

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CORF/ORF SERVICES

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.

Note: This article was revised on December 22, 2010, to reflect changes made to change request (CR) 7050 on December 21, 2010. The CR 7050 was revised based on policy changes required by the Physician Payment and Therapy Relief Act of 2010, which changed the multiple payment procedure reduction for therapy services in the office setting or a non-institutional setting to 20 percent, instead of 25 percent. The CR release date, transmittal number, and Web address for accessing CR 7050 were also revised. All other information remains the same. This information was previously published in the November 2010 *Medicare A Bulletin* pages 46-47.

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 and 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 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings.

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.

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 at <http://www.cms.gov/Transmittals/downloads/R826OTN.pdf>. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example based on the 75 percent reduction for institutional settings:

	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 at <http://www.cms.gov/Transmittals/downloads/R826OTN.pdf>. If you have any questions, please contact your carrier, FI, or A/B

Multiple procedure payment reduction for selected therapy services (continued)

MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7050 *Revised*

Related Change Request (CR) #: 7050

Related CR Release Date: December 21, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R826OTN

Implementation Date: January 3, 2011

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Reporting of service units for outpatient rehabilitation services

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

Provider types affected

Providers submitting claims to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (A/B MACs) are affected by this article.

What you need to know

Change request (CR) 7247 informs Medicare contractors that a table of *Current Procedure Terminology (CPT)* codes indicating maximum unit limitations was inadvertently deleted from Chapter 5, Section 20, of the *Medicare Claims Processing Manual*. CR 7247 reinserts that table. There are no changes to existing policy.

Additional information

The reinserted table is at the end of the revised manual chapter attached to CR 7247. That CR is available at <http://www.cms.gov/Transmittals/downloads/R2121CP.pdf>.

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

MLN Matters® Number: MM7247

Related Change Request (CR) #: 7247

Related CR Release Date: December 17, 2010

Effective Date: March 21, 2011

Related CR Transmittal #: R2121CP

Implementation Date: March 21, 2011

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New home health claims reporting requirements for G codes related to therapy and skilled nursing 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 home health agencies (HHAs) who bill Medicare regional home health intermediaries (RHHI) or Medicare administrative contractors (A/B MAC) for the provision of therapy and skilled nursing services to Medicare beneficiaries.

What you need to know

Change request 7182, from which this article is taken, announces the requirement (effective January 1, 2011) to report additional, and more specific, data about therapy and nursing visits on your home health (HH) claims. The January 1, 2011, effective date means that these new and revised G-codes should be used for home health episodes beginning on or after January 1, 2011.

This requirement includes:

- The revision of the current descriptions for the G-codes for physical therapists (G0151), occupational therapists (G0152), and speech-language pathologists (G0153), to include that they are to be used to report services that are provided by a qualified physical or occupational therapist, or speech language pathologist
- The addition of two new G-codes (G0157 and G0158) to report restorative physical therapy and occupational therapy provided by qualified therapy assistants

New home health claims reporting requirements for G codes related to therapy and skilled nursing services (continued)

- The addition of three new G-codes (G0159, G0160, and G0161, physical therapist, occupational therapist, and speech-language pathologist, respectively) to report the establishment, or delivery, of therapy maintenance programs by qualified therapists
- The revision of the current G-code definition for skilled nursing services (G0154), and the requirement that HHAs use this code only for the reporting of direct skilled nursing care to the patient by a licensed nurse (LPN or RN), and
- The addition of three new G-codes (G0162, G0163, and G0164) that are required to report: 1) the skilled services of a licensed nurse (RN only) in the management and evaluation of the care plan; 2) the observation and assessment of a patient's conditions when only the specialized skills of a licensed nurse (LPN or RN) can determine the patient's status until the treatment regimen is essentially stabilized; and 3) the skilled services of a licensed nurse (LPN or RN) in the training or education of a patient, a patient's family member, or caregiver.

You should ensure that your billing staff are aware of these new coding requirements on HHA therapy claims. It is important to note that only one G-code should be used per visit.

Background

Medicare makes payment under the home health prospective payment system (HH PPS) generally on the basis of a national standardized 60-day episode payment rate that includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services); and adjusts payment for the applicable case-mix and wage index.

The Centers for Medicare & Medicaid Services (CMS) currently uses the following G-codes to define therapy and skilled nursing services in the home health setting:

- G0151 Services of physical therapist in home health setting, each 15 minutes
- G0152 Services of an occupational therapist in home health setting, each 15 minutes
- G0153 Services of a speech language pathologist in home health setting, each 15 minutes, and
- G0154 Skilled services of a nurse in the home health setting, each 15 minutes to report the provision of skilled nursing services in the home.

In its March 2009 report, the Medicare Advisory Payment Commission (MedPAC) recommended that CMS improve the HH PPS to mitigate vulnerabilities. In the March 2010 report, it suggested that the HH PPS case-mix weights needed adjustment.

In order to respond to these recommendations, CMS needs more specific data on HH claims, and CR 7182 announces these new data requirements on types of bill (TOB) 32x and 33x, effective for episodes beginning on or after January 1, 2011.

Therapy services

To ensure that the therapy case-mix weights are updated accurately, CMS needs to collect additional data on the HH claim to differentiate between the therapy visits provided by therapy assistants and those provided by qualified therapists. (A qualified therapist is one who meets the personnel requirements in the Conditions of Participation (CoPs), at 42 CFR 484.4.)

