

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.fcsom.com/>.

Routing Suggestions:

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



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

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A MESSAGE TO PROVIDERS

MAC J9 Part A error rates and prepayment inpatient DRG medical review

As the Medicare administrative contractor (MAC) for Jurisdiction 9 (J9), First Coast Service Options, Inc. (FCSO) is committed to assisting the Centers for Medicare & Medicaid Services (CMS) in reaching the goal of reducing the national Medicare fee-for-service (FFS) paid claims error rate. Although FCSO has been successful in maintaining exceptional Part A error rates in the past, there are challenges that are impacting FCSO's ability to achieve CMS' current error rate reduction goal. As stated in CMS' November 16, 2010, press release announcing the 2010 national comprehensive error rate testing (CERT) error rates, claims reviewed in the 2010 report sample was held to more stringent review criteria which CMS initially implemented in 2009. The primary modification to the CERT review process involved strict adherence to documentation requirements outlined in Medicare regulations, statutes, and policies. CMS' press release also reported that the primary causes of errors nationally in the Medicare FFS program for 2010 are insufficient documentation and medically unnecessary services. Although CMS has not released the "November 2010 National Improper Payment Report" at this time, FCSO's analysis of CERT claims sample data indicates the same high impact issues at the Medicare administrative contractor (MAC) J9 level.

FCSO's initial response and outcomes

FCSO reacted quickly to the changes in review criteria that were implemented in 2009 and began widespread provider education on the new enforcement standards. Throughout 2010, FCSO continued aggressive documentation procurement to support the CERT documentation and review contractors and provided extensive provider education on medical documentation requirements through numerous venues.

Unfortunately, these efforts did not result in lowering the MAC J9 November 2010 error rate. The overall November 2010 MAC J9 Part A error rate is 12.25 percent. The November 2010 FCSO Part A MAC non-inpatient error rate is 4.66 percent. The largest contributors to the MAC J9 non-inpatient error rate are outpatient hospital claims and SNF inpatient claims, with the majority of errors resulting from insufficient documentation. Documentation procurement and education on documentation requirements will be further enhanced during 2011 in order to reduce these errors for the 2011 and 2012 report periods.

Due to the dollar impact of inpatient hospital claims, inpatient hospital diagnosis related group (DRG) errors made up the largest dollars included in the 12.25 percent overall MAC J9 Part A error rate. The November 2010 Part A MAC inpatient DRG error rate was 18.17 percent. This error rate was considerably higher than the national inpatient error rate. MAC J9 DRG errors identified by the CERT program in the 2010 report sample generally resulted from inpatient admissions that failed to meet medical necessity for an inpatient level of care. Insufficient documentation and incorrect DRG assignments accounted for most of the remaining DRG claim payment errors.

FCSO's next steps and impacts to providers

FCSO will continue to evaluate CERT findings to identify improvement opportunities that will have an impact on the contractor specific error rates in order to meet CMS' error rate goal of 8.5 percent by 2011 and 6.2 percent by 2012. In order to reduce the overall error rate, extensive medical review and education focus will be placed on inpatient hospital services during 2011. This includes implementing prepayment medical review for targeted DRG services in MAC J9 (excluding Puerto Rico and the U.S. Virgin Islands). During 2011, FCSO will perform widespread probe reviews on targeted DRGs in Puerto Rico. The two hospitals in the U.S. Virgin Islands are non-inpatient prospective payment system (IPPS) facilities.

Short stay DRGs in particular demonstrate a high potential for payment error at the national and MAC J9 level. Therefore, FCSO focused previous MAC J9 (excluding Puerto Rico) post payment medical review activities on several short stay DRGs deemed to be at high risk for payment error, including DRGs 313 (chest pain), 552 (medical back problem w/o MCC), 392 (Gastroenterology and miscellaneous digestive w/o MCC), 641 (nutritional miscellaneous metabolic disorder w/o MCC) and 227 (cardiac defibrillation w/o cardiac cath w/o MCC). Widespread probe reviews for DRG 313 resulted in a 55 percent error rate in 2009 and 76 percent in 2010. The MAC J9 CERT error rate for DRG 313 was over 60 percent (excluding Puerto Rico). Widespread probe reviews for DRG 552 resulted in an error rate of 70.92 percent in 2009 and 71.25 percent in 2010. Therefore, **effective March 1, 2011**, FCSO will perform 30 percent prepayment medical review on DRG 313 in MAC J9 (excluding Puerto Rico and the U.S. Virgin Islands). Later in 2011, FCSO also plans to implement 30 percent prepayment medical review for DRG 552 in MAC J9 (excluding Puerto Rico and the U.S. Virgin Islands).

In addition to targeted MAC J9 prepayment medical review (excluding Puerto Rico), certain providers will be identified for provider specific probe reviews based on data analysis indicators and widespread probe post payment medical reviews will be performed in Puerto Rico. FCSO also plans to carry out an aggressive inpatient DRG education and feedback initiative throughout MAC J9 during 2011. This initiative was kicked off early in January 2011 with a number of Florida facilities receiving onsite education and individual feedback. Additional site visits are planned for 2011, and FCSO will begin sending quarterly letters to all Part A providers. The quarterly letters will include detailed information regarding the facility's individual quarterly CERT error rate and the facility's MAC error rate based on claims hitting the DRG specific prepayment edits. FCSO will continue to look for other education and feedback venues and will continue to partner with associations and provider groups throughout the jurisdiction in order to successfully lower the MAC J9 error rates.

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

April update to the 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, nonphysician practitioners, and providers submitting claims to Medicare contractors (fiscal intermediaries, carriers or Part A/B Medicare administrative contractors, and regional home health intermediaries) for services provided to Medicare beneficiaries that are paid under the Medicare physician fee schedule (MPFS).

What you need to know

Payment files were issued to contractors based upon the CY 2011 Medicare physician fee schedule (MPFS) final rule, released on November 2, 2010, and published in the *Federal Register* on November 29, 2010. As previously described in change request (CR) 7300, these payment files were modified in accordance with the MPFS final rule correction notice released on December 30, 2010, and published in the *Federal Register* on January 11, 2011, and by relevant statutory changes applicable January 1, 2011, including the Physician Payment and Therapy Relief Act of 2010, and the Medicare and Medicaid Extenders Act of 2010.

This article is based on CR 7319, which details changes included in the April quarterly update to those payment files. Note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that were processed prior to implementation of CR 7319. However, contractors will adjust claims brought to their attention. Please be sure to inform your staff of these changes.

Background

Medicare physician fee schedule database (MPFSDB) payment file revisions

In order to reflect appropriate payment policy in line with the CY 2011 MPFS final rule, some payment indicators and practice expense (PE) relative-value units (RVUs) have been revised. New MPFS payment files have been created that include these changes.

MPFSDB indicator changes

The following codes have MPFSDB indicator changes:

HCPCS code	Short descriptor	Indicator
31579	Diagnostic laryngoscopy	Global surgery: 000
57155	Insert uteri tandems/ovoids	Co-surgeons: 2
64613	Destroy nerve neck muscle	Bilateral surgery: 2
64614	Destroy nerve extrem musc	Bilateral surgery: 2
77071	X-ray stress view	Bilateral surgery: 2
92511	Nasopharyngoscopy	Global surgery: 000

HCPCS code	Short descriptor	Indicator
93464 26	Exercise w/ hemodynamic meas	Multiple surgery: 0

Practice expense RVU changes

The following HCPCS codes have practice expense RVU changes. A detailed description of these changes may be found in CR 7319.

HCPCS code	Short descriptor
93503	Insert/place heart catheter
93224	Ecg monit/reprt up to 48 hrs
93225	Ecg monit/reprt up to 48 hrs
93226	Ecg monit/reprt up to 48 hrs

Added HCPCS code

The following HCPCS code has been added, effective April 1, 2011. More information on this addition may be found in CRs 7319 and 7299.

HCPCS code	Short descriptor
Q2040	Incobotulinumtoxin A

Discontinued HCPCS codes

The following HCPCS codes are discontinued for **dates of service on or after January 1, 2011**, that are processed on or after April 4, 2011.

HCPCS code	Short descriptor
90470	Immune admin H1N1 im/nasal
90663	Flu vacc pandemic H1N1

The following HCPCS codes are discontinued for **dates of service on or after April 1, 2011**, that are processed on or after April 4, 2011.

HCPCS code	Short descriptor
Q1003	Ntiol category 3
S2270	Insertion vaginal cylinder
S2344	Endosc balloon sinuplasty
S3905	Auto handheld diag nerv test

Correction to payment file OPPS cap "Imaging Payment Amount" field for CPT Code 92227

CPT code 92227 (Remote Dx retinal imaging), is subject to the OPPS payment cap determination and has an imaging cap indicator of 1. The CY 2011 MPFS relative value file correctly lists OPPS payment amounts (PE=0.53 and MP =0.02) for this code; however, these values were not carried over to the Imaging Payment Amount field in the Medicare contractor payment files, which listed the values as 0.00 for all carriers. This will be corrected in the MPFS payment files released for the April quarterly update, effective January 1, 2011.

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

Additional information

The official instruction, CR 7319, issued to your FI, carrier, or A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2167CP.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: MM7319

Related Change Request (CR) #: 7319

Related CR Release Date: February 25 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2167CP

Implementation Date: April 4, 2011

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Reprocessing claims affected by the Affordable Care Act and 2010 Medicare physician fee schedule changes

This message is for physicians, other practitioners, ambulance suppliers, inpatient/outpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, and any other provider type affected by the post-effective date implementation of select provisions of the Affordable Care Act and the 2010 Medicare physician fee schedule (MPFS).

On March 23, 2010, President Obama signed into law the Affordable Care Act. Various provisions of the new law were effective April 1, 2010, or earlier and, therefore, were implemented some time after their effective date. In addition, corrections to the 2010 MPFS were implemented at the same time as the Affordable Care Act revisions to the MPFS, with an effective date retroactive to January 1, 2010.

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-service claims will be reprocessed. Given this large workload, the Centers for Medicare & Medicaid Services (CMS) is taking steps to ensure that new claims coming into the Medicare program are processed timely and accurately, even as the retroactive adjustments are being made. CMS will begin to reprocess these claims over the next several weeks. CMS expects this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

In the majority of cases, you will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your affected claims. Please do not resubmit claims because they will be denied as duplicate claims and slow the retroactive adjustment process. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount (MPFS and ambulance fee schedule) cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, CMS believes these circumstances fall under the "good cause" criteria and is extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contactors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims. Underpayments will be included in the next regularly scheduled remittance after the adjustment. Overpayments resulting from institutional provider (e.g., hospitals, inpatient rehabilitation facilities, etc.) claim adjustments will be offset immediately, regardless of the amount, unless there are insufficient funds to make the offset. When these overpayments cannot be offset, the amounts will accumulate until a \$25 threshold is reached. At that time, a demand letter will be sent to the institutional provider. When a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than \$10, your contractor will not request repayment until the total amount owed accrues to at least \$10. See the *Financial Management Manual, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2* for more information.

CMS wants to remind physicians, practitioners, suppliers, and other providers, impacted by the retroactive increases in payment rates for claims affected by the Affordable Care Act and 2010 MPFS changes, of the Office of Inspector General policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new federal statutes or regulations. The policy may be found at http://oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.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 201102-18

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Affordable Care Act – Section 3113 – laboratory demonstration for certain complex diagnostic tests

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

Provider types affected

Clinical laboratories, hospitals and physicians submitting claims for certain complex diagnostic tests provided to Medicare beneficiaries to fiscal intermediaries [FIs], carriers, and A/B Medicare administrative contractors [MACs] may be affected by this article.

Provider action needed

Stop – impact to you

Section 3113 of the Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years beginning July 1, 2011, or until the one hundred million dollar (\$100,000,000) payment ceiling established for the demonstration has been reached.

Caution – what you need to know

The demonstration will establish a separate payment method for the demonstration tests with a date of service (DOS) that would, under standard Medicare rules, be bundled into the payment for an associated hospital inpatient stay. Under the demonstration, independent and hospital-based laboratories may bill separately for demonstration tests that are ordered within a 14 day period after a hospital discharge.

Note: Outpatient prospective payment system (OPPS) services, provided as part of an outpatient encounter, are currently separately payable and are, therefore, excluded from this demonstration.

Go – what you need to do

Change request (CR) 7278, on which this article is based, explains how to bill for the demonstration tests. Please read the *Background* section below for billing information for these claims. Be sure your staff is aware of these changes.

Background

The Affordable Care Act requires CMS to conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years, beginning July 1, 2011, or until the one hundred million dollar (\$100,000,000) payment ceiling has been reached. The demonstration will establish a separate payment method for these tests with a DOS that would, under standard Medicare rules, be bundled into the payment for an associated hospital inpatient stay.

Complex diagnostic laboratory test defined

Under this demonstration, the term “complex diagnostic laboratory” means a diagnostic laboratory test that is:

- An analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay
- Determined by the Secretary of Health & Human Services to be a laboratory test for which there is not an alternative test having equivalent performance characteristics
- Billed using a Health Care Procedure Coding System

(HCPCS) code other than a not otherwise classified code under the coding system

- Approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act, and
- Described in Section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)). This section of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm.

DOS rule

The DOS rule determines whether or not the laboratory service, under standard Medicare rules, is bundled into the diagnosis-related group (DRG) payment made to the hospital. In general, the DOS must be the date the specimen was collected.

- The test/service is bundled into the DRG if: 1) the test/service is ordered by the patient’s physician less than 14 days following the date of the patient’s discharge from the hospital; 2) the specimen was collected while the patient was undergoing a hospital surgical procedure; 3) it would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted; 4) the results of the test/service do not guide treatment provided during the hospital stay; and 5) the test/service was reasonable and medically necessary for treatment of an illness.
- The test/service is not bundled into the DRG if the test/service is ordered by the patient’s physician greater than 14 days following the date of the patient’s discharge from the hospital, allowing laboratories to directly bill Medicare Part B for the service.

Under the demonstration, CMS will allow independent and hospital-based laboratories to bill separately for certain complex diagnostic laboratory services that are ordered within a 14-day period after a hospital discharge. The DOS of the clinical diagnostic laboratory service must also be within the demonstration period, which runs from July 1, 2011, through June 30, 2013, inclusive, unless the dollar threshold is reached prior to June 30, 2013. Claims may be rejected if the DOS is greater than 14 days following the date of the patient’s discharge from a covered hospital stay.

Section 3113 Demonstration Fee Schedule

All HCPCS codes included in this demonstration will be identified on a “Section 3113 Demonstration Fee Schedule”. This fee schedule will be used to pay for HCPCS codes included in the demonstration and billed, using the demonstration project identifier 56, which needs to be entered:

- In item 19 on the CMS-1500 form
- In locator 63 on the UB04 form
- On the electronic claim in X12 837 Professional Claim (HIPAA version) in Loop 2300, REF02, REF01+P4, and

Affordable Care Act – Section 3113 – laboratory demonstration for certain complex diagnostic tests (continued)

- On the X12 837 Institutional claim (HIPAA version) in Loop 2300, REF02, G1 in REF01 DE 128.

Claims submitted with the 56 project identifier without a HCPCS code involved in the demonstration will be rejected with a reason code 96 (Non-covered charge(s)) and a remark code of M114 (This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a demonstration project. For more information regarding these projects, contact your local contractor.) Claims submitted with the project identifier 56 with a DOS outside the date range of the demonstration or after the \$100,000,000 limit is reached will be rejected with these same codes.

Payment under the demonstration is voluntary and available to any laboratory nationwide. There will be no locality variation on the Section 3113 Demonstration Fee Schedule.

HCPCS codes included in the demonstration project will be posted at <http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1240611&intNumPerPage=10>.

By submitting a claim with the Section 3113 Demonstration Project Identifier 56, the laboratory agrees to cooperate with the independent evaluation and the implementation contractors selected by CMS for purposes of this demonstration project. This may include providing data needed to assess the impact of the demonstration and participating in surveys and/or site visits as requested by these contractors.

Announcements and updates

Announcements and updates about this demonstration will be made via the project listserv available at: https://list.nih.gov/cgi-bin/wa.exe?SUBED1=MEDICARE_LAB_DEMO&A=1.

Note: Claims with the demonstration project identifier 56 may be rejected after the one hundred million dollar (\$100,000,000) payment ceiling has been met.

