Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers April 2011

Features

"Partnership for Patients" to improve care and lower costs for Americans

New partnership between the administration, private sector, hospitals, and doctors will make patient care safer and potentially save up to $50 billion

Health and Human Services Secretary Kathleen Sebelius, joined by leaders of major hospitals, employers, health plans, physicians, nurses, and patient advocates, announced the creation of the "Partnership for Patients," a new national partnership that will help save 60,000 lives by stopping millions of preventable injuries and complications in patient care over the next three years. The Partnership for Patients also has the potential to save up to $35 billion in health care costs, including up to $10 billion for Medicare. Over the next 10 years, the Partnership for Patients could reduce costs to Medicare by about $50 billion and result in billions more in Medicaid savings. Already, more than 500 hospitals, as well as physicians and nurses groups, consumer groups, and employers have pledged their commitment to the new initiative.

"Americans go the hospital to get well, but millions of patients are injured because of preventable complications and accidents," said Secretary Sebelius. "Working closely with hospitals, doctors, nurses, patients, families and employers, we will support efforts to help keep patients safe, improve care, and reduce costs. Working together, we can help eliminate preventable harm to patients."

Leaders from across the nation pledged their commitment to this new initiative. To launch this initiative, the Department of Health and Human Services (HHS) announced it would invest up to $1 billion in federal funding, made available under the Affordable Care Act. On Tuesday, April12, $500 million of that funding was made available through the Community-based Care Transitions Program. Up to $500 million more will be dedicated from the Centers for Medicare & Medicaid Services (CMS) Innovation Center to support new demonstrations related to reducing hospital-acquired conditions. The funding will be invested in reforms that help achieve two shared goals:

- **Keep hospital patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40-percent compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than 60,000 lives saved over the next three years.

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The *Medicare A Connection* represents formal notice of coverage policies. Articles included 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 within to ensure compliance with Medicare coverage and payment guidelines.

Partnership...*continued from page 1*

- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20-percent compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

The Partnership will target all forms of harm to patients but will start by asking hospitals to focus on nine types of medical errors and complications where the potential for dramatic reductions in harm rates has been demonstrated by pioneering hospitals and systems across the country. Examples include preventing adverse drug reactions, pressure ulcers, childbirth complications, and surgical site infections. The CMS Innovation Center will help hospitals adapt effective, evidence-based care improvements to target preventable patient injuries on a local level, developing innovative approaches to spreading and sharing

The Partnership will target nine types of medical errors and complications.

strategies among public and private partners in all states. Members of the partnership will identify specific steps they will take to reduce preventable injuries and complications in patient care.

"With new tools provided by the Affordable Care Act, we can aggressively implement programs that will help hospitals reduce preventable errors," said CMS Administrator Donald Berwick, M.D. "We will provide hospitals with incentives to improve the quality of health care, and provide real assistance to medical professionals and hospitals to support their efforts to reduce harm."

HHS has committed $500 million to community-based organizations partnering with eligible hospitals to help patients safely transition between settings of care. Today, community-based organizations and acute care hospitals that partner with community-based organizations can begin submitting applications for this funding. Applications are being accepted on a rolling basis. Awards will be made on an ongoing basis as funding permits.

In coordination with stakeholders from across the health care system, the CMS Innovation Center is planning to use up to $500 million in additional funding to test different models of improving patient care and patient engagement and collaboration in order to reduce hospital-acquired conditions and improve care transitions nationwide. These collaborative models will help hospitals adopt effective interventions for improving patient safety in their facilities.

The programs are just two of the many ways the Affordable Care Act is helping improve the health care system. Last month, HHS announced the first-ever National Quality Strategy, which will serve as a tool to help coordinate quality initiatives between public and private partners as well as to leverage and coordinate existing efforts by federal agencies and departments to improve patient care. HHS also announced new rules to help doctors, hospitals, and other providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). By 2015, a portion of Medicare payments to the majority of hospitals will be linked to whether hospitals are delivering safer care, using information technology effectively and meeting patient needs. Payment incentives and supports to improve quality and lower costs will also be available to state Medicaid programs.

"No single entity can improve care for millions of hospital patients alone," said Berwick. "Through strong partnerships at national, regional, state and local levels – including the public sector and some of the nation's largest companies – we are supporting the hospital community to significantly reduce harm to patients."

For more information about the Partnership for Patients, visit *www.HealthCare.gov/center/programs/partnership*. For a fact sheet on the announcement, visit *www.HealthCare.gov/news/factsheets/partnership04122011a.html*. For more information about the Community-based Care Transitions Program funding opportunity, visit *www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313*.

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

Source: CMS PERL 201104-30

Final reminder: Time is running out – have you responded to the MCPSS?

Do you have any thoughts on your interactions with the services you experience with us? Have any feedback, positive or constructive, to give the Centers for Medicare & Medicaid Services (CMS) about your experiences with us?

Don't miss your chance to tell – your opportunity to participate in the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) is quickly coming to an end and CMS still needs your feedback. If you have already responded to the 2011 MCPSS, thank you. If you have not, don't pass up this golden opportunity to let your voice be heard.

If you or your office received notification from CMS that you were randomly selected to participate in the 2011 MCPSS, this is your last chance to respond before the survey closes. Your feedback is very important. The MCPSS is your opportunity to tell CMS about your satisfaction with the processing and payment services you receive from us.

Completion of the survey should only take a few minutes, and can be done by yourself or your designee; just follow the instructions in your survey invitation. (If you do not have your invitation letter, contact the MCPSS provider helpline today at 800-654-1431 or *mcpss@scimetrika.com* for assistance.)

CMS will not provide information that identifies you or your practice or facility to anyone outside the study team, except as required by law.

(Note that only providers and suppliers who have been randomly selected and notified can participate in the 2011 MCPSS.)

For more information about the MCPSS, please visit *http://www.CMS.gov/MCPSS*.

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

Source: CMS PERL 201104-15

Sign-up for the ICD-10 industry update messages

Did you know that the Centers for Medicare & Medicaid Services (CMS) has an email update specific to ICD-10 that you can sign-up for?

The CMS ICD-10 industry email update provides subscribers with timely information about the upcoming version 5010 and ICD-10 transitions. Each message is delivered directly to your email inbox, supplying helpful reminders, information on new resources, and other ICD-10 and version 5010 news. Recent messages have covered important topics, such as:

- The partial code freeze prior to ICD-10 implementation;
- External testing of version 5010 transaction standards; and
- The General Equivalence Mappings (GEMs).

To sign up for the ICD-10 industry email updates, or to view previous email updates, visit *http://www.CMS.gov/ICD10/02d_CMS_ICD-10_Industry_Email_Updates.asp*. To keep up to date on version 5010 and ICD-10, and for the latest news and resources, be sure to keep current with *http://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 201103-54

Reminder: Medicare enrollment application fees and new screening categories

Find out how the provider enrollment provisions, effective March 25, affect you. Learn more about the following:

- Submission of provider application fees
- Establishment of provider enrollment screening categories
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type in a geographic area

MLN Matters® article MM7350 – titled "Implementation of Provider Enrollment Provisions in CMS-6028-FC" (*http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf*) – explains how Medicare will implement the above provisions cited in the recent regulation (CMS-6028-FC).

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

Source: CMS PERL 201104-05, 201103-60

Signature on requisition for clinical diagnostic laboratory tests

In the Monday, November 29, 2010, Medicare Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified non-physician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective Saturday, January 1, 2011. (A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.)

On Monday, December 20, 2010, CMS informed its contractors of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of or do not understand this policy. As such, CMS indicated that it will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS indicated that once the first quarter educational campaign is fully underway, it will expect requisitions to be signed.

After further input from the community, CMS has decided to focus the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Source: CMS PERL 201103-64

Reprocessing of claims for federally qualified health centers

Effective January 1, 2011, federally qualified health centers (FQHCs) began reporting detailed Healthcare Common Procedure Coding System (HCPCS) codes for all services rendered during the encounter/visit. The Centers for Medicare & Medicaid Services (CMS) instructed FQHC providers to submit charges associated with the encounter/visit on a 052x revenue line with an evaluation and management (E/M) HCPCS code.

CMS became aware that coinsurance may not be calculated correctly when claims are submitted with multiple 052x revenue lines on 77x bill types.

The fiscal intermediary shared system (FISS) has been updated to ensure coinsurance is applied to the 052x revenue line containing the E/M HCPCS code.

Please contact your Medicare contractor and identify any claims that have been processed incorrectly as outlined above. Your contractor will adjust all claims brought to their attention.

Source: CMS PERL 201104-20

Corrections to payments for certain multiple procedure payment reduction claims

It has been brought to the attention of the Centers for Medicare & Medicaid Services (CMS) that the fiscal intermediary shared system (FISS) is taking the multiple procedure payment reduction (MPPR) on claims regardless of whether the services were provided on the same day. As a result of this coding error, any therapy claims with dates of service on or after January 1, 2011, processed from January 3, 2011, through February 6, 2011, with one of the specified therapy codes in change request (CR) 7050 were processed incorrectly.

System changes were successfully implemented on February 7, 2011, and the CMS has instructed Medicare contractors to adjust claims that processed incorrectly.

CMS has also learned that the FISS was using a rate file which contains rates that reflect a 20 percent reduction rather than the 25 percent reduction that is appropriate for institutional claims. As a result of this error, all therapy services subject to the MPPR with dates of service on or after January 1, 2011, have been paid incorrect amounts.

Medicare contractors will install a corrected rate file in early May, and the CMS has instructed Medicare contractors to adjust claims that were paid incorrectly no later than June 30, 2011.

Source: CMS PERL 201104-21

April is National Minority Health Month

Please join with the Centers for Medicare & Medicaid Services (CMS) during National Minority Health Month to promote preventive benefits, which are often underutilized by minority populations. In general, low-income Americans and racial and ethnic minorities experience disproportionately higher rates of disease, fewer treatment options, and reduced access to care. Educating people about healthy behaviors and lifestyle modification can help to postpone and avoid illness and disease. In addition, detecting health problems at an early stage increases the chances of effectively treating them, often reducing suffering and costs. Medicare pays for many preventive services to help keep seniors and others with Medicare healthy. These preventive services can detect health problems early, when treatment works best, and can keep our most vulnerable populations from getting certain diseases. Medicare-covered preventive services include exams, immunizations, lab tests, screenings, and programs for health monitoring, as well as counseling and education to help Medicare beneficiaries maintain optimum health.

The Affordable Care Act made improvements to the Medicare program. As a result, starting in 2011, beneficiaries with original Medicare are eligible to receive a yearly “wellness” exam in addition to many preventive services.

Medicare-covered services:

Medicare provides coverage of the following preventive services and screenings, subject to beneficiary eligibility:

- Abdominal aortic aneurysm screening
- Bone mass measurements
- Cancer screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical and vaginal (pap test and pelvic exam)
  - Colorectal
  - Prostate
- Cardiovascular disease screenings
- Diabetes screening, supplies, and self-management training
- EKG screening
- Glaucoma screening
- HIV screening
- Immunizations
  - Hepatitis B
  - Influenza
  - Pneumococcal
- Medical nutrition therapy (beneficiaries with diabetes or renal disease)
- One-time “Welcome to Medicare” physical exam
- Tobacco use cessation counseling
- Annual wellness exam (new for 2011)

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Minority...*continued*

How can you help?

As a health care professional who provides services to seniors and other people with Medicare, CMS needs your help to ensure that all eligible Medicare beneficiaries take advantage of preventive services. We ask that you talk with your patients about their risk factors for various diseases and highlight the importance of prevention and early disease detection through the use of appropriate screenings (at the appropriate frequency).

Note: Many of these Medicare-covered services require provider referrals so we are counting on you to provide referrals when appropriate.

For more information:

- CMS Preventive Services website – *http://www.cms.gov/PrevntionGenInfo/*
- Medicare Learning Network® (MLN) preventive services educational products – *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*
- Quick Reference Information: Medicare Preventive Services – *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*
- The Office of Minority Health – *http://minorityhealth.hhs.gov/*

Together we can help to eliminate health disparities and achieve optimal health for all racial and ethnic groups.

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

Source: CMS PERL 201104-13

Effective date of certified provider or supplier agreement or approval

Provider types affected

This article is for providers and suppliers subject to survey and certification requirements.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7232 which clarifies instructions regarding the determination of the effective date of certified provider agreement or supplier approval.

Caution – what you need to know

The Code of Federal Regulations (42 CFR 489.13) has been revised to make it clearer that the date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met, and that such requirements include review and verification of an application to enroll in the Medicare program by the Centers for Medicare & Medicaid Services (CMS) legacy fiscal intermediary (FI), legacy carrier, or Medicare administrative contractor (MAC).

Go – what you need to do

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

Background

The fiscal year (FY) 2011 inpatient prospective payment system (IPPS) final rule was published on August 16, 2010, (75 FR50042) and was effective October 1, 2010 (see the FY 2011 IPPS final rule at *http://edocket.access.gpo.gov/2010/2010-19092.htm* on the Internet). Several provisions in the FY 2011 IPPS final rule amend Section 489.13 of the Code of Federal Regulations (42 CFR 489.13) which governs the determination of the effective date of a Medicare provider agreement or supplier approval for health care facilities that are subject to survey and certification. The revised Section 489.13 makes it clearer that:

- The date of a Medicare provider agreement or supplier approval may not be earlier than the latest date on which all applicable federal requirements have been met; and
- Such requirements include review and verification of an application to enroll in the Medicare program by the CMS legacy fiscal intermediary (FI), legacy carrier, regional home health intermediary (RHHI), or Medicare administrative contractor (MAC).

You can review revised 489.13 of the CFR at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=cbe4615ac0d1730fe7871c78553897f9;rgn=div2;view=text;node=20100816%3A1.77;idno=42;cc=ecfr;start=1;size=25* on the Internet.

These clarifications were necessary because a September 28, 2009, decision of the Appellate Division of the Departmental Appeals Board (DAB) interpreted Section 489.13 as not including enrollment application processing among federal requirements that must be met. You can review the DAB Decision No. 2271 at *http://www.gov/dab/decisions/dabdecisions/dab2271.pdf* on the Internet.

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Effective date...*continued*

In that case a state agency had:

- Conducted a survey of an applicant on July 6, 2007; and
- Received the FI's notice on November 21, 2007, recommending the applicant's enrollment approval.

The CMS regional office (RO) issued a provider approval effective November 21, 2007 (the date the FI recommended the applicant's enrollment approval), consistent with our traditional interpretation of Section 489.13. However, the DAB ruled that the effective date must be July 6, 2007 (the date the survey was conducted).

The DAB agreed with the applicant in this case that the requirement for the Medicare contractor to verify and determine whether an application should be approved is

- Not a requirement for the provider to meet (under Section 489.13), but rather
- A requirement for Medicare contractor action (DAB Decision No. 2271, page 5).

In accordance with Section 2003B of the *State Operations Manual* (SOM), state agencies and accreditation organizations are aware that they should perform a survey of a new facility after the MAC/legacy FI/legacy carrier has provided notice that:

- The information on the enrollment application has been verified, and
- Enrollment is being recommended.

However, circumstances do occur when the sequence is reversed, i.e., the survey occurs prior to enrollment verification activities. Accreditation organizations, in particular, often find it challenging to confirm whether the MAC, FI, RHHI, or carrier has completed its review and made a recommendation, since they are dependent upon the applicant providing copies of the pertinent notices.

When the survey occurs prior to the enrollment verification activities, CMS believes it is essential that the provider agreement or supplier approval date be based on the later date, i.e., the date the contractor determined that the enrollment application was verified and recommends approval.

There are other federal requirements not related to a facility's survey, such as the provision of required Office for Civil Rights documentation. Accordingly, the revised rule explicitly states in Section 489.13(b) that:

"Federal requirements include, but are not limited to –

1) Enrollment requirements established in part 424, Subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;
2) The requirements identified in (Sections) 489.10 and 489.12; and
3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.