CMS is meeting this data collection need by: 1) Revising, and requiring, the current descriptions for existing G-codes for physical therapists, occupational therapists, and speech-language pathologists, to include in the descriptions that they are intended to report services provided by a qualified physical or occupational therapist or speech language pathologist; and 2) Adding two new G-codes to report restorative physical therapy and occupational therapy by qualified therapy assistants.

These new code descriptions follow:

- G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
- G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
- G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
- G0157 Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes, and
- G0158 Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

Readers should note that while many of the new codes include the hospice setting in their description, CMS is not requiring hospices to use the new G-codes described at this time.

In addition, CMS is adding, and requiring, the following three new G-codes for reporting the establishment or delivery of therapy maintenance programs by qualified therapists:

- G0159 Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes
- G0160 Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes, and
- G0161 Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

New home health claims reporting requirements for G codes related to therapy and skilled nursing services (continued)

Skilled nursing services

The current definition for the existing G-code for skilled nursing services (G0154) is being revised, and CMS is requiring HHAs to use this code only for the reporting of direct skilled nursing care to the patient by a licensed nurse.

G0154 Direct skilled services of a licensed nurse (LPN or RN) in the home health or hospice setting, each 15 minutes.

Further, CMS is adding and requiring three new G-codes, one to be used to report the skilled services of a licensed nurse in the management and evaluation of the care plan, a second for the observation and assessment of a patient's conditions when only the specialized skills of a licensed nurse can determine the patient's status until the treatment regimen is essentially stabilized; and a third for the reporting of the training or education of a patient, a patient's family member, or caregiver:

G0162 Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).

G0163 Skilled services of a licensed nurse (LPN or RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

G0164 Skilled services of a licensed nurse (LPN or RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

Note: Please refer to Section 40.1.2.2, Chapter 7, on the *Medicare Benefit Policy Manual* for more information regarding management and evaluation of a patient's care plan observation and Section 40.1.2.1, Chapter 7, for more information regarding observation and assessment of a patient's condition.

CMS recognizes that, in the course of a visit, a nurse or qualified therapist could likely provide more than one of the nursing or therapy services reflected in the new and revised codes above. However, as noted above, HHAs must not report more than one G-code for the nursing visit regardless of the variety of nursing services provided during the visit. Similarly, the HHA must not report more than one G-code for the therapy visit, regardless of the variety of therapy services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the primary reason for the visit, which typically would be the service which the clinician spent most of his/her time. For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, we would expect the HHA to report the G-code which reflects the primary reason for the visit. Most times, this service will also be the service for which the nurse spent the most time. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code which reflects the primary reason for the visit. Most times, this service will also be the service for which the therapist spent the most time.

It is important to note that when HHA personnel visit a patient to initially assess the patient's eligibility for Medicare's home health benefit, such a visit is not a billable service. (Please refer to Section 70.2, Chapter 7, of the *Medicare Benefit Policy Manual*.) However, once eligibility is established, if skilled services are provided during this initial visit, the HHA should report the G-code which corresponds to the skilled service provided.

Additional information

You may find more information about new HH claims therapy and skilled nursing services G code reporting requirements by going to CR 7182, located at <http://www.cms.gov/transmittals/downloads/R824OTN.pdf>.

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

A download of these G-codes is available on the 2011 HCPCS File Page, located at <http://www.cms.gov/hcpcreleasecodesets/ANHPCPS/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1240961&intNumPerPage=10>.

MLN Matters® Number: MM7182

Related Change Request (CR) #: 7182

Related CR Release Date: December 17, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R824OTN

Implementation Date: January 3, 2011

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RURAL HEALTH CLINIC SERVICES

Medicare rural health clinics waiver of coinsurance and deductible claim processing issue

The Centers for Medicare & Medicaid Services (CMS) has identified an issue when Healthcare Common Procedure Coding System (HCPCS) codes are reported for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B on rural health clinic claims (71x) for dates of service on or after January 1, 2011. Since the additional revenue line(s) are not separately payable, the contractors have been instructed to move the charges associated with these revenue lines to the noncovered field and to override reason code 31577. This will allow the claim to continue processing and not delay payments. After implementation of change request (CR) 7208, transmittal 2122, on April 4, 2011, contractors will mass adjust these claims to ensure the charges are reflected as covered. Providers should not attempt to resubmit affected claims as their fiscal intermediary or Medicare administrative contractor will be initiating adjustments for the sole purpose of correcting the charges. Providers should anticipate the initiation of these adjustments within 30 calendar days after the implementation of CR 7208.

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

Source: CMS PERL 201012-32

Rural health clinics and federally qualified health centers billing guide

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

Provider types affected

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

What you need to know

This special edition article is based on change request (CR) 7038 and CR 7208, and it provides a billing guide for FQHCs and RHCs. It 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. It also explains how RHCs should bill for certain preventive services under the Affordable Care Act. Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the initial preventive physical examination (IPPE) provided by RHCs. However, to ensure coinsurance and deductible are not applied, detailed Healthcare Common Procedure Coding System (HCPCS) coding must be provided 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

Historically, RHCs and FQHCs billing instructions have been the same. However, effective January 1, 2011, the billing requirements will be different for each of these facilities' types.

As outlined in CR 7208, transmittal 2122, RHCs are only required to submit detailed HCPCS codes for preventive services with a United States Preventive Services Task Force (USPSTF) grade of A or B in order to waive coinsurance and deductible. As outlined in CR 7038 (see the related *MLN Matters*® article, MM7038 at <http://www.cms.gov/MLN MattersArticles/downloads/MM7038.pdf>), FQHCs are required to submit detailed HCPCS code(s) for all services rendered during the encounter.