Additional information

The official instruction, CR 7278, was issued to your FI, carrier, or A/B MAC regarding this change in two transmittals. One transmittal revised the *Medicare Claims Processing Manual* and it may be viewed at <http://www.cms.gov/Transmittals/downloads/R2144CP.pdf>. The other transmittal revised the *Demonstrations Manual* and it is available at <http://www.cms.gov/Transmittals/downloads/R67DEMO.pdf>.

MLN Matters® Number: MM7278

Related Change Request (CR) #: 7278

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Implementation Date: July 5, 2011

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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.

April 2011 quarterly ASP update and revision to prior files

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

Provider types affected

This article is for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment 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) 7298 which instructs your Medicare contractors to download and implement the April 2011 average sales price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised January 2011, October 2010, July 2010, and April 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 4, 2011, with dates of service April 1, 2011, through June 30, 2011. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

Section 1847A of The Medicare Modernization Act of 2003 (Section 303(c); see <http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf>) revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis.

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

April 2011 quarterly ASP update and revision to prior files (continued)

Files	Effective for dates of service
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010

Additional information

The official instruction, CR 7298, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2135CP.pdf>. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7298
 Related Change Request (CR) #: 7298
 Related CR Release Date: January 21, 2011
 Effective Date: April 1, 2011
 Related CR Transmittal #: R2135CP
 Implementation Date: April 4, 2011

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Information for institutional providers regarding the billing of 90662

Medicare institutional providers should not submit claims with procedure 90662 with dates of service on or after October 1, 2010, via roster billing; current editing prevents procedure 90662 to be billed on roster claims. Medicare systems are unable to hold roster claims submitted by institutional providers until system changes are implemented on July 5, 2011. Medicare institutional providers may submit their roster claims on an individual claim basis or hold their roster claims until July 5, 2011, and then submit as a roster bill at that time.

Source: CMS PERL 201101-43

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2011 DMEPOS fee schedule update

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

Note: This article was revised on January 25, 2011, to make the following changes: codes L3660, L3670, and L3675 were removed from the list of codes deleted from the HCPCS file; the purchase fee schedule calculation for complex rehabilitation power wheelchairs was added to the *Power-driven wheelchairs* section; and the language was clarified under the CY 2011 fee schedule update factor section. The transmittal number, CR date, and link for viewing the CR was also changed. This information was previously published in the January 2011 *Medicare A Bulletin*, pages 12-15.

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 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 year (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. 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

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

GENERAL INFORMATION

2011 DMEPOS fee schedule update (continued)

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
- 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
- L3672 and L3673.

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

2011 DMEPOS fee schedule update (continued)

Factor	Category
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 change request 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 4-13. The purchase fee schedule amount for complex rehabilitation power wheelchairs is equal to the rental fee (for months 1-3) divided by 0.15. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR 7248. This attachment identifies those codes where payment, when applicable, should be made at 15 percent of the purchase price for months 1-3 and 6 percent of the purchase price for months 4-13.

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 2-3 and 7.5 percent of the purchase price for rental months 4-13.

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/MLN MattersArticles/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:

- 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 percentage increase is 1.1 percent. Therefore, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent increase in the MFP, resulting in a net reduction of 0.1 percent for the MFP-adjusted update factor. In other words, the MFP-adjusted update factor of -0.1 percent is applied to the applicable CY 2010 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.

2011 DMEPOS fee schedule update (continued)

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 six months after the end of the 36th 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 was 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 durable medical equipment 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 that reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary durable medical equipment 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, 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/R2142CP.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 *Revised*
 Related Change Request (CR) #:7248
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Revised quarterly provider specific files now available

The revised January 2011 quarterly provider specific files (PSF) in statistical analysis system (SAS) and text formats are now available on the CMS website. The SAS data files are available at http://www.cms.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp in the *Downloads* section. The text data files are available at http://www.cms.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp in the *Downloads* section. If you use the provider specific text or SAS file data, please go to the respective page above and download the latest version of the PSF files.

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

Source: CMS PERL 201101-37

CMS conducting follow-up calls for CERT program

The Centers for Medicare & Medicaid Services (CMS) will be conducting follow-up calls to providers for the comprehensive error rate testing (CERT) program. You or your staff may be contacted to obtain all necessary medical record documentation for claims reviewed under the CERT program. Although you may have already received letters and telephone calls from the CERT contractor, these additional efforts by CMS to obtain adequate documentation may change your claim's status from "improper payment" to "proper payment." This will allow CMS to calculate a more accurate Medicare fee-for-service error rate, while also reducing the amount of improper payments.

Source: CMS PERL 201102-39

'Preparing for ICD-10 Implementation in 2011' transcript and recording now available

The Centers for Medicare & Medicaid Services (CMS) hosted a national provider teleconference on "Preparing for ICD-10 Implementation in 2011" on January 12, 2011. The written transcript and audio recording are now available at <http://www.cms.gov/ICD10/Tel10/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1242831&intNumPerPage=10>. To access the file, scroll down the Web page to the *Downloads* section and select the appropriate file.

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Source: CMS PERL 201101-47

Reminder – important information on the timely claims filing requirement

The Centers for Medicare & Medicaid Services (CMS) would like to remind Medicare fee-for-service physicians, providers, and suppliers submitting claims to Medicare for payment, as a result of the Patient Protection and Affordable Care Act (PPACA), effective immediately, all claims for services furnished on or after January 1, 2010, must be filed with your Medicare contractor no later than one calendar year (12 months) from the date of service – or Medicare will deny them.

In general, the start date for determining the one-year timely filing period is the date of service or "From" date on the claim. For institutional claims that include span dates of service (i.e., a "From" and "Through" date on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness. For claims submitted by physicians and other suppliers that include span dates of service, the line item "From" date is used for determining the date of service for claims filing timeliness.

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

- MM6960 – "Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months" – <http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf> on the CMS website.
- MM7080 – "Timely Claims Filing: Additional Instructions" – <http://www.cms.gov/MLNMattersArticles/downloads/MM7080.pdf> on the CMS website.
- MM7270 – "Changes to the Time Limits for Filing Medicare Fee-for-Service Claims" – <http://www.cms.gov/MLNMattersArticles/downloads/MM7270.pdf> on the CMS website.

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

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

Source: CMS PERL 201102-30, 201102-10

Changes to the time limits for filing Medicare fee-for-service claims

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

Provider types affected

This article is for all providers and suppliers submitting Part A and/or Part B claims to Medicare contractors (carriers, durable medical equipment 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 furnished to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7270, regarding changes to the time limits for filing Medicare fee-for-service (FFS) claims.

Caution – what you need to know

Section 6404 of the Affordable Care Act reduced the maximum period for submission of all Medicare FFS claims to no more than 12 months, or one calendar year, after the date of service. As a result of the passage of this legislation, the Centers for Medicare & Medicaid Services (CMS) is updating the *Medicare Claims Processing Manual* (Chapter 1) pertaining to the time limits for filing Medicare claims.

Go – what you need to do

CR 7270 also establishes exceptions, if certain conditions are met, to the time limit for filing Medicare claims. (See the *Background* and *Additional information* sections of this article, for further details regarding these changes.)

Background

The Social Security Act (Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B)) as well as the Medicare regulations at 42 CFR Section 424.44 (see http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr424.44.pdf), specify the time limits for filing Medicare FFS (Part A and Part B) claims.

Prior to the passage of the Affordable Care Act on March 23, 2010, a provider or supplier had from 15 to 27 months (depending on the date of service) to file a timely claim.

- For services furnished in the first nine months of a calendar year, claims had to be submitted to the appropriate Medicare contractor by December 31 of the following year.
- For services furnished in the last three months of a calendar year, claims had to be submitted to the appropriate Medicare contractor by December 31 of the second following year.

The Affordable Care Act (Section 6404) reduced the maximum period for submission of all Medicare FFS claims to no more than 12 months (one calendar year) after the date services were furnished. This time limit policy for claims submission became effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010, had to be submitted no later than December 31, 2010. The Affordable Care Act (Section 6404) also mandated that CMS may specify exceptions to the one calendar year time limit for filing

Medicare claims.

CR 7270 instructs that claims for services furnished:

- Prior to January 1, 2010, must be submitted no later than December 31, 2010.
- On or after January 1, 2010, the time limit for filing all Medicare FFS claims (Part A and Part B claims) is 12 months, or one calendar year from the date services were furnished.

Exceptions allowing extension of time limit

Medicare will allow for the following exceptions to the one calendar year time limit for filing FFS claims:

Administrative error: This is where the failure to meet the filing deadline was caused by error or misrepresentation of an employee, the Medicare contractor, or agent of the department that was performing Medicare functions and acting within the scope of its authority. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice that an error or misrepresentation was corrected.

Retroactive Medicare entitlement: This is where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notification of Medicare entitlement retroactive to or before the date of the furnished service.

Retroactive Medicare entitlement involving state

Medicaid agencies: This is where a state Medicaid agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. The state Medicaid agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which a state Medicaid agency recovered Medicaid payment from a provider or supplier.

Retroactive disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization:

This is where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE

Changes to the time limits for filing Medicare fee-for-service claims (continued)

provider organization recoups its payment from a provider or supplier six months or more after the date the service was furnished. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider or supplier.

Additional information

The official instruction, CR 7270, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2140CP.pdf>. Attached to CR 7270 are the revised Manual instructions, which provide complete details on the timely filing requirements, including the exceptions process. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters® Number: MM7270

Related Change Request (CR) #: 7270

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Implementation Date: February 22, 2011

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Medicare and Medicaid Research Review call for papers (ongoing submissions accepted)

The Medicare & Medicaid Research Review (MMRR) is soliciting studies, policy analyses, and program evaluations that use rigorous, scientific research methods. It is interested in papers addressing changes in coverage, quality, access, the organization and delivery of health services, payment for health services, and innovative methods. (Do not presume from the title that the scope is narrowly defined to include only research directly involving the Medicare, Medicaid, or the Children's Health Insurance Programs. It is not; though manuscripts should have results or conclusions that pertain to at least indirectly to these programs.)

Illustrative examples of topics include, but are not limited to:

- Development, use, and effects of quality-based and bundled-service payment models
- Impact of changes in cost sharing and coverage on care utilization patterns and outcomes
- Impact of Medicaid eligibility changes on the organization and delivery of care
- Descriptive analyses of longitudinal utilization and cost patterns among Medicare, Medicaid, and CHIP beneficiaries
- Impact of changes within the private health care system on Medicare, Medicaid, and CHIP, and
- Analyses of the types of health research questions amenable to quick study and implementation, and those questions that are not.

Submitted manuscripts must report the results of original scholarship. Manuscripts that are primarily editorial or opinion-based will not be considered. Manuscripts with results that directly support actionable recommendations will receive priority for publication. All manuscripts must be submitted by e-mail to MMRR-Editors@cms.hhs.gov following the guidelines available at http://www.CMS.gov/MMRR/Downloads/MMRR_Info_for_Authors_20101214.pdf.

Criteria for selection of manuscripts include:

1. Quality, rigor, and originality,
2. Significance and usefulness for informing the future of Medicare, Medicaid, and CHIP, and
3. Clarity of writing and presentation.

Peer reviewer guidelines are also available at <http://www.CMS.gov/MMRR/downloads/MMRRPeerRevGuidelines.pdf>.

Questions can be directed to David Bott, PhD, Editor-in-Chief, at MMRR-Editors@cms.hhs.gov.

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Source: CMS PERL 201102-24

Uninsured Americans with pre-existing conditions continue to gain coverage through Affordable Care Act

New resources available to increase awareness of new program for the uninsured

The U.S. Department of Health and Human Services (HHS) today made new resources available to the media, consumer groups, states, health care providers, and others to increase awareness of the Pre-existing Condition Insurance Plan (PCIP), a health plan for uninsured Americans with pre-existing conditions created by the Affordable Care Act.

Americans continue to enroll in the plan, which was created in 2010, to provide comprehensive health coverage – at the same price that otherwise healthy people pay – for uninsured Americans living with such conditions as cancer, diabetes, or heart disease, who have been unable to obtain affordable health insurance coverage.

This temporary program covers a broad range of health benefits and is designed as a bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. In 2014, all Americans – regardless of their health status – will have access to affordable coverage either through their employer or through a new competitive marketplace, and insurers will be prohibited from denying coverage to anyone based on their health status.

The Department is actively working with states, consumer groups, chronic disease organizations, health care providers, social workers, other federal agencies, and the insurance industry to promote the plan, including holding meetings with state officials, consumer groups, and others. New resources that are available to communities to help inform eligible Americans of the plan include a new web badge that links to <https://www.pcip.gov/>, as well as a new newsletter and website drop-in language that partners can use in their outreach efforts.

HHS' Center for Consumer Information and Insurance Oversight is also working with the U.S. Social Security Administration (SSA) on a comprehensive outreach campaign, putting information about the plan in the approximately 3.2 million social security disability insurance application receipts distributed each year. SSA is also promoting the Pre-existing Condition Insurance Plan in its advocate newsletter, its website, and on TVs in the waiting rooms of SSA's more than 600 field offices.

Resources available to consumer groups, media, states and others include:

- **PCIP.gov** (<https://www.pcip.gov/>) – this website offers information about eligibility, benefits and more. Consumers can find online and print applications for the plan in their state. Frequently asked questions are also available to help both organizations and consumers better understand the program.
- **Web badge** – a new website button was released today that groups can post on their website to link to <https://www.pcip.gov/>. To add the button to your website, visit www.HealthCare.gov/stay_connected.html and embed the code listed.
- **Newsletter and website drop-in language** – also released today, this language is ready for consumer groups, state or local governments or other organizations to simply drop into their newsletters or post on their websites to help educate consumers about their health insurance options. To find this language, visit www.HealthCare.gov/center/brochures.
- **Posters and brochures** – organizations can download or print English and Spanish language brochures and posters about PCIP to share with consumers. Find the brochures and posters here, www.HealthCare.gov/center/brochures.

The entire HHS press release can be found (February 10, 2011) at <http://www.hhs.gov/news/press/2011pres/02/20110210a.html>.

Visit <https://www.pcip.gov/> for more information on how the plan works in each state, including eligibility and how to apply. To find recent enrollment numbers, visit <http://www.healthcare.gov/news/factsheets/pcip02102011a.html>.

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Get motivated by Medicare ...

Find out about Provider Incentive Programs

- e-Prescribing (eRx)
- Electronic Health Records (EHR)
- Physician Quality Reporting System
- Primary Care Incentive Program (PCIP)

Available at <http://medicare.fcso.com/Landing/191460.asp>

February is American Heart Month

Heart disease is the leading cause of death for both men and women in the United States. Approximately every 25 seconds, an American will have a coronary event, yet many cases of heart disease can be prevented. The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of cardiovascular screening blood tests for eligible Medicare beneficiaries. These tests can help determine a beneficiary's cholesterol and other blood-lipid levels such as triglycerides. CMS recommends that all eligible beneficiaries take advantage of this coverage, which can determine whether beneficiaries may be at risk for cardiovascular disease.

Medicare coverage – the following cardiovascular screening blood tests are covered by Medicare for eligible beneficiaries for the early detection of cardiovascular disease:

- Total cholesterol test
- Cholesterol test for high-density lipoproteins
- Triglycerides test

These blood tests are covered once every five years for people with Medicare who have no apparent signs or symptoms of cardiovascular disease; the tests must be ordered by a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) treating the beneficiary.

What can you do? – CMS needs your help to ensure that all eligible people with Medicare take advantage of the cardiovascular screening blood tests that can help identify beneficiaries who may be at risk for cardiovascular disease.

More information – for more information about Medicare coverage of cardiovascular screening blood tests, please refer to the following resources:

- Expanded Benefits brochure – this Medicare Learning Network® (MLN) brochure provides Medicare fee-for-service providers with an overview of the Medicare-

covered cardiovascular screening blood tests, as well as the “Welcome to Medicare” visit and the ultrasound screening for abdominal aortic aneurysms. Read at http://www.CMS.gov/MLNProducts/downloads/expanded_benefits.pdf.

- Quick Reference Information: Medicare Preventive Services – this chart provides coverage and coding information on Medicare-covered preventive services including the cardiovascular screening blood tests. Read at http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- Cardiovascular Disease Screening page – this CMS page provides an overview of the cardiovascular screening blood tests covered by Medicare as well as information on educational resources for health care providers. Visit <http://www.CMS.gov/CardiovasDiseaseScreening>.
- The MLN Preventive Services Educational Products page – this page provides a list of MLN educational products related to Medicare-covered preventive services. These resources are specifically for Medicare fee-for-service providers and their staff. Visit at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp.

