Medicare A CONNECTION

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers June 2011

Features

Up to $500 million in Affordable Care Act funding will help health providers improve

The U.S. Department of Health and Human Services has announced that up to $500 million in Partnership for Patients funding will be available to help hospitals, health care provider organizations, and others improve care and stop millions of preventable injuries and complications related to health care acquired conditions and unnecessary readmissions. This funding, made available by the Affordable Care Act, will be awarded by the Centers for Medicare & Medicaid Services (CMS) Innovation Center (*http://innovations.cms.gov/*).

"Since the Partnership for Patients was announced, we have had an overwhelming response from hospitals, doctors, employers, and other partners who want to be a part of this historic effort to improve patient safety," said CMS Administrator Donald M Berwick, M.D. "We are now looking to contract with local and statewide entities that can foster and support hospitals' efforts to improve health care and reduce harm to patients."

The Partnership for Patients (refer to *http://www.healthcare.gov/center/programs/partnership/index.html*) is a new public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans. The Partnership's two goals are reducing harm in hospital settings by 40-percent and reducing hospital readmissions by 20 percent over a three-year period. To achieve these goals, the Partnership is seeking to contract with large health care systems, associations, state organizations, or other interested parties to support hospitals in the hard work of redesigning care processes to reduce harm. "Hospital Engagement Contractors" will be asked to do the following:

- Design intensive programs to teach and support hospitals in making care safer;
- Conduct trainings for hospitals and care providers;
- Provide technical assistance for hospitals and care providers; and
- Establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.

In addition to the Hospital Engagement Contractors, CMS will also be working with other contractors to develop and share ideas and practices that improve patient safety.

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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.

Funding...*continued from page 1*

These efforts include work with patients and families to understand their thoughts on how to best improve patient safety and transitions between different health care settings – such as when a patient is discharged from a hospital to a nursing home.

These contracts make available the first round of funding – which will ultimately total up to $500 million – that the Innovation Center has committed to this effort. Solicitations for proposals are available on the Federal Business Opportunities website at *www.FBO.gov* (solicitation number APP111513 at *https://www.fbo.gov/index?s=opportunity&id=b89fbfc7fd10c41903c7f6fa083bbfc7*).

When the Partnership for Patients (refer to *http://www.healthcare.gov/center/programs/partnership/index.html*) was announced, the Obama administration committed up to $1 billion in Affordable Care Act funding to help achieve its two goals; at the time of the announcement, up to $500 million was made available through the Community-based Care Transitions Program (refer to *http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313*) to ensure patients safely transition between settings of care. The announcement makes available the start of $500 million additional Innovation Center funds to help reduce health care acquired conditions and reduce unnecessary readmissions.

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Source: CMS PERL 201106-45

Major new effort to give consumers and employers better information about quality of care

Affordable Care Act provision provides new opportunity for the use of Medicare and private sector claims data in evaluating the performance of physicians, other providers, and suppliers

On Friday, June 3, the Centers for Medicare & Medicaid Services (CMS) proposed rules that will enable consumers and employers to select higher-quality, lower-cost physicians, hospitals and other health care providers in their area. The new rules will allow organizations that meet certain qualifications access to patient-protected Medicare data to produce public reports on physicians, hospitals and other health care providers. These reports will combine private sector claims data with Medicare claims data to identify which hospitals and doctors provide the highest quality, cost-effective care. This initiative is part of a broader effort by the Obama Administration, made possible by the Affordable Care Act, to improve care and lower costs.

"Making more Medicare data available can make it easier for employers and consumers to make smart decisions about their health care," said CMS Administrator Donald M. Berwick, MD. "Performance reports that include Medicare data will result in higher quality and more cost effective care. And making our health care system more transparent promotes competition and drives costs down."

For many years employers, consumers, providers, and quality measurement organizations have been frustrated with the limited and piecemeal availability of health care claims data. This has led many health plans to create provider performance reports based solely on the health plan's own claims, which often represent only a small proportion of a provider's overall practice. Providers can receive multiple, sometimes contradictory, reports from different insurers. Often, providers are unable to appeal or correct what they perceive to be inaccurate results in these reports. These factors sometimes lead to reports that neither providers nor consumers feel they can use.

This rule seeks to change the quality measurement landscape in a way that increases transparency for all stakeholders. "Qualified entities" that have the capacity to process the data accurately and safely would be required to combine the Medicare claims provided by CMS with private sector claims data, to produce quality reports that are more representative of how providers and suppliers are performing. The reports will help employers and consumers understand more about the relative performance of physicians and other providers in their area. In addition, these rules include strict privacy and security requirements for entities handling Medicare claims data.

This new program would provide for the following activities:

- CMS would provide standardized extracts of Medicare claims data from Parts A, B, and D to qualified entities. The data can only be used to evaluate provider and supplier performance and to generate public reports detailing the results.

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Quality...*continued*

- The data provided to the qualified entity will cover one or more specified geographic area(s).
- The qualified entity would pay a fee that covers CMS' cost of making the data available.
- To receive the Medicare claims data, qualified entities would need to have claims data from other sources. Combining claims data from multiple sources creates a more complete and accurate picture about provider and supplier performance.
- Publicly reporting the results calculated by the qualified entity is important for transparency in health care and consumer empowerment. To prevent mistakes, qualified entities must share the reports confidentially with providers and suppliers prior to their public release. This gives providers and suppliers an opportunity to review the reports and provide necessary corrections.
- Publicly released reports would contain aggregated information only, meaning that no individual patient/beneficiary data would be shared or be available.
- During the application process, qualified entities would need to demonstrate their capabilities to govern the access, use, and security of Medicare claims data. Qualified entities would be subject to strict security and privacy processes.
- CMS would continually monitor qualified entities, and entities that do not follow these procedures risk sanctions, including termination from the program.

Comments are welcome on this set of proposed rules.

These proposed rules are the next step in the effort to improve health care quality and ensure consumers have access to the best available information, using important new tools provided by the Affordable Care Act. The hospital value-based purchasing initiative will reward hospitals for the quality of care they provide to people with Medicare and help reduce health care costs. This initiative will be based on quality measures that hospitals have been reporting to 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*. 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. This proposed rule will complement the overall effort by the Obama Administration to improve quality, lower costs, and improve health by providing consumers and employers a more accurate picture of provider and supplier performance.

Access the *Federal Register* link for published rules at *http://www.gpoaccess.gov/fr/browse.html*.

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

Source: CMS PERL 201106-14

Medicare proposes new standards for community mental health centers

Proposed standards will improve quality and safety of mental health care

The Centers for Medicare & Medicaid Services (CMS) issued a proposed rule on June 16, 2011, that is designed to improve the quality and safety of treatment provided to more than 25,000 Medicare beneficiaries who receive care at community mental health centers (CMHCs) each year.

The notice of proposed rulemaking would establish conditions of participation (CoPs) for CMHCs for the first time. The proposed rule includes health and safety standards for CMHCs that participate in the Medicare program and are an important step in CMS' commitment to assuring the delivery of safe, quality care to clients of CMHCs. In particular, the proposed new conditions focus on a client-centered, outcome-oriented approach.

"This rule proposes new provisions that will protect the tens of thousands of Medicare beneficiaries who receive care from a CMHC every year," said CMS Administrator Donald M. Berwick. "Memorializing the best practices of behavioral healthcare in new Medicare standards gives us the unique opportunity to be sure that safe and effective client-focused care is available to all clients in all communities."

The proposed rule would establish conditions of participation, focusing on a client-centered, outcome-oriented approach.

CMHCs provide partial hospitalization services to Medicare beneficiaries – a comprehensive program of intensive mental health care services, which includes physician services, psychiatric nursing, counseling and social services. This unique Medicare benefit offers an alternative to inpatient treatment by focusing on the medical, emotional, social, and therapeutic needs of clients with acute mental illness, using a client-centered interdisciplinary approach.

As part of the proposed rule, CMS highlights steps CMHCs would be required to take in order to protect clients while under their care, aimed at meeting the specific needs of individual clients.

In particular, CMS proposes new standards for CMHCs in the following areas:

- Establishing qualifications for CMHC employees and contractors.
- Requiring CMHCs to notify clients of their rights and to investigate and report violations of client rights. These proposed requirements also promote continuity of care by emphasizing the need for communication regarding client needs at the time of discharge or transfer.
- Convening of a treatment team, developing an active treatment plan, and coordinating services to ensure an interdisciplinary approach to individualized client care.
- Creating a Quality Assessment and Performance Improvement (QAPI) program. The QAPI program will require CMHCs to identify program needs by evaluating outcome and client satisfaction data and making changes, as necessary, to improve their quality of care.
- Setting organization, governance, administration of services, and partial hospitalization services requirements, with an emphasis on governance structure.

The proposed rule would add CMHCs to the list of provider and supplier types that are already subject to conditions of participation and conditions for coverage under Medicare. These conditions apply both to health care entities seeking to become Medicare providers and to those continuing to participate in the Medicare program. The health and safety standards included in the conditions are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS implements these standards through State Departments of Health and private accrediting organizations recognized by CMS (through a process called "deeming"), which review provider practices to assure they meet or exceed the Medicare standards.

"This proposed rule demonstrates our commitment to quality and safety across settings and highlights the importance of effective, safe mental health care," said Patrick Conway, M.D., MSc, CMS Chief Medical Officer and Director of the Agency's Office of Clinical Standards and Quality.

CMS will accept public comments on the proposed rule until August 16, 2011, 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-3202-P."

The proposed rule is available online from the *Federal Register* at *http://www.ofr.gov/inspection.aspx#regular*.

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Source: CMS PERL 201106-34

Applications now available for FQHC medical home demonstration

The Innovation Center is pleased to announce that it is currently accepting applications from federally qualified health centers to participate in the Medicare federally qualified health center (FQHC) advanced primary care practice demonstration project. This demonstration is being conducted by Centers for Medicare & Medicaid Services (CMS) in partnership with the Health Resources and Services Administration (HRSA).

This three-year demonstration project will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients. It will show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs.

CMS and HRSA invite eligible FQHCs to submit an application to participate in this demonstration. Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, they will be paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agree to adopt care coordination practices that are recognized by the National Committee for Quality Assurance (NCQA). CMS and HRSA will provide technical assistance to help FQHCs achieve these goals.

More information on the FQHC demonstration can be found at *http://innovations.cms.gov*; complete details and instructions for applying and participating in the demonstration can be found at *www.fqhcmedicalhome.com*. CMS will be accepting applications from Monday, June 6, 2011, through 11:59 p.m. (ET) on Friday, August 12, 2011. If you have further questions, you may submit them to the CMS demonstration mailbox at *fqhc_mh_demo@cms.hhs.gov*.

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Source: CMS PERL 201106-16

No date set for expanded ordering/referring provider claim edits

The Centers for Medicare & Medicaid Services (CMS) has not yet determined when it will begin to apply the expanded edit for ordering/referring provider claims. These edits are applicable to ordering/referring providers that do not have a record in the provider enrollment, chain, and ownership system (PECOS). As previously stated, CMS will give providers ample notice before the ordering/referring provider claim edit is applied.

For information on the requirements for billing for ordering/referred services, review the *Medicare Learning Network's Medicare Enrollment Guidelines for Ordering/Referring Providers* fact sheet at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.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 201106-14

Three reminders for billing correctly for ordered/referred services

Any Medicare-enrolled Part B organizational provider, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier, or Part A home health agency (HHA) provider may file claims with ordering or referring information.

1. There are three basic requirements for ordering and referring:
   - The physician or non-physician practitioner must be enrolled in Medicare or in an opt-out status.
   - The national provider identifier (NPI) used for ordering/referring must be for an individual physician or non-physician practitioner (cannot be an organizational NPI).
   - The physician or non-physician practitioner must be of a specialist type that is eligible to order and refer.

   If you don't meet the three basic requirements listed above, refer to item #3 on how to obtain an NPI and enroll in Medicare for ordering and referring purposes.
2. Only Medicare-enrolled individual physicians and non-physician providers of a certain specialist type are eligible to order/refer for Part B and DMEPOS Medicare beneficiary services. (Organizational providers cannot order and refer.) Eligible individual physicians and non-physician providers include:
   - Doctor of medicine or osteopathy
   - Doctor of dental medicine
   - Doctor of dental surgery
   - Doctor of podiatric medicine
   - Doctor of optometry
   - Doctor of chiropractic medicine
   - Physician assistant
   - Certified clinical nurse specialist
   - Nurse practitioner
   - Clinical psychologist
   - Certified nurse midwife
   - Clinical social worker

   Only Medicare-enrolled individual physicians of a certain specialist type are eligible to order/refer for Part A when a plan of treatment is needed and submitted from an HHA for beneficiary services. These individuals include:
   - Doctor of medicine or osteopathy
   - Doctor of podiatric medicine
3. In order to order/refer, the provider must have an enrollment record in PECOS.
   - Providers who order or refer should verify their enrollment in PECOS. Note that receiving payments from Medicare does not necessarily mean you have an enrollment record in PECOS. The easiest way to check on enrollment status is by visiting Internet-based PECOS at *https://pecos.CMS.hhs.gov* and navigating to the "My Enrollments" page; if no record is displayed, you do not have an enrollment record in PECOS. (More detailed instructions on accessing and navigating internet-based PECOS are available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf*.) Another option is to check the Ordering and Referring Report at *http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp*.
   - If you believe an enrollment application has been submitted but no enrollment record exists in PECOS, check the list of pending applications, available at *http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp* (refer to the "Initial Physician Applications Pending Contractor Review" in the *Downloads* section).
   - Providers with neither an enrollment record in PECOS nor an entry on the list of pending applications should make arrangements to submit their enrollment application. Internet-based PECOS is the fastest and most efficient way to do so. For instructions, review the *Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners* at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.

For additional information, review the *Medicare Learning Network*'s *Medicare Enrollment Guidelines for Ordering/Referring Providers* fact sheet at *http://www.cms.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf*.

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Source: CMS PERL 201106-21

Are you submitting a handwritten Medicare enrollment application?

Medicare enrollment application forms are fillable on your computer. This means that you can fill out the information required by typing into the open fields while the form is displayed on your computer monitor. Filling out the forms this way before printing, signing and mailing means more easily-readable information -- which means fewer mistakes, questions, and delays when your application is processed. Be sure to make a copy of the signed form for your records before mailing.

Medicare provider enrollment application forms are available on the Centers for Medicare & Medicaid Services website at *https://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp*.

- CMS 855A – Application for Institutional Providers (*https://www.cms.gov/cmsforms/downloads/cms855a.pdf*)
- CMS 855B – Application for Clinics, Group Practices, and Certain Other Suppliers (*https://www.cms.gov/cmsforms/downloads/cms855b.pdf*)
- CMS 855I – Application for Physicians and Non-Physician Practitioners (*https://www.cms.gov/cmsforms/downloads/cms855i.pdf*)
- CMS 855R – Application for Reassignment of Medicare Benefits (*https://www.cms.gov/cmsforms/downloads/cms855r.pdf*)
- CMS 855S – Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers (*https://www.cms.gov/cmsforms/downloads/cms855s.pdf*)

Signatures are still required to be handwritten. Don't forget to complete this important step prior to mailing your typed form(s).

Keep in mind that typed forms are easier for Medicare to process, but the most efficient method for submitting your enrollment application is to use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). PECOS guides you through the enrollment application so you only supply information relevant to your application. PECOS also reduces the need for follow-up because of incomplete applications. Using Internet-based PECOS results in a more accurate application and saves you time and administrative costs. Visit Internet-Based PECOS at *http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp* to learn more.

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

Source: CMS PERL 201105-44

New FAQs – advanced diagnostic imaging accreditation

The Centers for Medicare & Medicaid Services (CMS) has posted 10 new FAQs on the topic of advanced diagnostic imaging accreditation. To review these FAQs, visit the CMS FAQ database at *http://questions.CMS.hhs.gov* and search for "advanced diagnostic imaging accreditation" (*http://questions.cms.hhs.gov/app/answers/list/kw/Advanced%20Diagnostic%20Imaging%20Accreditation/search/1*).

For more information on advanced diagnostic imaging accreditation, please visit *http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp*.

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Source: CMS PERL 201106-02

Men's Health Month and National Men's Health Week

June is Men's Health Month and Monday, June 13 marks the beginning of this year's National Men's Health Week, which culminates appropriately on Father's Day, Sunday, June 19. The theme for this year is "Awareness, Prevention, Education, and Family."

The purpose of Men's health month and week is to heighten public awareness of preventable health problems and encourage the early detection and treatment of diseases among men and boys. While Medicare now provides coverage for a wider array of preventive services and screenings, many men covered by Medicare are not fully using these services that can make a difference in the quality of their health. Your help is needed. Please join the Centers for Medicare & Medicaid Services in helping men with Medicare learn how they can live longer, healthier lives through disease prevention, early detection, and lifestyle modifications that support a healthier life.

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

- Colorectal and prostate cancer screenings
- Cardiovascular disease screenings
- Diabetes screening, diabetes self-management training, and medical nutrition therapy
- HIV screening
- Immunizations, including:
  - Hepatitis B
  - Influenza
  - Pneumococcal
- Smoking cessation counseling
- Annual wellness exam (new for 2011)

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

What can you do?

As a healthcare professional who provides care to men covered by Medicare you can help protect the health of your Medicare patients who may be at risk

for certain health issues by educating them about their risk factors and encouraging them to take advantage of the preventive services and screenings that are appropriate for them. **Note**: Many preventive services and screenings covered by Medicare require a referral.

Additional information

- Quick Reference Information: Medicare Preventive Services (*http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf*)
- *MLN Matters* Article MM7079 – "Annual Wellness Visit, Including Personalized Prevention Plan" (*http://www.cms.gov/mlnmattersarticles/downloads/MM7079.pdf*)
- Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (*http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf*)
- *Medicare Learning Network* Preventive Services Educational Products (*http://www.cms.gov/MLNProducts/35_PreventiveServices.asp*)
- Men's Health Month website (*http://www.menshealthmonth.org/*)
- Men's Health Week website (*http://www.menshealthmonth.org/week/index.html*)

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Source: CMS PERL 201106-20

National HIV Testing Day

Take the test – take control

National HIV Testing Day (NHTD) is an event organized by the National Association of People with AIDS (NAPWA) (*http://www.napwa.org/*) in partnership with other national and local entities across the country. The 17th annual NHTD took place this year on Monday, June 27, as part of an ongoing effort to combat the growing human immunodeficiency virus (HIV) epidemic by teaching those at risk the powerful reasons for learning one's HIV status. This initiative was unique in that the message "take the test, take control" came directly from those already living with HIV.

As the HIV epidemic turns thirty, the Centers for Medicare & Medicaid Services (CMS) reminds the health care community that Medicare provides coverage for HIV screening for Medicare beneficiaries at increased risk for HIV infection based on the United States Preventive Services Task Force (USPSTF) recommendations and subject to coverage and eligibility guidelines.

What can you do?

CMS urges Medicare providers to help the cause by educating seniors and other beneficiaries on the various preventive services covered by Medicare; for at-risk beneficiaries, use your office visits as an opportunity to inform your patients about the benefits of HIV screening. Medicare provides coverage for HIV screening as a Medicare Part B benefit; eligible beneficiaries may receive this service at no out-of-pocket cost (no coinsurance, copayment, or deductible). (Beneficiaries with any known prior diagnosis of HIV-related illness are not eligible for this screening test.)

Additional information

- CMS national coverage determination – NCD for screening for HIV (*http://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId=229&ver=19&NcaName=Screening+for+the+Human+Immunodeficiency+Virus+(HIV)+Infection&bc=BEAAAAAAAAAA&*)
- Medicare Learning Network's "Guide to Medicare Preventive Services" (*http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf*)
- MLN Matters article MM6786, "Screening for HIV" (*http://www.cms.gov/MLNMattersArticles/downloads/MM6786.pdf*)
- MLN's "HIV Screening" brochure (*http://www.cms.gov/MLNProducts/downloads/HIV_brochure_ICN905713.pdf*)
- US Preventive Services Task Force (USPSTF) -- Screening for HIV Recommendation Statement (*http://www.uspreventiveservicestaskforce.org/uspstf05/hiv/hivrs.htm#clinical*)
- Department of Health & Human Services – National HIV Testing (*http://www.aids.gov/awareness-days/*)
- NAPWA National HIV Testing Day (*http://www.napwa.org/*)

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Source: CMS PERL 201106-44

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.

Incentive Programs

CMS provides first Medicare EHR incentive payments totaling $75 million

Providers offered flexibility in adopting e-prescribing

The Centers for Medicare & Medicaid Services (CMS) announced on Thursday, May 26, that the first payments of the Medicare electronic health record (EHR) incentive program were distributed on May 19. As part of the American Recovery and Reinvestment Act, the Medicare EHR incentive program provides payments to eligible professionals (EPs) and hospitals that demonstrate meaningful use of certified EHR technology.

CMS Administrator Donald Berwick, M.D., explained in a statement that the payments are a crucial part of the nation's future, "We can bring America's health care system into the 21st century by adopting electronic health records and using electronic prescribing systems. Today's announcements are steps on the right path – toward the health IT system America needs, which will save lives, save money."

CMS noted that in addition to the $75 million given to providers participating in the Medicare program, 15 states have initiated their Medicaid EHR incentive programs since January 2011, and, to date, over $83 million in incentive payments has been made to qualified Medicaid providers.

The National Coordinator for Health Information Technology, Farzad Mostashari, M.D., ScM, said in a statement, "Through the EHR Incentive Programs, we are helping eligible providers invest in their technology infrastructure. But this isn't just about technology. The goal is better and safer health care, and that means it's about patients – about their health care and protection of their information."

Last Thursday, CMS also announced proposals for new flexibilities to help providers phase in the use of electronic prescribing. This program provides financial incentives, including payment adjustments beginning January 1, 2012, for EPs to encourage electronic prescribing (eRx).

The full press release can be found on the CMS website at *http://www.cms.gov/apps/media/press/release.asp?Counter=3968&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date*.