Listed below is a summary of the billing requirements for each facility that you need to know when submitting claims for either RHCs or FQHCs.

Rural health clinics (71x types of bill)

The professional components of preventive services are part of the overall encounter, and for TOB 71x, these services have always been billed on revenue lines with the appropriate site of service revenue code in the 052x series. In previous requirements, HCPCS codes have only been required to report certain preventive services subject to frequency limits.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are waived 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.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. Lab and technical components should continue to be billed as non-RHC services.

Basic rural health clinic billing for preventive services

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for

Rural health clinics and federally qualified health centers billing guide (continued)

these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance and deductible. For example, if the total charge for the visit is \$150, and \$50 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on \$100 of the total charge.

To ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052x series with the approved preventive service HCPCS code and the associated charges. For example, the service lines should be reported as follows:

Line	Revenue code	HCPCS code	Date of service	Charges
1	052x	01/01/2011	\$100.00	
2	052x	Preventive service code	01/01/2011	\$50.00

The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate, coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable to the service line with the preventive service.

Exceptions

If the only service provided is a preventive service, e.g., a screening pelvic exam, report only one line with the appropriate site of service revenue code 052x and the preventive service HCPCS code. The services will be paid based on the all inclusive rate. Coinsurance and deductible are not applicable.

Note: This example does not apply to the IPPE, as outlined with CR 6445 (see the related *MLN Matters*[®] article, MM6445, at <http://www.cms.gov/MLNArticles/downloads/MM6445.pdf>).

RHCs are not required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines on the 71x claims as the cost for these services are not included in the encounter. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. Coinsurance and deductible do not apply to either of these vaccines.

The hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration shall be carved out of the office visit and reported on a separate line as outlined in the above example. An encounter cannot be billed if vaccine administration is the only service the RHC provides. For additional information on incident to services, please see the *Medicare Benefit Policy Manual*, Chapter 13, Section 60 at <http://www.cms.gov/manuals/Downloads/bp102c13.pdf>.

RHCs do not receive any reimbursement on TOBs 71x for the technical component of services provided by clinics. This is because the technical component of services are not within the scope of Medicare-covered RHC services. The associated technical component of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

FQHCs – TOB 77x

The Affordable Care Act (Section 10501(i)(3)(A); see http://www.healthcare.gov/center/authorities/title_v_amendments.pdf) amended the Social Security Act (Section 1834; see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) by adding a new subsection (o) titled “Development and Implementation of Prospective Payment System”.

This subsection provides the statutory framework for development and implementation of a prospective payment system (PPS) for Medicare FQHCs. The Social Security Act (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 and 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 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 services provided during the encounter/visit by listing the appropriate HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes in order to develop the FQHC PPS set to be implemented in 2014. The additional data will not be utilized to determine current Medicare payment to FQHCs. The Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.

Basic FQHC billing requirements

For dates of service on or after January 1, 2011, all valid UB04 revenue codes except the following may be used to report the additional services that are needed for data collection and analysis purposes only:

- 002x-024x
- 029x
- 045x
- 054x
- 056x
- 060x
- 065x

Rural health clinics and federally qualified health centers billing guide (continued)

- 067x-072x
- 080x-088x
- 093x, or
- 096x-310x.

Medicare will make one payment at the all-inclusive rate for each date of service that contains a valid HCPCS code for professional services when one of the following revenue codes is present.

Revenue code	Definition
0521	Clinic visit by member to RHC/FQHC
0522	Home visit by RHC/FQHC practitioner
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)
0525	Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility
0527	RHC/FQHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area
0528	Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)

Payments for encounter/visits

Medicare will make an additional encounter payment at the all-inclusive rate on the same claim when:

- Effective January 1, 2011, two services lines are submitted with a 052x revenue code and one line contains modifier 59. Modifier 59 signifies that 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.
- Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900
- Diabetes self-management training (DSMT) is billed under revenue code 052x and HCPCS code G0108 and medical nutrition therapy (MNT) is billed under revenue code 052x and HCPCS code 97802, 97803, or G0270, and
- The initial preventive physical examination (IPPE) billed under revenue code 052s and HCPCS code G0402. This is a once in a lifetime benefit. HCPCS coding is required.

Note: Modifier 59 is not required for DSMT, MNT or IPPE in order to receive an additional encounter payment.

When reporting multiple services on FQHC claims, the 052x revenue line should include the total charges for all of the services provided during the encounter. For preventive services with a grade of A or B from the USPSTF, the charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is \$350.00, and \$50.00 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on \$300.00 of the total charge.

Example A

Line	Rev code	HCPCS code	Date of service	Charges
1	0521	Office visit	01/01	300.00
2	0636	Penicillin injection	01/01	125.00
3	0271	Wound cleaning	01/01	125.00
4	0771	Preventive service code	01/01	50.00

When reporting multiple services on the same day that are unrelated, modifier 59 must be used to report these services, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.