Additionally, visit the Centers for Disease Control and Prevention's American Heart Month website at http://www.CDC.gov/heartdisease/american_heart_month.htm

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Take advantage of FCSO's exclusive PDS report

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

ICD-9 and ICD-10 announcements

Agendas for the ICD-9-CM Coordination and Maintenance Committee meeting on March 9-10, 2011, are now available

Procedures topics, March 9, 2011

The agenda is posted in the “Downloads” section at http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp. Handouts will be available on this website a few days before the meeting.

Diagnosis topics, March 10, 2011

The link to the agenda is under “Upcoming Meeting, March 9-10, 2011” at http://www.cdc.gov/nchs/icd/icd9cm_maintenance.htm. Handouts will be available at this website a few days before the meeting. This will be the last meeting to address ICD-9-CM and ICD-10 code updates before the partial code freeze is implemented.

The ICD-10 MS-DRGs v28 Definitions Manual is now available from CMS

The ICD-10 MS-DRGs v28 Definitions Manual (based on FY2011 MS-DRGs) is now posted on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/ICD10/17_ICD10_MS_DRG_Conversion_Project.asp in the “Related Links Inside CMS” section. This update is part of the ICD-10 MS-DRG conversion project. In the conversion project, CMS is using the general equivalence mappings (GEMs) to convert CMS payment systems. CMS is sharing information learned from this project with other organizations facing similar conversion projects. Please note that the ICD-10 MS-DRGs will be subject to formal rulemaking. CMS also plans to post the ICD-10 FY 2011 Medicare code editor when it is completed in March 2011.

The ICD-10 abbreviated titles for both ICD-10-CM and ICD-10-PCS have been posted on the CMS website at http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp and http://www.cms.gov/ICD10/11b_2011_ICD10PCS.asp.

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DMEPOS medical equipment program offers value for Medicare beneficiaries

DMEPOS competitive bidding program focuses on providing access to high-quality products and services for people with Medicare

The Centers for Medicare & Medicaid Services (CMS) launched the first phase of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program on Saturday, January 1, 2011, in nine different areas of the country.

Through supplier competition, the program set new, lower payment rates for certain medical equipment and supplies, such as oxygen equipment, certain power wheelchairs, and mail order diabetic supplies. CMS estimates that Medicare and beneficiaries will pay 32 percent less on average for these equipment and supplies. In most cases, Medicare beneficiaries who obtain these items in the nine competitive bidding areas will need to get them from the Medicare suppliers that were awarded contracts in order to have the items covered under Medicare. More than four million Medicare beneficiaries living in the nine competitive bidding areas can save money through this new program, while continuing to have access to quality medical equipment from accredited suppliers they can trust.

CMS is pleased to report that implementation of the program is going very smoothly. CMS continues to deploy a wide array of resources across all of the competitive bidding areas to address any concerns that may arise, including local State Health Insurance and Assistance Program (SHIP) offices, specially-trained customer service representatives at 1-800-MEDICARE, and caseworkers in Medicare’s regional offices who all stand ready to assist beneficiaries who may have questions about the program. In addition, there is a complaint and inquiry process for beneficiaries, caregivers, doctors, referral agents, and suppliers to use for reporting concerns about a contract supplier or other competitive bidding implementation issues. This process is designed to ensure that all complaints are correctly routed, investigated, resolved, tracked, and reported.

To read the entire CMS press release issued on this topic on Wednesday, February, 16, 2011, visit http://www.CMS.gov/apps/media/press_releases.asp. Read more about how the Affordable Care Act improves Medicare at <http://www.Healthcare.gov/law/provisions/rebate/index.html>. And for additional information about the Medicare DMEPOS Competitive Bidding Program, please visit <http://www.CMS.gov/DMEPOSCompetitiveBid>.

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January is National Glaucoma Awareness Month

The month of January has been designated as National Glaucoma Awareness Month. As we approach the end of this month, you are asked to please join with the Centers for Medicare & Medicaid Services (CMS) in promoting increased awareness of glaucoma and the glaucoma screening service covered by Medicare. Glaucoma is the second most common cause of blindness in the U.S. and affects nearly four million Americans, half of whom do not even know that they have this disease. Through early detection and treatment, blindness can be prevented.

What can you do?

As a health care professional who provides care to seniors, as well as Medicare patients, you can help protect the vision of your patients who may be at high-risk for glaucoma. Please educate them about their risk factors and remind them of the importance of getting an annual glaucoma screening exam covered by Medicare.

Medicare coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high-risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older
- A Medicare-covered glaucoma screening includes:
 - A dilated eye examination with an intraocular pressure (IOP) measurement
 - A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination

Additional information

- **Glaucoma Screening Brochure** – this *Medicare Learning Network*® (MLN) brochure provides Medicare fee-for-service providers with an overview of the Medicare-covered glaucoma screening service. <http://www.cms.gov/MLNProducts/downloads/glaucoma.pdf>
- **Glaucoma Screening Web Page** – this CMS Web page provides an overview of the glaucoma screening service covered by Medicare as well as information on educational resources for health care providers. http://www.cms.gov/GlaucomaScreening/01_Overview.asp
- **The MLN Preventive Services Educational Products Web Page** – this Web page provides a list of MLN educational products related to Medicare-covered preventive services. These resources are specifically for Medicare fee-for-service providers and their staff. http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

For more information about National Glaucoma Awareness Month, please visit <http://preventblindness.org/news/observe.html>. Thank you for joining CMS in promoting increased awareness of glaucoma and the glaucoma screening benefit covered by Medicare.

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Source: CMS PERL 201101-42

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Calendar year 2011 home health PPS PC Pricer update

The calendar year (CY) 2011 home health prospective payment system (HH PPS) personal computer (PC) Pricer is now available for download. The HH PPS PC Pricers are on the web page, http://www.cms.hhs.gov/PCPricer/05_HH.asp, under the *Downloads* section. If you use the CY 2011 HH PPS PC Pricers, please go to the page above and download the latest versions of the PC Pricer.

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Source: CMS PERL 201102-08

Find fees faster: Try FCSO's fee schedule lookup

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

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.

Note: This article was revised on February 9, 2011, to reflect a revised change request (CR) 7182 that was issued on February 8, 2011. The CR release date, transmittal number, and the Web address for accessing the CR were revised in this article. All other information remains the same. This information was previously published in the January 2011 *Medicare A Bulletin* pages 58-60.

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

CR 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
- 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

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 Prospective Payment System (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.

New home health claims reporting requirements for G codes related to ... (continued)

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

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

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

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/R859OTN.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/hcpcsreleasecodesets/ANHCPCS/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1240961&intNumPerPage=10>.

New home health claims reporting requirements for G codes related to ... (continued)

MLN Matters® Number: MM7182 *Revised*
 Related Change Request (CR) #: 7182
 Related CR Release Date: February 8, 2011
 Effective Date: January 1, 2011
 Related CR Transmittal #: R859OTN
 Implementation Date: January 3, 2011

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ELECTRONIC HEALTH RECORDS

Stay informed about the EHR incentive programs

Have you registered for the Centers for Medicare & Medicaid Services (CMS) electronic health record (EHR) incentive programs yet? Registration for the Medicare and Medicaid EHR incentive programs has already begun, and providers and hospitals began receiving their Medicaid EHR incentive payments in January. The University of Kentucky Healthcare, the University of Kentucky's teaching hospital, and Central Baptist Hospital became the first hospitals to receive payments, and physicians at the Gastorf Family Clinic in Durant, OK, became the first eligible professionals to collect their initial Medicaid EHR incentive program payments.

Not sure if you are eligible to participate in the EHR incentive programs? Need help with registration? The Medicare and Medicaid EHR incentive programs Web page features several resources to assist you, including:

- **The eligibility widget** – in order to register, you must first find out if you qualify as an eligible professional or eligible hospital. The eligibility widget will walk you step-by-step through the eligibility requirements, letting you know if you qualify for the Medicare or Medicaid EHR incentive programs. You can find this resource on the CMS website at http://www.CMS.gov/EHRIncentivePrograms/15_Eligibility.asp.
- **Information about registration** – to help you prepare, a list of all the information you will need during your registration process is provided for both eligible professionals and eligible hospitals. You can find this resource on the CMS website at http://www.CMS.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#BOOKMARK2
- **The eligible professional registration webinar** – are you ready to register? Check out the registration webinar for eligible professionals, which provides video guidance to help you through the registration process. View at <http://www.YouTube.com/user/CMSHHSgov#p/u0/sKngNjd8Iuc>.
- **Hospital tip sheets** – located on the EHR incentive programs Web page are helpful tip sheets providing information on payment and eligibility guidelines for Medicare, Medicaid, and critical access hospitals. You can find these resources at http://www.CMS.gov/EHRIncentivePrograms/55_EducationalMaterials.asp.
- **EHR Listserv** – CMS has created a new Listserv specifically about the EHR incentive programs. The listserv will provide timely, authoritative information about the programs, including registration and attestation updates and details about the payment process. By subscribing to the Listserv, you'll be kept informed of upcoming deadlines and answers to the questions and concerns that we have gathered from eligible professionals and hospitals in the field. New updates will be emailed through the listserv to keep you informed of any developments, and subscribers will be notified of any new frequently asked questions (FAQs) published on the CMS EHR incentive programs' Web page. Sign up at and learn more http://www.CMS.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp.

Learn more about the EHR incentive programs and keep up to date at <http://www.CMS.gov/EHRIncentivePrograms>.

EHR incentive programs: Not sure where to start?

Everyone's talking about the Medicare and Medicaid EHR incentive programs. Not sure what it's all about? CMS has developed the following tip sheets to get you started. You can view them electronically or order free printed copies.

Payment and eligibility for professionals

- Eligibility flow chart (http://www.cms.gov/EHRIncentivePrograms/downloads/eligibility_flow_chart.pdf)
- Medicare tip sheet for eligible professionals (http://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf)
- Medicaid tip sheet for eligible professionals (http://www.cms.gov/MLNProducts/downloads/EHRIP_Eligible_Professionals_Tip_Sheet.pdf)
- Medicare EHR Incentive Program, Physician Quality Reporting System, and e-Prescribing Comparison (<http://www.cms.gov/MLNProducts/downloads/EHRIncentivePayments-ICN903691.pdf>)

*Stay informed about the EHR incentive programs (continued)***Payment and eligibility for hospitals**

- Tip sheet for Medicare hospitals (http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf)
- Tip sheet for critical access hospitals (http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_CAH.pdf)
- Tip sheet for Medicaid hospitals (http://www.cms.gov/MLNProducts/downloads/Medicaid_Hosp_Incentive_Payments_Tip_Sheets.pdf)
- For more information and the latest news and updates on the EHR incentive programs, visit <http://www.CMS.gov/EHRIncentivePrograms>.

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Source: CMS PERL 201102-40

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New tools to help register for the electronic health record incentive

New tools for providers include:

- **Interactive eligibility tool for eligible professionals:** Are you eligible to participate in the Medicare or Medicaid EHR incentive programs? Use the tool found at the bottom of the Eligibility page on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp.
- **Registration webinar for eligible professionals:** How do I register? CMS created a video containing step-by-step instructions to help ensure the registration process is a success. Watch the video found on the Registration and Attestation page of the CMS website at http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp.
- **Medicaid state launch dates and websites:** When will your state offer an EHR incentive program? Information on when registration will be available for Medicaid EHR incentive programs in specific states is posted on the Medicaid State Information page of the CMS website at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp. Click on the map for information about your state: State EHR Incentive Program Launch Times and HIT Websites at <http://www.cms.gov/apps/files/medicaid-HIT-sites/>.
- **Medscape participant self-assessment, Medicare and Medicaid EHR incentives:** What do you know and do you know enough? Earn continuing medical education credit while you learn. Take the Medscape EHR self-assessment at <http://www.cms.gov/EHRIncentivePrograms/>. Participation may require the user to log in to Medscape; however registration is free and does not require any commitment.

For more information about the EHR incentive programs and to register at www.cms.gov/EHRIncentivePrograms.

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

Source: CMS PERL 201101-41

EHR-related fact sheets now available in print

The following fact sheets related to electronic health records (EHR) are now available in print format from the *Medicare Learning Network*[®]. To place an order, visit <http://www.CMS.gov/MLNGenInfo>, scroll to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

- EHR Incentive Program for Critical Access Hospitals (ICN #904627)
- EHR Incentive Program for Medicare Hospitals (ICN #904626)
- Medicare Electronic Health Record Incentive Program for Eligible Professionals (ICN #903695)
- Medicaid Electronic Health Record Incentive Payments For Eligible Professionals (ICN #904763)
- Medicaid Hospital Incentive Payments Calculations (ICN #904764)
- Medicare EHR Incentive Program, Physician Quality Reporting System, and e-Prescribing Comparison (ICN #903691) – identifies opportunities for certain Medicare providers to receive incentive payments for participating in important Medicare initiatives.

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

Source: CMS PERL 201102-13

New Listserv for the Medicare and Medicaid electronic health record incentive

The Centers for Medicare & Medicaid Services (CMS) has a new Listserv about the Medicare and Medicaid electronic health record (EHR) incentive programs. The Listserv will provide timely, authoritative information about the programs, including registration and attestation updates, and details about the payment process.

By subscribing to the Listserv, CMS will keep you informed of upcoming deadlines and give you answers to the questions and concerns that have been gathered from eligible professionals and hospitals in the field. New updates will be emailed through the Listserv to keep you informed of any developments, and subscribers will be notified of any new frequently asked questions that are published on the CMS EHR incentive programs' website. These e-mail messages are another CMS resource, in addition to those listed below, that will help you navigate the EHR incentive programs.

CMS encourages you to let others know about the CMS EHR Listserv, and to share its messages. Go to http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp to join the Listserv and learn more.

The CMS EHR incentive programs website features the following resources:

- Path to payment (https://www.cms.gov/EHRIncentivePrograms/10_PathToPayment.asp) – learn the necessary steps to receiving payments for the meaningful use of electronic health records.
- Registration guides (https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp) – review a user guide of how to register and watch a video webinar that will help you navigate the registration website.
- Meaningful use (https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp) – read more about the details of meaningful use, including clinical quality measures, and how to meet the requirements.
- Calendar of important dates (http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp) – read more about key milestone dates for the EHR incentive program.

Want more information about the EHR incentive programs?

Make sure to visit the EHR incentive programs website at <http://www.cms.gov/EHRIncentivePrograms> for the latest news and updates on the EHR incentive programs.

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Source: CMS PERL 201102-22

Information for eligible professionals about registration for the electronic health record incentive programs

Designation of a third-party to register – at this time, there is no method available for a third-party to register multiple eligible professionals (EPs) for the Medicare and Medicaid electronic health record (EHR) incentive programs. Beginning in May, the Centers for Medicare & Medicaid Services (CMS) plans to implement functionality that will allow an EP to designate a third-party to register and attest on his or her behalf. CMS will release detailed information about that process when it is available.

Please be aware that currently EPs are not permitted to allow a practice manager or any other person to register in their place. Sharing your National Plan and Provider Enumeration System (NPPES) user ID and password with third-parties can place your information at risk. Until CMS implements new functionality in May, each EP should register himself or herself separately for the Medicare and Medicaid EHR incentive programs.

Registration for the Medicaid program – eligible professionals must select between the Medicare and Medicaid EHR incentive programs. If you register for the Medicaid EHR incentive program, when you select “Medicaid” on the registration screen, you will be asked to select a state from the drop-down menu. Only states with launched programs (i.e., states that are prepared to confirm your eligibility and make payments) are listed in that drop-down menu. Each month, CMS will add new states as they launch programs. If you have questions about when your state will launch, visit the Medicaid State Information Web page at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp. You may also contact your state Medicaid agency for more information about the program; visit State EHR Incentive Program Launch Dates and HIT websites at <http://www.cms.gov/apps/files/medicaid-HIT-sites/> for the Medicaid EHR incentive program links for each state Medicaid agency.

For more information about the Medicare & Medicaid EHR incentive programs and to register, visit <http://www.CMS.gov/EHRIncentivePrograms>.

