Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers May 2011

Features

CMS proposes to expand access to seasonal influenza immunization

Proposed requirement would make flu shots available to patients at most commonly visited Medicare-certified health care facilities

The Centers for Medicare & Medicaid Services (CMS) proposed new requirements for Medicare-certified providers that are designed to expand access to seasonal influenza vaccination. The notice of proposed rulemaking would update the conditions of participation and conditions for coverage for a number of provider types, in an effort to increase access to the vaccine, increase the number of patients receiving annual vaccination against seasonal influenza, and to decrease flu-linked morbidity and mortality.

"Today's proposed rule will expand Medicare beneficiaries' options for where to receive a flu shot during flu season," said CMS Administrator, Donald M. Berwick, M.D. "The new requirements would make flu shots available in more of the health care facilities that Medicare beneficiaries are most likely to visit, including hospitals and rural health clinics."

This proposed rule would require many Medicare providers and suppliers to offer all patients an annual influenza vaccination during flu season, unless medically contraindicated. As always, any patient would retain the right to decline any vaccination. This proposed requirement would extend to Medicare-certified:

- Hospitals, including short-term acute care, psychiatric, rehabilitation, long-term care, children's, and cancer
- Critical access hospitals (CAHs)
- Rural health clinics (RHCs)
- Federally qualified health centers (FQHCs), and
- End-stage renal disease (ESRD) facilities that offer dialysis services.

The proposed rule would update the conditions of participation and conditions for coverage for all of the provider types above. These rules apply to health care organizations that seek to begin and continue participating in the Medicare and Medicaid programs. The conditions are health and safety standards that are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS implements these standards through state departments of health and accrediting organizations recognized by CMS (through a process called "deeming"), which review provider practices to assure they meet or exceed the Medicare's condition standards.

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

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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.

Influenza...*continued from page 1*

In order to meet these proposed provisions, the providers and suppliers would need to develop and implement policies and procedures for offering and administering seasonal influenza vaccine. The proposed rule does allow for situations in which vaccine supplies may be unavailable or in short supply, and recognizes that providers and suppliers could not be held accountable for providing vaccine for all patients in such circumstances.

Additionally, the proposed rule would require the included providers and suppliers to develop policies and procedures that would allow them to offer vaccinations for pandemic influenza, in case of a future pandemic influenza event for which a vaccine is developed.

"This proposal will remove barriers for Medicare beneficiaries who want to receive annual flu shots as part of their preventive health routine," said Dr. Berwick. "While CMS believes that flu vaccination is the best way to keep beneficiaries and their families safe and healthy during flu season, our proposal respects the rights of beneficiaries and their families to choose whether the flu shot is best for them. However, we hope that by expanding the breadth of places where flu shots are offered, beneficiaries will make the choice about whether to vaccinate based on health needs rather than convenience or availability."

CMS will accept public comments on the CMS proposed rule until July 5 and will respond to comments in a final rule to be published in the coming months. To submit comments, please visit *http://www.regulations.gov* and search for rule "CMS-3213-P."

The proposed rule is available online from the *Federal Register* at *http://edocket.access.gpo.gov/2011/pdf/2011-10646.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 201104-59

Affordable Care Act gives providers new options to better coordinate health care

New accountable care organization models will improve patient care and could save Medicare up to $430 million

The Centers for Medicare & Medicaid Services (CMS) announced three Affordable Care Act initiatives designed to help put doctors, hospitals, and other health care providers on the path to becoming accountable care organizations (ACOs) and improve health care for Americans with Medicare.

First, The Center for Medicare & Medicaid Innovation (*http://innovations.cms.gov/*) is requesting applications for the new Pioneer ACO Model (*http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/*) that provides a faster path for mature ACOs that have already begun coordinating care for patients and are ready to move forward.

Second, the innovation center is seeking comment on the idea of the Advance Payment Initiative (*http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/*) that gives certain ACOs participating in the Medicare Shared Savings Program access to their shared savings up front, helping them make the infrastructure and staff investments crucial to successfully coordinating and improving care for patients.

Finally, providers interested in learning more about how to coordinate patient care through ACOs can attend free new accelerated development learning sessions (*https://acoregister.rti.org/*). These sessions will teach providers interested in becoming ACOs what steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care.

Together with the Medicare Shared Savings Program (*http://www.cms.gov/sharedsavingsprogram/*), the initiatives announced today give providers a broad range of options and support that reflect the varying needs of providers in embarking on delivery system reforms. CMS issued a proposed rule to implement the Medicare Shared Savings Program in March 2011 and is continuing to encourage and accept comments from providers and the public that will help strengthen the final rule.

These initiatives are part of a broader effort by the Obama Administration, made possible by the Affordable Care Act, to improve care and lower costs. For more information about all of these initiatives, visit the Center for Medicare & Medicaid Innovation website at *http://innovations.cms.gov/*.

To read the full CMS press release issued May 17, go to *http://www.cms.gov/apps/media/press/release.asp?counter=3957*.

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

Source: CMS PERL 201105-28

May is National Osteoporosis Awareness and Prevention Month

Please join with the Centers for Medicare & Medicaid Services (CMS) in promoting National Osteoporosis Awareness and Prevention Month. Estimates indicate that as many as 50 percent of Americans older than 50 will be at risk for osteoporosis fractures during their lifetimes. Osteoporosis is often called the "silent disease" because bone loss occurs without symptoms, but early diagnosis and treatment can reduce or prevent fractures from occurring.

Medicare coverage
Medicare provides coverage for bone mass measurements once every 24 months (or more often if medically-necessary) for a qualified Medicare beneficiary when ordered by a physician or qualified non-physician practitioner.

What can you do?
As a health care professional, you play a crucial role in helping your patients maintain strong, healthy bones throughout their life. While osteoporosis is not curable, it can be treated and managed. Here's how you can help:

- Talk with your patients about their risk factors.
- Encourage all eligible Medicare patients to take full advantage of Medicare's bone mass measurements benefit.
- Visit the websites listed below to learn more about National Osteoporosis Awareness and Prevention Month and Medicare coverage of bone mass measurements.

For more information

- Bone Mass Measurement Web page (*http://www.cms.gov/BoneMassMeasurement/*) – this CMS Web page provides an overview of information on provider resources for bone mass measurements.
- *Bone Mass Measurements Brochure* (*http://www.cms.gov/MLNProducts/downloads/Bone_Mass.pdf*) – this brochure provides fee-for-service health care professionals with an overview of Medicare's coverage of bone mass measurements.
- *Quick Reference Information: Medicare Preventive Services* (*http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*) – this chart provides coverage and coding information on Medicare-covered preventive services, including bone mass measurements.
- *The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Healthcare Professionals* (*http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*) – this comprehensive resource provides coverage and coding information on the array of Medicare-covered preventive services and screenings, including bone mass measurements.
- NIH Osteoporosis and Related Bone Diseases National Resource Center (*http://www.niams.nih.gov/Health_Info/Bone/default.asp*)
- The National Osteoporosis Foundation (*http://www.nof.org/*)

Together we can promote better awareness and healthier bones. Thank you for your support.

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Source: CMS PERL 201105-20

National Women's Health Week and National Women's Checkup Day

Mothers Day is Sunday, May 8, which kicks off the 12th annual National Women's Health Week and National Women's Checkup Day, Monday, May 9. "It's Your Time!" is the theme for the 2011 National Women's Health Week. This week-long national health observance empowers women to make their health a top priority. It also encourages them to take steps to improve their physical and mental health and lower their risks of certain diseases. Although Medicare is now helping to pay for more preventive services and screenings, many women with Medicare are not taking full advantage of them, leaving significant gaps in prevention. With your help, we can begin to close the prevention gap. Please join with the Centers for Medicare & Medicaid Services in helping women learn how they can live longer healthier lives through disease prevention, early detection, and lifestyle modifications.

Medicare coverage
Medicare provides coverage of many preventive services and screenings that are especially meaningful to women, including but not limited to:

- Bone mass measurements
- Cancer screenings
  - Breast (mammogram and clinical breast exam)
  - Cervical and vaginal (Pap test and pelvic exam)
  - Colorectal
- Cardiovascular disease screenings
- Diabetes screening
- HIV screening
- Immunizations
  - Hepatitis B
  - Influenza
  - Pneumococcal
- Tobacco-use cessation counseling
- Yearly wellness exam (new for 2011)

Note: While coverage by Medicare is subject to certain eligibility criteria, many preventive services and screenings can now be received with no out-of-pocket costs to the beneficiary.

What can you do?
As a provider of health care services to people with Medicare, CMS needs your help to ensure that women with Medicare are informed about the preventive services and screenings for which they may be eligible, they understand the importance of utilizing these services, and they are encouraged to use the services that are appropriate for them. Please remember to provide referrals for services when required.

For more information
- CMS Preventive Services Website (*http://www.cms.gov/PrevntionGenInfo/*)
- Quick Reference Information: Medicare Preventive Services (*http://www.cms.gov/PrevntionGenInfo/*)
- *Medicare Learning Network*® (*MLN*) Preventive Services Educational Products *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage*
- National Women's Health Week (*http://www.womenshealth.gov/whw/*)
- National Women's Checkup Day (*http://www.womenshealth.gov/whw/check-up-day/*)

This Mothers Day we can make a positive difference in the health of the women in our lives.

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Source: CMS PERL 201105-04

Corrections made to claims for certain institutional 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:

Outpatient hospitals

- Hospital outpatient prospective payment system (OPPS) claims containing surgical procedure codes *10000-69999* with PT modifier submitted on type of bill (TOB) 13x with dates of service on or after Saturday, January 1, 2011, are being suspended due to deductible incorrectly being applied. Medicare contractors have been instructed to hold claims impacted by this problem. A software correction is scheduled for July 2011.
- Hospital OPPS claims with dates of service on and after Saturday, January 1, 2011, containing hepatitis B vaccine administration Healthcare Common Procedure Coding System (HCPCS) code G0010 are incorrectly receiving deductible and coinsurance. Medicare contractors have been instructed to hold claims impacted by this problem. A software correction is scheduled for July 2011.
- Hospital outpatient (13x TOB) claims with dates of service on or after Saturday, January 1, 2011, containing HCPCS codes *90740, 90743, 90744, 90746*, and *90747* are not being paid. Medicare contractors have been instructed to hold claims impacted by this problem until a correction is implemented. A software correction is scheduled for June 2011.

Federally qualified health centers (FQHC)

- FQHCs (77x TOB) claims with dates of service on and after Saturday, January 1, 2011, containing HCPCS codes G0402, G0389, G0436, G0437, Q0091, G0101, G0130, *77078, 77079, 77080, 77081, 77083*, and *76977* are being processed and paid incorrectly due to coinsurance being incorrectly applied. Medicare contractors have been instructed to hold claims impacted by this problem until a correction is implemented. A software correction is scheduled for June 2011.

Critical access hospitals (CAH)

- CAHs (85x TOB) claims with dates of service on and after Saturday, January 1, 2011, containing HCPCS codes Q0091, G0101, *77052, 77057*, and G0202 are being processed and paid incorrectly due to coinsurance being incorrectly applied. Medicare contractors have been instructed to hold claims impacted by this problem until a correction is implemented. A software correction is scheduled for June 2011.

Update

Due to the unprecedented volume of claims reprocessing this year and the constraints placed on Medicare systems, reprocessing of claims for institutional preventive services specified in Provider Education Resource Listserv (PERL) 201104-17(*http://medicare.fcso.com/processing_issues/199367.asp*) will be completed by First Coast Service Options (FCSO) August 31, 2011, not May 31 as originally scheduled.

For more information, refer to PERL 201105-29 below.

Dialysis facilities (RDF)

- Hospital-based RDFs (72x TOB) claims with dates of service on and after Saturday, January 1, 2011, containing HCPCS codes *90743* and *90744* are not applying payment on the hepatitis B vaccine code line. In addition, free-standing RDFs claims with dates of service on and after Saturday, January 1, 2011, containing HCPCS code *90744*, are not applying payment on the hepatitis B vaccine code line. Medicare contractors have been instructed to hold claims impacted by these problems until a correction is implemented. A software correction is scheduled for June 2011.

As the software corrections are made, Medicare contractors will release any suspended claims and automatically reprocess claims for preventive services that have not been paid or erroneously applied deductible or coinsurance. **Reprocessing of claims that have been paid incorrectly for this issue will be completed by Wednesday, August 31, 2011**.

Providers who are billing for other payable services on the same claim as services that have been suspended and do not wish for their entire claim to be suspended may request the contractor to return the claim may remove the preventive service charge that is suspending until software corrections are implemented and then rebill an adjustment claim adding the preventive service that was initially removed (i.e., a dialysis provider may remove the hepatitis B HCPCS service in order to have all other payable dialysis services processed; then, after the Monday, June 6 software implementation, they may adjust the dialysis claim to add the hepatitis B HCPCS service that was originally removed to have all services processed).

Source: CMS PERL 201105-29

Incentive Programs

Medicare electronic health record incentive payments to be issued

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that incentive payments for the Medicare electronic health record (EHR) incentive program will be sent out the week of May 16. Providers who have successfully attested to having met meaningful use, and who have met all the other program requirements, can expect to receive their 2011 incentive payments soon.

What kind of payment can I expect?
Eligible professionals (EPs) participating in the Medicare EHR incentive program receive a payment based on 75 percent of their total Medicare allowed charges submitted no later than two months after the end of the 2011 calendar year. The maximum allowed charges used for a 2011 incentive payment is $24,000. This means that the maximum incentive payment an EP can receive for the first participation year is $18,000.

Please note that incentive payments will not be made to an EP until the EP meets the $24,000 threshold in allowed Medicare charges. Incentive payments to eligible hospitals and critical access hospitals are based on a number of factors, beginning with a $2 million base payment.

How are payments made?
Participants will receive their Medicare EHR incentive program payment the same way they receive payments for Medicare services, via electronic funds transfer or by paper check. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected during registration for the Medicare EHR incentive program. For electronic transfers, CMS will deposit incentive payments in the first bank account on file and it will appear on the bank statement as "EHR Incentive Payment."

Important: Medicare administrative contractors (MACs), carriers, and fiscal intermediaries will not be making these payments**.** CMS is working with a payment file development contractor to make these payments. Please do not contact your MAC regarding EHR incentive payments.

Medicaid EHR incentive program payments
Since January 2011, several states that started their Medicaid EHR incentive programs have made payments to many EPs and eligible hospitals who have met the requirements for the Medicaid EHR incentive program. To date, over $83 million in Medicaid incentive payments have been issued to EPs and eligible hospitals participating in the EHR incentive program.

To view a checklist of how to participate in the Medicare or Medicaid EHR incentive program, visit the Path to Payment section at *http://www.cms.gov/EHRIncentivePrograms/10_PathtoPayment.asp* of the EHR website.