Example B:

Line	Rev code	HCPCS code	Modifier	Date of service	Charges
1	0521	Office visit		01/01	150.00
2	0479	Removal of wax from ear		01/01	100.00
3	0521	Office visit	59	01/01	450.00
4	0271	Wound cleaning		01/01	150.00
5	0279	Bone setting with casting		01/01	300.00

When reporting an additional encounter for IPPE, the revenue lines should be reflected as follows:

Rural health clinics and federally qualified health centers billing guide (continued)

Example C:

Line	Rev code	HCPCS code	Date of service	Charges
1	0521	Office visit	01/01	75.00
2	0419	Breathing treatment	01/01	75.00
3	0521	IPPE (G0402)	01/01	150.00

As of January 01, 2011, for data collection and analysis for the PPS, FQHCs are required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines (PPV) on the 77x claims. The charges of these vaccines and the administration shall be carved out of the office visit and reported on a separate line as outlined in example A. The cost for these services will continue to be reimbursed through cost reporting. Coinsurance and deductible do not apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges for the vaccine and its administration shall be carved out of the office visit and report on a separate line as outlined in example A. An encounter cannot be billed if vaccine administration is the only service the FQHC provides. For additional information on incident to services, please see Chapter 13, Section 60 of the Medicare Benefit Policy Manual at <http://www.cms.gov/manuals/Downloads/bp102c13.pdf>.

Laboratory and technical components should continue to be billed as non-FQHC services.

Summary of differences

The chart below displays a list of elements and notes the differences between RHCs and FQHCs:

Element	RHCs	FQHCs
Revenue codes	052x series	All except: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x
HCPCS code	Required for preventive services only excluding flu and PPV	Required for all services rendered during encounter/visit
Modifier 59	Not applicable at this time	Should be used to report two distinct unrelated visits on the same day
DSMT and MNT	Not separately payable	All inclusive payment rate

Additional information

Additional information on vaccines may be found in the “Medicare Claims Processing Manual” (Chapter 1, Section 10) at <http://www.cms.gov/manuals/downloads/clm104c01.pdf>, and additional coverage requirements for the pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine may be found in the Medicare Benefit Policy Manual (Chapter 15) at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>.

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

MLN Matters® Number: SE1039
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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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 a 71x type of bill 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. For example, if the total charge for the visit is \$150, and \$50 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 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.

MLN Matters® Number: MM7208

Related Change Request (CR) #: 7208

Related CR Release Date: November 12, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R2093

Implementation Date: April 4, 2011

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ELECTRONIC DATA INTERCHANGE

Claim adjustment reason code, remittance advice remark code update, and MREP update

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

Provider types affected

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

Provider action needed

Change request (CR) 7250, from which this article is taken, announces the latest update of remittance advice remark codes (RARC) and claim adjustment reason codes (CARCs), effective April 1, 2011. Be sure your billing staff is aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some Coordination-of-Benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November, although the Committee meets every month.

Both code lists are posted at <http://www.wpc-edi.com/Codes> on the Washington Publishing Company (WPC) website. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 7250.

Additional information

To see the official instruction (CR 7250) issued to your Medicare carrier, RHHI, DME/MAC, FI and/or MAC, refer to <http://www.cms.gov/Transmittals/downloads/R2131CP.pdf>.

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

New codes – CARC

Code	Current Narrative	Effective Date Per WPC Posting
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010

Modified codes – CARC

Code	Modified Narrative	Effective Date Per WPC Posting
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. This change effective 7/1/2011: Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Note: If an adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10

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

Code	Modified Narrative	Effective Date Per WPC Posting
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	10/17/2010
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010
219	Based on extent of injury (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution). This change effective 7/1/2011: Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
W1	Workers Compensation State Fee Schedule Adjustment. This change effective 7/1/2011: Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010

Deactivated codes – CARC

None

New codes – RARC

Code	Current Narrative	Medicare Initiated
N540	Payment adjusted based on the interrupted stay policy.	Yes
N541	Mismatch between the submitted insurance type code and the information stored in our system.	Yes

*Claim adjustment reason code, remittance advice remark code update, and MREP update (continued)***Modified codes – RARC**

Code	Modified Narrative	Medicare Initiated
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	No

Deactivated codes – RARC

None

MLN Matters® Number: MM7250

Related Change Request (CR) #: 7250

Related CR Release Date: January 7, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2131CP

Implementation Date: April 4, 2011

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Claim status category and claim status code update

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

Provider types affected

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

Provider action needed

This article, based on change request (CR) 7259, explains that the claim status codes and claim status category codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement were updated during the January 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting are to be posted at <http://www.wpc-edi.com/content/view/180/223/> on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 4, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only claim status category codes and claim status codes approved by the national Code Maintenance Committee

in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1 and 005010X212). CMS has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (institutional or professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

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

The official instruction, (CR 7259), issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2120CP.pdf>.

MLN Matters® Number: MM7259

Related Change Request (CR) #: 7259

Related CR Release Date: December 17, 2010

Effective Date: April 1, 2011

Related CR Transmittal #: R2120CP

Implementation Date: April 4, 2011

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HIPAA 5010 & D.O. – implementation calendar and important reminders

During the transition to Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.O., you will be periodically reminded of important items and dates that may be of specific interest to the Medicare fee-for-service (FFS) provider/supplier community. Please see below to learn about current, upcoming, and past events that have taken place during this implementation process.

Important implementation reminders

Announcement: January 1, 2011, marked the beginning of the 5010/D.O. transition year

Readiness assessment: Have you done the following to be ready for 5010/D.O.?

http://www.cms.gov/Versions5010andD0/Downloads/Readiness_1.pdf

Readiness assessment: What do you need to have in place to test with your Medicare administrative contractor (MAC)?

http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf

Reminder: 5010/D.O. errata requirements and testing schedule can be found here

http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf

Reminder: Contact your MAC for their testing schedule

http://www.cms.gov/Versions5010andD0/Downloads/Reminder-Contact_MAC.pdf

Implementation calendar

January 2011

January 1: Beginning of transition year

January 11: Healthcare Information and Management Systems Society (HIMSS) 5010 industry readiness update *

<http://www.himss.org/asp/UnknownContent.asp?type=evt>

January 19: 5010 national call – errata/companion guides

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1243131&intNumPerPage=10>

January 25-27: 4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation *

<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=12B9F00000029>

Upcoming items

February 2011

February 20-24: HIMSS 11th Annual Conference & Exhibition *

<http://www.himss.org/ASP/eventsHome.asp>

March 2011

March 30: 5010 national call – provider testing and readiness

April 2011

TBD: MAC hosted outreach and education session – are you ready to test?