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

Source: CMS PERL 201102-17

FRAUD AND ABUSE

Health care fraud prevention and enforcement efforts recover record \$4 billion; new Affordable Care Act tools will help fight fraud

U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and U.S. Associate Attorney General Thomas J. Perrelli announced a new report showing that the government's health care fraud prevention and enforcement efforts recovered more than \$4 billion in taxpayer dollars in Fiscal Year (FY) 2010. This is the highest annual amount ever recovered from people who attempted to defraud seniors and taxpayers. In addition, HHS announced new rules authorized by the Affordable Care Act that will help the department work proactively to prevent and fight fraud, waste and abuse in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

These findings, released Monday, in the annual Health Care Fraud and Abuse Control Program (HCFAC) report, are a result of President Obama making the elimination of fraud, waste, and abuse a top priority in his administration. The success of this joint Department of Justice (DOJ) and HHS effort would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent waste, fraud and abuse in the Medicare and Medicaid programs and to crack down on the fraud perpetrators who are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with the new tools and resources provided by the Affordable Care Act, including the new rules announced Monday.

"President Obama has made it very clear that fraud and abuse of taxpayers' dollars are unacceptable. And for too long, our fraud prevention efforts have focused on chasing after taxpayer dollars after they have already been paid out," said Sebelius. "Thanks to the President's leadership and the new tools provided by the Affordable Care Act, we can focus on stopping fraud before it happens."

"Our aggressive pursuit of health care fraud has resulted in the largest recovery of taxpayer dollars in the history of the Justice Department," said Perrelli. "These actions are in large part because of the great work being led by the Health Care Fraud Prevention and Enforcement Action Team. Through this initiative, we are working in partnership with government, law enforcement and industry leaders, and the public to protect taxpayer dollars, control health care costs, and ensure the strength and integrity of our most essential health care programs."

Health care fraud and abuse control program report

More than \$4 billion stolen from federal health care programs was recovered and returned to the Medicare Health Insurance Trust Fund, the Treasury, and others in FY 2010. This is an unprecedented achievement for the Health Care Fraud and Abuse Control Program (HCFAC), a joint effort of the two departments to coordinate federal, state, and local law enforcement activities to fight health care fraud and abuse.

The Affordable Care Act provides additional tools and resources to help fight fraud that will help boost these efforts, including an additional \$350 million for HCFAC activities. The Administration is already using tools authorized by the Affordable Care Act, including enhanced screenings and enrollment requirements, increased data sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

HHS and DOJ have enhanced their coordination through HEAT and have expanded Medicare Fraud Strike Force teams since 2009. HHS and DOJ hosted a series of regional fraud prevention summits around the country, and sent letters to state attorneys general urging them to work with HHS and Federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud. During FY 2010, HEAT and the Medicare Fraud Strike Force expanded local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud.

In FY 2010, the total number of cities with Strike Force prosecution teams was increased to seven, all of which have teams of investigators and prosecutors dedicated to fighting fraud. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Strike Force enforcement accomplishments in all seven cities during FY 2010 include:

- 140 indictments involving charges filed against 284 defendants who collectively billed the Medicare program more than \$590 million;
- 217 guilty pleas negotiated and 19 jury trials litigated, winning guilty verdicts against 23 defendants; and
- Imprisonment for 146 defendants sentenced during the fiscal year, averaging more than 40 months of incarceration.

Including Strike Force matters, federal prosecutors opened 1,116 criminal health care fraud investigations as of the end of FY 2010, and filed criminal charges in 488 cases involving 931 defendants. A total of 726 defendants were convicted for health care fraud-related crimes during the year.

In addition to these criminal enforcement successes, 2010 was a record year for recoveries obtained in civil health care matters brought under the False Claims Act – more than \$2.5 billion, which is the largest in the history of the Department of Justice.

The HCFAC annual report can be found at <http://oig.hhs.gov/publications/hcfac.asp>. For more information on the joint DOJ-HHS Strike Force activities, visit: <http://www.StopMedicareFraud.gov/>.

Health care fraud prevention and enforcement efforts recover record \$4 billion; new affordable care act ... (continued)**New Affordable Care Act rules to fight health care fraud**

On Monday, January 24, HHS also announced new rules authorized by the Affordable Care Act which will help stop health care fraud. The provisions of the Affordable Care Act implemented through this final rule include new provider screening and enforcement measures to help keep bad actors out of Medicare, Medicaid, and CHIP. The final rule also contains important authority to suspend payments when a credible allegation of fraud is being investigated.

“Thanks to the new law, CMS now has additional resources to help detect fraud and stop criminals from getting into the system in the first place,” CMS Administrator Donald Berwick, M.D. said. “The Affordable Care Act’s new authorities allow us to develop sophisticated, new systems of monitoring and oversight to not only help us crack down on fraudulent activity scamming these programs, but also help us to prevent the loss of taxpayer dollars across the board for millions of American health care consumers.”

Specifically, the final rule:

- Creates a rigorous screening process for providers and suppliers enrolling Medicare, Medicaid, and CHIP to keep fraudulent providers out of those programs. Types of providers and suppliers that have been identified in the past as posing a higher risk of fraud, for example durable medical equipment suppliers, will be subject to a more thorough screening process.
- Requires new enrollment process for Medicaid and CHIP providers. Under the Affordable Care Act, states will have to screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding government. Providers that have been kicked out of Medicare or another state’s Medicaid or CHIP will be barred from all Medicaid and CHIP programs.

- Temporarily stops enrollment of new providers and suppliers. Medicare and state agencies will be on the lookout for trends that may indicate health care fraud – including using advanced predictive modeling software, such as that used to detect credit card fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients.
- Temporarily stops payments to providers and suppliers in cases of suspected fraud. Under the new rules, if there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

The full text of the press release issued on January 24 is available at <http://www.HHS.gov/news/press/2011pres/01/20110124a.html>.

A copy of the regulation went on display Monday, January 24, 2011, at the *Federal Register* and may be downloaded from the following link:

www.ofr.gov/inspection.aspx. Several days after the regulation is published, the preceding link will be deactivated and the published version of the regulation will be available on the National Archives website at www.archives.gov/federal-register/news.html. CMS will continue to take public comments on limited areas of this final rule for 60 days.

More information can be found at www.HealthCare.gov, a Web portal made available by the U.S. Department of Health and Human Services. A fact sheet on the new rules is available at www.HealthCare.gov/news/factsheets.

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Source: CMS PERL 201101-49, PERL 201101-46

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The countdown has begun ...

Are you ready for January 1?

Schedule your HIPAA-5010 testing today!

Call 888-670-0940, Option 1

Additional information on HIPAA-5010 at <http://medicare.fcso.com/HIPAA/>

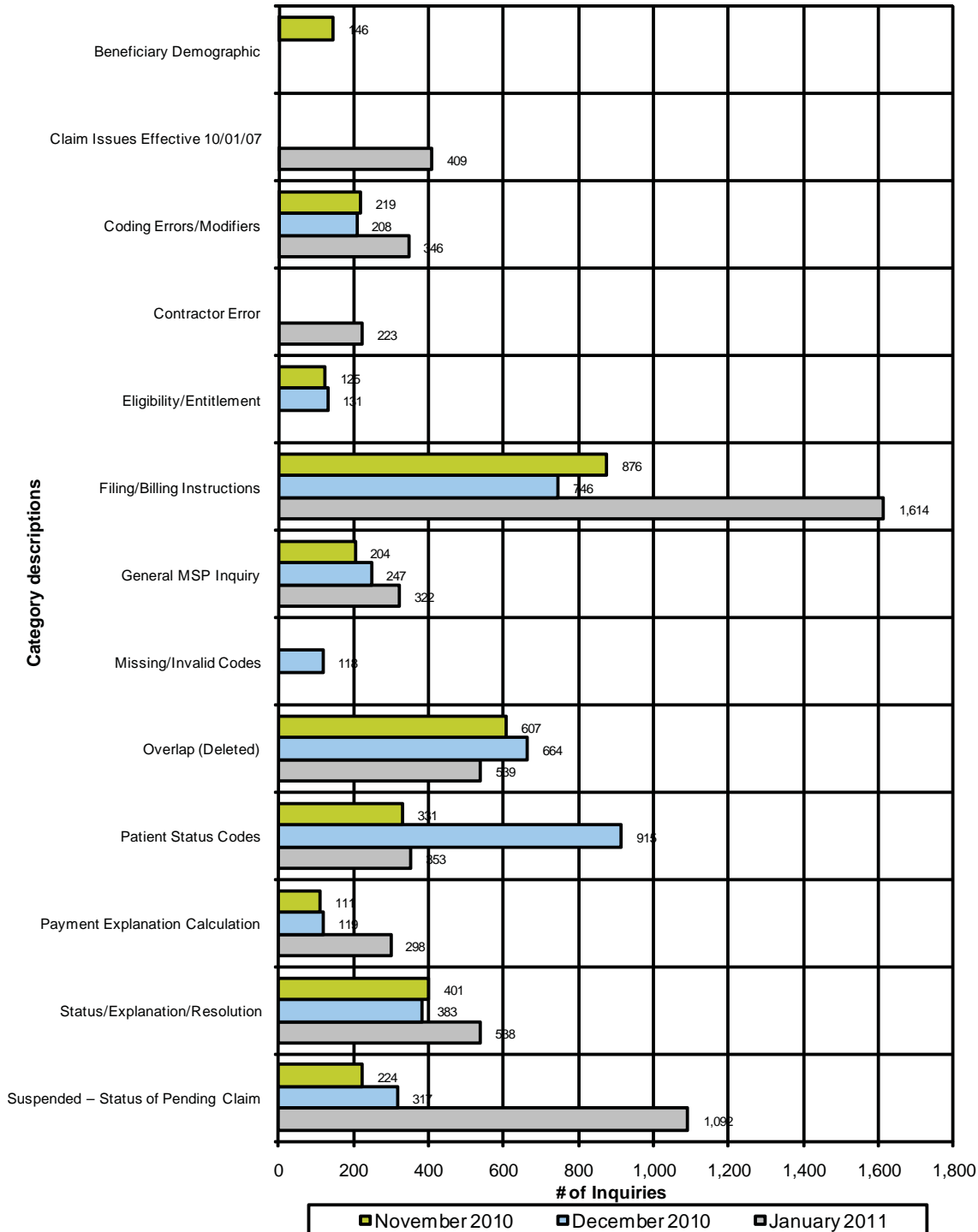
CLAIM AND INQUIRY SUMMARY DATA

Top inquiries, return to provider, and reject claims – November 2010-January 2011

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 November 2010-January 2011.

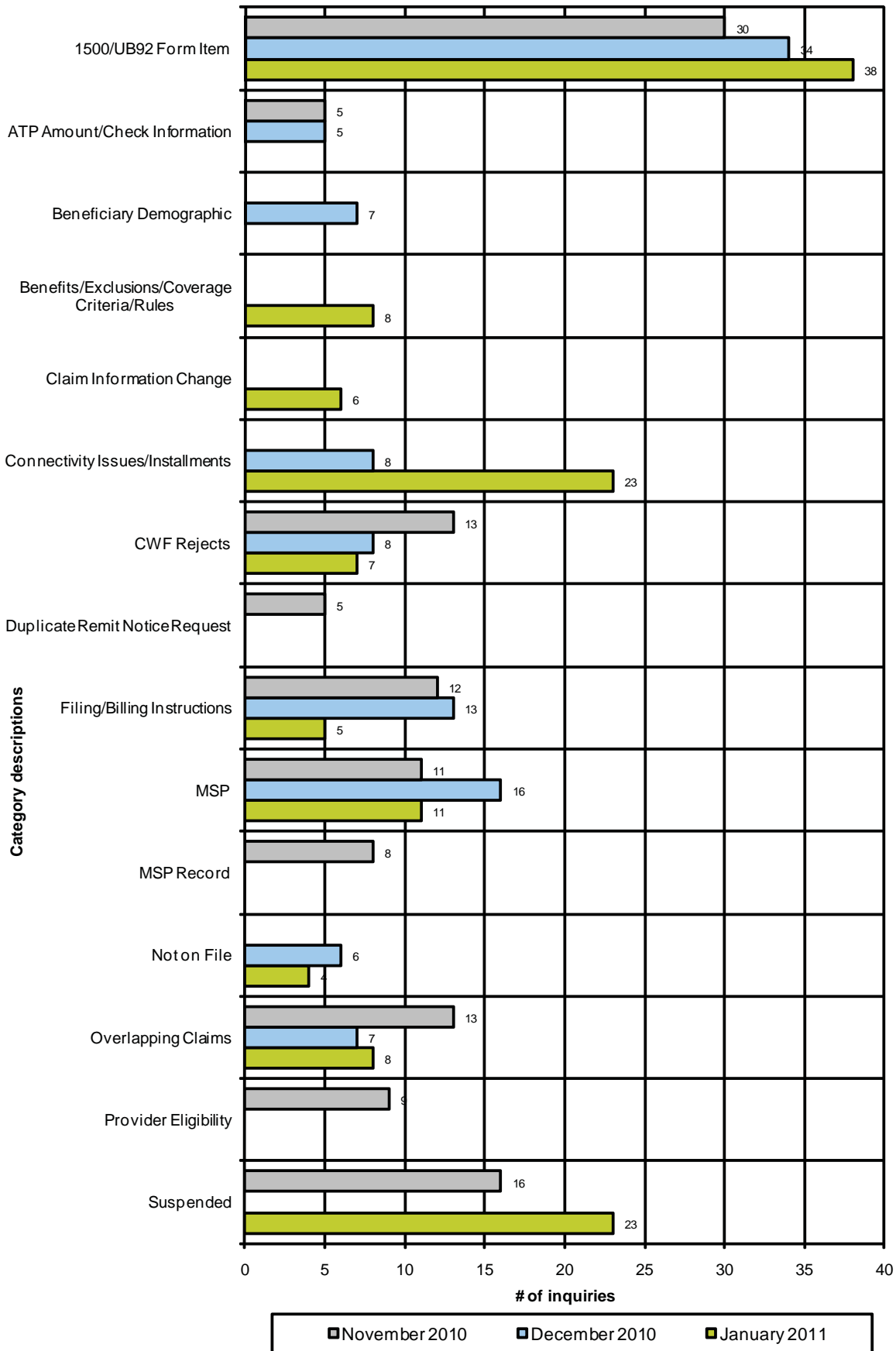
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at http://medicare.fcsoc.com/Inquiries_and_denials/index.asp.