Additional information

The official instruction, CR 7232, issued to your carriers, FIs, MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R372PI.pdf* on the CMS website. If you have any questions, please contact your carriers, FIs, A/B MACs, or RHHIs 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: MM7232
Related Change Request (CR) #: 7232
Related CR Release Date: March 25, 2011
Effective Date: October 1, 2010
Related CR Transmittal #: R372PI
Implementation Date: April 25, 2011

Medicare electronic health record incentive payment process

Provider types affected

This article is intended for Medicare eligible professionals (EPs), eligible hospitals, including Medicare Advantage affiliated hospitals, and critical access hospitals (CAHs) that are meaningful users of certified electronic health record (EHR) technology.

What you need to know

This article describes the payment process for the Medicare EHR incentive program.

Background

The American Recovery and Reinvestment Act (Recovery Act) of 2009 provides for incentive payments beginning in 2011 for Medicare EPs, eligible hospitals, including Medicare Advantage affiliated hospitals, and CAHs that are meaningful users of certified EHR technology.

Note: For information about the Medicaid EHR incentive program, please see *http://www.cms.gov/EhrIncentivePrograms* on the Centers for Medicare & Medicaid Services (CMS) website. For questions about how Medicaid incentive payments will be made, contact your state agency. Contact information may be found at *http://www.cms.gov/apps/files/statecontacts.pdf* on the CMS website.

Key points

Who is eligible for the Medicare EHR incentive program and how will payments be calculated?

Refer to the following products to determine which providers are eligible and how incentive payments are calculated. Sample payment calculations are provided.

- The *Medicare Electronic Health Record Incentive Program for Eligible Professionals* fact sheet is available at *http://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf* on the CMS website.
- The *EHR Incentive Program for Medicare Hospitals* fact sheet is available at *http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf* on the CMS website.
- The *EHR Incentive Program for Critical Access Hospitals* fact sheet is available at *http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_CAH.pdf* on the CMS website.

What must I do to get a Medicare EHR incentive payment?

- **Make sure you're eligible for the Medicare EHR incentive program.** View eligibility guidelines at *http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp* on the CMS website.
- **Get registered.** Registration is now open. Visit *http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp* for more details.
- **Use certified EHR technology.** To receive incentive payments, make sure the EHR technology you are using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology. Visit the Certified EHR Technology page at *http://www.cms.gov/EHRIncentivePrograms/25_Certification.asp* for more details.
- **Be a Meaningful User.** You have to successfully demonstrate "meaningful use" for a consecutive 90-day period in your first year of participation (and for a full year in each subsequent year) to receive EHR incentive payments. Visit the Meaningful Use page at *http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp* to learn about meaningful use objectives and measures.
- **Attest for incentive payments**. To get your EHR incentive payment, you must attest (legally state) through Medicare's secure website that you've demonstrated "meaningful use" with certified EHR technology. You can get to the secure attestation website through the new attestation page available at *http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage* on the CMS website. For more information on registration, attestation and meaningful use, go to *http://www.cms.gov/EHRIncentivePrograms* on the CMS website.

When will I receive a payment?

- Payments will be made approximately 4-8 weeks after the provider successfully attests to meaningful use, assuming the provider has met the allowed charges threshold. For more information, read the FAQ on payment at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10160/kw/payment/session/L3NpZC84ZW9CZk9yaw%3D%3D* on the CMS website.

How will I receive the incentive payment?

- If you are eligible for an incentive payment, the payment will be made to the taxpayer identification number you selected during registration. The payment will be deposited in the first bank account on file with CMS and will be noted as "EHR incentive payment" by the bank.

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EHR...*continued*

- If you receive payments for Medicare services via electronic funds transfer, you will receive your Medicare EHR incentive payment the same way. If you currently receive Medicare payments by paper check, you will also receive your first Medicare EHR incentive payment by paper check.

Important note: Medicare administration contractors (MACs), carriers, and fiscal intermediaries (FIs) will not be making these payments. CMS has contracted with a payment file development contractor to make these payments.

- **Don't:** Call your MAC/Carrier/FI with questions about your EHR incentive payment.
- **Instead:** Call the EHR information center. Contact information and hours of operation are contained in the *Additional Information* section of this article.

Why is the amount less than I thought?

- The Medicare & Medicaid EHR incentive program registration and attestation system contains a *Status Tab* at the top which will contain the amount of the incentive payment, the amount of tax or nontax offsets applied, and the adjustment reason code for any reduction. Providers will not receive a remittance advice (835) for this payment; however, an electronic remit (820) will be sent to the bank along with the payment. (See the *Additional Information* section below for contact information related to the offsets.)
- For those receiving paper checks, there will be a tear off pay stub which identifies offsets made to the incentive payment.

Additional information

For more information about offsets:

- Call the Internal Revenue Service (IRS) toll-free at 800-829-3903 for tax offsets.
- Call the Department of the Treasury, Financial Management Service (FMS) toll free at 800-304-3107 for nontax offsets.

For other frequently asked questions (FAQs) about the EHR incentive program, visit *http://www.cms.gov/EhrIncentivePrograms/* on the CMS website.

The EHR information center is open to assist the EHR provider community with inquiries. EHR information center hours of operation are 7:30 a.m.-6:30 p.m. (Central Time) Monday through Friday, except federal holidays. The center's toll free number is 888-734-6433 (primary number) or 888-734-6563 (TTY number).

To submit an inquiry to the EHR information center, visit *http://questions.cms.hhs.gov/app/ask/p/21,26,1139* on the CMS website.

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Medicare EHR incentive program attestation begins April 18

Attestation for the Medicare electronic health record (EHR) incentive program begins on April 18. To receive your Medicare EHR incentive payment, you must attest through the Centers for Medicare & Medicaid Services' (CMS') Web-based Medicare and Medicaid EHR incentive programs registration and attestation system.

You can preview selected screenshots of the attestation system at *http://www.cms.gov/EHRIncentivePrograms/Downloads/AttestationSneakPeek.pdf* to help you understand what the process will involve. Please note that these screenshots are only examples – the final appearance and language may incorporate additional changes.

CMS will release additional information about the Medicare attestation process soon, including user guides that provide step-by-step instructions for completing attestation, and educational webinars that describe the attestation process in depth.

Here is more information to help you prepare for Medicare attestation:

You need to understand the required meaningful use criteria to successfully attest. Meaningful use requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR incentive program are different:

EP meaningful use criteria – must report on 15 core measures, five of 10 menu measures, and six clinical quality measures, consisting of three required core measures and three additional measures.

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EHR...*continued*

- Go to the Stage 1 EHR Meaningful Use Specification Sheets for EPs at *https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf* for information on core and menu measures for EPs.
- Go to the Clinical Quality Measures page at *https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp* for information on the required clinical quality measures for EPs.

Eligible Hospital and CAH meaningful use criteria – Must report on 14 core measures, five of 10 menu measures, and 15 clinical quality measures.

- Go to the Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals and CAHs at *https://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf* for information on core and menu measures for eligible hospitals and CAHs.
- Go to the Clinical Quality Measures page at *https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp* for information on the required clinical quality measures for eligible hospitals and CAHs.

You should also make sure that you begin your 90-day reporting period in time to attest and receive a Medicare payment in 2011. The last day to begin your 90-day reporting period for 2011 incentive payments is:

- July 3, 2011, for eligible hospitals and CAHs
- October 1, 2011, for EPs

Under the Medicaid EHR incentive programs, the date when participants can begin attestation for adopting, implementing, upgrading, or demonstrating meaningful use of certified EHR technology varies by state. Go to the Medicaid State EHR Incentive Program Web tool at *https://www.cms.gov/apps/files/medicaid-HIT-sites/* for more information about your state's participation in the Medicaid EHR incentive program.

Want more information about the EHR incentive programs?
Make sure to visit the CMS EHR incentive programs Web page at *http://www.cms.gov/EHRIncentivePrograms/* for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201104-07, 201103-58

Attestation for the Medicare EHR incentive program

This means that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) can attest through the Centers for Medicare & Medicaid Services (CMS) Web-based attestation system and be on their way to receiving Medicare EHR incentive payments.

CMS can help you successfully attest
Several new CMS resources can help you successfully navigate the Medicare EHR incentive program:

- A new attestation page on the CMS EHR website at *https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp*, where participants in the Medicare EHR incentive program may find important information on attestation.
- The Meaningful Use Attestation Calculator at *http://www.cms.gov/apps/ehr/* allows EPs and eligible hospitals to check whether they have met meaningful use guidelines before they attest in the system. The calculator prints a copy of each EP's or eligible hospital's specific measure summary.
- The *Eligible Professional User Guide* at *https://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_User_Guide.pdf* and the *Eligible Hospital and Critical Access Hospital User Guide* at *https://www.cms.gov/EHRIncentivePrograms/Downloads/HospAttestationUserGuide.pdf* provide step-by-step guidance for EPs and eligible hospitals on navigating the attestation system.

Coming soon

- Attestation worksheets for EPs and eligible hospitals allow users to fill out their meaningful use measure values, so they have a quick reference tool to use while attesting.
- Attestation video webinars will provide a video version of the user guides for EPs, eligible hospitals and CAHs. The videos show EP and eligible hospital representatives completing the attestation process.

If you are not ready to attest, follow these steps to participate in the programs:

- Make sure you're eligible for the EHR incentive programs. View eligibility guidelines on

continued on next page

Attestation...*continued*

the Eligibility page at *http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp* and select the program in which you want to participate.

- Get registered. Registration is open for EPs, eligible hospitals, and CAHs. Visit the Registration page at *http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp* for more details.
- Use certified EHR technology. To receive incentive payments, make sure the EHR technology you're using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology. Visit our Certified EHR Technology page at *http://www.cms.gov/EHRIncentivePrograms/25_Certification.asp* for details.
- Be a Meaningful User. You have to successfully demonstrate "meaningful use" for a consecutive 90-day period in your first year of participation (and for a full year in each subsequent years) to receive EHR incentive payments. Visit our Meaningful Use page at *http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp* to learn about meaningful use objectives and measures.
- Attest for incentive payments. To get your EHR incentive payment, you must attest through Medicare's secure website that you've demonstrated meaningful use with certified EHR technology.

Want more information about the EHR incentive programs?
Make sure to visit the EHR incentive program website at *http://www.cms.gov/EHRIncentivePrograms/* for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201104-31

Alabama and Missouri have launched their Medicaid EHR programs

Recently, Alabama and Missouri began participating in the Medicaid electronic health record (EHR) incentive program. This means that eligible professionals (EPs) and eligible hospitals in Alabama and Missouri will be able to receive incentive payments through the Medicaid EHR incentive program. More information about the Medicaid EHR incentive program may be found on the Medicare and Medicaid EHR Incentive Program Basics page at *http://www.cms.gov/EHRIncentivePrograms/* of the Centers for Medicare & Medicaid Services' (CMS') EHR website.

If you are a resident of Alabama or Missouri and are eligible to participate in the Medicaid EHR incentive program, visit your state's Medicaid agency website for more information on your state's participation in the Medicaid EHR incentive program:

- Alabama – *http://www.onehealthrecord.alabama.gov/*
- Missouri – *http://www.dss.mo.gov/mhd/ehr/*

As of April 4, 13 states have launched their Medicaid EHR incentive programs, and six states have issued incentive payments to Medicaid EPs who have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months.

For a complete list of states that have already begun participation in the Medicaid EHR incentive program, see the state Medicaid information at *http://www.cms.gov/apps/files/statecontacts.pdf* document from the CMS EHR website.

Want more information about the EHR incentive programs?

Make sure to visit the EHR Incentive Programs website at *http://www.cms.gov/EHRIncentivePrograms/* or the latest news and updates on the EHR incentive programs.

Reminder: Attestation for the Medicare EHR incentive program is only a few weeks away. On April 18, Medicare EPs and eligible hospitals will be able to use the CMS Web-based attestation system to attest to meeting meaningful use criteria. Prepare now for this important milestone.

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

Source: CMS PERL 201104-19

Additional EHR incentive program FAQs now available on CMS' website

The Centers for Medicare & Medicaid Services (CMS) wants to keep you updated with the latest information on the Medicare and Medicaid electronic health record (EHR) incentive programs. Last week, CMS sent you a message highlighting some of the new frequently asked questions (FAQs) that have been posted to its website. Take a minute and review the remaining new FAQs on eligibility, certified EHR technology, meaningful use, and attestation.

New FAQs on eligibility

1. If I am receiving payments under the CMS electronic prescribing (eRx) incentive program, can I also receive Medicare and Medicaid EHR incentive payments? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10088/kw/10088/session/L3NpZC9BWUVtNXFvaw%3D%3D* .
2. Can EPs participate in the 2011 Physician Quality Reporting System (formerly called PQRI), 2011 electronic prescribing (eRx) incentive program, and the EHR incentive program (aka Meaningful Use) at the same time and earn incentives for each? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10474*.

New FAQs on certified EHR technology

1. If a provider feeds data from certified EHR technology to a data warehouse, can the provider report on Meaningful Use objectives and clinical quality measures from the data warehouse? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10153/kw/10153*.
2. For the Medicare and Medicaid EHR incentive programs, is an EP or eligible hospital limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? For example, if a complete EHR has been tested and certified using a specific workflow, is an EP or eligible hospital required to use that specific workflow when it demonstrates meaningful use? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10473* .
3. If data is captured using certified EHR technology, can an EP or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10465/kw/10465* .

New FAQs on meaningful use

1. If my certified EHR technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10467/kw/10467*.
2. If a State utilizes the option to include patient panels when looking at patient volume for the Medicaid EHR incentive program, what does it mean to have "unduplicated encounters"? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10476/kw/10476*.
3. Do specialty providers have to meet all of the meaningful use objectives for the Medicare and Medicaid EHR incentive programs, or can they ignore the objectives that are not relevant to their scope of practice? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10469/kw/10469*.
4. For the Medicare and Medicaid EHR incentive programs, does an eligible hospital have to count patients admitted to both the inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10468/kw/10468*.
5. For the Medicare and Medicaid EHR incentive programs, should patient encounters in an ambulatory surgical center (Place of Service 24) be included in the denominator for calculating that at least 50 percent or more of an EP's patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10466/kw/10466*.
6. To meet the meaningful use objective "use computerized provider order entry (CPOE)" for the Medicare and Medicaid EHR incentive programs, should EPs include hospital-based observation patients (billed under

continued on next page

FAQs...*continued*

POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10462/kw/10462*.

7. If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10475*.
8. Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective under the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.gov/app/answers/detail/a_id/10067/kw/10067*.

New FAQ on attestation

1. How will I attest for the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.gov/app/error/error_id/1*.

Additional information

Want more information about the EHR incentive programs? CMS will keep you informed of future updates to its FAQs throughout the duration of the CMS EHR incentive programs. Make sure to visit the CMS EHR incentive program at *http://www.cms.gov/EHRIncentivePrograms/* website for the latest news and updates on the EHR incentive programs.

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

Source: CMS PERL 201103-62

New dedicated Web page for the Medicare Shared Savings Program

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule, CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, in the *Federal Register*. The rule implements the Medicare Shared Savings Program (Shared Savings Program) and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated Web page at *www.cms.gov/sharedsavingsprogram* for Medicare fee-for-service (FFS) providers and other providers of services and suppliers. Bookmark the Web page and check back often, as CMS continues to add information on the program.

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

Source: CMS PERL 201104-12

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our Website highlights page at *http://medicare.fcso.com/Feedback/201743.asp* . You'll find the latest enhancements to our provider websites and find out how you can share your

New proposed rules regarding the Medicare Shared Savings Program

The U.S. Department of Health and Human Services (HHS) released proposed new rules to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

The Centers for Medicare & Medicaid Services (CMS) has worked closely with other federal agencies, including the Department of Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), the Federal Trade Commission (FTC), and Internal Revenue Service (IRS) to ensure that providers and suppliers have the clear and practical guidance they need to form ACOs without running afoul of the fraud and abuse, antitrust, and tax laws. Concurrently with the publication of this proposed rule, the following documents have been issued: a joint CMS and OIG notice and solicitation of public comments on potential waivers of certain fraud and abuse laws in connection with the Medicare Shared Savings Program; a joint FTC and DOJ proposed antitrust policy statement; and an IRS notice requesting comments regarding the need for additional tax guidance for tax-exempt organizations, including tax-exempt hospitals, participating in the Medicare Shared Savings Program.