May 2011

May 2-5: 20th Annual WEDI National Conference *

<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11917000006F1>

May 25: 5010 national call – topic to be determined

June 2011

TBD: National MAC testing day (for vendors, clearinghouses, and billing services, etc)

July 2011

TBD: MAC hosted outreach and education session – troubleshooting with your MAC

August 2011

August 31: 5010 national call – MAC panel

TBD: National MAC testing day (for providers)

October 2011

TBD: MAC hosted outreach and education session (last push for implementation)

October 24-27: WEDI 2011 fall conference *

<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11927000002B1>

December 2011

December 31: End of the transition year, and the beginning of 5010 production environment

HIPAA 5010 & D.O. – implementation calendar and important reminders (continued)**Past items****June 2010**

June 15: 5010 national call – ICD-10/5010 national provider call

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237787&intNumPerPage=10>

June 30: 5010 national call – 837 institutional claim transaction

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1236487&intNumPerPage=10>

July 2010

July 28: 5010 national call – 276/277 claim status inquiry and response transaction set

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237767&intNumPerPage=10>

August 2010

August 25: 5010 national call – 835 remittance advice transaction <http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1238739&intNumPerPage=10>

September 2010

September 27: 5010 national call – acknowledgement transactions (TA1, 999, 277CA)

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1239741&intNumPerPage=10>

October 2010

October 13: 5010/D.O. errata requirements and testing schedule released

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1239741&intNumPerPage=10>

October 27: 5010 national call – NCPDP version D.O. transaction <http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1240794&intNumPerPage=10>

November 2010

November 4: Version 5010 resource card published

http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf

November 8: WEDI 2010 fall conference *

<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=C31C0000002C>

November 17: 5010 national call – coordination of benefits (COB)

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241427&intNumPerPage=10>

December 2010

December 8: 5010 national call – MAC outreach and education activities and transaction-specific testing protocols

<http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241855&intNumPerPage=10>

For older national call information, please visit the 5010 national calls section of CMS' versions 5010 & D.O. Web page

<http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage>

* Information about events in which the Centers for Medicare & Medicaid Services (CMS) Medicare FFS staff participates may be applicable to the healthcare industry at large, though it is geared toward the Medicare FFS audience.

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Source: CMS PERL 201101-32

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Reminder: Contact your contractor for specific testing schedules for HIPAA version 5010 & D.0 transactions

Medicare fee-for-service (FFS) contractors will be ready to test the base versions of all transactions in January 2011 and the 5010/D.0 errata versions in April 2011. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, visit the “Downloads” section at <http://www.cms.gov/ElectronicBillingEDITrans>. For more information on testing protocols for 2011, visit http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf.

Only the base versions of the transactions will be available for testing in January 2011. Errata versions will be ready for testing in April 2011. A trading partner must be tested and approved on the errata versions before being moved into production.

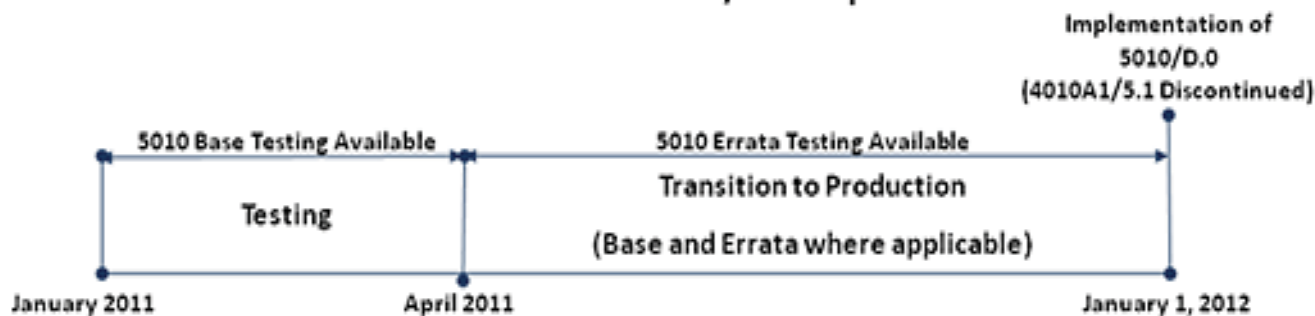
Background: The standards development organizations have made corrections to the 5010 and D.0 versions of certain transactions. The “errata” versions replace the base versions for HIPAA compliance. HIPAA compliance will require the implementation of the errata versions and the base versions for those transactions not affected by the errata, as listed below. The compliance date is January 2012.

Table 1. Transactions affected by the errata -- list of base and errata versions for 5010 and D.0.

Transactions affected by the errata version	Base version	Errata version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) version D.0 of the Telecom Standard	D.0	D.0 April 2009

Figure 1. Medicare FFS timeline for 5010/D.0 implementation: 1) Testing on base versions to begin in January 2011, 2) Testing and transition to production on errata version to begin in April 2011, and 3) Implementation of 5010/D.0 on January 1, 2012.