Detailed fact sheets on both the e-prescribing proposed rule and the EHR incentive payments can be found in the fact sheet section on the CMS website at *http://www.cms.gov/apps/media/fact_sheets.asp*.

Want more information about the EHR incentive programs?

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

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Source: CMS PERL 201106-07

Two new FAQs added to the EHR website

The Centers for Medicare & Medicaid Services (CMS) wants to keep you updated with the latest resources on the Medicare and Medicaid electronic health record (EHR) incentive programs. Two new frequently asked questions (FAQs) on clinical quality measures (CQMs) and meaningful use have been added to the CMS website. Take a minute and review these new FAQs.

1. For the Medicare and Medicaid EHR incentive programs, if the certified EHR technology possessed by an eligible professional (EP) generates zero denominators for all CQMs in the additional set that it can calculate, is the EP responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10648/session/L3NpZC81eDFBWkh1aw%3D%3D*.
2. For the Medicare and Medicaid EHR incentive programs, if certified EHR technology possessed by an EP includes the ability to calculate CQMs from the additional set that are not indicated by the EHR developer or on the Certified Health Information Technology Product List (CHPL) as tested and certified by an ONC -- Authorized Testing and Certification Body (ONC-ATCB), can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10649/session/L3NpZC81eDFBWkh1aw%3D%3D*.

For more information about the CQMs, take a look at the CQM Web page of the EHR website at *https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp*.

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 on the EHR incentive programs.

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Source: CMS PERL 201106-08

Register for national call on EHR incentive program basics

Date: Thursday, July 14
Time: 1:30-3:00 p.m. ET

Did you know that providers have received over $190 million in Medicare and Medicaid electronic health record (EHR) incentive payments through May? Don't be left behind. Learn what you need to do to be eligible for an incentive. Join the Centers for Medicare & Medicaid Services (CMS) for a national call for eligible professionals (EPs) on Medicare and Medicaid EHR incentive program basics.

Agenda

- Are you eligible?
- How much are the incentives and how are they calculated?
- How do you get started?
- What are major milestones regarding participation and payment?
- How do you report on meaningful use?
- Where can you find helpful resources?
- Question and answer session

Target audience

Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, chiropractors, nurse practitioners, certified nurse midwives, physician assistants (PA) who practice at a federally qualified health center (FQHC)/rural health center (RHC) led by a PA. (**Note:** Hospital-based EPs may not participate. An EP is considered hospital-based if 90 percent or more of the EPs services are performed in a hospital inpatient or emergency room setting.) Medicaid eligible professionals must meet patient volume criteria, providing services to those attributable to Medicaid or, in some cases, needy individuals.)

Registration

To register for this informative session, go to *http://www.eventsvc.com/palmettogba/071411*. **Registration will close at 1:30 p.m. ET on July 13, 2011, or when available space has been filled**. No exceptions will be made, so please be sure to register prior to this time.

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

Source: CMS PERL 201106-40

Update: Five new meaningful use FAQs posted

The Centers for Medicare & Medicaid Services (CMS) wants to keep you updated with the latest resources on the Medicare and Medicaid electronic health record (EHR) incentive programs. Five new frequently asked questions (FAQs) on meaningful use have been added to the CMS website. Take a minute and review these new FAQs.

1. For the meaningful use objective of "capability to exchange key clinical information" for the Medicare and Medicaid EHR incentive programs, does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10638*.
2. For the Medicare and Medicaid EHR incentive programs, how should an eligible professional (EP) who orders medications infrequently calculate the measure for the "computerized provider order entry (CPOE)" objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10639*.
3. How should patients in swing beds be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10640*.
4. How should nursery day patients be counted in the denominators of meaningful use measures for eligible hospitals and CAHs for the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10641*.
5. What lab tests should be included in the denominator of the measure for the "incorporate clinical lab-test results" objective under the Medicare and Medicaid EHR incentive programs? Read the answer at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10642*.

For more information about meaningful use and its requirements, take a look at the Meaningful Use Web page at *https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp* of the EHR website.

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 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 201105-37

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*

Foot care coverage guidelines

Provider types affected

This article is for informational purposes only for providers billing Medicare for foot care services. It is an overview of existing policy and no change in policy is being conveyed.

Medicare podiatry services

The scope of the practice for Podiatry is defined by state law and the individual state laws should be consulted in determining a specific podiatrist's (or doctor of podiatric medicine) scope of practice.

This article covers routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds, and infections.

Medicare covered foot care services

According to the *Medicare Benefit Policy Manual* (MBPM), Chapter 15, Section 290, Medicare covered foot care services only include medically necessary and reasonable foot care.

Exclusions from coverage

Certain foot care related services are not generally covered by Medicare. In general, the following services, whether performed by a podiatrist, osteopath, or doctor of medicine, and without regard to the difficulty or complexity of the procedure, are not covered by Medicare:

1. Treatment of flat foot

   The term "flat foot" is defined as a condition in which one or more arches of the foot have flattened out. Services or devices directed toward the care or correction of such conditions, including the prescription of supportive devices, are not covered.

2. Routine foot care

   Except as discussed below in the section entitled "Conditions that might justify coverage", routine foot care is excluded from coverage. Services that normally are considered routine and not covered by Medicare include the following:

   - The cutting or removal of corns and calluses;
   - The trimming, cutting, clipping, or debriding of nails; and
   - Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

3. Supportive devices for feet

   Orthopedic shoes and other supportive devices for the feet generally are not covered, except Medicare does cover such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, a narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

The following services are generally not covered – treatment of flat foot, routine foot care, and supportive devices for the feet.

Conditions that might justify coverage

The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine (and, therefore, excluded from coverage). Accordingly, foot care that would otherwise be considered routine may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet. In these instances, certain foot care procedures that otherwise are considered routine (e.g., cutting or removing corns and calluses, or trimming, cutting, clipping, or debriding nails) may pose a hazard when performed by a nonprofessional person on patients with such systemic conditions.

Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying conditions that might justify coverage for routine foot care:

- Diabetes mellitus *
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitis obliterans)
- Chronic thrombophlebitis *
- Peripheral neuropathies involving the feet
  - Associated with malnutrition and vitamin deficiency *
    - Malnutrition (general, pellagra)
    - Alcoholism

continued on next page

Foot...*continued*

- Malabsorption (celiac disease, tropical sprue)
- Pernicious anemia

- Associated with carcinoma *
- Associated with diabetes mellitus *
- Associated with drugs and toxins *
- Associated with multiple sclerosis *
- Associated with uremia (chronic renal disease)*
- Associated with traumatic injury
- Associated with leprosy or neurosyphilis
- Associated with hereditary disorders
  - Hereditary sensory radicular neuropathy
  - Angiokeratoma corporis diffusum (Fabry's)
  - Amyloid neuropathy

*When the patient's condition is one of those designated above by an asterisk (*), routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

In addition, the following may be covered:

- The treatment of warts (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.
- In the absence of a systemic condition, treatment of mycotic nails may be covered. The treatment of mycotic nails for an ambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. The treatment of mycotic nails for a nonambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

Presumption of coverage for routine services

When evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, please refer to the *Medicare Benefit Policy Manual*, Chapter 15, Section 290.

When the routine services are rendered by a podiatrist, your Medicare carrier may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type services.

The carrier may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

Foot care for patients with chronic disease

Diabetic sensory neuropathy: loss of protective sensation (LOPS)
Effective for services furnished on or after July 1, 2002, Medicare covers an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

Effective July 1, 2011, Medicare covers an evaluation of the feet no more often than every six months for diabetic sensory neuropathy and LOPS.

Please refer to the national coverage determination (NCD), entitled "Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (LOPS) (aka Diabetic Peripheral Neuropathy)" for more information. This NCD is available at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=171&ncdver=1&bc=BAAAgAAAAAAA&*.

Lower extremity wound care

Electrostimulation and electromagnetic therapy for wounds (claims submitted on or after July 6, 2004)
The Centers for Medicare & Medicaid Services

Foot...*continued*

(CMS) will allow for coverage for the use of electrical stimulation and electromagnetic therapy for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers when certain conditions are met

For more detailed information, please refer to national coverage determination (NCD) for "Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds," which can be found at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=131&ncdver=3&bc=BAABAAAAAAAA*.

Hyperbaric oxygen (HBO) therapy for hypoxic wounds and diabetic wounds of the lower extremities (CAG-00060N)

For claims submitted on or after April 1, 2000, HBO therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or type II diabetes and has a lower extremity wound that is due to diabetes;
- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, please refer to the NCD for hyperbaric oxygen therapy, which is available at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=12&ncdver=3&NCAId=37&ver=7&NcaName=Hyperbaric+Oxygen+Therapy+for+Hypoxic+Wounds+and+Diabetic+Wounds+of+the+Lower+Extremities&fromdb=true&IsPopup=y&bc=AAAAAAAAEAgA&*.

Additional billing guidelines

Claims involving complicating conditions

- When submitting claims for services furnished to Medicare beneficiaries who have complicating conditions, the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim, along with the approximate date that the beneficiary was last seen by the indicated physician.
- Document carefully any convincing evidence showing that non-professional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease. Stating that the beneficiary has a complicating condition such as diabetes does not of itself indicate the severity of the condition.
- Exceptional situations include initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only non-covered care.
- The exclusion of foot care is determined by the nature of the service and not according to who provides the service. When an itemized bill shows both covered services and non-covered services that are not integrally related to the covered service, the portion of the charges that are attributable to the non-covered services should be denied.
- Sometimes payment is made for incidental non-covered services that are performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if toenails must be trimmed in order to apply a cast to a fractured foot, then the charge for the trimming of nails would be covered.
- However, a separately itemized charge for this excluded service would not be allowed. Please refer to your Medicare contractor for questions about coverage that is "incident to" a covered procedure.
- Information about coverage Incident to Physician's Professional Services can also be found in the *Medicare Benefit Policy Manual*, Chapter 15, Covered Medical and Other Health Services, Section 60 – Services and Supplies.

Therapeutic shoes for individuals with diabetes (MBPM, Chapter 15, Section 140)

- Coverage of depth or custom-molded therapeutic shoes and inserts for individuals with diabetes is available as of May 1, 1993.
- These diabetic shoes are covered if the requirements specified in the *Medicare Benefits Policy Manual*, Chapter 15, Section 140, regarding certification and prescription are met.

continued on next page

Foot...*continued*

- This benefit provides for a pair of diabetic shoes each equipped so that the affected limb, as well as the remaining limb, is protected, even if only one foot suffers from diabetic foot disease.
- Claims for therapeutic shoes for diabetics are processed by the durable medical equipment Medicare administrative contractors (DME MACs). Therapeutic shoes for diabetics are not DME and are not considered DME or orthotics, but a separate category of coverage under Medicare Part B.

Related links

Medicare manuals

- The *Medicare Benefit Policy Manual*" Publication 100-2, Chapter 15, can be found at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*.
- The *Medicare Program Integrity Manual* can be found at *http://www.cms.gov/manuals/downloads/pim83c05.pdf*.
- The *National Coverage Determination Manual* can be found at *http://www.cms.gov/Manuals/IOM/itemdetail.asp?itemID=CMS014961*.

Local coverage decisions

- The Medicare Coverage Database provides access to local coverage decision articles published for Medicare contractors. These articles can be found at *http://www.cms.gov/mcd/index_local_alpha.asp?from=alphaarticle&letter=P*.

Related change requests and *MLN Matters* articles

- Program Memorandum Transmittal AB-02-096, Change Request 2269, "Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes" can be found at *http://www.cms.gov/Transmittals/downloads/AB02096.pdf*.
- Program Memorandum Transmittal AB-02-105, Change request 2272, "Medical Review of Medicare Payments for Nail Debridement Services," can be found at *http://www.cms.gov/Transmittals/Downloads/AB02105.pdf*.
- *MLN Matters* article, MM3430, "Reasonable charge update for 2005 splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses" can be found at *http://www.cms.gov/MLNMattersArticles/downloads/MM3430.pdf*.

MLN Matters® Number: SE1113
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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*.

National coverage determination for percutaneous transluminal angioplasty (PTA) (20.7)

Provider types affected

Physicians and hospitals submitting claims to fiscal intermediaries (FIs), carriers, and/or A/B Medicare administrative contractors (MACs) for percutaneous transluminal angioplasty (PTA) with carotid artery stenting (CAS) are affected.

What you need to know

This Special Edition contains no changes to current policy. This article describes current policies regarding PTA and CAS.

You need to know that the national coverage determination (NCD) 20.7 for PTA of the carotid artery concurrent with stenting is not changed by the new FDA-approved indications for the RX acculink carotid stent. Specifically:

- Procedures on patients who are not at high risk for CEA (i.e., patients at normal or standard risk) are covered by Medicare when these procedures are performed in FDA-approved post approval studies; and
- Patients who are not at high risk for CEA are eligible for Medicare coverage in Category B investigational device exemption (IDE) studies.

You may review the national coverage determination (NCD) for "Percutaneous Transluminal Angioplasty (PTA) (20.7)," which is available at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=201&ncdver=9&bc=BAABAAAAAAAA&*.

Background

On May 6, 2011, the Food and Drug Administration (FDA) approved use of the RX acculink carotid stent in patients who are not at high risk for adverse events from CEA. FDA approval of these new indications for normal or standard risk patients does not change the Medicare national coverage policy.

Additional information

The Category B IDE clinical trials regulation (42 CFR 405.201) is available at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr405_main_02.tpl*.

Information about routine costs under the clinical trials policy (Medicare NCD Manual 310.1) is available at *http://www.cms.gov/medicare-coverage-database/search/document-id-search-results.aspx?DocID=310.1&bc=gAAAAAAAAAAA&*.

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

MLN Matters® Number: SE1119
Related Change Request (CR) #: N/A
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Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Medicare now provides coverage for an annual wellness visit and initial preventive physical examination

The annual wellness visit (AWV) – new for 2011

Under the Affordable Care Act, Medicare beneficiaries may now receive coverage for an AWV, which is a yearly office visit that focuses on preventive health. During the AWV, health care providers will review a patient's history and risk factors for diseases, ensure that the patient's medication list is up to date, and provide personalized health advice and counseling. The first AWV also allows the provider to establish a written personalized prevention plan. This new benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary's health needs change over time. Download a complete list of the AWV components at *http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf*.

The initial preventive physical examination (IPPE)

In addition to the new AWV, Medicare also provides coverage for the IPPE, commonly known as the "Welcome to Medicare" visit (WMV). Medicare has provided coverage for this exam since 2005; it is provided as a one-time service to newly-enrolled beneficiaries. The IPPE is an introduction to Medicare and covered benefits, with a focus on health promotion and disease detection.

The IPPE must be performed within the first 12 months after the beneficiary's effective date of their Medicare Part B coverage. It contains a number of components that focus on prevention, including a complete medical/social/family history, a focused physical examination (i.e., body mass index, blood pressure, visual acuity), an assessment of functional ability, and counseling. Download a complete list of the IPPE components at *http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf*.

Important note: Medicare provides coverage of the AWV and the IPPE as Medicare Part B benefits. The beneficiary will pay nothing for the AWV and the IPPE (there is no coinsurance or copayment and no Medicare Part B deductible for these benefits). To learn more about the AWV and the IPPE, please refer to *Medicare Learning Network's Guide to Medicare Preventive Services for Medicare Fee-For-Service Providers and Suppliers* at *http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.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 201106-32

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:** 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.**

Revisions to LCDs

Clarification of a qualified physician statement – revisions to the LCDs

LCD ID number: L28779, L31465, L28768, L28770, L28823, L28846, L28834, L28936, L28974, L28990, L28999 (Florida)
LCD ID number: L28783, L31465, L28769, L28771, L28856, L28879, L28867, L28957, L28976, L29022, L29031 (Puerto Rico/U.S. Virgin Islands)

First Coast Services Options Inc. the Medicare administrative contractor jurisdiction 9 (MAC J9) received an outside request to review and clarify the intent of the certification and training statement found in the local coverage determinations (LCDs) for avastin and lucentis. That review resulted in the revision of the certification and training statement. As a result, the MAC J9 conducted a review of all LCDs that contained the training and certification statement and for those LCDs that contained the statement, has revised the statement to be consistent with the revisions mentioned above. The following LCDs have been revised: AJ7504 atgam (lymphocyte immune globulin, antithymocyte globulin [equine]), A95921 autonomic function tests, A71275 computed tomographic angiography of the chest, heart and coronary arteries, A74261 computed tomographic colonography, A43235 diagnostic and therapeutic esophagogastroduodenoscopy, AJ0740 ganciclovir and cidofovir, A95860 electromyography and nerve conduction studies, A93965 non-invasive evaluation of extremity veins, APULMDIAGSVCS pulmonary diagnostic services, AJ1080 testosterone cypionate and testosterone enanthate, and A36470 treatment of varicose veins of the lower extremity.

The statement in question is located in the “limitations” or “utilization guidelines” sections of the LCDs. In addition, LCDs that contained the statement in any associated “Coding Guidelines” attachment were also revised for consistency. The revised statement reads as follows: “The Centers for Medicare & Medicaid Services (CMS) on-line manual system, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 13, section 13.5.1 outlines that *reasonable and necessary services are ordered and/or furnished by qualified personnel.* A qualified physician for this service/procedure is defined as follows: a.) physician is properly enrolled in Medicare and b.) training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty in the United States and/or by the applicable specialty society in the United States.”

Effective date

These LCD revisions are effective for claims processed **on or after June 14, 2011**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section…” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

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 email address and select the subscription option that best meets your needs.

Intravitreal bevacizumab (Avastin®) – revision to the LCD

LCD ID number: L29933 (Florida)
LCD ID number: L29935 (Puerto Rico/U.S Virgin Islands)

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) was most recently revised on January 1, 2010. Since that time, the Medicare administrative contractor jurisdiction 9 (MAC J9) has re-evaluated the statement for training and qualification found in the LCD based on an outside request to clarify the intent of the statement. This statement is found under the "limitations" section of the LCD. The MAC J9 has revised the statement which now defines what a qualified physician is for the services described in the LCD. The previous statement limiting the performance of the service to a board-certified ophthalmologist has been removed.

Effective date

This LCD revision is effective for claims processed **on or after June 14, 2011**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

AJ1459: Intravenous immune globulin – revision to the LCD

LCD ID number: L28895 (Florida)
LCD ID number: L28917 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for intravenous immune globulin was most recently revised on April 7, 2011. Since that time, language regarding the diagnosis of common variable immunodeficiency (CVID) under the "Indications and Limitations of Coverage and/or Medical Necessity" section under subsection "a.) Primary humeral immunodeficiency syndromes" of the LCD has been revised based on a reconsideration request. The following revised language is included in the above section of the LCD:

- Laboratory reports demonstrating an IgG level of less than 400 mg/dl for the assay utilized, and lack of response to immunization (see below);

  OR

- An IgG level greater than or equal to 400mg/dl with evidence of recurrent severe infections with documented antibiotic therapy and lack of response to immunization (see below).

Effective date

This LCD revision is effective for services provided **on or after June 14, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to section…" drop-down menu at the top of the page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

AJ2778: Ranibizumab (Lucentis®) – revision to the LCD

LCD ID number: L28977 (Florida)
LCD ID number: L29010 (Puerto Rico/U.S Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) was most recently revised on October 3, 2010. Since that time, the Medicare administrative contractor jurisdiction 9 (MAC J9) has re-evaluated the statement for training and qualification found in the LCD based on an outside request to clarify the intent of the statement. This statement is found under the "limitations" section of the LCD. The MAC J9 has revised the statement which now defines what a qualified physician is for the services described in the LCD. The previous statement limiting the performance of the service to a board-certified ophthalmologist has been removed.

Effective date

This LCD revision is effective for claims processed **on or after June 14, 2011**. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

AJ7184: Hemophilia clotting factors – revision to the LCD

LCD ID number: L28851 (Florida)
LCD ID number: L28884 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for hemophilia clotting factors was most recently revised on January 1, 2011. Since that time, a revision was made to the LCD based on the Centers for Medicare & Medicaid Services (CMS) Transmittal 2207, change request (CR) 7303, dated April 29, 2011, CMS Transmittal 2227, CR 7303, dated May 24, 2011, and CMS Transmittal 2234, CR 7443, dated May 27, 2011 to delete HCPCS code J7184 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF:RCO) and replace it with HCPCS code Q2041 (Injection, von Willebrand factor complex (human), Wilate, 1 I.U. VWF:RCO) under the "*CPT*/HCPCS Codes" section of the LCD. In addition, the "Contractor's Determination Number" was changed to AJ7186.

Effective date

This LCD revision is effective for services provided **on or after July 1, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to section…" drop-down menu at the top of the page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

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

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

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

The local coverage determination (LCD) for rituximab (Rituxan®) was most recently revised on January 28, 2011. Since that time, a revision was made under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to include the following new Food and Drug Administration (FDA) approved indications:

- In combination with glucocorticoids, for the treatment of adult patients with Wegener's granulomatosis (WG) and microscopic polyangiitis (MPA)

In addition to the above, ICD-9-CM codes 446.0 (Polyarteritis nodosa [microscopic polyangiitis]) and 446.4 (Wegener's granulomatosis) were added under the "ICD-9 Codes that Support Medical Necessity" section of the LCD, and the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed **on or after June 23, 2011,** for services provided **on or after April 19, 2011**. First Coast Service Options, Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

ANCSVCS: Noncovered services – (C9729) revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised on June 7, 2011. Since that time, a revision was made to the LCD. The Centers for Medicare & Medicaid Services (CMS) April 2011 Update to the Hospital Outpatient Prospective Payment System (OPPS), change request (CR) 7342, transmittal 2174, dated March 18, 2011, lists HCPCS code C9729 (Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar) as a new code.

Since it has been determined that HCPCS code C9729 represents a "Minimally Invasive Lumbar Decompression (mild) for lumbar spinal stenosis" procedure, *CPT* code *64999* ("Minimally Invasive Lumbar Decompression (mild) for lumbar spinal stenosis") was removed from the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD and replaced with HCPCS code C9729.