Florida Part A top inquiries for November 2010-January 2011



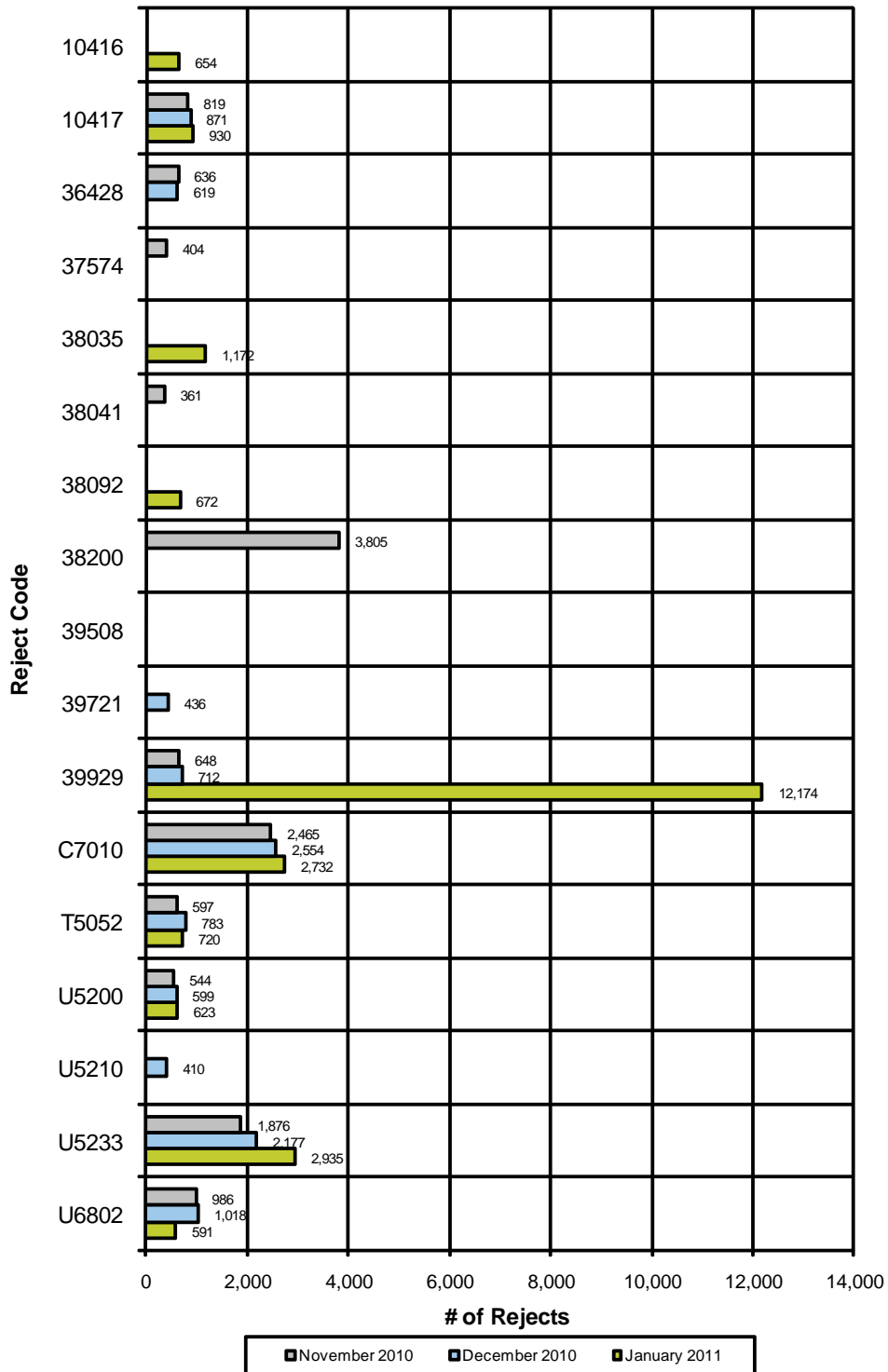
Top inquiries, return to provider, and reject claims for November 2010-January 2011 (continued)

Puerto Rico and U.S. Virgin Islands Part A top inquiries for November 2010-January 2011



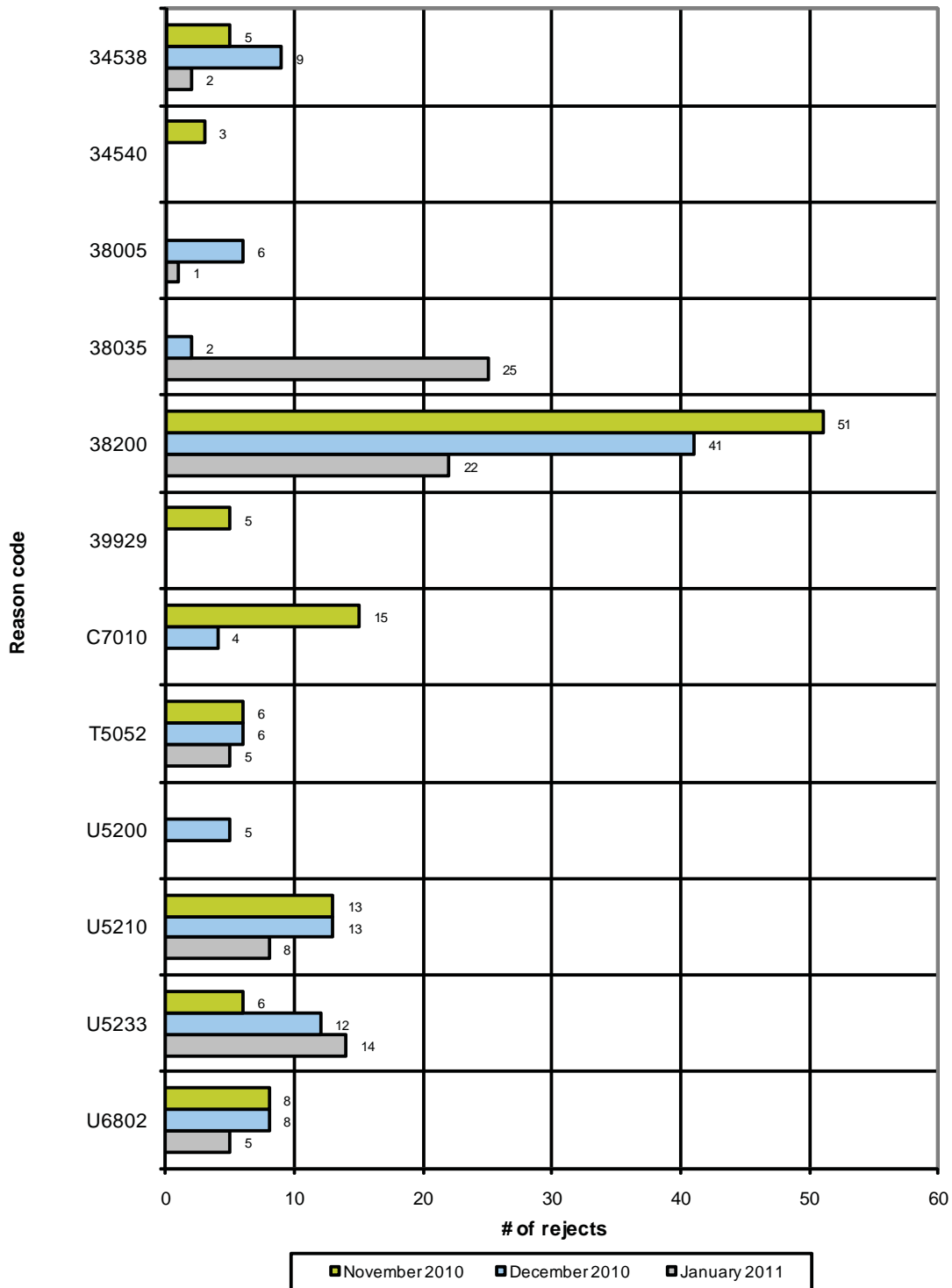
Top inquiries, return to provider, and reject claims for November 2010-January 2011 (continued)

Florida Part A top rejects for November 2010-January 2011



Top inquiries, return to provider, and reject claims for November 2010-January 2011 (continued)

U.S. Virgin Islands Part A top rejects for November 2010-January 2011

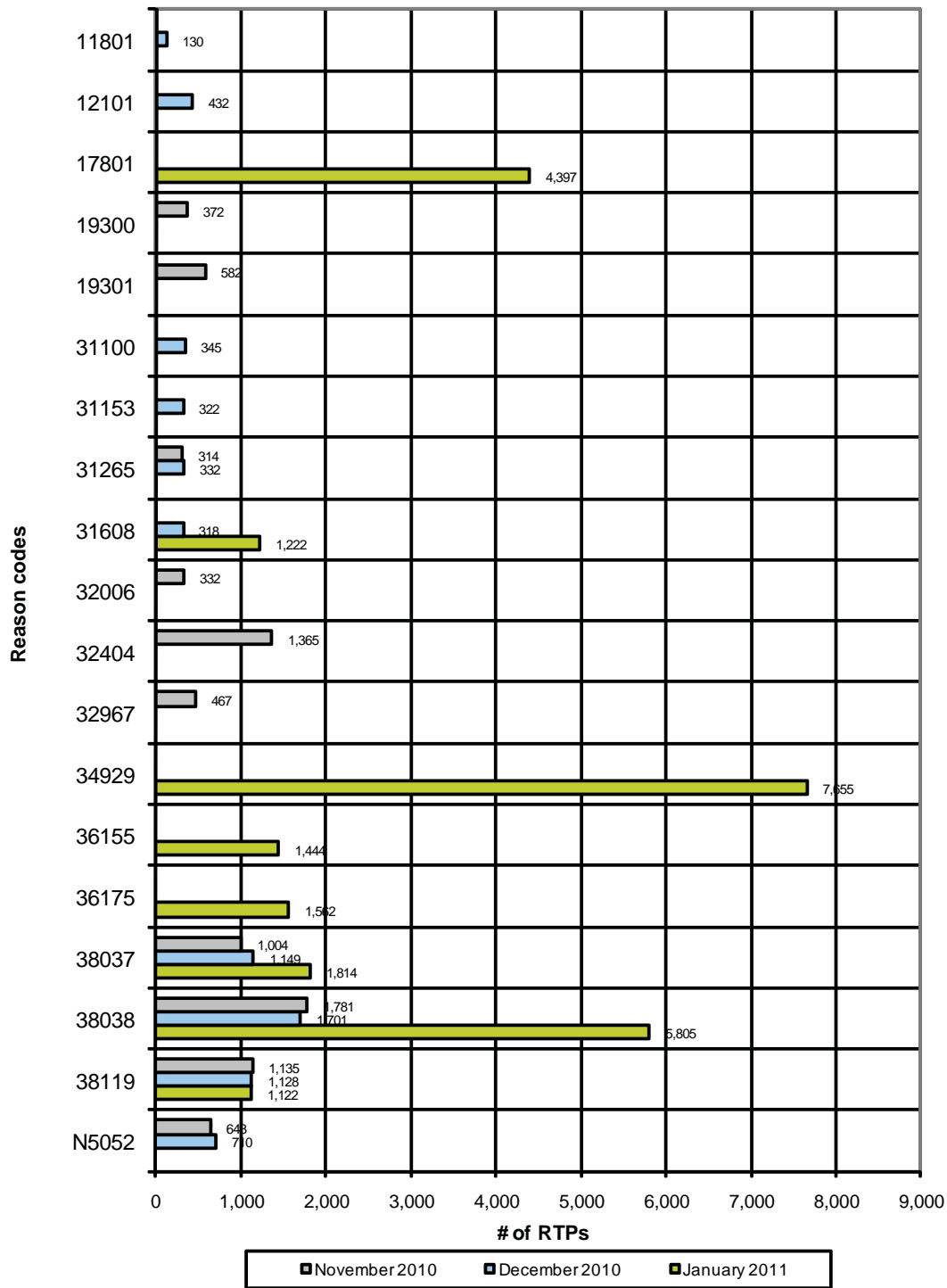


Keep Informed

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 November 2010-January 2011 (continued)

Florida Part A top return to providers (RTPs) for November 2010-January 2011

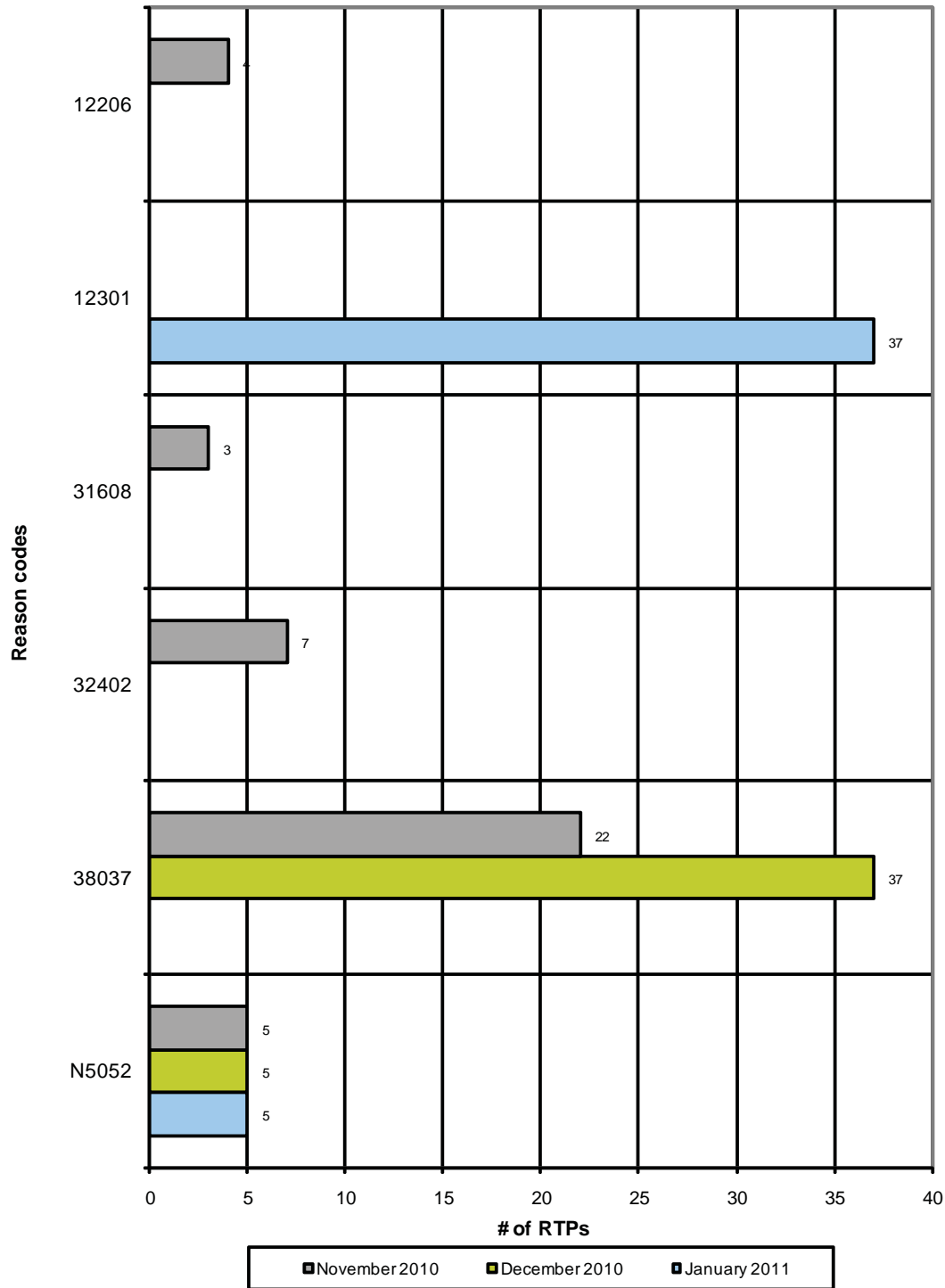


Educational Resources

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 November 2010-January 2011 (continued)

U.S. Virgin Islands Part A top return to providers (RTPs) for November 2010-January 2011



GENERAL COVERAGE

April 2011 quarterly HCPCS drug/biological code changes

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, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries [FIs], regional home health intermediaries [RHHIs], Medicare administrative contractors [A/B MACs], or durable medical equipment Medicare administrative contractors [DME MACs]) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 7299 announces that effective for claims with dates of service on or after April 1, 2011, HCPCS code Q2040 (Injection, incobotulinumtoxin A, 1 unit) will be payable by Medicare. Specifically, your contractors will accept Q2040 as a valid HCPCS code for dates of service on or after April 1, 2011, using type of service (TOS) 1, 9, and Medicare physician fee schedule database (MPFSDB) status indicator "X" (Statutorily excluded from physician fee schedule). You should make sure that your billing staffs are aware of this HCPCS code change.

Additional information

You may find the official instruction, CR 7299, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2147CP.pdf>. If you have any questions, please contact your carrier, FI, RHHI, 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: MM7299

Related Change Request (CR) #: 7299

Related CR Release Date: February 4, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2147CP

Implementation Date: April 4, 2011

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Clarifications for home health face-to-face encounter

Background

The Centers for Medicare & Medicaid Services is including the following clarifications to Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Home Health Services:

Due to new provisions mandated by passage of the Affordable Care Act, there are new statutory requirements regarding face-to-face encounters for certifications applicable to the home health program that must be updated in the home health chapter.

Policy

Section 6407 of the Affordable Care Act requires these face-to-face encounters with a physician for home health certifications. Details of the policy are provided in the above-mentioned chapter.

Source: Publication 100-02, Transmittal 139, change request 7329

Be proactive: Use the PDS report

- Identify negative billing patterns
- Benefit from peer comparisons
- Prevent recurring billing issues
- Improve your bottom line

Accessible through FCSO's PDS portal at <http://medicare.fcsso.com/reporting/index.asp>

Home health face-to-face encounter – a new home health certification requirement

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 certifying Medicare patients' need/eligibility for home health benefits, home health agencies (HHAs), and beneficiaries.

What you need to know

As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) has had a face-to-face encounter with the patient. Documentation regarding these encounters must be present on certifications for patients with starts of care on and after January 1, 2011. See the remainder of this article for details.