Medicare FFS Timeline for 5010/D.0 Implementation



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Source: CMS PERL 201012-40

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 your Medicare billing? Accessible through FCSO's PDS portal at <https://medicare.fcsso.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 specified 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 bottom line.

Reminder: Implementation of HIPAA version 5010 & D.0. transactions

The Centers for Medicare & Medicaid Services (CMS) would like to remind you of the following important message:

The purpose of this message is to clearly communicate the approach that Medicare fee-for-service (FFS) is taking to ensure compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) new versions of the Accredited Standards Committee (ASC) X12 and the National Council for Prescription Drug Programs (NCPDP) electronic data interchange (EDI) transactions.

The Standards Development Organizations have made corrections to the 5010 and D.0. versions of certain transactions. The errata versions replace the base versions for HIPAA compliance. Per the *Federal Register* (Vol. 75, No. 197, October 13, 2010, 62684–62686 [2010–25684] found at <http://edocket.access.gpo.gov/2010/pdf/2010-25684.pdf>), HIPAA compliance will require the implementation of the errata versions and the base versions for those transactions not affected by the errata, as listed below. Compliance with the errata must be achieved by the original regulation compliance date of January, 2012.

Table 1. Transactions affected by the errata -- list of base and errata versions for 5010 and D.0.

Transactions affected by the errata version	Base version	Errata version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) version D.0. of the Telecom Standard	D.0.	D.0. April 2009

Medicare FFS will implement the errata versions to meet HIPAA compliance requirements. Also in compliance with the published regulation (RIN 0938-AM50 of 45 CFR Part 162), Medicare FFS testing with external trading partners must begin in January 2011.

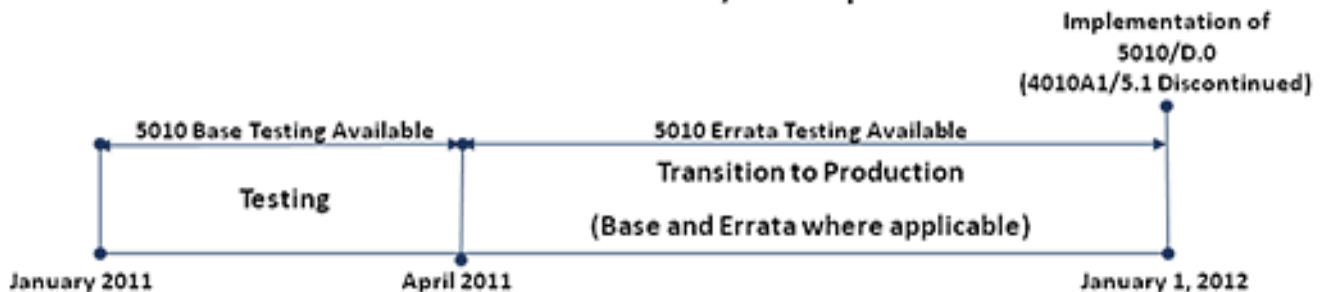
Testing

Medicare FFS contractors will be ready to test the base versions of all transactions in January 2011, and the 5010/D.0 errata versions in April 2011. Trading partners should contact their local Medicare FFS contractor for specific testing schedules. See <http://www.cms.gov/ElectronicBillingEDITrans/> under downloads, to find a Medicare FFS contractor in your state. For more information on testing protocols for 2011 see http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf.

Production

The errata versions will be available for Medicare FFS production in April 2011. The errata transactions must be tested

Medicare FFS Timeline for 5010/D.0 Implementation



before using them for production. As a result, Medicare FFS 5010/D.0 test-to-production transition will begin in April 2011. **Figure 1.** Medicare FFS timeline for 5010/D.0. implementation: 1) Testing on base versions to begin in January 2011, 2) Testing and transition to production on errata version to begin in April 2011, and 3) Implementation of 5010/D.0. on January 1, 2012.

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Source: CMS PERL 201012-19

Revision request for the adopted ASC X12 version 5010

On January 1, 2012, all Health Insurance Portability and Accountability Act of 1996 (HIPAA)-covered entities are required to use the adopted ASC X12 version 5010 (version 5010) standard for electronic health care transactions, known as the ASC X12 type 3 technical reports (TR3) or implementation guides.

Even though version 5010 has not yet been implemented, the work of the standards organization is ongoing. At this time, ASC X12 is giving stakeholders an opportunity to review and comment on the version 5010 implementation guide so that modifications can be made for the next version – 6020. Stakeholder input and consensus is critical, to ensure that the standards meet the needs of all who use them, and to increase the use of electronic commerce in health care. All interested parties and stakeholders are encouraged to submit recommendations for improvements to X12.

Revision requests and recommendations should be submitted through the designated standard maintenance organization (DSMO) website, <http://www.hipaa-dsmo.org>. The deadline to submit revision requests for the ASC X12 005010 TR3 is February 4, 2011. It is imperative to have all comments submitted by this deadline for them to be considered in the development of version 6020. Please share this notification with others in your own association or network as soon as possible.

While stakeholders are encouraged to respond to X12's request and participate in the standards process to the fullest extent feasible, this notification is not an indication of the Centers for Medicare & Medicaid Services' intent to adopt version 6020 at this time.

New versions of standards must complete the standard development organization's (SDO) balloting processing, be considered and recommended by the National Committee on Vital and Health Statistics (NCVHS), and then adopted through the notice and public comment rulemaking process before they can be adopted as HIPAA standards.

For more information, please visit <http://www.x12.org/TR3ChangeRequest> or <http://www.hipaa-dsmo.org>.