Effective date

This LCD revision is effective for claims processed **on or after June 23, 2011,** for services rendered **on or after April 1, 2011.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/.*

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

ANCSVCS: Noncovered services – (0275T) revision to the LCD

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

The local coverage determination (LCD) for noncovered services was most recently revised on June 23, 2011. Since that time, a revision was made to the LCD. Based on the Centers for Medicare & Medicaid Services (CMS) July 2011 Update to the Hospital Outpatient Prospective Payment System (OPPS), change request (CR) 7443, transmittal 2234, dated May 27, 2011, HCPCS code C9729 is being deleted from the "*CPT*/HCPCS Codes – Local Noncoverage Decisions – Procedures" section of the LCD and replaced with *CPT* code *0275T.*

- C9729 (Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar)
- *0275T (Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar).*

Effective date

This LCD revision is effective for services provided **on or after July 1, 2011.** First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

ASKINSUB: Skin substitutes – revision to the LCD

LCD ID number: L28985 (Florida)
LCD ID number: L29327 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for skin substitutes was most recently revised on February 13, 2011. Since that time, a revision was made to the LCD based on change request 7443, Transmittal 2234 (July 2011 Update of the Hospital Outpatient Prospective Payment System [OPPS]), dated May 27, 2011, issued by the Centers for Medicare & Medicaid Services (CMS).

An evaluation of HCPCS code C9365 (Oasis ultra tri-layer matrix, per square centimeter) determined that this skin substitute code should be added under the "*CPT*/HCPCS Codes" section of the LCD, under the subsection "The following HCPCS codes are not separately payable and are considered not medically reasonable and necessary products:".

Effective date

This LCD revision is effective for services provided **on or after July 1, 2011.** First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section…" drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

A77402: Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – revision to the LCD

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

The local coverage determination (LCD) for radiation therapy for T1 basal cell and squamous cell carcinomas of the skin was most recently revised on March 28, 2011. Since that time, upon further review of the existing language for the definition of a qualified physician under the ”Supervision and Training” section of the LCD, a revision was made for clarification of a qualified physician for this service and included the Nuclear Regulatory Commission (NRC). In addition, under the “Indications” section of the LCD for external beam radiation therapy (EBRT) and high dose rate (HDR) brachytherapy, the third and fourth bullets were revised to read as follows:

- Third bullet – Radiation therapy (RT) of basal cell carcinoma (BCC) or squamous cell carcinoma (SCC) on the torso, scalp, or below the knee may be considered medically reasonable and necessary if the patient has co-morbidities that would prevent surgical intervention of the lesion (e.g., MRSA; current anticoagulation or anti platelet treatment that cannot be discontinued); or
- Fourth bullet – Radiation therapy (RT) for basal cell carcinoma (BCC) or squamous cell carcinoma (SCC) below the knee, or on the scalp may be considered medically reasonable and necessary when surgical intervention to remove the lesion would require a skin graft and/or the closure would be complicated, for example due to chronic heart failure with lower extremity edema or due to difficult closure on the scalp.

Effective date

This LCD revision is effective for claims processed **on or after June 14, 2011**. First Coast Service Options Inc. (FCSO) LCDs are available through the CMS Medicare Coverage Database at *http://www.cms.gov/medicare-coverage-database/*.

Coding guidelines for an LCD (when present) may be found by selecting “LCD Attachments” in the “Jump to Section…” drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the “Display Future Effective Documents” link at the top of the list of LCDs page.

Additional Information

Florida Part A inpatient prepayment notification MS-DRG 460 (spinal fusion except cervical w/o MCC)

The November 2010 inpatient medical severity-diagnosis related group (MS-DRG) error rate for Part A Medicare administrative contractor (MAC) for jurisdiction 9 (J9) was 18.17 percent. This error rate is considerably higher than the national inpatient DRG rate. Based on comprehensive error rate testing (CERT) review findings, MS-DRG 460 (spinal fusion except cervical w/o MCC) has been identified as being high risk for payment error. A majority of CERT errors were assigned because the submitted documentation does not support the medical necessity of the procedure. Prepayment medical review editing for MS-DRG 460 will be initiated at 30 percent for claims processed **on or after June 23, 2011**.

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *http://medicare.fcso.com/PDS/index.asp.*

Healthcare provider taxonomy code updates effective July 1

Effective July 5, 2011, the Healthcare Provider Taxonomy Codes (HPTC) was updated. The HPTC is a national code set that allows medical providers to indicate their specialty. The National Uniform Claim Committee (NUCC) updates the code set twice a year with changes effective April 1, and October 1. The latest version of HPTC is available from the Washington Publishing Company website at: *www.wpc-edi.com/codes/taxonomy*. If a HPTC is reported to Medicare, it should be a valid code or a batch and/or claim level deletion (rejection) may occur. To ensure you do not receive a claim or file level rejection it is recommended that you verify the HPTC submitted is a valid code on the most recent HPTC listing. If you require assistance in updating the taxonomy code in your practice management system, please contact your software support vendor.

Source: Publication 100-04, Transmittal 2164, change request 7318

New FAQs available about HIPAA version 5010 implementation

The Centers for Medicare & Medicaid Services (CMS) has posted 18 new frequently asked questions (FAQs) about HIPAA version 5010 implementation, and one portable document format (PDF) document containing 27 questions and answers (Q&As) specific to the Wednesday, March 30 CMS-hosted 5010 national provider teleconference on provider testing and readiness. To review these FAQs, visit the CMS FAQ database at *http://questions.CMS.hhs.gov* and search for "5010" (or use a direct link to the "5010" search results at *http://questions.cms.hhs.gov/app/answers/list/kw/5010/sno/1/search/1/session/3NpZC9RSmpESmx1aw%3D%3D*), or go directly to the Q&As specific to the March 30 provider testing and readiness national provider teleconference at *http://questions.cms.hhs.gov/app/answers/detail/a_id/10647/kw/5010* .

Please check the CMS FAQ database regularly for newly-posted or updated information related to 5010.

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

Source: CMS PERL 201105-41

Test your version 5010 implementation efforts

The version 5010 compliance deadline of Sunday, January 1, 2012, is nearly six months away. **All HIPAA-covered entities need to prepare for this transition, which includes conducting external testing with all trading partners** (providers, clearinghouses, and vendors) to ensure timely compliance.

To assist with testing, the Centers for Medicare & Medicaid Services (CMS), in conjunction with the Medicare fee-for-service program, are holding a national 5010 testing day. The testing day will serve as an opportunity for trading partners to further test compliance efforts with the added benefit of live help desk support, and direct and immediate access to Medicare administrative contractors (MACs).

The national version 5010 testing day is scheduled for Wednesday, August 24. CMS hopes that all trading partners will participate so that they can have a timely and smooth transition to version 5010.

This testing day will help facilitate a better understanding of MAC testing protocols and the transition to version 5010; it is not meant to prohibit trading partners from further compliance testing. **All trading partners are encouraged to begin working with their MACs to test transactions as soon as possible.**

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

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

Source: CMS PERL 201106-31

National version 5010 testing days

Wednesday, June 15 and Wednesday, August 24

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 national 5010 testing days to be held Wednesday, June 15, 2011, and Wednesday, August 24, 2011. The national 5010 testing days are 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 days. This includes:

- Providers;
- Clearinghouses; and
- Vendors

More details concerning transactions to be tested are forthcoming from your local MAC. Additionally, there are several state Medicaid agencies that will be participating in the national 5010 testing days; more details will follow from them as well.

Again, CMS national 5010 testing days do 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, 2011, and Wednesday, August 24, 2011, 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 201106-18

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

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

Announcements

- January 1, 2011, marked the beginning of the 5010/D.0. transition year
- Versions 5010 & D.0 FAQs now available (*https://questions.cms.hhs.gov/app/answers/list/kw/5010*)
- National Testing Day message now available (*http://www.cms.gov/Versions5010andD0/Downloads/5010_National_Testing_Day_Message.pdf*)

Reminders

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

continued on next page

Calendar...*continued*

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

Readiness assessments

- Have you done the following to be ready for 5010/D.0.? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_1.pdf*)
- 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*)
- Do you know the implications of not being ready? (*http://www.cms.gov/Versions5010andD0/Downloads/Readiness_5010.pdf*)

Implementation calendar

Current events

June 2011
June 15: National MAC Testing Day (*http://medicare.fcso.com/Events/202566.asp*)

Upcoming events

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

August 2011
August 24: National MAC testing day
August 31: CMS-hosted Medicare fee-for-service national call – MAC panel questions & answers

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*)
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*)

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Calendar...*continued*

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: Moving Forward with Testing to Attain Implementation* (*http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=12B9F00000029*)

February 2011
February 20-24: Healthcare Information and Management Systems Society (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?

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*)

For older national call information, please visit the 5010 National Calls section of CMS' versions 5010 & D.0. Web page at *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 201106-11

Guidelines for accepting and processing reopenings via a secure Internet portal/application

Provider types affected

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

Provider action needed

Stop – impact to you

Effective October 1, 2011, you may have (depending on your contractor) an alternative, electronic method to submit your requests for Medicare fee-for-service (FFS) claim reopenings.

Caution – what you need to know

Change request (CR) 7420, from which this article is taken (effective October 1, 2011,) allows Medicare contractors to use a secure Internet portal/application to accept and process your requests for reopening Medicare FFS claims.

Go – what you need to do

You should make sure that your billing staffs are aware of this change.

Background

In response to requests from Medicare contractors, CR 7420 (from which this article is taken) updates the current instructions in the *Medicare Claims Processing Manual* Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), to allow them to accept claimant initiated reopening requests via a secure Internet portal/application – effective October 1, 2011. You can find this manual at *http://www.cms.gov/manuals/downloads/clm104c34.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

Note: Medicare contractors may not require you to file a reopening via a secure Internet portal/application. Also, contractors are not required to offer this electronic capability.

Medicare will have a number of requirements for Medicare contractors utilizing a secure Internet portal/application for reopening. Specifically, to provide this access, contractors will:

- Incorporate a formal registration process that contains validation of the electronic signature on the reopening request, which will include, at a minimum, the use of restricted user identifiers (IDs) and passwords, and a method for authenticating that the party has completed the portal registration process and has been properly identified by the system as an appropriate user.
- Include, in the appeals case file, an indication and/or description of the validation methodology; should a redetermination and/or higher level of appeal be submitted following an adverse reopening decision.
- Ensure that secure Internet portal/applications developed for reopening activities adhere to the security standards in the Health Insurance and Portability and Accountability Act (HIPAA); and comply with all CMS security requirements regarding protected health information prior to implementation.
- Issue a reopening decision or refusal to reopen via a secure Internet portal/application only if the party has submitted the request for reopening through that application.
- Provide adequate education to participating parties:
  - Regarding system capabilities/limitations prior to implementation and utilization of the secure portal; and
  - Reminding them that participation/enrollment in the secure portal/application is at their discretion and that they bear the responsibility for the authenticity of the information being attested to in the request.
- Include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this will include a statement indicating that the document was, “electronically signed by” or “verified/approved by,” etc.
- Ensure that appropriate procedures are in place, via the secure Internet/portal, to provide parties to the reopening with receipt confirmation of the reopening request, and instructions not to submit additional reopening requests for the same item/service via different venue (i.e., telephone, in writing, etc.).
- Consider decisions processed via a CMS approved secure Internet portal/application complete on the date the electronic reopening decision notice is transmitted to the party through the secure Internet portal/application.

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Guidelines...*continued*

- Ensure that there is a process in place by which a party can submit, via the secure application/portal; additional documentation/materials concurrent with the reopening request (i.e. ensure that the portal/application has the capability to accept additional documentation and/or other materials to support the reopening request.)
- Include a mechanism that tracks and marks the date/time of the notification so the submitting party is adequately informed about the timeframes required to ensure timely submission of future appeal requests for the item/service at issue, if applicable; and ensure that parties may save and print the refusal to reopen notice and the adverse revised determination/decision notice.
- Ensure that refusal to reopen and adverse revised determination notices transmitted via a secure Internet portal/application comply with the timeliness and content requirements as outlined in the *Medicare Claims Processing Manual*, Chapter 34.
- Provide hard copy adverse revised determination/decision notices to parties to the reopening who do not have access to the secure Internet portal/application; and ensure that these notices are mailed and/or otherwise transmitted on the same day the notice is transmitted via the secure portal/application.)
- Include the adverse revised determination/decision notice and any other related materials in the appeals case file if a valid appeal on the item/service is later requested.

Contractors will not issue a refusal to reopen notice if they begin processing a valid and timely request for redetermination as a reopening (clerical error or otherwise) and later determine that a reopening cannot be performed, or the determination cannot be changed. Rather, they will process the request as a valid/timely redetermination (as originally requested by the party) in accordance with the *Medicare Claims Processing Manual*, Chapter 29 (Appeals of Claims Decisions), which you can find at *http://www.cms.gov/manuals/downloads/clm104c29.pdf*.

Additional information

You can find the official instruction, CR 7420, issued to your FI or A/B MAC by visiting *http://www.cms.gov/transmittals/downloads/R2241CP.pdf*. You will find the updated *Medicare Claims Processing Manual*, Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), Sections 34.10 (Reopenings and Revisions of Claims Determinations and Decisions-General), 34.10.1 (Authority to Conduct a Reopening), 34.10.6.4 (Timeframes When a Party Requests an Adjudicator Reopen Their Decisions), 34.10.7 (Timeframes to Complete a Reopening Requested by a Party), 34.10.8 (Notice of a Revised Determination or Decision), and 34.10.13 (System and Processing Requirements for Use of Secure Internet Portal/Application to Support Reopening Activities) as an attachment to that CR. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7420
Related Change Request (CR) #: CR 7420
Related CR Release Date: June 17, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2241CP
Implementation Date: October 3, 2011

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Get ready for 5010 -- test now

Visit our HIPAA 5010 section of the provider website where you'll learn the latest news about HIPAA 5010, find out how to prepare for 5010 testing, and discover the resources you need to make your the transition to 5010 as smooth as possible. Don't wait -- call FCSO's EDI to test now -- 888-670-0940, option-5.

Claim status category code and claim status code update

Provider types affected

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

Provider action needed

This article, based on change request (CR) 7456, explains that the claim status codes and claim status category codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 were updated during the October 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at *http://www.wpc-edi.com/content/view/180/223/* on or about November 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on October 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

Background

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (institutional or professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional information

The official instruction, CR 7456 issued to your FI, A/B MAC, and DME MAC regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2243CP.pdf*. If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

MLN Matters® Number: MM7456
Related Change Request (CR) #: 7456
Related CR Release Date: June 17, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2243CP
Implementation Date: October 3, 2011

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Quarterly ICD-10 article reminds industry to get ready for version 5010

The Centers for Medicare & Medicaid Services (CMS) is committed to helping the industry transition to version 5010 and ICD-10. Each quarter, CMS contributes a column on the transition to version 5010 and ICD-10 in the American Health Information Management Association (AHIMA) publication ICD-TEN.

Our new article, *Will You Be Ready? This Month's Message from CMS*, (*https://newsletters.ahima.org/newsletters/ICDTen/2011/June/ready.html)* published in the June edition out this week, focuses on important information regarding the upcoming version 5010 transition and addresses industry readiness.

Version 5010 is just half a year away, so check out the article to find out more about what steps you can take to help reach compliance. Additionally, the article gives a sneak peek into new resources and tools CMS is developing to help the industry prepare for the transitions. Stay tuned for their debut in the coming weeks.

Keep up-to-date on version 5010 and ICD-10
Please visit *www.cms.gov/ICD10* for the latest news and resources to help you prepare!

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

Source: CMS PERL 201106-46

Quarterly HCPCS drug/biological code changes – July 2011 update

Provider types affected

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

What you need to know

Change request (CR) 7303 announces the quarterly updating of specific Healthcare Common Procedure Coding System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2011. You should make sure that your billing staffs are aware of these HCPCS code changes.

Non-payable code

Effective for claims with dates of service on or after July 1, 2011, Medicare will not pay for the following HCPCS code:

HCPCS code	Short description	Long description	MPFSDB status indicator
J7184	Wilate injection	Injection, von Willebrand factor complex (human), Wilate, 100 IU. VWF-RCO	I

Payable codes

Contractors will accept the codes in the following table as payable HCPCS codes for dates of service on or after July 1, 2011, using type of service (TOS) 1, 9, and Medicare physician fee schedule data base (MPFSDB) status indicator "E" (excluded from physician fee schedule by regulation):

HCPCS code	Short description	Long description
Q2041	Wilate injection	Injection, von Willebrand factor complex (human), Wilate, 1 IU VWF-RCO
Q2042	Hydroxyprogesterone caproate	Injection, hydroxyprogesterone caproate, 1 mg
Q2043	Sipuleucel-T auto CD54+	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
Q2044	Belimumab injection	Injection, belimumab, 10 mg

Additional information

You can find the official instruction, CR 7303, issued to your Medicare contractor by visiting *http://www.cms.gov/Transmittals/downloads/R2227CP.pdf*.

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

MLN Matters® Number: MM7303
Related Change Request (CR) #: 7303
Related CR Release Date: May 24, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2227CP
Implementation Date: July 5, 2011

Claims modifiers for use in the DMEPOS competitive bidding program

Note: This article was revised on June 21, 2011 to provide a new Web address for the single payment amounts. All other information remains unchanged. This information was previously published in the January 2011, *Medicare A Bulletin*, pages 25-28.

Provider types affected

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

Background

Under the DMEPOS competitive bidding program, beneficiaries with original Medicare who obtain competitive bidding items in designated CBAs are required to obtain these items from a contract supplier, unless an exception applies. The first phase of the program begins on January 1, 2011, in nine CBAs for nine product categories.

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

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

Competitive bidding modifiers

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

- J4 – DMEPOS item subject to DMEPOS competitive bidding program that is furnished by a hospital upon discharge.
- KG – DMEPOS item subject to DMEPOS competitive bidding program number 1.
- KK – DMEPOS item subject to DMEPOS competitive bidding program number 2.
- KU – DMEPOS item subject to DMEPOS competitive bidding program number 3.
- KW – DMEPOS item subject to DMEPOS competitive bidding program number 4.
- KY – DMEPOS item subject to DMEPOS competitive bidding program number 5.
- KL –DMEPOS item delivered via mail.
- KV – DMEPOS item subject to DMEPOS competitive bidding program that is furnished as part of a professional service.
- KT – Beneficiary resides in a competitive bidding area and travels outside that competitive bidding area and receives a competitive bid item.

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

Submit claims for competitive bidding items using the appropriate HCPCS code and corresponding modifier in effect.

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

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

- KE – DMEPOS item subject to DMEPOS competitive bidding program for use with non-competitive bid base equipment.

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How to use the modifiers

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

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

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

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier, to claims submitted for these items.

The J4 modifier should not be used by contract suppliers.

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

The KG, KK, KU and KW modifiers are modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and non-competitively bid items. For example, HCPCS code E0981 (wheelchair accessory, seat upholstery, replacement only, each) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a standard power wheelchair shall submit E0981 claims using the KG modifier. Contract suppliers for the complex rehabilitative power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a complex power wheelchair shall submit claims for E0981 using the KK modifier. Another example of the use of the KG modifier is with code A4636 (replacement, handgrip, cane, crutch, or walker, each). Contract suppliers for the walkers and related accessories product category in addition to other suppliers submitting claims for this accessory item when used with a walker shall submit A4636 claims using the KG modifier.

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

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

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

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

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

Until notified otherwise, grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. The single

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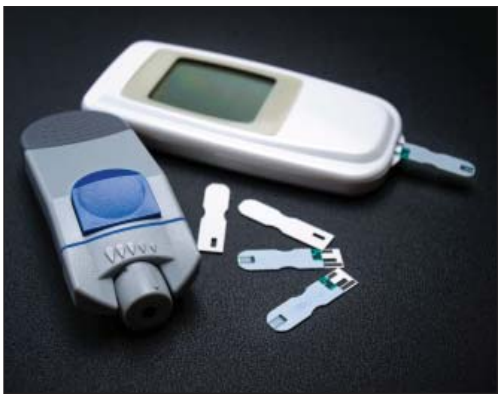
payment amounts for items included in the Round 1 Rebid of the DMEPOS competitive bidding program can be found under the Single Payment Amount tab on *http://www.dmecompetitivebid.com/SPA*. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. Also, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.

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

Mail order diabetic supplies – the KL modifier

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



Physicians and treating practitioners who furnish walkers and related accessories to their own patients but who are not contract suppliers – the KV modifier

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

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

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

The KV modifier should not be used by contract suppliers.

Traveling beneficiaries – the KT modifier

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

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

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

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

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

The KE modifier

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

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

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

Below is a chart that illustrates the relationship between the competitive bid modifiers (KG, KK, KU, and KW) and the KE modifier using competitively bid accessory code E0950:

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

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

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Additional information

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

For more information about the DMEPOS competitive bidding program, including a list of the first nine CBAs and items included in the program, visit *http://www.cms.gov/DMEPOSCompetitiveBid* on the Centers for Medicare & Medicaid Services (CMS) dedicated website.

Information for contract suppliers can be found at the CBIC website at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

Beneficiary-related information can be found at *http://www.medicare.gov*.

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

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New podcasts and 2012 ICD-10 procedure coding system files available

New podcasts available from the January 12 national provider call

Limited on time? The Centers for Medicare & Medicaid Services (CMS) has created four new podcasts from the audio of the January 12 national provider call on "Preparing for ICD-10 Implementation in 2011." These podcasts are perfect for the office, the car, or anywhere you carry a portable media player.

1. Welcome and ICD-10 Overview – Pat Brooks, CMS
2. Implementation Strategies for 2011 – Sue Bowman, AHIMA
3. Question and Answer Session, part 1
4. Question and Answer Session, part 2

These podcasts are now available at *http://www.CMS.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1242831*, in the "Downloads" section at the bottom of the page. Listen to all four or just the ones that fit your needs.

2012 ICD-10 procedure coding system files now available

CMS has posted files on the new procedure coding system, ICD-10-PCS, that has been developed as a replacement for ICD-9-CM, volume 3. These files are available on the 2012 ICD-10-PCS Web page at *http://www.CMS.gov/ICD10/11b15_2012_ICD10PCS.asp*, in the "Downloads" section at the bottom of the page.