Background

Since the inception of the benefit, the Social Security Act has required physicians to order and certify the need for Medicare home health services. This new mandate assures that the physician's order is based on current knowledge of the patient's condition.

As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed NPP has had a face-to-face encounter with the patient.

The Affordable Care Act describes NPPs who may perform this face-to-face patient encounter as a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Social Security Act), who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State law), or a physician assistant (as defined in section 1861(aa)(5) of the Social Security Act), under the supervision of the physician.

Home Health Prospective Payment System (HHPPS) final rule implementation provisions

The Centers for Medicare & Medicaid Services (CMS) implemented this provision of the Affordable Care Act via the HHPPS calendar year (CY) 2011 rulemaking. In that rule, CMS finalized the following:

- Documentation regarding these face-to-face encounters must be present on certifications for patients with starts of care on and after January 1, 2011.
- As part of the certification form itself, or as an addendum to it, the physician must document when the physician or allowed NPP saw the patient, and document how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.
- The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.
- In situations when a physician orders home health care for the patient based on a new condition that was not

evident during a visit within the 90 days prior to start of care, the certifying physician or NPP must see the patient within 30 days after admission. Specifically:

- If the certifying physician or NPP had not seen the patient in the 90 days prior to the start of care, a visit within 30 days of start of care would be required.
- If a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that accepted standards of practice would preclude the physician from ordering services without the physician or an NPP first examining the patient.

The Affordable Care Act and the final rule include several features to accommodate physician practice:

- In addition to allowing NPPs to conduct the face-to-face encounter, Medicare allows a physician who attended to the patient in an acute or post-acute setting, but does not follow patient in the community (such as a hospitalist) to certify the need for home health care based on their contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then "hand off" the patient's care to his or her community-based physician.
- Medicare will also allow physicians who attended to the patient in an acute or post-acute setting to certify the need for home health care based on their contact with the patient, initiate the orders for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care.
- The law allows the face-to-face encounter to occur via telehealth, in rural areas, in an approved originating site.

Plan of care (POC) and certification clarifications

Long-standing regulations have described the distinct content requirements for the POC and certification. The Affordable Care Act requires the face-to-face encounter and corresponding documentation as a certification requirement. Providers have the flexibility to implement the content requirements for both the POC and certification in a manner that best makes sense for them.

Prior to CY 2011, CMS manual guidance required the same physician to sign the certification and the POC. Beginning in CY 2011, CMS will allow additional flexibility associated with the POC when a patient is admitted to home health from an acute or post-acute setting. For such patients, CMS will allow physicians who attend to the patient in acute and post-acute settings to certify the need for home health care based on their face to face contact with the patient (which includes documentation of the face-to-face encounter), initiate the orders (POC) for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care. As described in the final HHPPS regulation, CMS continues to expect that, in most cases, the same physician will certify and establish and sign the POC. But the flexibility exists for

Home health face-to-face encounter – a new home health certification requirement (continued)

HH post-acute patients if needed.

Certain nonphysician practitioners can play an important role in the face to face encounter. For example, an allowed non-physician practitioner who attends to a patient in an acute setting or emergency room can collaborate with and inform the community certifying physician regarding his/her contact with the patient. The community physician could document the encounter and certify based on this information.

Additional information

Medicare home health plays a vital role in allowing patients to receive care at home as an alternative to extended hospital or nursing home care. Questions and answers regarding this requirement will be available the via

Medicare's home health agency website, <http://www.cms.gov/center/hha.asp>.

MLN Matters® Number: SE1038
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: January 1, 2011
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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Auto denial of claims submitted with a modifier GZ

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

Provider types affected

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

What you need to know

The Health and Human Services Office of General Counsel (OGC) has provided guidance that Medicare contractors that process both institutional and professional claims have discretion to automatically deny claims billed with the modifier GZ. The modifier GZ indicates that an advance beneficiary notice (ABN) was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. Medicare contractors will automatically deny claim line(s) items submitted with a modifier GZ, effective for dates of service on or after July 1, 2011. Further, your Medicare contractor will not perform complex medical review on any claim line item(s) submitted with the modifier GZ. In addition, line items denied due to the presence of the modifier GZ will reflect a claim adjustment reason code of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.) and a group code of CO (contractual obligation) to show provider/supplier liability.

Additional information

The official instruction, change request (CR) 7228, was issued to your carrier, FI, A/B MAC, and DME/MAC via two transmittals. The first transmittal modifies the *Medicare Claims Processing Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R2148CP.pdf>. The second transmittal modifies the *Medicare Program Integrity Manual* and it is at <http://www.cms.gov/Transmittals/downloads/R366PI.pdf>.

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

MLN Matters® Number: MM7228
 Related Change Request (CR) #: 7228
 Related CR Release Date: February 4, 2011
 Effective Date: July 1, 2011
 Related CR Transmittal #: R366PI and R2148CP
 Implementation Date: July 5, 2011

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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.

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

AJ9055: Cetuximab (Erbix[®]) – revision to the LCD

LCD ID number: L28802 (Florida)

LCD ID number: L28804 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cetuximab (Erbix[®]) was most recently revised on July 22, 2009. Since that time, based on consideration of current literature for “off label use” of Erbix[®] for the first -line treatment of advanced non-small cell lung cancer (NSCLC) in combination with cisplatin and vinorelbine chemotherapy drugs the ‘Indications and limitations of Coverage and/or Medical Necessity’ section of the LCD was updated. Also, the diagnosis code range 162.0-162.9 was added under the “ICD-9 Codes that Support Medical Necessity” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated to add additional references considered for this revision.

Effective date

This LCD revision is effective for services provided **on or after February 24, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

AJ9395: Fulvestrant (Faslodex[®]) – revision to the LCD

LCD ID number: L28844 (Florida)

LCD ID number: L28877 (Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) for fulvestrant (Faslodex[®]) 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 recommended dosing schedule language was revised under the “Utilization Guidelines” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after January 25, 2011**, for services provided **on or after September 9, 2010**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at <http://www.cms.gov/medicare-coverage-database/>. 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. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs 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.fcsso.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.

ADDITIONAL INFORMATION

C9272: Xgeva™ (denosumab)

Xgeva™ (denosumab) is a RANK ligand (RANKL) inhibitor indicated for prevention of skeletal-related events in patients with bone metastases from solid tumors. Xgeva™ is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. Xgeva™ was approved by the Food and Drug Administration (FDA) on November 18, 2010. Patients must be instructed to take 1000 mg. of calcium daily and at least 400 IU of vitamin D daily due to hypocalcemia being a contraindication. Xgeva™ is administered 120 mg every four weeks subcutaneous in the upper arm, upper thigh, or abdomen and should be administered by a health care professional.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self-administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly support the diagnosis and FDA guidance for use as well as the administration.

C9399/C9272: Prolia™ (denosumab)

Prolia™ (denosumab) is a RANK ligand (RANKL) inhibitor indicated for treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy. Prolia™ was approved by the Food and Drug Administration (FDA) on June 1, 2010. Patients must be instructed to take calcium 1000 mg. daily and at least 400 IU of vitamin D daily due to hypocalcemia being a contraindication. Prolia™ is administered 60 mg every six months subcutaneous in the upper arm, upper thigh or abdomen and should be administered by a healthcare professional.

In the absence of a national coverage determination (NCD) or local coverage determination (LCD), Medicare can consider coverage of a drug that is usually not self administered per the FDA indication when administered incident to a physician service or in the hospital setting. The medical record must clearly support the diagnosis and FDA guidance for use as well as the administration.

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HOSPITAL SERVICES

MMEA extension of reasonable cost payment for clinical lab tests furnished by hospitals in qualified rural areas

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

Provider types affected

Hospitals with fewer than 50 beds in qualified rural area, submitting claims to Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (A/B MACs), for outpatient clinical laboratory tests provided to Medicare beneficiaries are affected.

Provider action needed

Change request (CR) 7294, from which this article is taken, provides instruction to FIs and A/B MACs (effective for cost reporting periods beginning on or after July 1, 2011, through June 30, 2012) to extend the reasonable cost payment for clinical laboratory tests that furnish as part of your outpatient services.

You should make sure that your billing staffs are aware of this clinical laboratory test payment extension.

Background

- In compliance with Section 416 of the Medicare Modernization Act (MMA) of 2003, on February 13, 2004, the Centers for Medicare & Medicaid Services (CMS) issued CR3130 entitled: "MMA – Outpatient Clinical Laboratory Tests Furnished by Hospitals with Fewer Than 50 Beds in Qualified Rural Areas;" which implemented procedures to provide reasonable cost payment for outpatient clinical laboratory tests that hospitals with fewer than 50 beds furnished in qualified rural areas for cost reporting periods, beginning during the 2-year period beginning on July 1, 2004. Please refer to the associated article (MM3130) at <http://www.cms.gov/MLN MattersArticles/downloads/MM3130.pdf>.
- In compliance with Section 105 of the Tax Relief and Health Care Act (TRHCA) of 2006, on February 2, 2007, CMS issued CR 5493 entitled: "Outpatient Clinical Laboratory Tests Furnished by Hospitals With Fewer Than 50 Beds in Qualified Rural Areas;" to extend the 2-year provision outlined within CR 3130 for an additional cost-reporting year. Please refer to the associated article (MM5493) at <http://www.cms.gov/MLN MattersArticles/Downloads/mm5493.pdf>.
- Section 107 of the Medicare, Medicaid and State Children's Health Insurance Program Extension Act of 2007 extended reasonable cost payment for clinical laboratory tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2004, through June 30, 2008. For some hospitals, this affected services performed as late as June 30, 2009.

- Section 3122 of the Patient Protection and Affordable Care Act of 2010 re-instituted reasonable cost payment for clinical laboratory tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. For some hospitals, this could affect services performed as late as June 30, 2012.
- CR7294, from which this article is taken, announces that Section 109 of the Medicare and Medicaid Extenders Act of 2010 (MMEA) extends reasonable cost payment for clinical laboratory tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for another year to include cost reporting periods beginning on or after July 1, 2011, through June 30, 2012. For some hospitals, this could affect services performed as late as June 30, 2013.

Notes:

1. A qualified rural area (as identified using the Medicare zip code file) is defined as one with a population density in the lowest quartile of all rural county populations.
2. Effective for an entire cost reporting period beginning on or after July 1, 2011, through June 30, 2012, your FI or A/B MAC will calculate your payment for clinical laboratory services (on a Revenue Code 030X line submitted on either a 12X or 13X Type of Bill) on a reasonable cost basis.
3. Medicare beneficiaries are not liable for any deductible, coinsurance, or any other cost-sharing amount.

Additional information

You may find the official instruction, CR7294, issued to your FI or A/B MAC by visiting

<http://www.cms.gov/transmittals/downloads/R2136CP.pdf>.

If you have any questions, please contact your 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: MM7294

Related Change Request (CR) #: 7294

Related CR Release Date: January 21, 2011

Effective Date: For cost reporting periods beginning on or after July 1, 2011, through June 30, 2012

Related CR Transmittal #: R2136CP

Implementation Date: July 5, 2011

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Guidance on hospital inpatient admission decisions

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

Provider types affected

Inpatient acute care hospitals that bill Medicare contractors (fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries are affected.

What you need to know

It is important that any staff involved with the clinical decision to admit the patient stay abreast of all the Centers for Medicare & Medicaid Services (CMS) national inpatient hospital policy and national and local coverage determinations. Additionally, make sure medical documentation submitted demonstrates evidence of the clinical need for the patient to be admitted to the inpatient facility and fully and accurately identifies any subsequent care that was provided during the inpatient stay.

Background

Some hospitals have recently expressed concern about how the CMS recovery audit contractors (RACs), MACs, FIs, and the comprehensive error rate testing contractor (CERT) are utilizing screening criteria to analyze medical documentation and make a medical necessity determination on inpatient hospital claims.

There are several commercially available screening tools that Medicare contractors in specific jurisdictions may use to assist in the review of medical documentation to determine if a hospital admission is medically necessary. These include Interqual, Milliman, and other proprietary systems.

CMS policy guidance

To assist hospitals regarding inpatient admission decisions, CMS would refer hospitals to the following:

Program Integrity Manual guidance

Chapter 6, Section 6.5.1, of the *Medicare Program Integrity Manual* requires that contractor review staff use a screening tool as part of their medical review process for inpatient hospital claims. CMS does not require that the contractor use specific criteria nor endorse any particular brand of screening guidelines. CMS contractors are not required to pay a claim even if screening criteria indicate inpatient admission is appropriate. Conversely, CMS contractors are not required to automatically deny a claim that does not meet the admission guidelines of a screening tool. **In all cases, in addition to screening instruments, the reviewer shall apply his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.**

For each case, the review staff will utilize the following when making a medical necessity determination

- Admission criteria;
- Invasive procedure criteria;
- CMS coverage guidelines;
- Published CMS criteria; and
- Other screens, criteria, and guidelines (e.g., practice guidelines that are well accepted by the medical community).

Note: CMS considers the use of screening criteria as only one tool that should be utilized by contractors to

assist them in making an inpatient hospital claim determination.

Chapter 6, Section 6.5.2, of the *Medicare Program Integrity Manual* states that the review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

The reviewer will consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission.

Inpatient care, rather than outpatient care, is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay.

Chapter 6 of the *Medicare Program Integrity Manual*, Section 6.5 is available at <http://www.cms.gov/manuals/downloads/pim83c06.pdf>.

Medicare Benefit Policy Manual guidance

The *Medicare Benefit Policy Manual*, Chapter 1, Section 10 also contains relevant information regarding what constitutes an appropriate inpatient admission. According to that manual section, an inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark (i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis). However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;

Guidance on hospital inpatient admission decisions (continued)

- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital.

Chapter 1, Section 10 of the *Medicare Benefit Policy Manual* is at <http://www.cms.gov/manuals/Downloads/bp102c01.pdf>.

Additional Information

Chapter 6 of the *Medicare Program Integrity Manual*, Section 6.5 is available at

<http://www.cms.gov/manuals/downloads/pim83c06.pdf> and Chapter 1, Section 10 of the *Medicare Benefit Policy Manual* is at

<http://www.cms.gov/manuals/downloads/bp102c01.pdf>.

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

MLN Matters® Number: SE1037

Related Change Request (CR) #: N/A

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Implementation Date: N/A

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Update to the FISS End of POA Indicator logic for version 5010 837I

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

Provider types affected

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

Provider action needed

Make sure your billing and coding staffs are aware of these changes and properly code the present on admission (POA) indicator on every claim.

Background

Upon implementation of version 5010 of the 837I electronic health care claim, providers will no longer have the ability to report the end of POA indicator. This change has potential payment implications for inpatient prospective payment system (IPPS) hospitals due to their inability to report this indicator on version 5010. The grouper software relies on the End of POA indicator to apply the appropriate hospital acquired condition (HAC) logic when determining the diagnosis related group for claims from IPPS hospitals.

Change request (CR) 7280 modifies Fiscal Intermediary Shared System (FISS) logic to automatically populate the end of POA indicator with "Z" for IPPS hospitals using the version 5010 837I health care claim format. This ensures grouper will apply the appropriate HAC logic, when applicable.

Additional information

The official instruction, CR7280 issued to your FI or MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R851OTN.pdf>. If you have any 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>.

MLN Matters® Number: MM7280

Related Change Request (CR) #: 7280

Related CR Release Date: January 28, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R851OTN

Implementation Date: July 5, 2011

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Update – hospital inpatient value-based purchasing program

The Centers for Medicare & Medicaid Services issued a notice of proposed rulemaking

The hospital value-based purchasing program, which would apply beginning in fiscal year (FY) 2013 to payments for discharges occurring on or after Monday, 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 FY, the higher the hospital's value-based incentive payment would be.

CMS is accepting public comments on the proposed rule (CMS-3239-P) through Tuesday, March 8, 2011. To review a copy of the proposed rule ("Hospital Inpatient Value-Based Purchasing Program," CMS-3239-P), including instructions on how to submit comments, visit <http://www.gpo.gov/fdsys/pkg/FR-2011-01-13/pdf/2011-454.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 201101-40

Claims reprocessing for Section 508 and special exception hospitals

The Centers for Medicare & Medicaid Services (CMS) has identified inpatient and outpatient claims for Section 508 and special exception hospitals that need to be reprocessed. The Medicare and Medicaid Extenders Act of 2010 (MMEA), signed into law by President Obama on December 15, 2010, extended the Medicare Modernization Act Section 508 and special exception hospital reclassifications.