Additional information
For the latest news and updates on the EHR incentive programs visit the CMS EHR incentive programs website at *http://www.cms.gov/EHRIncentivePrograms/*

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

Source: CMS PERL 201105-32

Get motivated by Medicare …
Find out about Provider Incentive Programs

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

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

Try the Meaningful Use Attestation Calculator

CMS has launched a new attestation resource for the Medicare electronic health record (EHR) incentive program

All eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR incentive program must attest to having met meaningful use requirements in order to receive their EHR incentive payments.

The Meaningful Use Attestation Calculator at *http://www.cms.gov/apps/ehr/* helps Medicare EPs, eligible hospitals, and CAHs determine if they have met all of the objectives and their associated measures for meaningful use prior to completing attestation for the Medicare EHR incentive program. It is important to note that the tool does not calculate clinical quality measures (CQMs). (*https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp*). These measures are reported directly from a certified EHR and will need to be entered in the Web-based attestation system in order to receive an incentive payment. This calculator is not the same as the actual attestation; rather it is a tool that allows Medicare EPs to assess their readiness to successfully complete the attestation process.

The Meaningful Use Attestation Calculator will help prepare EPs, eligible hospitals, and CAHs for the attestation system. After entering their core and menu measure meaningful use data, the calculator will display whether a provider has met the necessary criteria for these objectives. The user can then print a copy of the measures they have entered and whether they have passed or failed each specific measure.

The calculator will indicate in red those measures for which the input values did not meet the required thresholds and will mark them as "failed."

You can find the Meaningful Use Attestation Calculator and more information about the attestation process at *https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage*.

Users can print a copy of the measures and whether they passed or failed each specific measure.

In order to better understand the meaningful use criteria, EPs, eligible hospitals, and CAHs can also review the Stage 1 Meaningful Use Specification Sheets for EPs (*https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf*) and eligible hospitals and CAHs (*https://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf*). These specification sheets contain detailed information on each core and menu meaningful use measure.

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

This service is provided to you by the Medicare and Medicaid EHR incentive programs at *https://www.cms.gov/ehrincentiveprograms/.*

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

Source: CMS PERL 201104-38

EHR incentive payment fact sheets now available in Spanish

Medicare EHR Incentive Payments for Eligible Professionals fact sheet

The *Medicare Electronic Health Record Incentive Payments for Eligible Professionals* fact sheet is now available in a Spanish version (ICN 906386). This fact sheet is designed to provide education on the **Medicare** electronic health record (EHR) incentive program for eligible professionals, and can be accessed on the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedicareEHRProgForEPs-ICN906388-sp.pdf*.

Medicaid EHR Incentive Payments for Eligible Professionals fact sheet

The *Medicaid Electronic Health Record Incentive Payments for Eligible Professionals* fact sheet is now available in a Spanish version (ICN 906388). This fact sheet is designed to provide education on **Medicaid** EHR incentive payments for eligible professionals, and can be accessed on the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Medicaid_EHRIncentivePayments_ICN906386-Sp.pdf*.

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Source: CMS PERL 201105-09

How do I get paid for the electronic health record incentive programs?

Payments for the Medicare and Medicaid electronic health record (EHR) incentive programs are distributed based on each year of participation, and follow a specific payment schedule (*https://www.cms.gov/EHRIncentivePrograms/35_Basics.asp*). Below are payment details on the Medicare and Medicaid EHR incentive programs. For an overview, see the *Medicare Learning Network* (*MLN*) Matters Special Edition article (SE1111) – Medicare Electronic Health Record (EHR) Incentive Payment Process at *http://www.cms.gov/MLNMattersArticles/Downloads/SE1111.pdf*.

Medicare EHR incentive program

- **Eligible professionals (EPs):** EPs can receive up to $44,000 over five years under the Medicare EHR incentive program. There's an additional incentive for EPs who provide services in a health professional shortage area (HPSA).To get the maximum incentive payment, Medicare EPs must begin participation by 2012.
- **Eligible hospitals and critical access hospitals (CAHs):** Incentive payments to eligible hospitals and CAHs may begin as early as 2011, and are based on a number of factors, beginning with a $2 million base payment.

Medicaid EHR incentive program

- **EPs:** The Medicaid EHR incentive program is voluntarily offered by states and territories. EPs can receive up to $63,750 over the six years that they choose to participate in the program. Medicaid EPs must initiate the program by 2016.
- **Eligible hospitals:** Medicaid hospitals that qualify for incentive payments may begin receiving incentive payments as early as fiscal year (FY) 2011. Hospital payments are based on a number of factors, beginning with a $2 million base payment. Medicaid hospitals must initiate the payments by 2016.

Important note: Medicare administration contractors (MACs), carriers, and fiscal intermediaries (FIs) will not be making Medicare EHR incentive 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

- Hours of operation: 7:30 a.m.-6:30 p.m. (Central Time) Monday through Friday, except federal holidays.
- 888-734-6433 (primary number) or 888-734-6563 (TTY number).

A revised FAQ on payment for the EHR incentive programs has been posted to the EHR website

Question: For the 2011 payment year, how and when will incentive payments for the Medicare EHR incentive program be made?

Answer: For EPs, incentive payments for the Medicare EHR incentive program will be made approximately four to eight weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Read the rest of the answer to this FAQ at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10160/session/L3NpZC9Gb3hCb0Rzaw%3D%3D*.

Want more information about the EHR incentive programs?

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

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Source: CMS PERL 201104-53

EHR incentive program – new FAQs added

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. New FAQs have been added to its website this month. Take a minute and review the new FAQs on attestation, meaningful use, certified EHR technology, and the path to payment.

Attestation

1. To what attestation statements must an eligible professional (EP), eligible hospital, or critical access hospital (CAH) agree in order to submit an attestation, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare EHR Incentive Program? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10589/p/21%2C26%2C11*.
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.hhs.gov/app/answers/detail/a_id/10474*.

Meaningful use

1. For the meaningful use objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid EHR Incentive Program, how should the numerator and denominator be calculated? Should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10284/p/21%2C26%2C11*.
2. For the meaningful use objective to "record and chart changes in vital signs" for the Medicare and Medicaid EHR Incentive Programs, can an EP claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10593/p/21%2C26%2C11*.
3. In order to meet the participation threshold of 50 percent of patient encounters in practice locations equipped with certified EHR technology for the Medicare and Medicaid EHR Incentive Programs, how should patient encounters be calculated? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10592/p/21%2C26%2C11*.
4. If an eligible hospital or CAH has a rehabilitation unit or a psychiatric unit that is part of the inpatient department and that bills under Place of Service (POS) code 21, but that is excluded from the inpatient prospective payment system (IPPS), should patients from these units be included in the denominator for the measures of meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10591/p/21%2C26%2C11*.

Certified EHR technology

1. If a provider purchases a certified complete EHR or has a combination of certified EHR modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10590/p/21%2C26%2C11*.

Path to payment

1. For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10160/p/21%2C26%2C11*.

Additional information

Want more information about the 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 201105-01

Indiana and Ohio launched Medicaid EHR incentive programs

On May 2, Indiana and Ohio opened their Medicaid electronic health record (EHR) incentive programs for registration to Medicaid eligible professionals (EPs) and eligible hospitals. EPs and eligible hospitals in these states are now able to receive Medicaid EHR incentive payments after successfully registering and attesting at the state level to having adopted, implemented, or upgraded certified EHR technology. More information about the Medicaid EHR incentive program can be found on the Medicare and Medicaid EHR Incentive Program Basics Web page at *http://www.cms.gov/EHRIncentivePrograms/35_Basics.asp#TopOfPage* of the Centers for Medicare & Medicaid Services (CMS) EHR website.

If you provide health care services to Medicaid beneficiaries in Indiana or Ohio, and want more information about participating in your state's Medicaid EHR incentive program, visit your state Medicaid agency website here:

- Indiana (*http://provider.indianamedicaid.com/general-provider-services/ehr-incentive-program.aspx*)
- Ohio (*http://jfs.ohio.gov/OHP/HIT%20Program.stm*)

As of May 2, 15 states have launched their Medicaid EHR incentive programs, and seven states have issued incentive payments to Medicaid EPs and eligible hospitals that have adopted, implemented, or upgraded certified EHR technology. CMS looks forward to announcing the launches of additional states' programs in the coming months.

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

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Source: CMS PERL 201105-07

New materials posted to the EHR website

New Medicare attestation resources

The Centers for Medicare & Medicaid Services (CMS) has developed attestation worksheets to help providers successfully attest to meeting meaningful use through the CMS Web-based attestation system.

These attestation worksheets allow eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) to log additional data for core and menu measures that might not be obtained only through their certified electronic health record (EHR) system. In order to provide complete and accurate information for certain of these measures, EPs and hospitals may have to include information from paper-based patient records or from other areas. (Please note that clinical quality measures must be reported directly from certified EHR technology.)

You can fill out the attestation worksheets electronically or manually, and then keep the worksheet on hand as you attest so your data is easily accessible.

You can find the worksheets by clicking the links below. Make sure to use the worksheet that pertains to you:

- *Attestation Worksheet for Eligible Professionals* (*https://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_Worksheet.pdf*)
- *Attestation Worksheet for Eligible Hospitals and Critical Access Hospitals* (*https://www.cms.gov/EHRIncentivePrograms/Downloads/Hospital_Attestation_Worksheet.pdf*)

Updates to the comprehensive EHR incentive program FAQs document

CMS has also posted the latest frequently asked questions (FAQs) document at *http://www.cms.gov/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf*. This interactive document provides updated FAQs up to the end of April 2011. Each FAQ is sorted by topic to help you more easily review information about various aspects of the EHR incentive programs. CMS will continue to provide updates as new FAQs are added.

Want more information about the EHR incentive programs?

For the latest news and updates on the EHR incentive programs, visit the CMS EHR Incentive Programs website at *http://www.cms.gov/EHRIncentivePrograms/.*

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

Source: CMS PERL 201105-25

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

Provider types affected

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

What you need to know

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

Background

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

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

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

Documentation of face-to-face encounters must be present on certifications for patients starting care on or after January 1, 2011.

Home health prospective payment system (HHPPS) final rule implementation provisions

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

- Documentation regarding these face-to-face encounters must be present on certifications for patients with starts of care on and after January 1, 2011.
- As part of the certification form itself, or as an addendum to it, the physician must document when the physician or allowed NPP saw the patient, and document how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.
- The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.
- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or NPP must see the patient within 30 days after admission. Specifically:
  - If the certifying physician or NPP had not seen the patient in the 90 days prior to the start of care, a visit within 30 days of start of care would be required.
  - If a patient saw the certifying physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that accepted standards of practice would preclude the physician from ordering services without the physician or an NPP first examining the patient.

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

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

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Encounter...*continued*

- The law allows the face-to-face encounter to occur via telehealth, in rural areas, in an approved originating site.

Plan of care (POC) and certification clarifications

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

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

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

Additional information

Medicare home health plays a vital role in allowing patients to receive care at home as an alternative to extended hospital or nursing home care. Questions and answers regarding this requirement will be available via Medicare's home health agency website at *http://www.cms.gov/center/hha.asp*.

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Physician certification and recertification of services manual changes

Background

CMS is including the following clarifications to Chapter 4, Physician Certification and Recertification of Services, of Pub. 100-01, the *Medicare General Information, Eligibility, and Entitlement Manual*:

Due to new provisions mandated by passage of the Affordable Care Act, there are new statutory requirements regarding face-to-face encounters for certifications applicable to the home health and hospice programs that must be updated in Chapter 4.

Policy

Sections 6407 and 3132 of the Affordable Care Act require these face-to-face encounters with a physician for home health and hospice certifications. Details of the policy are provided in the above-mentioned chapter.

For complete details on these manual changes, see the official instruction, CR 7377, issued to your FI, A/B MAC, and RHHI at *http://www.cms.gov/transmittals/downloads/R68GI.pdf*.

Manual changes for therapy services in home health

Note: This article was revised to reflect the revised change request (CR) 7374 issued on May 6, 2011. The CR release date, transmittal number, and the Web address for accessing CR7374 were revised. Per the revised CR, the article was updated with two minor editorial changes. All other information remains the same. This information was previously published in the April 2011 *Medicare A Connection*, pages 16-17.

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 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.

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 which services are provided, a qualified therapist (instead of an assistant) must provide the ordered

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Therapy...*continued*

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 the 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/R144BP.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 are available on the home health agency center of the CMS website at *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*.

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Power mobility device face-to-face examination checklist

Provider types affected

This Special Edition (SE) *MLN Matters*® article is intended for physicians or treating practitioners who prescribe a power mobility device (PMD) for Medicare beneficiaries. (In addition to a physician; a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD.) The article should also be of interest to durable medical equipment (DME) suppliers who submit claims to DME Medicare administrative contractors (DME MACs) for such equipment.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article as solely an educational guide to improve compliance with documentation requirements for the face-to-face examination that occurs prior to the physician or treating practitioner ordering a PMD for their Medicare patients. The article presents a checklist, which is a tool that providers may wish to use for this examination, in addition to some helpful tips to help providers and suppliers avoid denial of their PMD claims. **The use of this guide is not mandatory and does not ensure Medicare payment for a PMD, even if signed and dated.**

Background

Power wheelchairs and power operated vehicles (also known POVs or scooters) are collectively classified as power mobility devices (PMDs) and are covered under the Medicare Part B benefit. CMS defines a PMD as a covered item of DME that includes a power wheelchair or a POV that a beneficiary uses in the home. Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as mobility assistive equipment (MAE), which includes a continuum of technology from canes to power wheelchairs.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of portions of the medical record essential for supporting the medical necessity for the PMD in the beneficiary's home. In order to document the need for a PMD there are a few specific statutory requirements that must be met before the prescription is written:

1. An in-person visit between the ordering physician and the beneficiary must occur. This visit must document the decision to prescribe a PMD.
2. A medical evaluation must be performed by the ordering physician. The evaluation must clearly document the patient's functional status with attention to conditions affecting the beneficiary's mobility and their ability to perform activities of daily living within the home. This may be done all or in part by the ordering physician. If all or some of the medical examination is completed by another medical professional, the ordering physician must sign off on the report and incorporate it into their records.
3. Items 1 and 2 together are referred to as the face-to-face exam. Only after the face-to-face examination is completed may the prescribing physician write the prescription for a PMD. This prescription has seven required elements and is referred to as the seven-element order which must be entered on the prescription only by the physician.
4. The records of the face-to-face examination and the seven-element order must be forwarded to the PMD supplier within 45 days of the completion of the face-to-face examination
5. CMS' national coverage determination requires consideration as to what other items of mobility assistive equipment (MAE), e.g., canes, walkers, manual wheelchair, etc., might be used to resolve the beneficiary's mobility deficits. Information addressing MAE alternatives must be included in the face-to-face medical evaluation.