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Source: CMS PERL 201012-20

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Discover the benefits of electronic remittance advice

Do you receive standard paper remittance (SPR) advices?

Currently, 96 percent of the providers in the First Coast Service Options Inc. (FCSO) jurisdiction 9 (J9) submit their claims electronically. However, FCSO's records also show that 20 percent of all the Part A remittance advices and 40 percent of all the Part B remittance advices are sent to providers as paper instead of in an easy-to-use electronic format.

Why not "go electronic"?

Here are a few benefits to receiving electronic remittance advice (ERA):

- Receive your remittances the day the claim finalizes
- Reduce costs associated with:
 - Storage and maintenance of SPRs
 - Staff time to review and file SPRs

The Centers for Medicare & Medicaid Services (CMS) provides free software for you so that you can download, view, and print duplicate copies of Part A or B electronic remittances whenever you wish. If you currently submit your claims electronically and are not set up for electronic remittance, please complete the electronic data request form, available at http://medicare.fcso.com/EDI_forms/138245.pdf, prior to downloading the free software.

How do you get this free software?

- For Part A providers, download PC-Print Software http://medicare.fcso.com/PC-print_software/
- For Part B providers, download MREP software <http://medicare.fcso.com/MREP/>.

Your time and money are valuable. Save both by downloading the software for electronic remittance advices today.

EDUCATIONAL EVENTS

Upcoming provider outreach and educational events February – March 2011

Topic – Virtual Medifest 2011 – Registration is open

When: February 21-25
 Time: 8:00 a.m. – 5:00 p.m. ET **Delivery language:** English and Spanish
 Type of Event: Face-to-face event **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Topic – Bimonthly Medicare Part A ACT: Medicare changes and hot issues

When: Tuesday, March 8
 Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English
 Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Topic – Bimonthly Medicare Part A ACT: Medicare data and CMS initiatives

When: Tuesday, March 15
 Time: 2:00 – 3:30 p.m. ET **Delivery language:** English
 Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training website 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 a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

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

Please Note:

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

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

Keep checking our website, www.medicare.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 website and explore our catalog of online courses.

PREVENTIVE SERVICES

Flu shot reminder

Flu season is here. While seasonal flu outbreaks may occur as early as October, they usually peak in January. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Health care workers, who may spread the flu to high risk patients, should get vaccinated too. 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

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

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Source: CMS PERL 201101-12

OTHER EDUCATIONAL RESOURCES

New resources from the Medicare Learning Network

Web guide – Suite of Products and Resources for Inpatient Hospitals

A new educational Web guide is now available from the *Medicare Learning Network*[®]. The Suite of Products and Resources for Inpatient Hospitals provides Medicare Part A providers with an understanding of the various prospective payment system rates and classification criterion for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. It also provides business office management professionals with accurate, timely, and easy-to-understand billing and coding products as well as information to help understand and streamline claims submissions. This product is suggested for all Medicare fee-for-service inpatient hospital providers and is available in downloadable format at http://www.cms.gov/MLNEdWebGuide/45_MLN_Suite_of_Products_and_Resources_for_Inpatient_Hospitals.asp.

Fact sheet – Inpatient Rehabilitation Facility Prospective Payment System

The revised publication titled Inpatient Rehabilitation Facility Prospective Payment System (August 2010) is now available in print format from the *Medicare Learning Network*[®]. This fact sheet provides information about inpatient rehabilitation facility prospective payment system rates, classification criterion, and reasonable and necessary criteria. To place your order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

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

Source: CMS PERL 201012-44

New Web page for quality reporting for LTCHs, IRFs, and hospices

The Centers for Medicare & Medicaid Services (CMS) has created a Web page to support Section 3004 of the Affordable Care Act, Quality Reporting for Long Term Care Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs. This page has been created so the public can view information, and communications, related to Section 3004. This page is expected to expand as more information is provided. There is also provided a link for e-mailing comments, questions, or ideas to CMS pertaining to quality reporting and Section 3004.

The website link is: http://www.cms.gov/QualityInitiativesGenInfo/03_NewQualityReportingProgramsSection3004.asp. The e-mail address is (and can be found on the website): LTCH-IRF-Hospice-Quality-ReportingComments@cms.hhs.gov.

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

Source: CMS PERL 201012-25

New Medicare Learning Network publications

The following publications are 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.”

- *Hospice Payment System* (September 2010) – provides information about the coverage of hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on hospice payments, and the hospice option for Medicare Advantage enrollees.
- *Comprehensive Outpatient Rehabilitation Facility* (July 2010) – 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.

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Source: CMS PERL 201012-21

Glucose Testing Supplies: Complying with Documentation & Coverage Requirements fact sheet

The *Medicare Learning Network*[®] (MLN) would like to remind you that the *Glucose Testing Supplies: Complying with Documentation & Coverage Requirements* fact sheet has been developed to provide education on common Comprehensive Error Rate Testing (CERT) Program errors related to glucose testing supplies, which is currently one of the highest sources of CERT error rates. This fact sheet includes a checklist of the documentation needed to support claims submitted to Medicare for glucose testing supplies and is currently available in downloadable format at http://www.cms.gov/MLNProducts/downloads/GlucSup_DocCvge_FactSheet_ICN905104.pdf. Please visit the MLN Provider Compliance Web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp for additional resources that educate fee-for-service providers about common billing errors and other improper activities identified through the Centers for Medicare & Medicaid Services’ claim review programs, including CERT.

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Source: CMS PERL 201012-21

Fact sheet – DMEPOS Competitive Bidding Program Repairs and Replacements

The DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) Competitive Bidding Program is effective 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.