Although claims processing system changes have been made to pay an additional amount as required under MMEA, Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) claims received prior to the system changes need to be reprocessed. This includes IPPS claims from Section 508 and special exception hospitals with discharge dates on or after October 1, 2010, OPPS claims for Section 508 hospitals with dates of service on or after October 1, 2010, and OPPS claims for special exception hospitals with dates of service on or after January 1, 2011.

No action is required by Section 508 and special exception hospitals. Impacted claims will automatically be reprocessed no later than March 15, 2011, and any payment changes will be reflected on the remittance advice. Please note that this reprocessing does not apply to older claims that will require adjustment due to the enactment of the Affordable Care Act. More information about those claims will be forthcoming in the next several weeks.

Source: CMS PERL 201102-03

Correction – fiscal year 2011 inpatient prospective payment system PC

Pricer update

A date edit error was discovered in the fiscal year (FY) 2011 inpatient prospective payment system (PPS) PC Pricer. An updated version has been posted on the Centers for Medicare & Medicaid Services (CMS) website. If you use the FY 2011 inpatient PPS PC Pricer, please go to the CMS Web page at http://www.cms.gov/PCPricer/03_inpatient.asp, and download the latest version of the FY 2011 PC Pricer. This PC Pricer is for claims dated from October 1, 2010, to September 30, 2011. The update is dated February 14, 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 201102-33

Updated – fiscal year 2010 inpatient prospective payment system PC Pricer

The latest January 2011 provider data has been updated in the fiscal year (FY) 2010 inpatient prospective payment system PC Pricers. If you use the FY 2010 INP PPS PC Pricers, please go to the Centers for Medicare & Medicaid Services (CMS) Web page at http://www.cms.gov/PCPricer/03_inpatient.asp, and download the latest version of the PC Pricers. Note that there were two Pricers for FY 2010 for the following claim dates:

- October 1, 2009, through March 31, 2010
- April 1, 2010, through September 30, 2010

Both download modules changed. The update is dated February 17, 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 201102-38

Off-cycle release of the inpatient prospective payment system (IPPS) pricer to accept diagnosis codes and to pass a low-volume payment amount

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

Provider types affected

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

Provider action needed

Make sure your billing and coding staffs are aware of these changes and properly codes all appropriate diagnosis codes on every claim.

Background

Change request (CR) 7244 impacts certain hospitals that qualify for the low-volume payment adjustment under the inpatient prospective payment systems (IPPS). The low-volume payment amount calculated by the IPPS Pricer is an estimated interim payment. This estimated interim low-volume payment amount will be adjusted at cost report settlement, if any of the payment amounts upon which the low-volume payment amount is based are recalculated at cost report settlement (for example payments for disproportionate share hospital, indirect medical education, or federal rate versus hospital specific rate payments for sole community hospitals/Medicare dependent hospitals).

CR7244 contains changes to accommodate future new technology payment logic. The IPPS Pricer is being modified to accept the 25 diagnosis code fields (one principal plus 24 secondary diagnosis codes) on the bill record.

Lastly, CMS is revising the fiscal year (FY) 2003 and FY 2004 IPPS Pricer to assign a different labor share percentage for certain providers for future adjustments, which will be provided in future instructions to the Medicare contractors.

Additional information

The official instruction, CR7244 issued to your FI or MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R842OTN.pdf>. If you have any 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>.

MLN Matters® Number: MM7244

Related Change Request (CR) #: 7244

Related CR Release Date: January 21, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: 842OTN

Implementation Date: July 5, 2011

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'Swing Bed' fact sheet now available in print

The revised fact sheet titled "Swing Bed" (December 2010), which provides information about the requirements hospitals and critical access hospitals must meet in order to be granted approval to furnish either acute-level or skilled nursing facility-level care via a swing bed agreement, is now available in print format from the *Medicare Learning Network*®. To place your order, visit <http://www.CMS.gov/MLNGenInfo>, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

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

Source: CMS PERL 201101-50

Acute Care Hospital Inpatient Prospective Payment System fact sheet

The revised fact sheet titled *Acute Care Hospital Inpatient Prospective Payment System* (November 2010), which provides information about the basis for acute care hospital inpatient prospective payment system payment, payment rates, and how payment rates are set, is now available in print format from the *Medicare Learning Network*®. To place your order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

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

Source: CMS PERL 201101-44

‘Medicare Dependent Hospital’ fact sheet revised

The revised “Medicare Dependent Hospital” fact sheet (January 2011), which is designed to provide education about Medicare dependent hospital (MDH) classification criteria and MDH payments, is now available in downloadable format from the *Medicare Learning Network*® at <http://www.CMS.gov/MLNProducts/downloads/MedDependHospfctshst508.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 201102-13

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Source: CMS PERL 201102-34

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CRITICAL ACCESS HOSPITAL SERVICES

Certified registered nurse anesthetist services in a method II critical access hospital without a CRNA pass-through exemption

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

Provider types affected

This article is for method II critical access hospitals (CAHs) submitting claims to Medicare contractors (fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for anesthesia services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7207, which clarifies the payment calculation for certified registered nurse anesthetist (CRNA) services in a Method II CAH without a CRNA pass-through exemption.

Background

The Social Security Act (Section 1833(1)(H)); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet) states that the amounts paid for CRNAs will be 80 percent of the least of the actual charge or fee schedule amount. In addition, The Social Security Act (Section 1834(g)(2)(B)); see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet) states that professional services included within outpatient CAH services, will be paid 115 percent of such amounts as would otherwise be paid under this part if such services were not included in the outpatient CAH services.

Note: Services furnished by a CRNA are subject to the Part B deductible and coinsurance.

CRNAs rendering services in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for anesthesia services submitted on type of bill 85X with revenue code 964 (anesthesiologist (CRNA)).

Payment is currently being calculated for **non-medically directed** CRNA services in a Method II CAH **without** a CRNA pass-through exemption based on a 20 percent reduction of the fee schedule amount before deductible and coinsurance are calculated, and Change Request (CR) 7207 clarifies the payment calculation for these services.

CR7207 instructs that (for dates of service on or after July 1, 2007, Medicare contractors will pay for CRNA anesthesia services (*Current Procedural Terminology (CPT) codes 00100 through 01999*) submitted by a Method II CAH (**without a CRNA pass-through exemption**) on type of bill 85x with revenue code 964 and modifier QZ (CRNA service without medical direction by a physician) based on the lesser of the actual charges or the fee schedule amount as follows:

(Sum of base units plus time [anesthesia time divided by 15]) times conversion factor minus (deductible and coinsurance) times 1.15.

Additional information

The official instruction, CR 7207, issued to your FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2137CP.pdf> on the CMS website.

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

MLN Matters® Number: MM7207
 Related Change Request (CR) #: 7207
 Related CR Release Date: January 21, 2011
 Effective Date: July 1, 2007
 Related CR Transmittal #: R2137CP
 Implementation Date: July 5, 2011

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Critical access hospitals to receive free comparative data reports

Beginning in April 2011, the Centers for Medicare & Medicaid Services (CMS) will make free hospital-specific comparative data reports available to critical access hospitals (CAHs) nationwide. The report – known as PEPPER, or the “Program for Evaluating Payment Patterns Electronic Report” – provides hospital-specific data statistics for Medicare discharges at risk for improper payments. Hospitals can use the data to support internal auditing and monitoring activities. PEPPER is the only free report comparing a CAH’s Medicare billing practices with other CAHs in the state, Medicare administrative contractor (MAC) or fiscal intermediary (FI) jurisdiction, and the nation.

CMS has contracted with TMF Health Quality Institute to develop and distribute the reports, which were previously available only for short-term and long-term acute care hospitals. The PEPPERs will be distributed via a MyQualityNet secure file exchange on or about Monday, April 25. (MyQualityNet is a secure site accessible from the www.QualityNet.org; CAHs must have a QualityNet account in order to receive their PEPPER.) The PEPPER files will be sent to the hospital’s QualityNet administrators and to QualityNet user accounts with the PEPPER recipient role. CAHs may work with their quality improvement organization if they do not have a QualityNet administrator account.

For more information, including the PEPPER distribution schedule, a sample of the PEPPER for CAHs, and information about QualityNet accounts, visit www.PEPPERresources.org. CAH staffs are also encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

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Source: CMS PERL 201101-48

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SKILLED NURSING FACILITY SERVICES

Fiscal year 2011 skilled nursing facility PC Pricer update

To correct a diagnosis related group (DRG) print issue, and to provide updated provider data, the fiscal year (FY) 2011 skilled nursing facility (SNF) PC Pricer has been updated on the page/URL http://www.cms.gov/PCPricer/04_SNF.asp, under the “Skilled Nursing Facilities (SNF PPS) PC Pricer.” If you use the FY 2011 SNF PC Pricer, please go to the page above and download the SNF PC Pricer with the revised provider data.

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

Source: CMS PERL 201102-26

Reprocessing of skilled nursing facility and swing bed prospective payment system claims

The Centers for Medicare & Medicaid Services (CMS) discovered an error in the non-labor share percentage used for calculating skilled nursing facility (SNF) and swing bed (SB) prospective payment system (PPS) reimbursement for fiscal year 2011. The CMS is correcting this percentage in the SNF Pricer. Upon successful implementation, contractors will begin adjusting all previously adjudicated SNF and SB PPS claims with discharge dates on or after October 1, 2010, to apply correct reimbursement. This adjustment process may take up to 8-10 weeks to finalize. Be advised that the impact on the per-claim payment is very small.

In addition, CMS instructed contractors to suspend any newly submitted SNF and SB PPS claims, with discharge dates on or after October 1, 2010, at the contractor’s sites until the updated SNF Pricer is installed. CMS expects to complete full testing and installation by February 14, 2011.

Source: CMS PERL 201102-04

Correction – fiscal year 2011 skilled nursing facility PC Pricer update

To correct a pricing factor error, the fiscal year (FY) 2011 skilled nursing facility (SNF) PC Pricer has been updated on the page/URL http://www.cms.gov/PCPricer/04_SNF.asp, under the “Skilled Nursing Facilities (SNF PPS) PC Pricer.” If you use the FY 2011 SNF PC Pricer, please go to the page above and download the SNF PC Pricer posted February 14, 2011, with the corrected pricing factor.

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Source: CMS PERL 201102-32

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ESRD SERVICES

Clarification of existing policy regarding items and services included under the ESRD composite payment rate

Background

The Centers for Medicare & Medicaid Services (CMS) has received numerous inquiries about whether or not certain types of protective catheter coverings are considered to be an end-stage renal disease (ESRD)-related service and, as such, included under the ESRD composite rate. In response to these questions, this change request provides clarification to the existing policy regarding items and services included under the ESRD composite rate for dialysis patients, located in Pub 100-02, *Medicare Benefit Policy Manual*, Chapter 11, Section 30. As dressings or protective catheter coverings may be used to protect the dialysis access site, these supplies are considered ESRD-related and are included in the ESRD composite rate for all dialysis patients regardless of the method of dialysis, or where they receive dialysis treatment, and, therefore are not separately billable. All dressings and protective catheter coverings are also included in the ESRD prospective payment system (PPS) bundled payment amount, effective January 1, 2011.

Policy

ESRD facilities and monthly capitated payment (MCP) physicians and practitioners may determine that it is medically required for a dialysis patient to use dressings or protective access coverings, including catheter coverings, on their access site. All medically required dressings or protective access coverings used during or after dialysis to protect a dialysis patient's access site, including for example, coverings used for day-to-day activities such as bathing, are considered to be ESRD-related items. To the extent that dressings and protective access coverings, including catheter coverings, are determined to be medically required, an ESRD facility can provide them. Medicare payment for ESRD-related items and services are included in the ESRD composite payment rate, and are therefore included in the ESRD PPS, for all dialysis patients regardless of the method of dialysis or where they receive dialysis treatments.

Source: Pub 100-02, Transmittal 136, change request 7312

Revision of the ICD-9 CM codes recognized for a co-morbidity payment adjustment under the ESRD PPS

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], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries and paid under the end stage renal disease prospective payment system (ESRD PPS).

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7284 which points out that ICD-9-CM diagnosis codes 484.6 (pneumonia in aspergillosis) and 484.7 (pneumonia in other systemic mycoses) are two diagnoses that are not eligible for a co-morbidity payment adjustment under the ESRD PPS.

Caution – what you need to know

CR 7284 removes ICD-9-CM diagnosis codes 484.6 (pneumonia in aspergillosis) and 484.7 (pneumonia in other systemic mycoses) from the bacterial pneumonia co-morbidity category under the ESRD PPS to prevent incorrect payment on ESRD PPS claims effective January 1, 2011.

Go – what you need to do

The volume of claims reporting these codes is expected to be minimal, therefore, your Medicare contractors are not

required to identify and adjust any claims with these codes. ESRD facilities that identify claims requiring adjustments for these diagnoses should adjust their claims within the timely filing period.

Additional information

The official instruction, CR 7284, issued to your FIs and A/B MACs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R8400TN.pdf>

If you have any questions, please contact your FIs 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: MM7284

Related Change Request (CR) #: 7284

Related CR Release Date: January 21, 2011

Effective Date: January 1, 2011

Related CR Transmittal #:R8400TN

Implementation Date: July 5, 2011

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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 January 18, 2011. To reflect the revised change request (CR) 7064 that was issued on January 14, 2011. 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 January 2011 *Medicare A Bulletin* pages 51-55.

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.

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

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

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.

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.

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

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.

3. Low-volume facility adjustment: Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year. The three years preceding treatment data should be reflected on the last two settled cost reports and the most recent must be filed. The provider must notify their Medicare contractor if they believe they are eligible for the low-volume adjustment.

Change in processing home dialysis claims

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

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility, 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.

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

- 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
- 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: January 14, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2134CP

Implementation Date: January 3, 2011

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End-stage renal disease claims

The Centers for Medicare & Medicaid Services (CMS) has identified a problem with 2011 end-stage renal disease (ESRD) home dialysis claims. Payment for home dialysis claims for continuous ambulatory peritoneal dialysis (CAPD) and continuous cycling peritoneal dialysis (CCPD) are not being correctly adjusted for the daily rate resulting in overpayments for these claims. CMS will hold these claims to prevent the overpayments and reduce the number of necessary adjustments to claims. The claims will be released for processing on or before February 21, 2011. Contractors will be instructed to adjust claims that were paid incorrectly within 30 days. Hemodialysis claims are not impacted and will not be held. CMS regrets any inconvenience this may cause ESRD facilities.

Source: CMS PERL 201102-14

PSYCHIATRIC SERVICES

Updated – inpatient psychiatric facility prospective payment system PC Pricer

The inpatient psychiatric facility prospective payment system personal computer (IPF PPS PC) Pricer had a date edit error corrected, has been updated with January 2011, provider data for rate year (RY 2011), and has been updated on the Centers for Medicare & Medicaid Services (CMS) website for claims dates from October 1, 2010, to June 30, 2011. If you use the IPF PPS PC Pricer for RY 2011, please go to the page, http://www.cms.gov/PCPricer/09_inppsy.asp, under the Downloads section, and download the latest versions of the IPF PPS RY2011 PC Pricers, posted February 18, 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 201102-44

Try our E/M interactive worksheet

First Coast Service Options (FCSO) Inc. is proud of its exclusive E/M interactive worksheet, available at <http://medicare.fcso.com/EM/165590.asp>. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders. After you've tried the E/M interactive worksheet, send us your thoughts of this resource through our website feedback form, available at <http://medicare.fcso.com/Feedback/160958.asp>.

RURAL HEALTH CLINIC SERVICES

Waiver of coinsurance and deductible for preventive services for rural health clinics (RHCs), Section 4104 of the Affordable Care Act

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

Note: This article was revised on December 21, 2010, to reflect a revised change request (CR) 7208 issued on that date. The CR release date, transmittal number and Web address for accessing CR 7208 were revised in this article. All other information remains the same. This information was previously published in the January 2011, *Medicare A Bulletin* page 65.