The proposed rule and joint CMS/OIG notice are posted at *www.ofr.gov/inspection.aspx*.

For more information, read the fact sheet at *www.HealthCare.gov/news/factsheets/accountablecare03312011a.html*.

Comments on the proposed rule will be accepted until June 6, 2011, at *www.regulations.gov*.

CMS will respond to all comments in a final rule to be issued later this year.

The CMS dedicated website for providers of services and suppliers is *www.cms.gov/sharedsavingsprogram*.

The Proposed Antitrust Policy Statement is posted at *www.ftc.gov/opp/aco/*.

The IRS Guidance and Solicitation of Comments will be posted at *http://www.irs.gov/pub/irs-drop/n-11-20.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 201103-65

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.

Manual changes for therapy services in home health

Provider types affected

Home health agencies (HHAs) submitting claims to fiscal intermediaries (FIs), therapists, physicians, non-physician practitioners, regional home health intermediaries (RHHIs), and A/B Medicare administrative contractors (A/B MACs) for therapy services provided to Medicare beneficiaries in the home health setting are affected by this article.

Provider action needed

The calendar year (CY) 2011 Final Rule for home health provisions related to therapy services provided in the home health setting and corresponding regulation text changes necessitate updates to Chapter 7 of the *Medicare Benefit Policy Manual* (Home Health Services). Therapy provisions for this rule are effective April 1, 2011. Be sure your staff is aware of these changes.

Background

As mentioned, the CY 2011 Final Rule for home health included requirements related to how and when therapy services are to be provided in the home health setting, as well as documentation requirements for these visits. Accordingly, the *Medicare Benefit Policy Manual* is being updated via change request (CR) 7374 to document the policy revisions. Key changes of these updates are summarized as follows:

Assessment, measurement and documentation of therapy effectiveness

To ensure therapy services are effective, at defined points during a course of treatment for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

Initial therapy assessment

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals, in the clinical record.

Assess the patient using a method which allows for objective measurement of function and successive comparision of measurement.

Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/ measurement/ documentation (of that discipline).
- Where more than one discipline of therapy is being provided, at least once every 30 days, a qualified therapist from each of the disciplines must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof. In multi-discipline therapy cases, the qualified therapist would reassess functional items (and measure and document) those which correspond to the therapist's discipline and care plan goals. In cases where more than one discipline of therapy is being provided, the 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/ documentation (of that discipline).

Reassessment prior to the 14th and 20th therapy visit

- If a patient's course of therapy treatment reaches 13 therapy visits, for each therapy discipline for

continued on next page

Home health...*continued*

which services are provided, a qualified therapist (instead of an assistant) must provide the ordered 13th therapy service, functionally reassess the patient, and compare the resultant measurement to prior measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.

- Similarly, if a patient's course of therapy treatment reaches 19 therapy visits, a qualified therapist (instead of an assistant) must provide the ordered 19th therapy service, functionally reassess, measure and document effectiveness of therapy, or lack thereof.
- When the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at exactly the 13th visit, the qualified therapist's visit can occur after the 10th therapy visit, but no later than the 13th visit. Similarly, in rural areas or if documented exceptional circumstances exist, the qualified therapist's visit can occur after the 16th therapy visit but no later than the 19th therapy visit.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof close to but no later than the 13th and 19th therapy visit. The 13th and 19th therapy visit time-points relate to the sum total of therapy visits from all therapy disciplines. In multi-discipline therapy cases, the qualified therapist would reassess functional items and measure those which correspond to the therapist's discipline and care plan goals.
- Therapy services provided after the 13th and 19th visit (sum total of therapy visits from all therapy disciplines), are not covered until:
  - The qualified therapist(s) completes the assessment/measurement/documentation requirements;
  - The qualified therapist(s) determines if the goals of the plan of care have been achieved or if the plan of care may require updating. If needed, changes to therapy goals or an updated plan of care is sent to the physician for signature or discharge; and
  - If the measurement results do not reveal progress toward therapy goals and/or do not indicate that therapy is effective, but therapy continues, the qualified therapist(s) must document why the physician and therapist have determined therapy should be continued.

Note: Services involving activities for the general welfare of any patient (e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation) do not constitute skilled therapy. Non-skilled individuals without the supervision of a therapist can perform those services.

In order for therapy services to be covered, one of the following three conditions must be met:

1. The skills of a qualified therapist are needed to restore patient function;
2. The patient's condition requires a qualified therapist to design or establish a maintenance program; or
3. The skills of a qualified therapist are needed to perform maintenance therapy.

Additional information

For complete details on these manual changes, see the official instruction, CR 7374, issued to your FI, A/B MAC, and RHHI at *http://www.cms.gov/Transmittals/downloads/R142BP.pdf* and the policy in Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7 at *http://www.cms.gov/manuals/Downloads/bp102c07.pdf*.

Therapy questions and answers will also soon be available on the home health agency center of the CMS website (*http://www.cms.gov/center/hha.asp*).

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

MLN Matters® Number: MM7374
Related Change Request (CR) #: 7374
Related CR Release Date: April 15, 2011
Effective Date: April 1, 2011
Related CR Transmittal #: R142BP
Implementation Date: May 5, 2011

Home health and hospice face-to-face encounter requirement

Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects that home health agencies and hospices will have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services.

Section 6407 of the ACA established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she or a non-physician practitioner working with the physician, has seen the patient. The encounter must occur within the 90 days prior to the start of care, or within the 30 days after the start of care. Documentation of such an encounter must be present on certifications for patients with starts of care on or after January 1, 2011.

Similarly, section 3132(b) of the ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification and with each subsequent recertification. The encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The provision applies to recertifications on and after January 1, 2011.

On December 23, 2010, due to concerns that some providers needed additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services, CMS announced that it will expect full compliance with the requirements, beginning with the second quarter of calendar year (CY) 2011.

Throughout the first quarter of 2011, CMS has continued outreach efforts to educate providers, physicians, and other stakeholders affected by these new requirements. CMS has posted guidance materials including a *MLN Matters* article, questions and answers documents, training slides, and manual instructions which are available via CMS' home health agency center and hospice Web pages. CMS' Office of External Affairs and Regional Offices contacted state and local associations for physicians and home health agencies and advocacy groups to ensure awareness about the face-to-face encounter laws and to distribute the educational materials.

CMS will continue to address industry questions concerning the new requirements and will update information on its website at *http://www.cms.gov/center/hha.asp* and *http://www.cms.gov/center/hospice.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 201104-43, 201104-31, 201103-63

CMS issues proposed decision memorandum for PROVENGE®

The Centers for Medicare & Medicaid Services (CMS) issued a proposed decision memorandum to cover on-label use of Sipuleucel-T (PROVENGE®) under a national coverage determination on March 30. PROVENGE® is the only FDA-approved autologous cellular immunotherapy treatment for metastatic prostate cancer. It is labeled for use in men with asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Coverage of off-label use would be determined by Medicare's local contractors.

CMS will accept public comments on this proposed decision for 30 days. A final decision will be announced within 90 days.

For more details or to submit a public comment, please see the proposed decision memorandum at *http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=247&ver=8&NcaName=Autologous+Cellular+Immunotherapy+Treatment+of+Metastatic+Prostate+Cancer&bc=BEAAAAAAEAAA&* .

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

Source: CMS PERL 201104-09

Local Coverage Determinations

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (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 Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

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 website is considered the notice date.

Contents

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.**

Additions to LCDs

AJ7308: Topical photosensitizers used with PDT for actinic keratoses and certain skin cancers – new LCD

LCD ID number: L31807 (Florida/Puerto Rico/U.S. Virgin Islands)

Photodynamic therapy (PDT) involves the use of photochemical reactions mediated through the interaction of photosensitizing agents, light, and oxygen for the treatment of malignant or benign diseases. The most commonly used photosensitizers in PDT are aminolevulinic acid HCL (ALA) and methyl aminolevulinate (MAL). Currently, the only Food and Drug Administration (FDA) approved indication for ALA PDT and MAL PDT in dermatology is the treatment of actinic keratoses (AKs) on the face or scalp. Common off-label uses include the treatment of basal cell carcinoma (BCC), photoaging, acne, vulgaris, and Bowen's disease.

A local coverage determination (LCD) has been developed to provide coverage for two drugs, Levulan® Kerastick® (ALA) and Metvixia (MAL) Cream, used with PDT for the treatment of AKs on the face and scalp, as well as the off-label use of BCC and squamous cell carcinoma (Bowen's disease). This LCD gives indications and limitations of coverage, documentation requirements, utilization guidelines, ICD-9-CM codes and coding guidelines for the following HCPCS codes/descriptors for photosensitizing drugs:

- J7308 Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354 mg) [Levulan® Kerastick®]
- J7309 Methyl aminolevulinate (MAL) for topical administration, 16.8%, 1 gram [Metvixia Cream]

Effective date

This new LCD is effective for services provided **on or after June 7, 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.

Revisions to LCDs

ABotulinum Toxins: Botulinum toxins – revision to the LCD

LCD ID number: L28788 (Florida)
LCD ID number: L28790 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for botulinum toxins was most recently revised on March 10, 2011. Since that time, the LCD has been revised in accordance with the Centers for Medicare & Medicaid Services (CMS) transmittal 2147, change request 7299, dated February 4, 2011, and CMS transmittal 2174, change request 7342, dated March 18, 2011. In this regard, the "*CPT*/HCPCS Codes" section of the LCD has been revised to delete HCPCS C9278 and add HCPCS code Q2040 (Injection, incobotulinumtoxin a, 1 unit). The "ICD-9 Codes that Support Medical Necessity" section of the LCD has also been revised to add HCPCS code Q2040 (Injection, incobotulinumtoxin a, 1 unit).

The LCD "Coding Guidelines" attachment has also been revised to update the coding and billing information for incobotulinumtoxina (Xeomin®).

Effective date

This LCD revision is effective for claims processed **on or after April 4, 2011**, for services provided **on or after April 1, 2011.** 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.

AJ9310: Rituximab (Rituxan®) – revision to the LCD

LCD ID number: L28980 (Florida)
LCD ID number: L29013 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was most recently revised on February 18, 2010. Since that time, a revision was made under the "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD to update the approved Food and Drug Administration (FDA) indications dated January 28, 2011, for follicular CD20-positive, B-cell NHL in combination with first line chemotherapy and in patients achieving a complete or partial response to Rituxan® in combination with chemotherapy, as single-agent maintenance therapy. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated to add an additional FDA label reference considered for this revision.

Effective date

This LCD revision is effective for claims processed **on or after March 31, 2011**, for services provided **on or after January 28, 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.

ANCSVCS: Noncovered services – revision to the LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023 (Puerto Rico/U. S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised on February 13, 2011. Since that time, a reconsideration request was received and a determination was made to remove AlloMap® cardiac rejection test (*CPT* code *86849*) from the noncovered services LCD. However, emerging technologies or services not listed in the noncovered services LCD or removal of a procedure/service from its listing in the LCD is not a positive coverage statement since the Contractor currently has no LCD outlining the reasonable and necessary threshold for coverage. As with any claim submitted to Medicare, payment of a claim is not necessarily coverage if the documentation that supports the reasonable and necessary threshold for the individual patient has not been reviewed.

Currently, First Coast Service Options Inc. (FCSO) does not have a local coverage determination outlining coverage criterion for this service. Therefore, it is expected that claims for this service would be medically reasonable and necessary for the patient and performed according to standards of care. In order for a service to be considered medically reasonable and necessary, all of the following criteria must be met (CMS Manual Systems, *Medicare Program Integrity Manual*, Publication 100.08, Chapter 13, Section 13.5.1):

- Not experimental or investigational;
- The duration and frequency considered appropriate for the service;
- Furnished in accordance with accepted standards of medical practice for the treatment of the patient's condition;
- Furnished in a setting appropriate to the patient's medical needs and condition;
- Ordered and furnished by qualified personnel; and
- Meets, but does not exceed, the patient's medical need.

Medical records must be made available to FCSO Medicare upon request.

Effective date

This LCD revision is effective for services provided **on or after April 14, 2011**. 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.

ANCSVCS: Noncovered services – revision to the LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023 (Puerto Rico/U. S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised on April 14, 2011. Since that time, revisions were made to the LCD. Five Category III *CPT* codes from the Centers for Medicare & Medicaid Services (CMS) Annual 2011 HCPCS Update, change request (CR) 7121 were evaluated and were determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, Category III *CPT* codes *0239T, 0242T, 0243T, 0244T, and 0253T* were added to the noncovered services LCD.

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

- *0239T – Bioimpedance spectroscopy (BIS), measuring 100 frequencies or greater, direct measurement of extracellular fluid differences between the limbs*
- *0242T – Gastrointestinal tract transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report*
- *0243T – Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluation(s), with interpretation and report*
- *0244T – Continuous measurement of wheeze rate during treatment assessment or during sleep for documentation of nocturnal wheeze and cough for diagnostic evaluation 3 to 24 hours, with interpretation and report*
- *0253T – Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space*

Also, *CPT* code *22899 (*XClose® Tissue Repair System) was evaluated and was determined not to be medically reasonable and necessary at this time based on the current available published evidence (e.g., peer-reviewed medical literature, published studies, etc.). Therefore, *CPT* code *22899* (XClose® Tissue Repair System) was added to the LCD under the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD.

In addition, for LCD consistency, 11 *CPT* codes in the Part B NCSVCS LCD are being added to the Part A NCSVCS LCD under the "*CPT*/HCPCS Codes-Local Noncoverage Decisions – Laboratory Procedures" section:

- *84999*+ Neuronal thread protein (NTP)
- *84999*+ Lipoprotein, direct measurement, intermediate density lipoproteins (IDL) (remnant lipoproteins)
- *87557* Mycobacteria tuberculosis, quantification
- *87562* Mycobacteria avium-intracellulare, quantification
- *87580* Mycoplasma pneumoniae, direct probe technique
- *87581* Mycoplasma pneumoniae, amplified probe technique
- *87582* Mycoplasma pneumoniae, quantification
- *87592* Neisseria gonorrhoeae, quantification
- *87620* papillomavirus, human, direct probe technique
- *87622* papillomavirus, human, quantification
- *88349* Electron microscopy; scanning

+ Claims for these services will always be reviewed as they must currently be billed with an unlisted procedure

Effective date

This LCD revision is effective for services provided **on or after June 7, 2011**. First Coast Service Options Inc. 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.

Computed tomography (CT) scans – revisions to LCDs

LCD ID number: L28806, L28807, L28808, L28770 (Florida)
LCD ID number: L28813, L28814, L28815, L28771 (Puerto Rico/U.S. Virgin Islands)

First Coast Service Options Inc., the Medicare J9 MAC, has reviewed the local coverage determinations (LCDs) for computed tomography (CT) scans and determined that language located under the "Documentation Requirements" section of the LCD should be revised to make the language consistent among all CT LCDs and to ensure the language is in line with the literature that supports these requirements. In some instances the references were also updated. These revisions serve to further expand on existing language found in the LCD. The following LCDs have been revised: A70450 computed tomography scans of the head or brain, A71250 computed tomography of the thorax, A72192 computed tomography of the abdomen and pelvis, and A74261 computed tomographic colonography.

Effective date

These LCD revisions are effective for services provided **on or after April 5, 2011**. FCSO LCDs are available through the Centers for Medicare & Medicaid Services (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.

Magnetic resonance imaging (MRI) – revisions to LCDs

LCD ID number: L28904, L28905, L28906, L28907 (Florida)
LCD ID number: L28926, L28927, L28928, L28929 (Puerto Rico/U.S. Virgin Islands)

Revision 1

First Coast Services Options Inc., the Medicare J9 MAC, has reviewed the local coverage determinations (LCDs) for magnetic resonance imaging (MRI) and determined that the language located under the "Documentation Requirements" section of the LCD should be revised to make the language consistent among all MRI LCDs and to ensure the language is in line with the literature that supports these requirements. In some instances the references were also updated. These revisions serve to further expand on existing language found in the LCD. The following LCDs have been revised: A70540 magnetic resonance imaging of the orbit, face and/or neck, A70551 magnetic resonance imaging of the brain, A72141 magnetic resonance imaging of the spine, and A73218 magnetic resonance imaging of upper extremity.