The DMEPOS Competitive Bidding Program Repairs and Replacements fact sheet contains helpful information on the Competitive Bidding Program rules that apply when a DMEPOS item owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services noncontract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp, scroll down to “Downloads,” and select “DMEPOS Competitive Bidding Fact Sheets.”

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Source: CMS PERL 201012-44

Find your favorites fast – use Popular Links

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

New fact sheets on DMEPOS competitive bidding

The *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Billing Procedures for Upgrades Fact Sheet* is now available to download, free of charge, from the *Medicare Learning Network*[®].

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 fact sheet contains helpful information on program rules that apply when a beneficiary wants to obtain an upgrade -- that is, an item or a component of an item that exceeds the beneficiary's medical need. It includes information on which DMEPOS suppliers can provide the item, how the item will be paid, beneficiary liability, and advance beneficiary notice (ABN) requirements.

To view the fact sheet, please visit the "DMEPOS Competitive Bidding Educational Resources" page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp. Scroll to *Downloads* and select *DMEPOS Competitive Bidding Fact Sheets*.

Three new fact sheets on oxygen therapy supplies, positive airway pressure devices, and cardiac pacemakers

The *Medicare Learning Network*[®] has developed three new fact sheets to provide education on common comprehensive error rate testing (CERT) errors related to oxygen therapy supplies, positive airway pressure (PAP) devices, and cardiac pacemakers. These educational products are available in downloadable format at the URLs listed below:

Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements – includes a checklist of the documentation needed to support claims submitted to Medicare for oxygen therapy supplies. For more details, visit http://www.cms.gov/MLNProducts/downloads/OxgnThrpy_DocCvg_FactSheet_ICN904883.pdf.

Cardiac Pacemakers – provides a list of common errors identified through the CERT review process and the covered indications for dual-chamber pacemakers. For more details, visit http://www.cms.gov/MLNProducts/downloads/CERT_Pmaker_FactSheet_ICN905144.pdf.

Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements – includes a checklist of the documentation needed to support claims submitted to Medicare for PAP devices. For more details, visit http://www.cms.gov/MLNProducts/downloads/PAP_DocCvg_FactSheet_ICN905064.pdf.

For additional resources that educate fee-for-service providers about common billing errors and other improper activities identified through CMS's claim review programs, including CERT, please visit the MLN Provider Compliance Web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.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 201101-27

The virtual event of the year

Now is the time to enter the virtual world of Medicare right from your office. Imagine a conference that has:

- No travel expenses
- Live, pre-recorded, and web-based training sessions right from your own computer
- Live question and answer sessions for selected sessions
- Total cost for YOU – free

So, get ready for one of the biggest events of 2011 as First Coast Service Options hosts the first Virtual Medifest conference **on February 21-25**. Registration has begun so be sure to navigate your way to FCSOMedicareTraining.com before sessions get full.

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	\$
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Mail this form with payment to:
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Medicare Publications
P.O. Box 406443
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(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 REDETERMINATIONMedicare Part A Redetermination
and Appeals

P. O. Box 45053

Jacksonville, FL 32232-5053

MEDICARE SECONDARY PAYER**Information on hospital protocols****Admission questionnaires, audits**

MSP – Hospital Review

P. O. Box 45267

Jacksonville, FL 32232-5267

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

Medicare Secondary Payer

P. O. Box 2711

Jacksonville, FL 32231-0021

MSPRC DPP debt recovery**Automobile accident cases****Settlements/lawsuits****Other liabilities**

Auto/Liability Department – 17T

P. O. Box 44179

Jacksonville, FL 32231-4179

ELECTRONIC CLAIM FILING**Direct data entry (DDE) startup**

Direct Data Entry

P. O. Box 44071

Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Complaint Processing Unit

P. O. Box 45087

Jacksonville, FL 32232-5087

POST-PAY MEDICAL REVIEW

First Coast Service Options Inc.

P. O. Box 44159

Jacksonville, FL 32231-4159

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

Provider Audit and Reimbursement

Department (PAR)

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)

Attn: FOIA PAR – 16T

P. O. Box 45268

Jacksonville, FL 32232-5268

1-904-791-8430

PROVIDER ENROLLMENT

CMS-855 Applications

P. O. Box 44021

Jacksonville, FL 32231-4021

PROVIDER ENROLLMENT**American Diabetes Association****certificates**

Medicare Provider Enrollment – ADA

P. O. Box 2078

Jacksonville, FL 32231-0048

SPECIAL DELIVERY**Overnight mail and/or other****special courier services**

First Coast Service Options Inc.

532 Riverside Av.

Jacksonville, FL 32202-4914

Other important addresses

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

Palmetto 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

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.comCenters for Medicare & Medicaid
Serviceswww.cms.gov**BENEFICIARIES**Centers for Medicare & Medicaid
Serviceswww.medicare.gov

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 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

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 Jacksonville, FL 32232-5087

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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

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 Jacksonville, FL 32231-4159

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 P. O. Box 45268
 Jacksonville, FL 32232-5268
 1-904-791-8430

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 P.O. Box 45268
 Jacksonville, FL 32232-5268
 1-904-791-8430

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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

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

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**Durable medical equipment claims
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Fax
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Medicare websites

PROVIDERS

U.S.V.I. Medicare contractor
[medicare.fcso.com](http://www.medicare.fcso.com)

Centers for Medicare & Medicaid
 Services
www.cms.gov

BENEFICIARIES

Centers for Medicare & Medicaid
 Services
www.medicare.gov



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦