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 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/R2122CP.pdf>. Attachment A of CR 7208 contains a list of the current HCPCS codes for which the coinsurance and deductible are waived when provided by RHCs a result of Section 4104 of the Affordable Care Act. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

MLN Matters' Number: MM7208 *Revised*
 Related Change Request (CR) #: 7208
 Related CR Release Date: December 21, 2010
 Effective Date: January 1, 2011
 Related CR Transmittal #: R2122CP
 Implementation Date: April 4, 2011

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

'Rural Referral Center' fact sheet revised

The revised "Rural Referral Center" fact sheet (January 2011), which is designed to provide education on the rural referral center program that was established to support high-volume rural hospitals that treat a large number of complicated cases, is now available in downloadable format from the *Medicare Learning Network*® at http://www.CMS.gov/MLNProducts/downloads/Rural_Referral_Center_Fact_Sheet.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 201102-13

ELECTRONIC DATA INTERCHANGE

Some 837 institutional claims are not automatically crossing over to supplemental payers – provider action required

The Centers for Medicare & Medicaid Services (CMS) has identified a Medicare Part A institutional claims crossover problem that began December 21, 2010, where some institutional claims are not automatically crossing over to supplemental payers even though the provider Medicare remittance advice indicates otherwise. Until this problem is resolved, Medicare will continue to mail letters to the provider's correspondence address of record identifying the impacted claims by document control number, beneficiary health insurance claim number (HICN), and error code H45138 – "Service Facility Name was not expected because the Billing/Pay-to Provider (PRV) is present." Medicare providers receiving these letters will need to take action to send these claims to the beneficiary's supplemental payers until this problem is resolved. Medicare will not be able to automatically send (cross over) these claims to supplemental payers.

Background

In December 2010, the Fiscal Intermediary Shared System (FISS) began populating the Service Facility (loop 2310E) 837 information, as submitted on the provider's claim (837) to Medicare, for crossover claims purposes even though it duplicated the Billing Provider (loop 2010AA) or Pay-to Provider (loop 2010AB) 837 information. This duplication of information is causing error code H45138 at the COB Contractor (COBC). Under the Health Insurance Portability and Accountability Act (HIPAA) 837 transaction standards, entity-specific information presented within the Service Facility (2310E) loop cannot be the same as reported within either the Billing Provider (2010AA) loop or Pay-to Provider (2010AB) loop. (Note: Providers should also not be reporting the same taxonomy code information within the 2310E PRV as reported at the 2000A PRV level.)

Through analysis, FISS has determined that many providers have been, and still are, creating the same information at the 2310E loop, including taxonomy code, as appears in the 2000A level of the claim. The prohibition on doing this is further corroborated by CMS change request (CR) 5243 (R1133CP-MM5243), which instructed providers to report the Service Facility (2310E) loop in any 837 institutional claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay-to provider. Important: Providers should be aware that front-end editing to prevent the billing of duplicate information at the 2310E and 2000A levels will be activated at the Medicare contractors as part of the current fix to the H45138 problem.

Timeframes for systems fix and provider actions to avoid claims rejections and receipt of edit H45138

At this time, CMS estimates the current problem will be corrected no later than March 7, 2011. Medicare claims payment contractors are currently testing the FISS-developed system changes that will correct this problem and will implement the changes sooner if possible this month (February).

Prior to installation of the fix, providers should review and follow the instructions in CR 5243 to avoid having their claims not cross over due to error H45138 and avoid having their claims reject after the fix has been installed. This includes not submitting 837 entity information within the Service Facility (2310E) loop if it duplicates information within either the Billing Provider (2010AA) loop or Pay-to Provider (2010AB) loop. This would also apply to creation of the same taxonomy code at the 2310E PRV as was reported within the 2000A PRV.

Source: CMS PERL 201102-16

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Learn more on FCSO's Medicare training website

Have you started external testing of version 5010?

All Health Insurance Portability and Accountability Act (HIPAA) covered entities that submit transactions electronically are required to upgrade from version 4010A1 to version 5010 transaction standards by January 1, 2012.

Testing should be conducted both internally and with external business partners in preparation for the January 1, 2012, compliance deadline. Internal testing of version 5010 should have been completed by December 31, 2010. Now is the time to begin external testing.

Testing transactions using version 5010 standards will assure that you are able to send and receive compliant transactions effectively. And testing early will allow you to identify any potential issues, and address them in advance.

Stay ahead of the version 5010 and ICD-10 transitions! Know the deadlines and mark your calendars:

- **January 1, 2011** – begin external testing of version 5010 for electronic claims
 - Centers for Medicare & Medicaid Services (CMS) begins accepting version 5010 claims
 - Version 4010 claims continue to be accepted
- **December 31, 2011** – external testing of version 5010 for electronic claims must be complete to achieve Level II version 5010 compliance
- **January 1, 2012** – all electronic claims must use version 5010; version 4010A1 claims are no longer accepted
- **October 1, 2013** – claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures; CPT codes will continue to be used for outpatient services

CMS has resources that can help you with the version 5010 and ICD-10 transitions at www.cms.gov/icd10.

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

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

Source: CMS PERL 201102-06

HIPAA 5010 & D.0 – implementation calendar and important reminders

During the transition to Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.0., 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.0. transition year

Readiness assessment: Have you done the following to be ready for 5010/D.0.? at 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 contactor (MAC)? at http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf

Reminder: 5010/D.0. errata requirements and testing schedule at http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf

Reminder: Contact your MAC for their testing schedule at http://www.cms.gov/Versions5010andD0/Downloads/Reminder-Contact_MAC.pdf

Implementation calendar

February 2011

February 20-24: Healthcare Information and Management Systems Society (HIMSS) 11th Annual Conference & Exhibition* at <http://www.himss.org/ASP/eventsHome.asp>

Upcoming items

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* at <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* at <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

Past items

June 2010

June 15: 5010 national call – ICD-10/5010 national provider call at <http://www.cms.gov/Versions5010andD0/>

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

[V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237787&intNumPerPage=10](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 at <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 at <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) at <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 at http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf

October 27: 5010 national call – NCPDP version D.O. transaction at <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 at http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf

November 8: WEDI 2010 fall conference* at <http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=C31C0000002C>

November 17: 5010 national call – coordination of benefits (COB) at <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 at <http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241855&intNumPerPage=10>

January 2011

January 1: Beginning of transition year

January 11: HIMSS 5010 industry readiness update* <http://www.himss.org/asp/UnknownContent.asp?type=evt>

January 19: 5010 national call – errata/companion guides at <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* at <http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=12B9F00000029>

For older national call information, please visit the 5010 National Calls section of CMS' versions 5010 & D.O. Web page at <http://www.cms.gov/Versions5010andD0/V50/list.asp>.

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

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

Source: CMS PERL 201102-15

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The countdown has begun ...

Are you ready for January 1?

Schedule your HIPAA-5010 testing today!

Call 888-670-0940, Option 1

Additional information on HIPAA-5010 at <http://medicare.fcsso.com/HIPAA/>

Modifications to the implementation of the paperwork (PWK) segment for X12N version 5010

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

Provider types affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare administrative contractors [MACs], durable medical equipment Medicare administrative contractors [DME MACs], and fiscal intermediaries [FIs] including regional home health intermediaries [RHHIs]).

What you need to know

This article is based on change request (CR) 7306, which instructs Medicare contractors about additional business requirements that are necessary to complete the implementation of the PWK segment scheduled for July 2011 under CR 7041. An article related to CR 7041 is available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7041.pdf>. Of significance to the provider community is a change whereby Medicare contractors will only return an incomplete/incorrect fax/mail cover sheet, when such is received. In CR 7041, the attached data was to be returned as well, but that is no longer the case. Also, note that CR 7306 requires your contractor to mask any protected health information (PHI) on the fax/cover sheet returned to you.

In addition, the following changes will result from CR 7306:

- In PWK02, Medicare contractors will only use values BM and FX and will communicate that via the companion document. Other values will be accepted only in CMS-approved electronic claims attachment pilots based on agreements with willing trading partners.
- Medicare contractors will have the ability to accept the PWK02 value of EL for those contractors in a CMS-approved electronic claims attachment pilot.
- Contractors will allow seven calendar “waiting” days (from the date of receipt) for additional information to be submitted when the PWK02 value is EL.

Be sure your staffs are informed of this change.

Additional information

The official instruction, CR 7306, issued to your FI, carrier, A/B MAC, and DME/MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R849OTN.pdf>.

If you have any questions, please contact your FI, carrier, 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: MM7306

Related Change Request (CR) #: 7306

Related CR Release Date: January 28, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R849OTN

Implementation Date: July 5, 2011

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EDUCATIONAL EVENTS

Upcoming provider outreach and educational events

March – May 2011

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

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

Bimonthly Medicare Part A ACT: Medicare changes and hot issues - not yet open for registration

When: Tuesday, May 10
 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

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

'Quick Reference Information: Medicare Immunization Billing' chart now in print

The "Quick Reference Information: Medicare Immunization Billing" chart, which provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for influenza vaccine, pneumococcal vaccine, and Hepatitis V Virus (HBV) vaccine and their administration, is now available to order in hardcopy, free of charge, from the Medicare Learning Network®. To order your copy, visit the Preventive Services Educational products page at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp, scroll 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 201102-13

February flu shot reminder

It's not too late to give and get the flu vaccine. Take advantage of each office visit and continue to protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) recommends that patients, health care workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. **Get your flu vaccine -- not the flu.**

Remember – influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is not a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit the following CMS websites:

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

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

Source: CMS PERL 201102-01

OTHER EDUCATIONAL RESOURCES

Updates from the Medicare Learning Network

Publications For Your Medicare Beneficiaries fact sheet

The Medicare Learning Network® (MLN) has released a new product titled "*Publications For Your Medicare Beneficiaries*." This fact sheet lists a variety of beneficiary-related publications available to assist providers in responding to patients' questions related to Medicare, all of which can be printed and provided to patients. This product is available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/BenePubFS-ICN905183.pdf> and is suggested for all providers.

Guidelines for Teaching Physicians, Interns, and Residents fact sheet revised

The "Guidelines for Teaching Physicians, Interns, and Residents" (revised December 2010) is now available in downloadable format at <http://www.CMS.gov/MLNProducts/downloads/gdelinesteachgresfctsh.pdf>. This fact sheet provides information about payment for physician services in teaching settings, general documentation guidelines, and evaluation and management documentation guidelines.

HIPAA EDI Standards Web-based training revised

The MLN is now offering the revised *HIPAA EDI Standards* Web-based training (revised January 2011) for continuing education (CE) credit. The goal of this activity is to provide information to physicians, suppliers, and health care professionals regarding electronic billing and other health care electronic transactions such as the Administrative Simplification provisions of Health Insurance Portability and Accountability Act (HIPAA), electronic transaction standards and code sets required by HIPAA, and an overview of the steps involved in the Medicare electronic data interchange process. To take this training, visit <http://www.CMS.gov/MLNProducts> and click on "Web-Based Training Modules" under "Related Links Inside CMS."

Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers publication revised

The publication titled *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers* (revised October 2010) is designed to educate institutional and professional providers who bill Medicare with general remittance advice (RA) information. It includes instructions to help you interpret the RA received from Medicare and reconcile it against submitted claims and provides guidance on how to read electronic remittance advices (ERAs) and standard paper remittance advices (SPRs), as well as information on balancing an RA. This publication may be downloaded from http://www.CMS.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf.

Updates from the Medicare Learning Network (continued)*Evaluation and Management Services Guide* publication revised

The publication titled *Evaluation and Management Services Guide* (revised December 2010) is now available in downloadable format from the MLN at http://www.CMS.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf. This guide is designed to provide education on medical record documentation and evaluation and management billing and coding considerations. The “1995 Documentation Guidelines for Evaluation and Management Services” and the “1997 Documentation Guidelines for Evaluation and Management Services” are included in this publication.

CMS Email Subscription Service publication available in print

The educational tool titled *CMS Email Subscription Service* (revised October 2010), which provides education on the various CMS fee-for-service (FFS) electronic mailing lists, is now available in print format from the MLN. 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 201102-28

Revised brochure on the Medicare appeals process

The revised brochure titled *The Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers* (revised January 2011) is now available in downloadable format from the Medicare Learning Network[®] at <http://www.CMS.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf>. This brochure is designed to provide an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process.

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

Source: CMS PERL 201102-43

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Order form for Medicare Part A materials

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

ITEM	ACCOUNT NUMBER	COST PER ITEM	QUANTITY	TOTAL
Part A subscription – The Medicare Part A jurisdiction 9 publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications/ (English) or http://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2010 through September 2011.	40-500-150	Hardcopy \$33		
		CD-ROM \$55		
Language preference for subscription: English [<input type="checkbox"/>] Español [<input type="checkbox"/>]				
<i>Please write legibly</i>			Subtotal	\$
			Tax (<i>add % for your area</i>)	\$
			Total	\$

Mail this form with payment to:

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

Contact Name:

Provider/Office Name:

Telephone Number (include area code):

Mailing Address:

City:

State, ZIP Code:

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

Addresses**CLAIMS/CORRESPONDENCE****Claim status****Additional development****General correspondence****Coverage guidelines****Billing issues regarding****outpatient services, CORF, ORF, PHP**

Medicare Part A Customer Service

P. O. Box 2711

Jacksonville, FL 32231-0021

PART A REDETERMINATION

Medicare Part A Redetermination
and Appeals

P. O. Box 45053

Jacksonville, FL 32232-5053

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

MSP – Hospital Review

P. O. Box 45267

Jacksonville, FL 32232-5267

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

Medicare Secondary Payer

P. O. Box 2711

Jacksonville, FL 32231-0021

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

Auto/Liability Department – 17T

P. O. Box 44179

Jacksonville, FL 32231-4179

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

Direct Data Entry

P. O. Box 44071

Jacksonville, FL 32231-4071

FRAUD AND ABUSE

Complaint Processing Unit

P. O. Box 45087

Jacksonville, FL 32232-5087

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

Palmetto Government Benefit

Administrators

Medicare Part A

P.O. Box 100238

Columbia, SC 29202-3238

RAILROAD MEDICARE**Railroad retiree medical claims**

Palmetto Government Benefit

Administrators

P. O. Box 10066

Augusta, GA 30999-0001

POST-PAY MEDICAL REVIEW

First Coast Service Options Inc.

P. O. Box 44159

Jacksonville, FL 32231-4159

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

Provider Audit and Reimbursement

Department (PAR)

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

DURABLE MEDICAL EQUIPMENT**REGIONAL CARRIER (DMERC)****Durable medical equipment claims****Orthotic and prosthetic device claims****Take home supplies****Oral anti-cancer drugs**

CIGNA Government Services

P. O. Box 20010

Nashville, Tennessee 37202

Telephone numbers**PROVIDERS**

Customer service center toll-free

1-888-664-4112

Interactive voice response (IVR)

1-888-664-4112

Speech and hearing impaired

1-877-660-1759

BENEFICIARY

Customer service center toll-free

1-800-MEDICARE

1-800-633-4227

Speech and hearing impaired

1-800-754-7820

ELECTRONIC DATA INTERCHANGE

1-888-670-0940

Option 1

Transaction support

Option 2

PC-ACE support

Option 3

Direct data entry (DDE) support

Option 4

Enrollment support

Option 5

Electronic funds

(check return assistance only)

Option 6

Automated response line

PROVIDER EDUCATION & OUTREACH

Seminar registration hotline

1-904-791-8103

Seminar registration fax number

1-904-361-0407

PROVIDER ENROLLMENT

1-877-602-8816

CREDIT BALANCE REPORT

Debt recovery

1-904-791-6281

Fax

1-904-361-0359

Medicare websites**PROVIDERS**

Florida Medicare contractor

medicare.fcso.com

Centers for Medicare & Medicaid

Services

www.cms.gov

BENEFICIARIES

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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

MEDICARE SECONDARY PAYER Information on hospital protocols

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 MSP – Hospital Review
 P. O. Box 45267
 Jacksonville, FL 32232-5267

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 Jacksonville, FL 32231-0021

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 P.O. Box 100238
 Columbia, SC 29202-3238

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 Provider Audit and Reimbursement
 Department (PARD)
 P. O. Box 45268
 Jacksonville, FL 32232-5268
 1-904-791-8430

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

PROVIDER ENROLLMENT

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

PROVIDER ENROLLMENT American Diabetes Association certificates

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

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 Jacksonville, FL 32202-4914

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medicare.fcso.com

Centers for Medicare & Medicaid
 Services
www.cms.gov

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

MEDICARE A BULLETIN

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

♦ ATTENTION BILLING MANAGER ♦