CMS offers a checklist that providers may wish to use in the examination and documentation process and can be found in the *Attachment* section at the end of this article. The checklist contains the information that is essential for Medicare to determine the medical necessity of the PMD. **Please note, the checklist contained in this article is a guide and does not replace the underlying medical records.** The checklist outlines the information that is essential for Medicare to have in determining whether payment should be made for a PMD. It is provided for educational purposes and serves to help providers understand the types of information which Medicare believes is critical for providers to document the patient's medical need in the home and that the device can be used safely.

The evaluation should be tailored to the individual patient's conditions. The medical history should contain a well-documented description of your patient's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability.

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Device...*continued*

Tips to avoid denial of PMD claims

Medical records should contain enough information to support the coverage for a PMD. Currently, audits show medical records commonly lack documentation that justifies the need for payment.

The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must be directly related to the patient's use of a PMD. Key items to be addressed are:

- Why does the patient require the use of a PMD in the home to safely and effectively accomplish activities of daily living (ADLs)?
  - Examples of ADLs include but are not limited to bathing, grooming, dressing, toileting.
  - What are important medical history factors that demonstrate the patient's mobility limitations?
- Do the physical examination findings support the patient's claimed functional status (mobility level)?
  - **Physical examination (PE):** The information provided in the PE must support the pertinent history above. The information must not be recorded in vague and subjective terms (e.g., weak, breathless, tired, etc.), but instead must provide quantifiable, objective measures or tests of the abnormal characteristic (e.g., range of motion; manual muscle test scores; heart rate/respiratory rate/pulse oximetry). Each medical record is expected to be individualized to the unique characteristics of the patient. **Included in all exams must be a detailed description of the patient's observed ability or inability to transfer and/or walk.** Examples of other patient physical findings that would commonly be relevant to describe medical need for and ability to use a PMD include:
    - Height and weight ;
    - Limb abnormalities;
    - Strength, tone, coordination, reflexes, balance;
    - Heart rate, blood pressure, respiratory rate (at rest and with exertion)
    - Joint swelling, range of motion, erythema, subluxation;
    - Description of limb loss; and
    - Cardiopulmonary exam
- If the patient is thought to require a PMD due to **respiratory** illness or injury:
  - Does the patient use home oxygen? If yes, what is the frequency, duration, delivery system, and flow rate denoted? How far does the patient report that she/he can walk or self-propel a manual wheelchair before becoming short of breath (with best oxygenation provided)? Describe the ADLs that make him/her short of breath in the home (with best oxygenation provided) and the interventions that palliate them. How have these signs/symptoms changed over time?
- If the patient is thought to require a PMD due to **cardiovascular** illness or injury:
  - Specifically, describe any clinically significant increased heart rate, palpitations, or ischemic pain that occurs or worsens when the patient attempts or performs ADLs within the home (with best oxygenation provided)? What palliates these signs/symptoms? How far does the patient report that she/he can walk or self-propel a manual wheelchair before experiencing these signs/symptoms? How have these signs/symptoms changed over time?
- If the patient is thought to require a PMD due to **neuromusculoskeletal** illness or injury or malformed body member:
  - Describe the patient's impairments. For example, does the patient exhibit joint/bone signs/symptoms, changes in strength, coordination or tone? How do these signs/symptoms relate to the patient's functional state and the ability to perform ADLs in specific? How far does the patient report that she/he can walk or self-propel a manual wheelchair before these signs/symptoms interrupt that activity? How have these signs/symptoms changed over time?

Illustrative example of medical record documentation

This entry may result in a claim denied:

Mr. Smith is a male, age 72, with chronic obstructive pulmonary disease (COPD) who over the last few weeks has been having more shortness of breath (SOB). He states he is unable to walk for me today because he is too tired. Therefore he needs a PMD.

Instead consider an entry with this level of detail and support:

Mr. Smith is a 72 yo male with COPD, worsening gradually over the past year despite compliant use of XYZ meds, nebulizers and rescue inhalers. PFT's (attached) demonstrate the decline in lung function over the last 12 months. Now with the constant use of 2-3L NC O2 at home for the last month, he still can no longer walk to the bathroom, about 30 feet from his bed without significant SOB and overall discomfort. The kitchen is further from his bed. He says his bed/

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Device...*continued*

bath doorways and halls are wide enough for a scooter that will bring him to his toilet, sink and kitchen, all of which are on the same floor.

VS 138/84, Ht rate 88 RR 16 at rest on 3L NC

Vision – sufficient to read newspaper with glasses on

Cognition- OX3. Able to answer my questions without difficulty.

Ht XX Wt YY

Ambulation – Sit to stand was done without difficulty. Patient attempted to ambulate 50' in hallway, but needed to stop and rest 2 x's before he could accomplish. HR at first stop point (about 25') was 115 and RR was 32. Patient became slightly diaphoretic.

Lung exam – Hyperresonant percussion and distant breath sounds throughout. Occ wheezes.

Neuro – Hand grips of normal strength bilat. Patient able to maintain sit balance when laterally poked.

Steps carefully around objects in the room.

Alternative MAE equipment – Pt has attempted to use cane, walker or manual wheelchair unsuccessfully due to extreme fatigue with slight exertion described above.

Assessment – Pt seems good candidate for a scooter to carry him the necessary distances in his home to use toilet/sink and kitchen facilities. Home seems amenable to this device.

Accurate and complete documentation in the physician records regarding the face-to-face examination is extremely important to ensure the patient receives an appropriate PMD.

Additional information

If you have any questions, please visit the website of your DME MAC or contact them at their toll-free number. Their Web address and toll-free number are available at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

Attachment – Sample checklist for the PMD examination

Please note, this checklist is not mandatory and does not replace the underlying medical records.

The medical record for the patient includes the following history:

_____ Signs/symptoms that limit ambulation;

_____ Diagnoses that are responsible for these signs/symptoms;

_____ Medications or other treatment for these signs/symptoms;

_____ Progression of ambulation difficulty over time;

_____ Other diagnoses that may relate to ambulatory problems;

_____ How far the patient can ambulate without stopping and with what assistive device, such as a cane or walker;

_____ Pace of ambulation;

_____ History of falls, including frequency, circumstances leading to falls, what ambulatory assistance (cane, walker, wheelchair) is currently used and why it is not sufficient;

_____ What has changed in the patient's condition that now requires the use of a power mobility device;

_____ Reason for inability to use a manual wheelchair; such as assessment of upper body strength;

_____ Why does the patient need a power wheelchair rather than each level of mobility assistive equipment (cane, walker, optimally configured manual wheelchair, scooter)? What are the reasons that the patient should not or could not use other mobility assistive equipment in the home to satisfy their needs?; and

_____ Description of the home setting, including the ability to perform activities of daily living, as well as the ability to utilize the PMD in the home.

The physical examination is relevant to the patient's mobility needs and the medical record for the patient contains:

_____ Weight and height

_____ Musculoskeletal examination

- Arm and leg strength and range of motion;

_____ Neurological examination

- Gait
- Balance and coordination
- If the patient is capable of walking, the report should include a documented observation of ambulation (with use of cane or walker as appropriate)

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Screening for the human immunodeficiency virus infection

Note: This article was revised on April 27, 2011, to reflect the revised change request (CR) 6786, which was issued on April 22, 2011. In this article, the CR transmittal number, release date, and the Web address for accessing the CR were changed. All other information is the same. This information was previously published in the March 2011 *Medicare A Bulletin*, pages 51-53.

Provider types affected

This article is for all physicians, providers, and clinical diagnostic laboratories submitting claims to Medicare contractors [fiscal intermediaries (FI), carriers, and Part A/B Medicare administrative contractors (A/B MAC)] for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) has issued a new national coverage determination (NCD) that the evidence is adequate to conclude that screening for HIV infection is reasonable and necessary for prevention or early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Caution – what you need to know

Effective for claims with dates of service on and after December 8, 2009, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries, subject to the criteria in the *National Coverage Determination (NCD) Manual*, Sections 190.14 and 210.7, and the *Medicare Claims Processing Manual* (CPM), Chapter 18, Section 130. These manual sections are attached to the transmittals, which comprise CR 6786. This article is based on CR 6786, which provides the clinical and billing requirements for HIV screening tests for male and female Medicare beneficiaries, including pregnant Medicare beneficiaries.

Go – what you need to do

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

Background

Effective January 1, 2009, the CMS is authorized to add coverage of "additional preventive services" through the NCD process if certain statutory requirements are met, as provided under section 101(a) of the Medicare Improvements for Patients and Providers Act (MIPPA). One of those requirements is that the services be categorized as a grade A (strongly recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. The USPSTF strongly recommends screening for all adolescents and adults at risk for HIV infection, as well as all pregnant women.

Consequently, CMS will cover both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for:

- One annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines and in accordance with CR 6786.

  Note: 11 full months must elapse following the month in which the previous test was performed in order for the subsequent test to be covered.

- Three voluntary HIV screenings of pregnant Medicare beneficiaries at the following times: (1) when the diagnosis of pregnancy is known, (2) during the third trimester, and (3) at labor, if ordered by the woman's clinician.

  Note: Three tests will be covered for each term of pregnancy beginning with the date of the first test.

The USPSTF guideline upon which this policy is based contains eight increased-risk criteria. The first seven require the presence of both diagnosis codes V73.89 (Special screening for other specified viral disease) and V69.8 (Other problems related to lifestyle) for the claim to be paid. The last criterion, which covers persons reporting no increased risk factors, only requires diagnosis code V73.89 for the claim to be paid.

Note: Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following three new codes are to be implemented April 5, 2010, effective for dates of service on and after December 8, 2009, with the April 2010 outpatient code editor and the January 2011 clinical laboratory fee schedule (CLFS) updates:

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Screening...*continued*

- G0432 – infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
- G0433 – infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening, and
- G0435 – infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening.

Claims for the annual HIV screening must contain one of the new HCPCS along with a primary diagnosis code of V73.89, and when increased risk factors are reported, a secondary diagnosis code of V69.8. For claims for pregnant women, one of the new HCPCS codes must be reported with a primary diagnosis code of V73.89 and one secondary diagnosis code of either V22.0 (Supervision of normal first pregnancy), V22.1 (Supervision of other normal pregnancy), or V23.9 (Supervision of unspecified high-risk pregnancy). Institutional providers should also report revenue code 030X for claims for HIV screening.

When claims for HIV screening are denied because they are not billed with the proper diagnosis code(s) and/or HCPCS codes, Medicare will use a claim adjustment reason code (CARC) of 167 (This (these) diagnosis(es) is (are) not covered.). Where claims are denied because of edits regarding frequency of the tests, a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) will be used.

Medicare will pay for HIV screening tests for hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission (types of bills 12x, 13x, or 14x) on an inpatient Part B or outpatient basis in accordance with the terms of the Maryland waiver.

Prior to inclusion of the new G-codes on the CLFS, the above codes will be contractor-priced. Also, for dates of service between December 8, 2009, and April 4, 2010, unlisted procedure code 87999 may be used when paying for these services.

Note that for HIV screening claims with dates of service on or after December 8, 2009, through July 6, 2010, and processed before CR 6785 is implemented, Medicare will not adjust such claims automatically. However, your Medicare contractor will adjust such claims that you bring to their attention.

Additional information

CR 6786 consists of two transmittals, the first of which is at *http://www.cms.gov/Transmittals/downloads/R2163CP.pdf* and that transmittal updates the *Medicare Claims Processing Manual*. The other transmittal at *http://www.cms.gov/Transmittals/downloads/R131NCD.pdf* updates Medicare's NCD manual.

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

MLN Matters® Number: MM6786 *Revised*
Related Change Request (CR) #: 6786
Related CR Release Date: February 23, 2010
Effective Date: December 8, 2009
Related CR Transmittal #: R2163CP and R131NCD
Implementation Date: July 6, 2010

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

Try our E/M interactive worksheet

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

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. **Note:** Effective July 1, 2011, line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **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.**

Self-administered drug list (SAD) – Part A: J1559

The Centers for Medicare & Medicaid Services (CMS) provide 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 18, 2011**, the following drug has been added to the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A self-administered drug (SAD) list.

- J1559 Injection, immune globulin, (hizentra), 100 mg

The evaluation of drugs for addition to the SAD list is an on-going 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 through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

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.

Claim adjustment reason code and remittance advice remark code update

Provider types affected

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

Provider action needed

Change request (CR) 7369, from which this article is taken, announces the latest update of remittance advice remark codes (RARCs) and claim adjustment reason codes (CARCs) that are effective on July 1, 2011, for Medicare. Be sure your billing staff is aware of these changes.

Background

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

Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Washington Publishing Company (WPC) website. The following lists summarize the latest changes to these codes, as announced in CR 7369.

Additional information

To see the official instruction (CR 7369) issued to your Medicare carrier, RHHI, DME MAC, FI and/or MAC, refer to *http://www.cms.gov/Transmittals/downloads/R2213CP.pdf*.

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

CR 7369 changes

New codes – CARC

Code	Current narrative	Effective date per WPC posting
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	January 30, 2011

Modified codes – CARC:

None

Deactivated codes – CARC:

None

New codes – RARC:

Code	Current narrative	Medicare initiated
N542	Missing income verification.	No
N543	Incomplete/invalid income verification.	No

Modified codes – RARC:

Code	Current narrative	Medicare initiated
M37	Not covered when the patient is under age 35.	No
M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.	No

continued on next page

Code...*continued*

Code	Current narrative	Medicare initiated
N62	Dates of service span multiple rate periods. Resubmit separate claims.	No
N356	Not covered when performed with, or subsequent to, a non-covered service.	No
N383	Not covered when deemed cosmetic.	No
N410	Not covered unless the prescription changes.	No
N428	Not covered when performed in this place of service.	No
N429	Not covered when considered routine.	No
N431	Not covered with this procedure.	No

Deactivated codes – RARC:
None

MLN Matters® Number: MM7369
Related Change Request (CR) #: 7369
Related CR Release Date: May 6, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2213CP
Implementation Date: July 5, 2011

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June 15 is National Version 5010 Testing Day

The version 5010 compliance date – Sunday, January 1, 2012 – is fast approaching. All HIPAA-covered entities should be taking steps now to get ready, including conducting external testing to ensure timely compliance. Are you prepared for the transition? Medicare fee-for-service (FFS) trading partners are encouraged to contact their Medicare administrative contractors (MACs) now and facilitate testing to gain a better understanding of MAC testing protocols and the transition to version 5010.

To assist in this effort, the Centers for Medicare & Medicaid Services (CMS), in conjunction with the Medicare FFS program, announces a National 5010 Testing Day to be held Wednesday, June 15, 2011. National 5010 Testing Day is an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs.