Effective date

These LCD revisions are effective for services provided **on or after April 5, 2011**. FCSO LCDs are available through the Centers for Medicare & Medicaid (CMS) Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*.

Revision 2

In addition to the above noted revisions, the J9 MAC has revised the MRI LCDs based on instructions issued in change request 7296, dated March 4, 2011. Language has been added and/or deleted from the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCDs based on the revised language issued in change request 7296 for the national coverage determination (NCD) magnetic resonance imaging, section 220.2. The following LCDs have been revised: A70540 magnetic resonance imaging of the orbit, face and/or neck, A70551 magnetic resonance imaging of the brain, A72141 magnetic resonance imaging of the spine, and A73218 magnetic resonance imaging of upper extremity.

Effective date

These LCD revisions are effective for claims processed **on or after April 4, 2011**, for services provided **on or after February 24, 2011**. 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.

A78451: Myocardial perfusion imaging – revision to the LCD

LCD ID number: L28934 (Florida)
LCD ID number: L28955 (Puerto Rico/U.S Virgin Islands)

This local coverage determination (LCD) for myocardial perfusion imaging was most recently revised on January 1, 2010. Since that time, under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, diagnosis code 794.39 (Nonspecific abnormal results of function studies, cardiovascular, other) was added to the list of allowable ICD-9-CM diagnosis codes. This diagnosis is being added to support the indication in the LCD which states myocardial perfusion imaging is performed to determine if the patient has myocardial ischemia when there has been an abnormal or non-diagnostic standard exercise stress test.

Effective date

This LCD revision is effective for services provided **on or after April 15, 2011**. First Coast Service Options, (FCSO) Inc. 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.

Additional Information

Florida Part A inpatient prepayment review notification MS-DRG 470 (major joint replacement or reattachment of lower extremity)

The November 2010 Part A Medicare administrative contractor (MAC) for jurisdiction 9 (J9) inpatient diagnosis related group (DRG) error rate was 18.17%. This error rate is considerably higher than the national inpatient DRG error rate. Based on the comprehensive error rate testing (CERT) review findings, MS-DRG 470 (major joint replacement or reattachment of lower extremity) has been identified as being high risk for payment error. With a payment error rate of 23.90%, MS-DRG 470 had the highest amount of incorrectly paid dollars assigned to MAC J9. A majority of the errors are assigned because the submitted documentation does not support the medical necessity for the total knee replacement. Prepayment medical review editing for DRG 470 billed with ICD-9-CM procedure code 8154 (Total knee replacement) will be initiated at 10% for claims processed **on or after June 1, 2011**. In the near future, First Coast Service Options Inc. plans to release a draft LCD addressing major joint replacement.

Self-administered drug (SAD) list – Part A: C9399

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and, therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services provided **on or after June 4, 2011**, the following drug has been added to the Medicare administrative contractor (MAC), Jurisdiction 9 (J9), Part A SAD list:

- C9399 tesamorelin (Egrifta™)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (FCSO) SAD lists are available at *http://medicare.fcso.com/Self-administered_drugs/*.

Single and dual chamber cardiac pacemakers – draft LCD

The Jurisdiction 9 Medicare administrative contractor (J9 MAC) recently published a draft local coverage determination (LCD) for single and dual chamber cardiac pacemakers. Comments were received on this draft and were related to medical necessity criteria for single and dual chamber cardiac pacemakers, which are outlined in the *Medicare National Coverage Determinations (NCD) Manual for Cardiac Pacemakers,* Publication 100.03, Chapter 1, section 20.8. It was the intention of the J9 MAC to address issues identified through CERT (Comprehensive Error Rate Testing, the Medicare national program to assess claim(s) payment error rates) medical review of claims for single and dual chamber cardiac pacemakers. CERT medical review of claims demonstrated that patients were not meeting the criteria for coverage for dual chamber cardiac pacemakers as outlined in the NCD. Given that the comments received were related to medical necessity criteria for single and dual chamber cardiac pacemakers established by the NCD and considering that the J9 MAC does not have discretion to alter language of the NCD, the J9 MAC has determined the best approach at this time will be to not finalize the draft LCD for single and dual chamber cardiac pacemakers. Instead the MAC J9 is publishing this article to discuss the coverage for cardiac pacemakers.

The NCD for cardiac pacemakers includes language for the indications for dual chamber cardiac pacemakers which requires providers to justify in the medical record the insertion of a dual chamber cardiac pacemaker over a single chamber cardiac pacemaker. The specific coverage criteria for dual chamber cardiac pacemakers is as follows:

1. *Patients in whom single-chamber (ventricular pacing) at the time of pacemaker insertion elicits a definite drop in blood pressure, retrograde conduction, or discomfort.*
2. *Patients in whom the pacemaker syndrome (atrial ventricular asynchrony), with significant symptoms, has already been experienced with a pacemaker that is being replaced.*
3. *Patients whom even a relatively small increase in cardiac efficiency will importantly improve the quality of life, e.g., patients with congestive heart failure despite adequate other medical measures.*
4. *Patients in whom the pacemaker syndrome can be anticipated, e.g., in young and active people, etc.*

Whenever the following conditions (which represent overriding contraindications) are present, dual chamber pacemakers are not covered:

1. *Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium).*
2. *Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia.*
3. *A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged, e.g., the occasional patient with hypersensitive carotid sinus syndrome with syncope due to bradycardia and unresponsive to prophylactic medical measures.*
4. *Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third-degree) and/or type II second-degree AV block in association with bundle branch block.*

All other indications for dual-chamber cardiac pacing for which the Centers for Medicare & Medicaid Services (CMS) has not specifically indicated coverage remain nationally noncovered, except for Category B Investigational Device Exemptions (IDE) clinical trials, or as routine costs of dual-chamber cardiac pacing associated with clinical trials, in accordance with CMS Clinical Trial Policy contained in the *Medicare NCD Manual*, CMS Publication 100-03, Chapter 1, section 310.1 at *http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf*.on the CMS website.

Providers can access the *CERT Cardiac Pacemaker* fact sheet released in December 2010 by CMS at *http://www.hrsonline.org/Policy/CodingReimbursement/coverage/upload/CERT_Pmaker_FactSheet_ICN905144.pdf*.

The J9 MAC recommends that physician and allied health providers be familiar with the language in the NCD when determining the need for a single versus a dual chamber cardiac pacemaker and when documenting the medical justification for insertion of a dual chamber versus a single chamber cardiac pacemaker.

A37205: Non-coronary vascular stents – draft LCD article clarification

LCD ID number: DL31820 (Florida/Puerto Rico/U.S. Virgin Islands)

Numerous comments were received in regard to the draft non-coronary vascular stents local coverage determination (LCD) from practicing physicians, specialty societies, and other interested stakeholders from within and outside the Part A/B Medicare administrative contractor (MAC) jurisdiction 9 (J9).

MAC J9 has elected not to finalize this draft at this time. Options include taking a new draft through the next LCD cycle (summer). Such a draft may focus on more limited areas (such as lower extremity, etc.), but that has not been decided upon.

There are several reasons for not finalizing the current draft LCD at this time and they include the following:

1. New coding for the lower extremity (endovascular revascularization) and unclear impact on utilization.
2. Concerns with the application of the diagnosis to procedure codes noted in the LCD. Some indications had evidence support in the peer reviewed literature; some indications with evidence support could possibly be excluded given the limitations of procedure code descriptors and ICD-9-CM diagnosis codes addressed in the draft; and some indications without evidence support could be argued as covered based on broad application in conjunction with the draft LCD language.
3. The implications of the statement on Food and Drug Administration (FDA) approved indications for a device (stents in this case). The Medical Policy department has researched language to address standards of care, but did not want the LCD used to justify investigational/experimental procedures or over-utilization of certain procedures. Not directly related, there was concern that a broad statement would be interpreted as a positive coverage statement for other devices that are used off-label with little evidence. For example, the movement of the peripheral atherectomy codes for supra-inguinal arteries from Level 1, Category I to Category III suggests that there are new, emerging device technologies and these devices may have more limited indications. There are clearly circumstances in which these devices should be non-covered or limited to their FDA clearance when documentation can support the reasonable and necessary (R&N) indication for a particular patient.

LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/*.

A77402: Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – inappropriate denials

LCD ID number: L31512 (Florida/Puerto Rico/U.S. Virgin Islands)

First Coast Service Options Inc. (FCSO) recently implemented a new local coverage decision (LCD) addressing radiation therapy for T1 basal cell and squamous cell carcinomas of the skin. The LCD became effective February 13, 2011. Since implementation of the LCD, it has been brought to our attention that providers may be receiving inappropriate denials based on diagnosis codes related to the procedure codes listed in the LCD. FCSO has confirmed this and we are working diligently to correct this problem. Additionally, FCSO will identify all services that have been denied in error and make the appropriate adjustments. Providers will not need to resubmit denied claims or request an appeal for redetermination. FCSO apologizes for any inconvenience this may have caused our provider community.

FCSO LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/.*

90935-90937: Hemodialysis for treatment of schizophrenia – national coverage determination

The national coverage determination (NCD) for hemodialysis for treatment of schizophrenia (*Medicare National Coverage Determinations Manual*, Pub. 100-03, Chapter 1, section 130.8) indicates that *scientific evidence supporting use of hemodialysis as a safe and effective means of treatment of schizophrenia is inconclusive at this time. Accordingly, Medicare does not cover hemodialysis for treatment of schizophrenia.* First Coast Service Options Inc. has identified the following diagnoses to represent schizophrenia based on this NCD.

- 295.00-295.95 (Schizophrenic disorders)

Effective date

This article serves as a 45-day notice that hemodialysis for treatment of schizophrenia is not considered safe and effective when billed with diagnoses 295.00-295.95 effective for services provided **on or after June 1, 2011**.

Get news about LCDs delivered to your inbox

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the FCSO *eNews* mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your e-mail address and select the subscription option that best meets your needs.

Implementation of the PWK segment for X12N version 5010

Note: This article was revised on April 21, 2011, to reflect a revised change request (CR) 7041 issued on April 20, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing CR7041 have been revised. Also, a reference to *MLN Matters*® article special edition (SE) 1106 was added in the *Additional Information* section to give important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments. This information was previously published in the November 2010 *Medicare A Bulletin*, pages 50-51.

Provider types affected

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

Provider action needed

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

Background

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

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

The PWK segment allows for electronic submission of additional documentation via email and fax.

Key points for Medicare billers

Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at *http://www.cms.gov/Transmittals/downloads/R874OTN.pdf* on the CMS website.

- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation **after** the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send **all** relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the coordination of benefits contractor.

Additional information

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

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PWK...*continued*

The official instruction (CR 7041) issued to your MAC and/or FI/carrier is available at *http://www.cms.gov/Transmittals/downloads/R874OTN.pdf*.

You may also want to review *MLN Matters*® article MM7306 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7306.pdf*.

You may also want to review *MLN Matters*® article SE 1106 available at *http://www.cms.gov/MLNMattersArticles/downloads/SE 1106.pdf* for important reminders about the implementation of HIPAA 5010 and D.O., including fee-for-service implementation schedule and readiness assessments.

MLN Matters® Number: MM7041 Revised
Related Change Request (CR) #: 7041
Related CR Release Date: April 20, 2011
Effective Date for Providers: July 1, 2011
Related CR Transmittal #: R874OTN
Implementation Date: July 5, 2011

Version 5010 transaction standards deadline is approaching

There are less than 10 months until all HIPAA-covered entities need to transition from version 4010/4010A1 to version 5010 electronic transaction standards. With the January 1, 2012, deadline quickly approaching; you need to have taken the necessary steps to get ready.

Unlike the current version 4010/4010A1, version 5010 accommodates the ICD-10 codes and must be in place before the change over to ICD-10 on October 1, 2013. Version 5010 has the ability to tell your practice management or other system that you are using an ICD-10 versus an ICD-9 code.

A key step in preparing your office for this upgrade is testing transactions in the new version 5010 format. **If you have not already done so, you should begin external version 5010 testing now.**

Testing transactions using version 5010 standards will assure that you are able to send and receive compliant transactions effectively. Testing will also allow you to identify any potential issues and address them in advance of the January 1, 2012, compliance date.

Keep up-to-date on version 5010 and ICD-10
CMS has resources to help you prepare. Visit *http://www.cms.gov/ICD10* and click on "Version 5010."

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

Source: CMS PERL 201103-57

Implementation of errata for version 5010 – priority (type) of admission or visit code and reason code 11701

The Centers for Medicare & Medicaid Services (CMS) does not have a version 4010A1 direct data entry and a separate version 5010 direct data entry. The priority (type) of admission or visit code is now required on all version 4010A1 institutional claims submitted or corrected via direct data entry, as well as on version 5010 institutional claims, regardless of how they are submitted. Providers that are unsure which code to use are to use code 9 (information not available). Additional priority (type) of admission or visit code values and descriptions are available from the National Uniform Billing Committee (*www.NUBC.org*) or from your servicing Medicare administrative contractor (MAC). The priority (type) of admission or visit code is not required on 4010A1 institutional claims submitted or corrected via an 837.

For more information on version 5010, please visit *http://www.CMS.gov/Versions5010andD0*.

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

Source: CMS PERL 201104-22

Important reminders about HIPAA 5010 & D.0 implementation

Note: This article was published with the incorrect title in the March 2011 issue of the *Medicare Part A Bulletin*, pages 21-24.

Provider types affected

This *Special Edition MLN Matters*® article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The implementation of HIPAA 5010 and D.0 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that

Electronic data interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

Caution – what you need to know

Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This *Special Edition MLN Matters*® article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 Version 5010 and NCPDP Version D.0 standards. Remember that the HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with fee-for-service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate *MLN Matters* articles will address the ICD-10 implementation.

Go – what you need to do

In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness for these standards.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

More information about Medicare's EDI requirements is found in the *Medicare Claims Processing Manual*, Chapter 24 – "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at *http://www.cms.gov/manuals/downloads/clm104c24.pdf*. Electronic billing and EDI transaction information is found at *http://www.cms.gov/ElectronicBillingEDITrans/*. This section contains:

- EDI transaction and corresponding paper claims requirements;
- Links to those chapters of the *Medicare Claims Processing Manual* that contain further information on these types of transactions;
- The Administrative Simplification Compliance Act (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment;
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically; and
- EDI support furnished by Medicare contractors.

Current versions of the transaction standards (ASC X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. Therefore, on January 16, 2009, HHS announced a final rule that replaced the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively. The final rule (CMS-0009-F) titled, "Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards," is found at *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf*.

Subsequently, CMS is performing activities to convert from processing the ASC X12 Version 4010A1 to HIPAA ASC X12 Version 5010, and the NCPDP Version 5.1 to NCPDP Version D.0.

continued on next page

HIPAA...*continued*

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) **from the March 17, 2009, effective date of the regulation until January 1, 2012,** the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."
- Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

The CMS Medicare FFS implementation schedule is:

- Level I April 1-December 31, 2010;
- Level II January 1-December 31, 2011; and
- Fully compliant on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010, and NCPDP EDI standards Version 5.1 with Version D.0. For more information see *http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp*.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare FFS business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare FFS. Maintenance will be performed without notification, as needed to support Medicare FFS.

Readiness assessment 1 – Have you done the following to be ready for 5010/D.0?
Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 Errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit *http://www.cms.gov/Versions5010andD0/downloads/readiness_1.pdf* to see a summary of important information for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once. Be sure to start testing Version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful web links go to *http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp*.

Readiness assessment 2 – What do you need to have in place to test with your MAC?
Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of Versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.

- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:

- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted); and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 National Call presentation on Provider Outreach and Education – Transition Year Activities can be found at *http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf*.

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources can be found at *http://www.cms.gov/Versions5010andD0/*;
- Educational resources (i.e., MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at *http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp*; and
- The dedicated HIPAA 5010/D.0 Project Web page, which includes technical documents and communications at national conferences, can be found at *http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp*.