The ICD-10-PCS GEM Mappings and Reimbursement Mappings are coming soon:

- 2012 ICD-10-PCS GEM Mappings will be posted in October 2011
- 2012 ICD-10-PCS Reimbursement Mappings will be posted in December 2011

The 2011 ICD-10-CM Code Descriptions in Tabular Order file is also available

CMS has also posted a list of the 2011 ICD-10-CM code descriptions in tabular order – the order in which the code descriptions occur in the code book. This new tabular order version of ICD-10-CM will assist those who wish to identify a range of codes and make certain they have correctly identified all codes within the range. The 2011 Code Descriptions in Tabular Order file is now available in the "Downloads" section on the 2011 ICD-10 CM and GEMs Web page at *http://www.CMS.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp*.

Is your organization preparing for a smooth transition to ICD-10 October 1, 2013?

The CMS ICD-10 website at *http://www.cms.gov/icd10/* is a valuable resource to help you prepare for the health care industry's change from ICD-9 to ICD-10 for medical diagnosis and inpatient procedure coding; check back frequently for the latest news, resources, compliance timelines, and teleconference information. And while you are visiting the site, sign-up for the CMS ICD-10 Industry Email Updates at *http://www.cms.gov/ICD10/02d_CMS_ICD-10_Industry_Email_Updates.asp* to receive the latest information on the transition and new website content.

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

Source: CMS PERL 201106-42

Pharmacy billing for drugs provided "incident to" a physician service

Provider types affected

Pharmacies that submit claims for drugs to Medicare contractors [fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), A/B Medicare administrative contractors (A/B MACs), and durable medical equipment MACs)] are affected.

What you should know

This article is based on change request (CR) 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided "incident to" a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined.

This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

Background

Pharmacies billing drugs

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

Claims for these drugs are generally submitted to the durable medical equipment Medicare administrative contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.

In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When drugs may not be billed by pharmacies to Medicare Part B

Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician's office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered "incident to" a physician's service and pharmacies may not bill Medicare Part B under the "incident to" provision.

Payment limits

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

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Additional information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at *http://www.cms.gov/Transmittals/downloads/R2214CP.pdf*.

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

The following manual sections regarding billing drugs and biological and "incident to" services may be helpful:

- *Medicare Claims Processing Manual*, Chapter 17, Sections 20.1.3 and 50.B, available at *http://www.cms.gov/manuals/downloads/clm104c17.pdf*
- *Medicare Benefit Policy Manual*, Chapter 15, Sections 50.3 and 60.1, available at *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*.

MLN Matters® Number: MM7397
Related Change Request (CR) #: 7397
Related CR Release Date: May 13, 2011
Effective Date: June 29, 2011
Related CR Transmittal #: R2214CP
Implementation Date: June 29, 2011

Correct provider billing of Admission Date and Statement Covers Period

Provider types affected

Inpatient hospital providers who submit claims on the UB-04 claims form or its electronic equivalent to fiscal intermediaries (FI) and A/B Medicare administrative contractors (MAC) need to be aware of the clarifications in this article.

What you need to know

In collaboration with the National Uniform Billing Committee's (NUBC) definition for reporting of the Admission Date and Statement Covers Period elements on claims, the Centers for Medicare & Medicaid Services (CMS) would like to remind you to review the NUBC definitions for claims submitted on or after October 1, 2011.

This special article reminds you of the definitions for reporting the Admission Date and Statement Covers Period on claims.

- The Admission Date (Form Locator 12) is the date the patient was admitted as an inpatient to the facility (or indicates the start of care date for home health and hospice). It is reported on all inpatient claims regardless of whether it is an initial, interim, or final bill.
- The Statement Covers Period ("From" and "Through" dates in Form Locator 6) identifies the span of service dates included in a particular bill. The "From" date is the earliest date of service on the bill.

Previously, Medicare's Fiscal Intermediary Shared System (FISS) edits required that the Admission Date not be later than the "From" date on initial provider claims as required to match NUBC UB-92 definitions. In order to pass FISS edits and avoid getting a claim rejected, providers may have engineered workarounds that force the two dates to match.

CMS has issued instructions to FISS for modifying FISS edits regarding these data elements to match NUBC UB-04 definitions:

- Based on UB-04 definitions of these two data elements, CMS has modified FISS edits so Admission Date and "From" dates are not required to match.
- Based on UB-04 definitions of these two data elements, CMS has modified FISS edits so as not to compare the number of days in the Statement Covers Period to any other data element (e.g., total accommodation days reported in the revenue code section).

As a reminder, you should verify your systems edit logic for correct application of these data elements. If you implemented workaround routines, you need to deactivate them. You should contact your trading partners to ensure they are aware of the changes and that they are taking the appropriate steps to correct any edit logic. Please ensure that your staffs are aware of these upcoming changes.

Additional information

The *Medicare Learning Network* (*MLN*) has a fact sheet, *UB-04 Overview*, available at *http://www.cms.gov/MLNProducts/downloads/ub04_fact_sheet.pdf*. Current Medicare policy regarding the coding and edits on the relevant data elements are in the *Medicare Claims Processing Manual* in Chapter 25, Section 75.1 at *http://www.cms.gov/Manuals/downloads/clm104c25.pdf* and in Chapter 1, Section 80.3.2.2 at *http://www.cms.gov/Manuals/downloads/clm104c01.pdf*. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

Visit the NUBC website at *http://www.nubc.org/public/whatsnew/11_17_10%20NUBC%20Billing%20Alert.pdf* to learn more.

MLN Matters® Number: SE1117
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

What you should know about the GEMs and partial code freeze

General equivalence mappings (GEMs)

The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) created the national version of the GEMs to ensure that consistency in national data is maintained. The GEMs are tools that act mainly as a crosswalk between the ICD-9 and ICD-10 codes. You can look up an ICD-9 code and be provided with the most appropriate ICD-10 matches and vice versa. They are not a substitute for learning the new ICD-10 codes; however, they can assist users doing the following:

The GEMS are tools that act as a crosswalk between ICD-9 and ICD-10 codes.

- Translating lists of codes, code tables, or other coded data
- Converting a system or application containing ICD-9-CM codes
- Creating a "one-to-one" applied mapping (aka crosswalk) between code sets that will be used in an ongoing way to translate records or other coded data
- Studying the differences in meaning between the ICD-9-CM classification systems and the ICD-10-CM/PCS classification systems by looking at the GEMs entries for a given code or area of classification

The 2011 GEMs are posted to the CMS ICD-10 website. As a reminder, if you plan to use a GEM, per the Affordable Care Act, you must use the GEMs posted to the CMS website.

For more information on the GEMs, look at the GEMs Web pages (*https://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp#TopOfPage*) of the ICD-10 website.

Partial code freeze

Because continuous updates and changes to the existing code sets has the potential to make the transition to ICD-10 difficult, CMS will be implementing a partial code freeze on October 1, 2011. This is the last day for regular updates to both the ICD-9 and ICD-10 code sets.

Starting October 1, 2012, there will be only limited code updates to ICD-9-CM and ICD-10 code sets to capture new technology and new diseases. There will be no updates to ICD-9-CM on October 1, 2013, as the system will no longer be a HIPAA standard.

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

Please visit *www.cms.gov/ICD10* for the latest news and resources to help you prepare.

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

Source: CMS PERL 201105-38

Materials from the AAPC-CMS ICD-10 code-a-thon posted to website

If you weren't able to join the Centers for Medicare & Medicaid Services (CMS) for the American Academy of Professional Coders (AAPC)-CMS ICD-10 code-a-thon held on April 26, 2011, or if you just want a closer look at all the materials from the presentation, they are now available on the CMS website in the Latest News section at *http://www.cms.gov/ICD10/02b_Latest_News.asp*.

Posted materials include:

- Presentations from AAPC (*http://www.cms.gov/ICD10/Downloads/AAPCICD-10WillChangeEverything.pdf*) and CMS (*http://www.cms.gov/ICD10/Downloads/CMSICD-10Overview.pdf*) on ICD-10 and version 5010
- A transcript (*http://www.cms.gov/ICD10/Downloads/TranscriptMay92011.pdf*) and audio (*http://www.cms.gov/ICD10/Downloads/ICD-10CodeathonAudio.mp3*)of the presentations from the webinar

These materials should be helpful in getting informed and learning about the transitions to version 5010 and ICD-10. Feel free to share this information with colleagues, staff, or anyone interested in learning more about these important transitions.

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

Please visit *www.cms.gov/icd10* for the latest news and resources to help you prepare.

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

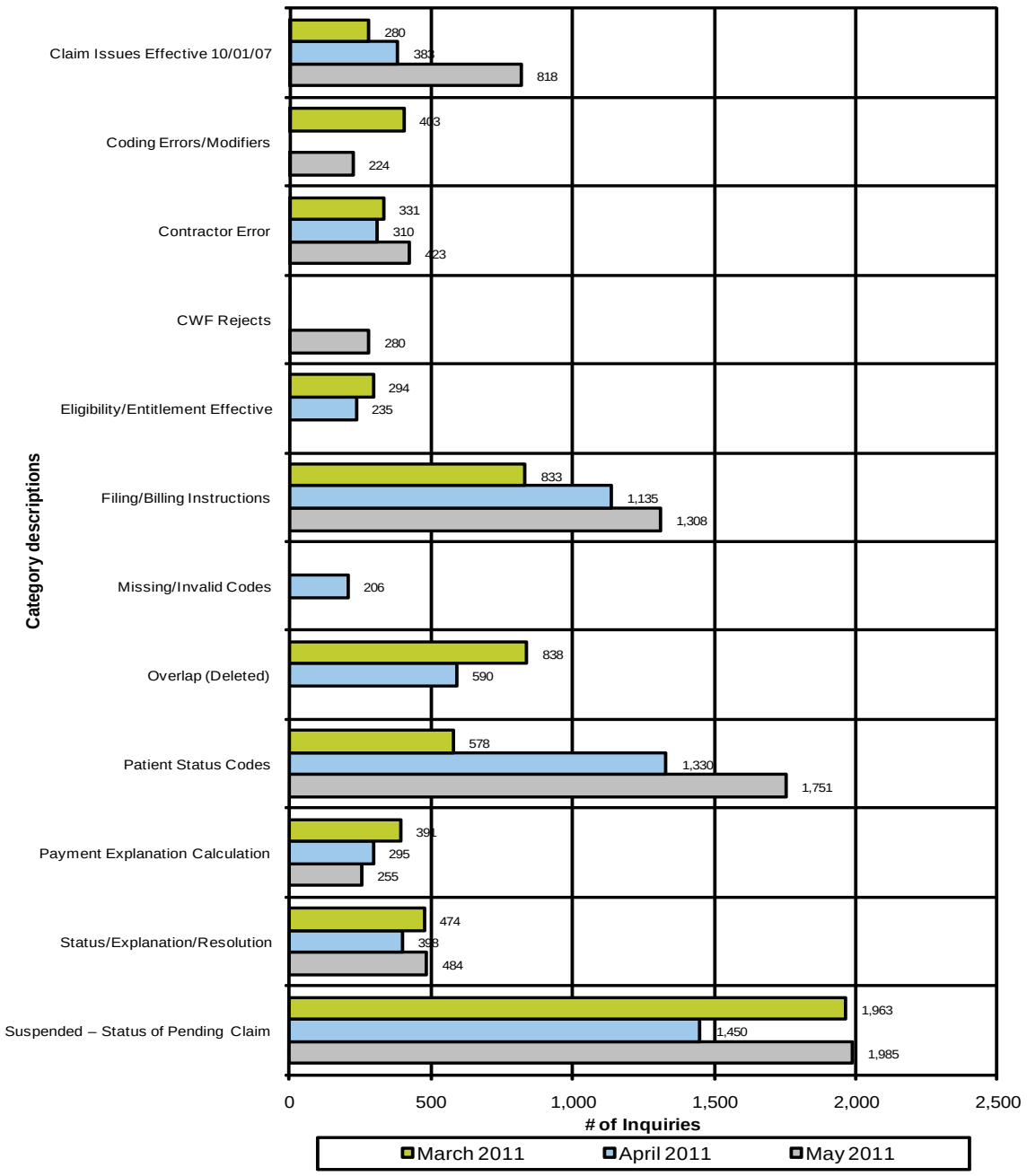
Source: CMS PERL 201106-26

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



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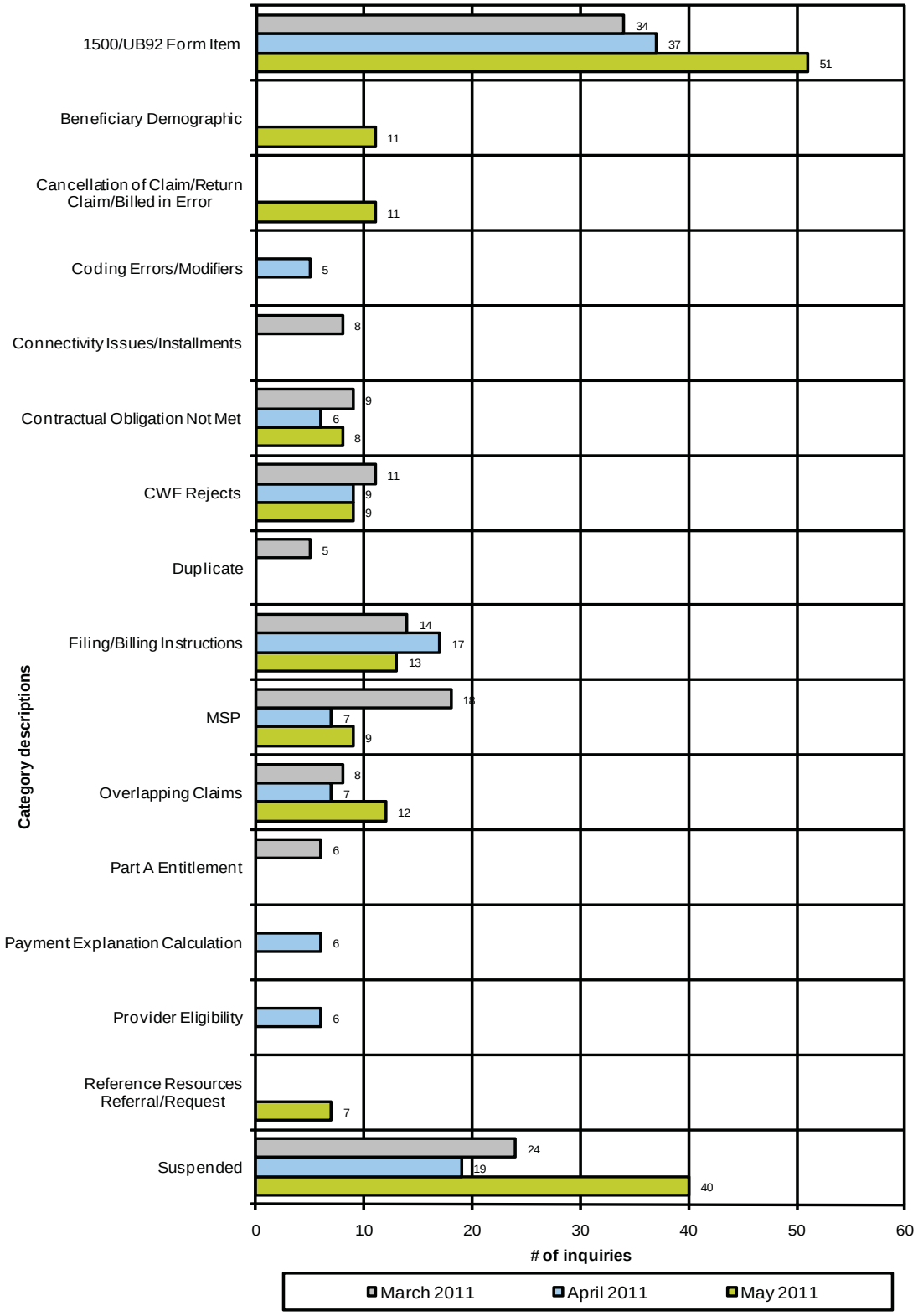
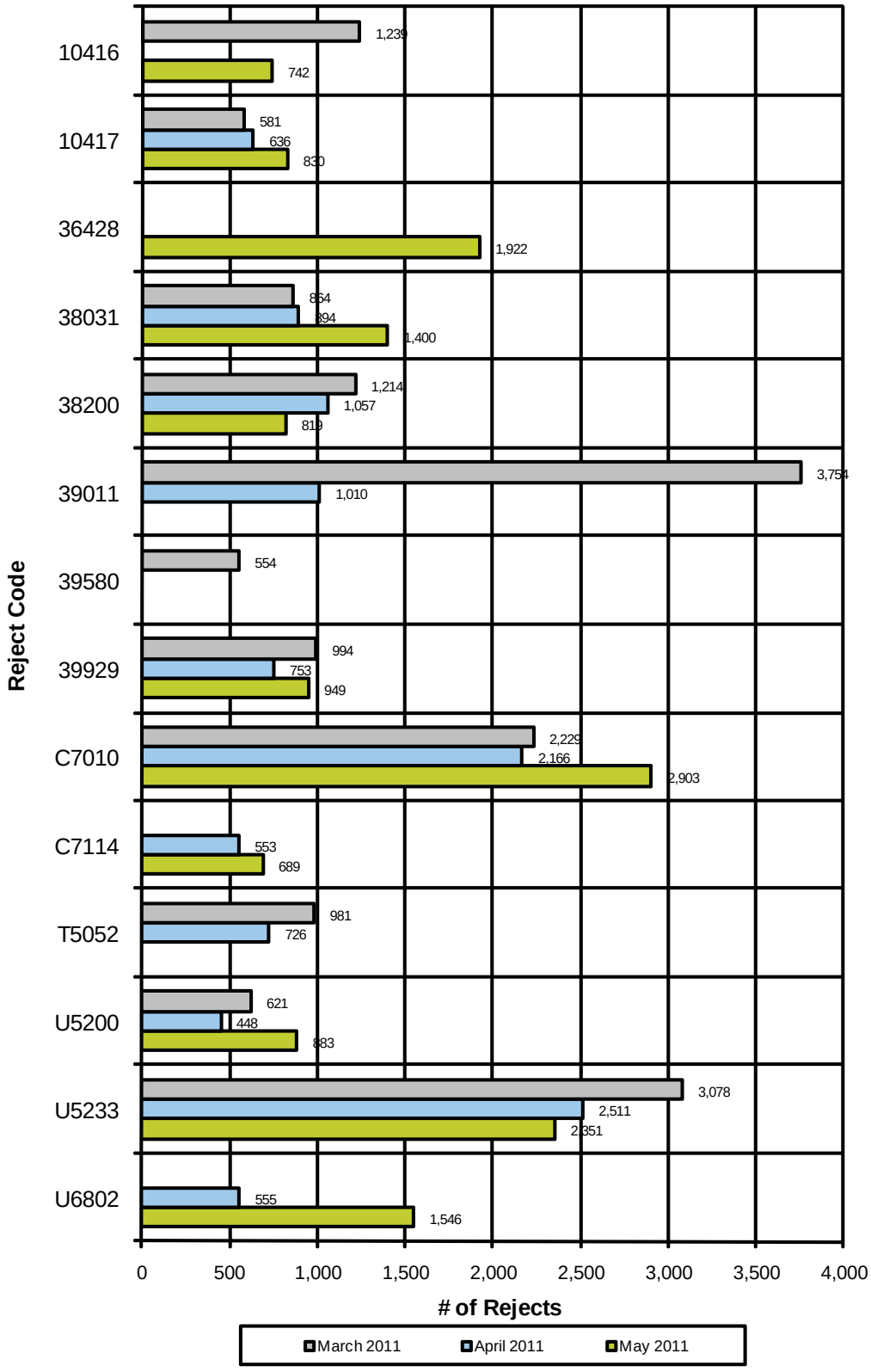
Inquiries...*continued*

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



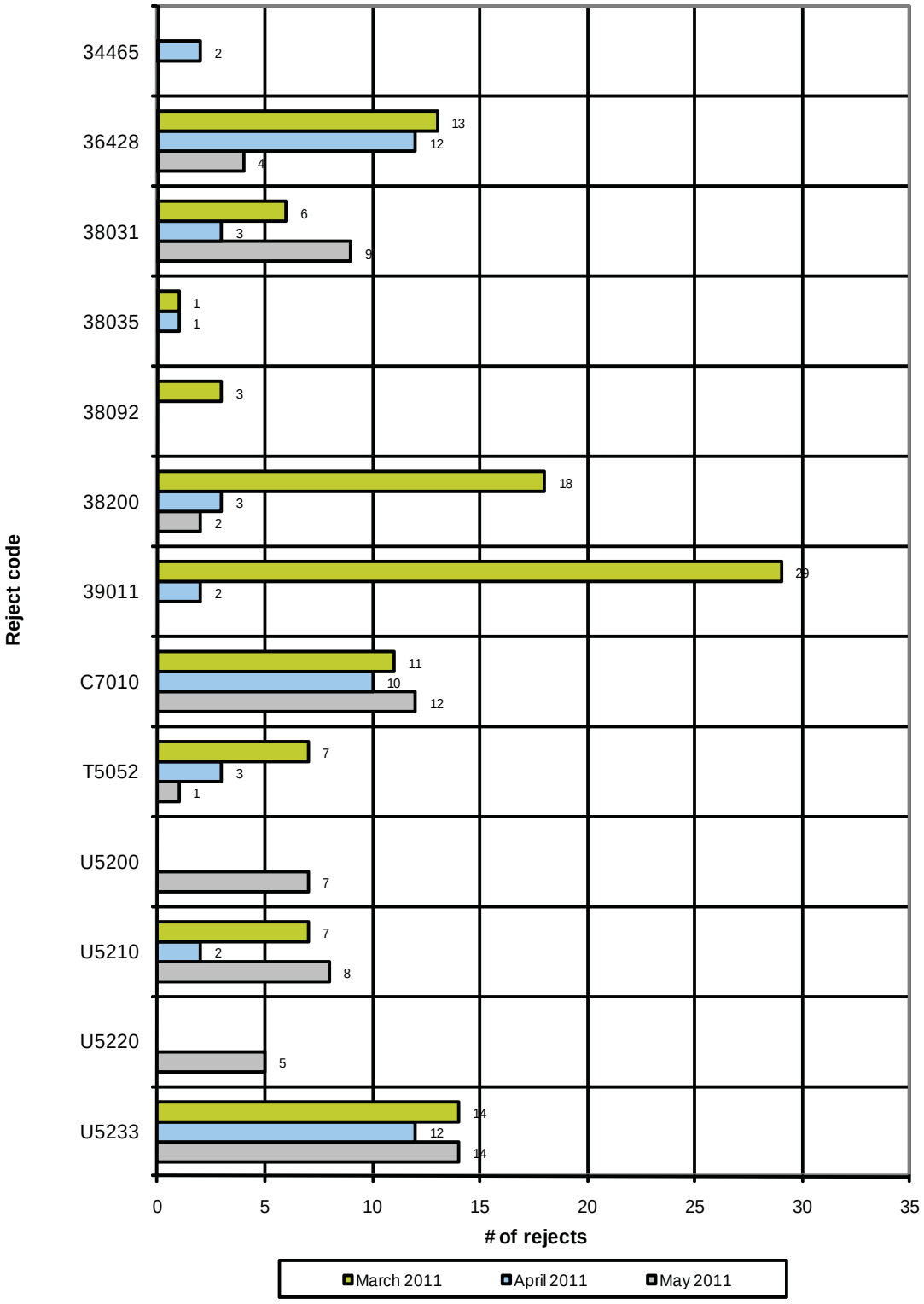
Florida Part A top rejects for March-May 2011