CMS encourages all trading partners to participate in the National 5010 Testing Day. This includes:

- Providers
- Clearinghouses
- Vendors

More details concerning transactions to be tested are forthcoming. Additionally, there are several state Medicaid agencies that will be participating in the National 5010 Testing Day; more details will follow.

Take advantage of this opportunity to test with real-time help desk support.

Again, CMS National 5010 Testing Day does not preclude trading partners from testing transactions immediately with their MAC. Don't wait. You are encouraged to begin working with your MAC now to ensure timely compliance. Note that successful testing is required before a trading partner may be placed into production.

CMS hopes all trading partners will join it on Wednesday, June 15 and take advantage of this great opportunity to ensure testing and transition efforts are on track. For more information on HIPAA Version 5010, 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 201105-06

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

During the transition to Health Insurance Portability and Accountability Act (HIPAA) versions 5010 and D.0., you will be periodically reminded of important items and dates that may be of specific interest to the Medicare fee-for-service (FFS) provider/supplier community. See below to learn about current, upcoming, and past events that have taken place during this implementation process.

Important implementation reminders

Announcement: January 1, 2011, marked the beginning of the 5010/D.0. transition year

Announcement: Versions 5010 & D.0 FAQs now available (**New**) (*https://questions.cms.hhs.gov/app/answers/list/kw/5010*)

Announcement: National Testing Day message now available (**New**) (*http://www.cms.gov/Versions5010andD0/Downloads/5010_National_Testing_Day_Message.pdf*)

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

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

Readiness assessment: Have you done the following to be ready for 5010/D.0.? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_1.pdf)*

Readiness assessment: What do you need to have in place to test with your Medicare administrative contactor (MAC)? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf)*

Readiness assessment: Do you know the implications of not being ready? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf)*

Implementation calendar

Current events

May 2011
May 2-5: 20th Annual WEDI National Conference *
(*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11917000006F1)*
May 25: CMS-hosted Medicare fee-for-service national call – call to action – test!
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1247188&intNumPerPage=10)*

Upcoming events

June 2011
June 15: National MAC testing day (for vendors, clearinghouses, and billing services, etc.)

July 2011
July 20: MAC hosted outreach and education session – troubleshooting with your MAC

August 2011
August 24: National MAC testing day (for providers)
August 31: CMS-hosted Medicare fee-for-service national call – MAC panel

October 2011
October 5: MAC hosted outreach and education session (last push for implementation)
October 24-27: WEDI 2011 fall conference*
(*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=11927000002B1)*

December 2011
December 31: End of the transition year, and the beginning of 5010 production environment

Past events

June 2010
June 15: 5010 national call – ICD-10/5010 national provider call
(*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237787&intNumPerPage=10)*

continued on next page

Calendar...*continued*

June 30: 5010 national call – 837 institutional claim transaction (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1236487&intNumPerPage=10*)

July 2010
July 28: 5010 national call – 276/277 claim status inquiry and response transaction set (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1237767&intNumPerPage=10*)

August 2010
August 25: 5010 national call – 835 remittance advice transaction (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1238739&intNumPerPage=10*)

September 2010
September 27: 5010 national call – acknowledgement transactions (TA1, 999, 277CA) (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1239741&intNumPerPage=10*)

October 2010
October 13: 5010/D.0. errata requirements and testing schedule released (*http://www.cms.gov/Versions5010andD0/Downloads/Errata_Req_and_Testing.pdf*)
October 27: 5010 national call – NCPDP version D.0. transaction (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1240794&intNumPerPage=10*)

November 2010
November 4: Version 5010 resource card published (*http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf*)
November 8: WEDI 2010 fall conference* (*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=C31C0000002C*)
November 17: 5010 national call – coordination of benefits (COB) (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241427&intNumPerPage=10*)

December 2010
December 8: 5010 national call – MAC outreach and education activities and transaction-specific testing protocols (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1241855&intNumPerPage=10*)

January 2011
January 1: Beginning of transition year
January 11: HIMSS 5010 industry readiness update* (*http://www.himss.org/asp/UnknownContent.asp?type=evt*)
January 19: 5010 national call – errata/companion guides (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1243131&intNumPerPage=10*)
January 25-27: 4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway* (*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=12B9F00000029*)

February 2011
February 20-24: HIMSS 11th Annual Conference & Exhibition* (*http://www.himss.org/ASP/eventsHome.asp*)

March 2011
March 1: New readiness assessment – Do you know the implications of not being ready? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf*)
March 30: CMS-hosted 5010 national call – provider testing and readiness (*http://www.cms.gov/Versions5010andD0/V50/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1244551&intNumPerPage=10*).

April 2011
April 4-11: Version 5010 test education week
April 27: MAC hosted outreach and education session – are you ready to test?

For older national call information, visit *http://www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage*.

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

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

Source: CMS PERL 201105-15

New HCPCS Q-codes for 2010-2011 seasonal influenza vaccines

Note: This article was revised on April 25, 2011, to reflect a revised change request (CR) 7234 issued on April 22. The CR 7234 was revised to update the price of HCPCS code Q2036 to $8.784 retroactive to October 1, 2010. This article was revised accordingly. This information was previously published in the December 2010 *Medicare A Bulletin*, pages 10-12.

Provider types affected

This article is for physicians and providers submitting claims to Medicare contractors [carriers, fiscal intermediaries (FIs), and/or Part A/B Medicare administrative contractors (A/B MACs)] for influenza vaccines provided to Medicare beneficiaries.

Provider action needed

The article is based on CR 7234 which establishes separate billing codes for each brand-name influenza vaccine product under *Current Procedural Terminology* (*CPT*) code *90658* and describes the process for updating the new specific Healthcare Common Procedure Coding System (HCPCS) codes and their payment allowances for Medicare during the 2010-2011 influenza season.

Background

CMS has created specific HCPCS codes and payment allowances to replace *CPT* code *90658* for Medicare billing purposes for the 2010-2011 influenza season.

Key points of CR 7234

The following describes the process for updating these specific HCPCS codes for Medicare payment effective for dates of service on or after October 1, 2010.

Effective for claims with dates of service on or after January 1, 2011, the following *CPT* code will no longer be payable for Medicare:

CPT code	Short description	Long description
90658	Flu vaccine, 3 yrs & >, im	*Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use*

Effective for claims with dates of service on or after October 1, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS code	Short description	Long description
Q2035	Afluria vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	Flulaval vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)
Q2037	Fluvirin vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	Fluzone vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	NOS flu vacc, 3 yrs & >, im	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified

Note: *CPT 90658* describes the regular dose vaccine that is supplied in a multi-dose vial for use in patients over three years of age. For dates of service on or after October 1, 2010, HCPCS codes Q2035, Q2036, Q2037, Q2038 and Q2039 (as listed in the table above) will replace the *CPT* code *90658* for Medicare payment purposes during the 2010-2011 influenza season. However, these HCPCS codes will not be recognized by the Medicare claims processing systems until January 1, 2011, when *CPT* code *90658* will no longer be recognized.

This instruction does not affect any other *CPT* codes. It is very important to distinguish between the various *CPT* and HCPCS codes which describe the different formulations of the influenza vaccines (i.e., pediatric dose, regular dose, high dose, preservative free, etc.). As a reference, the quarterly Part B drug pricing files includes a set of National Drug Code (NDC) to HCPCS crosswalks available at *http://www.cms.gov/McrPartBDrugAvgSalesPrice/*.

continued on next page

Q-codes...*continued*

Billing

In general, it is inappropriate for a provider to submit two claims for the same service on the same date. For dates of service between October 1, 2010, and December 31, 2010, the *CPT 90658* and the Q-codes will be valid for billing; however, providers may not bill Medicare for both the *CPT 90658* and any of the Q-codes for the same patient for the same date of service. Thus, if a provider vaccinates a beneficiary on any date between October 1, 2010, and December 31, 2010, the provider may either bill Medicare immediately using *CPT 90658*, or hold the claim and wait until January 1, 2011, to bill Medicare using the most appropriate Q-code. If a claim has already been submitted and processed using *CPT 90658*, then there is no need to use the Q-code for that same service.

For dates of service on or after January 1, 2011, providers may only bill Medicare for one of the HCPCS codes that appropriately describes the specific vaccine product administered.

Payment

The Medicare Part B payment limits for influenza vaccines are 95 percent of the average wholesale price (AWP) except where the vaccine is furnished in a setting that follows a cost-based or prospective payment system under Medicare. For example, where the vaccine is furnished in the hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC), payment for the vaccine is based on reasonable cost.

For dates of service on or after October 1, 2010, the Medicare Part B payment allowances in other situations are:

HCPCS code	Allowance
Q2036	$8.784
Q2037	$13.253
Q2038	$12.593

No national payment limits are available for Q2035 and Q2039. The payment limits for these two codes will be determined by the local claims processing contractor.

For dates of service on or after September 1, 2010, the corrected Medicare Part B payment allowance for *CPT 90655* is $14.858.

Important notes

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, nonphysician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Be aware that Medicare contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR 7324. However, they will adjust such claims that you bring to their attention.

Additional information

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

For complete details regarding this CR please see the official instruction (CR 7234) issued to your Medicare A/B MAC, carrier or FI at *http://www.cms.gov/Transmittals/downloads/R884OTN.pdf*.

Providers should be aware that educational products are available through the MLN Catalogue free of charge at *http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf*. The specific products that may be of interest to providers who use the information in MM 7234 are as follows:

1. The *Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B)* (*http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf)*.
2. The *Adult Immunizations* brochure provides a basic overview of Medicare's influenza, pneumococcal and hepatitis B vaccine benefits (*http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf*).

MLN Matters® Number: MM7234 Revised
Related Change Request (CR): 7234
Related CR Release Date: April 22, 2011
Effective Date: October 1, 2010 unless otherwise specified
Related CR Transmittal #: R884OTN
Implementation Date: January 3, 2011

New K-codes for suction pumps and wound dressings

Provider types affected

Providers and suppliers who bill Medicare administrative contractors (A/B MACs) or durable medical equipment contractors (DME MACs) for providing suction pumps and accompanying surgical dressings to Medicare beneficiaries.

Provider action needed

Effective July 1, 2011, Medicare will allow four new K-codes for billing suction pumps and accompanying surgical dressings. Ensure that your billing staffs are aware of these new K-codes, which are effective for dates of service on or after July 1, 2011. The codes and their descriptors are as follows:

- K0743 – suction pump, home model, portable, for use on wounds;
- K0744 – absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less;
- K0745 – absorptive wound dressing for use with suction pump, home model; portable, pad size more than 16 square inches but less than or equal to 48 square inches; and
- K0746 – absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches.

Note: The coverage type for these codes is "C," and their coverage is subject to your contractor's discretion. Further, the addition of these codes does not imply their coverage by Medicare.

Additional information

You can find the official instruction, change request (CR) 7411, issued to your A/B MAC or DME MAC by visiting *http://www.cms.gov/Transmittals/downloads/R2206CP.pdf*.

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

MLN Matters® Number: MM7411
Related Change Request (CR) #: CR 7411
Related CR Release Date: April 29, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2206CP
Implementation Date: July 5, 2011

Coding rules for chemotherapy administration and non-chemotherapy injections and infusion services

First Coast Service Options Inc has identified a Medicare claim coding issue for chemotherapy administration and non-chemotherapy injections and infusion services. This issue impacts the following *Current Procedural Terminology* (*CPT*) codes:

- *96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour*

  Note: *CPT* code *96365* is effective January 1, 2009, replacing *CPT* code *90765*.

- *96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)*

  Note: *CPT* code *96369* is effective January 1, 2009, replacing *CPT* code *90769*.

- *96413 Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug*

When administering multiple infusions, injections, or combinations, the physician should report only one "initial" service code unless the protocol requires that two separate IV sites must be used. If more than one "initial' service code is billed per day, the second initial service code will be denied unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol.

Note: Use modifier 59 to note a separate identifiable service.

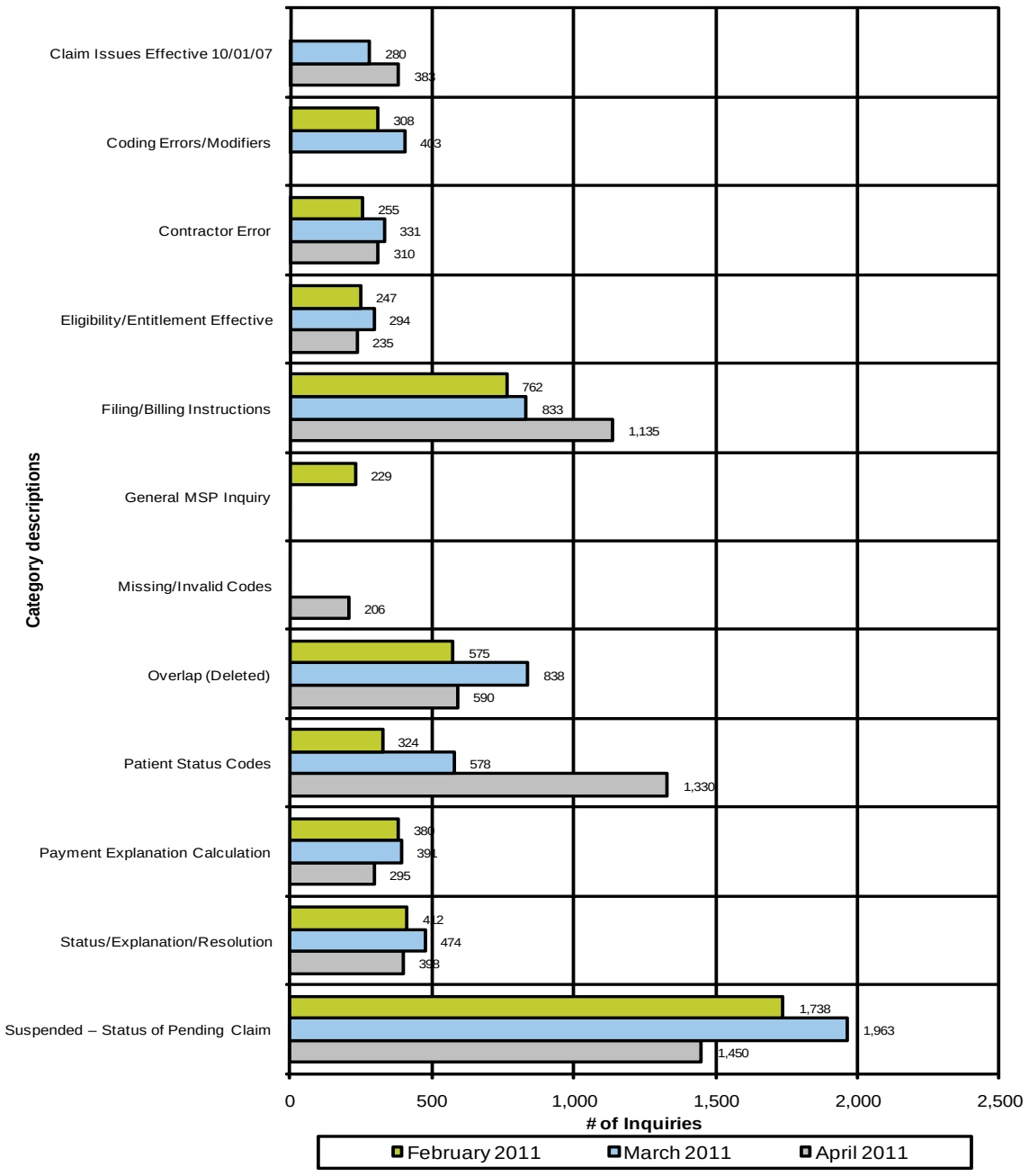
Source: Publication 100-04, Chapter 12, Section 30.5 (E)