Errata requirements and testing schedule
HIPAA Version 5010 has new Errata, which can be found at *http://www.cms.gov/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf* According to the published regulation (*Federal Register*, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. **Compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.**

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 Errata versions in April 2011.

continued on next page

HIPAA...*continued*

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading Partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, refer to the "Downloads" section at *http://www.cms.gov/ElectronicBillingEDITrans/*.

CMS 5010 provider outreach and education materials

CMS has developed nformation and educational resources pertaining to the topics listed below:

- Version 5010 – the new version of the X12 standards for HIPAA transactions;
- Version D.0 – the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation.

The information posted at *http://www.cms.gov/Versions5010andD0/01_overview.asp* may be applicable to the health care industry at large, or may be specifically Medicare-related information. The "Overview" Web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-related standards. The highlights and overview of these pages are as follows:

- Federal Regulation & Notices (http://www.cms.gov/Versions5010andD0/20_Federal_Regulation_and_Notices.asp)

  This Web page contains general information related to federal regulations and notices and contains the following link to the Final Rule for X12 5010, D.0 and 3.0 document. See *http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf*.

- CMS Communications (*http://www.cms.gov/Versions5010andD0/30_CMS_Communications.asp*) This CMS communications Web page includes Versions 5010 & D.0 implementation information and the following downloads:
  - 5010 Implementation Calendar; see *http://www.cms.gov/Versions5010andD0/Downloads/5010ImplementationCalendar.pdf*.
  - Readiness Assessment – What do you need to have in place to test with your MAC? see *http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf*.

- Educational Resources (*http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp*) The Educational Resources Web page includes information designed to increase national awareness and assist in the implementation of Versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the health care industry at large. This Web page includes:
  - Version 5010 Resource Card (see *http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf*);
  - *Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0* fact sheet see *http://www.cms.gov/Versions5010andD0/Downloads/w5010TransitionFctSht.pdf*);
  - *Checklist for Level I Testing Activities* (see *http://www.cms.gov/Versions5010andD0/Downloads/w5010PrepChklst.pdf*);
  - *Provider Action Checklist for a Smooth Transition* (see *http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf*); and
  - Versions 5010 and D.0 MLN Matters articles (see *http://www.cms.gov/Versions5010andD0/Downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf*.

- 5010 National Calls (*http://www.cms.gov/Versions5010andD0/V50/*) Throughout the implementation of version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 Web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional information

A *Special Edition MLN Matters*® article on the ICD-10 code set can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf*.

CMS is also using the open door forums and Listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the open door forums can be found at *http://www.cms.hhs.gov/OpenDoorForums/*. Information about Listservs (email updates) can be found at *http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/*.

If you have any questions, please contact your carrier, FI, A/B MAC or DME MAC at their toll-free number, found at *http://www.cms.gov/ElectronicBillingEDITrans/*.

MLN Matters® Number: SE1106
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Institutional providers – billing of codes for preventive services

The Centers for Medicare & Medicaid Services (CMS) has identified a Medicare claims processing system issue that is causing certain preventive services rendered in an institutional setting to be processed incorrectly. The following information provides the action that will be taken by Medicare claims administration contractors:

- Preventive service codes listed in change request (CR) 7012 and surgical procedure codes *10000-69999* furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services with dates of service on and after January 1, 2011, were suspended due to deductible and coinsurance being erroneously applied. A partial correction for this problem was implemented on April 4, 2011.
- Outpatient claims containing hepatitis B vaccines codes *90740-90747* submitted on type of bill 13x with dates of service on or after January 1, 2011, are suspending if they are the only service on the claim. Also, claims containing hepatitis B vaccine services are not being paid when other services are billed on the same claim. Medicare contractors have been instructed to hold claims impacted by this problem until a correction is implemented. Medicare providers will be notified of this correction via Listserv message.
- Outpatient prospective payment system (OPPS) claims containing codes G0402, G0389, Q0091, G0101, G0130, *77078, 77079, 77080, 77081, 77083, 76977*, G0104, G0105, G0106, G0120, G0121, G0008, G9141, G0009, G0436, and G0437 submitted on type of bill 13x with dates of service on or after January 1, 2011, are erroneously applying deductible and coinsurance. Medicare contractors have been instructed to hold claims impacted by this problem. A software correction is scheduled for May 9, 2011.

As the software corrections are made, Medicare contractors will release any suspended claims and automatically reprocess claims for preventive services and claims for surgical services billed with a PT modifier (first bullet) that have been paid incorrectly or erroneously applied deductible or coinsurance. Most reprocessing will be completed by May 31, 2011. However, claims being suspended for surgical services billed with a PT modifier (first bullet) reimbursed under OPPS will be released with the implementation of the integrated outpatient code editor (I/OCE) software in July 2011. Reprocessing of claims that have been paid incorrectly for this issue will be completed by July 31, 2011.

Contractors will automatically reprocess claims for preventive and surgical services billed with a PT modifier that have been paid incorrectly.

For further information, please see *MLN Matters*® article MM7012 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7012.pdf* issued on March 2, 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 201104-17

New *Comprehensive Error Rate Testing Signature Requirements* fact sheet

A new publication titled *Comprehensive Error Rate Testing (CERT) Signature Requirements* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf.* This fact sheet is designed to provide education on signature requirements to health care providers and includes information on the documentation needed to support a claim submitted to Medicare for medical services.

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

Source: CMS PERL 201104-34

Medicare drug screening test

Note: The title of this article was incorrectly published in the March 2011 issue of the *Medicare Part A Bulletin*, pages 19-20.

Provider types affected

This article is for clinical laboratories billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs).

Provider action needed

This article describes how clinical diagnostic laboratories should bill for certain types of tests that are covered under Medicare and paid based on the clinical laboratory fee schedule (CLFS). Specifically, the article addresses the billing of two CLFS Healthcare Common Procedure Coding System (HCPCS) test codes – G0431 (drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) – beginning January 1, 2011. HCPCS code G0434 is new for calendar year (CY) 2011. Please be certain that your billing staffs are aware of these changes.

Background

Each year, the Centers for Medicare & Medicaid Services (CMS) hosts an annual public meeting to discuss test codes that have been established by the *Current Procedural Terminology (CPT)* committee, and may be covered by Medicare, and paid based on the CLFS in the upcoming calendar year.

During the 2009 annual public meeting, CMS introduced two new CY 2010 HCPCS codes for reporting qualitative drug screen testing – G0430 (drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure), which was reported once per procedure and G0431, which is reported once per drug class. (Please note that G0430 was deleted beginning January 1, 2011). After the introduction of these codes, CMS determined that it needed to further refine these drug screen testing codes and revise the descriptors to avoid unnecessary or excessive utilization of code G0431 for relatively simple point-of-care tests that screen for multiple substances. During the 2010 annual public meeting, CMS introduced code G0434 to report qualitative point-of-care drug screen testing and to limit billing for such testing to one time per patient encounter. CMS also revised the descriptor for code G0431 to emphasize that the code describes all screening for multiple drug classes per patient encounter.

CMS recognizes that there could be rare instances where a patient requires multiple, medically necessary screening tests for drugs of abuse to be performed in a single day. For instance, a patient seen in an outpatient pain clinic who requires a drug screening test as a part of his/her care is later admitted to an emergency department after an automobile accident and requires another medically necessary drug screening test. The use of “per patient encounter” will allow payment to be made for this rare circumstance.

Effective January 1, 2011, CMS will utilize two test codes to report drug screen testing:

- G0434 (drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter) will be used to report very simple testing methods, such as dipsticks, cups, cassettes, and cards, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices). This code is also used to report any other type of drug screen testing using test(s) that are classified as Clinical Laboratory Improvement Amendments (CLIA) moderate complexity test(s), keeping the following points in mind:
  - G0434 includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups, cards, cassettes, etc, that are not CLIA waived.
  - Laboratories with a CLIA certificate of waiver may perform only those tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver shall bill using the QW modifier.
  - Laboratories with a CLIA certificate of compliance or accreditation may perform non-waived tests. Laboratories with a CLIA certificate of compliance or accreditation do not append the QW modifier to claim lines.
  - Only one unit of service for code G0434 can be billed per patient encounter regardless of the number of drug classes tested and irrespective of the use or presence of the QW modifier on claim lines.
- G0431 (drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) will be used to report more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented

continued on next page

Screening...*continued*

device is required to perform some or all of the screening tests for the patient. Note that the descriptor has been revised for CY 2011. This code may only be reported if the drug screen test(s) is classified as CLIA high complexity test(s) with the following restrictions:

- G0431 may only be reported when tests are performed using instrumented systems (i.e., durable systems capable of withstanding repeated use).
- CLIA waived tests and comparable non-waived tests may not be reported under test code G0431; they must be reported under test code G0434.
- CLIA moderate complexity tests should be reported under test code G0434 with one (1) Unit of Service (UOS).
- G0431 may only be reported once per patient encounter.
- Laboratories billing G0431 must not append the QW modifier to claim lines.

CMS has also made changes to the following related tests:

- G0430 was deleted as of January 1, 2011;
- *Code 80100* has not been priced under Medicare effective January 1, 2011; and
- *Code 80104* has not been priced under Medicare effective January 1, 2011.

Also, please remember that code 80101 has not been priced under Medicare since July 1, 2010.

Additional information

CMS publishes a list of test products with CLIA waived status each quarter. Providers may use this list to determine if a particular test product can be appropriately performed by a laboratory with a CLIA waiver and is eligible to be billed using the QW modifier. Concerning CLIA moderate or high complexity tests, providers should confirm a test's status with the test manufacturer.

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

Additional information concerning the CLFS can be found at *http://www.cms.hhs.gov/ClinicalLabFeeSched* on the CMS website.

MLN Matters® Number: SE1105
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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Healthcare Common Procedure Coding System (HCPCS) code set update

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

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

Source: CMS PERL 201104-01

HCPCS public meeting agendas for drugs, biologicals, and radiopharmaceuticals

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the scheduled release of the May 17-18, 2011, Healthcare Common Procedure Coding System (HCPCS) public meeting agendas for drugs, biologicals, and radiopharmaceuticals. These documents and the link for the corresponding public meeting registrations are located on the HCPCS website at *http://www.cms.gov/MedHCPCSGenInfo/08_HCPCSPublicMeetings.asp#TopOfPage*.

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

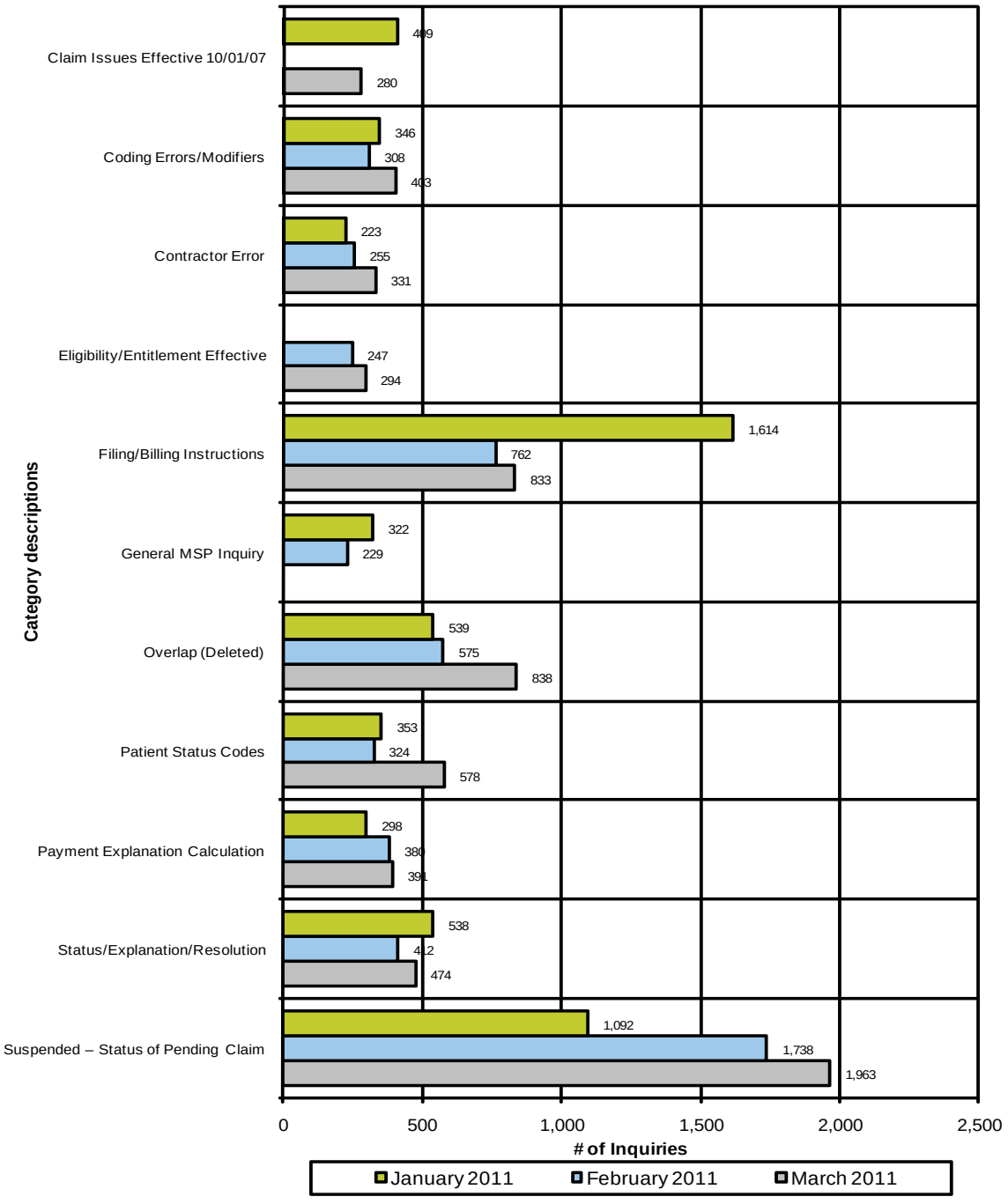
Source: CMS PERL 201104-30

Top inquiries, rejects, and return to provider claims – January-March 2011

The following charts demonstrate the available top number of inquiries, rejected claims, and reason codes for return to providers (RTPs) submitted to First Coast Service Options Inc. (FCSO), by Florida and U.S. Virgin Islands providers during January-March 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.fcso.com/Inquiries_and_denials/index.asp*.

Florida Part A top inquiries forJanuary-March 2011



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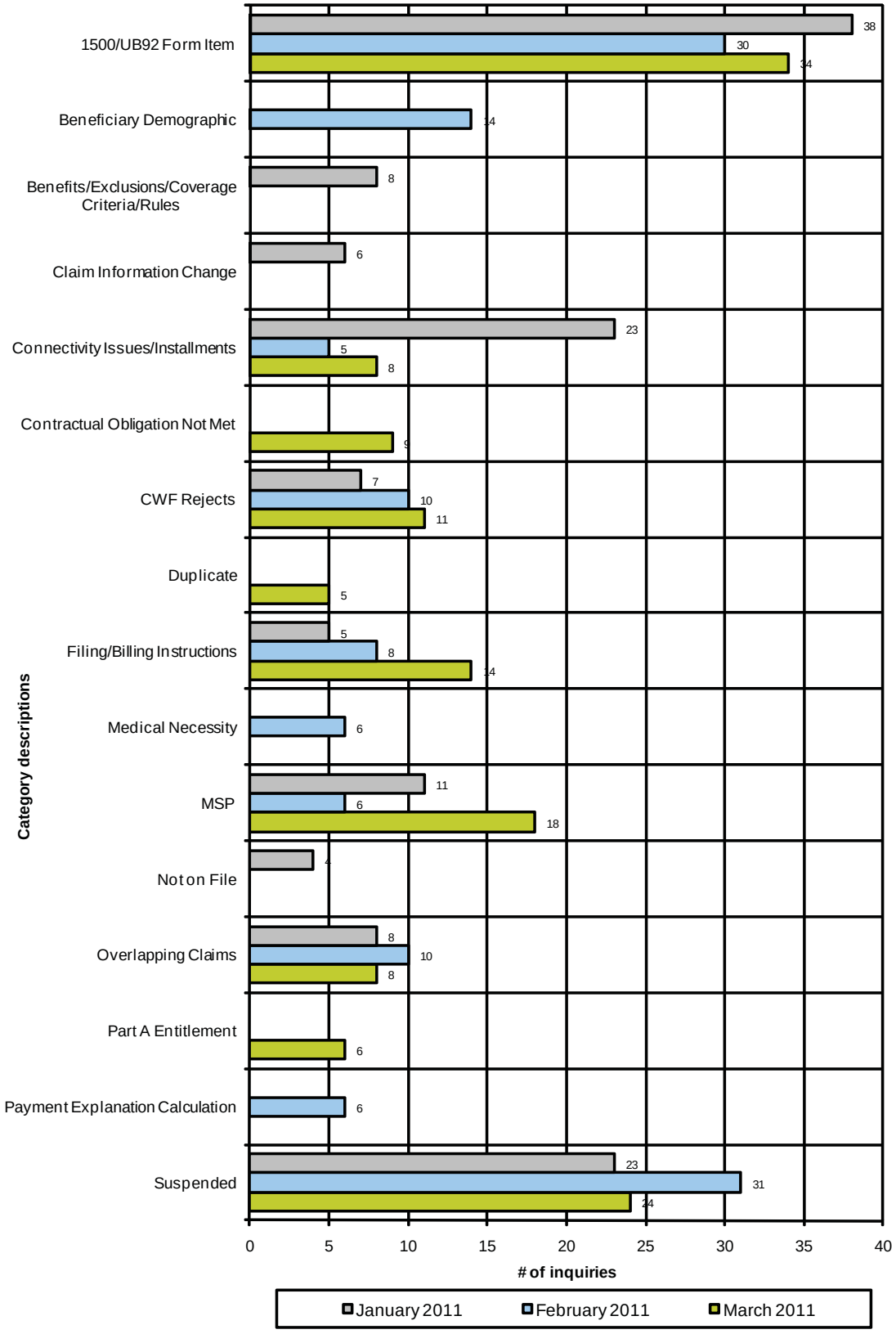
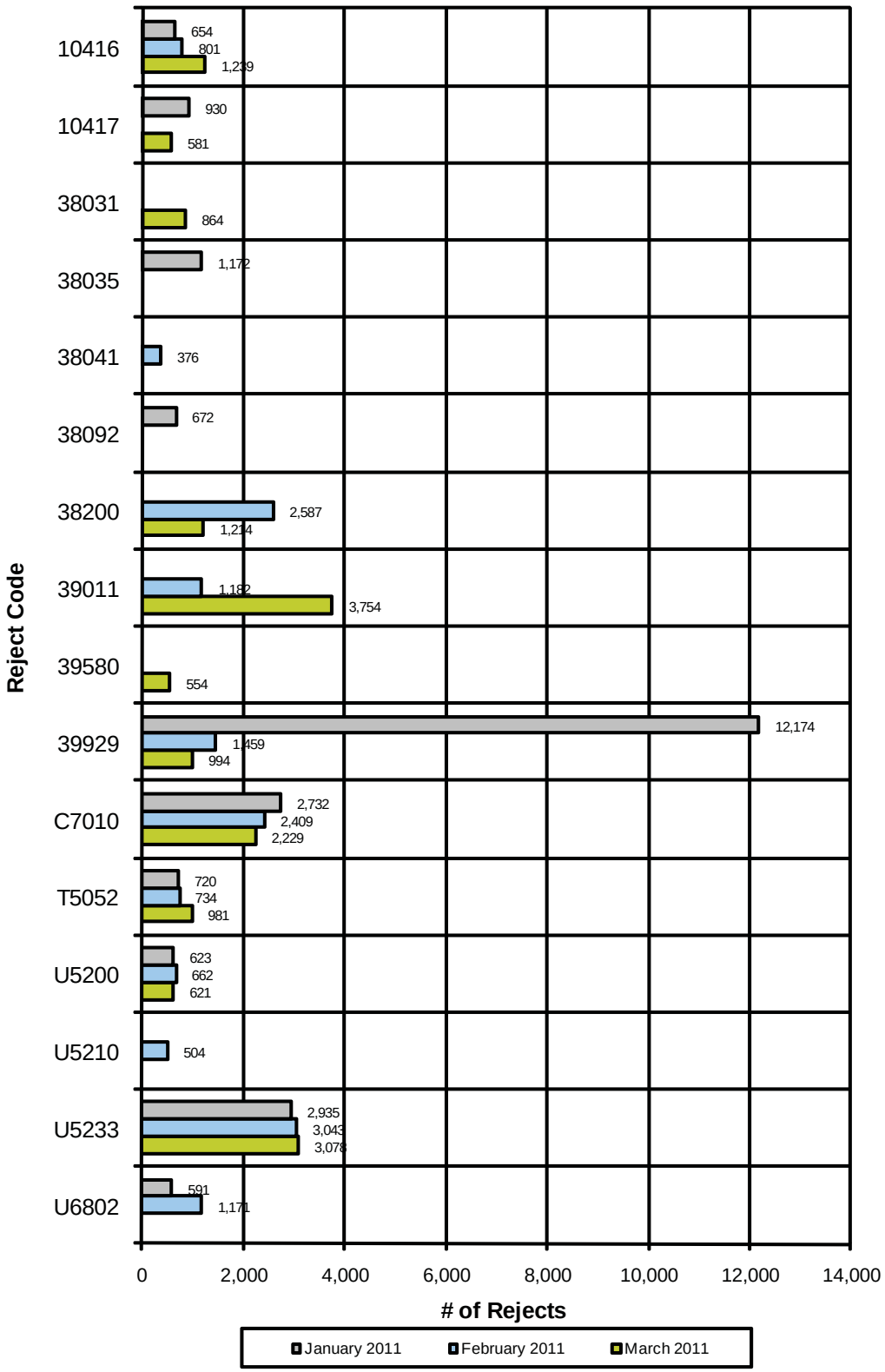
Inquiries...*continued*

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



Florida Part A top rejects for January-March 2011



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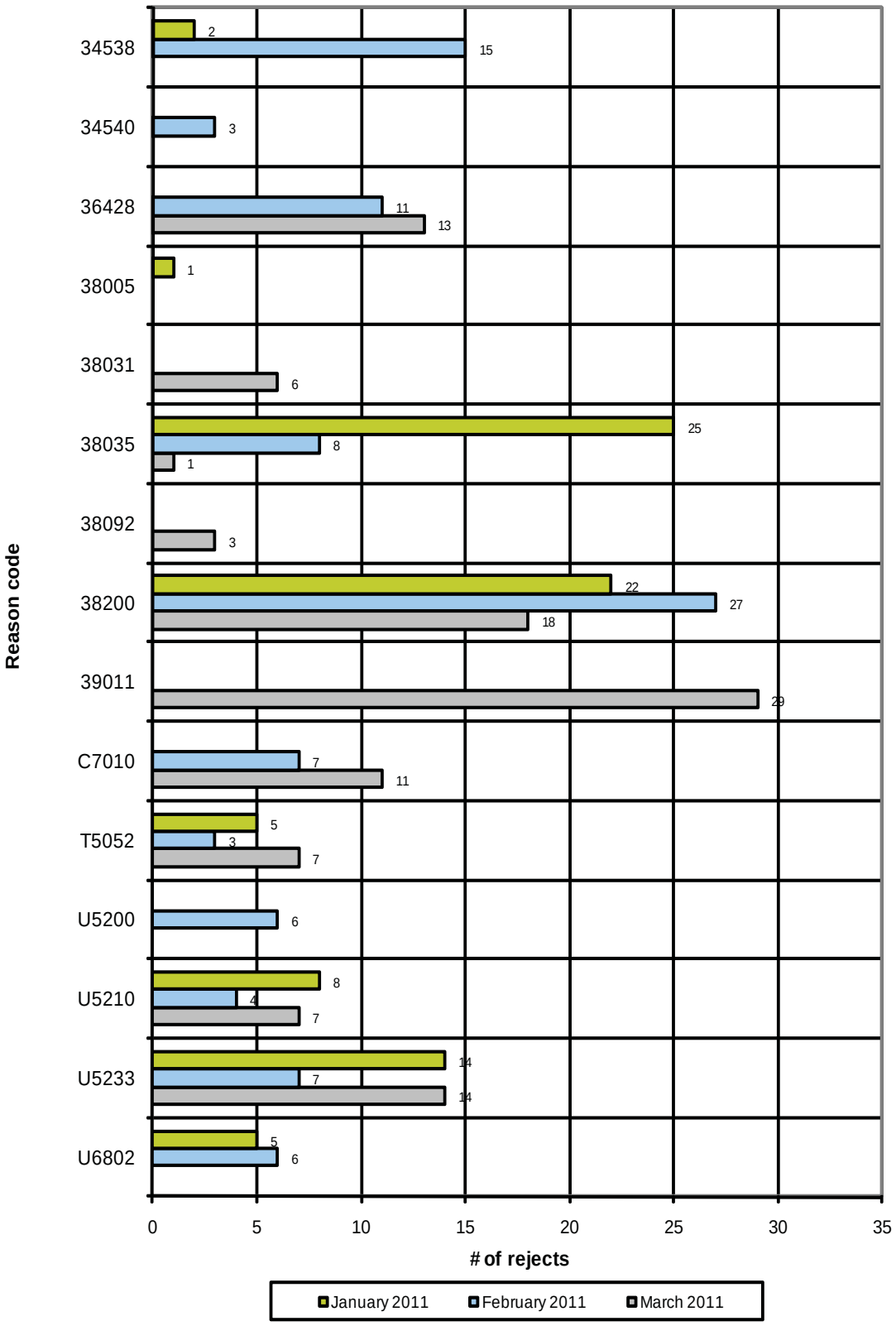
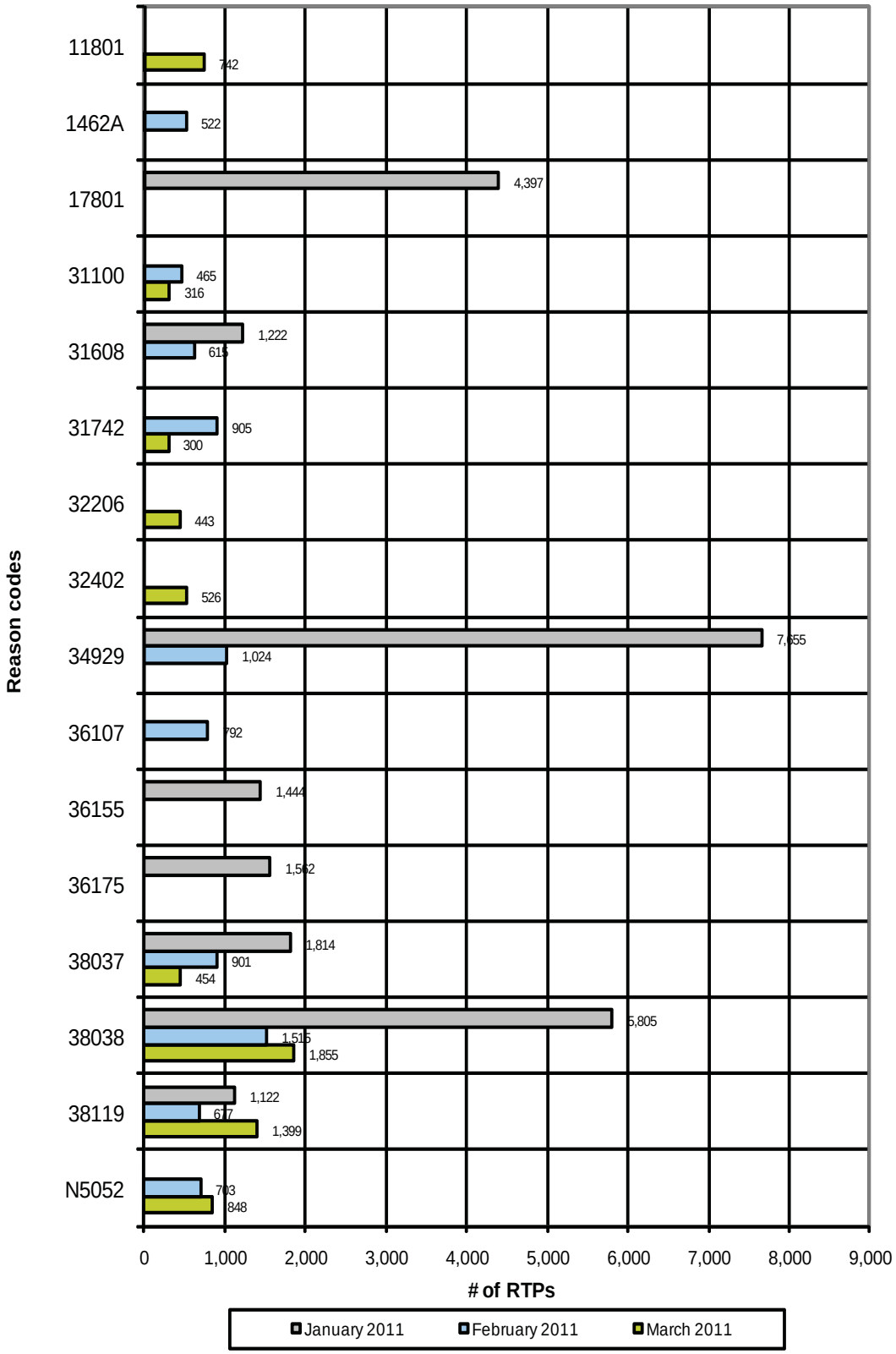
Rejects...*continued*

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



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



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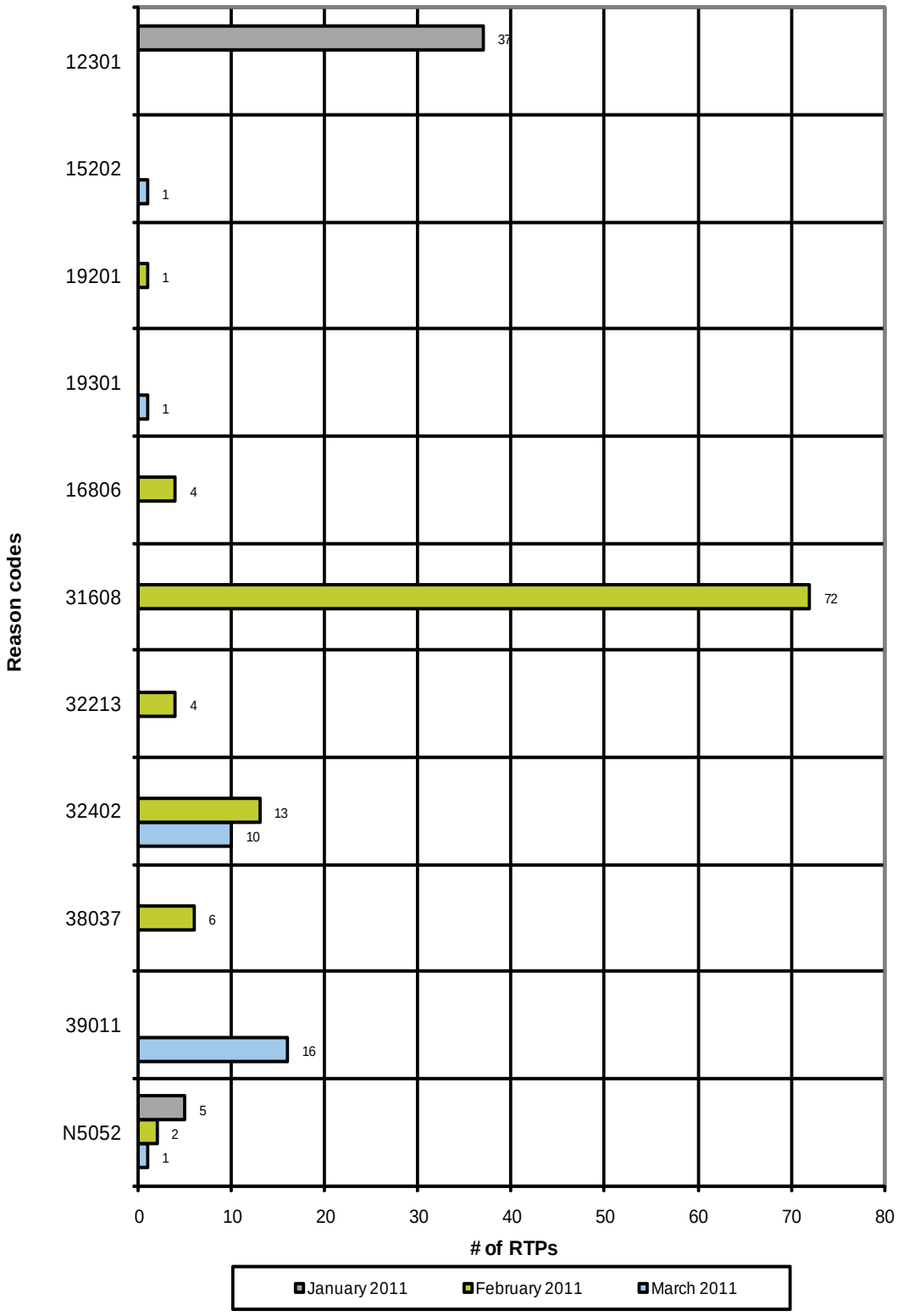
RTPs...*continued*

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



Calendar year 2011 outpatient prospective payment system pricer file update

The outpatient prospective payment system (OPPS) pricer Web page has been updated with new payment files for the 2011 update to the OPPS, as specified in change request (CR) 7342. The files are ready for download from the "2nd Quarter 2011 Files" section of the OPPS Pricer Web page at *http://www.cms.gov/PCPricer/OutPPS/list.asp*. If you use OPPS Pricer files, please go to this page and download the above files.