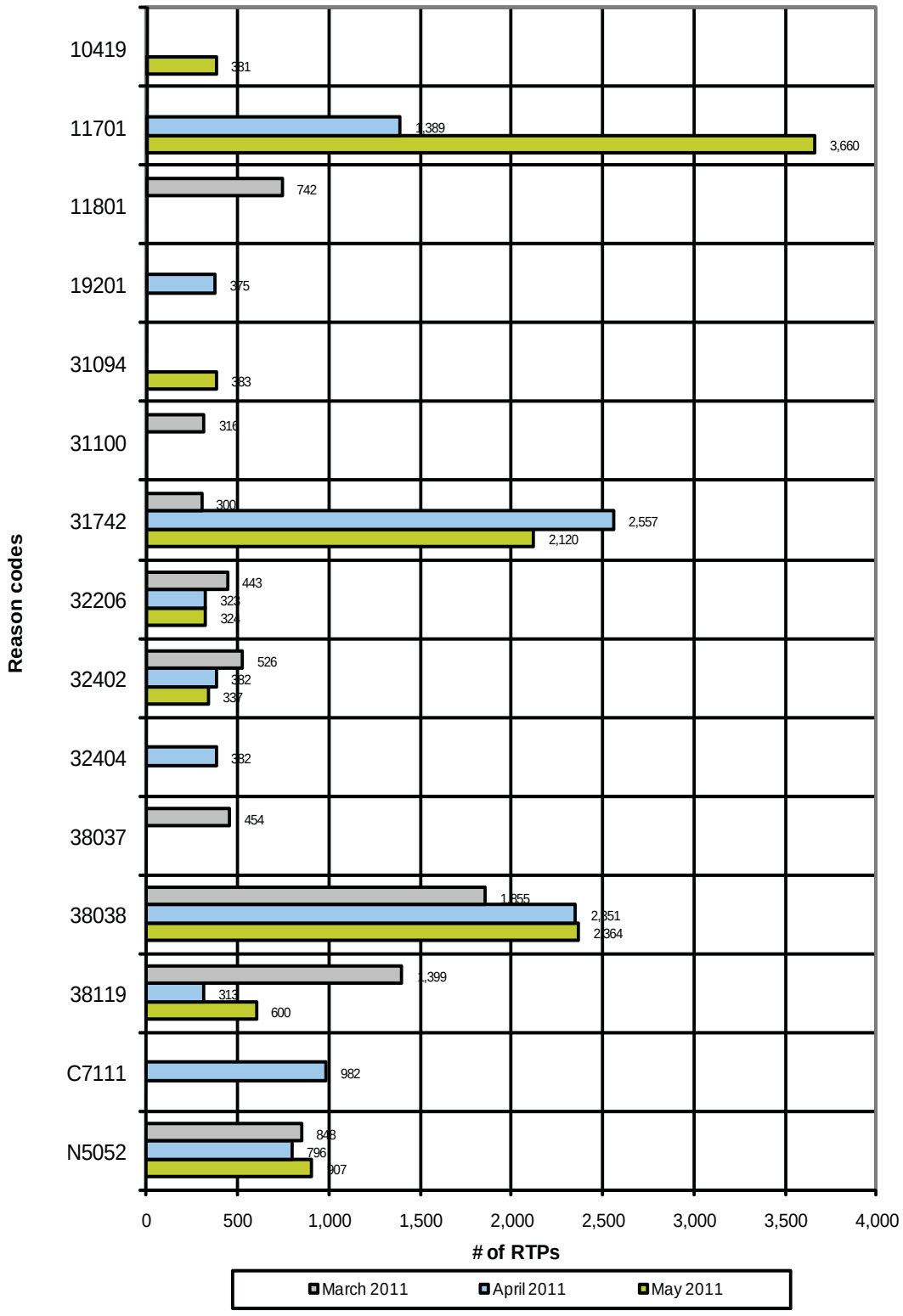
continued on next page

Rejects...*continued*

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



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



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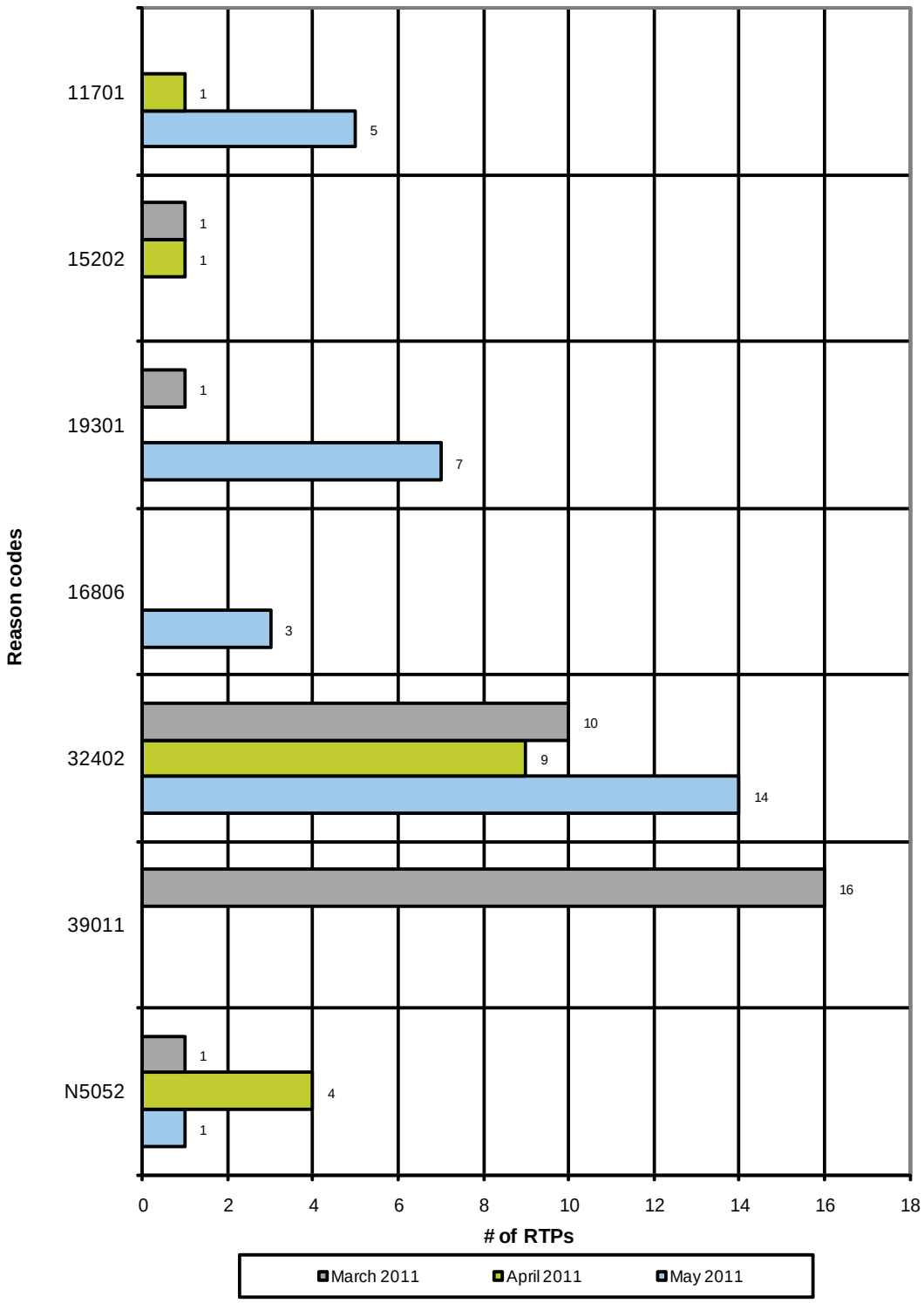
RTPs...*continued*

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



July 2011 integrated outpatient code editor specifications version 12.2

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7439, which describes changes to the integrated outpatient code editor (I/OCE) and OPPS to be implemented in the July 2011 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

Background

CR 7439 describes changes to billing instructions for various payment policies implemented in the July 2011 OPPS update. The July 2011 I/OCE changes are also discussed in CR 7439.

Note: The full list of I/OCE specifications can now be found at *http://www.cms.gov/OutpatientCodeEdit/* on the Centers for Medicare & Medicaid Services (CMS) website. In addition, numerous changes to ambulatory payment classification (APC), Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology (CPT)* codes, effective with the July 2011 I/OCE, are also listed in the Summary of Data Changes document attached to CR 7439. The CR is available at *http://www.cms.gov/Transmittals/downloads/R2224CP.pdf*.

A summary of the I/OCE modifications for July 2011 is within Appendix M, which is attached to CR 7439 and is summarized as follows:

- Effective January 1, 2011, Medicare will:
  - Implement logic to set payment adjustment flag (PAF) 4:
    - If modifier "PT" is present on any *CPT* code in the range *10000-69999* on a claim, apply PAF 4 to all codes in the range with the same date of service as the code with modifier PT. Exception: Do not apply PAF 4 to a line if any other PAF is applicable/already applied to the same line;
  - Add code G0010 to the list for PAF 9 (Deductible/coinsurance not applicable).
- Effective July 1, 2011, Medicare will:
  - Make HCPCS/APC/SI changes (See the Summary of Data Changes attached to CR 7439.);
  - Implement version 17.1 of the NCCI (as modified for applicable institutional providers). Edits 19, 20, 39 and 40 are affected; and
  - Update procedure/device and device/procedure edit requirements. Edits 71 and 77 are affected.

Additional information

The official instruction, CR 7439 issued to your Medicare MAC, RHHI or FI regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2224CP.pdf*.

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

MLN Matters® Number: MM7439
Related Change Request (CR) #: 7439
Related CR Release Date: May 20, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2224CP
Implementation Date: July 5, 2011

Manual revisions – payment changes for durable medical equipment, prosthetics, orthotics and supplies

Provider types affected

This article is for Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers that bill durable medical equipment Medicare administrative contractors (DME MACs) as well as providers that bill Medicare carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), or Part A/B Medicare administrative contractors (A/B MACs) for DMEPOS that they refer or order for Medicare beneficiaries.

What you need to know

Change request (CR) 7401, from which this article is developed, is the third installment of, and adds information to, Chapter 36 DMEPOS competitive bidding program in the *Medicare Claims Processing Manual* and provides additional information for Medicare contractors and suppliers on the round one rebid implementation. CR 5978 provided the first installment of Chapter 36 and details the initial requirements of this program. The phase one *MLN Matters*® article CR 5978 is available at *http://www.cms.gov/MLNMattersArticles/downloads/MM5978.pdf* on the Centers for Medicare & Medicaid services (CMS) website. CR 6119 provided the second installment of Chapter 36 and details the second phase of the manual revisions to this program. The related *MLN Matters*® article CR 6119 is available at *http://www.cms.gov/MLNMattersArticles/Downloads/MM6119.pdf*.

Background

The Medicare payment for most DMEPOS was traditionally based on fee schedules. When section 1847 of the Social Security Act (the Act), section 302(b) of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) was amended, a competitive bidding program was implemented to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

CMS issued the regulation for the competitive bidding program on April 10, 2007 (72 Federal Register 17992). Round one of the national competitive bidding (NCB) program was implemented on January 1, 2011. CR 7401 provides additional instructions on changes under the DMEPOS competitive bidding program. This regulation is available at *http://www.cms.gov/DMEPOSCompetitiveBid*.

Key points of CR 7401

There are seven additions to section 50 of Chapter 36 of the *Medicare Claims Processing Manual*; one is an update and the other six are new additions:

- Section 50.3 is updated to include new HCPCS modifiers developed to facilitate implementation of various policies that apply to certain competitive bidding items. The KG, KK, KU, KW, and KY modifiers are pricing modifiers that suppliers must use to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories.
  - For example, HCPCS code E0981 (wheelchair accessory, seat upholstery, replacement only, each) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category must submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category must use the KK modifier. All suppliers, including grandfathered suppliers, shall submit claims for competitive bid items using the aforementioned competitive bidding modifiers.
  - The KG and KK modifiers are used in Round I of the competitive bidding program and the KU and KW modifiers are reserved for future program use.

The six sections added to Chapter 36: 50.10 through 50.15 as follows:

- 50.10 - Claims submitted for hospitals who furnish competitively bid items;
  - Under DMEPOS competitive bidding, hospitals may furnish certain types of competitively bid DME to their patients on the date of discharge without submitting a bid and being awarded a

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Revisions...*continued*

contract. The DME items that a hospital may furnish as part of the exception are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. Payment for items furnished under this exception will be made based on the single payment amount for the item for the competitive bidding area (CBA) where the beneficiary resides. Separate payment is not made for walkers and related accessories furnished by a hospital on the date of admission because payment for these items are included in the Part A payment for inpatient facility services. Refer to the *Medicare Claims Processing Manual*, Chapter 1, 10.1.1.1 for instructions for submitting claims at *http://www.cms.gov/manuals/downloads/clm104c01.pdf*.

- 50.11 - Claims submitted for Medicare beneficiaries previously enrolled in a Medicare advantage (MA) plan;
  - Under DMEPOS competitive bidding, if a beneficiary resides in a CBA and elects to leave their MA plan or loses his/her coverage under this plan, the beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS competitive bidding program. However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier, meet the Medicare fee-for-service coverage criteria and documentation requirements, and must elect to become a grandfathered supplier. All competitive bid grandfathering rules apply in these situations.
- 50.12 – Claims for repairs and replacements;
  - Under the DMEPOS competitive bidding program, any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA. In these situations, Medicare payment for labor will be made based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment that are submitted with the RB modifier will be based on the single payment amount for the part, if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.
  - The replacement of an entire item, as opposed to the replacement of a part for repair purposes, which is subject to the DMEPOS competitive bidding program, must be furnished by a contract supplier. Medicare payment for the replacement item would be based on the single payment amount for the item in the beneficiary's CBA. Refer to the *Medicare Claims Processing Manual*, Chapter 20, 10-2 at *http://www.cms.gov/manuals/downloads/clm104c20.pdf* for instruction for submitting claims for repairs and replacements.
- 50.13 - Billing for oxygen contents to suppliers after the 36th month rental cap;
  - The Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period after the payment cap and of medical need for the remainder of the reasonable useful lifetime established for the equipment. This requirement continues to apply under the Medicare DMEPOS competitive bidding program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a CBA).
  - Should a beneficiary travel or temporarily relocate to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.
  - The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the

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Revisions...*continued*

single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.

- 50.14 - Purchased accessories & supplies for use with grandfathered equipment; and
  - Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011 for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:
    - Continuous positive airway pressure devices, respiratory assistive devices, and related supplies and accessories – A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562;
    - Hospital beds and related accessories – E0271, E0272, E0280, E0310; and
    - Walkers and related accessories – E0154, E0156, E0157 and E0158.
  - Grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. In addition, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.
  - After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.
- 50.15 - Hospitals providing walkers and related accessories to their patients on the date of discharge.
  - Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.
  - To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.
  - Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier, to claims submitted for these items.
  - The J4 modifier should not be used by contract suppliers.

Additional information

If you have any questions, please contact your Medicare carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*. The official instruction associated with this CR 7401, issued to your Medicare MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2231CP.pdf*.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at *http://www.cms.gov/DMEPOSCompetitiveBid/*. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

MLN Matters® Number: MM7401
Related Change Request (CR) #: 7401
Related CR Release Date: May 27, 2011
Effective Date: August 28, 2011
Related CR Transmittal #: R2231CP
Implementation Date: August 28, 2011

July quarterly update for 2011 DMEPOS fee schedule

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7416 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at *https://www.cms.gov/manuals/downloads/clm104c23.pdf*.

Key points of CR 7416

Fees added

The July quarterly update for the 2011 DMEPOS fee schedule Part B files established fee schedule amounts for Healthcare Common Procedure Coding System (HCPCS) codes A7020, E1831, and L5961, effective for claims with dates of service on or after January 1, 2011.

Note: Claims for codes A7020, E1831, and L5961 with dates of service on or after January 1, 2011, that were previously processed may be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Temporary K-codes

The following new K-codes will be added to contractor's system effective for dates of service July 1, 2011:

- 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
- K0746 – absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches

Note: The addition of these codes does not imply any health insurance coverage. Medicare contractors will follow their normal processes in determining whether sufficient evidence exists to determine if these items are reasonable and necessary and covered under Medicare.

Code updates

- HCPCS code E0571 (aerosol compressor, battery powered, for use with small volume nebulizer) will be made invalid for Medicare claims, effective July 1, 2011.
- The payment category for HCPCS code A4619 (face tent) is being revised as part of this quarterly update to move this nebulizer accessory from the DME payment category for oxygen and oxygen equipment to the DME payment category for inexpensive or other routinely purchased items, effective July 1, 2011. The DMEPOS fee schedule file will be updated to reflect this change.

Payment for oxygen contents

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. After the 36-month rental payment period (cap), separate payment may be made for oxygen contents for the remainder of the equipment's reasonable useful lifetime. However, separate payment for oxygen contents ends when replacement stationary oxygen equipment is furnished causing a new 36-month rental payment period to begin. Also, separate oxygen contents payment is allowable for beneficiary-owned stationary or portable gaseous or liquid oxygen equipment. Beginning with dates of service on or after the end date of service for the month representing the 36th payment for the stationary oxygen equipment (codes E0424, E0439, E1390 or E1391), a supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

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DMEPOS...*continued*

Oxygen equipment furnished in month 36	Monthly contents payment after the stationary cap
Oxygen concentrator (E1390, E1391, or E1392)	None
Portable gaseous or liquid transfilling equipment (K0738 or E0433)	None
E0424 stationary gaseous system	E0441 stationary gaseous contents
E0439 stationary liquid system	E0442 stationary liquid contents
E0431 portable gaseous system	E0443 portable gaseous contents
E0434 portable liquid system	E0444 portable liquid contents

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0433 or E0444) may begin following the stationary oxygen equipment payment cap AND before the end of the portable equipment cap (E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable equipment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparable damaged). Under no circumstances would monthly payment be made for both stationary oxygen equipment and either stationary or portable oxygen contents.

Proof-of-delivery requirements for oxygen contents

Following the oxygen equipment payment cap, oxygen content billing should be made on the anniversary date of the oxygen equipment billing.

At all times, the supplier is responsible for ensuring that the beneficiary has a sufficient quantity of oxygen contents and is never in danger of running out of contents. A maximum of three months of oxygen contents can be delivered to the beneficiary at one time and billed on a monthly basis. In these situations, the delivery date of the oxygen contents does not have to equal the date of service (anniversary date) on the claim, but in order to bill for contents for a specific month (i.e. the second or third month in the three month period), the supplier must have delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen, which may be less than monthly within the three month period. If the supplier delivers more than one month of oxygen contents at a time (two to three), the supplier is not entitled to payment for additional months two and three if medical need ceases before the date when the supplier would be entitled to bill for those months.

Payment for replacement of equipment after repairs

Under the regulations at 42 CFR 414.210(e)(4), a supplier that transfers title to a capped rental DME item to the beneficiary is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if it is determined that the item will not last until the end of its 5 year reasonable useful lifetime. In making this determination, Medicare contractors may consider whether the accumulated costs of repairing the item exceed 60 percent of the purchase fee schedule amount for the item.

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DMEPOS...*continued*

Furthermore, 42 CFR 424.57(14) requires a DMEPOS supplier to maintain or replace a Medicare-covered item it has rented to beneficiaries to its intended status after being repaired. Recent cases have arisen whereupon after multiple repairs, the item continues to malfunction. CR 7416 instructs your Medicare contractor to be aware of and educate suppliers of these regulatory requirements to replace DME items for which repairs have not restored the item. Also, after receipt of multiple repair claims, contractors will investigate suspicious claims for replacement equipment billed with its HCPCS code and the RA modifier.

Additional information

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

The official instruction associated with this CR 7416 issued to your Medicare carrier, FI, DME MAC, RHHI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2236CP.pdf*.

MLN Matters® Number: MM7416
Related Change Request (CR) #: 7416
Related CR Release Date: June 3, 2011
Effective Date: January 1, 2011, for fee schedule amounts for codes effective on that date; otherwise July 1, 2011
Related CR Transmittal #: R2236CP
Implementation Date: July 5, 2011

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Adjustments to end-stage renal disease claims

End-stage renal disease (ESRD) facilities may begin to see some of their claims being adjusted to correct various issues that have been found after the implementation of the new ESRD prospective payment system (PPS).