Top inquiries, rejects, and return to provider claims – February-April 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 February-April 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 for February-April 2011



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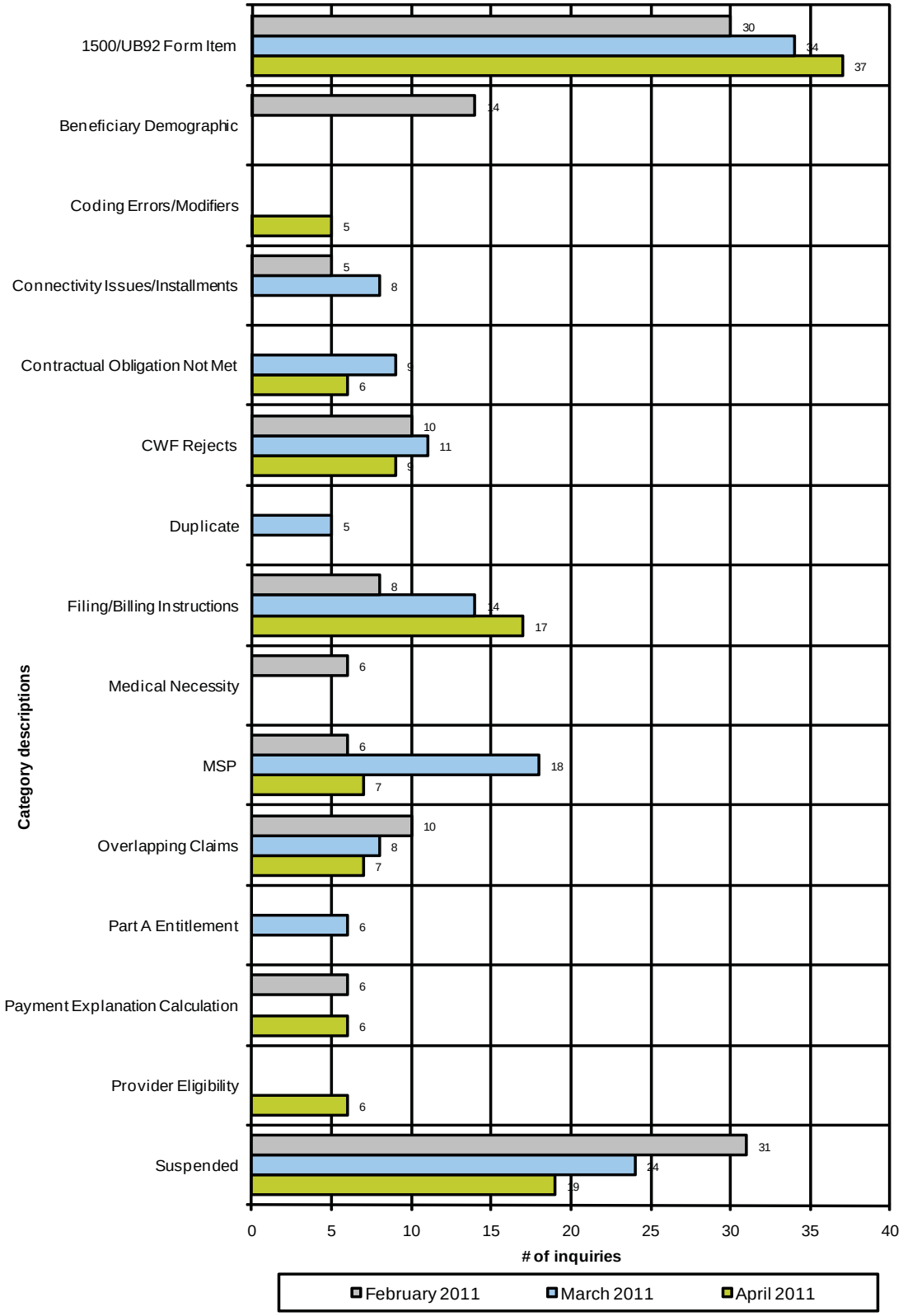
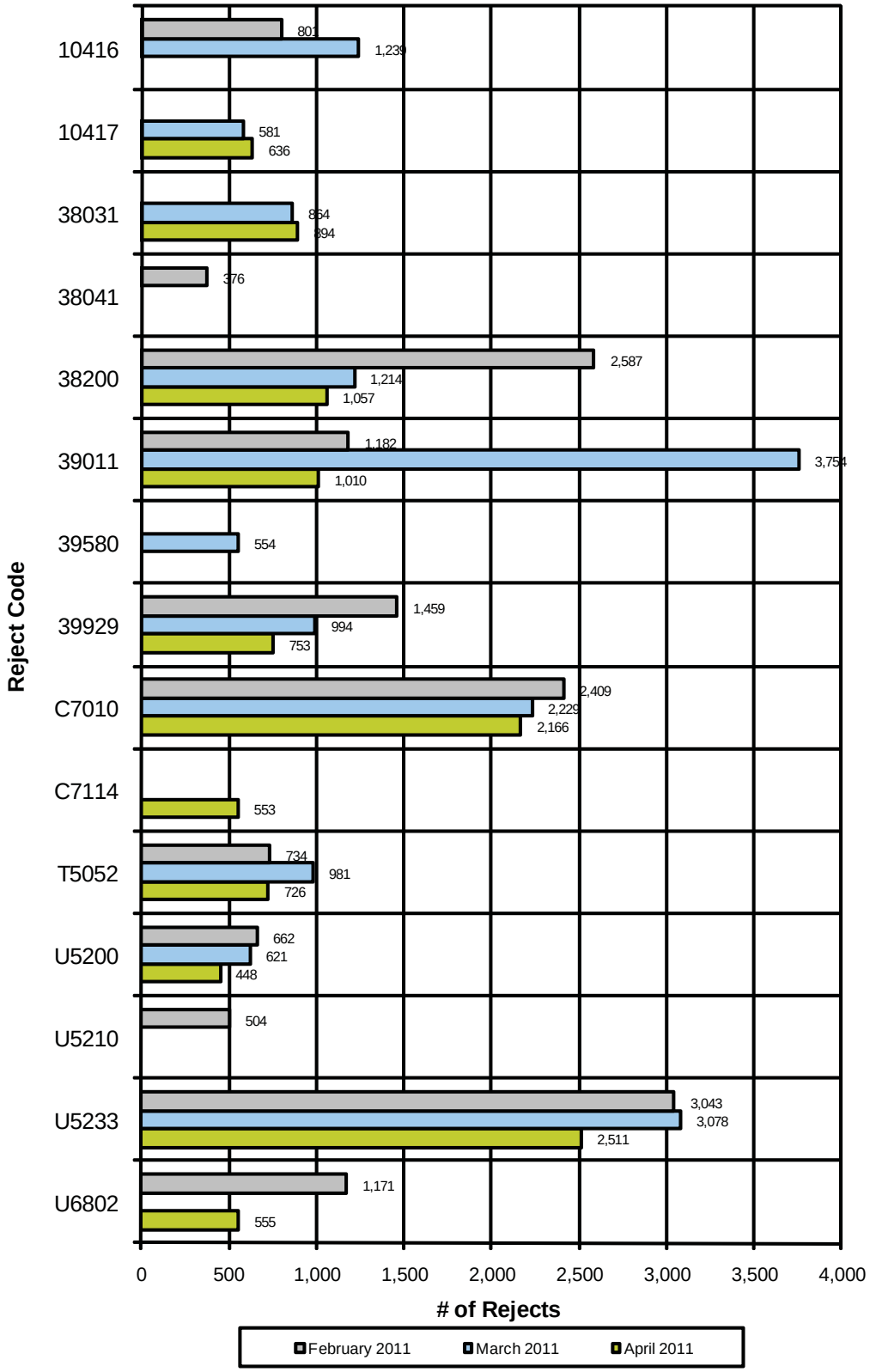
Inquiries...*continued*

Puerto Rico and U.S. Virgin Islands Part A top inquiries for February-April 2011



Florida Part A top rejects for February-April 2011



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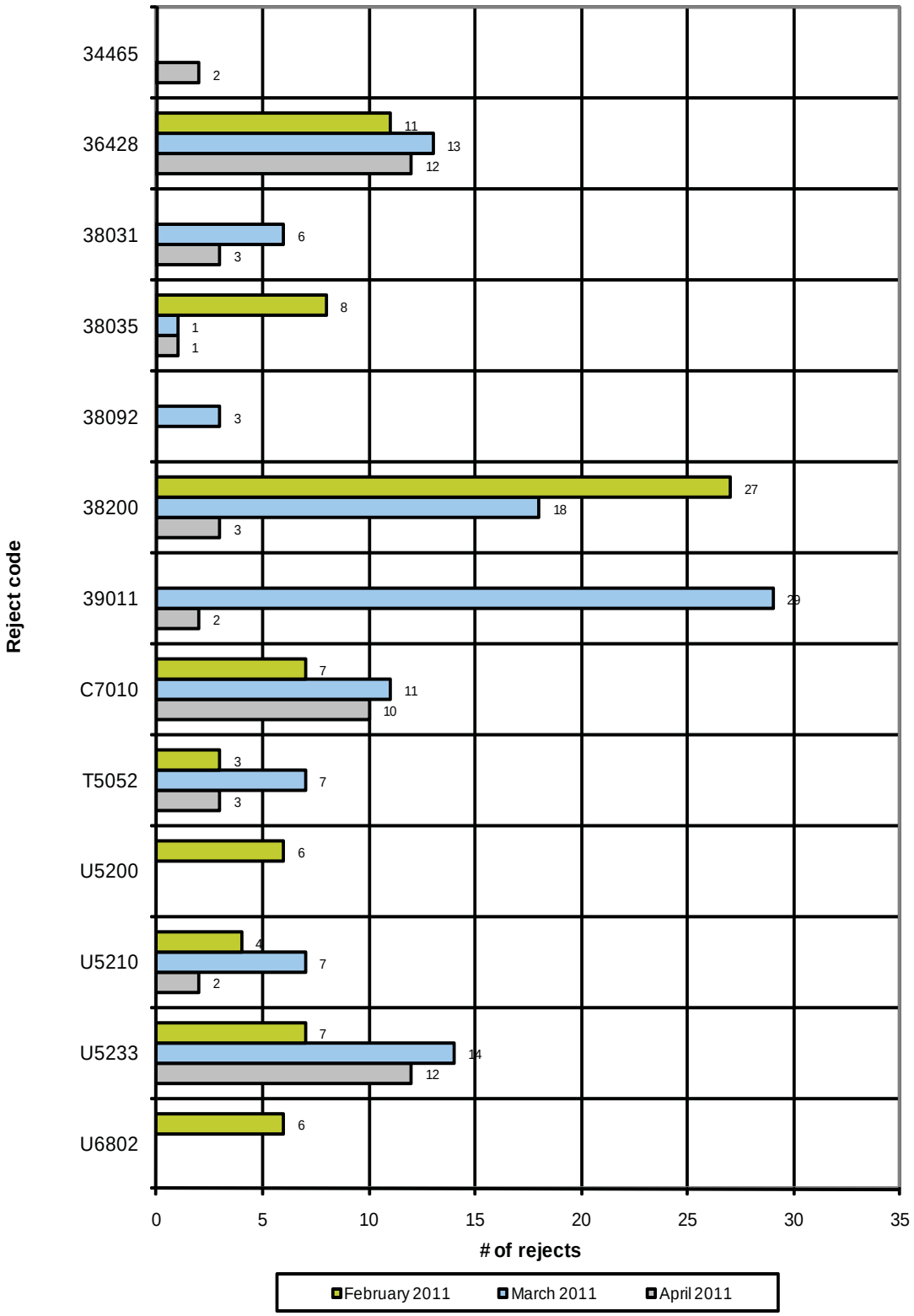
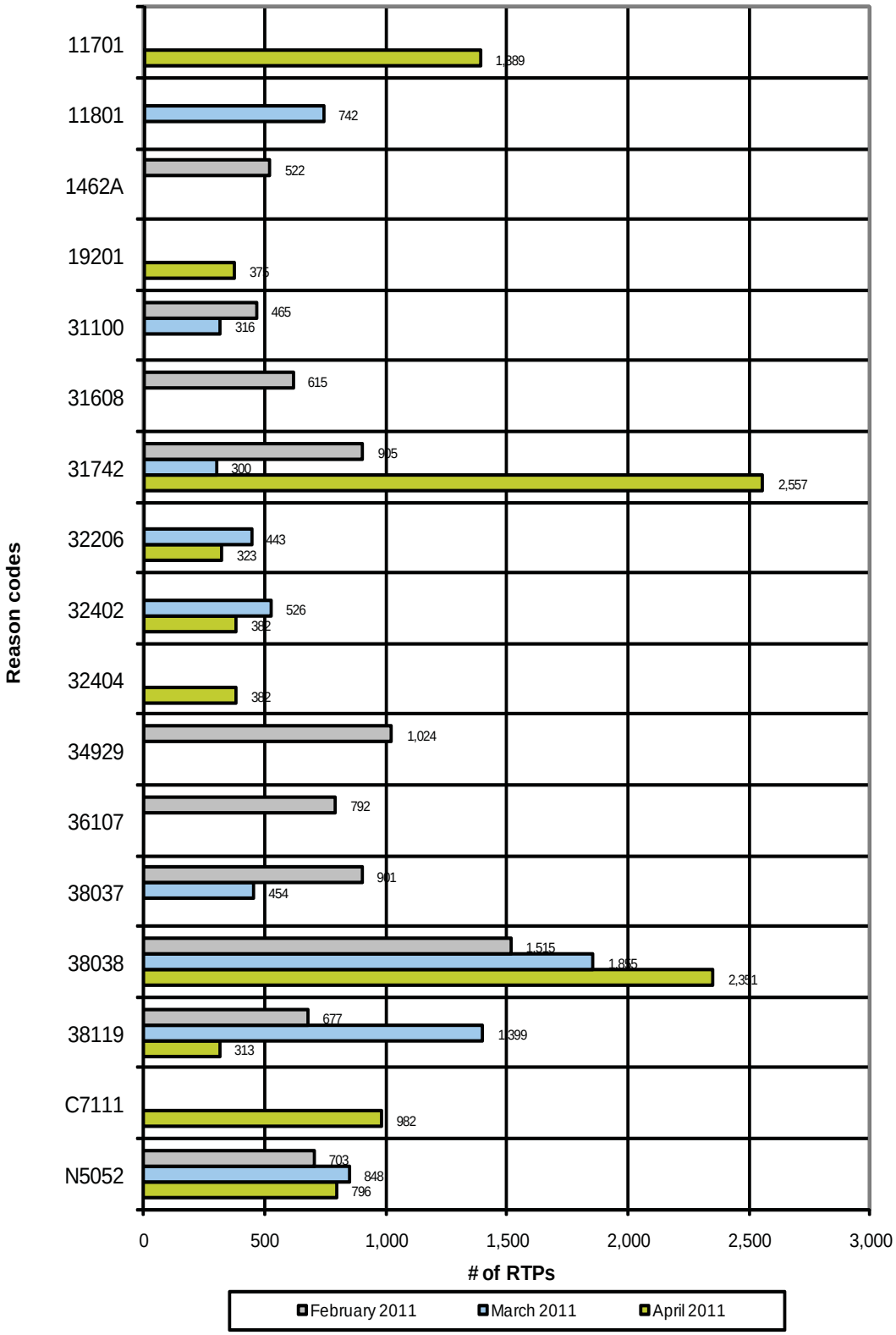
Rejects...*continued*