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

Source: CMS PERL 201103-59

April 2011 quarterly provider specific file update

The April 2011 quarterly provider specific files (PSF) SAS data files and text data files are now available on the Centers for Medicare & Medicaid Services (CMS) website. The SAS data files are available in the Downloads section at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp* and the text data files are available in the Downloads section at *http://www.cms.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp*. 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 201104-37

End-stage renal disease 2011 PC pricer

The Centers for Medicare & Medicaid Services (CMS) will be developing a 2011 end-stage renal disease prospective payment system PC Pricer. The PC Pricer is expected to be available by May 2011. The link to download the PC Pricer when available is *http://www.cms.gov/PCPricer/02e_ESRD_Pricer.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 201103-61

Updated October 2010 and January 2011 average sales price files now available

The Centers for Medicare and Medicaid Services (CMS) has posted revised October 2010 and January 2011 average sale price (ASP) pricing files, which are available for download at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

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

Source: CMS PERL 201104-02

July 2011 quarterly average sales price update and revisions to prior files

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7357, which instructs Medicare contractors to download and implement the July 2011 average sales price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2011, January 2011, October 2010, and July 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 July 1, 2011, with dates of service July 1, 2011, through September 30, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions.

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

Files	Effective for dates of service
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
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

Additional information

If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website. The official instruction (CR 7357) issued to your Medicare MAC, carrier, and FI may be found at *http://www.cms.gov/transmittals/downloads/R2182CP.pdf* on the CMS website.

MLN Matters® Number: MM7357
Related Change Request (CR) #: 7357
Related CR Release Date: March 25, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2182CP
Implementation Date: July 5, 2011

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Home Health Prospective Payment System fact sheet available in print

The *Home Health Prospective Payment System* fact sheet (revised January 2011) is now available in print format from the *Medicare Learning Network*® This fact sheet is designed to provide education on the home health prospective payment system (HH PPS), including background information and consolidated billing requirements, coverage of HH services, elements of the HH PPS, and additional requirements. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, 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 201104-34

Ambulance Fee Schedule fact sheet revised

The revised publication titled *Ambulance Fee Schedule* (revised March 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf*. This fact sheet is designed to provide education about the ambulance fee schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.

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

Source: CMS PERL 201104-25

Clinical laboratory fee schedule – removal of test code G0431QW and addition of test code G0434QW

The Centers for Medicare & Medicaid Services (CMS) is updating the status of two codes on the clinical laboratory fee schedule (CLFS):

- Effective April 1, 2011, code G0431QW is deleted from the CLFS. Code G0431 describes a high complexity test, and should not be reported with a modifier QW; the modifier QW indicates a Clinical Laboratory Improvement Amendments (CLIA) waived test.
- Effective April 1, 2011, code G0434QW is added to the CLFS. Code G0434 can describe a CLIA waived test. The use of the modifier QW to indicate a CLIA waived test is necessary for accurate claims processing.

Codes G0431 and G0434 will remain on the CLFS.

Source: CMS PERL 201104-18

New information to improve patient safety at America's hospitals

Hospital compare website offers new data about hospital acquired conditions at more than 4,700 hospitals across the nation

For the first time, Medicare patients can see how often hospitals report serious conditions that develop during an inpatient hospital stay and possibly harm patients. Important new data about the safety of care available in America's hospitals has been added to the Centers for Medicare & Medicaid Services' (CMS) Hospital Compare website.

The Hospital Compare website can be accessed at *www.HealthCare.gov/compare*.

"Any potentially preventable complication of care is unacceptable," said CMS Administrator Donald Berwick, M.D. "We at CMS are working together with the hospital and consumer community to bring hospital acquired conditions into the forefront and do all we can to eliminate harm from the very healthcare system intended to heal us."

These serious conditions, also known as hospital acquired conditions (or HACs), often result from improper procedures followed during inpatient care. The data release shows the number of times a HAC occurred for Medicare fee-for-service patients between October 2008 and June 2010. The numbers are reported as number of HACs per 1,000 discharges, and are not adjusted for hospitals' patient populations or case-mix.

Independent data from the Institute of Medicine estimates that as many as 98,000 people die in hospitals each year from medical errors that could have been prevented through proper care. Although not every HAC represents a medical error, the HAC rates provide important clues about the state of patient safety in America's hospitals. In particular, HACs show how often the following potentially life-threatening events take place:

- Blood infections from a catheter placed in the hospital;
- Urinary tract infections from a catheter placed in the hospital;
- Falls, burns, electric shock, broken bones, and other injuries during a hospital stay;
- Blood transfusions with incompatible blood;
- Pressure ulcers (also known as bed sores) that develop after a patient enters the hospital;
- Injuries and complications from air or gas bubbles entering a blood vessel;
- Objects left in patients after surgery (such as sponges or surgical instruments);
- Poor control of blood sugar for patients with diabetes.

As many as 98,000 people die in hospitals each year from medical errors that could have been prevented through proper care.

In total, CMS reports HAC rates for eight measures, which were selected because they incur high costs to the Medicare program or because they occur frequently during inpatient stays for Medicare patients. Furthermore, HACs usually result in higher reimbursement rates for hospitals when they occur as complications for an inpatient stay because they require more resources to care for the patient with the complication. Lastly, CMS considers HACs to be conditions that could have reasonably been prevented through the use of evidence-based guidelines for appropriate hospital inpatient care.

CMS has gathered HAC rates from hospitals since 2007. Since 2008, Medicare has not provided additional reimbursement for cases in which one of the HACs was reported as having developed through the course of a patient's hospital stay.

Rates for the eight HAC rates reported on Hospital Compare vary among hospitals. The most common HAC reported was injury from a fall or some other type of trauma, which occurred just once for every 2,000 discharges. Over 70 percent of hospitals reported at least one fall or trauma during the reporting period.

Rates for infection were also relatively common, with about 45 percent of hospitals reporting at least one blood or urinary tract infection developed during the hospital stay. Nationwide, a blood or urinary tract infection was reported once for every 3,300 discharges. Rates were lowest for instances of blood incompatibility, which was reported by less than 1 percent of hospitals and occurred once for every 1,000,000 discharges.

CMS is working with the members of the Hospital Quality Alliance – a national private-public partnership of hospital, consumer, provider, employer, payer, and government agencies – to make HAC data accessible to the public in meaningful, relevant, and easily understood ways that encourage health care quality

continued on next page

Patient safety...*continued*
improvement. Later this year, CMS will work with the Alliance and directly with consumers about how to fold HAC data directly into the Hospital Compare framework. For now, HAC data is available through a downloadable file linked to the Hospital Compare website.

CMS is also working with its Quality Improvement Organization (QIO) contractors and to give hospitals the resources they need to eliminate HACs as much as possible. For instance, QIOs have been working since 2008 with providers across the country to reduce rates of hospital-associated infections, slow rates of pressure ulcers in nursing homes and hospitals, and improve safety and reduce infection for surgery patients. More information about QIOs' efforts is online at *http://www.cms.gov/qualityimprovementorgs*.

In addition to information about HACs, Hospital Compare reports 25 inpatient and five outpatient process of care measures, readmission and mortality rates for certain conditions, three children's asthma care measures, and 10 measures that capture patient satisfaction with hospital care. The site also features information about the volume of certain hospital procedures performed and conditions treated for Medicare patients and what Medicare pays for those services.

The information contained on Hospital Compare is available for consumers to use in making health care decisions. However, consumers should gather information from multiple sources when choosing a hospital. For example, patients and caregivers could use the website to help them discuss plans of care with their trusted health care providers. In an emergency situation, patients should always go to the nearest, most easily accessible facility.

Consumers have relied on Hospital Compare since 2005 to provide information about the quality of care provided in over 4,700 of America's acute-care, critical access and children's hospitals. Hospital Compare is one of CMS' most popular websites, receiving about 1 million page views each month.

To review the HAC data CMS released today, please visit the "Hospital Spotlight" section of Hospital Compare online at *www.HealthCare.gov/compare*.

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

Source: CMS PERL 201104-14

Recovery audit program demonstration for inpatient hospitals podcast

The *Medicare Learning Network*® has released the first in a series of podcasts designed to educate fee-for-service providers about how to avoid common billing errors and other improper activities when dealing with the Medicare program. This podcast – titled *Recovery Audit Program (RAP) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals* – is based on *MLN Matters* special edition article SE1027 and discusses some of the 17 findings identified by the RAP in an effort to prevent future improper payment issues. To download this podcast, visit the MLN Multimedia Web page at *http://www.CMS.gov/MLNProducts/MLM/list.asp* and click on "Provider Compliance" from the list of topics. Please watch for future podcasts from the MLN.

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

Source: CMS PERL 201103-55

New recovery audit program for inpatient hospitals podcast

The *Medicare Learning Network*® has released the second in a series of podcasts designed to educate fee-for-service providers about how to avoid common billing errors and other improper activities when dealing with the Medicare program. This podcast, titled "Recovery Audit Program (RAP) Demonstration High-Risk Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals," is based on *MLN Matters* special edition article 1028 and discusses some of the findings identified by the RAP in an effort to prevent future improper payment issues. To download this podcast, visit the MLN multimedia Web page at *http://www.CMS.gov/MLNProducts/MLM/list.asp* and click on "Provider Compliance" from the list of items that contains the title of this podcast. Stay tuned for future podcasts from the MLN.

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

Source: CMS PERL 201104-34

Proposed Medicare hospital rules would help improve care quality

Proposal continues to tie annual update amount for many hospitals to participation in inpatient quality reporting program, supports efforts to lower health care costs

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update Medicare payment policies and rates for hospitals in fiscal year (FY) 2012. Proposals included in the rule would help support the Obama Administration's efforts to reform our health care delivery system by improving care quality and patient outcomes, addressing long-term health care cost growth, and supporting the goals of the recently announced Partnership for Patients.

"The proposals CMS is making today reflect an underlying premise that we can improve the quality of and access to care while at the same time slowing the growth in health care spending," said CMS Administrator Donald M. Berwick, M.D. "In fact, there is a growing body of evidence that improving care – focusing on the patient's needs, reducing unnecessary duplicate services, and avoiding costly mistakes and preventable healthcare acquired conditions – is key to reducing health care cost growth," he said.

The proposed rule would update payment policies and rates for acute care hospitals paid under the inpatient prospective payment system (IPPS), as well as hospitals paid under the long-term care hospital prospective payment system (LTCH PPS). The proposed rule would also improve and expand the hospital inpatient quality reporting program (IQR) with a greater focus on patient outcomes and experiences of care and establish the framework for a new quality reporting program that would apply to hospitals paid under the LTCH PPS.

Improving patient care

The proposed rule includes several quality improvement proposals that will support larger quality and patient safety efforts across the Department of Health and Human Services, including the Partnership for Patients. The Partnership for Patients is a new public-private partnership that will help improve the quality, safety and affordability of health care for Medicare, Medicaid and Child Health Insurance Program (CHIP) beneficiaries and, by extension, all Americans. One of the Partnership's goals is to decrease preventable complications during a transition from one care setting to another so that all hospital readmissions would be reduced by 20 percent by 2014 compared to 2010. Achieving this goal would mean more than 1.6 million additional patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Research by the Medicare Payment Advisory Commission (MedPAC) and others show that as many as 1 in 3 Medicare patients who leave the hospital will be readmitted within 30 days of discharge, and that a large portion of these readmissions can be avoided through well-coordinated, high-quality hospital care. To provide hospitals with an incentive to improve care coordination, the Affordable Care Act directs CMS to implement a hospital readmissions reduction program that will reduce payments beginning in FY 2013 to certain hospitals that have excess readmissions for certain selected conditions. Today's proposed rule proposes measures for rates of readmissions for three conditions – acute myocardial infarction (or heart attack), heart failure, and pneumonia. CMS is also proposing a methodology that would be used to calculate excess readmission rates for the program. Additional conditions may be added in future rulemaking. The payment adjustments will apply to hospital payments in FY 2013, beginning with discharges on or after October 1, 2012.

The proposed rule also includes proposals aimed at encouraging improvements in the quality of care in hospital inpatient settings, and makes proposals that would align the existing inpatient quality reporting program with a proposed new hospital value-based purchasing program required by the Affordable Care Act. The proposed rule also lays the groundwork for a quality reporting program under the LTCH PPS, by proposing the first measure set for reporting in FY 2013, for payment determination in FY 2014, and discusses specific quality considerations for hospitals providing acute-level care to patients requiring longer stays. To be paid under the LTCH PPS, a hospital must have an average length of stay for all patients it treats that exceeds 25 days.

Payment updates

The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 420 LTCHs, would be effective for discharges occurring on or after October 1, 2011. Under the proposed rule, CMS projects that Medicare operating payments to acute care hospitals for discharges occurring in FY 2012 would decrease by a projected $498 million or 0.5 percent in FY 2012 relative to FY 2011. This includes a hospital update of 1.5 percent (based on a projected market basket update of 2.8, reduced by a productivity adjustment and an additional 0.1 percent), increased by 1.1 percent in response to litigation, as well as a documentation and coding adjustment of -3.15 percentage points to account for changes in documentation and coding following adoption of the

continued on next page

Proposed rules...*continued*

Medicare severity DRGs that did not reflect actual increases in patients' severity of illness. Medicare payments to LTCHs in FY 2012 are projected to increase by $95 million or 1.9 percent.

The Medicare law requires CMS to pay acute care hospitals (with a few exceptions that are specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. These payment systems establish prospectively set rates based on the patient's diagnosis and the severity of the patient's medical condition. Under the IPPS and the LTCH PPS, a hospital receives a single payment for the case based on the payment classification assigned at discharge. The law requires CMS to update the payment rates for both types of hospitals annually to account for changes in the costs of goods and services used by these hospitals in treating Medicare patients, as well as for other factors.

The proposed rule can be downloaded from the Federal Register at: *http://www.ofr.gov/(X(1)S(0pg4mj34jefdgje5yrknosin))/OFRUpload/OFRData/2011-09644_PI.pdf* or *www.ofr.gov/inspection.aspx*.

CMS will accept public comments on the proposed rule until June 20, 2011, and will respond to them in a final rule to be issued by August 1, 2011.

Also, CMS issued fact sheets for additional information at *http://www.cms.gov/apps/media/fact_sheets.asp*.