One of the issues involves ESRD claims containing outlier payments; in some cases, outlier payments for home dialysis patients of facilities transitioning into the PPS were being overpaid and other outlier payments were underpaid as a result of deductible and coinsurance being applied to the Medicare-allowed payments for outlier. Where an outlier payment was already made, these adjustments will be automated by the contractor and no action is required by the provider. However, if an ESRD facility believes they were entitled to an outlier payment but did not receive one, they may notify their Medicare contractor and request the adjustment. In addition, for facilities transitioning into the PPS, the 3.1 percent budget neutrality adjustment was not being applied to the separately billable ESRD services between Saturday, January 1, 2011, and Thursday, March 31, 2011, and contractors will be required to adjust those claims.

ESRD facilities in Guam, American Samoa, and the Marianna Islands are excluded from the ESRD PPS. Claims being held for these providers will be released Monday, June 6, 2011.

Some ESRD facilities are experiencing claim rejections for edit codes 36330, 36342, 36357, and 36375. If your facility is affected, please review your claim and be sure that services included in the original composite rate payment system and, therefore, also included in the PPS, are not being reported on your claim. Only report separately those services that were previously separately payable drugs and laboratory services.

Source: CMS PERL 201105-43

Find fees faster: Try FCSO's fee schedule lookup

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

Laboratory demonstration for certain complex diagnostic tests

Note: Change request (CR) 7413 fully rescinds and replaces CR 7278.

Provider types affected

Clinical laboratories, hospitals and physicians submitting claims to fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs) for certain complex diagnostic tests provided to Medicare beneficiaries are affected.

Provider action needed

This article is based on change request (CR) 7413 which announces that the Centers for Medicare & Medicaid Services (CMS) will conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years beginning January 1, 2012, or until the one hundred million dollars ($100,000,000) payment ceiling established by the Affordable Care Act has been reached. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

The Affordable Care Act (Section 3113; see *http://www.govtrack.us/congress/billtext.xpd?bill=h111-3590*) requires CMS to conduct a demonstration project for certain complex diagnostic laboratory tests for a period of two years beginning January 1, 2012, or until the one hundred million dollars ($100,000,000) payment ceiling has been reached. This demonstration project will establish a separate payment method for these tests under which a clinical laboratory that would not normally receive direct payment from Medicare due to an "under arrangement" situation with a hospital, (as defined in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 5, Section 20) will receive a direct payment from Medicare for the performance of identified complex diagnostic laboratory tests.

Under the Affordable Care Act (Section 3113), the term "complex diagnostic laboratory test" means a diagnostic laboratory test that is:

- An analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;
- Determined by the Secretary of Health and Human Services to be a laboratory test for which there is not an alternative test having equivalent performance characteristics;
- Billed using a Healthcare Common Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

- Approved or cleared by the Food and Drug Administration (FDA) or covered under title XVIII of the Social Security Act; and
- Described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3)). See *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*.

The date of service (DOS) rule stated in 42 CFR 414.510 (see *http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol3/pdf/CFR-2009-title42-vol3-sec414-510.pdf*) is used to determine whether a hospital can bill Medicare directly for a clinical laboratory test provided by a laboratory (the hospital then would pay the laboratory if the laboratory provided the test "under arrangement") or whether a laboratory can bill Medicare directly for a clinical laboratory test. Under the demonstration project, a laboratory would receive direct payment from Medicare for an identified complex diagnostic laboratory test in situations where the laboratory would not otherwise receive direct payment from Medicare for the test because it provided that test "under arrangement" with a hospital (either in the inpatient or outpatient setting). All other Medicare rules for adjudicating laboratory claims continue to apply.

Under the demonstration project, CMS will allow both independent and hospital-based laboratories to bill separately for identified complex diagnostic laboratory tests in situations where the laboratory would not otherwise receive direct payment from Medicare for the test because it provided that test "under arrangement" with a hospital (either in the inpatient or outpatient setting). The DOS of the clinical diagnostic laboratory test must also be within the demonstration period, i.e., the DOS must be on or after January 1, 2012, and on or before the earlier of December 31, 2013, or the date on which the allowed funding is exhausted. Laboratories that perform the service must bill Medicare directly.

Participation in this demonstration is voluntary and available to any laboratory nationwide. There will be

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Lab...*continued*

no locality variation on the Section 3113 demonstration fee schedule, which will show the HCPCS included in the demonstration. All payments will be made under locality "DE" on the demonstration fee schedule. Changes to the 3113 demonstrations fee schedule, if any, will be made on a prospective basis, and will not be implemented retroactively.

CMS will provide Medicare contractors with the Section 3113 demonstration fee schedule containing the payment amounts for the list of services to be covered by the demonstration. These payment amounts will be national amounts.

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

Congress has established a payment ceiling for this demonstration of one hundred million dollars ($100,000,000) for payments of complex laboratory tests or until the 2 years from the start of the demonstration has passed, whichever comes first.

For the purpose of CR 7413, the period of the two-year demonstration period is between January 1, 2012, and December 31, 2013. Laboratories participating in this demonstration must bill the tests identified under the demonstration using the demonstration project identifier 56 in order to receive the special payment from the funding set aside for this demonstration.

Laboratories will report the demonstration project identifier 56 in item 19 on the CMS 1500 form, in locator 63 on the UB-04, on the electronic claim in X12N 837P (HIPAA version) Loop 2300, REF02, REF01=P4, and in X12N 837I (HIPAA version) Loop 2300, REF02, G1 in REF01 DE 128.

Note: Claims using the demonstration project identifier 56 received after the applicable threshold has been reached will be rejected back to the laboratory, and that threshold occurs:

- Once the one hundred million dollars ($100,000,000) payment ceiling has been reached in total payments with the demonstration project identifier 56, or
- Two years has passed from the start of this demonstration, whichever comes first.

Additional information

The official instruction, CR 7413, was issued to your carrier, FI, or A/B MAC via two transmittals. The first is *http://www.cms.gov/Transmittals/downloads/R2226CP.pdf*, which provides claims processing instructions. The second transmittal, *http://www.cms.gov/Transmittals/downloads/R73DEMO.pdf*, updates *Medicare's Demonstrations Manual*.

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: MM7413
Related Change Request (CR) #: 7413
Related CR Release Date: May 20, 2011
Effective Dates: January 1, 2012
Related CR Transmittal #: R2226CP and R73DEMO
Implementation Date: January 3, 2012

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Revised July 2010-April 2011 average sales price files now available

The Centers for Medicare and Medicaid Services (CMS) has posted revised average sales price (ASP) files for July 2010 through April 2011. All are available for download at: *http://www.cms.gov/McrPartBDrugAvgSalesPrice/* (see left menu for year-specific links).

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

Source: CMS PERL 201106-39

Pass-through payment for certified registered nurse anesthetist services

Provider types affected

This article is for critical access hospitals (CAHs), rural hospitals, and hospitals reclassified as rural submitting claims to Medicare contractors [fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)] for certified registered nurse anesthetist services (CRNA) services provided to Medicare beneficiaries.

What you need to know

In the fiscal year (FY) 2011 inpatient prospective payment system (IPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) amended the location requirements for CAHs and rural hospitals to be eligible for CRNA pass-through payments. The regulations were changed to state that effective with cost reporting periods beginning on or after October 1, 2011, in addition to CAHs and hospitals geographically located in a rural area, if a hospital has reclassified as rural, either under the IPPS or to become a CAH, under the regulations at 42 Code of Federal Regulations (CFR) 412.103, it is also eligible to receive CRNA pass-through payments.

In the calendar year (CY) 2011 outpatient PPS rule, the effective date of the CRNA policy change regarding location requirements was changed to December 2, 2010. Change request (CR) 7379 alerts Medicare contractors that effective December 2, 2010, in addition to hospitals and CAHs geographically located in rural areas, hospitals that have reclassified as rural, either under the IPPS or to become CAHs, under the regulations at 42 CFR 412.103 are also eligible to be paid based on reasonable cost.

Background

Certain hospitals and CAHs are eligible to be paid based on reasonable cost for CRNA services if they meet the requirements outlined at 42 CFR 412.113(c). Prior to a change in policy regarding location requirements made in the FY 2011 IPPS final rule, hospitals and CAHs were required to be geographically located in rural areas in order to be eligible for CRNA pass-through payments.

Note: Medicare contractors will not search and adjust claims processed prior to implementation of this change. However, they will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 7379 issued to your FI and/or A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2222CP.pdf*.

If you have any questions, please contact your FI and/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: MM7379
Related Change Request (CR) #: 7379
Related CR Release Date: May 20, 2011
Effective Date: December 2, 2010
Related CR Transmittal #: R2222CP
Implementation Date: October 3, 2011

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July update to the CY 2011 Medicare physician fee schedule database

Provider types affected

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

Provider action needed

This article is based on change request (CR) 7430, which provides the July 2011 update of the payment files that were issued to Medicare contractors based on the 2011 Medicare physician fee schedule (MPFS) final rule. Be sure your billing staff is aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values (RVUs) for physicians' services.

Previously, payment files were issued to Medicare contractors based on the 2011 MPFS final rule. CR 7430 amends those payment files. CR 7430 provides corrections, effective for dates of service on or after January 1, 2011, (unless otherwise noted) to those files. These changes include the following:

The following HCPCS codes have Medicare physician fee schedule database (MPFSDB) indicator changes:

HCPCS code	Short descriptor	Indicator	Effective date
22212	*Revision of thorax spine*	Co-Surgeons: 1	January 1, 2011
22222	*Revision of thorax spine*	Co-Surgeons: 1	January 1, 2011
31233	*Nasal/sinus endoscopy dx*	Assistant at surgery: 0	January 1, 2011
31235	*Nasal/sinus endoscopy dx*	Assistant at surgery: 0	January 1, 2011
64561	*Implant neuroelectrodes*	Bilateral surgery: 1	January 1, 2011
74176 TC	*Ct abd & pelvis*	Physician supervision of diagnostic procedures: 01	January 1, 2011
J7184	Wilate injection	Procedure status code: I	July 1, 2011

The following HCPCS codes have short descriptor changes:

HCPCS code	Short descriptor	Effective date
0251T	*Remov bronchial valve*	January 1, 2011
0252T	*Remov bronch valve addl*	January 1, 2011
22551	*Neck spine fuse&remov bel c2*	January 1, 2011
22900	*Exc abdl tum deep < 5 cm*	January 1, 2011
22901	*Exc abdl tum deep > 5 cm*	January 1, 2011
65779	*Cover eye w/membrane suture*	January 1, 2011
74176	*Short Descriptor Effective Date*	January 1, 2011
74176 TC	*Ct abd & pelvis*	January 1, 2011
74176 26	*Ct abd & pelvis*	January 1, 2011
74177	*Ct abd & pelvis*	January 1, 2011
74177 TC	*Ct abd & pelv w/contrast*	January 1, 2011
74177 26	*Ct abd & pelv w/contrast*	January 1, 2011
74178	*Ct abd & pelv w/contrast*	January 1, 2011
74178 TC	*Ct abd & pelv 1/> regns*	January 1, 2011
74178 26	*Ct abd & pelv 1/> regns*	January 1, 2011
88177	*Cytp fna eval ea addl*	January 1, 2011
88177 TC	*Cytp fna eval ea addl*	January 1, 2011
88177 26	*Cytp fna eval ea addl*	January 1, 2011
99218	*Initial observation care*	January 1, 2011

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Physician...*continued*

The following HCPCS codes will be added to the MPFS:

Please note, more information on HCPCS "T" code additions listed below will be found in CR 7443, July 2011 Update of the Hospital Outpatient Prospective Payment System, when it is released. (An article will be available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7443.pdf* upon release of the CR.) More information on HCPCS "J" and "Q" code additions listed below can be found in CR 7303, Quarterly HCPCS Drug/Biological Code Changes-July 2011 Update. (An article will be available for that CR at *http://www.cms.gov/MLNMattersArticles/downloads/MM7303.pdf*.) Additionally, policy and instructions on HCPCS Code Q2043 are addressed in CR 7431, Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer. Upon release of CR 7431, an article will be available at *http://www.cms.gov/MLNMattersArticles/downloads/MM7431.pdf*.

HCPCS code	Short descriptor	Effective date
0262T	*Impltj pulm vlv evasc appr*	July 1, 2011
0263T	*Im b1 mrw cel ther cmpl*	July 1, 2011
0264T	*Im b1 mrw cel ther xcl hrvst*	July 1, 2011
0265T	*Im b1 mrw cel ther hrvst onl*	July 1, 2011
0266T	*Implt/rpl crtd sns dev total*	July 1, 2011
0267T	*Implt/rpl crtd sns dev lead*	July 1, 2011
0268T	*Implt/rpl crtd sns dev gen*	July 1, 2011
0269T	*Rev/remvl crtd sns dev total*	July 1, 2011
0270T	*Rev/remvl crtd sns dev lead*	July 1, 2011
0271T	*Rev/remvl crtd sns dev gen*	July 1, 2011
0272T	*Interrogate crtd sns dev*	July 1, 2011
0273T	*Interrogate crtd sns w/pgrmg*	July 1, 2011
0274T	*Perq lamot/lam crv/thrc*	July 1, 2011
0275T	*Perq lamot/lam lumbar*	July 1, 2011
Q2041	*Wilate injection*	July 1, 2011
Q2042	*Hydroxyprogesterone caproate*	July 1, 2011
Q2043	*Sipuleucel-T auto CD54+*	July 1, 2011
Q2044	*Belimumab injection*	July 1, 2011

Additional information

In addition to the above, the Attachment of CR 7430 contains the long descriptors and all indicators relative to the new HCPCS codes in the preceding table. CR 7430 can be viewed at *http://www.cms.gov/Transmittals/downloads/R2223CP.pdf*.

Note: Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims that are affected by these changes. However, contractors will adjust such claims that you bring to their attention.

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

MLN Matters® Number: MM7430
Related Change Request (CR) #:7430
Related CR Release Date: May 20, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2223CP
Implementation Date: July 5, 2011

Update – inpatient psychiatric facilities PPS rate year 2012

Provider types affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for inpatient psychiatric services provided to Medicare beneficiaries and paid under the inpatient psychiatric facilities prospective payment system (IPF PPS) are affected.

Provider action needed

This article is based on change request (CR) 7367 which identifies changes that are required as part of the annual IPF PPS update from the rate year (RY) 2012 IPF PPS update notice, published on April 29, 2011. These changes are applicable to IPF discharges occurring during the rate year July 1, 2011, through September 30, 2012, and this is the sixth rate year (RY) update to the IPF PPS. The applicable previous year update is detailed in *MLN Matters*® article MM6986 and may be reviewed at *http://www.cms.gov/MLNMattersArticles/downloads/MM6986.pdf*. Make sure that your billing staff are aware of these IPF PPS changes.

Background

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually. The RY update is effective July 1-June 30, and the Medicare Severity Diagnosis Related Groups (MS-DRGs) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes are updated on October 1 of each year.

Note that, effective with RY 2012, the IPF PPS payment rate update period will switch from a RY that begins on July 1 ending on June 30 to a period that coincides with a fiscal year (FY.) To transition from a RY to a FY basis, the IPF PPS RY 2012 will cover the15 month period from July 1, 2011, – September 30, 2012. This change to the payment update period will allow one consolidated annual update to both the rates and the ICD-9-CM coding changes (MS-DRG and co-morbidities). Coding and rate changes will continue to be effective October 1 of each year thereafter.

Change request (CR) 7367 identifies changes that are required as part of the annual IPF PPS update from the RY 2012 IPF PPS update notice, published on April 29, 2011.

Key points of CR 7367

Market basket update

For RY 2012, CMS rebased and revised the FY 2002-based RPL (rehabilitation, psychiatric and long-term care) market basket to a FY 2008-based RPL market basket.

Section 1886(s)(3)(A) of the Social Security Act, which was added by Section 3401(f) of the Affordable Care Act, requires the application of an "Other Adjustment" that reduces any update to the IPF PPS base rate by 0.25 percentage point for the rate year beginning in 2012. Applying the market basket increase of 3.2 percent, with the "Other Adjustment" of -0.25 percentage point, and the wage index budget neutrality factor of 0.9995 to the RY 2011 Federal per diem base rate of $665.71 yields a Federal per diem base rate of $685.01 for RY 2012. Similarly, applying the market basket increase with the "Other Adjustment", and the wage index budget neutrality factor to the RY 2011 electroconvulsive therapy (ECT) rate yields an ECT rate of $294.91 for RY 2012.

Pricer updates

The federal per diem base rate is $685.01.

- The fixed dollar loss threshold amount is $7,340.00.
- The IPF PPS will use the FY 2011 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is 70.317 percent.
- The non-labor related share is 29.683 percent.
- The ECT rate is $294.91.

The national urban and rural cost to charge ratios for the IPF PPS RY 2012:

Cost to charge ratio	Median	Ceiling
Urban	0.5055	1.7643
Rural	0.6435	1.8199

CMS is applying the national median cost-to-charge ratios (CCRs) to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).

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Psychiatric...*continued*

- Other IPFs for whom the FI or A/B MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

MS-DRG update

The code set and adjustment factors are unchanged for the IPF PPS RY 2012.

FY 2010 pre-floor, pre-reclassified hospital wage index

CMS is using the updated wage index and the wage index budget neutrality factor of 0.9995.

COLA adjustment

The Office of Personal Management (OPM) began transitioning from cost of living adjustment (COLA) factors to a locality payment rate in FY 2010. The 2009 COLA factors were frozen in order to allow this transition. In order to provide a full COLA for Alaska and Hawaii, CMS is adopting the FY 2009 COLA rates obtained from the OPM website. The COLA rates for the areas of Alaska and Hawaii are reflected in the following two tables:

Alaska	Cost of living adjustment factor
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25

Hawaii	Cost of living adjustment factor
City and County of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Additional information

The official instruction, CR 7367, issued to your Medicare FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2220CP.pdf*.

If you have any questions, please contact your Medicare 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: MM7367
Related Change Request (CR) #: 7367
Related CR Release Date: May 20, 2011
Effective Date: Discharges on or after July 1, 2011
Related CR Transmittal #: R2220CP
Implementation Date: July 5, 2011

Reporting of recoupment for overpayment on the remittance advice

Note: This article was revised on June 10, 2011, to reflect a revised change request (CR) 6870 issued on June 9. The CR release date, transmittal number, implementation date for FISS, and the Web address for accessing CR 6870 have been revised. All other information is the same. This information was published in the May 2011 *Medicare A Connection*, pages 40-41.

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 can review Section 1893 at *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 CR6183 at *http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.)

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.

CR6870 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#

continued on next page

Overpayment...*continued*

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.

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 can find the guide "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/R906OTN.pdf*.

You may also want to review *MLN Matters*® article MM7068, 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: June 9, 2011
Effective Date: July 1, 2010
Related CR Transmittal #: R906OTN
Implementation Date: July 6, 2010, except July 5, 2011, for claims processed by the FISS system used by FIs and A/B MACs

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.

A7 claim adjustment reason code to force balance the remittance advice

The Centers for Medicare & Medicaid Services (CMS) has identified an institutional remittance advice problem where claim adjustment reason code A7 is being used to explain adjustments where other appropriate codes that better explain the adjustments are available. Be assured that CMS is working to resolve this problem and will inform providers when this issue has been resolved. CMS regrets any inconvenience this issue may have caused.

For more information on the remittance advice, please contact your local Medicare Administrative Contractor (MAC). A provider call center toll-free numbers directory can be found at *http://www.CMS.gov/MLNGenInfo*, in the "Downloads" section of the 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 201106-04

New electronic method for submitting Medicare graduate medical education affiliation agreements for teaching hospitals

Under the regulations at section 413.79(f) for direct graduate medical education (GME) and section 412.105(f)(1)(vi) for indirect medical education (IME), hospitals that cross-train residents in approved medical residency training programs may enter into Medicare GME affiliation agreements to elect to apply their direct GME and/or IME full-time equivalent (FTE) resident caps on an aggregate basis. Hospitals may adjust their FTE resident caps to reflect the rotation of residents among affiliated hospitals during an academic year. The regulations previously required hospitals that wished to affiliate to mail their signed Medicare GME affiliation agreements to their Medicare contractor and send a copy in the mail to the Centers for Medicare & Medicaid Services (CMS) central office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement would be in effect. In the August 16, 2010, inpatient prospective payment system (PPS) final rule (75 FR 50299), CMS finalized a policy to allow hospitals to submit Medicare GME affiliation agreements to CMS electronically. CMS has developed an electronic submission system for hospitals to send their Medicare GME affiliation agreements to CMS central office for the academic year beginning July 1, 2011. Hospitals wishing to affiliate beginning with the July 1, 2011-June 30, 2012, academic year should submit their Medicare GME affiliation agreements to CMS central office using the following email address: *Medicare_GME_Affiliation_Agreement@cms.hhs.gov*.

Medicare GME affiliation agreements for the July 1, 2011-June 30, 2012 academic year must be received by the email address above by **11:59 p.m. EDT on July 1, 2011**. If received by this time, you should receive an automatic reply indicating that your affiliation agreement submission was received timely for the July 1, 2011, academic year.

CMS encourages all teaching hospitals that wish to submit Medicare GME affiliation agreements to CMS to do so using this email address. CMS also encourages hospitals to submit the affiliation agreements in PDF format. However, because this is the first year that CMS is using this electronic submission system, it will also continue to accept hard copies of affiliation agreements that are submitted to the CMS central office no later than July 1, 2011. Faxes are not allowed. In addition, CMS will continue to accept modifications to Medicare GME affiliation agreements for the academic year July 1, 2010-June 30, 2011, in hard copy format as well. **Please do not submit amendments to the July 1, 2010-June 30, 2011, affiliation agreements to the email address.** Only new affiliation agreements for the academic year beginning on July 1, 2011, should be sent to this email address. (Modifications of the July 1, 2011-June 30, 2012, affiliation agreements may be submitted to this email address by June 30, 2012.)