U.S. Virgin Islands Part A top rejects for February-April 2011



Florida Part A top return to providers (RTPs) for February-April 2011



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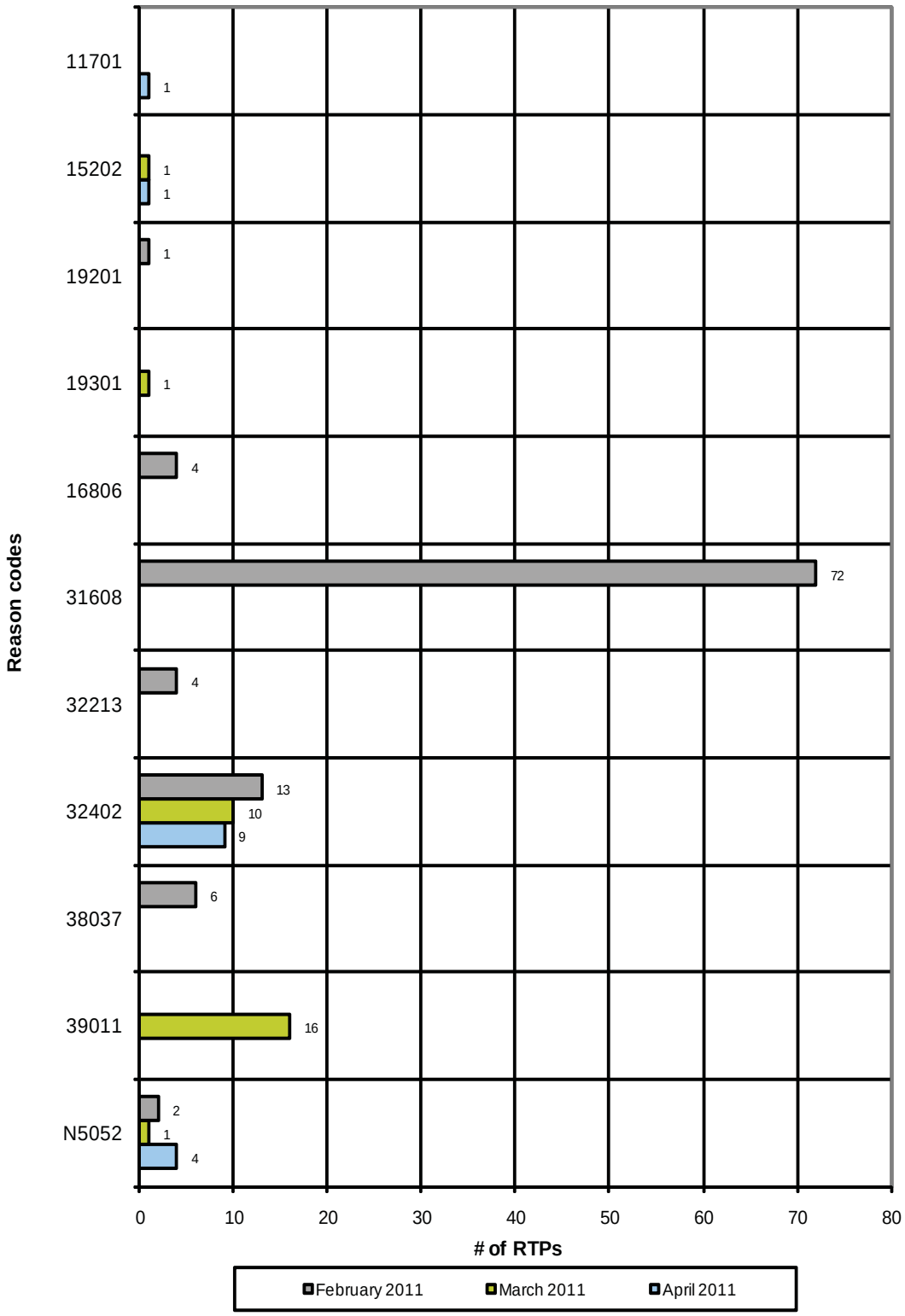
RTPs...*continued*

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



ESRD transition budget neutrality adjustment – correction

Provider types affected

Medicare certified end-stage renal disease (ESRD) facilities billing Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for ESRD dialysis services are affected.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7366 which corrects the ESRD transition budget neutrality adjustment.

Caution – what you need to know

CR 7366 instructs your Medicare contractors to amend the transition budget neutrality adjustment by replacing the 3.1 percent payment reduction to a zero percent payment budget neutrality adjustment for renal dialysis services provided on or after April 1, 2011. CR 7366 also instructs your Medicare contractor(s) to hold the ESRD claims with dates of service in April 2011 until the implementation of CR 7366 (April 9, 2011). Since ESRD claims are submitted monthly, April claims submitted in the first week of May will be held until May 9, 2011. This hold should not impact timely payments made to providers.

Go – what you need to do

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

Background

The Centers for Medicare & Medicaid Service (CMS) issued an interim final rule, which amends the ESRD transitional budget neutrality adjustment factor finalized in the calendar year (CY) 2011 ESRD prospective payment system (ESRD PPS) final rule published on August 12, 2010 (see *http://edocket.access.gpo.gov/2010/pdf/2010-18466.pdf* on the Internet). This adjustment will result in more accurate payments in CY 2011. Specifically, Section 1881(b)(14)(E)(iii) of the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1881.htm*) requires that an adjustment be made to payments for renal dialysis services provided by ESRD facilities during the transition so that estimated total amount of payments under the ESRD PPS, including payments under the transition, equals the estimated total amount of payments that would otherwise occur under the ESRD PPS without such a transition.

In the ESRD PPS final rule, CMS indicated that based on simulation of estimated payments, a 3.1 percent reduction would be applied to all payments made to Medicare certified ESRD facilities for renal-dialysis services provided on or after January 1, 2011, through December 31, 2011. CMS is amending this 3.1 percent reduction in the interim final rule to reflect the actual number of ESRD facilities that elected to receive 100 percent payment under the ESRD PPS.

As a result, a zero percent transition budget-neutrality adjustment will be applied to payments made to ESRD facilities for renal dialysis services provided on or after April 1, 2011, through December 31, 2011.

A zero percent transition budget-neutrality adjustment will be applied for services on or after April 1, 2011.

Also, CR 7366 instructs your Medicare contractors to hold the ESRD claims with dates of service in April 2011 until the implementation of CR 7366. Since ESRD claims are submitted monthly, April claims submitted in the first week of May will be held until May 9, 2011. This hold should not impact timely payments made to providers.

Additional information

The official instruction, CR 7366, issued to your FIs and A/B MACs may be viewed at *http://www.cms.gov/Transmittals/downloads/R887OTN.pdf*.

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

MLN Matters® Number: MM7366
Related Change Request (CR) #: CR 7366
Related CR Release Date: April 28, 2011
Effective Date: April 1, 2011
Related CR Transmittal #: R887OTN
Implementation Date: April 15, 2011

ESRD low volume adjustment and quarterly updates to the ESRD PPS

Provider types affected

End-stage renal dialysis providers submitting claims to Medicare contractors [fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)] for services provided to Medicare beneficiaries are affected.

What you need to know

This article is based on change request (CR) 7388 which provides instructions for the ESRD low volume adjustment for low volume facilities. CR 7388 allows for receiving the per treatment low volume adjustment payment after any applicable transitional blend is applied in a separate field.

Background

The end-stage renal disease (ESRD) prospective payment system (PPS) implemented on January 1, 2011, provides for payment adjustments to low volume facilities. The low volume adjustment is included in the per treatment PPS reimbursement amount that is sent from the Pricer program to the fiscal intermediary shared system (FISS).

End-stage renal dialysis providers may be eligible to receive a low volume facility adjustment to their rate if they meet certain criteria as outlined in CR 7064 (Transmittal 2134, dated January 14, 2011) as follows:

"Low-Volume Facility Adjustment: Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three (3) ears preceding the payment year. The 3 years preceding treatment data should be reflected on the last 2 settled cost reports and the most recent must be filed. The provider must notify their Medicare contractor if they believe they are eligible for the low-volume adjustment."

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

You can find CR 7064 at *http://www.cms.gov/transmittals/downloads/R2134CP.pdf* or its corresponding *MLN Matters*® article at *http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf*.

If they meet the above criteria, the ESRD facility must notify their Medicare contractor if they believe they are eligible for the low-volume adjustment.

CR 7388 allows for receiving the per treatment low volume adjustment payment after any applicable transitional blend is applied in a separate field.

Additional information

The official instruction, CR 7388, issued to your FIs and A/B MACs may be viewed at *http://www.cms.gov/Transmittals/downloads/R2195CP.pdf*. More information on the ESRD PPS is available at *http://www.cms.gov/ESRDPayment/01_Overview.asp*.

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

MLN Matters® Number: MM7388
Related Change Request (CR) #: CR 7388
Related CR Release Date: April 22, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2195CP
Implementation Date: October 3, 2011

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2011 outpatient prospective payment system Pricer file update

The outpatient prospective payment system (OPPS) Pricer Web page was recently updated to include the April 2011 update for outpatient provider data. Users may now access the April provider data update at *http://www.cms.gov/PCPricer/OutPPS/list.asp* by selecting 2011, and then downloading "2nd Quarter 2011 Files" from the OPPS Pricer 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 201105-30

Proposed rule for fiscal year 2012 hospice wage index

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule addressing the hospice wage index for fiscal year (FY) 2012. The proposed rule would increase Medicare payments to hospices by an estimated 2.3 percent for FY 2012 and establish a new quality reporting system authorized by the Affordable Care Act.

Under the proposed quality reporting system, hospices would be required to submit data on quality measures to CMS or have their annual increase factor reduced by 2 percentage points, starting in FY 2014. The proposed measures include one item endorsed by the National Quality Forum related to pain management and one structural measure related to participation in specific Quality Assessment and Performance Improvement (QAPI) programs.

The rule also proposes to change the way hospice patients are counted for purposes of the 2012 cap year and beyond. Federal law requires that CMS impose a limit on the aggregate Medicare payments a hospice provider receives annually. This rule proposes to change the current calculation of the cap and also proposes that the new counting method be applied to past years in certain instances. In addition, the proposed rule would allow hospice providers who do not want to change their patient counting method to elect to continue using the current methodology.

Finally, the proposed rule would modify the face-to-face encounter requirement for hospices, by proposing to remove the limitation that requires the hospice physician who performs the face-to-face encounter and attests to that encounter be the same physician who certifies the patient's terminal illness.

The proposed rule is now on display today at the Office of the Federal Register's Public Inspection Desk and will be available under "Special Filings," at *www.ofr.gov/inspection.aspx*.

CMS will accept comments on the proposed rule until June 27, 2011. More details about this proposed rule will also be available at *http://www.cms.hhs.gov/apps/media/press_releases.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 201104-55

2011 home health PPS PC Pricer update

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

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

Source: CMS PERL 201104-49

Medicare Physician Fee Schedule fact sheet now available in print

The publication titled *Medicare Physician Fee Schedule* is now available in print format from the *Medicare Learning Network*®. This fact sheet is designed to provide education on the Medicare physician fee schedule (PFS) including physician services, therapy services, Medicare PFS payment rates, and the Medicare PFS rates formula.

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 201104-48

2011 inpatient psychiatric facility PPS PC Pricer updates

The inpatient psychiatric facility (IPF) prospective payment system (PPS) PC Pricer has been updated with the April 2011 provider data, and has been updated on the Centers for Medicare & Medicaid Services (CMS) website for claims dates from October 1, 2010, to June 30, 2011. If you use the IPF PPS PC Pricer for rate year (RY) 2011, please go to the page, *http://www.cms.gov/PCPricer/09_inppsy.asp*, under the "Downloads" section, and download the latest versions of the IPF PPS RY 2011 PC Pricers, posted April 28, 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 201104-51

Inpatient psychiatric facilities prospective payment system update for rate year 2012

This final rule updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs) for discharges occurring during the rate year (RY) beginning July 1, 2011, through September 30, 2012. The final rule also changes the IPF prospective payment system (PPS) payment rate update period to a RY that coincides with a fiscal year (FY). In addition, the rule implements policy changes affecting the IPF PPS teaching adjustment. It also rebases and revises the rehabilitation, psychiatric, and long-term care (RPL) market basket, and makes some clarifications and corrections to terminology and regulations text. These regulations are effective on July 1, 2011.

To view CMS-1346-F, go to *http://www.cms.gov/InpatientPsychFacilPPS/IPFPPSRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1247139&intNumPerPage=10*.

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

Source: CMS PERL 201104-54

Medicare Part B average sales price – payments for Wilate and Flulaval

For the April 2011 average sales price quarterly update, the Centers for Medicare & Medicaid Services (CMS) is not publishing a payment limit for procedure code J7184 [Injection, Von Willebrand Factor Complex (Human), Wilate, Per 100 iu VWF:RCO] for claims with dates of service between April 1 and June 30. A price for Wilate may be found on the "April 2011 ASP Not Otherwise Classified (NOC)" pricing file available on the CMS website.

Additionally, as per updated change request 7234, CMS has updated the price for procedure code Q2036 (Flulaval vacc, 3 yrs & >, im) to $8.784 for the April 2011 ASP quarterly update. This updated price is effective for claims with dates of service on or after October 1, 2010. The revised price has been added to the October 2010 and January 2011 ASP pricing files.

These pricing files may be found on the CMS website at *http://www.CMS.gov/McrPartBDrugAvgSalesPrice*.

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

Source: CMS PERL 201105-10

Reporting of recoupment for overpayment on the remittance advice

Note: This article was revised on April 25, 2011, to correct a statement on page 2 that stated the RAC must report a recoupment in two steps. Actually, it is the remittance advice that reports the recoupment in two steps and the article has been corrected accordingly. All other information is the same. This information was previously published in the March 2011 *Medicare A Bulletin*, pages 32-33.

Provider types affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries [FIs], and/or A/B Medicare administrative contractors [A/B MACs]) for services provided to Medicare beneficiaries. CR 6870 does not apply to suppliers billing durable medical equipment (DME) MACs.

Provider action needed

This article is based on CR 6870 which instructs Medicare system maintainers how to report recoupment when there is a time difference between the creation and the collection of the recoupment.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractor (RAC) program to be in place by January 1, 2010. The goal of the RAC Program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and they can go back three years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 935) amended the Social Security Act (Title XVIII) and added to Section 1893 (The Medicare Integrity Program) a new paragraph (f) addressing this process. You may review Section 1893 *http://www.ssa.gov/OP_Home/ssact/title18/1893.htm*. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment (under the provisions of Section 935 of the MMA) can begin no earlier than the 41st day from the date of the first demand letter, and can happen only when a valid request for a redetermination has not been received within that period of time. See the *Medicare Learning Network*® (*MLN*) *Matters*® article related to CR 6183 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf*.

Under the scenario just described, the remittance advice (RA) has to report the actual recoupment in two steps:

- **Step I:** Reversal and correction to report the new payment and negate the original payment (actual recoupment of money does not happen here);
- **Step II:** Report the actual recoupment.

Recovered amounts reduce the total payment and are clearly reported in the RA to providers. CMS has learned that it is not providing enough detail currently in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step by step process regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done.

CR 6870 instructs the Medicare system maintainers (Fiscal Intermediary Standard System – FISS and Multi Carrier System – MCS) how to report on the RA when:

- An overpayment is identified, and
- Medicare actually recoups the overpayment.

The refund request is sent to the debtor in the form of an overpayment demand letter, and the demand letter includes an internal control number (ICN) or document control number (DCN) for tracking purposes that is also reported on the RA to link back to the demand letter. The recoupment will be reported on the RA in the following manner:

Step I:

Claim level:
The original payment is taken back and the new payment is established

Provider level:
PLB03-1 – PLB reason code FB (forward balance)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the adjustment amount to offset the net adjustment amount shown at the claim level. If the claim level net adjustment amount is positive, the PLB amount would be negative and vice versa.

continued on next page

Recoupment...*continued*

Step II:

Claim level:
No additional information at this step

Provider level:
PLB03-1 – PLB reason code WO (overpayment recovery)
PLB 03-2 shows the detail:
Part A: PLB-03-2
1-2: CS
3-19: Adjustment DCN#
20:30: HIC#
Part B: PLB-03-2
1-2: 00
3-19: Adjustment ICN#
20-30: HIC#

PLB04 shows the actual amount being recouped.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Additional information

CMS provides more information including an overview of and recent updates for the RAC program at http://www.cms.gov/RAC/. You may find the *Remittance Advice Guide for Medicare Providers, Physicians, Suppliers, and Billers* at *http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf*.

The official instruction, CR 6870, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R866OTN.pdf*.

You may also want to review *MLN Matters*® article MM 7068, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7068.pdf*. It instructs DME MACs to provide enough detail in the RA to enable DMEPOS suppliers to reconcile their claims.

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

MLN Matters® Number: MM6870 *Revised*
Related Change Request (CR) #: 6870
Related CR Release Date: March 4, 2011
Effective Date: July 1, 2010
Related CR Transmittal #: R866OTN
Implementation Date: July 6, 2010, except October 3, 2011, for claims processed by the FISS system used by FIs and A/B MACs

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Clarification of payment window for outpatient services treated as inpatient services

Note: This article was revised on May 17, 2011, to correct a date on page 2. The correct date for processing adjustments for impacted claims is after April 4, 2011. All other information remains the same. This information was previously published in the November 2010 *Medicare A Bulletin*, page 30.

Provider types affected

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

Provider action needed

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

Background

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

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

Additionally, outpatient non-diagnostic services, other than ambulance services (as denoted by revenue code 054x on the claim line) and maintenance renal dialysis services (Type of Bill 072x or Type of Bill 13x with HCPCS code G0257 along with other dialysis service lines identified by revenue codes 0270, 0304, 0634, 0635 and/or 0636 on the same date as G0257), provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's admission are deemed related to the admission; and thus, must be billed with the inpatient stay, unless the hospital attests to specific non-diagnostic services as being unrelated to the inpatient hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 to the separately billed outpatient non-diagnostic services claim.

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

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

Additional information

The official instruction, CR 7142, issued to your FI or MAC may be viewed at *http://www.cms.gov/Transmittals/downloads/R796OTN.pdf*.

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

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

Updates to *Medicare Claims Processing Manual*: Inpatient hospital billing

Provider types affected

Hospitals submitting claims to fiscal intermediaries (FI) and A/B Medicare administrative contractors (A/B MAC) for services provided to Medicare beneficiaries are affected by this article.

What you should know

This article is based on change request (CR) 7385, which informs you that the Centers for Medicare & Medicaid Services (CMS) is including the following correction and clarifications to *Medicare Claims Processing Manual*, Chapter 3 (Inpatient Hospital Billing):

- Corrects hemophilia diagnosis code descriptions (286.2 – "Congenital factor XI deficiency", 286.3 in order to make it plural, and 286.5 –"Hemorrhagic disorder due to intrinsic circulating anticoagulants") in Section 20.7.3 – Payment for Blood Clotting Factor Administered to Hemophilia Inpatients;
- Clarifies processing instructions for the non-outlier period after regular benefit days are exhausted in Section 40 of the manual to show that inpatient prospective payment system (PPS) uses occurrence span code 70 with the from and through dates of the non-outlier period after regular benefit days are exhausted; and
- Clarifies application of the Code First policy in Section 190.5.2 to show that Medicare systems search only the first secondary code for a psychiatric diagnosis code to assign the DRG-MS-DRG in order to pay Code First claims properly when the submitted PPS claim from an inpatient psychiatric facility shows the principal diagnosis code as non-psychiatric.

Note: These changes are corrections and clarifications only and reflect no changes in Medicare policy.

Additional information

The official instruction, CR 7385, issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2193CP.pdf*.

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

MLN Matters® Number: MM7385
Related Change Request (CR) #: 7385
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Effective Date: July 23, 2011
Related CR Transmittal #: R2193CP
Implementation Date: July 23, 2011

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New release of PEPPER now available

A new release of the Program for Evaluating Payment Patterns Electronic Report (PEPPER), which contains statistics through the first quarter of fiscal year 2011, is available for short-term acute care hospitals (open as of December 31, 2010). PEPPER files were distributed in late May 2011 through a My QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER-recipient role.

About PEPPER

PEPPER provides hospital-specific data statistics for Medicare severity diagnosis-related groups and discharges at high risk for improper payments. It is distributed by TMF® Health Quality Institute under contract with the Centers for Medicare & Medicaid Services. Visit *http://www.pepperresources.org/* to access resources for using PEPPER, including user guides (*http://www.pepperresources.org/LinkClick.aspx?fileticket=3IjlfXX5Wfc%3d&tabid=39)*, information about QualityNet accounts, frequently-asked questions (*http://www.pepperresources.org/FAQ.aspx)*, and examples of how other hospitals are using PEPPER.

Do you have questions or comments about PEPPER or need help obtaining your report? Visit the PEPPER Help Desk at *http://www.pepperresources.org/HelpContactUs.aspx*, or provide your input through the PEPPER feedback form at *http://www.surveymonkey.com/s/KZMB5BG*.

Administration implements Affordable Care Act provision to improve care and lower costs

Value-based purchasing will reward hospitals based on quality of care for patients

The Department of Health and Human Services (HHS) launched a new initiative which will reward hospitals for the quality of care they provide to people with Medicare and help reduce health care costs. Authorized by the Affordable Care Act, the hospital value-based purchasing program marks the beginning of an historic change in how Medicare pays health care providers and facilities – for the first time, 3,500 hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.

This initiative helps support the goals of the Partnership for Patients (*http://www.healthcare.gov/center/programs/partnership/index.html*), a new public-private partnership that will help improve the quality, safety and affordability of health care for all Americans. The Partnership for Patients has the potential over the next three years to save 60,000 lives and save up to $35 billion in U.S. health care costs, including up to $10 billion for Medicare. Over the next ten years, the Partnership for Patients could reduce costs to Medicare by about $50 billion and result in billions more in Medicaid savings.

"Changing the way we pay hospitals will improve the quality of care for seniors and save money for all of us," said HHS Secretary Kathleen Sebelius. "Under this initiative, Medicare will reward hospitals that provide high-quality care and keep their patients healthy. It's an important part of our work to improve the health of our nation and drive down costs. As hospitals work to improve their performance on these measures, all patients – not just Medicare patients – will benefit."

In fiscal year (FY) 2013, an estimated $850 million will be allocated to hospitals based on their overall performance on a set of quality measures that have been shown to improve clinical processes of care and patient satisfaction. This funding will be taken from what Medicare otherwise would have spent, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance.

"Medicare is in a unique position to reward hospitals for improving the quality of care they provide," said Centers for Medicare & Medicaid (CMS) Administrator Donald Berwick, M.D. "Under this new initiative, we will reward hospitals for delivering high-quality care, treating their patients with respect and compassion, and ensuring they have the opportunity to participate in decisions about their treatment."

Some of these measures will assess whether hospitals:

- Ensure that patients who may have had a heart attack receive care within 90 minutes;
- Provide care within a 24-hour window to surgery patients to prevent blood clots;
- Communicate discharge instructions to heart failure patients; and
- Ensure hospital facilities are clean and well maintained.

The measures to determine quality in the hospital value-based purchasing program focus on how closely hospitals follow best clinical practices and how well hospitals enhance patients' experiences of care. When hospitals follow these types of proven best practices, patients receive higher quality care and see better outcomes. And helping patients heal without complication can improve health and ultimately reduce health care costs. For example, ensuring heart failure patients receive clear instructions when they are discharged on their medications and other follow-up activities reduces the likelihood that they will suffer a preventable complication that would require them to be readmitted to the hospital.

The better a hospital does on its quality measures, the greater the reward it will receive from Medicare. The measures selected for the hospital value-based purchasing program in FY 2013 have been endorsed by national bodies of experts, including the National Quality Forum. Hospitals have been reporting on quality measures through the hospital inpatient quality reporting program since 2004 and that information is posted on the Hospital Compare website at *http://www.healthcare.gov/compare/index.html*. For a complete list of quality measures, visit *www.HealthCare.gov/news/factsheets/valuebasedpurchasing04292011b.html*.

continued on next page

Affordable...*continued*

In the future, CMS plans to add additional measures that focus on improved patient outcomes and prevention of hospital-acquired conditions. Measures that have reached very high compliance scores would likely be replaced, continuing to raise the quality bar.

The hospital value-based purchasing initiative is just one part of a wide-ranging effort by the Obama Administration to improve the quality of health care for all Americans, using important new tools provided by the Affordable Care Act. The Partnership for Patients is bringing together hospitals, doctors, nurses, pharmacists, employers, unions, and state and federal government committed to keeping patients from getting injured or sicker in the health care system and improving transitions between care settings. CMS will invest up to $1 billion to help drive these changes. In addition, proposed rules allowing Medicare to pay new Accountable Care Organizations (ACOs) to improve coordination of patient care are also expected to result in better care and lower costs.

For a fact sheet on the hospital value-based purchasing program, visit *www.HealthCare.gov/news/factsheets/valuebasedpurchasing04292011a.html*. To learn more about hospital value-based purchasing, please visit *www.cms.gov/HospitalQualityInits*.

The final rule establishing the program was placed on display at the *Federal Register*, and can be found online at *http://www.cms.gov/HospitalQualityInits/*.

More technical information about the final rule, including the measures CMS has included in the program, as well as CMS' scoring methodology, is included in a fact sheet posted on the Web page 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 201104-60

EHR incentive program hospital fact sheets now available in Spanish

Medicaid Hospital EHR Incentive Payments Calculations fact sheet

The Spanish translation of the *Medicaid Hospital Incentive Payments Calculations* fact sheet is now available (ICN 906387). This fact sheet is designed to provide education on how electronic health record (EHR) incentive payments are calculated for Medicaid hospitals, and can be accessed from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/EHR-Medicaid-Hospital-Incentive-Payment-ICN906387-Sp.pdf*.

EHR Incentive Program for Critical Access Hospitals fact sheet

The Spanish translation of the *EHR Incentive Program for Critical Access Hospitals* fact sheet is now available (ICN 906384). This fact sheet is designed to provide education on the Medicare EHR incentive program for critical access hospitals and can be accessed from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/EHR-CAHs_ICN906384-Sp.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 201105-21

Hospital Outpatient Prospective Payment System fact sheet revised

The revised publication titled *Hospital Outpatient Prospective Payment System* (revised March 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf*. This fact sheet is designed to provide education on the hospital outpatient prospective payment system (OPPS) including background, ambulatory payment classifications, how payment rates are set, and payment rates under the OPPS.

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

Source: CMS PERL 201105-09

Fiscal year 2011 inpatient PPS PC Pricers update

The latest April 2011 provider data has been updated in the fiscal year (FY) 2011 inpatient prospective payment system (INP PPS) PC Pricers. If you use the FY 2011 INP PPS PC Pricers, please go to the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPricer/03_inpatient.asp*, and download the latest version of the FY 2011 PC Pricer. The update is for claims dated from October 1, 2010, to September 30, 2011. The update is dated April 27, 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 201104-50

Critical Access Hospitals

Payment of licensed clinical social worker in a Method II critical access hospital

Provider types affected

This article is for licensed clinical social workers (LCSWs) who bill Medicare fiscal intermediaries (FIs) or Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in a Method II critical access hospital (CAH).

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7361 which outlines how LCSW payments are calculated by Medicare payments for services for which the LCSW reassigns his or her billing rights to Method II CAH, effective for claims with dates of service on or after October 1, 2011.

Caution – what you need to know

Payments are made by Medicare for the services of a LCSW when the procedure is billed on type of bill 85x with revenue code (RC) 96x, 97x, or 98x and the AJ modifier (clinical social worker).