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

Source: CMS PERL 201104-33

Critical Access Hospitals

PEPPER resources for use by critical access hospitals

Beginning in April 2011, the Centers for Medicare & Medicaid Services (CMS) will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) 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 by 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.

PEPPER will be distributed electronically to CAH QualityNet administrators and those who have basic user accounts with the PEPPER recipient role on or about Monday, April 25, via a My QualityNet secure file exchange. In preparation for receiving and downloading PEPPER from My QualityNet, these individuals should verify that their computer systems are equipped with the software and configuration required to use My QualityNet by following the steps at *www.qualitynet.org* (see "Getting Started With QualityNet" and "Test Your System.")

Additional information about downloading PEPPER from My QualityNet can be found at *http://www.pepperresources.org/PEPPER/DownloadingPEPPER.aspx* (includes system setup and test guide, troubleshooting tips and a guide for configuration changes for compatibility with QualityNet).

CAHs may work with their Quality Improvement Organization (QIO) to obtain a QualityNet administrator account by visiting *www.qualitynet.org* and clicking on the "Hospitals - Inpatient" link. Obtaining a My QualityNet account may take several weeks; CAHs should plan accordingly.

For more information, including the PEPPER distribution schedule, a sample PEPPER for CAHs and information about QualityNet accounts, visit the PEPPER website at *http://www.pepperresources.org*. CAH staff is encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

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

Source: CMS PERL 201104-03

Manual clarifications for skilled nursing facility Part A billing

Provider types affected

Skilled nursing facilities (SNFs), which submit claims to fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs), are affected by this article. This article contains no policy changes.

Provider action needed

This article is based on change request (CR) 7339, which provides various clarifications for SNF Part A billing. Please be sure to inform your staffs of these clarifications.

Background

The Centers for Medicare & Medicaid (CMS) is including the following clarifications (in italics) to the *Medicare Claims Processing Manual*, Chapter 6, SNF Inpatient Part A Billing.

Billing SNF prospective payment services (PPS)

When applicable, SNFs must submit occurrence code 16, date of last therapy, to indicate the last day of therapy services (e.g., physical therapy, occupational, and speech language pathology) for the beneficiary.

Coding PPS bills for ancillary services

For therapy services (revenue codes 042x, 043x, and 044x), units represent the number of sessions of therapy provided. For example, if the beneficiary received therapy for a total of 52 minutes (25 minutes concurrently and 27 minutes individually) in one session the units billed would be 1.

Reprocessing inpatient bills in sequence

When a beneficiary experiences multiple admissions (to the same or a different facility) during a benefit period, claims are processed by CWF in the same order that they are received, regardless of the dates on which expenses were incurred. This first-in-first-out (FI/FO) method of processing requests for payment facilitates prompt handling of claims.

If a SNF, any beneficiary, or secondary insurer have increased liability as a result of CWF's FI/FO processing, the SNF must notify the FI or A/B MAC to arrange reprocessing of all affected claims. This approach is not applicable if the liability stays the same, e.g., if the coinsurance or deductible amounts are applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage or if the beneficiary is responsible for payment of the first claim instead of the second.

The FI or A/B MAC will verify and cancel any bills posted out-of-sequence and request that any other FI or MAC involved also cancel any affected bills. The FI or MAC will reprocess all bills in the benefit period in the sequence of the beneficiary's stays to properly allocate days where payment is made in full by Medicare and to identify those days where the beneficiary is required to pay coinsurance.

Additional leave of absence guidance

Leave of absence (LOA) days are shown on the bill with revenue code 018x and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of the *Medicare Claims Processing Manual* at Section 30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates.

Clarification of technical component

Billing related to physician's services: The technical component (e.g., the component representing the performance of the diagnostic procedure itself) of physician services delivered to SNF inpatients are bundled into the Part A PPS payment and not paid separately.

Additional information

The official instruction, CR 7339 issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2183CP.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: MM7339
Related Change Request (CR) #: 7339
Related CR Release Date: March 25, 2011
Effective Date: June 28, 2011
Related CR Transmittal #: 2183CP
Implementation Date: June 28, 2011

Skilled nursing facility/long-term care open door forum

The next skilled nursing facility (SNF)/long-term care (LTC) open door forum is scheduled for Thursday, May 12, from 2:00-3:00 p.m. ET. If you wish to participate, dial 800-837-1935 conference ID 44708925. This call will be conference call only.

Please see the "Downloads" section at the following URL for the full participation announcement at *http://www.cms.gov/OpenDoorForums/25_ODF_SNFLTC.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 201104-28

July quarterly update of HCPCS codes for skilled nursing facility consolidated billing enforcement

Provider types affected

This article is for providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7345 which provides the July quarterly update to the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes used for skilled nursing facility (SNF) consolidated billing (CB) enforcement.

Caution – what you need to know

Changes to *Current Procedural Terminology (CPT)*/ HCPCS codes and Medicare physician fee schedule designations will be used to revise Medicare systems to allow your Medicare contractor(s) to make appropriate payments in accordance with policy for SNF consolidated billing in the *Medicare Claims Processing Manual* (Chapter 6, Section 20.6).

Go – what you need to do

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

Background

The Social Security Act (Section 1888; see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm* on the Internet) codifies SNF prospective payment system (PPS) and CB, and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS.

The new coding identified in each update describes the same services that are subject to SNF PPS payment by law, and no additional services are added by these routine updates. The new updates are required because of changes to the coding system, not because the services subject to SNF CB are being redefined.

Services excluded from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when the beneficiary is in a SNF stay.

Services not appearing on the exclusion lists submitted on claims to Medicare contractors (fiscal intermediaries (FIs), carriers, A/B Medicare administrative contractors (MACs) including durable medical equipment (DME) MACS) will not be paid by Medicare to any providers other than a SNF.

For non-therapy services:

- SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay;
- However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.

  In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

Note: Codes added or terminated with this update are available at *http://www.cms.gov/SNFConsolidatedBilling/71_2011Update.asp#TopOfPage* on the CMS website. A general explanation of the major categories for SNF CB can be found at *http://www.cms.gov/SNFConsolidatedBilling/Downloads/2011MajorCatExpl.pdf* on the CMS website.

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HCPCS...*continued*

CR 7345 instructs Medicare systems to add:

- *CPT codes 74176, 74177* and *74178* to major category I.A. [exclusion of services beyond the scope of an SNF (computerized axial tomography (CT) scans)] effective January 1, 2011;
- HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 to major category IV.B. [additional excluded preventive and screening services (vaccines (pneumococcal, flu or hepatitis B))] effective January 1, 2011;
- HCPCS code G0105 to major category IV.E. [additional excluded preventive and screening services (colorectal screening services)] effective January 1, 2011;
- *CPT codes 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93462, 93463, 93464, 93563, 93564, 93565, 93566, 93567* and *93568* to major category I.B. [exclusion of services beyond the scope of an SNF (cardiac catheterization)] effective January 1, 2011; and
- *CPT code 96466* to major category III.B [additional exclusion of services rendered by certified providers (chemotherapy administration)] effective January 1, 2011.

CR 7345 instructs Medicare systems to terminate:

- *CPT code 90658* from major category IV.B. [additional excluded preventive and screening services (vaccines (pneumococcal, flu or hepatitis B))] effective December 31, 2010; and
- *CPT codes 93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93539, 93540, 93541, 93542, 93543, 93544* and *93545* from major category I.B. [exclusion of services beyond the scope of an SNF (cardiac catheterization)] effective December 31, 2010;

Note: Your Medicare contractor(s) will reprocess claims affected by this instruction when you bring those claims to their attention.

Additional information

The official instruction, CR 7345, issued to your FIs and A/B MACs regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2184CP.pdf* on the CMS website.

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* on the CMS website.

MLN Matters® Number: MM7345
Related Change Request (CR) #: 7345
Related CR Release Date: March 25, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2184CP
Implementation Date: July 5, 2011

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

Note: This article was revised on March 30, 2011, 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 addition, reference to Attachment A of CR7208 was replaced with a link to CR7012 for a list of preventive services HCPCS codes. All other information remains the same. This information was previously published in the February 2011 *Medicare A Bulletin*, page 54.

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/R2186CP.pdf* on the CMS website. A list of the current HCPCS codes defined as preventive services under Medicare and the HCPCS codes for the IPPE and the annual wellness visit is in CR7012 at *http://www.cms.gov/Transmittals/downloads/R864OTN.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: MM7208 Revised
Related Change Request (CR) #: 7208
Related CR Release Date: March 28, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2186CP
Implementation Date: April 4, 2011

Educational Events

Upcoming provider outreach and educational events – May 2011

Overcoming 5010 testing barriers
When: Wednesday, May 11 **Time:** 10:00 – 11:00 a.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, May 17 **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

Transition to HIPAA version 5010 technical seminar: Session one
When: Tuesday, May 24 **Time:** 9:00 – 10:30 a.m. ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** U.S. Virgin Islands

Transition to HIPAA version 5010 technical seminar: Session two
When: Tuesday, May 24 **Time:** 1:00 – 2:30 p.m. ET **Delivery language:** English
Type of Event: Face-to-face **Focus:** U.S. Virgin Islands

Two easy ways to register

Online – Visit our provider training website at *www.fcsomedicaretraining.com*, logon 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 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: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *www.medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the FCSO Provider Education Registration Hotline at 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.

Other Educational Resources

Revised *Federally Qualified Health Center* fact sheet

The revised publication titled *Federally Qualified Health Center* (revised March 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/fqhcfactsheet.pdf*. This fact sheet is designed to provide education about the following as it relates to federally qualified health centers (FQHCs):

- Background
- FQHC designation
- Covered FQHC services
- FQHC preventive primary services that are not covered
- FQHC prospective payment system
- FQHC payments

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

Source: CMS PERL 201104-11

Medicare Disproportionate Share Hospital fact sheet revised

The revised publication titled *Medicare Disproportionate Share Hospital* (revised March 2011) is now available in downloadable format at *http://www.CMS.gov/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf*. This fact sheet is designed to provide education on Medicare disproportionate share hospitals (DSH) including background; methods to qualify for the Medicare DSH adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005 provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH hospital payment adjustment formulas.

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

Source: CMS PERL 201104-25

New *Mental Health Services* booklet

A new publication titled *Mental Health Services* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Mental_Health_Services_ICN903195.pdf*. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

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

Source: CMS PERL 201104-25

Three new Medicare-covered preventive services quick reference charts

- *The ABCs of Providing the Initial Preventive Physical Examination* quick reference chart provides Medicare fee-for-service providers a list of the elements of the initial preventive physical examination (IPPE), as well as coverage and coding information. To view the chart, please visit *http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf*.
- *The ABCs of Providing the Annual Wellness Visit* quick reference chart provides Medicare fee-for-service providers a list of the elements of the annual wellness visit (AWV), as well as coverage and coding information. To view the chart, please visit *http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf*.
- *The Medicare Preventive Services* quick reference chart provides Medicare fee-for-service providers coverage, coding, and payment information on the variety of preventive services covered by Medicare. To view the chart, please visit *http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*.

A hardcopy booklet containing all three charts, as well as the *Quick Reference Information: Medicare Immunization Billing* chart, will be available at a later date.

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Source: CMS PERL 201104-11

New fact sheets for DMEPOS suppliers

DMEPOS Quality Standards fact sheet

The new publication titled *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards* is now available in downloadable format from the *Medicare Learning Network®* at *http://www.CMS.gov/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf*. This fact sheet is designed to provide education on DMEPOS quality standards for Medicare deemed accreditation organizations (AOs) for DMEPOS suppliers. A hard copy version of this fact sheet will be available at a later date.

The Basics of DMEPOS Accreditation fact sheet

A new publication titled *The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation* is now available in downloadable format from the *Medicare Learning Network®* at *http://www.cms.gov/MLNProducts/downloads/DMEPOS_Basics_FactSheet_ICN905710.pdf*. This fact sheet is designed to provide education on the DMEPOS accreditation requirements, the types of providers who are exempt, and the process for becoming accredited. A hard copy version of this fact sheet will be available at a later date.

DMEPOS New Information for Pharmacies booklet

A new publication titled *Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) New Information for Pharmacies* is now available in downloadable format from the *Medicare Learning Network®* at *http://www.cms.gov/MLNProducts/downloads/DMEPOS_Pharm_FactSheet_ICN905711.pdf*. This booklet is designed to provide education for new pharmacies on how to obtain a DMEPOS accreditation exemption. In order to supply DMEPOS, pharmacies must be accredited by a CMS-approved independent national accreditation organization (AO) or must obtain an accreditation exemption. A hard copy version of this fact sheet will be available at a later date.

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Source: CMS PERL 201104-34

Evaluation and Management Services Guide is available in print

The publication titled *Evaluation and Management Services Guide* is now available in print format from the *Medicare Learning Network*® 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. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS" and select "MLN Product Ordering Page."

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Source: CMS PERL 201104-34

New information for compliance officers and billing and coding professionals

As part of ongoing efforts by the Centers for Medicare & Medicaid Services (CMS) to keep Medicare fee-for-service (FFS) providers aware of new and improved products, CMS encourages you to visit the Provider Compliance *Medicare Learning Network*® (*MLN*) Web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp#TopOfPage*, where you will find FFS provider materials to help you understand and avoid common billing errors and other improper activities identified through claim review programs. Be sure to pay particular attention to the listing of provider compliance national educational products at *http://www.cms.gov/MLNProducts/Downloads/ProvCmpl_Products.pdf*, from which you can quickly link to each available product. Also take a moment to review the first two issues of the *Medicare Quarterly Provider Compliance Newsletter* Volume 1, Issue 1 at *http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf?bcsi_scan_EF5B9DB7FD0B1BFD=IwKNPnaHXmgVnd/DbCGTSqN5F2EQAAAAsxgoAg==&bcsi_scan_filename=MedQtrlyComp_Newsletter_ICN904943.pdf* and Volume 1, Issue 2 at *http://www.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN905712.pdf?bcsi_scan_EF5B9DB7FD0B1BFD=2v+1ib8hw91xH4kWSXKyfFjnMdIQAAAAbx0oAg==&bcsi_scan_filename=MedQtrlyComp_Newsletter_ICN905712.pdf*. And like all *MLN* products, our downloadable compliance materials are available at no cost.

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

Source: CMS PERL 201103-55

Minimum data set (MDS) version 3.0 training materials update

The following videos have been posted to YouTube and are also available for download:

- Section M: Skin conditions;
- Evening Experts Panel Discussion;
- Dr. Deb Saliba's Introduction.

Please click on the appropriate YouTube Link under "Related Links Outside of CMS" at the following URL *http://www.cms.gov/OpenDoorForums/25_ODF_SNFLTC.asp*.

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

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

Source: CMS PERL 201103-53

Medical Privacy of Protected Health Information fact sheet revised

The revised publication titled *Medical Privacy of Protected Health Information* (revised January 2011) is now available from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNproducts/downloads/SE0726FactSheet.pdf*. This fact sheet contains resources and information regarding the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and how this applies to customary health care practices and other information on the Department of Health & Human Services (HHS) HIPAA Web 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 201103-55

New *Inpatient Rehabilitation Services* fact sheet

A new publication titled *Inpatient Rehabilitation Services* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/Inpatient_Rehab_Fact_Sheet_ICN905643.pdf*. This fact sheet is designed to provide education on inpatient rehabilitation services to health care providers, and includes information on the documentation needed to support a claim submitted to Medicare for inpatient rehabilitation services.

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

Source: CMS PERL 201104-34

Addresses – FCSO

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

Claims/correspondence
Florida:
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

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

Freedom of Information Act requests
(relative to cost reports and audits)

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

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
General information, conditional payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections
Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement (PARD)
P. O. Box 45268
Jacksonville, FL 32232-5268

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

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

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

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail and courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Addresses – other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)
Durable medical equipment, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CIGNA Government Services
P. O. Box 20010
Nashville, Tennessee 37202

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

Regional home health and hospice intermediary
Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Provider audit and reimbursement
904-791-8430

Provider education and outreach
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites

First Coast Service Options Inc. (Florida and U.S. Virgin Islands Medicare contractor)
medicare.fcso.com

Centers for Medicare & Medicaid Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

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