With regard to Medicare GME Affiliation Agreements that you may already have in place that are set to automatically renew on July 1, 2011, you may, but are not required to, send in by July 1 an electronic copy of the applicable Medicare GME affiliation agreement to *Medicare_GME_Affiliation_Agreement@cms.hhs.gov* .

Email Medicare GME affiliation agreements for July 1, 2011-June 30, 2012 to: *Medicare_GME_Affiliation_Agreement@cms.hhs.gov.*

In addition, please note that you are to continue to submit the “contractor copy” of your Medicare GME affiliation agreements to your Medicare contractor using the procedures your Medicare contractor has specified, either hard copy mail or by email, as applicable.

Medicare_GME_Affiliation_Agreement@cms.hhs.gov is a CMS email address only, and is not linked to the Medicare contractors.

Source: CMS PERL 201106-01

Important Medicare EHR incentive program deadline

Sunday, July 3, marked an important deadline for eligible hospitals and critical access hospitals (CAHs) – the last day that eligible hospitals and CAHs could begin their 90-day reporting period in fiscal year (FY) 2011 for the Medicare electronic health record (EHR) incentive program. For hospitals, this means that they must have begun their consecutive 90-day reporting period by Sunday, July 3, if they still want to successfully demonstrate meaningful use and receive an incentive payment for FY 2011.

Resources to help

The Centers for Medicare & Medicaid Services (CMS) has developed some tools to help providers attest. Eligible hospitals and CAHs who have completed their reporting period can use the CMS Eligible Hospital and CAH Attestation Worksheet at *http://www.cms.gov/EHRIncentivePrograms/Downloads/Hospital_Attestation_Worksheet.pdf* to log their meaningful use measures to use as a reference when attesting for the Medicare EHR incentive program in the CMS system.

Additionally, the Meaningful Use Attestation Calculator (*http://www.cms.gov/apps/ehr/*) allows eligible hospitals and CAHs to test whether or not they will successfully demonstrate meaningful use for the EHR incentive programs and the Attestation User Guide for Eligible Hospitals (*http://www.cms.gov/EHRIncentivePrograms/Downloads/HospAttestationUserGuide.pdf*) will walk eligible hospitals and CAHs through the attestation system, helping them to successfully attest to meeting meaningful use.

Looking ahead

Friday, September 30, is the last day of the federal fiscal year, marking the end of the reporting year for eligible hospitals and CAHs. See what other important dates are coming in 2011 by visiting the CMS Medicare and Medicaid EHR Incentive Programs Milestone Timeline (*http://www.cms.gov/EHRIncentivePrograms/Downloads/EHRIncentProgtimeline508V1.pdf*), or reviewing the "Important Dates" section of the EHR Incentive Programs Overview Web page at *http://www.cms.gov/EHRIncentivePrograms/01_Overview.asp*.

Want more information about the EHR incentive programs? Visit the CMS EHR Incentive Programs website at *http://www.cms.gov/EHRIncentivePrograms/* for the latest news and updates on the EHR incentive programs; also sign-up for the EHR Incentive Programs email update Listserv at *http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp*.

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Source: CMS PERL 201106-33

Medicare Disproportionate Share Hospital fact sheet available in print

The publication titled *Medicare Disproportionate Share Hospital* (revised March 2011) is now available in print format from the *Medicare Learning Network*®. This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals (DSH), including background; methods to qualify for the Medicare DSH adjustment; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005 provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH hospital payment adjustment formulas. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," and select "MLN Product Ordering Page."

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Source: CMS PERL 201105-39

Long-term care hospital PPS fact sheets revised

The fact sheets listed below provide education on the long-term care hospital prospective payment system (LTCH PPS). They have been recently updated and are available in downloadable format from the *Medicare Learning Network*®:

- *Long-Term Care Hospital Prospective Payment System: News* provides information about recent updates to the LTCH PPS final rule and can be found at *http://www.CMS.gov/MLNProducts/downloads/LTCH-News.pdf*
- *Long-Term Care Hospital Prospective Payment System: Interrupted Stay* describes the payment of interrupted stays in long-term care hospitals and can be found at *http://www.CMS.gov/MLNProducts/downloads/LTCH-IntStay.pdf*
- *Long-Term Care Hospital Prospective Payment System: Short-Stay Outliers* explains the calculation and payment of short-stay outliers (SSOs) under the LTCH PPS and can be found at *http://www.CMS.gov/MLNProducts/downloads/LTCH-ShortStay.pdf*
- *Long-Term Care Hospital Prospective Payment System: High-Cost Outliers* explains the calculation of high-cost outliers under the LTCH PPS and can be found at *http://www.CMS.gov/MLNProducts/downloads/LTCH-HighCost.pdf*
- *Long-Term Care Hospital Prospective Payment System: Payment Adjustment Policy* describes the payment adjustment policy under the LTCH PPS and can be found at *http://www.CMS.gov/MLNProducts/downloads/LTCHPaymentAdjustPolicy.pdf*

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Source: CMS PERL 201106-05

Hospital Outpatient Prospective Payment System fact sheet available in hard copy

The publication titled *Hospital Outpatient Prospective Payment System* (March 2011) is now available in print format from the *Medicare Learning Network*®. 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. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," click on "MLN Product Ordering Page", and select "Hospital Outpatient Prospective Payment System (ICN 006820)(Mar 2011)" to place your order.

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Source: CMS PERL 201106-23

July 2011 update of the hospital outpatient prospective payment system

Provider types affected

This article is for providers submitting claims to Medicare Contractors [fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)] for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 7443 which describes changes to and billing instructions for various payment policies implemented in the July 2011 OPPS update. The July 2011 integrated outpatient code editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in this change request (CR). Be sure your billing staffs are aware of these changes.

Background

CR 7443 describes changes to and billing instructions for various payment policies implemented in the July 2011 OPPS update. The July 2011 I/OCE and OPPS Pricer will reflect the HCPCS, APC, HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 7443. The July 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7439, "July 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.2." The related *MLN Matters*® article can be found on the Centers for Medicare & Medicaid Services (CMS) website at *http://www.cms.gov/MLNMattersArticles/downloads/MM7439.pdf*.

Key OPPS updates for July 2011

Changes to device edits for July 2011

Procedure-to-device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Procedures for which both a Device A and a Device B are specified, require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Device-to-procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at *http://www.cms.gov/HospitalOutpatientPPS/*.

New services

The following new services are assigned for separate payment under the OPPS, effective July 1, 2011:

Table 1 – New services assigned for separate payment under the OPPS effective July 1, 2011

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9730	7/1/2011	T	0415	Bronchial thermo, 1 lobe	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 1 lobe	$1,971.77	$459.92

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Outpatient...*continued*

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9731	7/1/2011	T	0415	Bronchial thermo, >1 lobe	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 2 or more lobes	$1,971.77	$459.92

Effective July 1, 2011, HCPCS code C9729 will be deleted and replaced with new Category III *Current Procedural Terminology* (*CPT*) code *0275T*. Category III *CPT* code *0275T* will be added to the payable codes in the OPPS and assigned to the same status indicator and APC assignment as its predecessor HCPCS code C9729. Providers reporting the intralaminar decompression procedure should use *CPT* code *0275T* beginning with services rendered on or after July 1, 2011. The table below summarizes the new coding information.

Table 2 – Coding change for the intralaminar decompression procedure effective July 1, 2011

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9729	7/1/2011	Deleted	Deleted	Percut lumbar lami	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar	N/A	N/A
0275T	7/1/2011	T	0208	*Perq lamot/lam lumbar*	*Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar*	$3,535.92	$707.19

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Outpatient...*continued*

Category III *CPT* codes

The American Medical Association (AMA) releases Category III *CPT* codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to calendar year (CY) 2006, CMS implemented new Category III *CPT* codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), CMS modified their process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III *CPT* codes and some of the C-codes that are payable under the OPPS and were created by CMS in response to applications for new technology services.

For the July 2011 update, CMS is implementing in the OPPS 14 Category III *CPT* codes that the AMA released in January 2011 for implementation on July 1, 2011. Of the 14 Category III *CPT* codes, 12 are separately payable under the hospital OPPS. The Category III *CPT* codes, status indicators, and APCs are shown in Table 3 below. Payment rates for these services can be found in Addendum B of the July 2011 OPPS Update that is posted on the CMS website.

Table 3 – Category III *CPT* codes implemented as of July 1, 2011

CPT code	Long descriptor	SI	APC
0262T	*Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach*	C	N/A
0263T	*Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest*	S	0112
0264T	*Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest*	S	0112
0265T	*Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy*	S	0112
0266T	*Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)*	C	N/A
0267T	*Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)*	T	0687
0268T	*Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)*	S	0039
0269T	*Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)*	T	0221

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Outpatient...*continued*

CPT code	Long descriptor	SI	APC
0270T	*Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)*	T	0687
0271T	*Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)*	T	0688
0272T	*Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)*	S	0218
0273T	*Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming*	S	0218
0274T	*Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic*	T	0208
0275T	*Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar*	T	0208

Billing for drugs, biologicals, and radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of an item described by a reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a “new” drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, “Unclassified drug or biological,” is only for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, and for which a specific HCPCS code has not been assigned.

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Outpatient...*continued*

a. Drugs and biologicals with payments based on average sales price (ASP) effective July 1, 2011

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead cost associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead cost of these pass-through items. CMS notes that for the third quarter of CY 2011, payment for drugs and biologicals with pass-through status is not made at the Part B drug competitive acquisition program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals that are a part of the Part B drug CAP program, as required by the statute.

In the CY 2011 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2011 release of the OPPS Pricer. The updated payment rates, effective July 1, 2011, will be included in the July 2011 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site. The addendums are at *http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp* on the CMS website.

b. Drugs and biologicals with OPPS pass-through status effective July 1, 2011

Seven drugs and biologicals have been granted OPPS pass-through status effective July 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 4 below.

Table 4 – Drugs and biologicals with OPPS pass-through status drugs and biological with OPPS pass-through status effective July 1, 2011

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/11
C9283*	Injection, acetaminophen, 10 mg	9283	G
C9284*	Injection, ipilimumab, 1 mg	9284	G
C9285*	Lidocaine 70 mg/tetracaine 70 mg, per patch	9285	G
C9365*	Oasis ultra tri-layer matrix, per square centimeter	9365	G
C9406*	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	9406	G
J1572	Injection, immune globulin, (flebogamma/ flebogamma dif), intravenous, non-lyophilized (e.g. liquid), 500 mg	0947	G
Q2044*	Injection, belimumab, 10 mg	1353	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2011.

c. New HCPCS codes effective July 1, 2011, for certain drugs and biologicals

Three new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biologicals listed above in Table 4) in the hospital outpatient setting for July 1, 2011. These codes are listed in Table 5 below and are effective for services furnished on or after July 1, 2011. HCPCS code Q2041 is replacing HCPCS code J7184 beginning on July 1, 2011, and HCPCS code Q2043 is replacing HCPCS code C9273 beginning on July 1, 2011.

Table 5 – New HCPCS codes effective July 1, 2011, for certain drugs and biologicals

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/11
Q2041	Injection, von willebrand factor complex (human), Wilate, 1 i.u. vwf:rco	1352	G
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	1354	K

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Outpatient...*continued*

HCPCS code	Long descriptor	APC	Status indicator effective 7/1/11
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	9273	G

Supplemental information on HCPCS code Q2043 (Provenge)
HCPCS code Q2043 is replacing HCPCS code C9273 beginning on July 1, 2011. In CR 7117, Transmittal 2050, dated September 17, 2010, CMS clarified the reporting of HCPCS code C9273. Since HCPCS code Q2043 is a replacement code for HCPCS code C9273, the reporting instructions for HCPCS code C9273 also apply to HCPCS code Q2043. That is, the language in the long descriptor of HCPCS code Q2043 that states "all other preparatory procedures" refers to the entire process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, sending the immune cells to the facility that prepares the immunotherapy product, and then transporting the immune cells back to the site of service to be administered to the patient.

d. Updated payment rate for HCPCS code J2505 effective April 1-June 30, 2010

The payment rate for HCPCS code J2505 was incorrect in the April 2010 OPPS Pricer. The corrected payment rate is listed in Table 6 below and has been installed in the July 2011 OPPS Pricer, effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after April 1, 2010, but prior to July 1, 2010, contain HCPCS code J2505, and were originally processed prior to the installation of the July 2011 OPPS Pricer.

Table 6 – Updated payment rates for HCPCS code J2505 effective April 1-June 31, 2010

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J2505	K	9119	Injection, pegfilgrastim 6mg	$2,386.39	$477.28

e. Updated payment rates for certain HCPCS codes effective July 1-September 30, 2010

The payment rates for several HCPCS codes were incorrect in the July 2010 OPPS Pricer. The corrected payment rates are listed in Table 7 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after July 1, 2010, but prior to October 1, 2010, contain a HCPCS code from Table 7, and were originally processed prior to the installation of the July 2011 OPPS Pricer.

Table 7 – Updated payment rates for certain HCPCS codes effective July 1-September 30, 2010

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J0150	K	0379	Injection adenosine 6 MG	$11.47	$2.29
J2430	K	0730	Pamidronate disodium /30 MG	$15.12	$3.02
J2505	K	9119	Injection, pegfilgrastim 6mg	$2,423.91	$484.78
J9065	K	0858	Inj cladribine per 1 MG	$25.61	$5.12
J9178	K	1167	Inj, epirubicin hcl, 2 mg	$2.19	$0.44
J9200	K	0827	Floxuridine injection	$34.99	$7.00
J9206	K	0830	Irinotecan injection	$3.36	$0.67
J9208	K	0831	Ifosfomide injection	$29.83	$5.97

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Outpatient...*continued*

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9209	K	0732	Mesna injection	$4.15	$0.83
J9211	K	0832	Idarubicin hcl injection	$41.14	$8.23
J9263	K	1738	Oxaliplatin	$4.35	$0.87
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$44.38	$8.88

f. Updated payment rates for certain HCPCS codes effective October 1-December 31, 2010

The payment rates for several HCPCS codes were incorrect in the October 2010 OPPS Pricer. The corrected payment rates are listed in Table 8 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on October 1, 2010, through implementation of the January 2011 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after October 1, 2010, but prior to January 1, 2011, contain a HCPCS code from Table 8, and were originally processed prior to the installation of the July 2011 OPPS Pricer.

Table 8 – Updated payment rates for certain HCPCS codes effective October 1-December 31, 2010

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J0150	K	0379	Injection adenosine 6 MG	$9.59	$1.92
J2430	K	0730	Pamidronate disodium /30 MG	$11.81	$2.36
J9065	K	0858	Inj cladribine per 1 MG	$24.97	$4.99
J9178	K	1167	Inj, epirubicin hcl, 2 mg	$9.17	$1.83
J9185	K	0842	Fludarabine phosphate inj	$158.16	$31.63
J9200	K	0827	Floxuridine injection	$32.17	$6.43
J9206	K	0830	Irinotecan injection	$4.68	$0.94
J9208	K	0831	Ifosfomide injection	$31.54	$6.31
J9209	K	0732	Mesna injection	$4.62	$0.92
J9211	K	0832	Idarubicin hcl injection	$84.06	$16.81
J9263	K	1738	Oxaliplatin	$4.60	$0.92
J9266	K	0843	Pegaspargase injection	$2,675.40	$535.08
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$33.48	$6.70

g. Updated payment rates for certain HCPCS codes effective January 1-March 31, 2011

The payment rates for several HCPCS codes were incorrect in the January 2011 OPPS Pricer. The corrected payment rates are listed in Table 9 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on January 1, 2011, through implementation of the April 2011 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2011, but prior to April 1, 2011, contain a HCPCS code from Table 9, and were originally processed prior to the installation of the July 2011 OPPS Pricer.

Table 9 – Updated payment rates for certain HCPCS codes effective January 1-March 31, 2011

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9065	K	0858	Inj cladribine per 1 MG	$24.93	$4.99
J9178	K	1167	Inj, epirubicin hcl, 2 mg	$1.90	$0.38

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HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9200	K	0827	Floxuridine injection	$37.92	$7.58
J9206	K	0830	Irinotecan injection	$5.31	$1.06
J9208	K	0831	Ifosfomide injection	$33.40	$6.68
J9211	K	0832	Idarubicin hcl injection	$118.41	$23.68
J9265	K	1309	Paclitaxel injection	$6.95	$1.39
J9266	K	0843	Pegaspargase injection	$2,701.13	$540.23
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$33.36	$6.67

h. Correct reporting of biologicals when used as implantable devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

i. Correct reporting of units for drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient; hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

As discussed in the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 17, Section 40 (see *http://www.cms.gov/manuals/downloads/clm104c17.pdf*), CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare

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pays for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

j. Reporting of outpatient diagnostic nuclear medicine procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year (CY) prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent CY, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

Where a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under the Social Security Act (section 1861(w)(1); see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*), and as discussed in 42 CFR 410.28(a)(1) (see *http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr410.28.pdf*) and defined in 42 CFR 409.3 (see *http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr409.3.pdf*), where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

g. Use of HCPCS code C9399

As stated in the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17, Section 90.3 (see *http://www.cms.gov/manuals/downloads/clm104c17.pdf*), hospitals are to report HCPCS code C9399, Unclassified drug or biological, solely for new outpatient drugs or biologicals that are approved by the FDA on or after January 1, 2004 and that are furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned. It is not appropriate to report HCPCS code C9399 for drugs and biologicals that are defined as usually self-administered drugs by the patient as defined in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2 (see *http://www.cms.gov/manuals/Downloads/bp102c15.pdf*).

Reporting hours of observation

Under current OPPS payment policy, observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). CMS is revising billing instructions to state that in situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services. CMS is updating the *Medicare Claims Processing Manual*, Pub.100-04, Chapter 4, Section 290.2.2 (which is included as an attachment to CR 7443) to reflect the revised observation reporting guidelines.

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Reporting critical care services under the OPPS

Beginning January 1, 2011, under revised AMA CPT Editorial Panel guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care (CPT codes 99291 and 99292). CMS continues to recognize the existing CPT codes for critical care services and has established a payment rate based on its historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE logic conditionally packages payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services does not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

Effective January 1, 2011, National Correct Coding Initiative edits for the hospital OPPS that disallow the reporting of critical care services with ancillary services will be deleted retroactive to January 1, 2011. The I/OCE generates Correct Coding Initiative (CCI) edits for OPPS hospitals. Providers whose claims contained lines that were denied or rejected due to the critical care CCI edits for ancillary services from January 1, 2011, through June 30, 2011, may request contractor adjustment of the previously processed claims.

Payment window for outpatient services treated as inpatient services

The payment window for outpatient services treated as inpatient services policy, specifically described in Transmittal 796, CR 7142, issued on October 29, 2010, (see the corresponding *MLN Matters* article for CR7142 at *http://www.cms.gov/MLNMattersArticles/downloads/MM7142.pdf*), states that 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. Hospitals may attest to specific non-diagnostic services as being unrelated to the inpatient stay (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding condition code 51 (definition "51 – Attestation of Unrelated Outpatient Non-diagnostic Services) to the separately billed outpatient non-diagnostic services claim starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010.

CMS is adding section 10.12 to the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 4, (which is included as an attachment to CR 7443) to reflect the regulatory and statutory policy changes outlined in CR7142. CMS is also revising section 180.7 of the *Claims Processing Manual*, Pub. 100-04, Chapter 4, (which is included as an attachment to CR 7443) to clarify that CMS will not pay for "inpatient-only" procedures that are provided to a patient in the outpatient setting on the date of the patient's inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission.

Billing for linear accelerator (robotic image-guided and non-robotic image-guided) SRS planning and delivery

CMS is updating the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 4, Section 200.3.4 (which is included as an attachment to CR 7443) to correct a typographical error citing HCPCS code G0039 rather than G0339.

Changes to OPPS Pricer logic

a. Rural sole community hospitals (SCH) and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Social Security

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Act, as added by Section 411 of Pub. L. 108-173. However, the rural SCH and EACH 7.1 percent payment increase does not apply to services billed on a non-patient bill type 014x.

b. Effective for claims with a date of service on or after January 1, 2011, the OPPS Pricer will not apply deductible and coinsurance amounts for preventive care services waived by Section 4104 of the Patient Protection and Affordable Care Act (the Affordable Care Act) as appropriate.

Additional items

Medicare contractors will adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2011, but prior to July 1, 2011, include *CPT* codes *99291* and/or *99292*, and were originally processed prior to the installation of the revised July 2011 I/OCE.

Medicare contractors will also adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2006, but prior to July 1, 2011, where the provider is a rural sole-community hospital that received the 7.1 percent add-on for laboratory services, contain a type of bill 14x, and were originally processed prior to the installation of the revised July 2011 I/OCE.

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries (FIs)/Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 7443, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2234CP.pdf*.

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

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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.

Recovery audit program DRG coding vulnerabilities for inpatient hospitals

Provider types affected

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

Provider action needed

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

Background

Section 302 of the Tax Relief and Health Care Act of 2006 made the recovery audit program permanent and required the Secretary to expand the program to all 50 states by no later than 2010. Each recovery auditor is responsible for identifying overpayment and underpayments in approximately a quarter of the country. The recovery audit program jurisdictions match the durable medical equipment Medicare administrative contractor (DME MAC) jurisdictions. [See the recovery audit program information at *http://www.cms.gov/RAC/01_Overview.asp#TopOfPage* on the Centers for Medicare & Medicaid Services (CMS) website.] In 2009, CMS developed a phased in approach to reviewing claims submitted in the FFS program. Recovery auditors began with automated and DRG validation review.

Issues/vulnerabilities

One of CMS' strategies to reduce the comprehensive error rate testing (CERT) error rate is to correct identified vulnerabilities discovered by the recovery auditors and other Medicare contractors. Recovery auditors have identified coding errors while performing DRG validation review. DRG validation review focuses on the hospital's selection of principal and secondary diagnoses and procedures on a claim. A significant amount of claims have an incorrect principal diagnosis.

Recovery auditors review the entire medical record when performing DRG validation. Some hospitals may choose to code the record prior to receiving the complete medical record (e.g., not waiting for discharge summary or operative reports). Hospitals do this at their own risk since they are responsible for reporting codes that accurately reflect the patient's conditions and procedures. Therefore hospitals may increase their chance of errors by choosing to code the case prior to receiving the complete medical record. Recovery auditors will not take this into consideration.

The emergency room report, history and physical (H&P), and early progress notes may indicate the patient has one condition, but continuing workup and evaluation may determine something entirely different. By having access to the complete medical record, more accurate codes can be assigned. Recovery auditors will review data from the entire medical record.

When coding claims, if there is conflicting or contradictory information in the medical record, a coder should query the attending physician to clarify the correct principal and secondary diagnoses.

Remember that the "Coding Clinic, First Quarter 2004" states, if there is conflicting physician documentation, and the coder fails to query the attending physician to resolve the conflict, hospitals are encouraged to code the attending physician's version. However, the failure of the attending physician to mention a consultant's diagnosis is not a conflict. So, if the consultant documents a diagnosis and the attending physician doesn't mention it at all, it is acceptable to code it. A conflict occurs when two physicians call the same condition two different things – for example, the attending physician documents a sprained ankle and the orthopedist refers to the same injury as a fracture.

As with all codes, clinical evidence should be present in the medical record to support code assignment. The Uniform Hospital Discharge Data Set (UHDDS) Guidelines for coding and reporting secondary diagnosis allow the reporting of any condition that is clinically evaluated, diagnostically tested for, therapeutically treated, or increases nursing care or the length of stay of the patient.

Principal diagnosis is defined in the UHDDS as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. When determining the principal diagnosis, all documentation by licensed, treating physicians in the medical record must be considered.

All ICD-9-CM coding guidelines can be found at: *http://www.cdc.gov/nchs/data/icd9/icdguide09.pdf*.

Additional information

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*.

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Critical Access Hospitals

Critical access hospital optional method election for outpatient services

Provider types affected

Critical access hospitals (CAHs) paid under the optional method election (Method II) submitting claims for outpatient services to fiscal intermediaries (FI) and A/B Medicare administrative contractors (A/B MAC) are affected by this article.

What you need to know

Prior to a change made in the fiscal year (FY) 2011 inpatient prospective payment system (IPPS) final rule, if a CAH chose to be paid under the optional method (Method II), it was required to make that election on an annual basis.

However, in the FY 2011 IPPS final rule, the Centers for Medicare & Medicaid Services (CMS) changed the regulations for the optional method election.

- Effective for cost reporting periods beginning on or after October 1, 2010, if you elected the optional method in your most recent cost reporting period beginning before October 1, 2010, that election remains in place until you submit a termination request to your FI or A/B MAC. You will no longer be required to make an annual election.
- Effective for cost reporting periods beginning on or after October 1, 2010, if you had not elected the optional method in your most recent cost reporting period beginning before October 1, 2010, and wish to elect the optional method or you had elected that method in your most recent cost reporting period beginning before October 1, 2010, but had terminated that election, and you wish to re-elect the optional method, that election remains in place until you submit a termination request to your FI or A/B MAC. You will no longer be required to make an annual election.
- Effective for cost reporting periods beginning on or after October 1, 2010, if you choose to terminate your optional method election, you must submit a termination request to your FI or A/B MAC at least 30 days prior to the start of the next cost reporting period.
- Effective for cost reporting periods beginning on or after October 1, 2010, if you had not been paid under the optional method in your most recent cost reporting period beginning before October 1, 2010, or had been paid using the optional method in your most recent cost reporting period beginning before October 1, 2010, but had terminated that election, and you choose to be paid under the optional method on or after October 1, 2010, you must make this election in writing and that election must be delivered to your FI or A/B MAC at least 30 days before the start of the first cost reporting period for which the election is effective.

Please be sure that your staffs are aware of these changes.

Background

CAHs can be paid for outpatient services using either the standard method (also referred to as “Method I”) or the optional method (also referred to as “Method II”). Under the standard method, the physician or practitioner is paid under the physician fee schedule for the professional service by their carrier or A/B MAC whereas, under the optional method, the physician or practitioner reassigns his or her billing rights to the CAH and the CAH is paid 115 percent of the physician fee schedule amount for the professional service by the FI or A/B MAC. Under both methods, facility services are reimbursed at 101 percent of reasonable cost.

Additional information

The official instruction, CR 7404 issued to your FI and A/B MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2232CP.pdf*. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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Implementation Date: October 3, 2011

October quarterly update to 2011 HCPCS codes used for SNF consolidated billing enforcement

Provider types affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs),) for skilled nursing facility (SNF) services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 7444 which provides the October quarterly update to the 2011 Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (CB) enforcement. CR 7444 instructs the Medicare system maintainers to add HCPCS code J0894 (Injection, decitabine, 1 mg) to the File 1 coding list for SNF CB and to Major III.A chemotherapy services list in the FI/A/B MAC file for dates of service on or after January 1, 2011.

Background

The Social Security Act (Section 1888; see *http://www.ssa.gov/OP_Home/ssact/title18/1888.htm*) codifies the skilled nursing facility prospective payment system (SNF PPS) and CB, and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. No additional services are added by these routine updates. New updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

Services excluded from the SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to Medicare contractors, including durable medical equipment (DME) MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR 7444 instructs that:

- Medicare system maintainers will add HCPCS code J0894 to the File 1 coding list for SNF CB for dates of service on or after January 1, 2011; and
- Medicare system maintainers will add HCPCS code J0894 to Major Category III. A chemotherapy services list in the FI/A/B MAC file effective January 1, 2011.

Note that Medicare contractors will reprocess claims affected by CR 7444 when brought to their attention.

Additional information

The official instruction, CR 7444, issued to your carriers, FIs, or A/B MACs regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R2237CP.pdf*.

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

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Implementation Date: October 3, 2011

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Manual clarifications for skilled nursing facility Part A billing

Note: This article was revised on June 21, 2011, to revise language listed under Ancillary Services (in bold). The CR release date, transmittal number, and the Web address for accessing change request (CR) 7339 were also revised in this article. This article was previously revised on June 15, 2011, to clarify the usage of occurrence code 16 and the definition of billed therapy units on Part A SNF claims. In addition, the effective and implementation dates were revised to allow providers time to adjust their billing systems. All other information remains the same. This information was previously published in the April 2011 *Medicare A Connection*, page 49.

Provider types affected

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

Provider action needed

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

Background

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

Billing SNF prospective payment services (PPS)

In all cases where an end of therapy (EOT) – other Medicare required assessment (OMRA) is completed, SNFs must submit occurrence code 16, date of last therapy, to indicate the last day of therapy services (e.g. physical therapy, occupational, and speech language pathology) for the beneficiary.

Coding PPS bills for ancillary services

For therapy services (revenue codes 042x, 043x, and 044x), units represent the number of sessions of therapy provided. For example, if the beneficiary received physical therapy, **occupational therapy or speech-language pathology** on May 1, that would be considered one calendar day and would be billed as one unit.

Reprocessing inpatient bills in sequence

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

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

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

Additional leave of absence guidance

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

Clarification of technical component

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

Additional information

The official instruction, CR 7339 issued to your FI or A/B MAC regarding this change may be viewed at *http://www.cms.gov/transmittals/downloads/R2245CP.pdf*.

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

MLN Matters® Number: MM7339 Revised
Related Change Request (CR) #: 7339
Related CR Release Date: June 17, 2011
Effective Date: August 1, 2011
Related CR Transmittal #: 2245CP
Implementation Date: August 1, 2011

Five star quality rating system

Previews displaying information about complaints and enforcement actions will be available for providers from the Certification and Survey Provider Enhanced Reports (CASPER) link located at the top of your Minimum Data Set (MDS) State Welcome page beginning Wednesday, June 15, 2011. Nursing Home Compare will display this information on July 21, 2011. The provider 5 star helpline (800-839-9290) will be open for an extended period through Tuesday, June 21, 2011. Provider questions may also be addressed to *bettercare@cms.hhs.gov*.

Information about complaints and enforcement actions will be available for providers from the CASPER link located on the MDS State Welcome page beginning Wednesday, June 15, 2011.

Source: CMS PERL 201106-27

Take advantage of FCSO's exclusive PDS report

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

Inpatient rehabilitation facility PPS PC Pricer update

The fiscal year (FY) 2011 inpatient rehabilitation facility (IRF) prospective payment system (PPS) PC Pricer has been updated with corrected provider data. The PC Pricer is ready for download from the Centers for Medicare & Medicaid Services (CMS) Web page at *http://www.cms.gov/PCPricer/06_IRF.asp*. If you use the IRF PPS PC Pricer, please go to the page above and download the latest version of the FY 2011 Pricers, updated June 15, 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 201106-28

Comprehensive Error Rate Testing – Outpatient Rehabilitation Therapy Services fact sheet

A new publication titled *Comprehensive Error Rate Testing (CERT) – Outpatient Rehabilitation Therapy Services* is now available from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/Outpatient_Rehabilitation_Fact_Sheet_ICN905365.pdf*. This fact sheet is designed to provide education on outpatient rehabilitation therapy services to Medicare fee-for-service 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 201106-41

Be proactive: Use the PDS report

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

Accessible through FCSO's PDS portal at *http://medicare.fcso.com/PDS/index.asp*

Educational Events

Upcoming provider outreach and educational events – July 2011

Bimonthly Medicare Part A ACT: Medicare changs and hot issues

When: Tuesday, July 12
Time: 11:30 a.m. – 1:00 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Bimonthly Medicare Part A ACT: Medicare data and CMS initiatives

When: Tuesday, July 19
Time: 2:00 – 3:30 p.m. ET **Delivery language:** English
Type of Event: Webcast **Focus:** Florida, Puerto Rico, and the U.S. Virgin Islands

Two easy ways to register

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

Comprehensive Error Rate Testing – Evaluation and Management Services: Overview fact sheet

A new publication titled *Comprehensive Error Rate Testing (CERT) -- Evaluation and Management (E/M) Services: Overview* is now available in downloadable format from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Evaluation_Management_Fact_Sheet_ICN905363.pdf*. This fact sheet is designed to provide education on evaluation and management services to Medicare fee-for-service 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 201105-39

How to Search the Medicare Coverage Database booklet revised

The publication titled How to Search the Medicare Coverage Database (revised April 2011) is now available in downloadable format from the *Medicare Learning Network*® at *http://www.cms.gov/MLNProducts/downloads/MedicareCvrgeDatabase_ICN901346.pdf*. It was designed to provide education about how to use the Medicare Coverage Database (MCD) and includes an explanation of the database and how to use the search, indexes and reports, and download features.

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

Source: CMS PERL 201105-39

How to Protect Your Identity Using the PECOS fact sheet revised

The fact sheet titled *How to Protect Your Identity Using the Provider Enrollment, Chain, and Ownership System (PECOS)* has been revised and may now be downloaded from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf*. This fact sheet is designed to provide education and step-by-step instructions on identity-protection when using Internet-based provider enrollment, chain, and ownership system (PECOS).

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

Source: CMS PERL 201106-23

HIV screening brochure

The *Human Immunodeficiency Virus (HIV) Screening* brochure, which is designed to provide education on Medicare-covered HIV screening, is now available in downloadable format, free-of-charge, from the *Medicare Learning Network*®. To view, print, or download the brochure, please visit *http://www.CMS.gov/MLNProducts/downloads/HIV_brochure_ICN905713.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 201106-41

Now available – *Guide to Medicare Preventive Services, Fourth Edition*

The Guide to Medicare Preventive Services, Fourth Edition, which is designed to provide education on Medicare's preventive benefits, has been updated to reflect Affordable Care Act provisions and may be downloaded free-of-charge from the *Medicare Learning Network*®. To view, print, or download this product, visit *http://www.CMS.gov/MLNProducts/downloads/MPS_guide_web-061305.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 201106-23

Updates from the *Medicare Learning Network*®

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 the page and check back often as a new "fast fact" will be added each month.

Information and Education Resources for Medicare Fee-For-Service Healthcare Providers fact sheet revised

The *Information and Education Resources for Medicare Fee-For-Service Healthcare Providers* fact sheet (revised May 2011) is now available for download at *http://www.CMS.gov/MLNProducts/downloads/FFS_health_care_professionals_fact_sheet.pdf*. This fact sheet details the information and education resources that the Centers for Medicare & Medicaid Services (CMS) has developed to help meet the Medicare business needs of FFS physicians and other health care professionals.

Mental Health Services booklet available in hard copy

A new publication titled *Mental Health Services* is now available in print format from the *Medicare Learning Network*®. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, eligible professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services. To place your order, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," and select "MLN Product Ordering Page." An errata sheet, which provides corrections or changes that have been identified since implementation of the publication, is available at *http://www.CMS.gov/MLNProducts/downloads/Errata_Sheet-Mental_Health_Services_ICN903195.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 201106-41

News from the *Medicare Learning Network*®

Redesigned *MLN Matters* article index

The 2004 through 2011 *MLN Matters*® article indices have been redesigned. These indices are based on common keywords and were updated to link directly to related *MLN Matters*® articles. To view an article associated with a particular keyword or phrase, simply click on the link related to that keyword or phrase from the index. Visit the *MLN Matters*® Articles Web page at *http://www.cms.gov/MLNMattersArticles/* or *http://www.CMS.gov/MLNProducts/downloads/2004-2011-Article-Index.pdf* for a complete index of articles released since 2004.

New and revised "Guided Pathways" booklets (basic, A & B, and provider specific)

The revised *MLN* "Guided Pathways" curriculum is designed to allow learners to easily identify and select resources by clicking on topics of interest. The curriculum begins with basic knowledge for all providers and then branches to information for either those enrolling on the 855B, I, and S forms or on the 855A form (or Internet-based PECOS equivalents). The new *MLN Guided Pathways Provider Specific* resource booklet provides various specialties of health care professionals, suppliers, and providers with resources specific to their specialty including Internet-only manuals (IOMs), *Medicare Learning Network*® publications, CMS Web pages, and more.

There are four resource booklets included in the series:

1. *MLN Guided Pathways to Medicare Resources – Basic Curriculum for Healthcare Professionals, Suppliers, and Providers* (April 2011, PDF) at *http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf*
2. MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Healthcare Providers (Part A – April 2011, PDF) *http://www.cms.gov/MLNEdWebGuide/downloads/Guided_Pathways_Intermediate_PartA_Booklet.pdf*
3. *MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Healthcare Professionals and Suppliers* (Part B – April 2011, PDF) at *http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Intermediate_PartB_Booklet.pdf*
4. *MLN Guided Pathways to Medicare Resources Provider Specific* (April 2011, PDF) at *http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf*

All of the MLN Guided Pathways booklets above can be located at *http://www.CMS.gov/MLNEdWebGuide/30_Guided_Pathways.asp*.

"World of Medicare" Web-based training revised

The "World of Medicare" Web-based training (WBT) course has been revised (as of January 2011). It is designed for health care professionals who want to understand the fundamentals of the Medicare program and covers Medicare Part A, Part B, Part C, and Part D; identifying Medicare beneficiary health insurance options; eligibility and enrollment; as well as recognizing how Medigap and Medicaid work with the Medicare program. This WBT course offers continuing education credits; please see the course description for details.

To access the training course, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," select "Web-Based Training (WBT) Modules," and then select "World of Medicare (Developed: January 2010/Revised January 2011)" from the list of trainings provided.

"Your Office in the World of Medicare" Web-based training revised

"Your Office in the World of Medicare" Web-based training (WBT) course has been revised (as of February 2011). It is designed to provide education on the fundamentals of the Medicare program, and includes information about Parts A, B, C, and D; beneficiary health insurance options; eligibility and enrollment; and how Medigap and Medicaid work with the Medicare Program. This WBT course offers continuing education credits; please see the course description for details.

To access the training course, visit *http://www.CMS.gov/MLNGenInfo*, scroll to "Related Links Inside CMS," select "Web-Based Training (WBT) Modules," and then select "Your Office in the World of Medicare (Developed: January 2010/Revised February 2011)" from the list of trainings provided.

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

Source: CMS PERL 201105-39

Information from the *Medicare Learning Network*®

Join the *MLN* education products Listserv

Want to be among the first to know about new and updated Medicare Learning Network® (MLN) products and resources? The MLN education products Listserv is for you.

By joining this Listserv, you will receive the latest news about new and revised MLN products, including information on Medicare-related topics such as provider enrollment, preventive services, claims processing, provider compliance, payment policies, and the MLN provider exhibit program. MLN products are created in a variety of formats, such as fact sheets, brochures, quick reference charts, podcasts, and web-based training courses, to meet your preferred learning style.

To sign up, visit *http://list.NIH.gov/searchlsv.html* and search for "MLN." Select "MLN_EDUCATION_PRODUCTS-L," (*https://list.nih.gov/cgi-bin/wa.exe?A0=mln_education_products-l*) then follow the prompts to obtain a password. Once you create a password, you will be able to subscribe to a list and change your subscription options.

The Centers for Medicare & Medicaid Services (CMS) looks forward to you joining the *Medicare Learning Network*® family. If you have any questions, please contact *MLN@cms.hhs.gov*.

New *Introduction to the Medicare Program* publication

A new booklet titled *Introduction to the Medicare Program* is now available from the *Medicare Learning Network*® at *http://www.CMS.gov/MLNProducts/downloads/Introduction_to_Medicare_ICN906285.pdf*. This publication is designed to provide education on the Medicare program, other health insurance plans, and organizations of interest to providers and beneficiaries.

Telehealth Services fact sheet now available in hard copy

The publication titled *Telehealth Services* (March 2011) is now available in print format from the *Medicare Learning Network*®. 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. 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 201106-35

CMS wants your feedback on its *MLN Matters*® articles

Your feedback is important to the Centers for Medicare & Medicaid Services (CMS). CMS uses your suggestions to help improve its *MLN Matters*® articles, so they better meet your educational needs. To evaluate *MLN Matters*® articles, please visit *http://www.CMS.gov/MLNProducts/85_Opinion.asp*, select "MLN Evaluations" from the "Related Links Inside CMS" section, and then select "MLN Matters Articles" from the list of products. Please send any comments or suggestions for *MLN Matters*® articles to *MLN@cms.hhs.gov*.

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

Source: CMS PERL 201106-23

News on CMS preventive services

Share the news; share the health – CMS prevention campaign kicks off

Help the Centers for Medicare & Medicaid Services (CMS) share the news about the important benefits of Medicare's preventive services, including the new annual wellness visit (AWV). Beginning January 1, 2011, the Affordable Care Act allowed for coverage of critical new benefits for Medicare beneficiaries, including the addition of a free AWV. This expanded coverage allows physicians to provide personalized prevention plan services that consider both age-appropriate preventive services available to all Medicare beneficiaries and additional services that may be appropriate to the patient's individual needs.

Note: Medicare provides coverage of the AWV as a Medicare Part B benefit. The beneficiary will pay nothing for the AWV as there is no coinsurance or copayment and no Medicare Part B deductible for these benefits.

Resources on the annual wellness visit

The *Medicare Learning Network®* is your source for educational products on Medicare policy. Several products are available to help you understand the components of the AWV and include information on coverage, coding, billing, reimbursement, and claims filing procedures.

- Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (*http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf*)
- MLN Matters Article MM7079: "Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)" (*http://www.cms.gov/MLNMattersArticles/downloads/MM7079.pdf*)
- Visit the Medicare Learning Network® Preventive Services Web page at *http://www.cms.gov/MLNProducts/35_PreventiveServices.asp* for a complete list of available products for Medicare fee-for-service providers and suppliers.
- Order materials at *http://productordering.cms.hhs.gov/* that you and your patients can use to start the conversation about Medicare's preventive services, including "Questions to Ask about Medicare Preventive Services" at *http://www.medicare.gov/Publications/Pubs/pdf/11542.pdf*.

Want to learn more and hear from CMS experts?

Save the date: A national provider call on "The ABCs of the Initial Preventive Physical Examination and Annual Wellness Visit" will be held on Thursday, July 21.

More people with Medicare receiving free preventive care

On June 20, CMS released a new report (available at *http://downloads.cms.gov/files/preventionreport.pdf)* showing that more than 5 million Americans with traditional Medicare – or nearly one in six people with Medicare – took advantage of one or more of the recommended preventive benefits now available for free thanks to the Affordable Care Act. According to the report, more that 5.5 million beneficiaries in traditional Medicare used one or more of the preventive benefits now covered without cost-sharing, including, most prominently, mammograms, bone-density screenings, and screenings for prostate cancer.

This announcement comes during Prevention & Wellness Month, as the Obama administration is highlighting announcements, activities, and tips that will help Americans get healthy and stay healthy.

A more extensive press release on this topic may be found at *http://www.CMS.gov/apps/media/press/release.asp?Counter=3987*.

New healthcare advisory on preventive services available from Medscape

For those who might not have already been aware, CMS has begun working with Medscape.org (*http://www.medscape.org/* to disseminate educational information of interest to the health care provider community as widely and effectively as possible.

Please note that a new Medscape Healthcare Advisory is available on preventive services, and may be found at *http://www.Medscape.org/viewarticle/743624*.

In addition, the Healthcare Reform Destination Page titled Healthcare Updates: Highlights from CMS, was launched on June 15, and is available at *http://www.Medscape.org/sites/advances/healthcare-updates*. This page is will serve as a destination for providers, encompassing CMS health reform content, continuing medical education (CME) activities and other resources, and information and links. This is a dynamic, "living" page that will be updated as additional content is developed and new topics are highlighted.

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

Source: CMS PERL 201106-44

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

Medicare Part A Connection subscription form

Medicare A Connection is published monthly by First Coast Service Options Inc. (FCSO).It is available in both Spanish and English, free of charge online at *http://medicare.fcso.com/Publications/* (English) or *http://medicareespanol.fcso.com/Publicaciones/* (Español).

Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published from October 2010 through September 2011.

To order an annual subscription, please complete and submit this form along with your check/money order payable to *FCSO Account # 40-500-150*.

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		Total		**$**

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Provider/Office Name: _____

Telephone Number (including area code): _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Medicare A *Connection*

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