Go – what you need to do

Make certain your billing staffs are aware of the payment calculations described in the *Background* section of this article.

Background

The Centers for Medicare & Medicaid Services (CMS) in the *Medicare Claims Processing Manual* Chapter 4, Section 250.12 outlines the following:

- The services of a LCSW that has reassigned billing rights to a Method II CAH are payable by Medicare when the procedure is billed on type of bill 85x with revenue code (RC) 96x, 97x, or 98x and the AJ modifier (clinical social worker);
- Under Section 1834(g)(2)(B) of the Social Security Act (the Act) outpatient professional services performed in a Method II CAH are paid 115 percent of such amounts as would otherwise be paid under the Act if the services were not included in the outpatient CAH services;
- Section 1833 (a)(1)(F) of the Act stipulates that payment for services performed by a LCSW shall be 80 percent of the lesser of the actual charges for the services or 75 percent of the amount determined for the payment of a psychologist; and
- Payment is calculated as follows: facility specific Medicare physician fee schedule amount times the LCSW reduction (75 percent) minus (deductible and coinsurance) times 115 percent.

Additional information

The official instruction, CR 7361, issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2202CP.pdf*. If you have any questions, please contact your Medicare contractor at their toll-free number, which is at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7361
Related Change Request (CR) #: N/A
Related CR Release Date: April 27, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2202CP
Implementation Date: October 3, 2011

Excluding certain HCPCS codes from SNF consolidated billing

Several new Healthcare Common Procedure Coding System (HCPCS) billing codes created for January 2011 were not excluded from the skilled nursing facility (SNF) consolidated billing bundled payment and allowed to be paid separately. Effective July 5, 2011, for dates of service on or after January 1, 2011, claim processing edits for institutional claims for computerized axial tomography (CT) scans codes (*74176, 74177*, and *74178*) will be revised to allow separate payment for these codes outside of the SNF consolidated billing bundled payment. These codes were already included in the annual update for physician and practitioner claims and claims have processed correctly.

Institutional providers that submitted claims with dates of service on or after January 1, 2011, would have had claims denied for these services. These providers should contact their Medicare fiscal intermediary or Medicare administrative contractor to have the claims reopened and reprocessed.

In addition, a policy decision has been made by the Centers for Medicare & Medicaid Services that Dacogen (HCPCS code J0894) meets the clinical parameters for exclusion from SNF consolidated billing as a high-intensity chemotherapy drug. Therefore, effective October 3, 2011, for claims with dates of service on or after January 1, 2011, claim processing edits will be revised to allow for the separate payment of HCPCS code J0894 outside of the SNF consolidated billing bundled payment.

Institutional providers, physicians, and practitioners that submitted claims with dates of service on or after January 1, 2011, would have had claims denied for these services. These providers should contact their Medicare carrier, fiscal intermediary, or Medicare administrative contractor to have the claims reopened and reprocessed.

If you have any additional questions please contact your Medicare carrier, fiscal intermediary, or Medicare administrative contractor.

Source: CMS PERL 201105-31

Proposed options for 2012 payment rates for skilled nursing facilities

Case-mix adjustment recalibration under review

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that discusses options the agency is considering for purposes of setting the 2012 Medicare payment rates for skilled nursing facilities (SNFs).

One option being considered reflects the standard rate update methodology which would provide an increase of $530 million, or 1.5 percentage points. The increase is derived from applying the 2012 market basket index of 2.7 percent reduced by 1.2 percentage points to account for greater efficiencies in the operation of nursing homes. This provision was called for in the Affordable Care Act.

The other option CMS is considering adjusts for an unexpected spike in nursing home payments during fiscal year (FY) 2011. Under this option, CMS would restore overall payments to their intended levels on a prospective basis which would require reducing FY 2012 payments to Medicare skilled nursing facilities by $3.94 billion, or 11.3 percent lower than payments for FY 2011.

The proposed rule went on display on April 28 at the *Federal Register's* Public Inspection Desk and is available under "Special Filings," at *http://www.ofr.gov/OFRUpload/OFRData/2011-10555_PI.pdf* or *http://www.federalregister.gov/inspection.aspx*.

Public comments on the proposal will be accepted until June 27. For more information please see the CMS press release issued (April 28) at *http://www.cms.gov/apps/media/press_releases.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 201104-52

Fiscal year 2011 and 2010 skilled nursing facility PC Pricer updates

The fiscal year (FY) 2011 and FY 2010 skilled nursing facility (SNF) PC Pricers have been updated with more current provider data at *http://www.cms.gov/PCPricer/04_SNF.asp*, under the "Skilled Nursing Facilities (SNF PPS) PC Pricer". If you use the FY 2011 or FY 2010 SNF PC Pricer, download the SNF PC Pricers posted May 6, 2011, which contain the more current provider data.

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

Source: CMS PERL 201105-16

Proposed payment, policy changes for inpatient rehabilitation facilities

Proposals would create new quality reporting program

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update Medicare payment policies and rates for inpatient rehabilitation facilities (IRFs) in fiscal year (FY) 2012. The rule proposes to increase payment rates under the IRF prospective payment system (PPS) by a projected 1.5 percent – an estimated $120 million nationwide. The projected update reflects a rebased and revised market basket specific to IRFs, inpatient psychiatric facilities, and long-term care hospitals (the reasonable performance level (RPL) market basket) – currently estimated at 2.8 percent for FY 2012 less a 1.3 percentage point reduction mandated by the Affordable Care Act.

The proposed rule, which would apply to more than 1,200 Medicare-participating IRFs, including approximately 200 freestanding IRFs and approximately 1,000 IRF units in acute care hospitals and critical access hospitals, seeks to establish a new quality reporting system authorized by the Affordable Care Act.

"The proposed rule would extend Medicare's ongoing efforts to use its payments to encourage better care for beneficiaries who are treated in inpatient rehabilitation facilities," said CMS Administrator Donald Berwick, M.D. "The measures IRFs would report under the proposed rule will pave the way for Medicare to work with IRFs to improve patient safety, prevent patients from picking up new illnesses during a hospitalization, and provide well-coordinated person-and-family-centered care."

The proposed quality reporting system is aligned with the goals of the Partnership for Patients, a new public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans. Initially, IRFs would submit data on two quality measures, "urinary catheter-associated urinary tract infection" and "pressure ulcers that are new or have worsened." These proposed measures represent two of the nine conditions the Partnership has identified as important places to begin in efforts to reduce harms to patients. A third measure that is currently under development is also discussed as a potential measure for future rulemaking cycles. It would address readmissions within 30 days to another inpatient stay, whether in an acute care hospital, rehabilitation facility, or other setting.

IRFs that do not submit quality data would see their payments reduced by two percentage points beginning in FY 2014. CMS anticipates adding measures for reporting in the future through rulemaking. CMS also plans to establish a process for making the measures data available to the public. As with other data published on the CMS website, IRFs choosing to report quality data would have an opportunity to review the data for accuracy before it became public.

Other provisions in the proposed rule include proposals to:

- Update the case-mix group (CMG) relative weights using FY 2010 IRF claims and FY 2009 IRF cost report data, and to set the high cost outlier threshold at $11,822 for FY 2012, compared with $11,410 for FY 2011. The proposed threshold is projected to maintain outlier payments at three percent of total payments under the IRF PPS in FY 2012.
- Continue using the pre-reclassified and pre-floor hospital wage data to determine the proposed FY 2012 rates. For this proposed rule, CMS used the final FY 2011 hospital inpatient prospective payment system (IPPS) pre-reclassified and pre-floor wage data. CMS is also proposing to update the rural, low-income patient (LIP), and teaching status adjustment factors using the most recent three years of data (FYs 2008 through 2010).
- Allow IRFs to receive temporary adjustments to their full-time equivalent (FTE) intern and resident caps if they take on interns and residents who are unable to complete their training because the IRF that had been training them either closed or ended its resident training program.

"IRFs need to be at the forefront of the quality movement because they play such a critical role in patient care," said Dr. Berwick. "They're called on to meet the needs of some of our most vulnerable patients, and they're responsible for making sure each one of them meets their rehabilitation goals and makes real progress towards improved functional independence."

CMS will accept comments on the proposed rule until June 21, 2011, and will address all comments in a final rule to be issued by August 1, 2011.
The proposed rule went on display on Friday, April 22 at the *Federal Register's* Public Inspection Desk and will be available under "Special Filings," at *http://www.ofr.gov/inspection.aspx*.

For more information, please see *http://www.cms.gov/InpatientRehabFacPPS/*.

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

Source: CMS PERL 201104-44

Inpatient rehabilitation facility prospective payment system PC Pricer updates

The fiscal year (FY) 2010 and FY 2011 inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC Pricers have been updated with the latest provider data. The PC Pricers are ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.hhs.gov/PCPricer/06_IRF.asp*. If you use the IRF PPS PC Pricers, please go to the page above and download the latest version of the FY 2010 and FY 2011 Pricers, posted April 29, 2011, in the Downloads section.

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

Source: CMS PERL 201104-58

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 thoughts and ideas with FCSO's Web team.

Educational Events

Upcoming provider outreach and educational events – June 2011

Recovery audit contractor (RAC) open forum – Part A

When: Tuesday, June 14
Time: 11:30 a.m. – 12:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

National 5010 Testing Day – Part A/B

When: Wednesday, June 15
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

Two easy ways to register

1. **Online** – Visit our provider training website at *www.fcsouniversity.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 a New Account" 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.

2. **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 offer CEUs. Learn more on the FCSO Medicare training website and explore our catalog of online courses.

Other Educational Resources

New *Interactive Guide to the Medicare Learning Network* CD-ROM

The *Medicare Learning Network*® has released a new CD-ROM titled *The Interactive Guide to the Medicare Learning Network*. This CD-ROM allows for a two-way flow of information between fee-for-service (FFS) providers and the *MLN*. Providers and other health care professionals can link directly from the products described on the CD-ROM to the MLN Web pages and the *MLN* catalog of products. Once there, users can then confidently download and print copies of the most up-to-date and accurate *MLN* products. To order the CD-ROM through the *MLN* product ordering system, visit *http://www.CMS.gov/MLNProducts*.

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

Source: CMS PERL 201104-48

Improving Quality of Care for Medicare Patients: Accountable Care Organizations fact sheet

The *Improving Quality of Care for Medicare Patients: Accountable Care Organizations* fact sheet, which is designed to provide education on quality of care standards for Accountable Care Organizations under the Medicare Shared Savings Program as proposed in the notice of proposed rulemaking, is now available in downloadable format from the *Medicare Learning Network*®. The sheet outlines information on proposed quality measures and proposed quality performance scoring under the five proposed domains, which include patient/caregiver experience, care coordination, patient safety, preventive health, and at risk population/frail elderly. It is available for viewing, printing, or downloading at:
http://www.CMS.gov/MLNProducts/downloads/ACO_Quality_Factsheet_ICN906104.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 201105-21

Three new fact sheets related to the Medicare Shared Savings Program

The *Medicare Learning Network*® has released three new fact sheets related to the recently released Notice of Proposed Rulemaking (NPRM) for the Medicare Shared Savings Program. All are available to view, download, and print, free of charge, from the *MLN*.

- *Summary of Proposed Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program* provides an overview of the NPRM. To access the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_NPRM_Summary_Factsheet_ICN906224.pdf.*
- *What Providers Need to Know: Accountable Care Organizations* provides information important to Medicare fee-for-service providers who may participate in the program. To access the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf*.
- *Federal Agencies Address Legal Issues Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* provides information about the Center for Medicare & Medicaid Services' (CMS) coordination with the Office of Inspector General, the Federal Trade Commission, and Department of Justice, and the Internal Revenue Service regarding issues related to the Shared Savings Program. To access the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_Federal_Agencies_Factsheet_ICN906225.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 201104-48

Medicare Shared Savings Program and Rural Providers fact sheet released

The *Medicare Learning Network*® has released the *Medicare Shared Savings Program and Rural Providers* fact sheet, which is designed to provide education on how the Medicare Shared Savings Program (as proposed in the Notice of Proposed Rulemaking) impacts rural providers. To view, print, or download the fact sheet, please visit *http://www.CMS.gov/MLNProducts/downloads/ACO_Rural_Factsheet_ICN906565.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 201105-34

New fast fact now available on *MLN* Provider Compliance Web page

A new fast fact has been added to the *Medicare Learning Network*® (*MLN*) Provider Compliance Web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp*, which contains educational fee-for-service (FFS) provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions directly from this Web page – and be sure to bookmark this page and check back often as a new fast fact will be added each month.

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

Source: CMS PERL 201105-21

Provider compliance "Fast Facts" and newsletter

"Fast Facts" now available on *MLN* provider compliance Web page

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 educational products, CMS encourages you to visit the *Medicare Learning Network*® (MLN) provider compliance Web page at *http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp*. It contains educational FFS provider materials to help you understand – and avoid – common billing errors and other improper activities identified through claim review programs. You can now review quick tips on relevant provider compliance issues and corrective actions directly from this Web page. Be sure to bookmark this page and check back often as a new "fast fact" will be added each month.

April 2011 issue of *Quarterly Provider Compliance Newsletter* released

The next issue of the *Medicare Quarterly Provider Compliance Newsletter* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903696.pdf*. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare program and is released on a quarterly basis. In this issue, a number of recovery audit findings that affect inpatient rehabilitation facilities, inpatient hospitals, physicians, non-physician practitioners, and outpatient hospitals are presented. The newsletter now features a series of tips and suggestions on relevant topics and an interactive index of previously-issued newsletters, which can be found at *http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.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 201105-09

Telehealth Services fact sheet revised

The revised publication titled *Telehealth Services* (revised March 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf*. This fact sheet is designed to provide education on services furnished to eligible Medicare beneficiaries via a telecommunications system, including originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, and billing and payment for the originating site facility fee.

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

Source: CMS PERL 201105-09

New *Signature Requirements* fact sheet

A new publication titled *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 201104-48

Three fact sheets now available in hard copy

The following fact sheets are now available in print format from the *Medicare Learning Network*®:

- *Clinical Laboratory Fee Schedule* (revised February 2011) – which is designed to provide education on the clinical laboratory fee schedule including background information, coverage of clinical laboratory services, and how payment rates are set.
- *Ambulance Fee Schedule* (March 2011) – which is designed to provide education on the ambulance fee schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.
- *Federally Qualified Health Center* (March 2011) – which is designed to provide education on federally qualified health centers (FQHC) including background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC prospective payment system; FQHC payments; and Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions that impact FQHCs.

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 201105-34

Medicare Enrollment Guidelines for Ordering/Referring Providers fact sheet released

A new publication titled *Medicare Enrollment Guidelines for Ordering/Referring Providers* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers, and includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A home health agency, Part B, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) beneficiary 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 201105-34

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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